



MediCorp Health System

Medical Staff Bylaws of
Mary Washington Hospital, Inc.

And

MediCorp at Stafford, LLC
(dba Stafford Hospital Center)



Medical Staff Bylaws

Part 1

Medical Staff Structure

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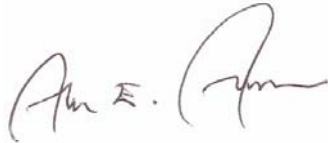


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**MEDICAL STAFF BYLAWS
OF
MARY WASHINGTON HOSPITAL, INC. AND MEDICORP AT STAFFORD LLC**

ADOPTION

1. These Medical Staff Bylaws are adopted and made effective for each Hospital upon approval of its Board of Trustees, superseding and replacing any and all previous Medical Staff Bylaws, and henceforth all activities and actions of the Medical Staff and of each individual who is appointed or reappointed to the Mary Washington Hospital, Inc. or MediCorp at Stafford LLC (dba Stafford Hospital Center) Medical Staff, or who is exercising Clinical Privileges at Mary Washington Hospital, Inc. or shall be taken under and pursuant to the requirements of these bylaws.
2. The present rules and regulations and policies or procedures of the Medical Staff of Mary Washington Hospital, Inc. and MediCorp at Stafford LLC 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.

<u>Mary Washington Hospital</u>	<u>Stafford Hospital Center</u>
Adopted: April 1998	Adopted: October 15, 2008
Reviewed Without Revision: April 2001	
Revised: September 10, 2002; December 13, 2005; January 24, 2007; May 30, 2007; February 19, 2008; October 15, 2008	
	
Chair, Medical Executive Committee	Chair, Medical Executive Committee
	
Chief Executive Officer	Chief Executive Officer

PREAMBLE

WHEREAS, each Hospital's Board of Trustees recognizes that each Physician, Dentist and Podiatrist appointed to the Medical Staff has responsibility for the exercise of professional judgment in the care and treatment of patients, and

WHEREAS, the Board, in accordance with legal and accreditation requirements, has delegated to the organized Medical Staff through its committees and Departments the duties and responsibilities as set forth in these Bylaws and Policy on Allied Health Professionals the responsibility for establishing a uniform standard of quality patient care, treatment, and services; for supervising and monitoring the quality of care, treatment, and services provided by practitioners with Clinical Privileges; and for making recommendations concerning application for appointment, reappointment and Clinical Privileges; and

WHEREAS, the Medical Staff recognizes and accepts the responsibility for self governance and responsibilities in the efforts of the Hospital to foster prevention, amelioration and cure of illness, disease and injury, and to provide or assist in providing medical education and continuing medical education for Medical Staff Appointees, other health care professionals, and residents, interns, medical students and nurses;

THEREFORE, to discharge those duties and responsibilities, and to provide for an orderly process concerning matters of election, meetings, duties and procedures, the officers, Departments and committees of the Medical Staff as described in these bylaws assume responsibility for fulfilling those duties and functions delegated to them by the Board of Trustees.

ARTICLE I

DEFINITIONS

The following definitions shall apply to terms used in these bylaws:

- 1) "Appointee" means any Physician, Dentist and Podiatrist who has been granted Medical Staff appointment and Clinical Privileges by the Board to practice at one or both of the Hospitals.
- 2) "Board" means either the Board of Trustees of Mary Washington Hospital, Inc. or the Board of Trustees MediCorp at Stafford Hospital LLC (dba Stafford Hospital Center) each of which has overall responsibility for conduct of the respective Hospitals.
- 3) "Chief Executive Officer" means the chief officer of MediCorp Health System or the CEO's designee.
- 4) "Chief of Service", "Service Chief" or "Department Chief" means the individual who has overall responsibility for the management of one of the clinical Departments of the Medical Staff.
- 5) "Clinical Privileges" or "privileges" means the authorization granted by the Board to an applicant, Medical Staff Appointee or licensed independent practitioner to render specific patient care services in one of the Hospitals within defined limits.
- 6) "Conflict of Interest" means any situation in which, because of an individual's dual interests, a serious risk arises that the individual will not be able to exercise independent or objective judgment.
- 7) "Dentist" includes a doctor of dental surgery ("D.D.S.") and doctor of dental medicine ("D.M.D.").
- 8) "Division" means an optional subspecialty component of a Medical Staff Department.
- 9) "Ex Officio" means by virtue of an office or position held, with voting rights unless otherwise specified.
- 10) "Executive Committee" means the Executive Committee of the Medical Staff, unless specifically written "Executive Committee of the Board."
- 11) "Good standing" means a Medical Staff Appointee who is not under suspension or any restriction regarding staff appointment or admitting or Clinical Privileges at the Hospital and/or at any other health care facility or organization.
- 12) "Hospital" means the facility where the applicant, Medical Staff Appointee, or licensed independent practitioner seeks or holds appointment to the Medical Staff and/or Clinical Privileges, Mary Washington Hospital, Inc. or MediCorp at Stafford LLC (dba Stafford Hospital Center).
- 13) "Medical Staff" means all Physicians, Dentists and Podiatrists who are given privileges to treat patients at the Hospital.
- 14) "Oral Surgeon" is an individual who has completed a postgraduate oral/maxillofacial program.
- 15) "Physicians" includes both doctors of medicine ("M.D.s") and doctors of osteopathy ("D.O.s").
- 16) "Podiatrist" means a doctor of podiatric medicine ("D.P.M.").
- 17) "President of the Hospital" means either the President of Mary Washington Hospital or the President of Stafford Hospital Center depending upon the facility and Medical Staff Appointee involved.

- 18) "Professional review action" means an action or recommendation of a Professional review body which is taken or made in the conduct of a Professional review activity, which is based on the competence or professional conduct of a staff Appointee, and which affects or may affect adversely the Clinical Privileges or appointment of the staff Appointee.
- 19) "Professional review activity" means a peer review activity of a Professional Review Body with respect to an individual Medical Staff applicant or Appointee (a) to determine whether the Medical Staff applicant or Appointee may have Clinical Privileges with respect to his/her appointment; (b) to determine the scope or conditions of those Clinical Privileges and appointment; and (c) to change or modify such privileges and/or appointment.
- 20) "Professional review body" means a health care entity (such as the Hospital) and the Hospital governing body or any Hospital or MediCorp Health System committee that conducts Professional review activity, and includes any committee of the Medical Staff when assisting the governing body in a professional peer review activity.
- 21) "Self-government" means the duty of Medical Staff leaders, committees and Departments of the Medical Staff to initiate and carry out the functions delegated by the Board and to fulfill the obligations provided for in these bylaws.
- 22) "System" or "MediCorp Health System" includes inpatient or ambulatory services provided by Mary Washington Hospital, Inc., Stafford Hospital Center, Fredericksburg Ambulatory Surgery Center, and other MediCorp Health System facilities that provide medical services to patients.
- 23) "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/her care while a patient at the Hospital.
- 24) "Voluntary" or "automatic relinquishment" of Medical Staff appointment and/or Clinical Privileges means a lapse in appointment and/or Clinical Privileges deemed to occur as a result of stated conditions.

Words used in these bylaws shall be read as the masculine or feminine gender, and as the singular or plural, as the content requires. The captions or headings are for convenience only and are not intended to limit or define the scope or effect of any provision of these bylaws.

ARTICLE II

CATEGORIES OF THE MEDICAL STAFF

All appointments to the Medical Staff shall be made by the Board and shall be to one of the following categories of the staff. All Appointees shall be assigned to a specific clinical Department, but shall be eligible for Clinical Privileges in other Departments as applied for and recommended pursuant to these bylaws and the Policy on Medical Staff Appointment, Reappointment and Clinical Privileges and approved by the Board. All initial appointments to the Medical Staff regardless of the category of the staff to which appointment is made and all initial Clinical Privileges shall be provisional for twelve (12) months from the date of the appointment (the appointment term may be longer or shorter) as recommended by the Credentials Committee.

ARTICLE II – PART A: ACTIVE STAFF

1. The Active Staff shall consist of those Physicians, Dentists and Podiatrists who regularly attend, admit or are involved in the treatment of patients at the Hospital. By accepting appointment to the Active Staff, each Appointee shall agree to assume all the functions and responsibilities of appointment to the Active Staff, including where appropriate, care for unassigned patients, emergency service care, consultation and teaching assignments, and participation in quality assessment and monitoring activities, including the evaluation of provisional Appointees. They shall be located close enough to the Hospital to fulfill their responsibilities and to provide timely and continuous care for their patients in the Hospital.
2. Active Staff Appointees shall be entitled to vote, hold office, serve as Chiefs of Departments, as chairpersons of clinical Divisions and as chairpersons and members of Medical Staff committees. They shall be encouraged to attend Medical Staff and Department/Division and committee meetings as appropriate and to pay staff dues.
3. Initial Active Staff Appointments and Clinical Privileges shall be provisional for at least twelve (12) months. Provisional appointees shall not be entitled to serve as chairpersons of clinical Divisions or staff committees. They shall be ineligible to hold Medical Staff office or serve as Chiefs of Departments, but may be appointed to committees.
4. In order to remain on the Active Staff, an individual must assume reasonable service, Medical Staff committee and Hospital responsibilities. Failure to fulfill such responsibilities shall cause the Medical Staff appointment of the individual to lapse at the end of the appointment period. In such a situation, the individual must reapply and appointment shall be made only if the Executive Committee and the Board are satisfied that the individual is willing to discharge the above responsibilities.
5. Active Staff are authorized to access patient information via the electronic patient information system, as permitted by law and Hospital policy.

ARTICLE II – PART B: CONSULTING STAFF

1. The Consulting Staff shall consist of Physicians, Dentists or Podiatrists of recognized distinction and expertise in an area underserved by Appointees to the Medical Staff, as determined by the Medical Executive Committee. Appointment to this category shall authorize the Appointee to have the authority to provide independent acute care services to in-patients.
2. Appointment to the Consulting Staff does not entitle the Appointee to admit patients, to vote, to hold staff offices, or to serve on Medical Staff committees. Consulting Staff Appointees shall be encouraged to attend Medical Staff and Department/Division meetings as appropriate and required to pay staff dues.

3. Clinical Privileges granted to Consulting Staff Appointees shall be provisional for at least the first twelve (12) months of their appointment.
4. Consulting Staff are authorized to access patient information via the electronic patient information system, as permitted by law and Hospital policy.

ARTICLE II – PART C: AFFILIATE STAFF

1. The Affiliate Staff shall consist of Physicians, Dentists or Podiatrists of demonstrated competence qualified for staff appointment who intend to be involved in the care of patients on a limited basis. The Affiliate Staff category shall not be used as a mechanism to avoid the obligations of Active Staff appointment.
2. An Affiliate is not afforded acute care admitting, attending or primary surgical privileges. An Affiliate may provide inpatient consultations, be the primary practitioner for outpatient diagnostic or invasive procedures and serve as a surgical assistant to an Active Staff Appointee consistent with approved Clinical Privileges.
3. If an Affiliate is involved in the care of more than twelve (12) patients per year, the Affiliate may be required to transfer to the Active Staff. Refusal to accept transfer shall be deemed a voluntary relinquishment of appointment and Clinical Privileges.
4. Affiliates must have an association with an Active Appointee/on-call group with acute care privileges in the same specialty to ensure continuity of patient care. Failure to maintain an ongoing association shall be deemed a voluntary relinquishment of appointment and Clinical Privileges.
5. An Affiliate must be able to provide proof of an acceptable relationship to support assessment of the Affiliate's current clinical competence. Examples of possible relationships include: partnership with a member of the Active Staff; Active category appointment at another institution deemed acceptable by the Credentials Committee; membership in a NCQA accredited health plan; Physician AMA accreditation; or other program deemed by the Credentials Committee as an equivalent.
6. An Affiliate must be willing to participate in the Emergency Department's outlying referral roster.
7. Affiliates may not vote or hold office. They may, but are not required to, attend staff meetings, Department or Division meetings and committee meetings. They must pay Medical Staff dues and assessments.
8. An Affiliate Physician may, but is not required to, be included on the ED unassigned call roster for patients treated and released from the ED and/or being discharged from the Hospitalist Service. Affiliate Staff are not required to take primary call.
9. Clinical Privileges granted to Affiliate Staff Appointees shall be provisional for at least the first twelve (12) months of their appointment.
10. Affiliate Staff are authorized to access patient information via the electronic patient information system, as permitted by law and Hospital policy.

ARTICLE II – PART D: REFERRAL STAFF

(Revised January 24, 2007)

1. The Referral Staff shall consist of those Physicians who desire to be associated with the Hospital, but who do not desire inpatient Clinical Privileges. Clinical Privileges available to Referral Staff are limited to being authorized to perform a History & Physical (H&P) and ordering outpatient treatment (example, infusion services). The primary purpose of the Referral Staff is to provide physicians the opportunity to access the Hospital for outpatient services, promote professional and educational opportunities, including continuing medical education endeavors, and to permit such individuals to access inpatient Hospital services for their patients by direct referral of patients to other Appointees on the Medical Staff.
2. Individuals requesting Referral Staff appointment shall be required to submit an application for initial appointment and for reappointment every two (2) years as prescribed by the Policy on Medical Staff Appointment, Reappointment and Clinical Privileges. They are encouraged to attend educational activities of the Medical Staff and the Hospital. Referral Staff will be surveyed annually to verify their continued interest in appointment to the Referral Staff.
3. Referral Staff Appointees shall be ineligible to vote or hold office unless otherwise specified in the Medical Staff Bylaws. Referral Staff shall be ineligible to serve on Medical Staff committees. They shall be required to pay any staff dues and assessments as determined by the Medical Executive Committee.
4. Referral Staff are authorized to access patient information via the on-line patient information system.
5. Referral Staff may visit their hospitalized patients on a social basis and may review the inpatient medical record but are not authorized to write orders or progress notes.
6. A History and Physical (H&P) performed in the office of a Referral physician may be used as the inpatient H&P conditioned upon the H&P being performed within the timeframe outlined in the Medical Staff Rules & Regulations and the Hospital H&P Standard. Referral Staff are authorized to use the Hospital's transcription service for H&Ps.
7. A Referral Physician may, at his/her discretion, be included on the ED unassigned call roster for patients treated and released from the ED and/or being discharged from the Hospitalist Service.
8. Any Referral Staff Appointee who desires to transfer to another staff category and/or to request Clinical Privileges must meet the qualifications, standards and requirements for appointment and Clinical Privileges as set forth in the Policy on Medical Staff Appointment, Reappointment and Clinical Privileges and these bylaws.

ARTICLE II – PART E: COURTESY STAFF

(Adopted January 24, 2007)

1. The Courtesy Staff shall consist of those physicians who desire to be associated with the Hospital, but who do not desire inpatient privileges or to write orders for outpatient treatment/therapy (example, infusion services).
2. Individuals requesting Courtesy Staff appointment shall be required to submit an application for initial appointment and for reappointment as prescribed by the Policy on Medical Staff Appointment, Reappointment and Clinical Privileges. They shall meet threshold qualifications for staff appointment except they shall be exempt from the professional liability insurance and board certification requirements. Courtesy Staff will be surveyed annually to verify their continued interest in appointment to the Courtesy Staff.

3. Courtesy Staff are encouraged to attend continuing medical educational activities sponsored by the Hospital.
4. Courtesy Staff Appointees shall be ineligible to vote, hold office, or serve on Medical Staff committees, unless specifically invited to participate in a committee.
5. Courtesy Staff shall be required to pay staff dues and assessments as established by the Medical Executive Committee.
6. Courtesy Staff are authorized to access patient information via the on-line patient information system.
7. Courtesy Staff may visit their hospitalized patients on a social basis and may review the inpatient medical record but are not authorized to write orders or progress notes.
8. Patient information from the office of the Courtesy Staff Appointee may be forwarded to the Hospital medical record to serve as reference information only. Courtesy Staff do not have Clinical Privileges, including the privilege to perform a History & Physical.
9. A Courtesy Staff Appointee may, at his/her discretion, be included on the ED unassigned call roster for patients treated and released from the ED and/or being discharged from the Hospitalist Service.
10. The grant of appointment to physicians as Courtesy Staff Appointees is a courtesy only, which may be terminated by the Board upon recommendation of the Executive Committee with thirty (30) days written notice, without rights to a hearing or appeal as set forth in the Policy on Medical Staff Appointment, Reappointment and Clinical Privileges.
11. Any Courtesy Staff Appointee who desires to transfer to another staff category and to request Clinical Privileges must meet the qualifications, standards, and requirements for appointment and Clinical Privileges as set forth in the Policy on Medical Staff Appointment, Reappointment and Clinical Privileges and these bylaws.

ARTICLE II – PART F: HONORARY STAFF

1. The Honorary Staff shall consist of Medical Staff Appointees who have retired from active Hospital practice or other Physicians, Dentists or Podiatrists or scientists who are of outstanding reputation, not necessarily residing in the community.
2. Persons appointed to the Honorary Staff shall not be eligible to admit or attend patients, to vote, to hold office, and may be appointed to Medical Staff committees. They may, but are not required to attend any Medical Staff meetings. Honorary Staff shall not be required to pay Medical Staff dues or assessments.

ARTICLE III

STRUCTURE OF THE MEDICAL STAFF

ARTICLE III – PART A: GENERAL

Section 1. Medical Staff Year:

For the purpose of these bylaws the Medical Staff year commences on the 1st day of January and ends on the 31st day of December each year.

Section 2. Dues:

The Medical Staff shall pay annual staff dues to the Hospital's Medical Staff account as may be required by the Executive Committee and approved by the Board from time to time. Signatories to this account shall be the President and Vice President.

Section 3. Officers:

The officers of the Medical Staff shall be the President and Vice President.

Section 4. Qualifications of Officers, Chiefs, Credentials Chair, Division Chairs and Clinical Medical Directors:

Only those Active Staff Appointees who satisfy the following criteria shall be eligible to serve as Medical Staff officers, Department chiefs, Division chairpersons, committee chairpersons and Clinical Medical Directors:

1. while serving as a medical staff officer or department chief, the officer or chief shall not serve as a medical staff officer, department chief/chair, or credentials chair at any other hospital, including another MediCorp hospital;
2. shall be certified by an appropriate specialty board or has affirmatively established comparable competence through the credentialing process;
3. be appointed in good standing to the Active Staff of the Hospital and continue so during their term of office;
4. have no pending adverse recommendations concerning staff appointment or Clinical Privileges;
5. have demonstrated interest in maintaining quality medical care by the Hospital;
6. not be presently serving as a Medical Staff or corporate officer, Department chief, Division chairperson, committee chairperson or in another formal leadership role at another Hospital or health care facility, and shall not so serve during the term of office;
7. have constructively participated in Medical Staff affairs, including peer review activities;
8. have demonstrated leadership ability;
9. be willing to discharge faithfully the duties and responsibilities of the position to which the individual is elected or appointed;
10. be knowledgeable concerning the duties of the office;
11. possess written and oral communication skills;

12. possess and have demonstrated an ability for harmonious, professional interpersonal relationships;
13. do not have an employment or other contractual arrangement with another competing Hospital, health care system or entity, or payor organization not affiliated with this Hospital or otherwise have any business interest that would cause the individual's interests to conflict with the Hospital's commitment to the community or would provide incentives or encouragement, direct or indirect, for the Physician to refer patients to other facilities for reasons unrelated to clear patient preference or medical needs; and
14. devote the time necessary to fulfill responsibilities of the position including, but not limited to, preparing for and attending relevant meetings.

All Medical Staff officers, Department chiefs, credentials chair, Division chairpersons, committee chairpersons and medical directors must possess at least the above qualifications and maintain such qualifications during their term of office. Failure to do so shall automatically create a vacancy in the office involved.

Section 5. President of the Medical Staff:

The President shall:

1. act as the principal elected official of the Medical Staff and the Hospital, in coordination and cooperation with the Department Chiefs, the President of the Hospital, and Chief Executive Officer in matters of mutual concern involving the Hospital and MediCorp Health System;
2. call, preside at and be responsible for the agenda of all regular and special meetings of the Medical Staff;
3. make recommendations for appointment of Medical Staff to standing and/or ad-hoc committees, as may be established, except the Executive and Credentials Committees, in accordance with the provisions of these bylaws;
4. serve as Chairperson of the Executive Committee;
5. may attend any standing or ad-hoc Committee meeting without vote, unless otherwise stipulated in these Bylaws;
6. represent the views, policies, needs and grievances of the Medical Staff and report on the medical activities of the staff to the Board, the President of the Hospital, and to the Chief Executive Officer;
7. provide day-to-day liaison on medical matters with the Chief Executive Officer, Credentials Chair, Department Chiefs, President of the Hospital and the Board; and
8. receive and interpret the policies of the Board to the Medical Staff and report to the Board on the performance and maintenance of quality with respect to the delegated responsibility of the Medical Staff to provide medical care.

Section 6. Vice President of the Medical Staff:

The Vice President shall:

1. assume all the duties and have the authority of the President of the Medical Staff in the event of the President's temporary inability to perform due to illness, absence from the community or unavailability for any other reason;
2. collect staff dues and funds, and make disbursements authorized by the Executive Committee or its designee;
3. call meetings on order of the President of the Medical Staff;
4. serve on the Executive Committee;
5. automatically succeed the President, should the office of President become vacated for any reason;
6. perform such duties as are assigned by the President; and
7. serve as an Ex Officio member of the Credentials Committee (with vote).

Section 7. Election of Officers:

Nominating Committee:

1. At least three (3) months before the scheduled date of the next Medical Staff election, the President of the Medical Staff shall appoint a Nominating Committee consisting of five (5) Active Staff Appointees.
2. Nomination and Election of Officers:
 - a) The Nominating Committee shall prepare a slate of nominees for each office.
 - b) Nominations for officers of the Medical Staff shall be presented by the Nominating Committee and by any other Medical Staff Appointee prior to each annual meeting. Any nomination made by an Appointee other than the Nominating Committee must be submitted, in writing, to the Nominating Committee at least three (3) days prior to the election. In order to be included on the ballot as a candidate, each nominee must possess all the qualifications set forth in Section 4 of this Part.
 - c) The candidates who receive a majority vote of those Medical Staff Appointees eligible to vote and present at the meeting at the time the vote is taken shall be elected. The vote shall be by written secret ballot if there is more than one (1) candidate. The election of each officer shall become effective at the start of the next Medical Staff year. No officer shall serve in the same office for more than four (4) successive years without a lapse of one (1) year.
 - d) In any election, if there are three (3) or more candidates for an office and no candidate receives a majority vote, there shall then be successive balloting such that the name of the candidate receiving the fewest votes is omitted from each successive slate until a majority is obtained by one (1) candidate.

Section 8. Conflict of Interest:

1. In any instance where an Officer, Service Chief, Division Chairperson, Clinical Medical Director, Committee Chairperson, or member of any Medical Staff committee has or reasonably could be perceived to have a Conflict of Interest or to be biased in any matter involving another Medical Staff Appointee that comes before such individual or committee, or in any instance where any such individual or committee member initiated the request for review involving that Appointee, such individual or member shall not participate in the discussion or voting on the matter, and shall be excused from any meeting during that time, although that individual or committee member may be asked, and may answer, any questions concerning the matter before leaving. As a matter of procedure, the chairperson of that committee designated to make such a review shall inquire, prior to any discussion of the matter, whether any member has any Conflict of Interest or bias. The existence of a potential Conflict of Interest or bias on the part of any committee member may be called to the attention of the chairperson by any committee member with knowledge of the matter.
2. A Department Chief or Division chairperson, as the case may be, shall have a duty to delegate review of applications for appointment, reappointment or Clinical Privileges, or questions that may arise to another member of the Department, if the Department chief or Division chairperson has a Conflict of Interest with the individual under review, or could be reasonably perceived to be biased.

Section 9. Removal of Officers:

1. The Executive Committee, by a two-thirds (2/3) vote of the full voting membership of the Committee, may remove any Medical Staff officer for conduct detrimental to the interests of the Hospital or MediCorp Health System, or if the officer is suffering from a physical or mental infirmity that renders the individual incapable of fulfilling the duties of that office, provided that notice of the meeting at which such action shall be decided is given in writing to such officer at least ten (10) days prior to the date of the meeting. The officer shall be afforded the opportunity to speak prior to the taking of any vote on such removal.
2. An officer who is found by the Board to no longer meet any of the qualifications set forth in Section 4 of this Part shall automatically relinquish his/her office.

Section 10. Vacancies in Office:

If there is a vacancy in the office of the President of the Medical Staff prior to the expiration of the President's term, the Vice President shall assume the duties and authority of the President for the remainder of the unexpired term. If there is a vacancy in any other office, the Executive Committee shall appoint another Appointee possessing the qualifications set forth in Section 4 of this Part to serve out the remainder of the unexpired term.

ARTICLE III – PART B: MEETINGS OF THE MEDICAL STAFF

Section 1. Annual Staff Meeting:

Medical Staff officers for the ensuing year shall be elected at the Annual Meeting of the Medical Staff in November.

Section 2. Regular Staff Meetings:

The Medical Staff shall hold regular meetings on dates set at the beginning of the year by the President of the Medical Staff, for the purpose of receiving and acting on Medical Staff reports and recommendations, to receive reports from management and to act on any other matters placed on the agenda by the President.

Section 3. Special Staff Meetings:

Special meetings of the Medical Staff may be called at any time by the President of the Medical Staff, a majority of the Executive Committee, or a petition signed by not less than one-fourth (1/4) of the voting staff. In the event that it is necessary for the staff to act on a question without being able to meet, the voting staff may be presented with the question by ballot. The ballot may be distributed in hard copy or electronically. All proposed amendments to the Medical Staff Bylaws shall be conducted in accordance with the ballot procedures described in Medical Staff Bylaws Article X, "Medical Staff Bylaws Amendment Process". These procedures shall also be used for election of Medical Staff Officers and may be used for other issues at the discretion of the Medical Staff President.

Section 4. Quorum:

The presence of one-fourth (1/4) of the persons eligible to vote shall constitute a quorum for any regular or special meeting of the Medical Staff.

Section 5. Agenda:

The agenda at any regular or special Medical Staff meeting and its conduct shall be set by the President of the Medical Staff.

Section 6. Minutes:

Minutes of each meeting of each department and each committee shall be prepared and shall include a record of the attendance of members, a summary of recommendations made, and the votes taken on each matter. Copies thereof shall be promptly forwarded to the Executive Committee. A permanent file of the minutes of each department, division and each committee meeting shall be maintained by the Hospital.

ARTICLE III – PART C: DEPARTMENT AND COMMITTEE MEETINGS

Section 1. Department Meetings:

1. Members of each Department shall meet as a Department at the discretion of the Department Chief, but not less than four (4) times each year at times set by the Chief of the Department to review and evaluate the clinical work of the Department, to consider the findings of ongoing quality assessment, monitoring and performance improvement activities, and to discuss any other matters concerning the Department. The agenda for the meeting and its general conduct shall be set by the Chief. Each Department shall maintain a permanent record of its findings, proceedings and actions, and shall make a report after each meeting to the Executive Committee, the President of the Hospital, and the Chief Executive Officer. Divisions within Departments shall meet at the call of the Division chairperson.
2. If meeting as a full Department does not best achieve the functions previously described, the Chief, with the agreement of the Division chair(s), may waive the four (4) meetings of the full Department. In this case, the Department's specialty Divisions shall meet not less than four (4) times per year. Waiver of the full Department meetings shall not be interpreted as relinquishment of the Department Chief's responsibility to maintain appropriate oversight regarding assigned Division activities or to maintain appropriate communication with the Division chairs and Appointees.

Section 2. Committee Meetings:

All committees shall meet at least quarterly, unless otherwise specified, at a time set by the chairperson of the committee. The agenda for the meeting and its general conduct shall be set by the chairperson. Each committee shall maintain a permanent record of its findings, proceedings and actions, and shall make a report after each meeting to the Executive Committee, the President of the Hospital and the Chief Executive Officer.

Section 3. Special Department and Committee Meetings:

1. A special meeting of any Department, Division or committee may be called by or at the request of the appropriate Chief or chairperson, the President of the Medical Staff or by a petition signed by not less than one-fourth (1/4) of the members of the Department or committee.
2. In the event that it is necessary for a Department or committee to act on a question without being able to meet, the voting members may be presented with the question via ballot and their vote returned to the Chief or chairperson of the Department or committee. When using a ballot process, the voting process shall be conducted using the procedures for amending the Medical Staff Bylaws as described in Medical Staff Bylaws Article X, paragraph three (3). Such a vote shall be binding so long as the question is voted on by a majority of the Department or committee members eligible to vote.

Section 4. Quorum:

Unless stated otherwise in Medical Staff Bylaws Section VI, Parts A-F (Medical Staff Committees), the presence of one-fourth (1/4) of the total membership of the Department or committee eligible to vote at any regular or special meeting (but in no event less than two (2) members) shall constitute a quorum. Once a quorum is established, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the meeting. Proxy votes are not allowed. The Chair is not obligated to proceed with a vote if a quorum is not present at the time of the vote. If a quorum is not present, or the Chair feels that an issue is best addressed by providing members the opportunity to vote via ballot, the ballot process shall be conducted using the procedures for amending the Medical Staff Bylaws as described in Medical Staff Bylaws Article X, paragraph three (3).

Section 5. Minutes:

Minutes of each meeting of each department and each committee shall be prepared and shall include a record of the attendance of members, a summary of recommendations made, and the votes taken on each matter. The minutes shall be signed by the presiding officer and recording secretary; copies thereof shall be promptly forwarded to the Executive Committee. A permanent file of the minutes of each department, division and each committee meeting shall be maintained by the Hospital.

ARTICLE III – PART D: PROVISIONS COMMON TO ALL MEETINGS**Section 1. Notice of Meetings:**

Notice of meetings of the Medical Staff and regular meetings of Departments, Divisions and committees shall be provided to the Medical Staff in advance of such meetings. Such notice shall state the date, time and place of the meeting. Notice shall be deemed delivered when it is distributed to Medical Staff mailboxes at the Hospital or sent via the electronic information system. Such distribution shall be deemed to be actual notice and the failure to retrieve a meeting notice shall not be an acceptable excuse for nonattendance. The actual attendance of any individual at any meeting shall constitute a waiver of that individual's notice of said meeting.

Section 2. Attendance Requirements:

1. Each Active Staff Appointee is expected routinely to attend all Medical Staff meetings and applicable Department, Division and committee meetings. Attendance shall be recorded as "present" or "absent." Medical Staff Appointees are accountable for communicating with the appropriate meeting chair if they anticipate being consistently absent from assigned meetings. Meeting attendance shall be evaluated at the time of reappointment. Failure to attend meetings may result in category reassignment.
2. Any Medical Staff Appointee whose clinical work is scheduled for discussion at a regular Department or Division meeting shall be notified that his/her attendance is expected and shall be invited to present the case. The Chief of the Department or Division chair shall give the individual at least five (5) days' advance written notice of the time and place of the meeting at which attendance is expected. If the individual makes a timely request for postponement, supported by an adequate showing that the absence will be unavoidable, the presentation may be postponed by the Department Chief (or by the Executive Committee if the Department Chief is the individual involved) until not later than the next regularly scheduled meeting. Otherwise, the pertinent clinical information shall be presented and discussed as scheduled.
3. Whenever there is an apparent or suspected serious deviation from standard clinical practice or expected professional behavior involving any Appointee, the appropriate Department Chief or Division Chair shall notify the individual that the individual is required to attend a meeting to consider the matter. The conference shall be held with the Department Chief and, if appropriate, the Division Chair. The chairperson of the Credentials Committee, the Division Chair or other Medical Staff leader may attend the meeting at the invitation of the Department Chief. The notice to the Appointee regarding this conference shall be given personally or in writing at least five (5) days prior to the conference and shall inform the Appointee that attendance at the meeting is mandatory.
4. The failure of an individual to attend a conference to which notice was given that attendance was mandatory shall be reported to the Executive Committee. Unless excused by the Executive Committee upon showing of good cause, such failure shall constitute voluntary relinquishment of all or such portion of the individual's admitting privileges as the Executive Committee may direct. Such relinquishment shall remain in effect until the matter is resolved.
5. Apparent or suspected deviations from expected professional behavior shall be addressed in accordance with the Medical Staff and Allied Health Professionals Conduct Policy.
6. Persons appointed to the Consulting or Affiliate Staff categories of the Medical Staff shall be permitted to attend and participate in departmental meetings, but shall not be required to do so as a condition of continued staff appointment.

Section 3. Rules of Order:

The Chair shall be responsible for the orderly conduct of the meeting.

Section 4. Voting:

Any individual who, by virtue of position, attends a meeting in more than one (1) capacity shall be entitled to only one (1) vote.

ARTICLE IV

OTHER MEDICAL STAFF DOCUMENTS

Section 1. Contents of Other Documents:

1. In addition to the Medical Staff Bylaws, policies and Rules and Regulations exist that apply 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 and Rules and Regulations will be considered an integral part of the Medical Staff Bylaws.
2. The Credentialing Policy will address, but is not limited to, the following matters: qualifications for appointment, the process for granting initial appointment, Clinical Privileges, reappointment, collegial interventions, the investigation process and the process for hearing and appeals.
3. The Policy for Allied Health Professionals will address the following matters as they relate to allied health professionals: the process for determining the need for new classes of allied health professionals, qualifications for practice, the process for granting Clinical Privileges or a scope of practice initially and on an ongoing basis, collegial intervention, suspensions, and procedural rights.
4. An amendment to the Credentialing Policy, the Allied Health Professionals Policy or the Rules and Regulations may be made by a majority vote of the members of the Medical Executive Committee present and voting at any meeting of that committee where a quorum exists. At least 14 days prior the Medical Executive Committee vote on an amendment to the Credentialing Policy, Allied Health Professionals Policy, or the Rules and Regulations, notice will be distributed in written or electronic form and mailed to each Medical Executive Committee member. Any member of the Medical Staff, or any allied health professional, if applicable, may submit written comments to the Medical Executive Committee. The Credentialing Policy, Allied Health Professionals Policy or the Rules and Regulations also may be amended by the Board, as outlined in each of these documents.
5. All other policies of the Medical Staff may be adopted and amended by a majority vote of the Medical Executive Committee. No prior notice is required.
6. Adoption of and changes to the Credentialing Policy, the Rules and Regulations, and other Medical Staff policies will become effective only when approved by the Board.

ARTICLE V

CLINICAL DEPARTMENTS

ARTICLE V – PART A1 LIST OF MARY WASHINGTON HOSPITAL DEPARTMENTS

Clinical services shall be provided in clinical Departments. In order to accomplish this, the following clinical Departments are established. Additional Departments or Divisions of Departments, as required from time to time, may be established by the Board after considering recommendations from the Executive Committee. Representation by Division members at consolidated Department meetings, including voting privileges, may be more specifically defined in a Department's Rules and Regulations, if adopted.

1. Diagnostic and Support Services
 - Anesthesia
 - Emergency Medicine
 - Pathology
 - Radiology
2. Surgical Services
 - Cardio-Thoracic
 - Dentistry
 - ENT
 - General Surgery
 - Neurosurgery
 - Ophthalmology
 - Oral Maxillofacial Surgery
 - Orthopedic
 - Plastic Surgery
 - Podiatry
 - Urology
3. Medical Services
 - Cardiology
 - Primary & Subspecialty Medicine
 - Psychiatry
4. OB-Gyn
5. Pediatrics

ARTICLE V – PART A2: LIST OF STAFFORD HOSPITAL CENTER DEPARTMENTS

Clinical services shall be provided in clinical Departments. In order to accomplish this, the following clinical Departments are established. Additional Departments or Divisions or Departments, as required from time to time, may be established by the Board after considering recommendations from the Executive Committee. Representation by Division members at consolidated Department meetings, including voting privileges, may be more specifically defined in a Department's Rules and Regulations, if adopted.

