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MEDICAL STAFF BYLAWS

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

The definitions that apply to terms used in all the Medical Staff documents are set forth in Appendix A to these Bylaws.

1.B. DELEGATION OF FUNCTIONS

(1) When a function under these Bylaws is to be carried out by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a practitioner or Hospital employee (or a committee of such individuals). Any such designee must treat and maintain all credentialing, privileging, and peer review information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of the Medical Staff Bylaws and related policies. In addition, the delegating individual or committee is responsible for ensuring that the designee appropriately performs the function in question. Any documentation created by the designee are records of the committee that is ultimately responsible for the review in a particular matter.

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

1.C. MEDICAL STAFF DUES

(1) Annual Medical Staff dues shall be as recommended by the MEC and may vary depending upon staff category and/or privilege status.

(2) Dues shall be payable upon request. Failure to pay dues shall result in automatic relinquishment of clinical privileges and/or ineligibility to apply for Medical Staff reappointment.

(3) Signatories to the Hospital's Medical Staff account shall be the President of the Medical Staff and the President-Elect of the Medical Staff.

ARTICLE 2

CATEGORIES OF THE MEDICAL STAFF

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

2.A. ACTIVE STAFF

2.A.1. Qualifications:

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

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

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

Guidelines:

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

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

** The member will be transferred to another staff category that best reflects his or her relationship to the Medical Staff and the Hospital (options – Associate, Consulting, or Affiliate). Members with fewer than six patient contacts will be transferred to the Affiliate Staff.

2.A.2. Prerogatives:

Active Staff members may:

(a) admit patients without limitation, except as otherwise provided in their specific delineation of clinical privileges, the Bylaws or Bylaws-related documents, or as limited by the Board;

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

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

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

2.A.3. Responsibilities:

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

(a) serving on committees, as requested;

(b) providing specialty coverage for the Emergency Department and accepting referrals from the Emergency Department for follow-up care of patients treated in the Emergency Department;

(c) providing care for unassigned patients;

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

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

(f) accepting inpatient consultations, when requested;

(g) paying any applicable application fees, dues, and assessments; and

(h) performing assigned duties.

2.B. ASSOCIATE STAFF

2.B.1. Qualifications:

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

(a) do not meet the criteria for appointment to the Active Staff;

(b) are involved in at least six, but fewer than 24, patient contacts per two-year appointment term; and

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

Guidelines:

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

* Any member who has fewer than six patient contacts during his or her two-year appointment term will be transferred to the Affiliate Staff.

** Any member who has 24 or more patient contacts during his or her two-year appointment term shall be automatically transferred to Active Staff status.

2.B.2. Prerogatives and Responsibilities:

Associate Staff members:

(a) may admit and/or provide care for up to 24 patients as described in this staff category, except as otherwise provided in their specific delineation of clinical privileges, the Bylaws or Bylaws-related documents, or as limited by the Board;

(b) may attend and participate in Medical Staff, department, and section meetings (without vote);

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

(d) may be invited to serve on committees (with vote);

(e) are generally excused from providing specialty coverage for the Emergency Department for unassigned patients, but:

(1) must assume the care of any of their patients who present to the Emergency Department when requested to do so by an Emergency Department physician; and

(2) will be required to provide specialty coverage if the MEC, after considering the recommendation of the relevant clinical department, determines that there are insufficient Active Staff members in a particular specialty area to perform these responsibilities;

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

(g) shall exercise such clinical privileges as are granted to them; and

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

2.C. CONSULTING STAFF

2.C.1. Qualifications:

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

(a) are of demonstrated professional ability and expertise who provide a service not otherwise available or in very limited supply on the Active Staff in the discretion of the Credentials Committee (should the service become readily available on the Active Staff, the Consulting Staff members would not be eligible to request continued Consulting Staff status at the time of their next reappointments and would have to transfer to a different staff category if they desire continued appointment) or participate in special collaborative relationships with WakeMed;

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

(c) at each reappointment time, complete the primary hospital affiliation form and provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information provided from other health care entities that formally collaborate with WakeMed, information from another hospital, information from the

individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians). In addition, due to decreased clinical activity, all clinical activity performed by Consulting Staff members shall be subject to focused professional practice evaluation throughout the appointment term.