1. Diagnostic and Support Services
 - Anesthesia
 - Emergency Medicine
 - Pathology
 - Radiology

2. Surgical Services
 - General Surgery
 - Orthopaedics
 - OB-Gyn
3. Medical Services
 - All Adult Primary & Subspecialty Medicine
 - Newborn Medical Services

ARTICLE V – PART B: FUNCTIONS OF DEPARTMENTS

1. Each clinical Department Chief shall recommend to the Credentials Committee written criteria for the assignment of Clinical Privileges within the Department and each of its Divisions. Such criteria shall be consistent with and subject to the bylaws, policies, rules and regulations of the Medical Staff and the Hospital. These criteria shall be effective when approved by the Board. Clinical Privileges shall be based upon demonstrated competence, training and experience within the specialties covered by the Department.
2. Each Department (or Division), with the guidance of the Physician Quality Management Committee (“PQM-C”), shall monitor and evaluate medical care on a retrospective, concurrent or prospective basis in all major clinical activities of the Department or Division. Priority shall be given to clinical services that are high volume and high risk. This monitoring and evaluation includes:
 - a) the identification and collection of information about important aspects of patient care provided in the Department;
 - b) the identification of the performance indicators used to monitor the quality and appropriateness of the important aspects of care;
 - c) evaluation of the quality and appropriateness of care.
3. Each Department (or Division) shall recommend, subject to approval and adoption by the Executive Committee and Board, objective criteria that reflect current knowledge and clinical experience. These criteria shall be used by each Department or Division or by the Hospital’s quality assessment program to monitor and evaluate patient care. This includes providing clear direction to non-Medical Staff who support data collection. When important problems in patient care and clinical performance or opportunities to improve care are identified, each Department or Division shall document the actions taken and evaluate the effectiveness of such actions.
4. In discharging these functions, each Department and Division shall submit recommendations to the Medical Executive Committee, PQM-C or other appropriate committees handling utilization and/or quality management. The Credentials Committee shall be notified whenever further investigation and action is indicated, involving any individual member of the Department. Copies of these recommendations shall be filed with the Executive Committee, the President of the Hospital, and the Chief Executive Officer.

ARTICLE V – PART C: DEPARTMENT/SERVICE CHIEFS

1. The Chief of each Department shall be an appointee to the Active Staff who possesses the qualifications set forth in Article III, Part A, and Section 4 of these bylaws and elected by a majority vote of the Active members of the Department. After the election is held, the individual elected is subject to Board approval prior to assuming the position. Department Chiefs shall serve a term as established by the Department up to, but not exceeding, five (5) years with no limitation on total terms served. Each Department shall establish procedures for identifying candidates. The procedures shall be ratified by the Medical Executive Committee.
2. Approximately six (6) months prior to the end of the incumbent Chief's term, members of the Department shall be notified of the opportunity and process for electing a Chief. Prior to election, the Department shall seek the advice and counsel of the Medical Staff President, the President of the Hospital, and Chief Executive Officer. All applicants for Chief will be interviewed by a management-physician team with four (4) members appointed by the Medical Staff President, of which at least two (2) shall be Active Staff of the Department, and four (4) members appointed by Hospital leadership. Applicants who meet the required qualifications will be presented to the appropriate Medical Staff Department for election. The Department shall be afforded the opportunity for feedback from the Interview Team about the relative qualifications of the applicant(s) in a manner considered appropriate by the Department.
3. If a Chief vacancy occurs, the Department, following advice and counsel of the Medical Staff President, the President of the Hospital, and Chief Executive Officer, will appoint an interim Chief who must possess the qualifications set forth in Article III, Part A and Section 4 of these Bylaws. The appointed interim Chief must be ratified by a majority vote of the Department at the next Department meeting, no later than one (1) month after the appointment.
4. All concerns regarding a specific Chief's performance, or related to any of the issue(s) addressed in the Medical Staff Bylaws, including but not limited to issues related to election, removal and roles or responsibilities of the Chief position should be forwarded to the Medical Staff President. The Medical Staff President, in collaboration with the President of the Hospital and Chief Executive Officer or his/her designee, shall meet with the appropriate individuals to discuss the concerns and will develop a course of action. If they are unable to resolve the issues(s), the Medical Staff President shall refer the issues(s) to the Medical Executive Committee. If the Medical Staff Executive Committee is unsuccessful in resolving the issues(s) directly, the issue(s), accompanied by the recommendation of the Medical Executive Committee, will be referred to the Board Medical Affairs Committee.
5. Department Chiefs may be removed from office by the Medical Executive Committee upon receipt of a recommendation of two-thirds (2/3) vote of the Active members of the Department, or in the absence of such recommendation, the Medical Executive Committee may remove a Chief on its own by a two-thirds (2/3) vote of the Medical Executive Committee if either of the following occurs:
 - The Chief ceases to be a member in good standing of the Medical Staff
 - The Chief suffers an involuntary loss or significant limitation of practice privileges that directly affects the Chief's ability to carry out the responsibilities of Chief

If removal is required, or a vacancy occurs, a new election will be held according to established departmental procedures within six (6) months.

ARTICLE V – PART D: FUNCTIONS OF DEPARTMENT/SERVICE CHIEFS

Each Chief shall assume responsibility for the following roles and responsibilities outlined below personally or via delegations to an appropriate Division Chair(s) or Medical Director(s). The Department Chief, following input from the affected Division(s), shall delineate the roles, responsibilities, and authority delegated by the Chief to Division Chairs and/or Medical Directors. In addition to the general roles and responsibilities outlined below, each Department may, at their discretion and in collaboration with the Chief Medical Officer, develop a Chief Position Description that defines qualifications, roles, responsibilities and authority specific to the Department's scope of clinical services. The Department-specific Job Description shall be developed by the representatives from the Divisions assigned to the Department in collaboration with the Department Chief and Chief Medical Officer and approved by the Department, Medical Executive Committee and Board of Trustees.

1. clinically related activities of the Department;
2. administratively related activities of the Department, unless otherwise provided by the Hospital;
3. continuing surveillance of the professional performance of all individuals in the Department who have delineated Clinical Privileges;
4. recommending to the Medical Staff the criteria for Clinical Privileges that are relevant to the care provided in the Department;
5. recommending Clinical Privileges for Appointees assigned to the Department to include making a report to the Credentials Committee concerning the appointment, reappointment, and delineation of Clinical Privileges for all applicants seeking Clinical Privileges in the Department;
6. assessing and recommending to Medical Staff leadership and other relevant Hospital authority off-site sources for needed patient care, treatment, and services not provided by the Department or the organization;
7. the integration of the Department and relevant services into the primary functions of the organization;
8. the coordination and integration of interDepartmental and intraDepartmental services;
9. the development and implementation of policies and procedures that guide and support the provision of care, treatment, and services;
10. the recommendation for a sufficient number of qualified and competent persons to provide care, treatment, and services;
11. the determination of the qualifications and competence of Department or service staff who are not LIPs and who provide patient care, treatment and services;
12. the continuous assessment and improvement of the quality of care, treatment, and services;
13. the maintenance of appropriate quality control programs, if applicable;
14. the orientation and continuing education of all persons in the Department or service;
15. recommendations for space and other resources needed by the Department or services including assisting with prioritization of space and resources;
16. shall service as a member of the Executive Committee;

17. appoint ad hoc committees, work groups, and teams as necessary to carry out continuous performance assessment and improvement activities;
18. be responsible for the evaluation of all provisional Appointees and report thereon to the Credentials Committee;
19. assist the Hospital, in accordance with the provisions of these bylaws, with respect to the granting of temporary privileges within the Department, and with the evaluation of requests for temporary privileges;
20. be responsible within the Department for the enforcement of the MediCorp Health System, Hospital and Medical Staff bylaws, policies, rules and regulations;
21. be responsible for implementation within the Department of actions taken by the Board and the Executive Committee;
22. assist Hospital management in the preparation of reports and such budget planning pertaining to the Department; and
23. establish Divisions or sections within the Department, subject to the approval of the Executive Committee and the Board.

ARTICLE V – PART E: DIVISION CHAIRS

1. Division chairs shall be Appointees of the Active Staff, approved by the Board, who possess qualifications outlined at Article III, Part A, Section 4 of these bylaws.
2. The Chair shall be responsible for assisting the Department Chief with Department functions as delegated by the Chief and outlined in Article V – Part D of these bylaws. The Chair's primary responsibility shall be to assist with development of qualification criteria for Clinical Privileges exercised by the Division, peer review and performance improvement. This includes being the first contact for credentials review and peer review for the Division and submitting opinions and recommendations to the Department Chief. It shall be the Chair's responsibility to inform the Chief of quality concerns identified by the Division.
3. If the Division has been granted a position on the Medical Executive Committee, the Chair shall assume responsibility for attending the Executive Committee meetings.
4. Concerns regarding the performance of the chair should be forwarded to the appropriate Service Chief who shall review the concerns with the Chair. Prior to election the current Division Chair shall appoint a nominating committee which shall include the Department Chief. In lieu of a nominating committee, the Division may stipulate that the Division Chair is appointed by the Department Chief. The Chief shall make good faith efforts to solicit input from the Division prior to appointment. A Department Chief may concurrently serve as Division Chair. The election or appointment of the Chair shall occur annually. Unless otherwise provided in the Department's rules and regulations, there shall be no limit on the number of total terms served.
5. A Division Chair may be removed by a two-thirds (2/3) vote of the Division or by a two-thirds (2/3) vote of the Medical Executive Committee upon recommendation of the Department Chief, following input from the effected Division.

ARTICLE V – PART F: CLINICAL MEDICAL DIRECTORS

Management, in consultation with the appropriate Service Chief, may determine that Medical Directorship positions, with defined duties, are necessary to provide medical expertise and direction beyond that provided by Service Chiefs or other elected Medical Staff positions. Medical oversight for Medical Director Positions shall be assigned to an appropriate Service Chief. The process for selection or removal of Medical Directors shall be at the discretion of management with input provided by the Service Chief.

ARTICLE VI

COMMITTEES OF THE MEDICAL STAFF

ARTICLE VI – PART A: APPOINTMENT

Section 1. Chairpersons:

1. All committee chairpersons, unless otherwise provided for in these bylaws, shall be appointed by the Board after receiving and considering recommendations from the President of the Medical Staff. Unless otherwise provided in these bylaws, all chairpersons shall be selected based on the criteria set forth in Article III, Part A, Section 4 of these bylaws. Such appointments will be made by the Board, at its first meeting after the end of the Medical Staff year, for an initial term of one (1) year.
2. Except as otherwise provided in these bylaws, after serving an initial term a chairperson may be reappointed by the Board from year to year for a maximum of three (3) additional yearly terms upon recommendation from the President of the Medical Staff, President of the Hospital, and the Chief Executive Officer.

Section 2. Members:

1. Except as otherwise provided for in these bylaws, or other Policy as may be established by the Medical Staff, members of each Medical Staff committee shall be appointed yearly by the President of each Hospital's Medical Staff, in consultation with the President of the Hospital and Chief Executive Officer, not more than thirty (30) days after the annual meeting of the Medical Staff, and there shall be no limitation in the number of terms they may serve. All appointed members may be removed and vacancies filled at the discretion of the President of the Medical Staff.
2. Unless otherwise specified the President of the Hospital, Chief Executive Officer, Chief Medical Officer, and the President of the Medical Staff or their respective designees shall be members, *Ex Officio*, without vote, on all committees.

ARTICLE VI – PART B1: EXECUTIVE COMMITTEE

Section 1A. Composition of Mary Washington Hospital (MWH) Executive Committee:

1. The Executive Committee shall consist of the officers of the Medical Staff, the Chief of each clinical Department and representatives from each of the following medical specialties: Anesthesia, Adult Hospitalist, Cardiology, Emergency Medicine, General Surgery, Medicine, Obstetrics/Gynecology, Orthopedic Surgery, Pathology, Pediatrics, Psychiatry and Radiology. Other representatives may be appointed by the Executive Committee. No Active Staff Appointee shall be ineligible for membership solely based on professional discipline or specialty.
2. The President of the Medical Staff shall be Chairperson of the Executive Committee.
3. The MediCorp Chief Executive Officer/Hospital President and Chief Operating Officer, and MediCorp Health System Chief Nursing Officer shall be members, ex-officio without vote.
4. The physician serving on the Credentials Committee as Chair or Vice Chair shall be a member ex-officio with vote on matters pertaining to credentialing.
5. The Physician Quality Management Chair shall be a member ex-officio with vote on matters pertaining to Physician Quality Management Committee recommendations and duties.

6. The Chief Medical Officer shall be a member ex-officio with vote.
7. The Sr. Vice President for Hospital Operations, Vice President Nursing, Vice President Clinical Support, and others as invited by the Medical Executive Committee shall attend without vote.
8. A majority of voting Executive Committee members shall be fully licensed Physicians appointed to the Active category of the Medical Staff.
9. Attendance shall be required at seventy-five percent (75%) of all meetings. Designated alternates, approved in advance by the Board, may attend when a committee member must be absent. The designated alternate shall have voting privileges. If neither the committee member nor the designated alternate can attend a meeting, the member may request another Appointee to attend in his/her place. This alternate representative, however, shall not have voting privileges. The committee members' failure to meet this attendance requirement shall result in removal from the Committee.

Section 1B. Composition of Stafford Hospital Center (SHC) Executive Committee:

1. The Executive Committee shall consist of the officers of the Medical Staff, the Chief of each clinical Department, the Division chairs or their designated representative, a Hospitalist physician representative, a community based physician representing the Medical Services Department, and the additional physician and hospital leadership representatives listed below. No Active Staff Appointee shall be ineligible for membership solely based on professional discipline or specialty.
2. The President of the Medical Staff shall be the Chairperson of the Executive Committee.
3. The MediCorp Chief Executive Officer, President of Stafford Hospital Center, and MediCorp Health System Chief Nursing Officer shall be members, ex-officio without vote.
4. The physician serving on the Credentials Committee as Chair or Vice-Chair shall be a member ex-officio with vote on matters pertaining to credentialing.
5. The Physician Quality Management Committee Chairperson or his designee shall be a member ex-officio with vote on matters pertaining to Physician Quality Management Committee recommendations and duties.
6. The Chief Medical officer shall be a member ex-officio with vote.
7. The Sr. Vice President for Hospital Operations, Hospital's Medical Director, Administrative Director Nursing Services, Administrative Director Professional and Support Services, and others as invited by the Medical Executive Committee may attend without vote.
8. A majority of voting Executive Committee members shall be fully licensed Physicians appointed to the Active category of the Medical Staff.
9. Attendance shall be required at seventy-five percent (75%) of all meetings. Designated alternates, approved in advance by the Board, may attend when a committee member must be absent. The designated alternate shall have voting privileges. If neither the committee member nor the designated alternated can attend a meeting, the member may request another Appointee to attend in his/her place. This alternate representative, however, shall not have voting privileges. The committee member's failure to meet this attendance requirement shall result in removal from the Committee.

Section 2. Duties:

The duties of the Executive Committee shall be:

1. to represent and act on behalf of the organized Medical Staff between Medical Staff meetings in all matters, without requirement of subsequent approval by the staff, subject only to any limitations imposed by these bylaws;
2. to coordinate the activities and general policies of the various Departments;
3. to receive and act upon those Department, committee and other assigned activity group reports as specified in these bylaws, and make recommendations concerning them to the President of the Hospital, Chief Executive Officer and the Board;
4. to implement policies of MediCorp Health System and the Hospital that affect the Medical Staff;
5. to provide effective communication and liaison among the Medical Staff, the President of the Hospital, the Chief Executive Officer and the Board;
6. to keep the Medical Staff abreast of applicable accreditation and regulatory requirements affecting the Hospital and MediCorp Health System;
7. to enforce MediCorp Health System, Hospital and Medical Staff rules in the best interest of patient care and of the Hospital, with regard to all persons who hold appointment to the Medical Staff;
8. to refer situations involving questions of the clinical competence, patient care and treatment, case management, or inappropriate behavior of any Medical Staff Appointee to the Credentials Committee and review and act on the reports and recommendations submitted by the Credentials Committee;
9. to refer situations involving questions of the inappropriate behavior of any individual with Clinical Privileges to the Professional Conduct Committee and review and act on the reports and recommendations submitted by the Professional Conduct Committee;
10. to be responsible for participation of the Medical Staff in Performance improvement Activities;
11. to review the Bylaws, policies, rules and regulations, and associated documents of the Medical Staff, including but not limited to the mechanisms designed to evaluate the credentials and to delineate the Clinical Privileges of Medical Staff applicants and Appointees, to terminate Medical Staff appointment and Clinical Privileges and to provide a fair hearing, and to recommend such changes as may be necessary or desirable to the Board;
12. to determine minimum continuing education requirements for Appointees to the staff;
13. to review, through support of the Credentials Committee, the credentials of all applicants and make recommendations for appointment to the Medical Staff, assignment to Departments and delineation of Clinical Privileges;
14. to review all information available regarding the performance and clinical competence of persons who hold appointments to the Medical Staff and as a result of such review make recommendations regarding status changes, reappointment, and Clinical Privileges;
15. to organize and establish priorities pertaining to the Medical Staff's participation in organizational performance improvement processes;
16. in conjunction with the Physician Quality Management Committee, to establish peer review guidelines and periodically evaluate and revise such activities;

17. to recommend Medical Staff structure and processes necessary to fulfill duties and functions assigned by the Board; and
18. to make recommendation for the Board's consideration about the opening and closing of clinical services.

Section 3. Meetings, Reports and Recommendations:

1. The Executive Committee shall meet no less than ten (10) times each year or more often if necessary to transact pending business. Recommendations of the Executive Committee shall be transmitted to the Board. The Chairperson of the Executive Committee shall be available to meet with the Board or its applicable committee on all recommendations that the Executive Committee may make.
2. Between meetings of the Executive Committee, an ad hoc committee composed of the officers of the Medical Staff and the Department Chiefs shall be empowered to act in situations of urgent or confidential concern where not prohibited by these bylaws.

ARTICLE VI – PART C: MARY WASHINGTON HOSPITAL (MWH) AND STAFFORD HOSPITAL CENTER (SHC) CREDENTIALS COMMITTEE CREDENTIALS COMMITTEE

Section 1. Composition:

1. The MWH and SHC Credentials Committee shall consist of the two (2) most recent Past Presidents of each Hospital who are still Appointees to the Hospital's Active Staff, the Medical Staff Vice Presidents and two (2) Appointees from the Active Medical Staff of each Hospital, all of whom shall be voting members of the Committee. The Executive Committee of each Hospital shall appoint the two (2) at-large active medical staff members of the Committee. The Executive Committee of SHC also shall appoint two (2) active SHC medical staff members to serve on the Committee until Past Presidents of Stafford Hospital Center's Medical Staff are available for committee membership. The Department Chiefs of each Hospital also shall be non-voting members of this committee and their primary role on the committee shall be to present applicants for Medical Staff appointment, reappointment and privileges at each Hospital. If the Committee members do not have the clinical expertise required for a specific issue, the Committee is authorized to solicit consultation from staff currently appointed / privileged by MWH-SHC or from an appropriate external source.
2. The Chair and Vice Chair shall be an Active Staff Appointee of MWH and SHC appointed by the Chief Executive Officer following endorsement by the MWH-SHC Credentials Committee and Medical Executive Committees of MWH and SHC. The Chair and Vice Chair must meet the qualifications for the Credentials Chair position as outlined in Article II, Part A, Section 4, of the Medical Staff Bylaws. Prior experience on the Credentials Committee or holding a leadership position at a MediCorp Hospital is required. The Chair shall serve a five (5) year term with no limit on number of terms served. The Chair shall be a member ex-officio without vote on the MWH and SHC Board Medical Affairs Committees.
3. The incumbent Chair, with input from the Credentials Committee, shall recommend to the MediCorp Health System Chief Executive Officer one member of the Committee to serve as the Vice Chair. The Vice Chair's duties will include fulfilling the duties of the Chair in the Chair's absence, assisting with the Chair's duties as assigned, and gaining the experience and knowledge required to assume the Chair position. The Vice Chair shall serve a two (2) year term with no limit on number of terms served. The Chair and Vice Chair, through their mutual agreement, shall each serve as the primary Credentials Committee contact for either MWH or SHC and serve on the appropriate Medical Executive Committee (MEC) as a member ex-officio of the MEC with vote on matters pertaining to the credentialing.

4. The Chairman of the Board of Trustees of MediCorp Health System shall appoint one individual to serve as a liaison between the Credentials Committee and the Board, without vote.
5. Service on this committee shall be considered as the primary Medical Staff obligation of each member of the committee, except the Department Chiefs, and other Medical Staff duties shall not interfere. If at any time the continued workability of the committee is threatened by the inability or unwillingness of any of the Past Presidents or other appointed members to serve, another individual shall be appointed to fill the vacancy by the appropriate Hospital's Medical Staff President following consultation with the Credentials Committee Chair and Vice Chair and endorsement of the appropriate Medical Executive Committee.
6. Attendance shall be required at seventy five percent (75%) of all meetings. Failure to meet this attendance requirement shall result in removal from the Committee.
7. Members of the Credentials Committee appointed by the Medical Executive Committee shall serve a one (1) year term with no limitation on the number of terms served. The term for the members serving by virtue of being a Past President will conclude when the Immediate Past President rotates onto the Committee.
8. In the event the Chair position becomes vacant, the Vice Chair shall assume the duties of the Chair pending appointment of a new Chair. The Chief Executive Officer shall proceed with appointment of a Chair of the Credentials Committee consistent with the process described in paragraph two (2) of this section. There shall be no limitation on the number of terms the Chair may serve. Removal of the Chair shall be at the discretion of the MediCorp Health System Chief Executive Officer with approval of the MediCorp Health System Board.
9. The primary role of the Credentials Committee Chair shall be as a meeting facilitator. The Chair shall vote only in the event of a tie.
10. The Board of Trustees, following recommendation of the Credentials Committee and Medical Executive Committees may waive term limits and/or the Active Staff category requirement for any member of the Credentials Committee, including the Chair and Vice Chair, if the waiver is considered to promote patient care and safety and the orderly and efficient operations of the credentialing process.

Section 2. Duties:

The duties of the Credentials Committee shall be:

1. to review the credentials of all applicants for Medical Staff appointment, reappointment and Clinical Privileges at each Hospital, to make investigations of and interview such applicants as may be necessary, and to make a written report of its findings and recommendations;
2. to review the credentials of all applicants who request to practice at either Hospital as Allied Health Professionals, to conduct investigations of and interview such applicants as may be necessary, and to make a written report of its findings and recommendations; and
3. to review, as questions arise, all information available regarding the clinical competence and behavior of persons currently appointed to the Medical Staff, granted privileges at either Hospital, and of those practicing as Allied Health Professionals and, as a result of such review, to make a written report of its findings and recommendations.

Section 3. Meetings, Reports and Recommendations:

1. The Credentials Committee shall meet as often as necessary to accomplish its duties, shall maintain a permanent record of its proceedings and actions, and shall report its recommendations to the Executive Committee, the President of the Hospital, the Chief Executive Officer and the Board. The Chairperson of the Credentials Committee shall be available to meet with the Board or its committee on all recommendations that the Credentials Committee may make.
2. A quorum is defined as those voting members present and voting, but in no event shall constitute less than two (2) members.

ARTICLE VI – PART D: MARY WASHINGTON HOSPITAL (MWH) AND STAFFORD HOSPITAL CENTER (SHC) PRACTITIONER HEALTH RESOURCE GROUP (PHRG)

(Approved and Organized September 2002)

Section 1. Composition:

The chairperson of the PHRG shall be the Chief Medical Officer (“CMO”). The PHRG shall also include: a) a minimum of three (3) MWH Medical Staff Appointees recommended by the Medical Leadership Council and approved by the MWH Executive Committee and Board of Trustees, and b) a minimum of two (2) SHC Medical Staff Appointees recommended by the CMO and approved by the Executive Committee and Stafford Hospital Center Board of Trustees. One of the members shall be the MWH Medical Director of Behavioral Health Care / Division of Psychiatry.

1. There shall be no limitation on years of service on the PHRG.
2. PHRG members must be willing to become educated on a wide variety of issues affecting practitioner health.
3. The PHRG will meet as often as required to meet their objectives. PHRG members must be willing to meet on an as needed basis on short notice.
4. Concerns regarding the performance of PHRG members should be referred to the Chief Medical Officer who shall have the authority to remove a member.
5. In the event the position of Chief Medical Officer becomes vacant, the CEO shall designate one of the PHRG members as interim chair.

Section 2. Duties:

1. Assumes responsibility for recommending to the Medical Staffs and Boards of Trustees processes to identify and manage matters of individual health that are separate from the disciplinary function. Health includes the physical, mental, and emotional well being of the practitioner as it relates to the safe and orderly delivery of patient care.
2. Educates the Medical Staffs and other organization staff about illness and impairment recognition issues specific to practitioners appointed to the medical and allied health professional staff and maintains the confidentiality of informants.
3. Ensures the organization has a process available to practitioners for self-referral and to address referrals by other organization staff.
4. Evaluates the credibility of the complaint, allegation or concern.

5. Facilitates referral of the affected practitioner to appropriate professional internal or external resources for diagnosis and treatment of the condition or concern.
6. Maintains confidentiality of the practitioner who seeks or is referred for assistance except as limited by law, ethical obligation, or when patient safety is threatened.
7. Monitors the affected practitioner's performance until the rehabilitation, including aftercare program, or conditions of appointment are complete.
8. Reports to appropriate medical and Hospital leadership instances in which a practitioner's performance is considered unsafe.

Section 3. Reports and Recommendations:

The PHRG shall seek the input of the Medical Executive Committees on any policies and procedures implemented by the PHRG.

ARTICLE VI – PART E: MARY WASHINGTON HOSPITAL (MWH) AND STAFFORD HOSPITAL CENTER (SHC) MEDICAL STAFF BYLAWS, RULES & REGULATIONS & STANDARDS COMMITTEE

Section 1: Composition:

1. The Committee shall be composed of the current Medical Staff Officers of Mary Washington Hospital and Stafford Hospital Center and the Health System Chief Medical Officer (CMO) or the CMO's designee.
2. The Committee members shall select a member of the Medical Staff who is not currently serving as a Medical Staff Officer or Department Chief at any Hospital to serve as Chair. The Chair shall have prior medical staff leadership experience at Mary Washington Hospital or Stafford Hospital Center as a Medical Staff Officer or Department Chief. The Chair must hold current medical staff appointment, which may include Honorary Staff appointment, at Mary Washington Hospital or Stafford Hospital Center. The Chair will serve a two (2) year term with no limit on terms served. The role of the Chair shall be to serve as a facilitator and work with appropriate hospital staff and legal counsel, when deemed necessary, to develop recommendations and working drafts to present to the Committee.
3. The Committee may request the assistance of other Medical Staff members on an ad-hoc basis.

Section 2: Duties

The duties of the Committee, which shall function as a subcommittee of the Mary Washington Hospital and Stafford Hospital Center Medical Executive Committees shall be to:

1. Provide a formal structure for conducting periodic review and revision to documents that establish medical staff practice at Mary Washington Hospital and Stafford Hospital Center including: medical staff bylaws; rules & regulations and policies/standards.
2. Submit recommendations to the Medical Executive Committees for revisions to these documents as required to meet regulatory / accreditation standards.
3. Receive and evaluate requests or recommendations from the Medical Executive Committees, other Medical Staff Committees, or Medical Staff members related to the scope of documents outlined in Article VI, Part F, Section 2-1 above.

4. Prior to submitting recommendations to the Medical Staff Executive Committee regarding a Medical Staff Committee's composition or duties, the Bylaws Committee shall solicit input from the affected Committee(s).

Section 3. Reports and Recommendations:

1. The Committee shall meet on an ad-hoc basis as frequently as necessary to fulfill the Committee's duties.
2. All reports and recommendations shall be submitted to the Mary Washington Hospital and Stafford Hospital Center Medical Executive Committees.

ARTICLE VI – PART F: THE MARY WASHINGTON HOSPITAL (MWH) AND STAFFORD HOSPITAL CENTER (SHC) PHYSICIAN QUALITY MANAGEMENT COMMITTEE (“PQM-C”)

(Approved December 2005, Organized January 2006)

Section 1. Composition:

1. The PQM will be composed of a representative group of Active Medical Staff appointed by the PQM Chair or elected by their Division with approval by the Appointee's Hospital Board of Trustees.
2. The PQM-C shall have at least one representative from the Hospitals' Medical Staff Departments and shall include representatives from the following services: Anesthesia, Emergency Medicine, Adult Hospitalist Services, Pathology, Radiology, Obstetrics & Gynecology, Pediatrics, at least three (3) representatives from the Department of Surgery, and at least three (3) representatives from the Department of Medicine. A Physician serving on the Credentials, Medical Executive, or Board Medical Affairs Committee(s) at either Hospital is ineligible to serve on the PQM-C.
3. The Chief Medical Officer (CMO) or his/her designee shall be an ex-officio member without vote. When the committee is considering referring a matter to the Credentials Committee, the CMO will be recused. The primary role of the CMO shall be to communicate the Committee's concerns and/or requests for improvement regarding Hospital operations.
4. A Medical Support Services (MSS) representative shall serve as a recorder. MSS staff supporting the peer review function shall attend to assist with record review and data interpretation.
5. The MediCorp Health System Vice President, Quality and Medical Directors for Mary Washington Hospital and Stafford Medical Center shall be members ex-officio without vote.
6. Other Physicians or Hospital staff may be invited to attend on an as needed basis without vote.
7. Members shall serve three (3) year terms with a maximum two (2) consecutive terms.
8. The Chair of PQM shall serve a five (5) year term with a two (2) term limit.
9. The PQM Committee elects the Chair from among the applicants with review by the MEC and appointment by the System Board. Applicants must meet criteria at Article III, Part A, Section 4 of the Medical Staff Bylaws, except that Physicians in any staff category, including Honorary Staff, are eligible to serve as PQM-C Chair.
10. When a vacancy occurs, the PQM-C shall appoint an interim Chair and the application process will begin. When a vacancy occurs in the PQM-C membership, the vacancy will be approved in accordance with Part E, Section 1.1 of this Article.

11. The primary role of the PQM-C Chair shall be as a meeting facilitator. The Chair shall vote only in the event of a tie.

Section 2. Duties:

The duties of the PQM-C, a professional review body formed in furtherance of the Hospital's peer review function including the performance of focused review of Medical Staff members, shall be to:

1. Validate that the Medical Staffs, through the Medical Staff Department/Division structure have a functional process for addressing case review and that issues are being addressed in a timely manner consistent with established peer review guidelines.
2. With input from the Medical Staff Departments and/or Divisions, identify measures that reflect important areas of Medical Staff performance.
3. Serve as the central oversight structure for Medical Staff peer review and other medical staff performance improvement functions as assigned by the Medical Executive Committee.
4. Prioritize use of resources for measuring Medical Staff performance.
5. Coordinate design and implementation of Physician performance data for feedback and reappointment.
6. Maintain emphasis on developing collegial approaches to improving Medical Staff performance versus discipline.
7. Submit recommendations to the MEC(s) with respect to identified opportunities to improve Medical Staff performance.
8. Coordinate and conduct complex case reviews that involve multiple medical specialties in accordance with Peer Review Policy.
9. If a Medical Staff Department/Division fails to perform a case conference in a timely manner, is unable to resolve a clinical issue through collegial measures, the case will be referred to the PQM-C for review and disposition in accordance with Peer Review Policy.
10. Monitor critical performance rates related to Medical Staff compliance with Medical Staff/organizational rules/standards and/or adherence to evidence-based practices and make recommendations to the MEC and/or Department Chief regarding same.

Section 3. Meetings, Reports and Recommendations:

1. The PQM-C will meet monthly or on an as needed basis. Failure to maintain seventy-five percent (75%) meeting attendance shall result in removal from the Committee. Attendance will be reviewed annually. Excused absences will be at the discretion of the Chair.
2. Meetings to review an issue related to the performance of a specific Physician will be conducted in accordance with the Peer Review Policy. The Physician shall be invited to and expected to attend. Legal counsel will not attend and meetings will not be recorded or transcribed.
3. The PQM-C will refer cases as necessary to the Credentials Committee and shall report to the appropriate MEC for informational purposes.

ARTICLE VI – PART F: PERFORMANCE IMPROVEMENT AND REVIEW FUNCTIONS

1. Performance Improvement functions involving the Medical Staff shall be performed by various committees (including but not limited to the Physician Quality Management Committee, the Credentials Committee, and the Pharmacy and Therapeutics Committee), Hospital departments, performance improvement teams, and individuals as designated by the Executive Committee. The Executive Committee or its designee shall lead and participate in the systemic evaluation and monitoring of the quality/appropriateness of patient care. This shall include participation in process measurement, assessment, and improvement including but not limited to:
 - medical assessment and treatment of patients;
 - use of information about adverse privileging decisions for any practitioner privileged through the medical staff process;
 - use of medications;
 - use of blood and blood components;
 - operative and other procedure(s);
 - appropriateness of clinical practice patterns;
 - significant departures from established patterns of clinical practice;
 - use of developed criteria for autopsies;
2. Information used as part of the performance improvement mechanisms, measurement, or assessment includes the following:
 - Sentinel event data;
 - Patient safety data
3. The Executive Committee shall approve the components of the Hospital's performance improvement plan relating to patient care annually. This document shall describe the plan's annual objectives and the organization, scope, and mechanisms for overseeing monitoring and evaluation activities.
4. When the performance improvement and review activity or data relates to specific practitioners, this data will be shared with the appropriate Department Chief. All practitioner specific performance improvement data and activities are considered confidential and privileged.

ARTICLE VII

BOARD APPROVAL AND INDEMNIFICATION

Any Medical Staff Officer, Department Chief, Division Chair, Committee Chair, committee member and individual staff Appointee who acts for and on behalf of the Hospital in discharging duties, functions or responsibilities stated in these Medical Staff Bylaws, the Policy on Medical Staff Appointment, Reappointment and Clinical Privileges, the Medical Staff Organizational Manual and/or the Policy on Allied Health Professionals, shall be indemnified, to the fullest extent permitted by law, when the appointment and/or election of the individual has been approved by the Board.

ARTICLE VIII
LEGAL COUNSEL

ARTICLE VIII – PART A: AUTHORIZATION

The Medical Staff shall have the option of utilizing legal counsel designated and/or retained by the Hospital, for matters relative to the purpose and responsibilities of the Medical Staff under these bylaws, at the expense of the Hospital, or the Medical Staff may engage separate legal counsel, at the expense of the Medical Staff.

ARTICLE VIII – PART B: SELECTION OF SEPARATE LEGAL COUNSEL

The selection of legal counsel will be performed on an as needed basis. Prior to selection the Medical Staff President will inform the Medical Staff that the Medical Executive Committee is evaluating legal counsel and specific attorneys or firms will be considered if submitted by a specific date. The Executive Committee will be responsible for selecting counsel they feel best qualified to serve the Medical Staff.

ARTICLE VIII – PART C: UTILIZATION OF SERVICES OF MEDICAL STAFF LEGAL COUNSEL

The President of the Medical Staff shall be authorized to utilize the Services of the approved legal counsel at his/her discretion with respect to matters relative to the purposes and responsibilities of the Medical Staff under these bylaws. An Appointee to the Medical Staff may bring issues he/she believes require a legal opinion directly to the attention of the President of the Medical Staff or the Executive Committee through his/her Department Chief for consideration. The Executive Committee will decide if the issue warrants legal consultation and the Appointee will be informed of the action of the Executive Committee through his/her Department Chief. Specific issues believed by Appointees to the Medical Staff to warrant legal consideration will also be referred to legal counsel upon presentation to the President of the Medical Staff of a petition stating the specific issues and signed by at least fifty percent (50%) of the active Appointees to the Medical Staff. The Executive Committee will be responsible for monitoring the use of legal counsel by the President and may specifically authorize the Chairperson of the Credentials Committee to consult with legal counsel on an ongoing basis on legal matters specific to the Committee's areas of responsibility.

ARTICLE VIII – PART D: FUNDING FOR SERVICES OF MEDICAL STAFF LEGAL COUNSEL

Funding for legal counsel will be maintained in a separate Medical Staff Fund that will be disbursed by the President of the Medical Staff. All new Appointees to the Active Medical Staff shall be assessed a legal fund assessment of \$100.00. The fund will be maintained by an annual assessment of \$25.00 per each Active Medical Staff Appointee that shall be collected along with the annual Medical Staff dues. In the event the fund is inadequate to cover authorized use of legal counsel, an additional special assessment of the Medical Staff will be made, following approval by a majority of the Medical Staff in attendance at any regular or special Medical Staff meeting. The fund will continue in perpetuity, however, in the event the fund level exceeds the estimated expenditures for the following two (2) years, the Executive Committee may approve the cancellation of the annual assessment on a year-to-year basis.

ARTICLE IX

RULES AND REGULATIONS OF THE MEDICAL STAFF

1. Medical Staff rules and regulations, as may be necessary to implement more specifically the general principles of conduct found in these bylaws, shall be adopted in accordance with this Article. Rules and regulations shall set standards of practice that are to be required of each individual exercising Clinical Privileges in the Hospital and shall act as an aid to evaluating performance under, and compliance with, these standards. Rules and regulations shall have the same force and effect as the bylaws.
2. Rules and regulations may be adopted, amended, repealed or added by vote of the Executive Committee at any regular or special meeting, provided that copies of the proposed amendments, additions or repeals have been provided to the Medical Staff at least fourteen (14) days before being voted upon and further provided that all written comments on the proposed changes by persons holding current appointments to the Medical Staff are brought to the attention of the Executive Committee before the change is voted upon. Adoption of and changes to the rules and regulations shall become effective only when approved by the Board.
3. Rules and regulations may also be adopted, amended, repealed or added by the Medical Staff at a regular meeting or special meeting called for that purpose, in accordance with the procedure used in amending the Medical Staff Bylaws as described in Article X; provided, however that a majority of the votes of the staff present shall be required. All such changes shall become effective only when approved by the Board.
4. The rules and regulations may not be unilaterally amended. However, the rules and regulations may be amended by the Board on its own motion provided that any such amendment is first submitted to the Credentials and Executive Committees and Medical Affairs Committee for review and comment at least thirty (30) days prior to any final action by the Board on such amendment. Instances where such action by the Board shall be warranted shall include: action to comply with changes in federal and state laws that affect the Hospital; requirements imposed by the Hospital's general and professional liability or Director's and Officer's insurance carrier; and action to comply with state Licensure requirement, JCAHO Accreditation Standards and applicable Medicare/Medicaid Conditions of Participation.
5. When significant changes are made in the rules and regulations, Medical Staff Appointees and others affected by the changes will be notified and provided copies of or electronic access to the changes.

ARTICLE X

AMENDMENTS

1. The Mary Washington Hospital (MWH) and Stafford Hospital Center (SHC) Medical Executive Committees (MECs) have overall responsibility for the Medical Staff Bylaws, including proposed amendments. The MECs, through the Medical Staff Bylaws, Rules & Regulations, and Standards Committee, are responsible for periodically reviewing the Bylaws and determining if revisions are indicated. All proposed amendments of these bylaws shall receive an affirmative vote of two-thirds (2/3) of the Executive Committees prior to being presented to the Active Medical Staff for vote.
2. The Medical Staff President(s) on behalf of the Medical Executive Committee(s) shall notify the affected Active Medical Staff(s) of all proposed amendments. The Active Staff will vote on the proposed amendment via ballot. The voting process will be conducted in accordance with procedures described below. Distribution of communications and ballots to the Active Medical Staff using US mail, fax, and electronic information system shall be deemed to constitute actual notice. The Medical Staff President, at his discretion, may present the proposed amendments at Medical Staff meetings, including but not limited to, Medical Staff Business Meetings and/or Medical Staff Department / Division meetings. Individuals who have been granted Active Medical Staff appointment at MWH and SHC shall be allowed one (1) vote on issues that apply jointly to MWH and SHC.
3. The period of time to return the ballot shall be not less than fourteen (14) days and no longer than thirty (30) days. The deadline for submitting the ballot shall be stated on the ballot. Ballots must be signed and dated to assure that the individual is authorized to vote. If multiple ballots are received by the same individual, only the most recent ballot will be counted. Medical Staff who are on leave of absence remain eligible to vote. Proxy votes are not allowed. The Amendment shall be adopted if it receives the affirmative vote of two-thirds (2/3) of the votes cast. Amendments so adopted shall be effective when approved by the Board with the exception of amendments to bring the Bylaws into compliance with licensing, accreditation or other regulatory standards which may be implemented prior to final Board approval.
4. The Bylaws may not be unilaterally amended. However, the bylaws may be amended by the Board on its own motion provided that any such amendment is first submitted to the Credentials and Executive Committees for review and comment at least thirty (30) days prior to any final action by the Board on such amendment. Instances where such action by the Board shall be warranted shall include: action to comply with changes in federal and state laws that affect the Hospital and/or MediCorp Health System; requirements imposed by the Hospital's general and professional liability or Director's and Officer's insurance carrier; and action to comply with state Licensure requirement, JCAHO Accreditation Standards and applicable Medicare/Medicaid Conditions of Participation.
5. The Medical Executive Committee shall have the power to adopt such amendments to the bylaws as are, in the committee's judgment, technical or legal modifications or clarifications, reorganization or renumbering, or amendments made necessary because of punctuation, spelling or other errors of grammar or expression. Such amendments shall be effective immediately and shall be permanent if not disapproved by the Medical Staff or the Board within sixty (60) days of adoption by the Executive Committee. The action to amend may be taken by a motion acted upon in the same manner as any other motion before the Executive Committee. Immediately upon adoption, such amendments shall be sent to the President of the Hospital and the Chief Executive Officer and shall be posted on the Medical Staff bulletin board for at least fourteen (14) days.
6. When significant changes are made in the bylaws, Medical Staff Appointees and others affected by the changes will be notified and provided copies of or electronic access to the changes.



Medical Staff Bylaws

Part 2

Credentialing Policy

Appointment, Reappointment, Clinical Privileges
Corrective Actions, Investigation, Fair Hearing, & Appeal

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ARTICLE I

DEFINITIONS

The following definitions shall apply to terms used in this policy:

1. "Allied Health Professional" means a Licensed Independent Practitioner or a Licensed Dependent Practitioner.
2. "Appointee" means any Physician, Dentist and Podiatrist who has been granted Medical Staff appointment and Clinical Privileges by the Board to practice at one or both of the Hospitals.
3. "Board" means either the Board of Trustees of Mary Washington Hospital, Inc. or the Board of Trustees of MediCorp at Stafford LLC (dba Stafford Hospital Center) each of which has overall responsibility for conduct of the respective hospital.
4. "Chief Executive Officer" means the chief officer of the MediCorp Health System or the CEO's designee.
5. "Chief of Service", "Service Chief", or "Department Chief" means the individual who has overall responsibility for the management of one of the clinical Departments of the Medical Staff as defined in the Medical Staff Bylaws of Mary Washington Hospital, Inc, and MediCorp at Stafford, LLC Article V, Part A1 (Mary Washington Hospital Departments) and A2 (Stafford Hospital Center Departments),
6. "Clinical Privileges" or "privileges" means the authorization granted by the Board to Medical Staff Appointee or other independent practitioner to render specific patient care services in one of the Hospitals within defined limits.
7. "Conflict of Interest" means any situation in which, because of an individual's dual interests, a serious risk arises that the individual will not be able to exercise independent of object judgment.
8. "Criminal Conviction" includes, but is not limited to, conviction of, or a plea of guilty or nolo contendere, for any felony, or for any misdemeanor related to the practice of a health care profession, or to any Federal Health Program or any fraud and abuse, third party reimbursement or controlled substances law.
9. "Dentist" includes a doctor of dental surgery ("D.D.S.") and doctor of dental medicine ("D.M.D.").
10. "Executive Committee" means the Executive Committee of the Medical Staff unless specifically written "Executive Committee of the Board."
11. "Federal Health Program" means Medicare, Medicaid or any other federal or state program providing health care benefits, which is funded directly or indirectly by the United States government.
12. "Good standing" means a Medical Staff Appointee who is not under suspension or any restriction regarding staff appointment or admitting or Clinical Privileges at the Hospital and/or at any other MediCorp health care facility or organization.
13. "Hospital" means the facility where the applicant, Medical Staff Appointee, or license independent practitioner seeks or holds appointment to the Medical Staff and/or Clinical Privileges, Mary Washington, Inc. or Stafford Hospital Center.,

14. "Medical Staff" means all Physicians, Dentists, and Podiatrists who are given privileges to treat patients at the Hospital.
15. "Licensed Independent Practitioner" means a non-Physician practitioner who is licensed or certified by his or her respective state board and who is granted Clinical Privileges and may function independently in the Hospital within the scope of his or her license or certification.
16. "Licensed Dependent Practitioner" means a non-Physician practitioner who is not a Hospital employee and who must function in the Hospital only as an employee of a Physician on the Medical Staff and/or under the direction of such a Physician within the scope of his or her license or certification.
17. "Medical Affairs Committee" means either the Medical Affairs Committee of Mary Washington Hospital, Inc. or MediCorp at Stafford, LLC depending upon where the Appointee seeks or holds Clinical Privileges.
18. "Medical Staff" means all Physicians, Dentists and Podiatrists who are given privileges to treat patients at the Hospital.
19. "Oral Surgeon" is an individual who has completed a postgraduate oral/maxillofacial program.
20. "Physicians" includes both doctors of medicine ("M.D.s") and doctors of osteopathy ("D.O.s").
21. "Podiatrist" means a doctor of podiatric medicine ("D.P.M.").
22. "President of the Hospital" means either the President of Mary Washington Hospital or the President of Stafford Hospital Center depending upon the facility and Medical Staff Appointee involved.
23. "Professional review action" means an action or recommendation of a Professional Review Body which is taken or made in the conduct of professional peer review activity, which is based on the competence or professional conduct of an Appointee, and which affects or may affect, the Clinical Privileges or appointment of the Appointee.
24. "Professional review activity" means a peer review activity of the Hospital with respect to an individual Medical Staff applicant or Appointee (a) to determine whether the Medical Staff applicant or Appointee may have Clinical Privileges with respect to his/her appointment; (b) to determine the scope or conditions of those Clinical Privileges and appointment; and (c) to change or modify such privileges and/or appointment.
25. "Professional review body" means the Board or any Board committee that conducts professional peer review activity, and includes any committee of the Medical Staff when assisting the Board in a professional peer review activity.
26. "Self-government" means the duty of officers, committees and departments of the Medical Staff to initiate and carry out the functions delegated by the Board and to fulfill the obligations provided for in this policy.
27. "System" or "MediCorp Health System" includes Mary Washington, Inc., Stafford Hospital Center, Fredericksburg Ambulatory Surgery Center, and other MediCorp Health System facilities that provide medical services to patients.
28. "Telemedicine" means the exchange of medical information from one site to another via electronic communication for the purpose of improving patient care, treatment, and services. In this Policy, Telemedicine refers to services provided i) by healthcare providers who are not

members of the Hospital's medical staff and ii) at healthcare facilities not affiliated with the Hospital or the System, for the purpose of providing care to Hospital patients.

29. "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/her care while a patient at the Hospital.
30. "Voluntary" or "automatic relinquishment" of Medical Staff appointment and/or Clinical Privileges means a lapse in appointment and/or Clinical Privileges deemed to automatically occur as a result of stated conditions.

Words used in this policy shall be read as the masculine or feminine gender, and as the singular or plural, as the content requires. The captions or headings are for convenience only and are not intended to limit or define the scope or effect of any provision of this policy.

ARTICLE II

APPOINTMENT TO THE MEDICAL STAFF

ARTICLE II – PART A: QUALIFICATIONS FOR APPOINTMENT

Section 1. General:

1. Medical Staff appointment/reappointment to the Hospital is a privilege, granted by the Board following Medical Staff recommendation, extended only to professionally competent individuals who continuously meet the qualifications, standards and requirements set forth in this policy and in policies as may be adopted by the Board. All individuals, including those in administrative positions, practicing medicine, dentistry and podiatry in this Hospital must first have been appointed to the Medical Staff. Appointments shall be for a period not to exceed two (2) years. Initial appointments may be for a period of less than two (2) years in order to cycle the Appointee into the specialty-specific appointment review cycle.
2. All processes described in this Article shall be subject to the confidentiality provisions described in Article III, Part G of this policy.

ARTICLE II – PART A:

Section 2. Threshold Qualifications:

Only Physicians, Dentists, and Podiatrists that satisfy the following threshold conditions shall be qualified for initial appointment to the Medical Staff:

- a) currently possess an unrestricted license to practice in this state;
- b) are located (office and residence) within the primary service or secondary area as determined by the Board of the Hospital and capable of responding to the hospital when on-call in accordance with reasonable response time requirements established for the specialty / clinical privileges. These response times shall be recommended by the active medical staff members of the Division/Department, Medical Executive Committee and approved by the Hospital Board of Trustees. If specialty or privilege specific response times have not been established, the general response times for ED call shall apply (20 minutes to respond by phone and 30 minutes to respond in person). For initial appointment and privileges requests, an estimate of the applicant's response time to the hospital from the applicant's home and office shall be based on driving directions/time obtained from reliable source(s) as determined by the Medical Staff Support/Credentialing Office. Physicians requesting/granted Clinical Privileges for medical specialties that provide continuous in-house (24/7) services shall be exempt from the requirement for a personal residence within the primary service area conditioned upon the personal residence location not adversely impacting the service coverage. In the event the Physician is no longer practicing in a 24/7 capacity, the Physician shall be expected to meet the office and residence threshold qualification and must submit a request for a waiver in accordance with Article II – Part A, Section 3 of this Policy. Physicians granted Clinical Privileges who do not reside in the primary service area as of the effective date of this provision shall be deemed to have been waived from the primary service area residence requirement. However, in the event that a Physician's personal residence raises question with respect to the Physician's ability to provide timely and continuous patient care, the Physician will be required to submit a patient coverage plan deemed acceptable by the Medical Executive Committee and Board of the Hospital.
- c) possess current, valid professional liability insurance coverage in such form and in amounts satisfactory to the Hospital;
- d) are not currently excluded from participation in any federal or state health program;
- e) possess a NPI (National Provider Identifier);
- f) has successfully graduated from an approved school of medicine, osteopathy, dentistry, or other professional education program appropriate to the clinical specialty and have successfully completed an accredited ACGME/AOA residency training program, of at least

- three (3) years, in the specialty in which the applicant seeks Clinical Privileges, or a dental surgery training program accredited by the American Association of Oral and Maxillofacial Surgery and/or the Commission on Dental Education of the American Dental Association, or a podiatric surgical residency program accredited by the Council on Podiatry Education of the American Podiatry Association;
- g) are certified by the appropriate specialty board or of the American Board of Medical Specialties (“ABMS”) or American Osteopathic Association (“AOA”) in the area in which privileges are requested, and thereafter certified as follows: within 5 years of initial appointment if appointment occurred between April 1998 to September 9, 2002. Effective September 10, 2002, certification required within 5 years of completion of training (residency/fellowship), unless such requirement is waived by the Board after considering the specific competence, training and experience of the individual in question, or waived by the Board for those applicants and Appointees who practice in medical subspecialties where there are specific practice prerequisites for admissibility to board examination. This requirement shall be applicable only to those individuals who apply for initial Medical Staff appointment and for Clinical Privileges on or after April, 1998. For those practitioners who must satisfy this threshold qualification, maintenance of Board certification shall be required for reappointment unless a waiver is granted.
 - (1) Oral surgeon applicants and Appointees requesting surgical privileges must be certified or admissible to examination for certification by the American Board of Oral and Maxillofacial Surgery; and
 - (2) Podiatrist applicants and Appointees must be certified or admissible to examination for certification by the American Board of Podiatric Surgery;
 - h) can document their:
 - (1) background, experience, training and demonstrated competence;
 - (2) adherence to the ethics of their profession;
 - (3) good reputation and character;
 - (4) ability to perform the Clinical Privileges requested safely and competently; and
 - (5) ability to work harmoniously with others as required by these Bylaws and the Practitioner Conduct and Wellness Policy;
 - (6) appropriate peer recommendations pertaining to clinical and/or technical knowledge and skills, and
 - (7) to the extent required to meet the qualifications and duties established by the Medical Staff Bylaws and related policies, ability to read, write and communicate in standard English.
 - i) have never had a Criminal Conviction as defined herein;
 - j) agrees in writing to comply with the Conditions of Appointment as relevant to the applicant’s requested staff category and/or clinical privileges.

ARTICLE II – PART A:

Section 3. Waiver:

1. Article II, Part A, Sections 2(b), (g), and (h) above outline the office and residence location requirements, Board certification requirements, and criminal background standards that must be satisfied for the granting of Medical Staff appointment and Clinical Privileges at the Hospital. Those requirements were established by the Medical Staff and the Hospital and represent the benchmark standards that are expected of, and will be applied to, all individuals who seek appointment and Clinical Privileges to practice at the Hospital.
2. Any individual may request that an exception be made, and that the geographic requirements, board certification requirements, and/or the fact of a Criminal Conviction be waived.
 - a) When a request is made to waive the office and residence location requirements, the individual requesting the waiver shall bear the burden of demonstrating he can meet the Hospital response time requirements established by the Department/division through a

coverage plan or other arrangements approved pursuant to the process set forth in this Credentialing Policy.

- b) When a request to waive board certification is made, the individual requesting the waiver shall bear the burden of demonstrating that his or her education, training, experience and competence are equivalent to, or exceed, the Hospital's board certification requirements.
 - c) When a request to waive the criminal background standard is made, the individual requesting the waiver shall bear the burden of demonstrating exceptional circumstances (such as evidence that the Criminal Conviction will not impede the individual's ability to satisfy the Hospital's patient care or welfare standards, the rules and regulations of the Hospital or Medical Staff, and will not impede the objectives or efficient operations of the Hospital).
3. The Board may grant a waiver in exceptional cases after considering the findings of the Credentials and Executive Committees, or other committee designated by the Board, regarding the specific qualifications, office and residence geographic requirements, or criminal background of the individual in question. The findings shall include a statement concerning what is in the best interests of patients, the Hospital and the community served by the Hospital.
 4. In the event the Board determines not to grant a waiver, the individual requesting the exception shall not be entitled to a hearing as set forth in this Policy and will be considered ineligible to request appointment or Clinical Privileges. In the case of an individual applying for Medical Staff appointment or Clinical Privileges, the application shall not be processed.
 5. If the Board grants a waiver to an individual, that waiver shall not be deemed to set a precedent for any other staff applicant or staff Appointee.

ARTICLE II – PART A:

Section 4. No Entitlement to Appointment:

No individual shall be entitled to appointment to the Medical Staff or to exercise particular Clinical Privileges in the Hospital merely by virtue of the fact that such individual:

- a) is licensed to practice a profession in this or any other state;
- b) is a member of any particular professional organization;
- c) has had in the past, or currently has, Medical Staff appointment or privileges at any Hospital or health care facility;
- d) resides and/or has an office within the geographic service area of the Hospital as defined by the Board; or
- e) is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity.

ARTICLE II – PART A:

Section 5. Non-Discrimination Policy:

No individual shall be denied appointment on the basis of sex, race, creed, religion, color or national origin, or on the basis of any criteria unrelated to the delivery of quality patient care, to professional qualifications or to the Hospital's purposes, needs and capabilities.

ARTICLE II – PART B: CONDITIONS OF APPOINTMENT

Section 1. Duties of Appointees:

Appointment to the Medical Staff shall require that each Appointee conduct his/her practice in accordance with the following areas of general competencies and assume such reasonable duties and responsibilities as the Medical Staff, through its Medical Executive Committee, or the Board shall require.

1. Patient Care - Practitioners are expected to provide patient care that is compassionate, appropriate and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life.
 - 1.1. The practitioner will maintain timely, concise medical records to promote the patient care continuum.
 - 1.2. The practitioner or the practitioner's coverage will see the patient at least daily or more frequently if required based on the patient's needs and acuity. The practitioner or his coverage shall write a progress note at least daily and whenever there is a significant change in the patient's condition or plan of care. The practitioner's coverage must be a practitioner of equivalent education, training and approved clinical privileges unless an alternate coverage plan has been approved by the Credentials and Medical Executive Committees and Board of Trustees.
 - 1.3. The practitioner will supervise allied health professionals including physician assistants, nurse practitioners, and other authorized staff for whom the practitioner has agreed to serve as the supervising physician. If the supervising practitioner's personal involvement is deemed necessary by physicians, the practitioner shall be available in a timely fashion.
 - 1.4. The practitioner will meet on-call responsibilities in accordance with relevant Medical Staff Rules & Regulations and Policies.
2. Medical / Clinical Knowledge – Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and the application of their knowledge to patient care and the education of others.
 - 2.1. The practitioner will participate in ongoing continuing education relevant to clinical privileges granted.
 - 2.2. The practitioner is expected to share knowledge with professional peers, hospital staff, and patients for the purpose of improving quality and the orderly and efficient delivery of patient care by the health system.
3. Practice-based Learning and Improvement – Practitioners are expected to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.
 - 3.1. The practitioner will utilize his/her professional judgment and practice in accordance with evidence based medicine, current professional standards of care and patient care protocols/guidelines adopted by the hospital.
 - 3.2. The practitioner will actively participate in activities to improve patient care including but not limited to peer review activities, participation in medical staff/hospital committees, division/department level peer review, patient care conferences and performance improvement teams.
4. Interpersonal and Communication Skills – Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams.
 - 4.1. Patients and/or their representative will be provided timely updates regarding their care plan.
 - 4.2. Patient and/or their families will be afforded the opportunity to be actively involved in making decisions related to their care.

- 4.3. The practitioner will work collaboratively with the hospital regarding medical error disclosure.
- 4.4. The practitioner will consistently respond to calls and pages from peers and hospital staff within twenty (20) minutes.
- 4.5. The practitioner will comply with the medical staff consultation guidelines. Direct communication between the practitioners requesting and providing consults is the preferred communication method and is strongly encouraged. The practitioner will adhere to the following consultation expectations:
 - 4.5.1. When requesting a consult, the reason for requesting the consult shall be clearly communicated either verbally or in writing with an indication of the urgency of the consult request so the consultant may appropriately prioritize patient care. If the patient care need is urgent or stat, the practitioner will personally notify the consultant and verify that the consultant will be available.
 - 4.5.2. Consultants will perform routine consults within 24 hours of receipt of the consult request.
5. Professionalism – Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, and understanding and sensitivity to diversity and a responsible attitude toward their patients, their profession, and society.
 - 5.1. The practitioner will comply with the Medical Staff & Allied Health Professional Conduct Policy, and Practitioner Health and Wellness Policies.
 - 5.2. The practitioner will utilize the services of the Physician Health Resource Group (PHRG) to promote his/her personal health and well being, if needed.
6. Methods to Improve Patient Care – Practitioners are expected to demonstrate both an understanding of the context in which health care is provided at the Hospital and the ability to apply this knowledge to improve and optimize patient care.
 - 6.1. The practitioner will assist in the design of patient care processes necessary to achieve excellent performance in patient care including national patient safety goals and national, local, and hospital quality goals.
 - 6.2. Through the medical staff self governance process, the practitioner will encourage and mentor peers and hospital staff toward achievement of excellence in patient care.
 - 6.3. The practitioner will give and receive performance feedback instructively and in the spirit of continuous improvement.
 - 6.4. When actively participating in peer review and performance improvement activities, the practitioner will maintain respect for all parties involved, will maintain confidentiality of information to protect the privileged nature of peer review, and will declare a conflict of interest when appropriate.
7. Commitment to Self-Governance – Practitioners are expected to actively participate in the design of a medical staff structure and processes that will efficiently and effectively address functions delegated to the Medical Staff by the Board of Trustees. Medical Staff self-governance functions shall include activities related to credentialing, privileging, focused peer review, ongoing peer review, formal investigations, fair hearings, participation in performance improvement activities, medical staff medical record compliance, compliance with conduct standards, and physician health.
 - 7.1. Practitioners are expected to work within the established medical staff structure and processes.
 - 7.2. Practitioners are expected to actively participate in medical staff functions including attendance at Department/Division meetings and participation on Medical Staff Committees.
 - 7.3. If there is a concern regarding patient safety or the well being of a health provider, the practitioner who has observed the potential problem will promptly refer the matter to any of the following: a Medical Staff Officer, Department Chief or Division Chair.

ARTICLE II – PART B:

Section 2. Professional Conduct:

Individuals appointed to the Medical Staff or granted clinical privileges shall be expected to relate in a positive and professional manner to other health professionals, and to cooperate and work collegially with the Medical Staff leadership and Hospital management and personnel, as outlined in the Rules and Regulations, the Practitioner Conduct and Wellness Policy, applicable laws, regulations, and ethical standards. Professional conduct shall also include, but not be limited to, each Appointee's obligation to present himself or herself at the Hospital physically and mentally capable of providing safe and competent care to his or her patients.

ARTICLE II – PART C: APPLICATION FOR INITIAL APPOINTMENT AND CLINICAL PRIVILEGES

Section 1. Information:

1. Applications for appointment to the Medical Staff shall be in writing, and submitted on forms obtained from the Mary Washington Hospital Centralized Credentialing Service (Credentialing Service).
2. The application shall contain a request for specific Clinical Privileges desired by the applicant and shall require detailed information concerning the applicant's professional qualifications including:
 - a) the names and complete addresses of at least two (2) professional peers (Physicians, Dentists, Podiatrists or other practitioners, as appropriate) who have had recent experience in observing and working with the applicant, and who can provide adequate information pertaining to the applicant's present professional competence, character, limitations, if any, with respect to Clinical Privileges requested by the applicant. Except in situations where no other qualified references are available (as solely determined by the Credentialing Service) these references may not be from individuals associated or about to be associated with the applicant in professional practice or personally related to the applicant. At least one (1) reference shall be from the same specialty area as the applicant. For individuals who currently hold staff appointment and/or clinical privileges at a MediCorp Hospital and are applying for appointment and/or clinical privileges at another MediCorp Hospital, the two peer references will be waived. The applicant's current clinical competence will be validated by the appropriate MediCorp Hospital Division Chair and/or Department Chief. However, if there is insufficient clinical practice information available from the MediCorp Hospital where the applicant currently holds appointment and/or clinical privileges or the applicant is requesting clinical privileges not previously granted by a MediCorp Hospital, the applicant will be required to provide peer references as described in this section;
 - b) the names and complete addresses of the chiefs or chairpersons of each department of any and all hospitals or other institutions at which the applicant has worked or trained (i.e., the individuals who served as chiefs or chairpersons at the time the applicant worked in the particular department). If the number of hospitals the applicant has worked in is great or if a number of years have passed since the applicant worked at a particular hospital, the Credentials Committee and the Board may take into consideration such factors;
 - c) information as to whether the applicant's Medical Staff appointment or Clinical Privileges have ever been withdrawn, denied, revoked, suspended, subjected to probationary or other conditions, reduced, not exercised, or not renewed at any other Hospital or health care facility, or voluntarily or involuntarily relinquished;
 - d) information as to whether the applicant has ever voluntarily or involuntarily withdrawn his/her application for appointment, reappointment and Clinical Privileges, or resigned

from the Medical Staff before final decision by a Hospital's or health care facility's governing board;

- e) information as to whether the applicant's license to practice any profession in any state, or Drug Enforcement Administration license, or membership in any local, state or national professional organization is or has ever been voluntarily or involuntarily relinquished, suspended, modified, terminated, restricted or has/is currently being challenged. (The submitted application shall include a list or copy and verification of all the applicant's current licenses to practice, as well as copies of Drug Enforcement Administration license, medical, dental or podiatric school diploma and certificates from all post graduate training programs completed);
 - f) information as to whether the applicant has currently in force professional liability insurance coverage, the name of the insurance company and the amount and classification of such coverage, and whether said insurance coverage covers the Clinical Privileges the applicant or Appointee seeks to exercise at the Hospital;
 - g) a consent to the release of information from the applicant's present and past professional liability insurance carriers;
 - h) information concerning the applicant's professional liability claims experience, specifically information concerning pending claims, final judgments or settlements:
 - (1) the substance of the allegations
 - (2) the findings
 - (3) the ultimate disposition and
 - (4) any additional information concerning such proceedings or actions as the Credentials Committee or the Board may deem appropriate;
 - i) information concerning any professional misconduct proceedings and any malpractice actions involving the applicant in this state or any other state, whether such proceedings are closed or still pending, as well as information concerning whether the applicant has been subject to sanctions of any kind imposed by any health care facility, professional review organization or licensing authority or whether there has been any proceeding instituted therefore;
 - j) information concerning the suspension or termination for any period of time of the right or privilege to participate in Medicare, Medicaid, any other government sponsored program, or any private or public medical insurance program, and information as to whether the applicant is currently under investigation;
 - k) current information regarding the applicant's health status with respect to the applicant's ability to exercise the privileges requested and to perform the duties and responsibilities of appointment in general;
 - l) information as to whether the applicant has ever been named as a defendant in a criminal action and/or convicted of a crime with details about any such instance.
 - m) a complete chronological listing of the applicant's professional and educational appointments, employment, or positions;
 - n) information on the applicant's eligibility to work in the United States, if applicable;
 - o) a current picture hospital ID card or a valid picture ID issued by a state or federal agency (e.g. driver's license or passport);
 - p) the applicant's signature; and
 - q) such other information as the Board may require.
3. The history of malpractice verdicts and the settlement of malpractice claims, as well as pending claims, will be evaluated as a criterion for appointment, reappointment, and the granting of Clinical Privileges. However, the mere presence of verdicts, settlements or claims shall not, in and of themselves, be sufficient to deny appointment or particular Clinical Privileges. The evaluation shall consider the extent to which verdicts, settlements or claims evidence a pattern of care that raises questions concerning the individual's clinical competence, or whether a verdict, settlement or claim in and of itself, represents such deviation from standard medical practice as to raise overall questions regarding the applicant's clinical competence, skill in the particular clinical privilege, or general behavior.

4. Effective July 2007, an applicant for initial appointment shall sign the documents necessary to authorize the Hospital to conduct a criminal background check, directly or through a third party, and to allow the disclosure of all records relating to applicant's background to the Hospital and its authorized agents. If an initial applicant currently holds medical staff appointment at another MediCorp Hospital (Mary Washington Hospital or Stafford Medical Center) and requests appointment to another MediCorp Hospital, the criminal background check initially obtained shall fulfill the criminal background check requirement. Medical Staff appointed to the MWH Medical Staff prior to the requirement for a criminal background check and requesting initial appointment to SHC will be waived from the criminal background check requirement.
5. The applicant's signature shall constitute agreement:
 - a) that the applicant has received and had an opportunity to read a copy of the Medical Staff Bylaws, Rules, Regulations and Policies of the Medical Staff as are in force at the time of application, and agrees to be bound by the terms thereof in all matters relating to consideration of the application without regard to whether or not appointment to the Medical Staff and/or Clinical Privileges are granted;
 - b) that any misrepresentation or misstatement in or omission from, the application, whether intentional or not, shall constitute cause for immediate cessation of the processing of the application and no further processing shall occur. In the event that an appointment or reappointment has been granted prior to discovery of such misrepresentation, misstatement or omission, such discovery may be deemed to constitute Voluntary relinquishment of Clinical Privileges and Medical Staff appointment. In either situation, there shall be no entitlement to any hearing or appeal rights as set forth in this policy or referenced in the Medical Staff Bylaws or Rules and Regulations;
 - c) that the hearing and appeal procedures set forth in this policy shall be the sole and exclusive remedy with respect to any professional review action taken at this Hospital;
 - d) to authorize the release of all information necessary for an evaluation of the individual's qualifications for initial or continued appointment, reappointment and/or Clinical Privileges;
 - e) not to sue the System, its officers, directors, or members, the Medical Staff or anyone acting by or for the Hospital and its Medical Staff for any matter relating to the application for appointment, reappointment or Clinical Privileges, or relating to the evaluation of the applicant's qualifications on any matter related to appointment, reappointment or Clinical Privileges; and
 - f) to extend absolute immunity to the System, its Medical Staff and all individuals acting by or for the Hospital and/or its Medical Staff for all matters relating to appointment, reappointment and Clinical Privileges or the individual's qualifications for the same.

ARTICLE II – PART C:

Section 2. Basic Responsibilities and Requirements of Applicants and Appointees:

1. Every applicant for Medical Staff appointment or reappointment, as a condition of consideration of initial appointment and as a condition of continued Medical Staff appointment if granted, shall specifically agree to:
 - a) provide appropriate continuous and timely care and supervision to all patients in the System for whom the individual has responsibility;
 - b) abide by all bylaws and policies of the Hospital, including all bylaws, rules and regulations of the Medical Staff as shall be in force during the time the individual is appointed to the Medical Staff;
 - c) accept committee assignments and such other reasonable duties and responsibilities as shall be assigned;
 - d) promptly notify the Chief Executive Officer or designee, the appropriate Service Chief and the President of the Medical Staff, with or without request, of new or updated information that is pertinent to any question on the application form, including, but not limited to, any

- change in eligibility for payments by third party payors or for participation status in any Federal Health Program, any exclusions or other sanctions imposed or recommended by the Federal Department of Health and Human Services or any state, and/or receipt of any PRO citation and/or quality denial letter concerning alleged quality of care problems;
- e) appear for personal interviews upon request in regard to the application;
 - f) use the Hospital and its facilities, and/or have a sufficient interaction to allow the Hospital, through assessment by appropriate Medical Staff committees and department chiefs, to evaluate in a continuing manner the current competence of the Appointee;
 - g) refrain from illegal fee splitting or other illegal inducements relating to patient referral;
 - h) refrain from delegating responsibility for diagnoses or care of hospitalized patients to any individual who is not qualified to undertake this responsibility or who is not adequately supervised;
 - i) refrain from deceiving patients as to the identity of an operating surgeon or any other individual providing treatment or services;
 - j) seek consultation whenever necessary;
 - k) abide by generally recognized ethical principles applicable to the applicant's or Appointee's profession;
 - l) participate in the monitoring and evaluation activities of clinical departments;
 - m) complete in a timely manner the medical and other required records for all patients as required by this policy, the rules and regulations and other applicable policies of the Hospital;
 - n) work cooperatively with Medical Staff Appointees, Allied Health Professionals, nurses and other Hospital personnel;
 - o) pay promptly any applicable Medical Staff assessments; and
 - p) participate in continuing education programs for the benefit of the individual and for the benefit of other professionals and Hospital personnel.