2.C.2. Prerogatives and Responsibilities:

Consulting Staff members:

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

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

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

(d) may be invited to serve on committees (with vote);

(e) are excused from providing specialty coverage for the Emergency Department and providing care for unassigned patients;

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

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

2.D. AFFILIATE STAFF

2.D.1. Qualifications:

The Affiliate Staff consists of those physicians, dentists, oral surgeons, podiatrists, and psychologists who:

(a) desire to be associated with, but who do not intend to establish a clinical practice at, this Hospital and meet the eligibility criteria set forth in the Medical Staff Credentials Policy with the exception of Section 2.A.1(b), (c), (j), (k), (l), (m), (n), (p), (q), and (r); and

(b) have indicated or demonstrated a willingness to assume all the responsibilities of membership on the Affiliate Staff as outlined in Section 2.D.2.

The primary purpose of the Affiliate Staff is to promote professional and educational opportunities, including continuing medical education, and to permit these individuals to access Hospital services for their patients by referral of patients to Active Staff members for admission and care.

2.D.2. Prerogatives and Responsibilities:

Affiliate Staff members:

(a) may attend meetings of the Medical Staff and applicable departments (without vote);

(b) may not hold office or serve as department chairs or committee chairs;

(c) shall generally have no staff committee responsibilities, but may be invited to serve on committees (with vote);

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

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

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

(g) are encouraged to communicate directly with Active Staff members about the care of any patients referred, as well as to visit any such patients;

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

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

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

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

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

(m) must pay any applicable application fees, dues, and assessments.

2.E. HONORARY STAFF

2.E.1. Qualifications:

(a) The Honorary Staff shall consist of practitioners who have retired from the practice of medicine in this Hospital after serving for more than 10 years, who are in good standing, and who have been recommended for Honorary Staff appointment by the MEC.

(b) The designation of Honorary Staff appointment is permanent. As such, there is no need for the individual to submit a reappointment application/reappointment processing.

2.E.2. Prerogatives and Responsibilities:

Honorary Staff members:

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

(b) may attend Medical Staff, department, and section meetings (without vote);

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

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

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

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

ARTICLE 3

OFFICERS

3.A. DESIGNATION

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

3.B. ELIGIBILITY CRITERIA

Only those members of the Active Staff who satisfy the following criteria initially and continuously, as determined by the MEC, shall be eligible to serve as an officer of the Medical Staff or as an at-large member of the MEC, unless an exception is recommended by the Leadership Council. They must:

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

(2) have no past or pending adverse recommendations concerning Medical Staff appointment or clinical privileges;

(3) not presently be serving as a Medical Staff officer, Board member or department chair at any other hospital not affiliated with WakeMed and shall not so serve during their term of office;

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

(5) have experience in a leadership position or other involvement in performance improvement functions at this Hospital;

(6) attend continuing education relating to Medical Staff leadership, credentialing, and/or peer review functions prior to or during the term of the office;

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

(8) disclose any financial relationship (i.e., an ownership or investment interest or a compensation arrangement) with an entity that competes with the Hospital or any affiliate. This does not apply to services provided within a practitioner's office and billed under the same provider number used by the practitioner. The Leadership Council shall assess any such conflicts to determine whether they are such that they render the individual ineligible for the position.

3.C. DUTIES

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

The President of the Medical Staff shall:

(a) act in coordination and cooperation with Hospital Administration, including the dyad leadership, in matters of mutual concern involving the care of patients in the Hospital and the professional conduct of practitioners;

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

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

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

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

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

3.C.2. President-Elect of the Medical Staff:

The President-Elect of the Medical Staff shall:

(a) assume all duties of the President of the Medical Staff and act with full authority as President of the Medical Staff when the President of the Medical Staff is unavailable within a reasonable period of time;

(b) serve on the MEC and the Leadership Council;

(c) shall become President of the Medical Staff at the conclusion of his/her term; and

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

3.C.3. Immediate Past President of the Medical Staff:

The Immediate Past President of the Medical Staff shall:

(a) serve on the MEC, with vote;

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

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

3.D. NOMINATIONS

(1) The Leadership Council shall convene at least 45 days prior to the election and shall submit the names of at least one qualified nominee for the office of President-Elect of the Medical Staff and two at-large members of the MEC. All nominees must meet the eligibility criteria in Section 3.B and agree to serve, if elected. Notice of the nominees shall be provided to the Medical Staff at least 21 days prior to the election.

(2) Additional nominations may also be submitted in writing by petition signed by at least 10% of the Active Staff at least 14 days prior to the election. In order for a nomination to be added to the ballot, the candidate must meet the qualifications in Section 3.B, in the judgment of the Leadership Council, and be willing to serve.