ARTICLE II – PART C:

Section 3. Burden of Providing Information:

1. The applicant shall have the burden of producing information deemed adequate for a proper evaluation of competence, character, ethics and other qualifications, and of resolving any doubts about such qualifications.
2. The applicant shall have the burden of providing evidence that all the statements made and information given on the application are true and correct.
3. Those individuals who fail to meet the threshold criteria shall be so notified and their application will not be processed.
4. Until the applicant has provided all information requested by or on behalf of the Hospital, the application for appointment or reappointment will be deemed incomplete and will not be processed. Should information provided in the initial application for appointment change during the course of an appointment year, the Appointee has the burden to provide information about such change to the Credentials Committee sufficient for the Credentials Committee's review and assessment.

ARTICLE II – PART C:

Section 4. Authorization to Obtain Information:

The following statements, which shall be included on the application form and which form a part of this policy, are express conditions applicable to any Medical Staff applicant, any Appointee to the Medical Staff and to all others having or seeking Clinical Privileges at the Hospital. By applying for appointment, reappointment or Clinical Privileges, the applicant expressly accepts

these conditions during the processing and consideration of the application, whether or not appointment or Clinical Privileges are granted. This acceptance also applies during the time of any appointment or reappointment.

1. Immunity:

a) To the fullest extent permitted by law, the applicant or Appointee releases from any and all liability and extends absolute immunity to the Hospital, its authorized representatives and appropriate third parties, with respect to any acts, communications or documents, recommendations or disclosures involving the applicant or Appointee, concerning the following:

- 1) applications for appointment or Clinical Privileges, including temporary privileges;
- 2) evaluations concerning reappointment or changes in Clinical Privileges;
- 3) proceedings for suspension or reduction of Clinical Privileges or for revocation of Medical Staff appointment or any other disciplinary sanction;
- 4) precautionary suspension;
- 5) hearings and appellate reviews;
- 6) medical care evaluations;
- 7) utilization reviews;
- 8) other activities relating to the quality of patient care or professional conduct;
- 9) matters or inquires concerning the applicant's or Appointee's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics or behavior; and/or
- 10) any other matter that might directly or indirectly relate to the applicant's or Appointee's competence, to patient care, or to the orderly operation of this or any other health care facility.

b) Authorization to Obtain Information:

The applicant or Appointee specifically authorizes the System, the Hospital and their authorized representatives to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior, or any other matter reasonably having a bearing on the applicant's or Appointee's satisfaction of the criteria for initial and continued appointment to the Medical Staff. This authorization also covers the right to inspect or obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of said third parties that may be relevant to such questions. The individual also specifically authorizes said third parties to release said information to the System, the Hospital and their authorized representatives upon request.

c) Authorization to Release Information:

The applicant or Appointee specifically authorizes the System, the Hospital and their authorized representatives to release such information to other Hospitals, health care facilities and their agents, who solicit such information for the purpose of evaluating the applicant's or Appointee's professional qualifications pursuant to a request for appointment and/or Clinical Privileges.

ARTICLE II – PART D: APPLICATION PROCESSING AND TIME FRAMES

Section 1. Submission of Application:

1. The application for Medical Staff appointment shall be submitted by the applicant to the Medical Staff Office. It must be accompanied by payment of such processing fees as shall be determined from time to time. After reviewing (a) the application to determine that all questions have been answered and that the applicant satisfies the threshold qualifications for the membership category and/or Clinical Privileges sought; (b) all references and other information or materials deemed pertinent, and after verifying the information provided in the

application with the primary sources, (c) the result of the applicant's criminal background check; and (d) after making inquiry to the National Practitioner Data Bank, the Medical Staff Office shall transmit the complete application and all supporting materials to the appropriate Service Chief.

2. The Medical Staff Office may post or circulate the name of the applicant so that each Medical Staff Appointee may have an opportunity to submit to the Credentials Committee, in writing, information bearing on the applicant's qualifications for staff appointment or Clinical Privileges. In addition, any current Medical Staff Appointee shall have the right to appear in person before the Credentials Committee to discuss in private and in confidence any concerns the Appointee may have about the applicant.
3. An application shall be deemed to be complete when all questions on the application form have been answered, all supporting documentation has been supplied and all information verified. An application shall become incomplete if the need arises for new, additional or clarifying information anytime during the evaluation. All individuals and groups required to act on an application for staff appointment must do so in a timely and good faith manner, except for good cause such as an incomplete application. For individuals this shall generally be interpreted as within (thirty) 30 days of receipt and for Committees at the next regularly scheduled meeting. The Medical Staff and Board will work collaboratively in an effort to act on completed applications within four (4) months of determining that the application is complete. This time period is deemed a guideline and not a directive such as to create rights to a practitioner.
4. Any application that continues to be incomplete ninety (90) days after the applicant has been notified of the additional information required shall be deemed to be withdrawn. It is the responsibility of the applicant to provide a complete application, including adequate responses from references. An incomplete application will not be processed.
5. An individual whose application is not processed for any reason may apply for Medical Staff initial appointment only once every two (2) years. This limitation shall not apply when an individual's application is not processed because the Hospital was not accepting applications for privileges in the individual's specialty. In such situations, the individual may reapply for initial appointment to the Medical Staff when the Hospital Board decides to reopen a department or division of the Medical Staff and to accept applications for the particular specialty.

ARTICLE II – PART D:

Section 2. Chief of Service Procedure:

1. The Chief of each Service/Department in which the applicant seeks Clinical Privileges shall, in a timely manner, provide the Credentials Committee with a recommendation concerning the applicant's qualifications for the requested Clinical Privileges. As part of the process of making the recommendation, the Chief of Service/Department has the right to meet with the applicant to discuss any aspect of the application, qualifications and requested Clinical Privileges.
2. The Chief of Service/Department, or the individual within the department or division to whom the Chief has assigned this responsibility, shall evaluate the applicant's education, training, experience and conduct and make inquiries with respect to the same to the applicant's past or current department chief(s), residency training director and others who may have knowledge about the applicant's education, training, experience and ability to work with others.

3. The Chief of Service/Department shall be available to the Credentials Committee to answer any questions that may be raised with respect to that Chief's recommendation and basis thereof.

ARTICLE II – PART D:

Section 3. Credentials Committee Procedure:

1. At its next regular meeting after receipt of the Service Chief's or Division Chairperson's recommendation, the Credentials Committee shall examine evidence of the applicant's character, professional competence, qualifications, prior behavior and ethical standing and determine, through information contained in references given by the applicant and from other sources available to the committee, including the report and findings from the Chief of each clinical department or the Division Chairperson for the division in which privileges are sought, whether the applicant has established and satisfied all of the necessary qualifications for appointment and for the Clinical Privileges requested.
2. After determining that the applicant has satisfied the necessary qualifications for appointment and Privileges, the Credentials Committee may require the applicant to undergo a physical and/or mental examination by a Physician or Physicians satisfactory to the Credentials Committee. The results of any such examination shall be made available to the Committee for its consideration. Failure of an applicant to undergo such an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall constitute a Voluntary withdrawal of the application for appointment and Clinical Privileges, and all processing of the application shall cease.
3. The Credentials Committee shall have the right to require the applicant to meet with the Committee or its designee to discuss any aspect of the applicant's application, qualifications, or Clinical Privileges requested. The Committee may also determine that additional information is required. In this instance the Committee will notify the applicant the application is incomplete, specify why the application has been deemed incomplete, clarify the information required and note a deadline for submitting the required information.
4. The Credentials Committee may use the expertise of the Chief, or any member of the department or division, or an outside consultant, if additional information is required regarding the applicant's qualifications.
5. If after considering the report of the clinical department Chief concerned or the report of the Division Chairperson of the division concerned the Credentials Committee's recommendation for appointment is favorable, the Credentials Committee shall recommend provisional appointment and provisional department assignment. All recommendations to appoint, including provisional appointment, must specifically recommend the Clinical Privileges to be granted, which may be qualified by any probationary or other conditions or restrictions as deemed appropriate by the Committee.
6. If the recommendation of the Credentials Committee will be delayed longer than ninety (90) days, the Chairperson of the Credentials Committee shall send a letter to the applicant, with a copy to the Executive Committee and Chief Executive Officer, explaining the reasons for the delay.

ARTICLE II – PART D:

Section 4. Credentials Committee Report:

1. The Credentials Committee shall send its recommendation to the Executive Committee. Recommendations which are adverse must be accompanied by an explanation. The

completed application and all supporting documentation shall be available to support the Credentials Committee's findings and recommendation.

2. The Chairperson of the Credentials Committee shall be available to the Executive Committee (and to the Board) to answer any questions that may be raised with respect to the Credentials Committee's findings and recommendation.

ARTICLE II – PART D:

Section 5. Executive Committee Procedure:

1. At its next regular meeting after receipt of recommendation of the Credentials Committee, the Executive Committee shall:
 - a) adopt the findings and recommendation of the Credentials Committee;
 - b) refer the matter back to the Credentials Committee for further consideration and preparation of responses (in a timely manner) to specific questions raised by the Executive Committee prior to its final recommendation; or
 - c) set forth in its recommendation its reasons, along with supporting information, for its disagreement with the Credentials Committee's recommendation. Thereafter, the Executive Committee's recommendation shall be forwarded, together with the Credentials Committee's findings and recommendation, through the Chief Executive Officer to the Medical Affairs Committee.

ARTICLE II – PART D:

Section 6. Medical Affairs Committee Procedure:

1. At its next regular meeting after receipt of the recommendations of the Executive Committee, the Medical Affairs Committee shall:
 - a. Adopt the findings and recommendations of the Executive Committee;
 - b. Refer the matter back to the Executive Committee for further consideration and preparation of responses (in a timely manner) to specific questions raised by the Medical Affairs Committee prior to its final recommendation; or
 - c. Set forth in its recommendation its reason, along with supporting information, for its disagreement with the Executive Committee's recommendation. Thereafter, the Medical Affairs Committee's recommendation shall be forwarded, together with the Executive Committee's and Credentials Committee's findings and recommendations, through the Chief Executive Officer to the Board.
2. If the recommendation of the Medical Affairs Committee would entitle the applicant to request a hearing pursuant to this policy, it shall be forwarded to the Chief Executive Officer who shall promptly notify the applicant in writing, certified mail, return receipt requested. The Chief Executive Officer shall then hold the application until after the applicant has exercised or waived the right to a hearing and appeal, as provided in this policy, after which the Chief Executive Officer shall forward the recommendation of the Medical Affairs Committee, together with the complete application and all supporting documentation to the Board for further action

ARTICLE II – PART D:

Section 7. Procedure Thereafter:

1. Upon receipt of a complete application with favorable recommendation from the Medical Affairs Committee that the applicant be granted initial appointment and the requested Clinical Privileges, and after giving due consideration to any comments from the Executive Committee and the Credentials Committee, the Board may:
 - a) appoint the applicant and grant Clinical Privileges as recommended; or

- b) refer the matter back to the Medical Affairs Committee or to another source inside or outside the Hospital for additional research or information; or
 - c) reject the recommendation.
2. The Board may delegate to a committee, consisting of at least two (2) Board members, action on appointment, reappointment, and Clinical Privileges if there has been a favorable recommendation from the Credentials and Executive Committee and there is no evidence of the following: current or previously successful challenge to licensure or regulation, involuntary termination, limitation, reduction, denial, or loss of appointment or privileges at any other Hospital or other entity, or an unusual pattern or excessive number of professional liability actions resulting in a final judgment against the applicant.
 3. Prior to the Board rejecting a favorable recommendation, the Chairperson of the Medical Affairs Committee will be given the opportunity to discuss the reasons for the recommendation of the Medical Affairs Committee with the Board. The Board's final decision and the reasons in support thereof shall be sent to the Chief Executive Officer, who shall promptly notify the applicant in writing, certified mail, return receipt requested.

ARTICLE II – PART E: PROVISIONAL APPOINTMENT

Section 1. Duration of Initial Provisional Appointment and Clinical Privileges:

1. All initial appointments to the Medical Staff regardless of the category of the staff to which the appointment is made, and all initial Clinical Privileges shall be provisional for a period of twelve (12) months from the date of the appointment or longer if recommended by the Credentials Committee.
2. All grants of additional Clinical Privileges to existing Medical Staff Appointees shall also be provisional. The duration and/or terms of such provisional period shall be recommended by the Credentials Committee after consulting with the appropriate department chief.
3. During this provisional period, the individual shall be evaluated by the Chief(s) or Chair(s) of the service or services in which the individual has Clinical Privileges, and by the relevant committees of the Medical Staff and the Hospital as to the individual's clinical competence, general behavior and conduct in the Hospital.
4. Continued appointment and/or Clinical Privileges after the provisional period shall be conditioned on an evaluation of the factors set forth in Section 2, #3 of this Part.
5. Provisional Clinical Privileges shall be adjusted to reflect clinical competence at the end of the provisional period or sooner if warranted.

ARTICLE II – PART E:

Section 2. Duties of Provisional Appointees:

1. During the provisional period, an Appointee must demonstrate all of the qualifications may exercise all of the prerogatives and must fulfill all of the obligations attendant to the assigned staff category.
2. Each Appointee must arrange or cooperate in the arrangement of the required numbers and types of cases to be reviewed/observed by the department chief and/or designated proctors, if required.
3. Failure of the provisional Appointee to admit, treat or attend to a sufficient volume of patients or to have a sufficient interaction within the System during the provisional period (sufficient to

permit observation and assessment), or failure of the Appointee, during the provisional period, to fulfill all requirements of appointment relating to meeting attendance, completion of medical records, and/or cooperation with monitoring or proctoring conditions as outlined in this policy, shall render the provisional Appointee ineligible for continued appointment and Clinical Privileges unless the failure to meet such requirements is based upon good cause. In the absence of good cause, the appointment and all Clinical Privileges shall expire at the end of the provisional period. The individual may be permitted to reapply for initial appointment in accordance with this policy, provided the individual can demonstrate a greater interest in or intention to use the System in the future.

ARTICLE II – PART F: CLINICAL PRIVILEGES

Section 1. General:

1. Medical Staff appointment or reappointment shall not automatically confer any Clinical Privileges or right to practice within the Health System. Clinical Privileges shall be granted for a period not to exceed two (2) years. Clinical Privileges may be granted for a period of less than two (2) years in order to cycle the Appointee into the specialty-specific appointment review cycle.
2. Medical Staff, including those in administrative positions, may be granted Hospital/facility-specific Clinical Privileges and/or to admit as granted by the Board following Medical Staff recommendation.
3. The grant of Clinical Privileges shall carry with it acceptance of the obligations of such privileges including emergency service and other rotational obligations.
4. Clinical Privileges shall be voluntarily relinquished only in the manner that provides for the orderly transfer of patient care and administrative obligations.
5. The Clinical Privileges recommended to the Board shall be based upon consideration of the following:
 - a) the applicant's education, successful completion of an approved training program, experience, demonstrated current competence and judgment, references, utilization patterns and ability to perform the privileges requested competently and safely;
 - b) the applicant's ability to meet all current criteria for the requested Clinical Privileges;
 - c) availability of qualified Physicians or other appropriate Appointees to provide medical coverage for the applicant in case of the applicant's illness or unavailability;
 - d) adequate levels of professional liability insurance coverage with respect to the Clinical Privileges requested;
 - e) patient care needs and the System's available resources and personnel;
 - f) any previously successful or currently pending challenges to any licensure or registration, or the Voluntary or involuntary relinquishment of such licensure or registration;
 - g) any information concerning professional review actions, Voluntary or involuntary termination of Medical Staff appointment or Voluntary or involuntary relinquishment, limitation, reduction, or loss of Clinical Privileges at another Hospital; and
 - h) other relevant information, including a written report and findings by the chief of each of the clinical services in which such privileges are sought.
6. The applicant shall have the burden of establishing qualifications for and competence to exercise the Clinical Privileges requested.
7. The recommendations of the Chief(s) and/or Chairs of the clinical service(s) in which privileges are sought shall be forwarded to the Credentials Committee and processed as a part of the initial application for staff appointment.

ARTICLE II – PART F:

Section 2. Clinical Privileges for Dentists:

1. The scope and extent of surgical procedures that a Dentist may perform shall be delineated and recommended in the same manner as other Clinical Privileges.
2. Surgical procedures performed by Dentists shall be under the overall supervision of the Chief of the Surgery Department. A medical history and physical examination of the patient shall be made and recorded by a Physician who holds an appointment to the Medical Staff before dental surgery shall be scheduled for performance and a designated Physician shall be responsible for the medical care of the patient throughout the period of hospitalization.
3. Oral surgeons who admit patients without underlying health problems (classified as ASA I and II) may perform a complete admission history and physical examination and assess the medical risks of the procedure on the patient if they are deemed qualified to do so by the Credentials Committee. A designated Physician shall be responsible for the medical care of the patient throughout the period of hospitalization. "Oral Surgeons" shall be interpreted to refer to licensed Dentists who have successfully completed a postgraduate program in oral and maxillofacial surgery accredited by the American Association of Oral and Maxillofacial Surgery and/or the Commission on Dental Education of the American Dental Association.
4. The Dentist shall be responsible for the dental care of the patient, including the dental history and dental physical examination, as well as all appropriate elements of the patient's record. Dentists may write orders within the scope of their license and consistent with the Medical Staff rules and regulations and in compliance with the Hospital and Medical Staff bylaws and this policy.

ARTICLE II – PART F:

Section 3. Clinical Privileges for Podiatrists:

1. The scope and extent of surgical procedures that a Podiatrist may perform shall be delineated and recommended in the same manner as other Clinical Privileges and in accordance with provisions of the policy governing such individuals as may be adopted by the Board from time to time.
2. Surgical procedures performed by Podiatrists shall be under the overall supervision of the Chief of the Surgery Department. A medical history and physical examination of each patient shall have taken place and been recorded in the medical record by a Physician who holds an appointment to the Medical Staff before podiatric surgery shall be performed and a designated Physician shall be responsible for the medical care of the patient throughout the period of hospitalization.
3. The Podiatrist shall be responsible for the podiatric care of the patient, including the podiatric history and the podiatric physical examination, as well as all appropriate elements of the patient's record. Podiatrists may write orders which are within the scope of their license, consistent with the Medical Staff rules and regulations and in compliance with Hospital and Medical Staff bylaws and this policy.

ARTICLE II – PART F:

Section 4. Supervision of Licensed Dependent Practitioners:

Any Physician who employs a Licensed Dependent Practitioner to perform clinical activities/functions shall be responsible for the direction and supervision of the on-site and/or day-to-day patient care activities of the individual. All Physicians employing such individuals are

advised to consult the System's Policy on Allied Health Professionals for details concerning the use of Licensed Dependent Practitioners in the System.

ARTICLE II – PART F:

Section 5. Clinical Privileges After Age 65:

1. The Credentials Committee shall specifically consider the mental and physical capabilities of each Appointee who has attained the age of 65 years and who has Clinical Privileges at the Hospital. Recommendations by the Credentials Committee for continued Clinical Privileges for Appointees between the ages 65 and 75 shall be made annually and shall be based upon an evaluation of the individual's current knowledge, skills, conduct and ability to perform the privileges requested competently and safely.
2. Upon attaining the age of 75, Medical Staff Appointees shall no longer have Clinical Privileges to admit or care for patients within the System. They shall be ineligible to vote, hold offices and serve on committees. They shall pay no staff dues and shall assume full Honorary Staff status with attendant prerogatives unless an exception continuing privileges is recommended by the Credentials, Executive and Medical Affairs Committees and approved by the Board.

ARTICLE II – PART F:

Section 6. Telemedicine Privileges:

1. The Hospital Board will determine the clinical services to be provided through Telemedicine after considering the recommendations of the appropriate Department Services Chief(s), the Credentials Committee, the Medical Executive Committee, and/or the Medical Affairs Committee.
2. Telemedicine privileges may be granted to Licensed Independent Practitioners who have either total or shared responsibility for patient care, treatment, and services (as evidenced by having the authority to write orders and direct care, treatment, and services) through medical information exchanged from one site to another via electronic communication. Individuals granted privileges to provide Telemedicine services shall not be appointed to the Medical Staff.
3. To process a request for Telemedicine privileges, the Hospital may: i) credential and grant privileges to the practitioner in the same manner as for any other applicant (the applicant shall complete a Medical Staff application as if the applicant was applying for on-site Clinical Privileges) or ii) credential and grant privileges to the practitioner in accordance with the provisions of these bylaws but utilize credentialing information from the practitioner's primary hospital/organization, provided that hospital/organization is accredited by the Joint Commission on Accreditation of Healthcare Organizations. If option ii) is utilized, the Hospital shall obtain: i) primary source verification that the practitioner's primary hospital/organization currently is JCAHO accredited, ii) primary source verification of the scope and current status of the practitioner's Clinical Privileges, iii) confirmation that the practitioner's current malpractice insurance is not less than the malpractice cap established by Virginia law (unless coverage is waived based upon immediate patient need), iv) electronic verification of the practitioner's HHS-OIG and Excluded Individual/Entity status, AMA Profile, Board certification status, DEA status (if authorization to prescribe will be within the scope of privileges), and v) information from the practitioner's primary hospital/organization useful to assess the practitioner's quality of care, treatment, and services which, at a minimum, shall include all adverse outcomes related to sentinel events considered reviewable by JCAHO that resulted from the Telemedicine services provided and complaints about the practitioner from patients, LIPs, or staff at the primary hospital/organization.

4. At a minimum, practitioner must concurrently maintain privileges for the same scope of services at the distant site as he or she has requested and has been granted at the Hospital. The Hospital will periodically review the practitioner's performance of the Privileges requested and upon request will provide information resulting from that review to the distant site.
5. If the Telemedicine services are required for a pressing clinical need, the Hospital may grant temporary privileges in accordance with the relevant section of Part H of this Policy.

ARTICLE II – PART G: VOLUNTARY RELINQUISHMENT OF PRIVILEGES

Section 1. Request to Relinquish Clinical Privileges:

1. A Medical Staff Appointee who desires to relinquish voluntarily any of the Clinical Privileges granted at any time during the appointment period may submit a written request to the President of the Medical Staff specifying the clinical privilege(s) to be relinquished. Said relinquishment of privileges shall not be effective until acknowledged in writing by the Credentials Committee.
2. The procedure set forth in this Part shall not apply to situations where the Appointee has been deemed by the System to have automatically relinquished privileges pursuant to this policy, the Medical Staff bylaws, rules and regulations or the System bylaws or policies.
3. Likewise, voluntary relinquishment of Clinical Privileges while under an investigation or in return for not conducting an investigation shall be considered a "surrender" of such privileges and shall be so reported when so required.

ARTICLE II – PART G:

Section 2. Procedure for Relinquishment of Clinical Privileges:

1. Upon the receipt of a request to relinquish one (1) or more Clinical Privileges, the President of the Medical Staff and or the Credentials Committee shall review the request and forward a recommendation to the Board for final action. The President of the Medical Staff and/or the Credentials Committee may request a meeting with the Appointee involved if the decrease of the Clinical Privileges would create a deficiency in available System services. A report of such meeting shall be submitted to the Board with the recommendation of the President of the Medical Staff and/or the Credentials Committee.
2. The Board shall act on the request and its decision shall be reported in writing by the Chief Executive Officer to the Appointee, the Medical Affairs Committee, the Executive Committee, the Credentials Committee and the Chief of the applicable department. The decision of the Board shall specify a date on which relinquishment of clinical privilege(s) shall become effective.
3. Failure to request relinquishment of any Clinical Privileges pursuant to this Part or to adhere to the effective date specified by the Board for the relinquishment of the Clinical Privileges in question shall constitute grounds for professional review action pursuant to this policy.

ARTICLE II – PART H: PROCEDURE FOR TEMPORARY CLINICAL PRIVILEGES

Section 1. Temporary Clinical Privileges for Applicants:

The Chief Executive Officer or his authorized designee may, following favorable recommendation of the Medical Staff President or his designee (Service Chief or Credentials Chair) grant temporary Clinical Privileges to a new applicant not to exceed 120 days when the application is

awaiting review of the Medical Staff Executive Committee and Board. The following must be verified before Clinical Privileges are granted: current licensure; relevant training and experience; current competence and ability to perform requested privileges; a query and evaluation of the NPDB; the applicant has submitted a complete application; no current or previously successful challenge to licensure or relevant registration; no involuntary termination of Medical Staff membership at another organization; no history of involuntary limitation, reduction, denial, or loss of Clinical Privileges and verification of required malpractice coverage. Temporary Clinical Privileges shall not be routinely granted prior to a favorable recommendation from the Credentials Committee. However, temporary privileges may be granted prior to Credentials Committee review conditioned upon the criteria noted above being met and a determination that failure to grant temporary privileges will not be in the best interest of patient care, or disrupt the orderly and efficient operation of the System. Temporary privileges are considered a courtesy only. The Medical Staff and CEO are not obligated to grant temporary privileges. Neither the grant, denial, nor termination, of temporary privileges shall entitle the individual concerned to request any procedural rights provided in this policy.

ARTICLE II – PART H:

Section 2. Temporary Privileges for Non-Applicants For Important Patient Care Need:

Temporary Clinical Privileges for care of a specific patient or patients for a limited time, not to exceed 120 days, may be granted by the Chief Executive Officer to an individual who is not an applicant for appointment following verification of licensure, current competence and malpractice coverage. Temporary privileges for care of specific patients shall not be used as a mechanism to avoid the complete credentialing process. Examples of appropriate indications include, but are not limited to: the patient requires services not provided by currently privileged staff or a staff Appointee requires surgical assistant services not available by currently privileged staff. Neither the grant, denial, nor termination of temporary privileges for specific patient care needs shall entitle the individual concerned to request any procedural rights provided in this policy.

ARTICLE II – PART H:

Section 3. Special Requirements:

Special requirements of supervision and reporting may be imposed by the Service Chief concerned on any individual granted temporary Clinical Privileges. Temporary privileges shall be immediately terminated by the Chief Executive Officer or a designee upon notice of any failure by the individual to comply with such special conditions.

ARTICLE II – PART H:

Section 4. Temporary Clinical Privileges for Covering Practitioners:

1. In extraordinary circumstances the Chief Executive Officer, after consultation with the appropriate Division Chair and Chief of Service, the President of the Medical Staff and the Credentials Chair, may grant an individual temporarily covering for a specific Appointee of the Medical Staff (or to temporarily fill a staff vacancy) temporary admitting and Clinical Privileges to attend and treat patients of that Appointee for a specified limited period (customarily not to exceed thirty (30) days). This shall be done in the same manner and upon the same conditions as set forth in Section 1 of this Part, provided that the Chief Executive Officer shall first obtain such individual's signed acknowledgement that the individual has received and had an opportunity to read copies of the Hospital bylaws, this policy and Medical Staff bylaws, rules and regulations which are then in force, and agrees to be bound by the terms thereof.

2. The individual serving as a covering practitioner must complete a request for temporary Clinical Privileges form and must have in force and effect a current license to practice in this state, an unlimited DEA license, if applicable, and professional liability insurance in an amount and terms acceptable to the Hospital. Neither the grant, denial, nor termination, of such temporary privileges shall entitle the individual concerned to request any procedural rights provided in this policy.

ARTICLE II – PART H:

Section 5. Termination of Temporary Clinical Privileges:

1. The Chief Executive Officer may, at any time after consulting with the President of the Medical Staff, the Credentials Committee Chairperson or the Chief of Service responsible for the individual's supervision, terminate temporary admitting privileges. Clinical Privileges shall then be terminated when the individual's inpatients are discharged from the Hospital. However, where it is determined that the care or safety of such patients would be endangered by continued treatment by the individual granted temporary privileges, a termination of temporary Clinical Privileges may be imposed by the Chief Executive Officer, the Credentials Chair, the Chief of Service or the President of the Staff and such termination shall be immediately effective.
2. The appropriate Chief of Service or the President of the Medical Staff shall assign to a Medical Staff Appointee responsibility for the care of such individual's patients until they are discharged from the Hospital, giving consideration wherever possible to the wishes of the patient in the selection of the substitute.
3. The granting of any temporary admitting and Clinical Privileges is a courtesy on the part of the Hospital and any or all may be terminated if a clinical question or concern has been raised. Neither the grant, denial, nor termination of such privileges shall entitle the individual concerned to request the procedural rights provided in this policy.
4. Temporary privileges shall be automatically terminated at such time as the Credentials Committee recommends not to appoint the applicant to the staff. Similarly, temporary Clinical Privileges shall be modified to conform to the recommendation of the Credentials Committee that the applicant be granted Clinical Privileges different from the temporary privileges.

ARTICLE II – PART H:

Section 6. Emergency Privileges for Current Staff Appointees:

1. For the purpose of this section, an "emergency" is defined as a condition in which serious, permanent harm would result to a patient, or in which the life of a patient is in immediate danger, and any delay in administering treatment would add to that harm or danger.
2. In case of a life-threatening emergency, any Medical Staff Appointee with Clinical Privileges may, to the degree permitted by his or her license, and regardless of his or her service or staff status, provide patient care, treatment, and services necessary to save the life of a patient, using every facility of the Hospital necessary, including calling for any consultation necessary or desirable.
3. When the emergency situation no longer exists, the patient's care will be returned to the attending or other appropriate staff Appointee.

ARTICLE II – PART H:

Section 7. Disaster Privileges for Medical Volunteers:

1. Disaster privileges may be granted when the emergency management plan has been activated and current medical Appointees are unable to handle the immediate needs of patients. The Medical Control Office, in collaboration with other Medical Staff Appointees and Incident Command officials, will determine the types of medical professionals required during the disaster.
2. The Chief Executive Officer, Medical Control Officer, Medical Staff President, or their designees, are authorized to grant "disaster Clinical Privileges" upon presentation of any of the following:
 - a) current Hospital picture ID card;
 - b) current license to practice and valid picture ID issued by a state or federal agency;
 - c) identification indicating that the individual is a Physician member of a disaster medical assistance team (DMAT)
 - d) identification that the individual has been granted authority to render patient care in emergency circumstances (such authority being granted by a federal, state, or municipal entity)
 - e) identification by current Hospital or Medical Staff member(s) with personal knowledge regarding the Physician's identity or who possess personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during a disaster.
3. The verification of licensure and current competence shall begin as soon as the immediate situation is under control in accordance with customary procedures used to verify licensure and competence for individuals granted temporary privileges to meet an important patient care need. The verification process will be conducted consistent with available communication methods. Primary source verification shall be completed within 72 hours unless extraordinary circumstances exist that prevent such verification. The Hospital shall make a decision, based on information regarding the professional practice of the volunteer, within 72 hours regarding the continuation of the disaster privileges initially granted.
4. Individuals granted disaster privileges shall provide patient care consistent with their training. Their work shall be under the supervision of the appropriate Department Chief/Division Chair or their medical designee, who shall be responsible for overseeing, through direct observation, mentoring and/or clinical record review, the professional performance of the individual granted disaster privileges. The individual will be supplied with an appropriate identification. Authorization to practice will be documented and transmitted to the appropriate office.
5. Upon the officially declared conclusion of the disaster situation, the Disaster Medical Officer, in consultation with the appropriate Department Chiefs, shall provide for an orderly assignment of patients to fully credentialed Appointees. Once the transfer has been accomplished, an individual's disaster privileges shall be deemed automatically relinquished.
6. Individuals authorized to grant disaster privileges are not required to grant disaster privileges to specific individuals. They shall make a determination on a case-by-case basis.
7. Granting disaster privileges to medical volunteers shall not be interpreted as a determination that the medical volunteer meets the threshold conditions for Medical Staff appointment.
8. A decision not to grant disaster privileges or to terminate disaster privileges shall not be considered an adverse professional review recommendation.

ARTICLE III

ACTIONS AFFECTING MEDICAL STAFF APPOINTEES

ARTICLE III – PART A: PROCEDURE FOR REAPPOINTMENT

Continuous satisfaction of all threshold qualifications and compliance with all terms, conditions and procedures relating to initial appointment set forth in Article II of this policy shall be required for continued appointment and Clinical Privileges and shall apply to reappointment. No individual shall be entitled to reappointment to the Medical Staff or to continue exercising particular Clinical Privileges in the Hospital merely by virtue of the fact that such individual has had in the past, or currently has, Medical Staff appointment or privileges at the Hospital or any other health care facility.

ARTICLE III – PART A:

Section 1. Application:

1. Each current Appointee who is eligible to be reappointed to the Medical Staff shall be responsible for completing the reappointment application form. The reappointment application shall be provided to the Appointee at least five (5) months prior to the expiration of the Appointee's current appointment period. It shall be submitted to the Medical Staff Office at least four (4) months prior to the expiration of the Appointee's current appointment period. Failure, without just cause, to submit an application by that time will result in automatic expiration of the Appointee's appointment and Clinical Privileges at the end of the then current Medical Staff year.

2. Reappointment, if granted by the Board, shall be for a period of not more than two (2) years, with approximately one-half of the staff appointed in even numbered years and the other half in odd numbered years, with reappointments staggered in a manner established by the Medical Staff Office.

ARTICLE III – PART A:

Section 2. Factors to be Considered:

1. Each recommendation concerning reappointment of an individual currently appointed to the Medical Staff shall be based upon such Appointee's:
 - a) patient contacts at the Hospital during the previous appointment term;
 - b) ethical behavior, clinical competence and clinical judgment in the treatment of patients;
 - c) attendance at Medical Staff, departmental and committee meetings, and participation in staff duties;
 - d) compliance with the bylaws, policies and rules and regulations of the Medical Staff and the Hospital;
 - e) behavior within the System, including cooperation with Medical Staff and Hospital personnel as it relates to patient care, the orderly operation of this Hospital and the general attitude toward patients and staff;
 - f) use of the System's facilities for patients, taking into consideration the individual's comparative utilization patterns;
 - g) ability to perform the Clinical Privileges requested competently and safely;
 - h) capacity to treat patients as indicated by the results of the System's quality assessment/performance improvement activities or other reasonable indicators of continuing qualifications;
 - i) at the time of reappointment the applicant shall attest in writing that she/he has obtained continuing education in accordance with relevant Virginia licensing requirements and agrees that, if requested, she/he will provide proof of attendance/participation in CME

activities in accordance with the guidelines established for biennial license renewal. In addition to the general CME attestation, the applicant shall provide documentation verifying participation in specific CME activities specifically required by the applicant's assigned department/division, medical specialty/sub-specialty and/or requested Clinical Privileges;

- j) current professional liability insurance status and pending malpractice challenges, including claims, lawsuits, judgments and settlements;
 - k) validation of current licensure, including voluntary or involuntary relinquishment of licensure and currently pending challenges to any license or registration;
 - l) continuing board certification as outlined in Article II, Part A, Section 2(g), but any previously board certified Appointee who was appointed to the Medical Staff on or after January 1, 2005 and whose certification has lapsed shall have two (2) years to recertify in his primary specialty(ies) after the expiration of his board certification before he no longer is eligible for reappointment and Clinical Privileges;
 - m) voluntary or involuntary termination of Medical Staff appointment or voluntary or involuntary limitation, reduction, or loss of Clinical Privileges at another Hospital or health care facility, not including a voluntary personal decision by the applicant to request a lesser scope of Clinical Privileges upon reappointment or during the term of appointment;
 - n) participation in Medical Staff quality, performance improvement and peer review activities as requested;
 - o) relevant findings from the Hospital's quality assessment/performance improvement activities; and
 - p) other reasonable indicators of continuing qualifications.
2. To be eligible to apply for renewal of Clinical Privileges, an individual must satisfy the threshold qualifications in Article II, Part A, Section 2 and must have performed sufficient procedures, treatments, or therapies in the previous appointment term to enable the Chief of Service and the Credentials Committee to assess the applicant's clinical competence. An individual seeking reappointment who has minimal activity shall have a recommendation from the primary Hospital where she/he practices and/or such other information as may be requested before the individual's reappointment application shall be considered complete and processed further.

ARTICLE III – PART A:

Section 3. Chief of Service/Department or Division Chairperson Procedure:

1. The Medical Staff Office shall send to the Chief of each Service, or the Department or Division chairperson, a current list of all Appointees who have Clinical Privileges in that service, together with a description of the Clinical Privileges each holds and any requested changes proposed, accompanied by copies of their applications.
2. The Chief of Service or the Department or Division chairperson shall provide the Credentials Committee with a recommendation concerning each individual seeking reappointment. The Chief or Department/Division chairperson shall include the basis for any changes recommended in staff category, or Clinical Privileges, or for non-reappointment. The Chief of the Service or Department/Division chairperson concerned shall be available to the Credentials Committee to answer any questions that may be raised with respect to any such report. If the applicant did not submit the application timely, the Chief or Department/Division chairperson is not obligated to submit a recommendation until the Chief or Department/Division chairperson has sufficient time to review the material.

ARTICLE III – PART A:

Section 4. Credentials Committee Procedure:

1. The Credentials Committee, after receiving the recommendation from each Chief of Service, may review all pertinent information available, including all information provided from other committees of the Medical Staff and from management, for the purpose of determining its recommendations for staff reappointment, for change in staff category and for the granting of Clinical Privileges for the ensuing appointment period.
2. After determining that the Appointee is qualified for reappointment and privileges, the Credentials Committee may require an individual currently seeking reappointment to undergo a physical and/or mental examination by a Physician or Physicians satisfactory to the Credentials Committee either as part of the reapplication process or at anytime during the appointment period to aid it in determining whether Clinical Privileges should be granted or continued. The results of such examination shall be available for the Credentials Committee's consideration. Failure of an individual seeking reappointment to undergo such an examination within a reasonable time after being requested to do so in writing by the Credentials Committee, shall constitute a voluntary relinquishment of all Clinical Privileges until such time as the Credentials Committee has received the examination results and has had a reasonable opportunity to evaluate them and make a recommendation thereon.
3. The Credentials Committee shall have the right to require the individual to meet with the Committee Chair or designated Committee members to discuss any aspect of the individual's reappointment application, qualifications, or Clinical Privileges requested.
4. The Credentials Committee may use the expertise of the Chief of Service, or any member of the Service, or an outside consultant, if additional information is required regarding the individual's qualifications for reappointment.
5. If, after considering the report of the Chief concerned, the Credentials Committee's recommendation is favorable, it shall recommend reappointment and the specific Clinical Privileges to be granted, which may be qualified by any probationary or other conditions or restrictions, as deemed appropriate by the committee.

ARTICLE III – PART A:

Section 5. Executive Committee Procedure:

1. The Credentials Committee shall forward its recommendations, including specific details pertaining to an adverse recommendation, to the Executive Committee in time for the Executive Committee to consider the individual's reappointment at its regularly scheduled meeting before the expiration of the applicant's appointment period. The completed application and all supporting documentation shall be available to the Executive Committee to support the Credentials Committee's findings and recommendation. The Chairperson of the Credentials Committee shall be available to the Executive Committee, the Medical Affairs Committee or the Board to answer any questions that may be raised with respect to the recommendation.
2. At its next regular meeting after receipt of the written findings and recommendation of the Credentials Committee, the Executive Committee shall:
 - a) adopt the findings and recommendation of the Credentials Committee;
 - b) refer the matter back to the Credentials Committee for further consideration and preparation of responses to specific questions raised by the Executive Committee prior to its final recommendation; or
 - c) set forth in its recommendation its reasons, along with supporting information, for its disagreement with the Credentials Committee's recommendation. Thereafter, the

Executive Committee's recommendation shall be forwarded, together with the Credentials Committee's findings and recommendation, to the Medical Affairs Committee.

3. At its next regular meeting after receipt of the written findings and recommendation of the Executive Committee, the Medical Affairs Committee shall:
 - a) adopt the findings and recommendations of the Executive Committee;
 - b) refer the matter back to the Executive Committee for further consideration and preparation of response to specific questions raised by the Medical Affairs Committee prior to its final recommendation; or
 - c) set forth in its recommendation its reasons, along with supporting information, for its disagreement with the Executive Committee's recommendation. Thereafter, the Medical Affairs Committee's recommendation shall be forwarded, together with the Executive Committee's and Credentials Committee's findings and recommendation, through the Chief Executive Officer, to the Board.
4. The Medical Affairs Committee shall transmit its written recommendations concerning the reappointment, Clinical Privileges and, where applicable, change in staff category, of each person currently holding a Medical Staff appointment, to the Board, through the Chief Executive Officer, for reappointment consideration and further action.
5. Any recommendation by the Executive Committee that would entitle the affected individual to request the procedural rights provided in this policy shall be forwarded to the Chief Executive Officer who shall promptly notify the affected individual by certified mail, return receipt requested. The Chief Executive Officer shall then hold the recommendation until after the individual has exercised or has waived the right to a hearing as provided in this policy. The Board shall take no final action until the individual has exercised or has waived the procedural rights provided in this policy. Thereafter, the Chief Executive Officer shall forward the recommendation of the Medical Affairs Committee, together with all supporting documentation to the Board. The Chairpersons of the Credentials, the Executive and Medical Affairs Committees shall be available to the Board to answer any questions that may be raised with respect to the recommendation.

ARTICLE III – PART A:

Section 6. Meeting with Affected Individual:

If, during the processing of an individual's reappointment request, it becomes apparent to the Credentials Committee or its Chairperson that the Committee is considering a recommendation that would deny reappointment, deny a requested change in staff category or Clinical Privileges, or reduce Clinical Privileges, the Chairperson of the Credentials Committee may notify the individual of the general tenor of the possible recommendation and ask if the individual desires to meet with the Committee prior to any final recommendation by the Committee. At such meeting, the affected individual shall be informed of the general nature of the evidence supporting the action contemplated and shall be invited to discuss, explain or refute it. This interview shall not constitute a hearing and none of the procedural rules provided in this policy with respect to hearings shall apply. Minutes of the discussion in the meeting shall not be kept. However, the Committee shall indicate as part of its report to the Executive Committee whether such a meeting occurred and shall include a summary of the meeting.

ARTICLE III – PART B: PROCEDURES FOR REQUESTING EXTENSION OF CLINICAL PRIVILEGES

Section 1. Application for Additional Clinical Privileges:

For the purposes of this section, the term “Additional Clinical Privileges” is defined as those Clinical Privileges for which competency criteria have been established by the System. Whenever, during the term of appointment, Additional Clinical Privileges are desired, the Appointee requesting increased privileges shall submit a written application to the Medical Staff Office on a form approved by the Board. The application shall state in detail the specific Additional Clinical Privileges desired and the individual’s relevant recent training and experience, which justify the additional privileges. This application shall be transmitted by the Medical Staff Office to the appropriate department chief. Thereafter, it shall be processed in the same manner as an application for initial Clinical Privileges.

ARTICLE III – PART B:

Section 2. Factors to be Considered:

1. Recommendations for Additional Clinical Privileges shall be based upon:
 - a) patient care needs and the System’s available resources and personnel;
 - b) relevant recent training;
 - c) observation of patient care provided;
 - d) review of the records of patients treated within the System;
 - e) results of any System quality assessment/performance improvement activities;
 - f) applicant’s ability to meet the qualifications and criteria for the Clinical Privileges requested; and
 - g) other reasonable indicators of the individual’s continuing qualifications for the privileges in question.
2. The recommendation for additional privileges may carry with it such requirements for supervision or consultation or other conditions, for such periods of time as are thought necessary.

ARTICLE III – PART B:

Section 3. Clinical Privileges for New Procedures:

For the purposes of this section, the term “New Procedure or Service” is defined as those medical or surgical procedures for which competency criteria have not been established by the System. The Appointee’s Chief or Division Chairperson, as the case may be, initially shall determine whether the procedure or service requested is new. Whenever a Medical Staff Appointee requests Clinical Privileges to perform a New Procedure or Service not currently being performed at the Hospital (or a significant new technique to perform an existing procedure), the following process shall be followed:

1. The Appointee shall first be informed by the Chief Executive Officer (or designee) that the request will be processed after a determination has been made regarding whether the procedure or service will be offered within the System and, if so, the minimum qualifications that an Appointee must possess to be eligible to request the Clinical Privileges in question. The application shall be submitted to the Chief Executive Officer who shall refer the matter to the Board to determine whether to permit the New Procedure or Service to be performed at the Hospital.
2. The Credentials Committee or Executive Committee shall prepare a report that outlines the following:

- a) how requests for similar privilege(s) have been processed in the past (if applicable),
 - b) the specialists/sub specialists who are likely to request this Clinical Privilege,
 - c) the positions of specialty societies or certifying Boards,
 - d) the training available in residency programs in the specialties likely to request this privilege,
 - e) in the case of new procedures, the training available outside of residency programs,
 - f) criteria required by other hospitals with similar resources, personnel, and facilities,
 - g) the ability of Medical Staff leaders and members to review the competency of practitioners who will perform the procedures,
 - h) availability of qualified Physicians to provide medical coverage for the practitioner in case of the applicant's unavailability, and
 - i) other information deemed relevant by the committee.
3. The practitioner requesting privileges to perform the New Procedure or Service also may be asked to provide clinical information about the procedure, a list of training programs and evaluations for Medical Staff leaders to contact prior to making their report, and other information requested.
 4. After receiving the Committee's report and recommendations from the Executive and Credentials Committees, the Board (or its designee) shall make a preliminary determination as to whether the New Procedure or Service is one that will be offered to patients. One of the factors to be considered by the Board in reaching its determination is whether the System has the capabilities, including support services, space and equipment to perform the New Procedure or Service.
 5. If the Board (or its designee) determines to offer the procedure or service, the Credentials Committee shall develop threshold credentialing criteria to guide in the determination of those individuals who are eligible to request the Clinical Privileges at the Hospital. In developing such criteria, the Credentials Committee shall conduct research and consult with experts, including those on the System's Medical Staff and those outside the Hospital, and develop recommendations regarding:
 - a) the minimum education, training and experience necessary to perform the procedure or service,
 - b) the extent of monitoring and supervision that should be required if privileges are granted, and
 - c) the criteria and/or indications for when the procedure or service is appropriate.
 6. The Credentials Committee shall forward its recommendations to the Executive Committee, which shall review the matter and forward its recommendation to the Board (or its designee) for final action.
 7. The Board (or its designee) shall then establish the minimum threshold qualifications that an individual must demonstrate in order to be eligible to request the Clinical Privileges in question.
 8. Once the foregoing steps are completed, the specific requests from eligible Medical Staff Appointees who wish to perform the New Procedure or Service shall be processed in accordance with Article III, Part B, Section 2 of this policy.
 9. Procedures that are clinically or procedurally similar to or adaptations of an existing procedures and do not pose a greater risk to patients are not "New Procedures or Services" as that term is used in this Section. Accordingly, the Board may consider and approve criteria for Clinical Privileges to perform a new, but clinically similar procedure and also grant a qualified practitioner's request for such Clinical Privileges.

ARTICLE III – PART B:

Section 4. Clinical Privileges that Cross Specialty Lines:

Whenever a Medical Staff Appointee requests Clinical Privileges that traditionally have been exercised only by individuals from another specialty, the following process shall be followed:

1. The Appointee shall first be informed by the Chief Executive Officer (or a designee) that the request will not be processed until the steps outlined in this section have been completed and a determination has been made regarding the Appointee's eligibility to request the Clinical Privileges in question.
2. The Credentials Committee shall then investigate the matter and prepare a report and recommendation for the Executive Committee and the Board (or its designee). Specifically, the Credentials Committee shall conduct research and consult with experts, including those on the Medical Staff (individuals on the Medical Staff with special interest and/or expertise in the privileges in question) and those outside the Hospital (e.g., other hospitals, residency training programs, specialty societies).
3. The Credentials Committee shall then develop recommendations regarding
 - a) the minimum education, training and experience necessary to perform the Clinical Privileges in question, and
 - b) the extent of monitoring and supervision that may be required.These recommendations may or may not permit individuals from different specialties to request the privileges at issue. The Credentials Committee shall forward its recommendations to the Executive Committee, which shall review the matter and forward its recommendations to the Board (or its designee) for final action.
4. The Board (or its designee) shall then establish the minimum threshold qualifications that an individual must demonstrate in order to be eligible to request the Clinical Privileges in question.
5. Once the foregoing steps are completed, the specific requests from eligible Medical Staff Appointees who wish to exercise the privileges in question shall be processed in accordance with Article III, Part B, Section 2 of this policy.

ARTICLE III – PART C: CONCERNS INVOLVING PRACTITIONER PERFORMANCE/BEHAVIOR AND CORRECTIVE ACTIONS

Section 1. Initial Review:

1. Whenever a serious concern or question has been raised, or where collegial efforts have not resolved an issue, regarding:
 - a) the clinical competence or clinical practice of any Medical Staff Appointee;
 - b) the care or treatment of a patient or patients or management of a case by any Medical Staff Appointee;
 - c) the known or suspected violation by any Medical Staff Appointee of applicable ethical standards or the bylaws, policies, rules or regulations of the Hospital or the Medical Staff, including, but not limited to the Hospital's quality assessment/performance improvement, risk management and utilization review programs;
 - d) behavior or conduct on the part of any Medical Staff Appointee that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff, including the inability of the Appointee to work harmoniously with others; and/or
 - e) any other matter concerning an Appointee's qualifications for initial or continued appointment;

the matter shall be referred to the Medical Staff President or in his/ her absence the individual delegated to act on his / her behalf. The Medical Staff President or his/her designee shall make sufficient inquiry to satisfy him/herself that the concern or question raised is credible and requires further review.

- a) If the matter involves professional conduct, it shall be handled in accordance with Medical Staff Policies that address practitioner health and/or conduct, whichever the Medical Staff President determines is most appropriate based upon the circumstances prompting the request for review.
- b) If the matter involves clinical performance, the Medical Staff President, after conferring with individuals who may have relevant information, including but not limited to the Department Chief and/or Division Chair and the affected Appointee, may delegate review of the matter to a Department/ Division peer review process or refer the matter to the Physician Quality Management Committee (PQM-C) if she/he believes the matter can be adequately addressed through informal proceedings. If the PQM-C's efforts to work with the practitioner to resolve clinical performance issues are not successful, the PQM-C Chairperson shall notify the MEC. The MEC shall consider the information provided by the PQM-C Chairperson and shall refer the matter to the Credentials Committee for formal investigation if it deems appropriate.
- c) Alternatively, if the Medical Staff President feels the matter cannot be adequately addressed through informal proceedings, the Medical Staff President shall convene the Medical Executive Committee. The MEC shall refer the matter to the Credentials Committee for formal investigation if it deems appropriate.
- d) Nothing in this section shall restrict the Medical Staff President, or others as authorized in this Policy, to issue a precautionary suspension as outlined in Article III. Part D, Section 1.

ARTICLE III – PART C:

Section 2. Initiation of Investigation:

1. When a concern or question involving clinical competence or behavior/conduct has been referred to the Credentials Committee by the President of the Medical Staff or the MEC, the Credentials Committee shall resolve to and thereafter shall begin a formal investigation. The Credentials Committee shall give written notice of the investigation to the Appointee, by hand or by certified mail, return receipt requested unless, in the Committee's judgment, informing the Appointee would compromise the investigation or disrupt the operations of the Hospital or the Medical Staff.
2. Alternately, the Board may determine to begin an investigation where a serious issue has been raised or where collegial efforts have not resolved an issue. If it chooses to commence an investigation, it shall formally resolve to do so before the investigation commences. The Board may delegate the actual investigation to the Credentials Committee, a subcommittee of the Board, or an ad hoc committee. The Board or the entity to whom it delegates the investigation shall follow the investigative procedures outlined in this Policy.
3. The Chairperson of the Credentials Committee shall promptly notify the President of the Medical Staff, the appropriate Chief of Service and Chief Executive Officer in writing of all such requests and any investigations, and shall keep them fully informed of all actions taken in connection therewith.

ARTICLE III – PART C:

Section 3. Investigative Procedure:

Upon formally resolving to conduct an investigation, the Credentials Committee shall meet as soon as possible to decide the following:

1. If the concern states sufficient information to warrant a recommendation, the Credentials Committee, at its discretion, may make such a recommendation, with or without a personal interview with the individual being investigated.
2. If the concern does not state sufficient information to warrant a recommendation, the Credentials Committee shall immediately investigate the matter, appoint a subcommittee to do so, or appoint an ad hoc investigating committee consisting of a minimum of three (3) persons, who may or may not hold appointments to the Medical Staff. However, at least one (1) of the persons shall be from the MediCorp System. If the concern involves clinical competence, the ad hoc investigating committee shall include a peer of the individual (e.g. Physician, Dentist, Podiatrist). This ad hoc investigating committee shall not include partners, associates or relatives of the individual being investigated. The ad hoc investigating committee shall not contain any practitioner who is in direct economic competition with the affected Appointee.
3. The Credentials Committee, its subcommittee or the ad hoc investigating committee shall have available to it the full resources of the Medical Staff and the Hospital, as well as the authority to use independent expert review, if needed. Independent expert review should be considered if the clinical expertise needed to conduct the review is not available on the Medical Staff; the individual under review is likely to raise, or has raised questions about the objectivity of other practitioners on the Medical Staff; or the individuals with the necessary clinical expertise would not be able to conduct a review without risk of allegations of bias, even if such allegations are unfounded. Members of the investigating committee shall abide by the Medical Staff Bylaws provisions governing conflicts of interests (Article III, A, 8) and shall refrain from participating in any investigation as outlined in the Bylaws when the individual could be perceived to have a conflict of interest or to be biased.
4. The committee may require a physical and/or mental examination of the individual being investigated (including chemical testing) by a Physician or Physicians satisfactory to the committee and shall require that the results of such examination be made available for the committee's consideration. The affected Appointee may propose names of examining Physicians for consideration.
5. The Chairperson of the Credentials Committee shall act as a facilitator and guide for the Committee throughout the investigation. Except in situations where a vote is necessary and the Committee is equally divided, the Chairperson shall not vote. The individual being investigated shall have an opportunity to meet with the investigating committee before it makes its report. Within a reasonable time prior to the meeting, the individual shall be informed of the general nature of the evidence supporting the question being investigated and shall be invited to discuss, explain or refute it. This interview shall not constitute a hearing, and none of the procedural rules provided in this policy with respect to hearings shall apply. When possible as part of its investigation, the investigating committee should interview the initiating party directly. At the discretion of the chairperson of the investigating committee, the individual who raised the concern about the affected Appointee may be present during the committee's interview of the Appointee. The Appointee may request to meet with the voting members of the investigating committee without the initiating party being present and this request shall be granted or denied by the chair of the investigating party. A summary of the committee's interview shall be made by the investigating committee and included with its report to the Credentials Committee. The committee also shall advise the MEC or PQMC of the outcome of its investigation.
6. If a subcommittee or ad hoc investigating committee is used, the Credentials Committee may accept, modify or reject the recommendation it receives from that committee.
7. The investigating body shall make a reasonable effort to complete the investigation and issue its report within 30 days of the request for investigation being issued, provide that an outside

review is not necessary. When an independent expert review is necessary, the investigating committee shall make a reasonable effort to complete the investigation and issue its report within 60 to 90 days of receiving the results of the independent expert review.

8. These time frames are intended to serve as guidelines and, as such shall not be deemed to create any right for an individual to have an investigation completed within such time periods. In the event that the investigating committee is unable to complete the investigation and issue its report within these time frames, it shall inform the affected individual of the reason for the delay and the approximate date on which it expects to complete the investigation and issue its report.
9. In making their recommendations, the investigating body shall strive to achieve a consensus as to what is in the best interests of patient care and the smooth operation of the Hospital, while balancing fairness to the affected practitioner, recognizing that fairness does not require that the affected practitioner agree with the recommendation. The goal of the investigation shall be to fully understand all factors related to the practitioner's performance. Whenever possible, the investigating body will work with the practitioner to design a voluntary performance improvement plan. The committees may consider, as appropriate: relevant literature and clinical practice guidelines; all of the opinions and views that were expressed throughout the review, including report(s) from any outside review(s); and any information or explanations provide by the individual under the review.

ARTICLE III – PART C:

Section 4. Procedure Thereafter:

1. At the conclusion of the investigation, the Credentials Committee may:
 - a) determine that no action is justified;
 - b) issue a written warning;
 - c) issue a letter of reprimand;
 - d) impose terms of probation;
 - e) impose a requirement for consultation;
 - f) recommend reduction of Clinical Privileges;
 - g) recommend suspension of Clinical Privileges for a period of time;
 - h) recommend revocation of staff appointment; or
 - i) make such other recommendations as it deems necessary or appropriate.
2. If the action of the Credentials Committee does not entitle the individual to request a hearing, the action shall take effect immediately. A report of the action taken and reasons therefore, shall be made to the Executive Committee, the Medical Affairs Committee, and to the Board through the Chief Executive Officer. The Credentials Committee's action shall stand, without right of appeal by the Appointee, unless modified by a reviewing committee or the Board so as to constitute an action entitling the Appointee to request a hearing as outlined in Article IV of this policy.
3. If the action of the Credentials Committee does entitle the individual to request a hearing, the Credentials Committee shall forward its recommendation to the Executive Committee, and thereafter to the Medical Affairs Committee, and the Chairperson of the Credentials Committee shall be available to the Executive Committee and to the Medical Affairs Committee to answer any questions that may be raised with respect to the recommendation.
4. After reviewing the findings and recommendations of the Credentials Committee, and, if necessary, meeting with the Chairperson of the Credentials Committee, the Executive Committee shall, in a timely manner:
 - a) adopt the recommendation of the Credentials Committee;

- b) refer the matter back to the Credentials Committee for its further investigation and preparation of responses to specific questions raised by the Executive Committee prior to its final recommendation; or
 - c) set forth in its report and recommendation its reasons, along with supporting information, for its disagreement with the Credentials Committee's recommendation, and forward its recommendation, together with the Credentials Committee's findings and recommendation, to the Medical Affairs Committee.
5. After reviewing the findings and recommendations of the Executive Committee, and if necessary, meeting with the Chairperson of the Executive Committee, the Medical Affairs Committee shall, in a timely manner:
- a) adopt the recommendation of the Executive Committee;
 - b) refer the matter back to the Executive Committee for its further investigation and preparation of responses to specific questions raised by the Medical Affairs Committee prior to its final recommendation; or
 - c) set forth in its report and recommendation its reasons, along with supporting information for its disagreement with the Executive Committee's recommendation, and forward its recommendation, together with the Executive Committee's findings and recommendation to the Board through the Chief Executive Officer.
6. Any recommendation by the Medical Affairs Committee that would entitle the affected individual to request a hearing shall be forwarded to the Chief Executive Officer who shall promptly notify the affected individual by certified mail, return receipt requested. The Chief Executive Officer shall then hold the recommendation until after the individual has exercised or has waived the right to a hearing or appeal as provided in this policy, after which the Chief Executive Officer shall forward the recommendation of the Medical Affairs Committee, together with all supporting information, to the Board (or its committee). The Chairperson of the Medical Affairs Committee shall be available to the Board (or its committee) to answer any questions that may be raised with respect to the recommendation.

ARTICLE III – PART D: PRECAUTIONARY SUSPENSION OF CLINICAL PRIVILEGES

Section 1. Grounds for Precautionary Suspension:

1. The President of the Medical Staff, the Chief Executive Officer, the Service Chiefs, and the Executive Vice-President of Medical Affairs each shall each have the authority to suspend all or any portion of the Clinical Privileges of a Medical Staff Appointee or other individual whenever failure to take such action may result in an imminent danger to the health and/or safety of any individual. Such precautionary suspension shall be deemed an interim precautionary step in the Professional Review Activity related to the ultimate professional review action that may be taken with respect to the suspended individual, but is not a complete professional review action in and of itself. It shall not imply any final finding of responsibility for the situation that caused the suspension.
2. Such precautionary suspension shall become effective immediately upon imposition and the affected practitioner shall be informed. The precautionary suspension shall be reported in writing to the Chief Executive Officer, the President of the Medical Staff, the appropriate Service Chief and the Credentials Chair. The precautionary action shall be ratified, modified or lifted by the Credentials Committee within five (5) calendar days.

ARTICLE III – PART D:

Section 2. Credentials Committee Procedure:

1. Any individual who exercises authority under Section 1 of this Part to suspend Clinical Privileges as a precaution shall immediately report this action to the Chairperson of the Credentials Committee to take further action in the matter.

2. When a precautionary suspension has been imposed, an immediate review by the Credentials Committee of the matter resulting in precautionary suspension shall be completed within five business days. The Credentials committee first shall decide whether to continue the precautionary measure or to modify or remove the suspension pending its investigation. If the Committee's full review of the issues cannot be completed within 30 days of the imposition of the precautionary measure, the reasons for the delay shall be transmitted to the Board so it may consider whether the precautionary suspension should be lifted prior to the restriction being in effect for 30 days. In the event the precautionary suspension is lifted, the Credentials Committee shall take such further action as is required in the manner specified under Part C of this Article.

ARTICLE III – PART D:

Section 3. Care of Suspended Individual's Patients:

1. Immediately upon the imposition of a precautionary suspension, the appropriate department Chief or, if unavailable, the President of the Medical Staff, shall assign to another individual, with appropriate Clinical Privileges, responsibility for care of the suspended individual's patients still in the Hospital. The assignment shall be effective until such time as the patients are discharged. The wishes of the patient shall be considered in the selection of the assigned Appointee.
2. It shall be the duty of all Medical Staff Appointees to cooperate with the President of the Medical Staff, the Service Chief concerned, the Credentials Committee and the Chief Executive Officer in enforcing all suspensions.

ARTICLE III – PART E: AUTOMATIC RELINQUISHMENT OF PRIVILEGES AND LEAVE OF ABSENCE

Section 1. Failure to Complete Medical Records:

The elective and emergency admitting Clinical Privileges of any individual may be deemed to be automatically relinquished for failure to complete medical records in accordance with applicable regulations governing the same, after written notification, certified mail, return receipt requested of such delinquency. Such relinquishment shall continue until all the records of the individual's patients are no longer delinquent. Failure to complete the medical records that caused relinquishment of Clinical Privileges within sixty (60) days from the relinquishment of such privileges may constitute a voluntary relinquishment of all Clinical Privileges and resignation from the Medical Staff.

ARTICLE III – PART E:

Section 2. Action by Federal or State Licensing Agency:

1. Action by the appropriate federal and/or state licensing board or agency revoking, limiting or suspending an individual's professional license, or loss or lapse of state license to practice for any reason, shall result in automatic relinquishment of all Hospital Clinical Privileges as of that date, until the matter is resolved, and an application for reinstatement of privileges has been approved by the Credentials Committee and the Board. In the event the individual's license is only partially restricted, the Clinical Privileges that would be affected by the license restriction shall be similarly restricted. The affected individual shall be provided verbal and written notification of the relinquishment of Clinical Privileges.
2. Whenever an individual's federal or state controlled substance certificate is revoked, limited, or suspended, the individual shall automatically and correspondingly be divested of the right

to prescribe medications covered by the certificate as of the time such action becomes effective and through its term. Whenever an individual's state or federal controlled substance certificate is subject to probation, the individual's right to prescribe such medications shall automatically become subject to the same terms of the probation as of the date such action becomes effective throughout its term. The affected individual shall be provided verbal and written notification of the relinquishment of Clinical Privileges.

ARTICLE III – PART E:

Section 3. Failure to be Adequately Insured:

If at any time an Appointee's professional liability insurance coverage lapses, falls below the malpractice liability cap established by Virginia law then in effect, is terminated or otherwise ceases to be in effect (in whole or in part), the Appointee's Clinical Privileges that would be affected shall be automatically relinquished or restricted as applicable as of that date until the matter is resolved or adequate professional liability insurance coverage is restored.

ARTICLE III – PART E:

Section 4. Failure to Satisfy Continuing Education Requirements:

1. Failure, following appropriate notification by the Credentials Committee, to satisfy Medical Staff mandated continuing education requirements and/or to provide documentation of specific CME as requested shall be deemed to constitute a voluntary relinquishment of Medical Staff appointment and Clinical Privileges and shall be sufficient grounds for refusing to consider the individual for reappointment. Such failures shall be documented and specifically considered by the Credentials Committee when making recommendations for reappointment and by the Board when making its final decisions. The Credentials Committee may recommend that the individual be granted a limited or conditional reappointment.
2. Any Appointee who is ineligible for reappointment for failure to satisfy continuing education requirements shall be entitled to meet with a committee to be designated by the Board before final action is taken. This meeting with the Board committee shall not be conducted under the procedural rules provided in this policy.
3. If reappointment is refused by the Board, the individual shall be eligible to reapply for staff appointment and Clinical Privileges and the application shall be processed in the same manner as if it were an initial application.

ARTICLE III – PART E:

Section 5. Failure to Provide Requested Information:

If at any time an Appointee fails to provide required information pursuant to a formal request by the Credentials Committee or the Chief Executive Officer, the Appointee's Clinical Privileges shall be deemed to be voluntarily relinquished until the required information is provided to the satisfaction of the requesting party. For purposes of this section "required information" shall refer to

- physical or mental examination reports as specified elsewhere in this policy, or
- information necessary to explain an investigation, professional review action, or resignation from another health care facility or agency.

ARTICLE III – PART E:

Section 6. Procedure for Leave of Absence:

1. Individuals appointed to the Medical Staff or granted Clinical Privileges may, for good cause, be granted leaves of absence by the Board for a definitely stated period of time. Absence for

longer than the period of time granted shall constitute voluntary resignation of Medical Staff appointment and Clinical Privileges unless an exception is made by the Board upon recommendation of the Executive Committee.

2. A leave of absence must be requested in writing for any absence from Medical Staff and/or patient care responsibilities longer than thirty (30) days or when temporary privileges for a covering Physician are being requested. Leaves of absences should not exceed twelve (12) months absent extraordinary circumstances.
3. Written requests for leaves of absence shall be submitted to the Medical Staff office and shall state the beginning and ending dates of the requested leave and the general reason for the leave requested. The written request of a solo practitioner must outline the arrangements made for patient coverage and access to medical records during the requested leave of absence. The Appointee requesting leave must provide a contact address and telephone number to the Medical Staff office so he/she can be reached during any leave granted if necessary. The Medical Staff office shall transmit the request, together with recommendations from the Medical Staff President, the Appointee's Chief of Service, and the VPMA to the Chief Executive Officer for action by the Board. The Chief Executive Officer shall also notify the Credentials and Executive Committees of all such requests.
4. During a leave of absence, a practitioner may not exercise any Clinical Privileges. In addition, the practitioner shall be excused from all Medical Staff responsibilities including meeting attendance, committee service, and call obligations.
5. If the Hospital becomes aware that the practitioner has been absent from Medical Staff or patient care responsibilities for longer than thirty (30) days, the Hospital may place the practitioner on a leave of absence. The Hospital also may place a practitioner on a leave of absence for absences less than thirty (30) days when it becomes aware of a serious issue regarding the practitioner's ability to competently perform the Clinical Privileges granted. The Hospital will make good faith efforts to advise the practitioner he/she has been placed on a leave of absence using the last known contact information.
6. At the conclusion of the leave of absence, the individual may be reinstated, upon filing a written statement with the Chief Executive Officer summarizing the professional activities undertaken during the leave of absence. The individual shall also provide such other information as may be requested by the Hospital at the time.
7. If the leave of absence was for medical reasons, then the Appointee must submit a report from his or her attending Physician indicating that the Appointee is physically and/or mentally capable of resuming a Hospital practice and exercising the Clinical Privileges requested competently and safely. The Appointee shall also provide such other information as may be requested by the Hospital at that time. All information shall be forwarded by the Chief Executive Officer to the Credentials Committee. After considering all relevant information, the Credentials Committee shall then make a recommendation regarding reinstatement to the Board for final action.
8. In acting upon the request for reinstatement, the Board may approve reinstatement either to the same or a different staff category, and may limit or modify the Clinical Privileges to be extended to the individual upon reinstatement.
9. Absences for longer than one year (absent extraordinary circumstances as determined by the Board) shall result in automatic relinquishment of Medical Staff appointment and Clinical Privileges.
10. If a practitioner's current appointment or Clinical Privileges are due to expire during the leave, the practitioner must apply for reappointment during the absence period or his/her

appointment and Clinical Privileges shall lapse at the end of the current appointment period. If a practitioner's appointment or Clinical Privileges lapse because the practitioner failed to apply for reappointment and privileges, the practitioner may be required to submit a new application for appointment and Clinical Privileges.

11. Leaves of absences are not a matter of right. In the event it is determined that an individual has not shown good cause for a leave, or when a request for extension of a leave is not granted, the determination shall be final with no recourse to a hearing and appeal.

ARTICLE III – PART F: INFORMAL PEER REVIEW PROCEEDINGS

1. Nothing in this policy or the Medical Staff bylaws shall preclude collegial efforts to address questions or concerns relating to an individual's practice and conduct at the Hospital. This policy specifically encourages collegial steps where there is a reasonable likelihood that such steps may improve performance before it requires formal investigation. The goal of such efforts is to arrive at voluntary, responsive actions by the individual. A Medical Staff leader or other of Hospital management may handle these matters using other applicable policies.
2. All efforts of Medical Staff leaders (Medical Staff Officers, appropriate Service Chiefs and Committee Chairpersons) and Hospital management in this regard are intended to be, and are, part of the Hospital's quality/performance improvement and professional review activities.
3. Collegial efforts may involve counseling and educating colleagues when questions arise concerning their clinical practice or professional conduct and may include, but are not limited to:
 - a) educating and advising colleagues of all applicable policies, such as policies regarding appropriate behavior, emergency call obligations and the timely and adequate completion of medical records;
 - b) follow up on any questions or concerns raised about the clinical practice and/or conduct of staff Appointees and recommending activities such as proctoring, monitoring, consultation and letters of guidance;
 - c) sharing with individuals comparative quality, utilization, and other relevant information in order to assist those individuals to conform their practices to appropriate norms; and
 - d) focused review and additional training or education.
4. Collegial efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders, depending on the circumstances. Such efforts, including documented and undocumented interactions, shall be considered to be confidential performance improvement and professional and peer review activities. They shall not, in and of themselves, give rise to any procedural rights.
5. Medical Staff leaders also may handle matters using other applicable policies (e.g., Practitioner Conduct and Wellness Policy, Sexual Harassment Policy).