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

3.E. ELECTION

(1) Elections shall be held solely by written or electronic ballot returned to Medical Staff Services in the manner as indicated on the ballot at the time it is distributed. Ballots shall be provided to all members of the Active Staff and completed ballots must be received in Medical Staff Services by the date indicated on the ballot. Those who receive a majority of the votes cast shall be elected, subject to Board confirmation, which confirmation shall signify that the individual is entitled to legal protections and indemnification by the Board for acting in a Medical Staff leadership role. If no candidate receives a simple majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes.

(2) In the alternative, and in the discretion of the MEC, elections may occur at called meetings of the Medical Staff. Candidates receiving a majority of votes cast at the meeting by those members of the Active Staff present and voting at that meeting shall be elected, subject to Board confirmation, which confirmation shall signify that the individual is entitled to legal protections and indemnification by the Board for acting in a Medical Staff leadership role. If no candidate receives a simple majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes.

3.F. TERM OF OFFICE

Officers and at-large MEC members shall serve for a term of two years or until a successor is elected or appointed. The term of office shall commence on the first day of the staff year following election.

3.G. REMOVAL

(1) Removal of an elected officer or a member of the MEC may be effectuated by a two-thirds vote of the MEC for:

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

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

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

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

(2) At least 10 days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action is to be considered. The individual shall be afforded an opportunity to speak to the MEC and shall be excused from the meeting prior the MEC's deliberations and vote on removal.

3.H. VACANCIES

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

ARTICLE 4

CLINICAL DEPARTMENTS AND SECTIONS

4.A. ORGANIZATION

The Medical Staff shall be organized into departments and sections as determined by the MEC and listed in the Organization Manual. The MEC may create new departments, eliminate departments, create or eliminate sections within departments, or otherwise reorganize the department structure, in accordance with the amendment provisions contained in the Organization Manual.

4.B. ASSIGNMENT TO DEPARTMENTS AND SECTIONS

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

(2) A Medical Staff member may request a change in department or section assignment to reflect a change in his or her clinical practice.

(3) Department or section assignment may be transferred at the discretion of the MEC.

4.C. FUNCTIONS OF DEPARTMENTS

The departments shall be organized for the purpose of implementing processes (i) to monitor and evaluate the quality and appropriateness of the care of patients served by the departments, (ii) to monitor the practice of all those with clinical privileges in a given department, (iii) to assure emergency call coverage for all patients, and (iv) to recommend guidelines to the MEC for recognition of approved training programs and post-graduate programs commensurate with the resources available at the Hospital.

4.D. QUALIFICATIONS OF ELECTED DEPARTMENT CHAIRS AND VICE CHAIRS

Each department chair and vice chair shall satisfy the eligibility criteria in Section 3.B unless waived by the Leadership Council.

4.E. APPOINTMENT AND REMOVAL OF DEPARTMENT CHAIRS AND VICE CHAIRS

(1) Except as otherwise provided by contract, department chairs and vice chairs shall be elected by the department, subject to MEC approval and confirmation by the Board. Candidates for department chair and vice chair shall be as recommended

by the Leadership Council after the Leadership Council has first solicited input from the members of the relevant clinical department. Candidates must meet the qualifications in Section 3.B, unless waived by the MEC, and be willing to serve. The election shall be by written or electronic ballot with votes to be returned as indicated on the ballot. All ballots must be received by Medical Staff Services by the day of the election. Those who receive a majority of the votes cast shall be elected.

(2) Any department chair or vice chair may be removed by a two-thirds vote of the department or by a two-thirds vote of the MEC after reasonable notice and opportunity to be heard. Grounds for removal shall be:

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

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

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

(d) an infirmity that renders the Medical Staff member incapable of fulfilling the duties of that office.

(3) Prior to the initiation of any removal action, the Medical Staff member shall be given written notice of the date of the meeting at which such action shall be taken at least 10 days prior to the date of the meeting. The Medical Staff member shall be afforded an opportunity to speak to the department or MEC, as applicable, and shall be excused from the meeting prior to the department's or MEC's deliberations and vote on removal.

(4) Elected department chairs and vice chairs shall serve a term of two years and may be reelected for one consecutive term.

4.F. DUTIES OF DEPARTMENT CHAIRS

Department chairs shall work in collaboration with Medical Staff Leaders and other Hospital personnel to be responsible collectively for the following:

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

(2) all administratively-related activities of the department, unless otherwise provided for by the Hospital;

(3) continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges;

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

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

(6) the integration of the department into the primary functions of the Hospital;

(7) the coordination and integration of interdepartmental and intradepartmental services;

(8) the development and implementation of policies and procedures that guide and support the provision of care, treatment and services;

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

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

(11) continuous assessment and improvement of the quality of care and services provided;

(12) maintenance of quality monitoring programs, as appropriate;

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

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

(15) the orientation and continuing education of all persons in the department;

(16) appointing section chiefs as necessary; and

(17) performing all functions authorized in the Credentials Policy, including collegial intervention.