ARTICLE III – PART G: CONFIDENTIALITY AND REPORTING

1. Actions taken and recommendations made pursuant to this policy shall be treated as confidential in accordance with applicable legal requirements and such policies regarding confidentiality as may be adopted by the Board. In addition, reports of actions taken pursuant to this policy shall be made by the Chief Executive Officer to such governmental agencies as may be required by law.
2. All records and other information generated in connection with and/or as a result of professional review activities shall be confidential, and each individual or committee member participating in such review activities shall agree to make no disclosures of any such

information except as authorized, in writing, by the Chief Executive Officer or by legal counsel to the Hospital. Any breach of confidentiality by an individual or committee member may result in a professional review action, and/or may result in appropriate legal action to ensure that confidentiality is preserved, including application to a court of law for injunctive or other relief.

ARTICLE III – PART H: PEER REVIEW PROTECTION

All minutes, reports, recommendations, communications and actions made or taken pursuant to this policy are deemed to be covered by the provisions of VA Code Ann. §§ 8.01-581.13, 8.01-581.16, 8.01-581.17 and 8.01-581.19:1, and all federal and state statute providing protection to peer review or related activities. Furthermore, the committees and/or panels charged with making reports, findings, recommendations or investigations pursuant to this policy shall be considered to be acting on behalf of the Hospital and its Board when engaged in such professional review activities and thus shall be deemed to be “professional review bodies” as that term is defined in the Health Care Quality Improvement Act of 1986.

ARTICLE IV

HEARING AND APPEAL PROCEDURES

ARTICLE IV – PART A: INITIATION OF HEARING

Section 1. Grounds for Hearing:

1. An applicant or an individual holding a Medical Staff appointment shall be entitled to request a hearing whenever one (1) of the following adverse professional review recommendations has been made by the Medical Affairs Committee:
 - a) denial of initial Medical Staff appointment;
 - b) denial of Medical Staff reappointment;
 - c) revocation of Medical Staff appointment;
 - d) denial of requested initial Clinical Privileges;
 - e) denial of requested additional Clinical Privileges;
 - f) decrease or restriction of Clinical Privileges;
 - g) suspension of Medical Staff appointment or Clinical Privileges (other than precautionary suspension in excess of fourteen (14) days); or
 - h) imposition of mandatory concurring consultation requirement.
2. No other professional review recommendations except those enumerated in (1) of this Section shall entitle the individual to request a hearing. This Article IV shall apply to Licensed Independent Practitioners as outlined in the Policy on Allied Health Professionals.
3. The affected individual shall also be entitled to request a hearing before the Board enters a final decision, in the event the Board should determine, without a similar adverse recommendation from the Medical Affairs Committee, to take any action set forth above.
4. The hearing shall be conducted in as informal a manner as possible, subject to the rules and procedures set forth in this policy.
5. Neither voluntary nor automatic relinquishment of Clinical Privileges, as provided in this policy, nor the imposition of any general consultation requirement, nor the imposition of a requirement for retraining, additional training or continuing education, shall constitute grounds for a hearing, but shall take effect without hearing or appeal.

ARTICLE IV – PART B: THE HEARING

Section 1. Notice of Recommendation:

When a recommendation is made which, according to this policy entitles an individual to request a hearing prior to a final decision of the Board, the affected individual shall promptly be given notice by the Chief Executive Officer, in writing, certified mail, return receipt requested. This notice shall contain:

- a) a statement of the adverse professional review recommendation made and the general reasons for it;
- b) notice that the individual has the right to request a hearing on the adverse recommendation within thirty (30) days of receipt of this notice; and
- c) a copy of this Article outlining the rights in the hearing as provided for in this policy.

If a practitioner retains legal counsel, all notices and communications set forth in this Article IV may be served upon the practitioner's counsel and may be sent by regular first class mail.

ARTICLE IV – PART B:

Section 2. Request for Hearing:

An individual shall have thirty (30) days following the date of the receipt of such notice within which to request the hearing. The request shall be in writing to the Chief Executive Officer. In the event the individual does not request a hearing within the time and in the manner required by this policy, the individual shall be deemed to have waived the right to the hearing and any appellate review and to have accepted the action involved. That action shall become effective immediately upon final Board action.

ARTICLE IV – PART B:

Section 3. Notice of Hearing and Statement of Reasons:

1. Upon receipt from a practitioner of a timely and proper request for hearing, the Chief Executive Officer shall deliver the same to the Chair of the Medical Affairs Committee if the request for hearing was prompted by an adverse recommendation of that Committee, or to the Chair of the Board if the request for hearing was prompted by an adverse recommendation or action of the Board. The Medical Affairs Committee Chairperson or the Board Chairperson, as applicable, shall schedule the hearing and shall give written notice, certified mail, return receipt requested, to the person who requested the hearing. The Medical Affairs Committee Chairperson also shall notify the Chairperson of the MEC of the request for a hearing. The notice shall include:
 - a) the time, place and date of the hearing;
 - b) a proposed list of witnesses, as known at that time, but which may be modified, who will give testimony or present evidence at the hearing in support of the Medical Affairs Committee or the Board;
 - c) the names of the Hearing Panel members and Presiding Officer or Hearing Officer if known; and
 - d) a statement of the specific reasons for the adverse recommendation, as well as the list of patient records and information supporting the recommendation. This statement, and the list of supporting patient record numbers and other supporting information, may be revised or amended at any time, even during the hearing, so long as the additional material is relevant to the appointment or Clinical Privileges of the individual requesting the hearing, and the individual receives notice of any revision or amendment to the statement. The individual and counsel shall have sufficient time, up to thirty (30) days, to study this additional information and rebut it.
2. The hearing shall begin as soon as practicable, but no sooner than thirty (30) days after the notice of the hearing unless an earlier hearing date has been specifically agreed to in writing by the parties. The date or time of any hearing may be rescheduled with the mutual consent of the parties.

ARTICLE IV – PART B:

Section 4. Witness List:

1. The individual requesting the hearing shall provide a written list of the names and addresses of the individuals expected to offer testimony or evidence on the affected individual's behalf within ten (10) days after receiving notice of the hearing and shall include a brief summary of the nature of the anticipated testimony.
2. The witness list of the Hospital in support of the adverse recommendation of the Medical Affairs Committee (or the Board as outlined in Part A, Section 1, Part 3 of this Article) shall include a brief summary of the nature of the anticipated testimony. The witness list of either party may, in the discretion of the Presiding Officer or Hearing Panel Chairperson, be

supplemented or amended at any time during the course of the hearing, provided that notice of the change is given to the other party. The Presiding Officer shall have the authority to limit the number of witnesses, especially character witnesses or witnesses whose testimony is merely cumulative, as set forth in Section 5 of this Part.

ARTICLE IV – PART B:

Section 5. Hearing Panel, Presiding Officer and Hearing Officer:

1. Hearing Panel:

- a) When a hearing is requested, the Chief Executive Officer, acting for the Board, and the President of the Medical Staff or the Chairperson of the Board (if the hearing is occasioned by a Board determination), shall appoint a Hearing Panel which shall be composed of not less than three (3) nor more than five (5) members. The Hearing Panel shall be composed of Medical Staff Appointees who shall not have actively participated in the consideration of the matter involved at any previous level or of Physicians or laypersons not connected with the Hospital or any combination of such persons. Knowledge of the matter involved shall not preclude any individual from serving as a member of the Hearing Panel. Such appointment shall include designation of a Chairperson or a Presiding Officer, at the discretion of the Chief Executive Officer.
- b) The Hearing Panel shall not include any individual who is in direct economic competition with the affected person or any individual who is professionally associated with or related to the affected individual.

2. Presiding Officer:

- a) In lieu of a Hearing Panel Chairperson, the Chief Executive Officer may appoint an active or retired attorney at law as Presiding Officer. Such Presiding Officer must not act as a prosecuting officer, or as an advocate for either side at the hearing. The Presiding Officer may participate in the private deliberations of the Hearing Panel and be a legal advisor to it, but shall not be entitled to vote on its recommendations.
- b) If no Presiding Officer has been appointed, a Chairperson of the Hearing Panel shall be appointed by the Chief Executive Officer to serve as the Presiding Officer, and the Chairperson shall be entitled to one (1) vote.
- c) The Presiding Officer (or Hearing Panel Chairperson) shall:
 - act to insure that all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process;
 - prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, abusive or that causes undue delay;
 - maintain decorum throughout the hearing;
 - determine the order of procedure throughout the hearing;
 - have the authority and discretion, in accordance with this policy, to make rulings on all questions which pertain to matters of procedure and to the admissibility of evidence;
 - act in such a way that all information relevant to the appointment or Clinical Privileges of the individual requesting the hearing is considered by the Hearing Panel in formulating its recommendations; and
 - conduct argument by counsel on procedural points outside the presence of the Hearing Panel unless the Panel wishes to be present.

- d) The Presiding Officer or Hearing Panel Chairperson may be advised by legal counsel to the Hospital with regard to the hearing procedure.
3. Hearing Officer:
- a) As an alternative to the Hearing Panel described in paragraph (1) of this Section, the Chief Executive Officer, after consulting with the President of the Medical Staff (and Chairperson of the Board if the hearing was occasioned by a Board determination), may instead appoint a Hearing Officer to perform the functions that would otherwise be carried out by the Hearing Panel. If the hearing involves clinical issues, the Hearing Officer must be a Physician. If the hearing involves non-clinical issues, the Hearing Officer shall preferably be an attorney at law.
 - b) The Hearing Officer may not be in direct economic competition with the individual requesting the hearing, and shall not act as a prosecuting officer or as an advocate to either side at the hearing. If the Hearing Officer is an attorney, he or she shall not represent clients in direct economic competition with the affected individual. In the event a Hearing Officer is appointed instead of a Hearing Panel, all references in this Article to the "Hearing Panel" or "Presiding Officer" shall be deemed to refer instead to the Hearing Officer, unless the context would clearly otherwise require.

ARTICLE IV – PART C: HEARING PROCEDURE

Section 1. Discovery:

1. There is no right to discovery in connection with the hearing. However, the individual requesting the hearing shall be entitled, upon specific written request, to the following, provided that the written request must state that all documents shall be maintained as confidential and shall not be disclosed or used for any purpose outside of the hearing:
 - a) copies of, or reasonable access to, all patient medical records referred to in the Statement of Reasons, at the individual's expense;
 - b) reports of experts relied upon by the Medical Affairs Committee or the Board;
 - c) redacted copies of relevant committee or department/division meeting minutes (such provision does not constitute a waiver of the state peer review protection statute); and
 - d) copies of any other documents relied upon by the Medical Affairs Committee (or the Board).
2. Prior to the hearing, on dates set by the Presiding Officer or agreed upon by counsel for both sides, each party shall provide the other party with a list of proposed exhibits. All objections to documents or witnesses to the extent then reasonably known, shall be submitted in writing in advance of the hearing. The Presiding Officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.
3. Prior to the hearing, on dates set by the Presiding Officer, the individual requesting the hearing shall, upon specific request, provide the Medical Affairs Committee (or the Board), copies of any expert report or other documents relied upon by the individual.
4. Neither the affected individual, nor his or her attorney, nor any other person on behalf of the affected individual, shall contact Hospital employees appearing on the Hospital's witness list concerning the subject matter of the hearing, unless specifically agreed upon by counsel.
5. Neither the Hospital, nor its attorney, nor any other person on behalf of the Hospital shall contact those persons appearing on the affected individual's witness list concerning the subject matter of the hearing, unless such witness is also listed as a witness for the Hospital or unless specifically agreed upon by the affected individual's counsel.

ARTICLE IV – PART C:

Section 2. Pre-Hearing Conference:

The Presiding Officer shall require counsel for the individual and for the Hospital's Medical Affairs Committee (or the Board) to participate in a pre-hearing conference for purposes of resolving all procedural questions in advance of the hearing. At this conference counsel for the individual may state his/her objections (and the grounds therefore) to any person named to serve on the Hearing Panel or to the Hearing Officer. The Presiding Officer (or Hearing Officer) shall have the sole authority to rule on the objections; counsel for the individual may preserve his objections on the record. The Presiding Officer may specifically require that:

- a) all documentary evidence be exchanged by the parties prior to this conference and any objections to the documents be made at this conference and be resolved by the Presiding Officer;
- b) evidence unrelated to the reasons for the adverse recommendation or unrelated to the individual's qualifications for appointment or the relevant Clinical Privileges be excluded;
- c) the names of all witnesses and a brief statement of their anticipated testimony be exchanged by the parties if not previously provided;
- d) the time granted to each witness' testimony and cross-examination be agreed upon, or determined by the Presiding Officer, in advance; and
- e) witnesses and documentation not provided and agreed upon in advance of the hearing shall be excluded from the hearing, except upon a showing of good cause.

ARTICLE IV – PART C:

Section 3. Failure to Appear:

Failure, without good cause, of the individual requesting the hearing to appear and proceed at such a hearing shall be deemed to constitute voluntary acceptance of the pending adverse professional review recommendations or actions, which shall then be forwarded to the Board for final action.

ARTICLE IV – PART C:

Section 4. Record of Hearing:

The Hearing Panel shall maintain a record of the hearing by a stenographic reporter present to make a record of the hearing or a recording of the proceedings. The cost of such reporter shall be borne by the Hospital, but copies of the transcript shall be provided to the individual requesting the hearing at that individual's expense. Oral evidence shall be taken only on oath or affirmation administered by any person designated by such body and entitled to notarize documents in this State.

ARTICLE IV – PART C:

Section 5. Rights of Both Sides:

1. At a hearing the Hospital Medical Affairs Committee or Board representative, and the affected practitioner shall have the following rights, subject to reasonable limits determined by the Presiding Officer:
 - a) to call and examine witnesses to the extent available;
 - b) to introduce exhibits;
 - c) to cross-examine any witness on any matter relevant to the issues and to rebut any evidence;
 - d) representation by counsel who may call, examine and cross-examine witnesses, and present the case. Both sides shall notify the other of the name of that counsel at least ten (10) days prior to the date of the hearing; and

- e) to submit a written statement at the close of the hearing.
2. Any individual requesting a hearing who does not testify in his or her own behalf may be called and examined as if under cross-examination.
3. The Hearing Panel may question the witnesses, call additional witnesses or request additional documentary evidence.
4. The CEO shall be permitted to attend the hearing on behalf of the Hospital. The Medical Affairs Committee or the Board, whichever body triggered the hearing, may appoint an Appointee to the Medical Staff who is in Good Standing or Board member, as applicable, to attend the hearing on behalf of the Medical Affairs Committee or the Board respectively.
5. All representatives and/or legal counsel must have agreed that the hearing is confidential and privileged and have agreed to maintain such confidentiality and privilege.
6. Other than the Hearing Officer/Committee, stenographer, and those persons permitted to attend the hearing as provided in this Article, the hearing shall be closed and not open to the public.

ARTICLE IV – PART C:

Section 6. Admissibility of Evidence:

The hearing shall not be conducted according to rules of evidence. Hearsay evidence shall not be excluded merely because it constitutes hearsay. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.

ARTICLE IV – PART C:

Section 7. Post-Hearing Statement:

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

ARTICLE IV – PART C:

Section 8. Official Notice:

The Presiding Officer shall have the discretion to take official notice of any matters, either technical or scientific, relating to the issues under consideration that could have been judicially noticed by the courts of this State. Participants in the hearing shall be informed of the matters to be officially noticed and such matters shall be noted in the record of the hearing. Either party shall have the opportunity to request that a matter be officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority. Reasonable additional time shall be granted, if requested, to present written rebuttal of any evidence admitted on official notice.

ARTICLE IV – PART C:

Section 9. Postponements and Extensions:

Postponements and extensions of time beyond any time limit set forth in this policy may be requested by anyone but shall be permitted only by the Presiding Officer or the Chief Executive Officer, on a showing of good cause.

ARTICLE IV – PART D: HEARING CONCLUSION, DELIBERATIONS AND RECOMMENDATIONS

Section 1. Order of Presentation:

The Medical Affairs Committee or the Board, depending on whose recommendation prompted the hearing initially, shall first present evidence in support of its adverse professional review recommendation. Thereafter, the burden shall shift to the individual who requested the hearing to present evidence.

ARTICLE IV – PART D:

Section 2. Basis of Recommendation:

1. The Hearing Panel shall recommend in favor of the Medical Affairs Committee (or the Board) unless it finds that the individual who requested the hearing has proved that the adverse recommendation that prompted the hearing was arbitrary, capricious, or not supported by substantial evidence.
2. The recommendation of the Hearing Panel shall be based on the evidence produced at the hearing. This evidence may consist of the following:
 - a) oral testimony of witnesses;
 - b) post-hearing statements;
 - c) any information regarding the individual who requested the hearing so long as that information has been admitted into evidence at the hearing and the person who requested the hearing had the opportunity to comment on and, by other evidence, refute it;
 - d) any and all applications, references and accompanying documents;
 - e) other documented evidence, including medical records; and
 - f) any other information presented at the hearing.

ARTICLE IV – PART D:

Section 3. Adjournment and Conclusion:

The Presiding Officer may, without special notice, adjourn the hearing and reconvene the same at the convenience and with the agreement of the participants. Upon conclusion of the presentation of evidence by the parties and/or questions by the Hearing Panel, the hearing shall be closed.

ARTICLE IV – PART D:

Section 4. Deliberations and Recommendation of the Hearing Panel:

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

ARTICLE IV – PART D:

Section 5. Disposition of Hearing Panel Report:

The Hearing Panel shall deliver its report and recommendation to the Chief Executive Officer who shall forward it, along with all supporting documentation, to the Board for further action. The Chief

Executive Officer shall also send a copy of the report and recommendation, certified mail, return receipt requested, to the individual who requested the hearing, and to the Medical Affairs Committee for information and comment.

ARTICLE IV – PART E: APPEAL PROCEDURE

Section 1. Time for Appeal:

Within ten (10) days after notice of the Hearing Panel's recommendation, either party may request to appeal the recommendation. The request shall be in writing and must include a statement(s) of the reasons for appeal and the specific facts or circumstance which justify further review. Such written request shall be delivered to the Chief Executive Officer either in person or by certified mail, return receipt requested. If appellate review is not requested in writing within ten (10) days as provided herein, the parties shall be deemed to have waived the right to appeal, and the Hearing Panel's report and recommendation shall be forwarded to the Board for final action.

ARTICLE IV – PART E:

Section 2. Grounds for Appeal:

The grounds for appeal shall be limited to the following:

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

ARTICLE IV – PART E:

Section 3. Time, Place and Notice:

Whenever an appeal is requested as set forth in the preceding sections, the Chairperson of the Board shall, as soon as arrangements can reasonably be made, taking into account the schedules of all participants, schedule and arrange for an appellate review. The affected individual shall be given notice of the time, place and date of the appellate review. When a request for appellate review is from an Appointee who is under a suspension then in effect, the appellate Review Panel shall be convened not more than fourteen (14) days from the date of receipt of the request of an appeal unless the individual agrees to a longer period. The time for appellate review may be extended by the Chairperson of the Board for good cause.

ARTICLE IV – PART E:

Section 4. Nature of Appellate Review:

1. The Chairperson of the Board shall appoint a Review Panel composed of not less than three (3) persons, either members of the Board or others, including but not limited to reputable persons outside the Hospital, to consider the record upon which the recommendation before it was made, or the Board may hear the appeal as a whole body.
2. The Review Panel may in its discretion accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Hearing Panel proceedings. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence or that any opportunity to admit it at the hearing was denied.
3. Each party shall have the right to present a written statement in support of its position on appeal. In its sole discretion, the Review Panel may allow each party and its representative

(counsel) to appear personally and make oral argument not to exceed thirty (30) minutes. The Review Panel shall recommend final action to the Board.

4. The Board may affirm, modify or reverse the recommendation of the Review Panel or, in its discretion, refer the matter for further review and recommendation, or make its own decision based upon the Board's ultimate legal responsibility to grant appointment and Clinical Privileges. In the event the Board determines to modify or reverse the recommendation of the Review Panel and such action would entitle the affected individual to request a hearing in accordance with this policy, it shall so notify the affected individual through the Chief Executive Officer, and shall take no final action thereon until the individual has exercised or has waived the procedural rights provided in this policy.

ARTICLE IV – PART E:

Section 5. Appellate Review in the Event of Board Modification or Reversal of Hearing Panel Recommendation:

In the event the Board determines to modify or reverse the recommendation of a Hearing Panel in a matter in which the individual did not request appellate review pursuant to Section 1 of this Part, and such action would adversely affect the individual, the Board shall notify the affected individual through the Chief Executive Officer that he or she may appeal the proposed modification or reversal. The Board shall take no final professional review action until the individual has exercised or has waived the procedural right provided in this Part.

ARTICLE IV – PART E:

Section 6. Final Decision of the Board:

Within thirty (30) days after receipt of the Review Panel's recommendation, the Board shall render a final decision in writing, including specific reasons, and shall deliver copies to the affected individual and to the Chairpersons of the Credentials, Executive and Medical Affairs Committees, in person or by certified mail, return receipt requested.

ARTICLE IV – PART E:

Section 7. Further Review:

Except where the matter is referred for further action and recommendation, in accordance with Section 4 of this Part, the final decision of the Board following the appeal shall be effective immediately and shall not be subject for further review. If the matter is referred pursuant to Section 4 of this Part for further action and recommendation, such recommendation shall be promptly made to the Board in accordance with the instructions given by the Board. This further review process and the report back to the Board shall in no event exceed thirty (30) days, except as the parties may otherwise stipulate.

ARTICLE IV – PART E:

Section 8. Right to One Hearing and One Appeal Only:

No applicant or Medical Staff Appointee shall be entitled to more than one (1) hearing and one (1) appeal on any matter which may be the subject of an appeal. If the Board determines to deny initial Medical Staff appointment or reappointment to an applicant, or to revoke or terminate the Medical Staff appointment and/or Clinical Privileges of a current Appointee, that individual may not apply for staff appointment or for those Clinical Privileges at this Hospital for a period of five (5) years unless the Board provides otherwise.

Section 9. Exhaustion of Remedies:

Any practitioner applicant or Appointee to the Medical Staff must exhaust the remedies afforded by this Article IV before resorting to any form of legal action.

ARTICLE V


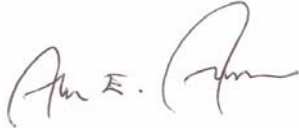


AMENDMENTS

1. This policy may be amended by a majority vote of the members of the Executive Committee present and voting at any meeting of that committee where a quorum exists, provided that the written recommendations of the Credentials Committee concerning the proposed amendments shall have first been received and reviewed by the Executive Committee. Notice of all proposed amendments shall be distributed to the Medical Staff at least 14 days prior to the Executive Committee meeting. Any Medical Staff Appointee shall have the right to submit written comments to the Executive Committee regarding the amendment. No such amendment shall be effective unless and until it has been approved by the Board.
2. This policy may not be unilaterally amended. However, this policy may be amended by the Board on its own motion provided that any such amendment is first submitted to the Credentials, Executive and Medical Affairs Committees for review and comment at least thirty (30) days prior to any final action by the Board on such amendment. Instances where such action by the Board shall be warranted shall include:
 - a) action to comply with changes in federal and state laws that affect this Hospital and the Hospital corporation, including any of its entities;
 - b) requirements imposed by the Hospital's general and professional liability or Director's and Officer's insurance carrier; and
 - c) action to comply with state licensure requirements, JCAHO Accreditation Standards and Medicare/Medicaid Conditions of Participation for Hospitals.

ARTICLE VI

ADOPTION

This Policy on Medical Staff Appointment, Reappointment and Clinical Privileges is adopted and made effective upon approval of the Board for each Hospital, superseding and replacing any and all other Medical Staff bylaws, rules and regulations, policies, manuals or Hospital policies pertaining to the subject matter thereof.

<u>Mary Washington Hospital</u>	<u>Stafford Hospital Center</u>
Adopted: April 1998	Adopted: October 15, 2008
Reviewed Without Revision: April 2001	
Revised: April 1999; October 1999; September 2002; November 2003; January 24, 2007; October 15, 2008	
	
Chair, Medical Executive Committee	Chair, Medical Executive Committee
	
Chief Executive Officer	Chief Executive Officer



Medical Staff Rules & Regulations

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Medical Staff Rules & Regulations

SECTION A: ADMISSION AND DISCHARGE OF PATIENTS

A.1 Admitting Responsibilities

A.1. All admissions shall be by an individual privileged to admit based on assigned staff category and privileges consistent with state law and other regulatory requirements as may apply. The admission shall be by an individual whose clinical specialty is appropriate to the patient's medical needs.

A.1.a. The admission order should identify the attending physician. If not otherwise specified, the admitting physician shall be considered the attending physician.

A.1.b. The designated attending, or his coverage, is responsible for: the ongoing medical care and treatment of each patient assigned to his/her service; prompt completion and accuracy of the medical record; providing timely and clear patient care orders; communicating with the patient and family regarding the medical plan of care; transmitting medical records, if appropriate, to referring practitioner or a facility receiving a patient in transfer; and providing appropriate discharge instructions.

A.1.c. Whenever any or all of these responsibilities are transferred to another appointee, a statement recording the transfer of such responsibility shall be entered on the order sheet of the patient's medical record. A written physician order is required to formally change attending physician designation. The responsibility for writing the order is the responsibility of the current attending or his/her physician coverage. The current attending is responsible for communicating with the physician who will be assuming care for the patient to assure orderly transfer of service.

A.2 Allied Health Professionals - Allied Health Professionals may, if authorized by the Board and with appropriate support and supervision by the Allied Health Professional's employing/supervising medical staff appointee, initiate the procedure for admitting a patient (for example, a mid-wife). The supervising medical staff appointee or his coverage shall be available, appropriately supervise the Allied Health Professional and retain, at all times, the overall responsibility for the patient's care throughout the hospitalization.

A.3 Admission Diagnosis & Special Precautions

A.3.a. The first progress note, "admission note", shall provide a provisional diagnosis and critical findings from the admission exam sufficient for other practitioners to provide patient care pending availability of the documented history and physical report.

A.3.b. The admitting practitioner shall notify hospital staff of any situation which places the patient, family or persons caring for the patient in danger from any source in order that appropriate safety precautions may be taken.

A.4 Assignment of Patients - Patients requiring admission from the Emergency Department who do not have a previously established patient-physician relationship appropriate to the patient's current medical needs shall be assigned to an appointee of the Medical Staff on the unassigned on-call schedule. Please refer to the section of the Rules & Regulations related to Emergency Services and On-Call Responsibilities for additional information.

A.5 Continuity of Care and Responsibilities for Hospitalized Patients - Practitioners must provide timely and appropriate professional care for hospitalized patients by being available, or having available through his office, a qualified alternate appointee with whom prior arrangements have been made. Failure of an appointee to meet these requirements may result in correction action.

A.6 Bed Assignment For Admitted Patients - Practitioners must provide sufficient clinical information for hospital staff to make appropriate bed assignments and facilitate triage activities. Bed assignments shall be made in accordance with current patient care needs and hospital capacity.

A.6.a. Pre-operative admissions include patients already scheduled for surgery. If it is not possible to handle all such admissions the Department Chief and OR Director will coordinate a plan of action.

A.7. Transfer Priorities - Except in emergencies, no patients shall be transferred to another unit without prior consultation with and approval of the attending.

A.8 Admission/Transfer from Special Care Units - Admission, transfer to and discharge from Special Care Units shall be conducted in accordance with relevant hospital standards.

A.9 Care of Patients With Psychiatric And Substance Abuse Problems - Psychiatric consultations should be initiated for patients with known or suspected psychiatric and substance abuse problems. The nursing staff shall be completely informed of the need for suicide precautions. A psychiatric consultation shall be requested on any patient known or suspected to be suicidal.

A.10 Documentation for Justifying Continued Hospitalization - The attending and consulting staff shall document care in a manner which clearly delineates the need for admission and continued acute care. This shall include providing documentation in accordance with hospital standards and external agencies, including but not limited to, hospital licensure agency, CMS peer/quality review organization, accrediting bodies and third party payors. Discharge needs shall be anticipated and documented so that there is sufficient time for hospital staff to plan and coordinate arrangements for the appropriate continuum of care and patient or family education.

A.11 Discharge Documentation - Patients shall be discharged on order of an attending, or his designated coverage. Discharge instructions shall be documented in accordance with hospital standards. The attending or discharging physician shall be responsible for preparing discharge instructions in accordance with hospital standard. Should a patient leave the hospital against the advice of the attending, or without proper discharge, a notation of the incident shall be made in the patient's medical record.

A.12 Management of Patient at the Time of Death - The management of the patient at the time of death shall be carried out in accordance with hospital standard. The physician is responsible for completing the required documentation in conformance to the statutes of the Commonwealth of Virginia.

A.13 Autopsies - An autopsy shall be performed only with written consent of a legally authorized individual in accordance with the statutes of the Commonwealth of Virginia or as otherwise required by law. The Medical Staff shall make an attempt to secure autopsies as outlined in the hospital Autopsy Utilization Plan.

SECTION B: CONSULTATIONS

B.1. A consultation shall be obtained when the patient requires care that is outside the attending practitioner's specialty and/or approved scope of privileges.

B.2. Staff are expected to request and provide consultation in a timely manner in accordance with the guidelines set forth in Medical Staff Regulation Section H, "Inpatient Consultations".

SECTION C: GENERAL CONDUCT OF PATIENT CARE

C.1 History & Physical Exams For Inpatients & Surgical Patients - A history and physical (H&P) examination must be performed by an individual privileged/authorized to perform an H&P. All H&Ps must be performed or countersigned by a medical doctor (M.D.), doctor of osteopathy (O.D), oral surgeon, dentist or podiatrist who has been granted such privileges, for all patients admitted to the hospital and patients scheduled for surgery (procedures performed in the main OR and C-Section Suite). The H&P for an admitted patient must be performed no later than 24 hours after admission. If a medical history and physical examination have been performed within 30 days before the admission (calculated from the date the H&P was originally dictated/documentated) the H&P may be used conditioned upon the patient being evaluated by an individual authorized/privileged to perform a H&P and documenting in the medical record no later than 24 hours after admission that the H&P is unchanged or noting updates and/or additions to the H&P. For patients undergoing surgery, the pre-surgery assessment performed and documented by the Anesthesiologist shall serve as the H&P update date. Staff shall comply with a requirements set forth in the Medical Staff H&P Standard.

C.1.a. History and Physical For Non-inpatient (Outpatient) Invasive Procedures - A focused history and physical must be performed within 30 days prior to a non-inpatient (outpatient) invasive procedure performed in conjunction with procedural (moderate) sedation. The focused history and physical shall include findings relevant to the planned procedure/service, conditions for which the patient is currently being treated, current medications, drug allergies, and indications for the planned procedure/service. Social history is not required unless relevant to the planned procedure/service. If the H&P was performed more than 30 days prior to the outpatient service, another H&P must be performed prior to sedation/procedure. The original H&P may be retained in the medical record for reference. A H&P performed within 30 days, but prior to the date of the outpatient service/procedure, must be updated on the date of the procedure prior to sedation/procedure. For the H&P update, the patient must be assessed accompanied by documentation in the medical record by an individual privileged to perform a H&P indicating that the H&P is current or noting any changes to the H&P (example, "patient assessed, no changes to the H&P"). If the outpatient/service is performed in conjunction with sedation/anesthesia administered by an Anesthesiologist, the Anesthesiologist's pre-sedation/anesthesia assessment and documentation shall serve as the H&P pre-procedure update. In addition to the H&P, a pre-sedation assessment shall be performed in accordance with guidelines established in the Hospital's Procedural/Moderate Sedation Standard/Policy.

C.2 Progress Notes - Progress notes shall be recorded daily by the attending practitioner or his coverage/designee at the time of observation sufficient to permit continuity of care and transferability. Progress notes should provide a chronological pertinent report of the patient's course of care. Entries must be legible and authenticated (signed) by the persons responsible for evaluating the patients. Progress notes shall be dated and timed.

C.3 Orders - Patient care orders shall be initiated by an appointee of the medical staff or an authorized allied health professional consistent with his/her approved clinical privileges or authorized scope of practice and in accordance with the practitioner's professional licensure/registration. Orders shall be signed, dated and timed.

C.3.a - Legibility - Orders and progress notes shall be written clearly, legibly and completely. Orders which are illegible or improperly written shall not be carried out until rewritten or understood. A pattern of illegible documentation may result in documentation restrictions imposed by the Medical Executive Committee.

C.3.b - FAX Orders – Signed, dated, and timed facsimile (FAX) orders may be used in accordance with organizational procedure.

C.3.c - Verbal Orders - Verbal orders may be used in accordance with the organization's Verbal Orders (Read Back) Standard. Verbal orders must be dated, timed, and authenticated by the ordering practitioner or another practitioner who is responsible for the care of the patient. Verbal order must be authenticated (signed) in accordance with Virginia regulations (72 hrs.)

C.3.d - Protocol Orders – Protocol Orders may be used in accordance with the organization's Protocol Implementation Standard.

C.3.e. – Other Medical Record Entries – All medical record entries must be legible, complete, dated, timed and authenticated by the author.

C.3.f. - The attending and consulting practitioner(s) shall maintain appropriate communication to ensure the appropriateness of medications and other patient care orders specific to the patient's current condition and care setting. Practitioners performing surgical, invasive, or diagnostic procedures are responsible for reviewing current orders for appropriateness. Under no circumstances shall any medication(s) be discontinued without notifying the practitioner, or his coverage, who initiated the order.

C.4 Drugs - All drugs and medications administered to patients shall conform to standards established by the Pharmacy and Pharmacy and Therapeutics Committee. The Committee shall have jurisdiction for policies and procedures concerning automatic stop orders and for control and administration of drugs brought into the hospital by the patient for the patient's use while hospitalized.

C.5 Radiology Service Requests The requesting practitioner is responsible for providing on the request form the reason(s) for the radiological examination. Authenticated reports of radiological examinations shall be placed in the patient's medical records within twenty-four (24) hours except those examinations which may require double readings.

C.6 Pathology Service Requests –Requests for pathological examination of tissue shall contain sufficient reasons(s) for the pathological examination. Authenticated reports of pathological tissue examination shall be placed in the patient's medical record within 24-72 hours, except when special studies or additional consultation is required, or because of intervention of the weekend or holiday. When a report is delayed, a provisional report may be submitted, pending the final report.

C.7. Laboratory Studies shall be performed by the Department of Pathology or by an appropriately licensed and accredited reference laboratory recommended by the Department of Pathology and approved by the Medical Staff

C.8 Removal of Tissue or Foreign Body All specimens removed during a surgical procedure will be referred to the Department of Pathology for examination and documentation unless exempted from referral by the Department of Surgery following consultation with the Pathology. Specimens without pathology will be referred for peer review to the appropriate clinical division.

C.9 Infection Control Surveillance Standards for the surveillance of hospital infections and the control thereof shall be developed and reviewed by the Infection Control Committee.

C.10 Blood Usage Policy - Transfusion and blood usage standards shall be developed by the Blood Bank Director. The Blood Bank Director, or his designee, may intervene if concurrent utilization monitors raise question with regards to clinical justification for blood. If patterns of questionable utilization are identified, they shall be brought to the attention of the appropriate medical services.

C.11 Disaster Plan In the event of major disaster, external or internal, the disaster plan developed by the Hospital shall be in effect. Once initiated, Department Chiefs shall be available to assist management implement the plan and will determine most appropriate utilization of medical resources, including medical volunteers. Appointees of the Medical Staff shall cooperate in any change in direction of professional care of their patients as may be deemed necessary. In the event routine Communication methods are disrupted during a major disaster, medical staff should report to the Medical Staff Office/Lounge and await assignment.

C.12 Institutional Review Board – Drugs and medical devices for clinical investigation shall be approved and utilized consistent with standards established by the Institutional Review Board.

SECTION D: SURGICAL PROCEDURES

D.1 Authorization and Informed Consent Authorization from the patient or the appropriate individual acting on the patients behalf shall be obtained prior to operative or significant invasive procedures consistent with the hospital's standard on consent.

D.2 Anesthesia Records – Anesthesia assessments prior to surgery, during surgery and post-surgery will be performed in accordance with guidelines established by the Division of Anesthesia.

D.3 Operative Report Requirements – A detailed operative report, dictated or written, shall be performed by the practitioner performing the surgery. The report shall be completed as soon as possible after surgery, filed in the medical record and authenticated. The official operative report must identify the surgeon and surgical assistants; contain a description of surgical findings; operative technique used; any unusual surgical events or complications and actions taken in response; blood loss including transfusion and adverse transfusion reactions, if any; specimens removed; post-operative diagnosis; and any other relevant information necessary.

D.3.a A post-operative note shall be documented following surgery by the surgeon. The note shall indicate who performed the procedure; the general nature of the procedure performed; how the patient tolerated the procedure; significant findings, including excessive blood loss; and any unusual operative or immediate post-operative events and actions taken.

D.3.b. Vasectomies, salpingectomies and abortions performed in Mary Washington Hospital shall conform with the statutes of the Commonwealth of Virginia.

D.4 Policy Development The Department of Surgery, in cooperation with the Operating Room Committee, shall maintain surveillance of and develop standards/policies for the surgical suite. All practitioners shall practice in accordance with the established standards. Noncompliance may be the basis for corrective action.

SECTION E: EMERGENCY SERVICES (ED) AND UNASSIGNED ON-CALL REQUIREMENTS

E.1 Evaluation by Emergency Department Physicians

E.1.a An Emergency Department physician or their physician's assistant shall give initial emergency treatment to all patients who present to the Emergency Department unless the patient requests their physician or has made arrangements to meet a physician in the department. The Emergency Department physician, however, shall retain the obligation to evaluate and begin treatment prior to the arrival of the patient's physician if life-threatening or health-threatening situations appear present where a lapse in time could produce greater incapacity or protracted convalescence unless immediate attention and care is given by the Emergency Department physician or his emergency consultant.

E.2 Patient Requesting Primary Physician

E.2.a. If the patient requests his primary or other specific physician, immediate contact with that doctor, or his covering, will be made, who may either elect to see the patient or refer the patient back to the E.D. physician for evaluation. If the Emergency Department is unable to establish contact with the patient's requested physician or his coverage after twenty (20) minutes of appropriate attempts, the patient will be asked if he wants to be seen by the emergency physician.

E.2.b. If there will be a delay before the patient's requested physician can come to the E.D., the patient shall be informed and given the alternative of being seen by the E.D. physician. If at any time the patient becomes unstable, the E.D. doctor will initiate care.

E.3 EMTALA Compliance

Notwithstanding any provision of these bylaws or rules & regulations, the Emergency Department shall at all times comply with applicable rules and regulations, both state and federal, including, but not limited to, EMTALA.. A medical screening examination will be performed to determine if an emergency medical condition exists by an Emergency Department physician, staff physician, or non-physician practitioner authorized to conduct a medical screening exam ("qualified medical personnel"). Non-physician categories approved to perform medical screening exams include: Emergency Department Physician Assistant (PA) working under the supervision of an ED physician or, for Obstetrical patients, specifically designated L&D RNs performing a screening exam in accordance with criteria approved by the OB Department with telephone contact with staff Obstetrician.

E.4. Guidelines for Specialty Referral

E.4. a The Medical Staff shall provide a major and specialty call roster and related guidelines in order to promote timely, orderly, and appropriate emergency medical care. The Medical Staff recognizes that once a patient has been evaluated by an emergency department physician that a patient/physician relationship has been established. The Emergency Department physician may vary from these guidelines utilizing his/her professional judgment and knowledge regarding the patient's immediate medical needs. Guidelines for follow-up referrals will be found in Section E.9.

E.4.b If medical consultation, specialized treatment, or hospital admission is warranted by the patient's condition, the Emergency Department physician shall contact the patient's physician or his coverage. If the patient does not have an established physician appropriate for the patient's current medical needs, the physician on ED call will be contacted unless the patient requests a specific physician who is willing to accept the patient and able to respond in a timely manner. Refer to Section G, "On-Call Responsibilities", for more specific details related to unassigned on-call issues.

E.5 Admission Orders

E.5.a. Physician orders must be given (verbal or written) prior to admitting Emergency Department patients to the Hospital. STAT orders on admitted patients should be carried out on the ward unless there is excessive delay transferring the patient to the ward. STAT orders to be carried out in the Emergency Department must be written on the Emergency Department sheet. STAT orders on patients going directly to O.R. will be carried out in the Emergency Department unless otherwise directed by the attending physician.

SECTION F: MEDICAL RECORD MANAGEMENT

F. 1 Purpose of the Medical Record – A medical record must be maintained for every persons evaluated or treated as an inpatient, outpatient, or emergency patient. The purpose of a thorough and timely medical records contributes to quality patient care by access to important clinical information necessary to plan the patient’s care plan and promote continuity of care.

F.2. Medical Record Content – The medical record must be sufficiently detailed to enable the practitioners responsible for the patient to provide continuing care of the patient to determine later what the patient’s condition was at a specific time; to understand the diagnostic and therapeutic procedures performed, determine the patient’s response to treatment; provide necessary background for a consultant; for another practitioner to assume the care of the patient at any time; and allow for the retrieval of information required for medical record coding and various clinical review/audit functions such as utilization, quality review and peer review.

F.3. Diagnostic and Therapeutic Reports – The medical record must contain reports pertinent to care of the patient including: pathology and clinical laboratory reports; imaging studies; other diagnostic results; surgery/invasive procedures; and results of medical assessments and treatments. Diagnostic, surgical and other therapeutic procedures must recorded and authenticated (signed). Reports of care from other facilities may be entered into the record for informational purposes.

F.4. Discharge Diagnoses & Procedures - A complete listing of diagnoses and procedures must be completed and signed by the attending physician or his coverage at the time of discharge or as soon as possible thereafter. The principal (primary) diagnosis shall be the condition, established after study, to be chiefly responsible for occasioning the admission of the patient to the hospital. Secondary diagnoses will be all conditions that exist at the time of the admission or that develop subsequently and affect the treatment and/or length of stay. The attending/discharging practitioner is responsible for the accuracy of the text description of the diagnoses and procedures. Medical records coding staff are responsible for accurate assignment of diagnosis and procedure codes.

F.5 Discharge Summary – A inpatient discharge summary should concisely summarize the reason for hospitalization; significant findings; surgical and other significant invasive procedures performed; general description of the course of inpatient care; condition on discharge; and planned follow-up. In lieu of a dictated discharge summary, a final progress note may be entered into the record for patients who required less than a forty-eight (48) hours/ two (2) days length of stay, to include (including uncomplicated obstetrical deliveries and normal newborns.)

F. 6. Use of Signature Stamps – A signature stamp is defined as a stamp facsimile of the practitioner’s signature. A practitioner who plans to use a signature stamp, must provide the medical records department with his/ her signed statement that she/he will be the only person who will utilize the stamp.

F.6.a. A typed name stamp used in conjunction with the practitioner’s signature for the purpose of helping staff identify the signature is does not require a signed statement. A name stamp may not be used in lieu of a signature.

F.7. Medical Abbreviations – Practitioners shall comply with the hospital’s standard on Abbreviations & Dose Expressions.

F.8. Medical Record Completion and Delinquency - Medical records without required reports and authentication shall be classified as “incomplete” by the Medical Records Department. If the record remains incomplete thirty (30) days following the patient’s discharge/treatment, the record will be categorized as “delinquent”.

F.8.1. –The Medical Staff recognizes the importance of the medical record as an integral element of quality patient care and as it impacts regulatory compliance and hospital finances. The Chiefs of Service are delegated responsibility for promoting compliance with medical record completion requirements.

F.8.2. - The Medical Records Department is responsible for developing and implementing a process for notifying practitioners of the status of their medical records completion. Medical Records is responsible for informing the Chiefs of Services if practitioners fail to respond to requests to complete medical records.

F.8.3. – The Medical Executive Committee has ultimate medical authority for developing procedures to promote timely medical record completion.

F.8.4 - The Department Chief is responsible for taking actions necessary to ensure practitioners assigned to the department are making appropriate efforts to complete medical records consistent with the requirements set forth herein. Any practitioner with incomplete records is subject to automatic relinquishment of clinical privileges as outlined in the Medical Staff Credentialing Policy Article III, Part E, Section 1 ("Failure to Complete Medical Records). However, the Chief may waive imposition of relinquishment of clinical privileges if s/he believes relinquishment will adversely impact patient care and/or the orderly operation of the hospital. If suspension is to be instituted, the Chief shall provide the affected practitioner with a written notice of the suspension. Such notice shall also be provided to the admissions staff and, if applicable, other patient care areas. When notified of suspension, the involved practitioner shall be responsible for making arrangements for medical coverage of his patients and notifying the patient and family of such transfer. Unless otherwise stipulated by the Chief, reinstatement of clinical privileges may be instituted when the medical records have been verified as complete which includes required authentication (signature). Notice of reinstatement shall be provided to the admissions staff and patient care areas.

SECTION G: ON-CALL RESPONSIBILITIES

1. General Responsibilities: Private Practice and Unassigned Patient On-Call Schedules

1.1. All physicians granted clinical privileges are responsible for having appropriate on-call arrangements for patients in their private practice. All private practice call schedules shall be provided directly to the Communications (Health Link) Department no less than ten (10) calendar days prior to the end of the current schedule in order to provide sufficient time to prepare the unassigned Emergency Department (ED) call schedules. All revisions to private practice call schedules shall be provided to the Communications Department as soon as possible. The Communications Department will provide the ED with the roster of on-call physicians on a daily basis.

1.2. The overall responsibility for assuring that there are adequate plans for providing on-call services for patients who do not have an established patient-physician relationship, "unassigned patients", has been delegated by the Board of Trustees to the Medical Executive Committee (MEC). ("Unassigned patients" is defined as in the Medical Staff Bylaws as follows: 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/her care while at patient at the Hospital.)

1.2.1. The unassigned call schedules will be used for both ED and inpatient

consultations. An individual consulted because she/he is on unassigned call must provide the requested consultation.

- 1.2.2. Regulations governing on-call obligations for consult requests from the ED shall be governed by this document.
 - 1.2.3. Regulations governing obligations related to inpatient consult requests shall be governed by the Medical Staff Rule & Regulation titled "Consultations".
 - 1.2.4. The unassigned on-call schedules may be general specialty (e.g., orthopedics) or by /sub-specialty (hand surgery, spine surgery), as recommended by the relevant Medical Staff Division Chairs and Department Chiefs and approved by the MEC. A sub-specialty call schedule may be implemented only if it does not compromise the ability of the hospital to meet community and ED call coverage needs for the relevant general specialty call. Sub-specialists are expected to assist the ED with patient screening examinations and discharge or transfer arrangements, if indicated.
- 1.3. The Division Chairperson, or his/her designee, on behalf of the Hospital, is responsible for developing on-call schedules utilized for unassigned patients. Division Chairs will provide affected physicians the opportunity to design the guidelines that will be used to prepare unassigned on-call assignments. The Chair will submit the on-call guidelines in writing to the Medical Staff Office for reference. If a Division has not been established for a specific medical specialty, the Department Chief shall appoint a designee to assume responsibilities as outlined in this Policy. If a Division Chair or designee has not been identified or is unavailable when an issue arises, the Department Chief or his designee will be responsible.
 - 1.3.1. Division Chairs may request the Hospital's assistance with preparation of unassigned call schedules. Should a disagreement arise regarding call schedule assignments, the Division Chair or his physician designee shall be responsible for resolving the matter.
 - 1.3.2. Division Chairs will consider the needs of patients in developing the unassigned on-call schedules, including when certain specialties cannot be covered due to an insufficient number of physicians in the specialty to provide continuous (24/7) on-call services.
 - 1.3.2.1. It's expected that any medical specialty with 3 physicians will be able to provide fulltime call coverage (24 hours a day 365 days a year). Any specialty with 3 or more physicians that proposes to provide less than fulltime coverage must provide the MEC with specific reasons why fulltime coverage cannot be provided.
 - 1.3.2.2. Specialties that do not have at least 3 physicians are not required to provide fulltime coverage. In this instance the level of coverage will be prorated according to the number of available physicians. (Example, 2 physicians will be expected to provide 2/3 coverage, approximately 240 days of coverage). The prorated on-call coverage plan must take into consideration the needs of the community and ED. The prorated coverage must include a reasonable number of weekend days and holidays. Nothing in this section is intended to prevent physicians from providing more on-call coverage.
 - 1.4. The goal of the Hospital and Medical Staff is to provide on-call services on a continuous basis (24/7) for all medical services available at the Hospital. This may not be able to be accomplished if there are an insufficient number of physicians on staff for a particular

specialty/subspecialty.

1.4.1. Whenever there are insufficient physicians available to provide 24/7 coverage, the Division Chair and Department Chief, following consultation with the affected physicians, shall provide the MEC with an on-call Plan. The Plan shall take into consideration:

1.4.1.1. the number of physicians currently on staff for the specialty/sub-specialty in question;

1.4.1.2. the number of physicians considered necessary to provide 24/7 coverage for the specialty/sub-specialty;

1.4.1.3. a recommended call coverage Plan, which shall include proposed on-call days per month per physician currently on staff, and

1.4.1.4. transfer arrangements for days when coverage cannot be provided by the existing medical staff.

1.4.2. Following receipt and review of the proposed call coverage Plan, the MEC has the following options:

1.4.2.1. approve the proposed plan as presented;

1.4.2.2. remand the proposed plan with or without MEC comments and/or recommendations back to the Division Chair and Department Chief for clarification; or

1.4.2.3. reject the proposed plan.

Until a final resolution has been reached, the MEC has the authority to implement an on-call plan.

1.4.3. If the physician(s) affected by a decision of the MEC disagree(s) with the opinion of the MEC, the physician(s) may request a review by the Hospital Board of Trustees. The review will be conducted by the Board or its designated Committee. The decision of the Board or its designated Committee shall be binding.

1.4.4. Whenever the MEC feels the lack of physicians in a specific specialty/subspecialty poses a threat to patient care and/or the orderly operation of the Hospital, the MEC and Hospital Administration shall collaborate on a plan of action. The MEC Chair and Hospital Administration shall appraise the Board of Trustees of actions planned and taken.

1.5. Members of the Medical Staff have an obligation, but not a right, to share on-call duties. Medical Staff members who are relieved of on-call responsibilities for any reason may be assigned other duties so that all members share as equitably as possible in Medical Staff responsibilities. Removing a member from the on-call schedule, for any reason, does not trigger the hearing and appeals procedures in the Medical Staff Bylaws.

2. On-Call Physician's Response to Call from the ED

2.1. When an on-call physician is contacted by the Emergency Department and requested to respond, the on-call physician must:

- 2.1.1. be available by telephone to the Emergency Department within 20 minutes;
- 2.1.2. respond in person to the ED, if so requested by the ED physician or other physician requesting consultation, within thirty (30) minutes if the requesting physician feels the patient requires emergent care. Nothing in this Policy is intended to prohibit the Medical Staff from establishing response times that are less than thirty (30) minutes for specific medical specialties, patient care situations, or patient care units. The Emergency Department or other requesting physician, in consultation with the on-call physician, will determine whether the patient's condition requires the on-call physician to see the patient as soon as possible;
- 2.1.3. if it's determined that an ED patient requires transfer to another facility, the ED physician and on-call physician(s), if any have been consulted, shall collaborate on transfer arrangements. On-call physicians must be available to assist the ED with transfer arrangements including speaking directly with physicians at the receiving facility. If there is a disagreement between the transferring and receiving facility pertaining to care of the patient prior to or during transfer, the physician(s) on-call must be available to speak directly with the physician(s) at the receiving facility to finalize the patient's care plan;
- 2.1.4. when a patient requires admission the following options are available:
 - 2.1.4.1. an ED Physician or other physician who has personally examined the patient may determine that a patient must be seen by a staff physician in a specific specialty prior to the patient being transported from the ED to another hospital unit. If requested to personally evaluate the patient in the ED, the on-call physician must respond to the physician's request and personally examine the patient in the ED in a timely manner.
 - 2.1.4.2. If the ED physician concurs that the on-call physician does not need to personally evaluate the patient in the ED, the on-call physician may direct that the patient be admitted to the hospital and provide verbal orders until his/her arrival.
 - 2.1.4.3. The admitting physician may request that the patient be admitted to his/her service with a patient evaluation and admission orders written by an appropriate Hospitalist service, if available. The physician designated as the attending physician, or his designated coverage must personally exam the patient as soon as possible based upon the acuity of the patient and in no circumstances more than 24 hours post admission. Attending physicians are expected to exercise reasonable professional judgment when determining how soon following admission to personally evaluate a patient. The maximum 24 hours shall not be used as a rationale for not seeing a patient with acute needs in a timely manner. Nothing in this Policy is intended to prohibit the Medical Staff from establishing post admission patient assessment time frames that are less than 24 hours for specific medical specialties, patient care situations, or patient care units.
 - 2.1.4.4. A staff physician may request that the patient be admitted to an appropriate Hospitalist service, The Hospitalist Service is not obligated to assume attending physician responsibilities if the medical condition necessitating admission is not within the domain of the Hospitalist Services' medical specialty. The Hospitalist will be available to serve as a consultant on a specific issue or may agree to work with the attending throughout the course of inpatient care to co-manage the patient with the staff physician retaining

attending physician responsibilities. At all times the attending physician shall be responsible for the patient's overall coordination of care including daily rounds and a daily progress note.

- 2.1.5. In all situations for patients in the ED, the determination of the ED physician will be controlling until such time as the patient has been discharged from the ED or the patient admitted and moved to another patient care unit with responsibility for the patient's ongoing care transferred to the admitting/attending physician and consultant(s), if applicable, or the patient transferred to another facility.
- 2.2. If the scheduled on-call physician is unable to respond due to circumstances beyond the physician's control, the ED physician will determine whether to attempt to contact another physician on the Medical Staff or arrange for a transfer pursuant to this Policy.
- 2.3. If the physician on unassigned call is consulted about a patient with whom there is pending litigation or threat of litigation, or with whom she/he has formally severed the doctor/patient relationship with proper documentation, that physician is responsible for seeing the patient unless she/he personally arranges for alternative care.

3. Transfer Arrangements

- 3.1. When possible, transfer arrangements with another hospital that can provide specialty service should be made to cover a service currently not provided by the Hospital or when there is no on-call physician scheduled to provide coverage at the Hospital. If a patient presents needing care when a specialty is not available/covered, the patient will be transferred in accordance with applicable Hospital transfer procedures.

4. Concurrent Services Provided by the On-Call Physician (On-Call at Multiple Hospitals and Elective Surgery)

- 4.1. On call physicians may be simultaneously involved in ongoing patient care (such as surgeons operating and/or physicians who cover multiple facilities being actively involved in patient care at another facility) and, consequently, cannot be in two places at once. Physicians who find themselves in such situations must notify the Emergency Department within the stated phone response time of the conflict and inform the ED if arrangements have been made for another physician to provide back up unassigned call coverage. If a back up call physician is not available, this will be noted in the appropriate patient record. The ED physician may then determine if the case in question can wait for the on call physician or initiate another course of care which may include transfer to another facility as appropriate to the best interests of the patient.
- 4.2. Whenever there is concern that allowing physicians to perform surgery or on-call services at other facilities is compromising patient care the issue should be referred to the Department Chief responsible for the medical service in question. If the concern pertains to a specific physician's unavailability, the matter shall be handled in accordance with section nine (9) of this Policy.
- 4.3. Nothing in this Policy is intended to restrict the authority of the Medical Executive Committee or a specific Medical Staff Department, Division, or Specialty from establishing more restrictive standards for concurrent surgery or on-call services at another facility in order to promote patient safety and quality patient care.

5. Resignation of Privileges

5.1. As a general rule, physicians will not be permitted to resign privileges at the Hospital that are included in the core privileges for their specialty.

5.1.1. Physicians who have voluntarily limited their practice and/or have been exempted from clinical privileges within a core are expected to maintain sufficient competence to perform an initial patient screening exam and/or assist the requesting physician with patient stabilization and preparation for transfer to another facility.

5.2. Members of the Medical Staff will not be permitted to resign specific clinical privileges for the purpose of avoiding on-call responsibility.

5.3. If a physician responds to a call and requires additional expertise to take care of the patient, the physician should attempt to stabilize the patient and then request an appropriate consult or institute an appropriate transfer, whichever is in the patient's best interest.

6. Timely Follow-Up Care For Patients Treated and Released From The ED

6.1. Patients who have an established private patient-physician relationship will be referred to that physician if the physician's specialty is appropriate for the patient's follow-up care needs. In all other situations the patient will be referred to the physician on unassigned call for follow-up.

6.2. An on-call physician is responsible for the care of a patient through the episode that created the emergency medical condition, including providing one (1) office follow-up visit related to that ED episode. The follow-up visit should be provided, as close as possible, to the follow-up timeframe specified in the patient's ED discharge instructions.

6.2.1. A patient referred to a physician on unassigned call for post-ED follow-up care must be seen by the physician or his coverage regardless of the patient's ability to pay. However, this Policy is not intended to restrict the ability of the on-call physician from billing the ED referred patient for office-based services.

7. Allied Health Professionals

7.1. Physician Assistants ("PAs") and nurse practitioner (NP) may provide patient assessment/screening exams and patient care on behalf of the PA/NP's authorized supervising physician(s) subject to the following conditions:

7.1.1. At all times the on-call schedule must identify the physician who is on-call and the physician must be available to respond to the ED by phone and/or in person consistent with the time frames established for the physician's specialty or, if specialty specific time frames have not been established, the physician must be available in accordance with the time frames as outlined in Section 2 of this document. Any decision to use a PA/NP to respond initially to the Emergency Department must be made by the on-call physician on a case by case basis.

7.1.2. If the on-call physician and the ED physician do not agree regarding delegation of assessment and/or treatment of a specific patient to a PA/NP, the ED physician shall be the final decision-maker.

7.1.3. At all times the supervising physician and PA/APRN are responsible for assuring

that services provided are within the PA's/NP's approved scope of practice/clinical privileges.

8. Criteria for Retirement or Removal From Unassigned ED Call

8.1. A physician shall be eligible to request retirement from ED unassigned call if she/he has reached a specific age or specified years of unassigned ED call service for any MediCorp Hospital.

8.1.1. Unless otherwise stipulated, the criteria for retirement shall be 60 years of age or 25 years of unassigned ED call, whichever occurs first. However, such retirement shall not be automatic. Requests for retirement from unassigned ED call must be submitted in writing to the Division Chair, if one has been elected or appointed, with a copy to the Department Chief. The physician will not be removed from unassigned call until the request is approved by the Division Chair and Department Chief.

8.1.2. A physician may be excused from unassigned ED call for health related reasons.

8.1.3. All requests for removal or reduced unassigned ED call are subject to review and approval of the appropriate Division Chair, Department Chief, and the MEC.

8.1.4. If a physician's request for removal from or reduced unassigned ED call is not approved by the Division Chair and/or Department Chief, the physician may request a review by the MEC. The request for review by the MEC shall be submitted in writing to the Medical Staff President with a copy to the Division Chair and Department Chief. The letter shall include the reasons why the affected physician is requesting removal from, or reduced, unassigned ED call. Prior to making a decision on the request, the MEC shall afford the physician the opportunity to present the request to the MEC in person. The MEC shall also afford the Division Chair and/or Department Chief the opportunity to explain why the affected physician's request was not approved. The MEC's decision shall be communicated to the affected physician in writing with a copy to the Division Chair and Department Chief.

8.1.4.1. If the physician(s) affected by the decision of the MEC disagree with the opinion of the MEC, the physician(s) may request a review by the Hospital Board of Trustees. The review will be conducted by the Board or its designated Committee. The decision of the Board or its designated Committee shall be binding.

9. Policy Enforcement

9.1. An on-call physician's unavailability when on call is a serious matter. The requesting party is obligated to report these situations to the appropriate Department Chief(s). The Chief(s) shall review the issue in a timely manner and determine how to address the situation. If the refusal or failure to respond is found to be deliberate, or represents a pattern of non-compliance, the matter may be referred to the Medical Staff President and/or Medical Executive Committee for further review and action.

SECTION H: INPATIENT CONSULTATIONS

1. Policy Statement

- 1.1. Quality patient care, as well as the orderly and efficient operations of the Hospital, requires Medical Staff members to cooperate with colleagues in the performance of consultations when requested by the Emergency Department and the patient's assigned physician(s) or family. Collaboration and cooperation between Medical Staff appointees is essential in ensuring that the medical needs of patients are met in a timely and professional manner. Availability of the skills and expertise of each Medical Staff appointee enhances the level of patient care offered to the community and contributes to the professional growth of each Medical Staff appointee. It is the duty of the Medical Staff, through the Executive Committee, to adopt and enforce consultation regulations that promote appropriate and timely consultations.

2. Clarification of Terminology

- 2.1. Words shall be read as the masculine or feminine gender, and as the singular or plural, as the content requires. Headings are for convenience only and are not intended to limit or define the scope or effect of the provisions set forth herein.

3. Definitions

- 3.1. "Appointee" means any physician, dentist and podiatrist who has been granted Medical Staff appointment and clinical privileges by the Board to practice at the hospital or at a healthcare facility of the MediCorp Health System. With respect to this regulation, "appointee" shall be interpreted as the practitioner the consultation has been directed to *OR* the practitioner's coverage.
- 3.2. "Chief of Service", "Service Chief" or "Department Chief" means the individual who has overall responsibility for the management of the clinical departments of the Medical Staff as defined in the Medical Staff Bylaws.
- 3.3. "Extenuating Circumstances" means circumstances the appointee could not have reasonably anticipated and/or planned for in advance including, but not limited to, an atypically high volume of urgent/emergent consultations, situations when the appointee is, or will be, actively involved in the care of a patient and cannot leave the current patient to assume care for another.
- 3.4. "Medical Staff" means all physicians, dentists, and podiatrists who are given privileges to treat patients at the hospital.
- 3.5. "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/her care while a patient at the hospital.

4. General Requirements

- 4.1. Consultation requests must be documented in the patient's medical record and consultations must be performed in a timely manner. The individual requesting the consultation is responsible for ensuring that the consultation request is communicated to the consultant or to a member of the consultant's staff. Direct communication is strongly encouraged between the individuals requesting and providing consultations.

- 4.2. Non-Urgent Consultations must be performed within 24 hours of receipt by the consultant of the consultation request, unless the individual requesting the consultation indicates otherwise.
- 4.3. Urgent/Stat Consultations must be completed within the timeframe indicated by the individual requesting the consultation. The individual requesting the urgent/stat consultation must personally notify the consultant of the urgent/stat nature of the request and verify that the consultant is available.
- 4.4. The attending physician remains responsible for the coordination of the patient's care including a daily medical assessment and progress note. If the attending physician and the consultant agree, the consultant may assume responsibility for the coordination of the patient's care. This must be clearly documented in the patient's record by both the attending physician and the consultant.
- 4.5. Appointees are expected to accept consultation requests. If an appointee is unable to accept a request for consultation, the appointee must personally notify the individual requesting the consult. Urgent/stat consultations must be accepted unless the individual requesting the consultation and the consultant agree that an urgent/stat consultation is not required or either the consultant or requesting physician arranges for an immediately available substitute.
- 4.6. Appointees must accept a consult request when on ED unassigned/big call. In the event extenuating circumstances make it impossible for the appointee to accept the consult, the appointee is responsible for arranging a consultation by another appointee in the same specialty and notifying the individual requesting the consultation of such arrangement. If the consultant on unassigned/big call is actively involved in the care of another patient and cannot leave that patient in order to perform the urgent/emergent consult within a reasonable time period, this shall be communicated to the requesting physician who shall redirect the consultation request to another physician.
- 4.7. Concerns related to non-compliance with this Policy, including inappropriate consultation requests, should be referred to the appropriate Chief of Service or his coverage. In accordance with the duties delegated to the Chief of Service as outlined in the Medical Staff Bylaws, the Chief is responsible for enforcing the consultation requirements set forth in these regulations.
- 4.8. Refusal to respond to consult requests may result in disciplinary action.
- 4.9. Refusal or failure to perform a consultation that results in, or may result in, danger to the health and/or safety of any patient or to the orderly operations of the Hospital, should be reported to the appropriate Chief of Service, the Medical Staff President/Chair, Medical Executive Committee and/or the Hospital's Senior Administrator, who may take whatever action is necessary to ensure the health and/or safety of the patient or the orderly operations of the Hospital. Such actions may include requiring the consultant to perform the consultation. Refusal to perform the required consultation may result in a precautionary suspension of all of the appointee's clinical privileges as described in the Medical Staff Bylaws or other disciplinary measures.

5. Circumstances Requiring Consultation

- 5.1. Consultations are required for the following circumstances:

5.1.1. the patient requires care that is outside the expertise and/or clinical privileges of the attending physician.

5.2. The Medical Executive Committee (in conjunction with the Chiefs of Service) shall establish additional guidelines, as necessary, setting forth criteria under which consultation is required.

6. Responsibilities of the Appointee Requesting a Consultation

6.1. The patient should be informed that a consultation is indicated and given the opportunity to express his preference for a specific medical staff appointee or group practice. Physicians are expected to personally examine the patient and review the medical record prior to requesting a consultation. However, the attending/requesting physician is not expected to delay requesting a consult when medical information currently available indicates that an evaluation by an appointee in another specialty is indicated. All requests for consultations shall be recorded in the physician's order section of the medical record. Appointees should direct the consultation request to a specific staff appointee or group practice. The consult request should include the following:

6.1.1. the reason(s) for the consultation request;

6.1.2. pertinent clinical and laboratory findings;

6.1.3. identification of the nature of the consultation request, an order written as, "consult Dr. "x", with no further clarification, shall be interpreted as a request for a "non-urgent" consultation;

6.1.4. a request that the consultant assume responsibility for the coordination of the patient's care, if so desired by the attending.

6.2. Compliance with all applicable General Requirements as set forth in Section 1.

7. Responsibilities of the Consultant

7.1. Documentation in the patient's medical record of the consultation, including, as appropriate, clinical and laboratory findings. Except in the event of an emergency, such documentation must be made prior to the surgery or invasive diagnostic procedures.

7.2. Documentation of any follow-up that will be provided, including the date on which the consultant will no longer see the patient.

7.3. Compliance with all applicable General Requirements as set forth in Section 1.


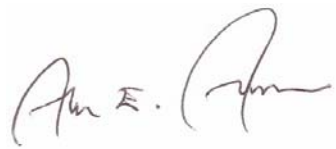


8. Responsibilities Associated with Transferring Patients to Other Facilities

8.1. If a determination is made that an inpatient requires transfer to another facility, the attending physician has overall responsibility for coordinating the transfer. If a consultant recommends transfer, or if the attending physician requires the assistance of the consultant, the consultant shall provide assistance as requested by the attending physician. The attending and consultant(s) shall work collaboratively to assure the following are accomplished:

8.1.1. discussing the medical indications, risks and benefits with the patient and/or the patient's family or designated representative to determine if the patient or family have any preferences related to facilities;

- 8.1.2. contacting the facility to discuss the case and assure that facility is able to accept the patient;
- 8.1.3. completing all transfer documentation as required by the hospital's transfer policy;
- 8.1.4. being available to the hospital staff should any issues arise related to the transfer;
- 8.1.5. shall continue to be available to provide care to the patient until the patient has been transferred to the receiving facility

Adoption

<u>Mary Washington Hospital</u>	<u>Stafford Hospital Center</u>
Adopted: April 1998	Adopted: October 15, 2008
Revised: April 1999; September 2002; September 2003; January 2004; April 25, 2007; September 07, 2007; October 15, 2008	
	
Chair, Medical Executive Committee	Chair, Medical Executive Committee
	
Chief Executive Officer	Chief Executive Officer

MARY WASHINGTON HOSPITAL
OF THE
MEDICORP HEALTH SYSTEM

POLICY ON ALLIED HEALTH PROFESSIONALS



Policy On Allied Health Professionals

MediCorp Health System

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ARTICLE I

DEFINITIONS

The following definitions shall apply to terms used in this policy:

1. "Allied Health Professional" means a Licensed Independent Practitioner as defined at item (10) or a Licensed Dependent Practitioner as defined at item (11).
2. "Appointee" means any physician, dentist or podiatrist who has been granted Medical Staff appointment and clinical privileges by the Board to practice at the hospital or at any health care facility of the Mediacorp Health System.
3. "Board" means the Board of Directors of the MediCorp Health System, which has the overall responsibility for the conduct of the hospital and all health care facilities of the Health System.
4. "Chief Executive Officer" means the President of the hospital or the President's designee.
5. "Criminal Conviction" shall include, but is not limited to, conviction of or a plea of guilty or nolo contendere, for any felony, or for any misdemeanor related to the practice of a healthcare professional or federal health program, fraud or abuse, third party reimbursement or controlled substances.
6. "Dentist" shall be interpreted to include a doctor of dental surgery ("D.D.S.") and doctor of dental medicine ("D.M.D.").
7. "Clinical Privileges" or "privileges" or clinical functions or activities means the authorization granted by the Board to a licensed independent practitioner to provide specific patient care services in the hospital within defined limits.
8. "Executive Committee" means the Executive Committee of the Medical Staff unless specifically written "Executive Committee of the Board".
9. "Hospital" means the Mary Washington Hospital or Snowden of Fredericksburg of the MediCorp Health System.
10. "Licensed Independent Practitioner" means a non-physician practitioner who is licensed or certified by his or her respective state board and who is granted clinical privileges and may function independently in the hospital within the scope of his or her license or certification.
11. "Licensed Dependent Practitioner" means a non-physician practitioner who is not a hospital employee and who must function in the hospital only as an employee of a physician on the Medical Staff and/or under direct supervision of such a physician within the scope of his or her license or certification.
12. "Medical Staff" means all physicians, dentists and podiatrists who are given privileges to treat patients at the hospital.
13. "Physicians" shall be interpreted to include both doctors of medicine (M.D.s") and doctors of osteopathy ("D.O.s").
14. "Scope of practice" or "protocol" means the clinical activities, tasks and functions permitted to be carried out by a licensed dependent practitioner under physician supervision.

15. "Voluntary" or "automatic relinquishment" of clinical privileges or scope of practice means a lapse in clinical privileges or scope of practice deemed to automatically occur as a result of stated conditions.

Words used in this policy shall be read as the masculine or feminine gender, and as the singular or plural, as the content requires. The captions or headings are for convenience only and are not intended to limit or define the scope or effect of any provision of this policy.