4.G. DUTIES OF DEPARTMENT VICE CHAIRS

Vice chairs shall carry out the duties requested by department chairs. Upon request, these duties may include:

(1) assisting with the review of applications for initial appointment, reappointment, and clinical privileges, including interviewing applicants;

(2) evaluation of individuals to assist with Ongoing Professional Practice Evaluation and Focused Professional Practice Evaluation;

(3) participation in the development of criteria for clinical privileges;

(4) reviewing and reporting on the professional performance of individuals practicing within the section;

(5) attending meetings of the MEC, with vote, in the absence of the department chair; and

(6) serving in the absence of the department chair.

4.H. CLINICAL SECTIONS

4.H.1. Section Requirements:

Sections shall generally have no meeting or minutes requirements. Only when sections are making formal recommendations to a department will a report be required from the section chief.

4.H.2. Section Activities:

Sections may perform any of the following activities:

(a) continuing education;

(b) performing professional practice evaluation/peer review and/or performance improvement opportunities through a sanctioned Medical Staff or Hospital committee;

(c) grand rounds;

(d) discussion of policy or equipment needs;

(e) development of recommendations for department chair; and

(f) any other functions as may be delegated by the department chair.

4.H.3. Section Chiefs:

The relevant department chair may appoint a section chief to be responsible for duties as may be delegated by the department chair. Candidates for section chief shall be identified and recommended to the department chair by the Leadership Council after soliciting input from the members of the relevant section.

ARTICLE 5

MEDICAL STAFF COMMITTEES AND
PERFORMANCE IMPROVEMENT FUNCTIONS

5.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

This Article and the Medical Staff Organization Manual outline the Medical Staff committees that carry out ongoing and focused professional practice evaluations and other performance improvement functions that are delegated to the Medical Staff by the Board. All committees of the Medical Staff are peer review committees that have been appointed to perform protected peer review functions.

5.B. APPOINTMENT OF COMMITTEE CHAIRS AND MEMBERS

(1) Unless otherwise indicated, all committee chairs shall be appointed by the Leadership Council. Appointed committee chairs shall recommend committee members to the Leadership Council for approval. Advanced Practice Providers may be appointed to serve as voting members of Medical Staff committees. Committee chairs shall be selected based on the criteria set forth in Section 3.B of these Bylaws, and all committee members must signify their willingness to meet basic expectations of committee membership as set forth in Section 3.B of the Organization Manual.

(2) Unless otherwise indicated, committee chairs and members shall be appointed for initial terms of two years, but may be reappointed for additional terms. Except as provided herein, all appointed chairs and members may be removed and vacancies filled by the Leadership Council.

(3) Unless otherwise indicated, all Hospital and administrative representatives on the committees shall be appointed by the CEO, in consultation with the CQO and/or CMO, and the President of the Medical Staff. All such representatives shall serve on the committees, without vote.

(4) Unless otherwise indicated, the President of the Medical Staff, the CQO, the applicable CMO, and the CEO shall be members, *ex officio*, without vote, on all Medical Staff committees.

5.C. MEDICAL EXECUTIVE COMMITTEE

5.C.1. Composition:

(a) The MEC shall include the following voting members:

- the President of the Medical Staff;

- the President-Elect of the Medical Staff;
- the Immediate Past President of the Medical Staff;
- the department chairs;
- the Chair of the WakeMed Credentials Committee; and
- two elected at-large members of the Medical Staff.

(b) The CEO, the relevant CMOs, CQO, COO, the CNO, the relevant Senior VP and Administrator, Hospital legal counsel, the Executive Director of Nursing/Vice President of Nursing, and the Medical Staff Services support staff shall serve as *ex officio*, non-voting members.

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

(d) Other Medical Staff members or Hospital personnel may be invited to attend one or more MEC meetings (as guests, without vote) in order to assist the MEC in its discussions and deliberations regarding an issue on its agenda. These individuals shall be present only for the relevant agenda item and shall be excused for all others. Such individuals are an integral part of the committee's functioning and are bound by the same confidentiality requirements as the standing members of the MEC.

5.C.2. Duties:

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

(a) acting on behalf of the Medical Staff in the intervals between Medical Staff meetings;

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

(1) the Medical Staff's structure;

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

(3) applicants for Medical Staff appointment and reappointment;

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

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

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

(7) hearing procedures;

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

(d) receiving and acting on reports and recommendations from Medical Staff committees, departments, and other groups as appropriate, and making appropriate recommendations for improvement when there are significant departures from established or expected clinical practice patterns;

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

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

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

(h) prioritizing continuing medical education activities;

(i) ensuring, in conjunction with the clinical departments, that the on-call roster is sufficient to meet the needs of the Hospital and the community it serves;

(j) reviewing, or delegating to the Bylaws Committee the responsibility to review, at least once every five years, the Bylaws, policies, Rules and Regulations, and associated documents of the Medical Staff and recommending such changes as may be necessary or desirable; and

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

5.C.3. Meetings:

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

5.D. PERFORMANCE IMPROVEMENT FUNCTIONS

The Medical Staff is actively involved in performance improvement functions, including reviewing data and recommending and implementing processes to address the following:

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

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

(3) medical assessment and treatment of patients;

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

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

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

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

(8) appropriateness of clinical practice patterns;

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

(10) education of patients and families;

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

(12) accurate, timely and legible completion of medical records;

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

(14) the use of developed criteria for autopsies;

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

(16) nosocomial infections and the potential for infection;

(17) unnecessary procedures or treatment; and

(18) appropriate resource utilization.

5.E. CREATION OF STANDING COMMITTEES

In accordance with the amendment provisions in the Organization Manual, the MEC may establish additional committees to perform one or more staff functions and may dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical Staff functions. Any function required to be performed by these Bylaws which is not assigned to an individual Medical Staff member, a standing committee, or a special task force shall be performed or delegated by the MEC.

5.F. SPECIAL COMMITTEES

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

ARTICLE 6

MEETINGS

6.A. MEDICAL STAFF YEAR

The Medical Staff year is January 1 to December 31.

6.B. MEDICAL STAFF MEETINGS

6.B.1. Regular Meetings:

The Medical Staff shall meet as needed.

6.B.2. Special Meetings:

Special meetings of the Medical Staff may be called by the President of the Medical Staff, the MEC, the Board, or by a petition signed by not less than 10% of the Active Staff.

6.C. DEPARTMENT AND COMMITTEE MEETINGS

6.C.1. Regular Meetings:

Except as otherwise provided in these Bylaws or in the Medical Staff Organization Manual, each department and committee shall meet as often as necessary to fulfill their responsibilities, at times set by the Presiding Officer.

6.C.2. Special Meetings:

A special meeting of any department or committee may be called by or at the request of the Presiding Officer, the President of the Medical Staff, or by a petition signed by not less than 10% of the Active Staff members of the department or committee, but not by fewer than two members.

6.D. PROVISIONS COMMON TO ALL MEETINGS

6.D.1. Notice of Meetings:

(a) Medical Staff members shall be provided notice of all regular meetings of the Medical Staff and regular meetings of departments and committees at least seven days in advance of the meetings. The primary mechanism utilized for providing notice will be e-mail; however, notice may also be provided by mail, facsimile, hand delivery, posting in a designated electronic or physical location, or telephone at least seven days prior to the meetings. All notices shall provide the date, time, and place of the meetings.

(b) When a special meeting of the Medical Staff, a department, and/or a committee is called, all of the provisions in paragraph (a) shall apply except that the notice period shall be reduced to 48 hours and posting may not be the sole mechanism used for providing notice of a special meeting.

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

6.D.2. Quorum and Voting:

(a) For any regular or special meeting of the Medical Staff, department, or committee, those voting members present (but not fewer than two) shall constitute a quorum. The exception to this general rule is that for meetings of the MEC, the Committee for Professional Enhancement, and the Leadership Council, the presence of at least 50% of the voting members of the committee shall constitute a quorum.

(b) Once a quorum is established, the business of the meeting may continue and all actions taken shall be binding.

(c) Recommendations and actions of the Medical Staff, departments, and committees shall be by consensus whenever possible. In the event it is necessary to vote on an issue, that issue will be determined by a majority vote of those individuals present. Voting may be by written ballot at the discretion of the Presiding Officer.

(d) The voting members of the Medical Staff, a department, or a committee may also be presented with a question by mail, facsimile, e-mail, hand delivery, website posting, survey monkey, or telephone and their votes returned to the Presiding Officer by the method designated in the notice. Except for actions by the MEC, the Committee for Professional Enhancement, and the Leadership Council (which require a 50% quorum), a quorum for purposes of these votes shall be the number of responses returned to the Presiding Officer by the date indicated. The question raised shall be determined in the affirmative if a majority of the responses returned has so indicated.

(e) At the discretion of the Presiding Officer, one or more Medical Staff members may participate in a meeting by telephone or video conference.

6.D.3. Agenda:

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

6.D.4. Rules of Order:

The latest edition of Robert's Rules of Order Revised may be used for reference at all meetings and elections, but shall not be binding. Specific provisions of these Bylaws and Medical Staff, department, or committee custom shall prevail at all meetings, and the Presiding Officer (Medical Staff Officer, department chair, or committee chair, as applicable) shall have the authority to rule definitively on all matters of procedure.

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

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

(b) A summary of all recommendations and actions of the Medical Staff, departments, and committees shall be transmitted to the MEC and to the CEO for purposes of keeping the Board apprised of the activities of the Medical Staff and its departments and committees.

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

6.D.6. Confidentiality:

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

6.D.7. Attendance Requirements:

(a) Attendance at meetings of the MEC, the Committee for Professional Enhancement, the Leadership Council, and the WakeMed Credentials Committee is required. All members are required to attend at least 75% of all regular and special meetings of these committees. Failure to attend the required number of meetings may result in replacement of the member.

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

ARTICLE 7

INDEMNIFICATION

The Hospital shall insure and indemnify all Medical Staff members who are acting in good faith for and on behalf of the Hospital in discharging their responsibilities and professional review activities pursuant to these Bylaws, the Credentials Policy, the Medical Staff Organization Manual, and/or the Policy on Advanced Practice Providers, to the fullest extent permitted by law, in accordance with applicable provisions of the Hospital's corporate bylaws.

ARTICLE 8

BASIC STEPS AND DETAILS

The details associated with the following Basic Steps are contained in the Credentials Policy and the Advanced Practice Providers Policy in a more expansive form.

8.A. QUALIFICATIONS FOR APPOINTMENT

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

8.B. PROCESS FOR PRIVILEGING

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

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

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

8.D. DISASTER PRIVILEGING

When the disaster plan has been implemented, the CEO, CQO, CMO, or President of the Medical Staff may use a modified credentialing process to grant disaster privileges after verification of the volunteer's identity and licensure.

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

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

(a) fails to do any of the following:

(i) timely complete medical records;

(ii) satisfy threshold eligibility criteria;

(iii) provide requested information;

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

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

(vi) fails to timely pay dues;

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

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

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

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

8.F. INDICATIONS AND PROCESS FOR PRECAUTIONARY SUSPENSION

(1) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the MEC, OR any Medical Staff Officer or department chair, acting in conjunction with the CQO, CMO, or the CEO, is authorized to suspend or restrict all or any portion of an individual's clinical privileges as a precaution pending an investigation.

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

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

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

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

8.G. INDICATIONS AND PROCESS FOR RECOMMENDING TERMINATION OR SUSPENSION OF APPOINTMENT AND PRIVILEGES OR REDUCTION OF PRIVILEGES

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

8.H. HEARING AND APPEAL PROCESS, INCLUDING PROCESS FOR SCHEDULING AND CONDUCTING HEARINGS AND THE COMPOSITION OF THE HEARING PANEL

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

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

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

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

(5) Both sides will have the following rights, subject to reasonable limits determined by the Presiding Officer: (a) to call and examine witnesses, to the extent they are available and willing to testify; (b) to introduce exhibits; (c) to cross-examine any witness on any matter relevant to the issues; (d) to have representation by counsel who may call, examine, and cross-examine witnesses and present the case; and (e) to submit proposed findings, conclusions, and recommendations to the Hearing Panel in the form of a post-hearing statement submitted at the close of the hearing.

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

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

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

ARTICLE 9

AMENDMENTS

9.A. MEDICAL STAFF BYLAWS

(1) Amendments to these Bylaws may be proposed by a petition signed by at least 10% of the Active Staff of either Hospital, by the WakeMed Bylaws Committee, or by either Hospital's MEC. All proposed amendments, regardless of the manner in which they are proposed, shall be reviewed by the WakeMed Leadership Council prior to the voting process below being initiated in order that the Leadership Council may determine whether the proposed amendment is relevant to both WakeMed Hospitals and therefore should be forwarded by the Leadership Council to that hospital for consideration by its respective MEC.

(2) All proposed amendments to these Bylaws must be reviewed by the two MECs prior to a vote by the Medical Staff. The MECs may hold a Medical Staff meeting with the relevant Medical Staff to discuss proposed amendments; however, voting shall not take place at a meeting but, rather, will be accomplished in accordance with this section. The MECs shall present all proposed amendments to the voting staffs by written or electronic ballot to be returned to the Medical Staff Office by the date indicated on the ballot, which date shall be at least 14 days after the proposed amendment was provided to the voting staffs. Along with the proposed amendments, the MEC may, in its discretion, provide a written report on them either favorably or unfavorably. To be adopted, the amendment must receive a majority of the votes cast.

(3) The MECs shall have the power to adopt such clarifications to these Bylaws which are needed because of renumbering, punctuation, spelling or errors of grammar, change of name(s) or title(s), or as mandated by law as determined by Hospital legal counsel.

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

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

(6) Neither the Medical Staffs nor the Board shall unilaterally (without seeking the advice of the other party) amend these Bylaws.

(7) The Appendices to the Bylaws may be modified or supplemented by action of the Board, after receiving the recommendation of the MECs, without the necessity of formal amendment of these Bylaws.

9.B. OTHER MEDICAL STAFF DOCUMENTS

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

(2) An amendment to the Credentials Policy, Medical Staff Organization Manual, Advanced Practice Providers Policy, or the Medical Staff Rules and Regulations may be made by a majority vote of the members of the MEC present and voting at any meeting of that committee where a quorum exists. Notice of all proposed amendments to these documents shall be posted on the Medical Staff bulletin board and/or provided via mail, facsimile, or e-mail to each voting member of the Medical Staff at least 14 days prior to the MEC meeting when the vote is to take place. Any member of the voting staff may submit written comments on the amendments to the MEC.

(3) The present Medical Staff Rules and Regulations are hereby readopted and placed into effect insofar as they are consistent with these Bylaws, until such time as they are amended in accordance with the terms of these Bylaws. To the extent any present Rules and Regulations are inconsistent with these Bylaws, they are of no force or effect.

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

(5) Amendments to the Medical Staff policies referenced above in this Section and to the Rules and Regulations may also be proposed by a petition signed by at least 20% of the voting members of the Medical Staff. Any such proposed amendments will be reviewed by the MEC, which shall report on the proposed amendments either favorably or unfavorably before they are forwarded to the Board for its final action.

(6) Adoption of and changes to the Credentials Policy, Medical Staff Organization Manual, Advanced Practice Providers Policy, Medical Staff Rules and Regulations, and other Medical Staff policies will become effective upon majority vote of the members of the MEC present and voting at any meeting of that committee where a quorum exists.

9.C. CONFLICT MANAGEMENT PROCESS

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

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

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

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

a special meeting of the Medical Staff to discuss the conflict may be called by a petition signed by at least 20% of the voting staff. The agenda for that meeting will be limited to attempting to resolve the differences that exist with respect to the amendment(s) or policy at issue.

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

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

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

ARTICLE 10

ADOPTION

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

WakeMed Cary

Medical Staff: February 3, 2019

Board of Directors: March 5, 2019

WakeMed Raleigh

Medical Staff: February 3, 2019

Board of Directors: March 5, 2019

APPENDIX A

DEFINITIONS

The following definitions shall apply to terms used in these Medical Staff Bylaws and all related Medical Staff policies, including, but not limited to, the Medical Staff Credentials Policy, the Medical Staff Rules and Regulations, the Medical Staff Organization Manual, and the Policy on Advanced Practice Providers:

(1) "ADMINISTRATIVE TEAM" means the Chief Executive Officer, the Chief Medical Officer, the Chief Operating Officer, and the Chief Quality and Medical Staff Officer.

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

(3) "CHIEF EXECUTIVE OFFICER" ("CEO") means the individual appointed by the Board to act on its behalf in the overall management of the Hospital.

(4) "CHIEF MEDICAL OFFICER" ("CMO") means the individual appointed by the Board to act as the chief medical officer of the Hospital, in cooperation with the President of the Medical Staff.

(5) "CHIEF QUALITY AND MEDICAL STAFF OFFICER" ("CQMSO" or "CQO") means the individual appointed by the Board to act as the chief quality officer of the Hospital, in cooperation with the President of the Medical Staff.

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

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

(8) "DAYS" means calendar days.

(9) "DENTIST" means a doctor of dental surgery ("D.D.S.") or doctor of dental medicine ("D.M.D.").

(10) "HOSPITAL" means WakeMed Raleigh, which includes WakeMed North Family Health & Women's Hospital, or WakeMed Cary, and other Healthplexes operating under the same CMS Certification Number ("CCN") as either hospital.

(11) "MEDICAL EXECUTIVE COMMITTEE" ("MEC") means the Medical Staff Executive Committee.

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

(13) "MEDICAL STAFF LEADER" means any Medical Staff Officer, department chair, section chief, and committee chair.

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

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

(16) "ORAL AND MAXILLOFACIAL SURGEON" means an individual with a D.D.S. or a D.M.D. degree, who has completed additional training in oral and maxillofacial surgery.

(17) "PATIENT CONTACTS" means any admission, consultation, procedure, physical response to emergency call, evaluation, treatment or service performed in the Hospital or its outpatient facilities. Patient contacts do not include referrals for diagnostic or laboratory tests or x-rays.

(18) "PHYSICIAN" means both doctors of medicine ("M.D.s") and doctors of osteopathy ("D.O.s").

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

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

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

(22) "UNASSIGNED PATIENT" means any individual who comes to the Hospital for care and treatment who does not have an attending physician, or whose attending physician or designated alternate is unavailable to attend the patient, or who does not want the prior attending physician to provide him or her care while a patient at the Hospital. For purposes of determining whether a patient has an attending physician, if a member of the

Medical Staff has not treated a patient for more than three years, that practitioner is not considered to be the patient's attending physician. In addition, for purposes of this definition, a treatment relationship between a patient and a physician begins when the physician or his or her appropriately credentialed designated practitioner (i.e., resident or Advanced Practice Provider) has actually evaluated or treated the patient, or has communicated a treatment plan for the patient to another physician or relevant provider. The mere fact that a patient may have scheduled an appointment with a physician, but has not yet been seen by that physician, does not establish a treatment relationship.

APPENDIX B

MEDICAL STAFF CATEGORIES SUMMARY

	Active	Associate	Consulting	Affiliate	Honorary
Basic Requirements					
Number of hospital contacts/2-year	≥ 24	≥ 6 & < 24	NA	N	N
Rights					
Admit	Y	≥ 6 & < 24	N	N	N
Exercise clinical privileges	Y	Y	Y	N	N
May attend meetings	Y	Y	Y	Y	Y
Voting privileges	Y	P	P	N	P
Hold office	Y	N, unless waiver	N, unless waiver	N	N, unless waiver
Responsibilities					
Serve on committees	Y	Y	Y	Y	Y
Dues	Y	Y	Y	Y	N
Comply w/ guidelines	Y	Y	Y	N	N

Y = Yes
N = No
NA = Not Applicable
P = Partial (with respect to voting, only when appointed to a committee)

APPENDIX C

HISTORY AND PHYSICAL EXAMINATIONS

(a) General Documentation Requirements

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

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

- patient identification;
- chief complaint;
- history of present illness;
- review of systems;
- personal medical history, including medications and allergies;
- family medical history;
- social history, including any abuse or neglect;
- physical examination, to include pertinent findings in those organ systems relevant to the presenting illness and to co-existing diagnoses;
- data reviewed;
- assessments, including problem list;
- plan of treatment; and
- if applicable, signs of abuse, neglect, addiction, or emotional/behavioral disorder, which will be specifically documented in the physical examination, and any need for restraint or seclusion which will be documented in the plan of treatment.

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

(b) Individuals Who May Perform H&Ps

The following types of practitioners may generally perform histories and physicals at the Hospital pursuant to appropriately granted Medical Staff appointment or permission to practice and clinical privileges:

(1) physicians;

(2) podiatrists (in accordance with the Medical Staff Credentials Policy);

(3) dentists (in accordance with the Medical Staff Credentials Policy);

(4) certified nurse midwives;

(5) certified registered nurse practitioners; and

(6) physician assistants.

(c) H&Ps Performed Prior to Admission

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

(2) If a medical history and physical examination has been completed within the 30-day period prior to admission or registration, a durable, legible copy of this report may be used in the patient's medical record. However, in these circumstances, the patient must also be evaluated within 24 hours of the time of admission/registration or prior to surgery/invasive procedure, whichever comes first, and an update recorded in the medical record by an individual who has been granted clinical privileges to complete histories and physicals.

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

(4) In the case of readmission of a patient, all previous records will be made available by the Hospital for review and use by the attending physician.

(d) Cancellations, Delays, and Emergency Situations

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

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

APPENDIX D

AUTHORIZED QUALIFIED MEDICAL PERSONNEL

Individuals who are authorized to perform medical screening examinations are set forth in the Administrative – Patient Care policy entitled EMTALA Qualified Medical Personnel.