ARTICLE II

SCOPE AND OVERVIEW OF POLICY

1. This policy addresses those allied health professionals who are permitted to practice or provide services at the hospital and its facilities, and are not hospital employees.
2. Only those classes of allied health professionals that have been approved by the Board shall be permitted to practice at the hospital.
3. All allied health professionals who are permitted to practice at the hospital shall be classified in one of two broad categories, "Licensed Independent Practitioners" or "Licensed Dependent Practitioners," each having a slightly different relationship to the hospital.
4. The "Licensed Independent Practitioners" category shall include all those allied health professionals who are licensed under state law and authorized by the hospital to function independently in the hospital and who are granted clinical privileges. These individuals generally can bill independently for the services they provide and they require no formal or direct supervision by a physician. A current listing of the types of allied health professionals functioning in the hospital as Licensed Independent Practitioners is attached to this policy as Appendix A. This Appendix may be modified or supplemented hereafter by action of the Board without the necessity of further amendment of this policy.
5. The "Licensed Dependent Practitioners" category shall include all allied health professionals who are authorized to function in the hospital only as employees of, or under direct supervision of, a physician(s) appointed to the Medical Staff and pursuant to a defined scope of practice. The employing and/or supervising physician(s) shall remain fully responsible for the actions of the Licensed Dependent Practitioner in the hospital. A current listing of the types of allied health professionals functioning in the hospital as Licensed Dependent Practitioners is attached to this policy as Appendix B. This Appendix may be modified or supplemented without the necessity of further amendment of this policy.
6. Other documents, including scopes of practice and protocols, may supplement this Policy. Items addressed may include the following:
 - a) any specific qualifications and/or training that the allied health professional must possess beyond those set forth in this policy;
 - b) a detailed description of the allied health professional's authorized clinical privileges or scope of practice;
 - c) any specific conditions that apply to the allied health professional's functioning within the hospital; and
 - d) all supervision requirements, if applicable.

ARTICLE III

APPLICATION

Section 1. General Qualifications of Applicants:

Any allied health professional that applies to practice at the hospital as a Licensed Independent Practitioner or Licensed Dependent Practitioner shall:

- a) possess a current unlimited license or certificate to practice his or her profession in the Commonwealth of Virginia;
- b) be located close enough to the hospital to provide timely and continuous care for patients in the hospital;
- c) be covered by current, valid professional liability insurance coverage in such form and in amounts satisfactory to the hospital;
- d) have never been the subject of a criminal conviction as defined in Article I; and
- e) is not excluded from a federal program (OIG Exclusion)
- f) be able to document his or her:
 - (1) background, education, relevant training, experience and current demonstrated clinical competence,
 - (2) adherence to the ethics of his or her profession,
 - (3) good reputation and character,
 - (4) ability to perform the clinical privileges or scope of practice requested,
 - (5) ability to work cooperatively with others sufficiently to insure the hospital that all patients treated by the individual will receive quality care and that the hospital will be able to operate in an orderly manner, and
 - (6) Drug Enforcement Administration (DEA) registration number, where applicable.

Section 2. No Entitlement to Medical Staff Appointment:

Allied Health Professionals who are applying to practice at the hospital shall not be eligible for appointment to the Medical Staff, or entitled to the rights, privileges and/or prerogatives of Medical Staff appointment.

Section 3. Hospital Employees:

Individuals who are employees of the hospital shall be governed by such hospital policies, manuals and descriptions as may be established from time to time by hospital management. Where applicable, the Chief Executive Officer or a designee shall consult appropriate Medical Staff appointees and/or committees regarding the qualifications of those hospital employees whose responsibilities require the delineation of clinical privileges or scope of practice.

Section 4. Non-Discrimination Policy:

No individual shall be denied permission to practice at the hospital on the basis of sex, disability, familial status, race, creed, religion, color or national origin, or on the basis of any criteria unrelated to professional qualifications or to the hospital's purposes, needs and capabilities.

Section 5. Assumption of Duties and Responsibilities:

As a condition of consideration of an application and as a condition of continued permission to practice in the hospital, all allied health professionals shall assume such reasonable duties and responsibilities as the Allied Health Professionals Review Committee, the Executive Committee and/or the Board shall require, including:

- a) providing appropriate continuous and timely care and supervision to all patients in the hospital for whom the individual has responsibility;

- b) abiding by all bylaws and policies of the hospital, including all bylaws, rules and regulations of the Medical Staff as shall be in force during the time the individual is granted permission to practice in the hospital;
- c) accepting committee assignments and such other reasonable duties and responsibilities as shall be assigned;
- d) providing to the hospital, in a timely manner, with or without request, and as it occurs, new or updated information that is pertinent to any question on the application form;
- e) appearing for personal interviews as requested in regard to the application;
- f) paying such dues and assessments as established by the hospital;
- g) refraining from illegal fee splitting or other illegal inducements relating to patient referral;
- h) refraining from practicing outside the scope of his or her license or certification and from assuming responsibility for diagnoses or care of hospitalized patients for which he or she is not qualified or without adequate supervision;
- i) refraining from deceiving patients as to his or her status as an allied health professional;
- j) seeking consultation of a member of the Medical Staff whenever necessary or as required by the scope of practice or delineation of clinical privileges;
- k) promptly notifying the Chief Executive Officer or a designee, and the Senior Medical Officer of any change in eligibility for payments by third-party payors or for participation in Medicare, including any sanctions imposed or recommended by the federal Department of Health and Human Services, and/or the receipt of a PRO citation and/or quality denial letter concerning alleged quality problems in patient care;
- l) abiding by generally recognized ethical principles applicable to the individual's profession;
- m) participating in quality evaluation and performance improvement activities of the hospital;
- n) completing, in a timely manner, the medical and other required records for all patients as required by the Medical Staff bylaws, rules and regulations, this policy and other applicable policies of the hospital;
- o) working cooperatively with Medical Staff appointees, other allied health professionals, nurses and other hospital personnel so as not to adversely affect patient care; and
- p) participating in applicable continuing education programs.

Section 6. Professional Conduct:

Allied health professionals who are granted permission to practice in the hospital are expected to relate in a positive and professional manner to other health care professionals, and to cooperate and work collegially with the Medical Staff leadership and hospital management and personnel. Professional conduct shall also include, but not be limited to, each individual's obligation to present himself or herself at the hospital physically and mentally capable of providing safe and competent care to patients.

Section 7. Eligibility To Receive An Application

1. The potential applicant shall indicate the clinical activities he /she desires to perform.
2. An application for permission to practice in the hospital shall be sent only to those classes of allied health professionals who have been approved by the Board, who meet the general qualifications set forth in this policy, and who meet the specific qualifications relating to each applicant's area of practice.
3. If the class of allied health professional in question has not been approved by the Board, the potential applicant will be informed an application will not be released until the Board has made a determination to approve a new class of allied health professional.

Section 8. Information to be Submitted With Applications:

1. Application forms shall be sent from the Medical Staff Office to those individuals whose area of clinical practice has been approved by the Board.
2. The application form shall require detailed information concerning the applicant's professional qualifications, including:
 - a) the names and addresses individuals who have had recent experience in observing and working with the applicant, and who can provide adequate information pertaining to the applicant's current professional competence and character;
 - b) the names and addresses of the department chiefs and/or supervising physician(s) at any and all hospitals or other institutions at which the applicant has worked or trained;
 - c) information as to whether the applicant's permission to practice and/or affiliation has ever been voluntarily or involuntarily relinquished, denied, revoked, suspended, reduced, or not renewed at any hospital or health care facility;
 - d) information as to whether the applicant has ever voluntarily or involuntarily withdrawn his or her application or resigned before a final decision by a hospital's or health care facility's governing board or designee;
 - e) information as to whether the applicant's
 - membership in any local, state, or national professional society,
 - license or certification to practice any profession in any state, or
 - Drug Enforcement Administration certification (if applicable) is, or has ever been voluntarily or involuntarily relinquished, suspended, modified, terminated, restricted, or is currently being challenged;
 - f) information concerning the applicant's professional liability insurance coverage, including the name of the insurance company, the amount and classification of such coverage, whether said insurance policy covers the clinical privileges or scope of practice the applicant requests, and a consent to the release of information from present and past professional liability insurance carriers;
 - g) information concerning the applicant's malpractice litigation experience and/or any professional misconduct proceedings involving the applicant, in this state or any other state, whether such proceedings are closed or still pending, including the substance of the allegations of such proceedings or actions, the substance of the findings of such proceedings or actions, the ultimate disposition of any such proceedings or actions that have been closed, and any additional information concerning such proceedings or actions as the applicant or the hospital may deem appropriate;
 - h) information concerning the suspension or termination for any period of time of the right or privilege to participate in Medicare, Medicaid, or any other government sponsored program or any private or public medical insurance program;
 - i) current information regarding the applicant's ability to perform safely and competently the clinical privileges or scope of practice requested;
 - j) information as to whether the applicant has ever been a defendant in a criminal action or convicted of a crime, including details about any such instance;
 - k) information regarding the citizenship and/or visa status of the applicant;
 - l) the applicant's signature and the sponsoring/employing physician's signature for licensed dependent practitioners; and
 - m) such other information as the hospital may require.
3. Any application that does not provide the information requested on the application form shall not be considered or processed.
4. If the application does not confirm the applicant's general qualifications as outlined in Article III, Section I, the applicant shall be informed that she / he is not eligible for consideration and application processing will not proceed.

Section 9. Submission of Application:

1. Completed applications shall be submitted to the Medical Staff Office and must be accompanied by the designated non-refundable processing fee. After reviewing the application to determine that all questions have been answered, and after reviewing all references and other information or materials deemed pertinent, and after verifying the information provided in the application with the primary sources, the Medical Staff Office shall provide the completed application along with all supporting materials to the members of the Allied Health Professionals Review Committee
2. An application shall be deemed to be complete when all questions on the application form have been answered, all supporting documentation has been supplied and all information verified. An application shall become incomplete if the need arises for new, additional or clarifying information anytime during the evaluation.
3. Any application that continues to be incomplete ninety (90) days after the applicant has been notified of the additional information required shall be deemed to be withdrawn. It is the responsibility of the applicant to provide a complete application, including adequate responses from references. An incomplete application will not be processed.

Section 10. Burden of Providing Information:

1. The applicant shall have the burden of producing information deemed adequate by the hospital for a proper evaluation of competence, character, ethics, and other qualifications, and of resolving any doubts about such qualifications.
2. The applicant shall have the burden of proving that all the statements made and information given on the application are true and correct. Any misstatement, omission and/or representation on the application, whether intentional or not, shall constitute cause for immediate cessation of the processing of the application, and no further processing shall occur. In the event that Licensed Independent Practitioner or Licensed Dependent Practitioner status has been granted prior to discovery of such misstatement, misrepresentation or omission, such discovery shall result in automatic relinquishment of all clinical privileges or scope of practice and resignation as a Licensed Independent Practitioner or Licensed Dependent Practitioner. In either situation, there will be no entitlement to the procedural rights provided in this policy.

Section 11. Release and Immunity:

By applying for permission to practice in the hospital, applicants expressly accept and agree to the following conditions (whether or not permission is granted):

1. The applicant specifically authorizes the hospital and its authorized representatives to consult with any third party who may have information bearing on the applicant's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior, or any other matter reasonably having a bearing on the applicant's qualifications to practice as a Licensed Independent Practitioner or Licensed Dependent Practitioner. This authorization includes the right to inspect or obtain any and all communications, reports, records and documents from said third parties. The applicant also specifically authorizes said third parties to release said information to the hospital and its authorized representatives upon request.
2. To the fullest extent permitted by law, the applicant releases from any and all liability, extends absolute immunity to, and agrees not to sue the hospital, its authorized representatives, and any third parties with respect to any acts, communications or documents, recommendations, or disclosures involving the applicant.

Section 12. Procedure For Temporary Clinical Privileges / Authorization To Practice

The Chief Executive Officer or his authorized designee may, following favorable recommendation of the Medical Staff President or his designee (Service Chief or Credentials Chair) grant temporary clinical privileges or authorization practice to a new applicant not to exceed 120 days when the application is awaiting review of the Medical Staff Executive Committee and Board. The following must be verified before clinical privileges are granted: current licensure; relevant training and experience; current competence and ability to patient care duties as outlined in the requested clinical privileges, scope of practice or job description; a query and evaluation of the NPDB (if applicable to the type of Allied Health professional in question); the applicant has submitted a complete application; no current or previously successful challenge to licensure or relevant registration; no involuntary termination of medical staff membership at another organization; no history of involuntary limitation, reduction, denial, or loss of clinical privileges and verification of required malpractice coverage. Temporary clinical privileges shall not be routinely granted prior to a favorable recommendation from the Credentials Committee. However, temporary privileges may be granted prior to Credentials Committee review conditioned upon the criteria noted above being met and a determination that failure to grant temporary privileges will result in an undue hardship to the applicant, not be in the best interest of patient care, or disrupt the orderly and efficient operation of the organization. Temporary privileges are considered a courtesy only. The Medical Staff and CEO are not obligated to grant temporary privileges. Neither the grant, denial, nor termination, of temporary privileges shall entitle the individual concerned to request any procedural rights provided in this policy.

ARTICLE IV

ALLIED HEALTH PROFESSIONALS REVIEW COMMITTEE

Section 1. Composition:

The Allied Health Professionals Review Committee shall be a subcommittee of the Credentials Committee. Permanent members include the Chairperson of the Credentials Committee, or designee, who shall serve as chairperson of the committee, the Vice President for Nursing Services and the Medical Staff Support Services designee. Ad hoc members of the committee, depending on the type of allied health professional being considered, may include the relevant service chief(s) or designee(s), and relevant hospital managers(s) or nurse manager(s).

Section 2. Duties:

The Allied Health Professionals Review Committee members shall:

- a) evaluate and make recommendations regarding the need for the services that could be provided by classes of allied health professionals that are not currently permitted to practice in the hospital;
- b) recommend, with input from appropriate medical staff, for each class of allied health professional permitted by the Board to practice in the hospital the education, training and experience requirements for applicants, the scope of practice or clinical privileges to be granted, any specific conditions that apply to the practitioners' functioning within the hospital, any ongoing supervision and evaluation requirements, and malpractice insurance requirements;
- c) review, as questions arise, all information available regarding the clinical competence and behavior of allied health professionals currently permitted to practice in the hospital and, as a result of such review, to make a written report of its findings and recommendations to the Credentials Committee.

Section 3. Meetings, Reports and Recommendations:

The Allied Health Professionals Review Committee shall meet as often as necessary to accomplish its duties shall maintain a record of its actions. The Chairperson of the committee shall be available to meet with the Board, its committee, the Executive Committee or the Chief Executive Officer on all recommendations that the Allied Health Professionals Review Committee may make.

ARTICLE V

CREDENTIALING PROCEDURE

Section 1. Review by the Allied Health Professionals Review Committee:

1. The appropriate hospital manager, sponsoring physician and/or clinical service chief shall examine the application and all supporting information and documentation, and make a recommendation to the regarding the applicant's qualifications for the clinical privileges or scope of practice requested.
2. The Hospital may use the expertise of any individual on the Medical Staff or at the hospital, or an outside consultant, if additional information is required regarding the applicant's qualifications. In evaluating the application, the Allied Health Professionals Review Committee may also meet with the applicant and, when applicable, the employing or supervising physician.
3. If the Allied Health Professionals Review Committee's initial is considering a recommendation adverse to the applicant, when applicable, the employing or supervising physician shall be given the opportunity to meet with the Allied Health Professionals Review Committee before a final recommendation is made. This meeting shall be informal and shall not be considered a hearing. Following this meeting, the Allied Health Professionals Review Committee shall make a recommendation to the Credentials Committee

Section 2. Permission to Practice and Renewal of Permission to Practice:

1. Permission to practice in the hospital is a courtesy extended by the Board and shall be granted for a period not to exceed two (2) years. Renewal of clinical privileges or scope of practice shall be granted only upon submission of a completed renewal application.
2. Once an application for renewal of clinical privileges or permission to practice has been completed and submitted to the Medical Staff Office, it shall be evaluated in the same manner and follow the same procedures outlined in this policy regarding initial applications.

Section 3. Questions of Clinical Competence & Fair Hearing:

1. The appropriate hospital manager, sponsoring physician and/or clinical service chief shall review the matter and all supporting information and documentation, and make a written report to the Allied Health Professionals Review Committee regarding the issue of clinical competence.
2. If the Allied Health Professional is a Hospital employee, the issue shall be handled in accordance with the Human Resource policies, included but not limited to, progressive counseling and grievance procedures.
3. If the Allied Health Professional is not an employee, the issues will be investigated by the Allied Health Professional Committee and Credentials Committee. In evaluating the matter, the Allied Health Professionals Review Committee may also meet with the applicant and, when applicable, the employing or supervising physician.
4. If the Allied Health Professionals Review Committee's initial recommendation is to terminate, revoke or modify the allied health professional's clinical privileges or scope of practice, when applicable, the employing or supervising physician shall be given the opportunity to meet with the Allied Health Professionals Review Committee before a final recommendation is made. This meeting shall be informal, part of the peer review process.

5. Following this meeting, the Allied Health Professionals Review Committee shall make a recommendation to the Credentials Committee. If the Allied Health Professionals Review Committee's recommendation to the Credentials Committee is adverse, the employing or supervising physician shall be given the opportunity to meet with the Credentials Committee before a decision by the Credentials Committee is made. The Credentials Committee shall have the authority to render a final decision on all dependent allied health professional issues of clinical competence.
6. If a matter involves a licensed independent practitioner eligible for clinical privileges, the fair hearing and appeal procedures as described in the Medical Staff Policy on Appointment, Reappointment and Clinical Privileges will be utilized if the Credentials Committee proposes an adverse recommendation.

ARTICLE VI

CONDITIONS OF PRACTICE APPLICABLE TO LICENSED DEPENDENT PRACTITIONERS

Section 1. Supervision by Employing or Supervising Physician:

1. Any activities permitted by the Board to be performed at the hospital by a Licensed Dependent Practitioner shall be performed only under the direct supervision of the physician employing or supervising that individual. Except as provided by law or hospital policy, "direct supervision" shall not require the actual physical presence of the employing or supervising physician.
2. Licensed Dependent Practitioners may function in the hospital only so long as they remain employees of, or are directly supervised by, a physician currently appointed to the Medical Staff. Should the Medical Staff appointment or clinical privileges of the staff physician employing/supervising a Licensed Dependent Practitioner be limited, revoked or terminated, the Licensed Dependent Practitioner's permission to practice in the hospital shall be deemed to be automatically relinquished. The Allied Health Professionals Review Committee may recommend that the Licensed Dependent Practitioner be permitted to arrange for supervision by another physician appointed to the Medical Staff.

Section 2. Questions Regarding Authority of Licensed Dependent Practitioner:

1. Should any Medical Staff appointee or hospital employee who is licensed or certified by the Commonwealth of Virginia have any question regarding the clinical competence or authority of a Licensed Dependent Practitioner either to act or to issue instructions outside the physical presence of the employing or supervising physician in a particular instance, such Medical Staff appointee or hospital employee shall have the right to require that the Licensed Dependent Practitioner's employer or supervisor validate, either at the time or later, the instructions of the Licensed Dependent Practitioner. Any act or instruction of the Licensed Dependent Practitioner shall be delayed until such time as the staff appointee or hospital employee can be certain that the act is clearly within the scope of the Licensed Dependent Practitioner's activities as permitted by the Board.
2. Any question regarding the professional conduct of a Licensed Dependent Practitioner shall be reported to the Credentials Chair or the Chief Executive Officer. At all times the employing or supervising physician shall remain responsible for all acts of the Licensed Dependent Practitioner while at the hospital.

Section 3. Responsibilities of Employing or Supervising Physician:

1. The number of Licensed Dependent Practitioners acting as employees of or under the supervision of one (1) physician, as well as the acts they may undertake, shall be consistent with applicable state statutes and regulations, the rules and regulations of the Medical Staff and the policies of the Board.
2. It shall be the responsibility of the physician employing or supervising the Licensed Dependent Practitioner to provide, or to arrange for, professional liability insurance coverage for the Licensed Dependent Practitioner in amounts required by the Board that covers any activities of the Licensed Dependent Practitioner at the hospital and to furnish evidence of such coverage to the hospital.
3. It shall be the responsibility of the physician employing or supervising the Licensed Dependent Practitioner to complete performance evaluations of the Licensed Dependent Practitioner and to submit it to the Allied Health Professionals Review Committee.

4. It shall be the responsibility of the physician employing or supervising the Licensed Dependent Practitioner to ensure that such individual does not exceed the approved scope of practice.

ARTICLE VII

NEW CLASSES OF ALLIED HEALTH PROFESSIONALS AND APPROVAL OF SCOPES OF PRACTICE AND CLINICAL PRIVILEGES

Section 1. New Classes of Allied Health Professionals:

Whenever a class of allied health professional is proposed that is not currently permitted to practice in the hospital, the following process shall be followed:

1. If an applicant requests an application for a class of allied health professional not currently permitted to practice in the hospital, that individual shall be so notified.
2. The matter shall then be referred to the Credentials Committee who, after receiving findings and recommendations from the Allied Health Professionals Review Committee shall make a determination as to whether the new category of allied health professional should be permitted to practice in the hospital.
3. The Credentials Committee recommendation shall be then forwarded to the Executive Committee. The Executive Committee's recommendation and the Credentials Committee recommendation, if different from the Executive Committee, shall be then forwarded to the Medical Affairs Committee whose recommendation shall be forwarded to the Board (or its designee) for final action.
4. Once the foregoing steps are completed, the specific request from the applicant and future applicants shall be processed in accordance with Article III.

Section 2. Approval of Scopes of Practice and Clinical Privileges:

Approval of job descriptions, scopes of practice and clinical privileges for allied health professionals shall follow the following process:

1. The Allied Health Professionals Review Committee, after input by the appropriate Medical Staff Department, shall refer the proposed scope of practice or clinical privileges to the Credentials Committee;
2. The matter shall then be referred to the Executive Committee, then to the Medical Affairs Committee, then to the Board for final action. The Executive Committee, the Medical Affairs Committee or the Board may remand the proposed scopes of practice or clinical privileges for further study and review to the Allied Health Professionals Review Committee.

ARTICLE VIII

AMENDMENTS

1. This Policy on Allied Health Professionals may be amended, upon recommendation of the Credentials Committee, by a majority vote of the members of the Executive Committee present and voting at any meeting of that committee where a quorum exists, provided that the written recommendations of the Allied Health Professionals Review Committee and the Credentials Committee concerning the proposed amendments shall have first been received and reviewed by the Executive Committee. In addition, notice of all proposed amendments shall be distributed to the Medical Staff at least fourteen (14) days prior to the Executive Committee meeting and any Medical Staff member shall have the right to submit written comments to the Executive Committee regarding the same prior to such meeting. No amendment to this Policy shall be effective unless and until it has been approved by the Board.
2. This Policy may also be amended by the Board on its own motion provided that any such amendment is first submitted to the Allied Health Professionals Review Committee, Credentials Committee and the Executive Committee for review and comment at least thirty (30) days prior to any final action by the Board. Instances where such action by the Board shall be warranted shall be limited to the following:
 - a) action to comply with changes in federal and state laws that affect the hospital and the hospital corporation, including any of its entities;
 - b) action to comply with requirements imposed by the hospital's general and professional liability of Director's and Officer's insurance carrier; and
 - c) action to comply with state licensure requirements, JCAHO Accreditation Standards, other applicable accreditation or certifying agencies, the Medicare Conditions of Participation for Hospitals and/or requirements applicable to the Medicaid Program.

ARTICLE IX

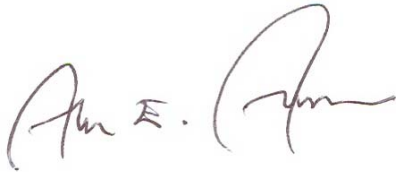
ADOPTION

This Policy on Allied Health Professionals is adopted and made effective upon approval of the Board, superseding and replacing any and all other Medical Staff bylaws, rules, regulations, policies, manuals or hospital policies, rules and regulations pertaining to the subject matter thereof.


Adopted by the Medical Staff: April, 1998

Approved by the Board: May, 1998

Revised:
March, 2001
September 2002

A handwritten signature in black ink, appearing to read "Allen E. Aaronson".

Dr. Allen Aaronson, Medical Staff President

A handwritten signature in black ink, appearing to read "Fred M. Rankin III".

Mr. Fred M. Rankin III, President & CEO

APPENDIX A

Those allied health professionals currently practicing as Licensed Independent Practitioners at the hospital are as follows:

- Clinical Psychologists
- Licensed Clinical Social Worker (Snowden at Fredericksburg)
- Licensed Professional Counselors (Snowden at Fredericksburg)

APPENDIX B

Those allied health professionals currently practicing as Licensed Dependent Practitioners (Physician-Employed/Sponsored) at the hospital are as follows:

- Nurse Practitioners
- Surgical Assistants
- Physician Employed Nurses
- Physician Assistants
- Perfusionists
- Audiologists

**MediCorp Health System
Stafford Hospital Center**

**Medical/Allied Health Staff Privilege Access
Department: Medical Staff**

Purpose

To ensure that each practitioner on the Medical or Allied Health Staff of Stafford Hospital Center exercise the privileges (or scope of practice) at the Hospital provides only those services for which he or she has been determined to be competent, the Medical Executive Committee approves these procedures outlining hospital staff access to each practitioner's approved privileges or scope of practice. There are additional demographic data to which other individuals in the Hospital must have access. The processes outlined below, and approved by the Medical Executive Committee, will provide Hospital staff with the necessary information in a timely manner, and ensure that practitioners do not perform procedures beyond the scope of privileges or practice that he or she has been granted.

Procedure

Centralized Credentialing Services (CCS) at Mary Washington Hospital shall retain the original privilege delineation forms, as well as any revisions to each practitioner's privileges approved, in the appropriate practitioner's credentials file. Additionally, CCS shall maintain up-to-date privilege listings in the MIDAS+ Seeker credentialing database, and Master Approved Privilege Listing books in the Operating Room at Stafford Hospital Center. These shall be updated when new practitioners join or leave the staff, and when privileges for a given practitioner are revised.

When changes to a provider's privileges are approved, including additions to or resignations from the Medical Staff, notification is sent to administrative and clinical personnel throughout the hospital as soon as possible. In addition, this information is posted to the MHS Bulletin Board and the Physician Dashboard, where every MHS Associate and Medical Staff member can view the information.

At any given time, all Associates and Medical Staff members have access to the Provider Privileges database (PPr) (a Lotus Notes-housed database that provides lists of approved privileges for each Medical Staff member or Allied Health Professional with approved privileges, as well as other relevant information) and the Midas+ Seeker Privileges Inquiry Module. Nursing staff are trained to use the PPr and Seeker Privileges Inquiry as part of their Competency Based Orientation Tools. In the event that the PPr and Seeker Privileges Inquiry are unavailable, due to power failure or other system failures, the Nursing Supervisors will be able to access the Master Approved Privilege Listing books in the Operating Room at Stafford Hospital Center. The PPr is updated every evening in a direct interface with MIDAS+ Seeker. Information available on the PPr includes each Member's:

1. Photo and scanned signature
2. Staff ID, NPI and UPIN numbers (if available)
3. Gender, Specialty, Service, Status and Category
4. Primary practice address and contact information
5. Listing of approved privileges and excluded or proctored privileges

Should a question arise concerning whether or not a practitioner is approved for a particular privilege, the below procedure should be followed:

Monday – Friday, 7:30 a.m. – 5:00 p.m.

The appropriate department director/manager or nursing unit coordinator (or designee) shall contact CCS to verify the practitioner's privileges. CCS shall advise appropriate Department Chief, Division Chair, the Medical Staff President, or the Credentials Committee Chair as needed.

All other times (evenings, weekends, and holidays)

The appropriate department director/manager or nursing unit coordinator (or designee) shall contact the Nursing Supervisor, who shall review the privilege listing, and contact the appropriate Department Chief, Division Chairman, the President of the Medical Staff, or the Credentials Committee Chair as needed to clarify privileges or intervene with the practitioner. CCS shall be contacted as soon as they are available during normal working hours to notify Department staff of the issue.

If it is determined, following consultation with the appropriate Department Chief, Division Chair, the Medical Staff President, or the Credentials Committee Chair, that the practitioner is not approved for a particular privilege, the below procedure shall be followed:

Monday – Friday, 7:30 a.m. – 5:00 p.m.

CCS will inform the involved practitioner that he/she is not approved for the privilege in question. The practitioner will then be informed of the steps necessary to request additional privileges (refer to New Medical Staff Procedure/Technology Approval Policy).

All other times (evenings, weekends, and holidays)

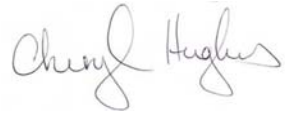
The appropriate Department Chief, Division Chair, the Medical Staff President, or the Credentials Committee Chair will inform the involved practitioner that he/she is not approved for the particular privilege. The practitioner will be requested to contact CCS on the next working day to obtain information about the steps necessary to request additional privileges (refer to New Medical Staff Procedure/Technology Approval Policy).

Should the practitioner proceed with performing the privilege after being informed that he/she does not have the appropriate privilege, the involved department director/manager, nursing unit coordinator, or nursing supervisor should document, via a S.A.F.E. report, that the practitioner performed a privilege beyond the scope of his/her current approved privileges. This documentation should be routed through Medical Support Services, who will follow up with the involved practitioner and the appropriate clinical Department Chief, as necessary.

Should any disagreement occur over such a situation, CCS should be contacted during normal working hours, or the Administrator On Call should be contacted after hours, who will contact the involved clinical Department Chief, if necessary, to intercede in the matter.

Approved:

December 17, 2008



Signatures:

Operations Manager, Medical Staff Services



Administrative Director, Nursing and Patient Care Services



Interim Medical Staff President & Chair, SHC Medical Executive
Committee

**MediCorp Health System
Stafford Hospital Center**

**Medical Staff New Procedure/Technology Approval
Department: Medical Staff**

Purpose

New procedures or technologies that have the potential to offer improvement to the care, treatment, and/or services provided at Stafford Hospital Center may require Board of Trustees approval. Criteria for the use of these procedures/technologies must be established and approved by the Board of Trustees before any Medical Staff member will be allowed to take advantage of the innovation. The Joint Commission specifies what must be taken into consideration before approval for the use of a new procedure/technology can be granted. This policy is meant to serve as supplement to the procedures and requirements set forth in the Medical Staff Bylaws Credentialing Policy, Article III – Part B, Section 3.

Definitions

New procedures for which competency criteria have not been established must be approved by the Board of Trustees. Procedures that are clinically or procedurally similar to or adaptations of an existing procedures and do not pose a greater risk to patients are not “New Procedures or Services” as that term is used in this Section. Accordingly, the Board may consider and approve criteria for Clinical Privileges to perform a new, but clinically similar procedure and also grant a qualified practitioner’s request for such Clinical Privileges.*

The Appointee’s Chief or Division Chairperson, as the case may be, initially shall determine whether the procedure or service requested is new. Whenever a Medical Staff Appointee requests Clinical Privileges to perform a New Procedure or Service not currently being performed at the Hospital (or a significant new technique to perform an existing procedure), the following process shall be followed.†

Procedure

Before granting approval of a medical staff member’s request for a new procedure/technology, the Board of Trustees must determine if it is feasible to approve the request. The Board of Trustees will take into consideration the availability of resources, including information regarding resources, equipment, and type of personnel necessary to support the requested privilege, by following the processes outlined below. Refer to the Medical Staff Bylaws Credentialing Policy, Article III – Part B, Section 3 for more information. The Credentialing Policy establishes the process by which the request will be considered.

Applicant Request

By submitting a request, the applicant agrees to outcome analysis of cases in which the procedure/technology is used. Outcome studies will be supported by all SHC departments and committees involved in quality management. In addition, the applicant may be expected to appear at Credentials Committee to discuss the new procedure/technology. Applicants must submit specific documentation, as outlined below, to Centralized Credentialing Service at Mary

* Medical Staff Bylaws Credentialing Policy, Article III – Part B, Section 3.6.

† Medical Staff Bylaws Credentialing Policy, Article III – Part B, Section 3.

Washington Hospital. A request will not be considered complete until all of the information outlined below is received. Upon receipt of a request, the CEO shall be notified, who will subsequently notify the applicant that the request will be processed after a determination has been made regarding whether the procedure or service will be offered within the System and, if so, the minimum qualifications that an Appointee must possess to be eligible to request the Clinical Privileges in question.[‡] During the processes outlined below, Centralized Credentialing Services will keep the Credentials and Medical Executive Committees apprised of the status of the request at each Committee meeting.

The applicant must submit a letter containing the following information:

1. His or her specific training, experience, and competence in performing the procedure;
2. The rationale for the new procedure/technology, including a statement of patient risk;
3. An outline of the planned method of outcome analysis;

The applicant must complete the New Technology/Procedure Briefing (attached), providing information about the following:

1. Anticipated additional education for nursing and other staff;
2. OR setup (if applicable);
3. Name and contact information for three (3) hospitals that currently use the new procedure/technology;
4. Desired date of implementation;
5. Continuing education courses required to perform the procedure or use the technology;
6. Possible privileging criteria.

The applicant must submit documentation about the new procedure/technology, including:

1. Indications for use;
2. Results as reported by others;
3. Risks and complications;
4. Alternative approaches;
5. Research involving the new procedure/technology;
6. Course materials (if applicable);
7. Manufacturer's materials (if applicable);
8. FDA approvals.

Feasibility Study

Upon receipt of a completed request for a new procedure/technology, Centralized Credentialing Services will forward the request and related documentation to the Director of any clinical units that will be impacted by the new procedure/technology. The Director will be asked to complete the New Technology/Procedure Assessment (attached), providing information about the following:

1. Space requirements;
2. Education necessary for nursing and other staff;
3. Equipment and supplies that must be purchased;
4. Anticipated time frame for readiness;
5. Any other relevant information.

[‡] Medical Staff Bylaws Credentialing Policy, Article III – Part B, Section 3.1.

Recommendations

When Centralized Credentialing Services receives completed information from the unit Director(s), the request will be forwarded on as follows:

1. Requests involving operative equipment or procedures will be forwarded to the Surgical Services Council for review and recommendation;
2. All requests will be forwarded to the Senior Vice President/Administrator for review and recommendation;

Approval of Service at SHC

Based on the feasibility study and recommendations, The Credentials Committee or Executive Committee shall prepare a report for submission to the Board of Trustees.[§]

After receiving the Committee's report and recommendations from the Executive and Credentials Committees, the Board (or its designee) shall make a preliminary determination as to whether the New Procedure or Service is one that will be offered to patients. One of the factors to be considered by the Board in reaching its determination is whether the System has the capabilities, including support services, space and equipment to perform the New Procedure or Service.^{**}

Development of Criteria

Upon approval of the new service at SHC, Centralized Credentialing Services will research and develop potential criteria for privileging of the new procedure/technology. All requests will be forwarded to the appropriate Division or Department for review and revision of the proposed privileging criteria, with a recommendation by the appropriate Chair or Chief submitted to the Credentials Committee.

The Credentials Committee will develop recommendations regarding:

- the minimum education, training and experience necessary to perform the procedure or service,
- the extent of monitoring and supervision that should be required if privileges are granted, and
- the criteria and/or indications for when the procedure or service is appropriate.

The Credentials Committee shall forward its recommendations to the applicable Executive Committee, which shall review the matter and forward its recommendation to the Board (or its designee) for final action.^{††}

Approval of Request for Privileges

Once the foregoing steps are completed, the specific requests from eligible Medical Staff Appointees who wish to perform the New Procedure or Service shall be processed in accordance with Article III, Part B, Section 2 of this policy.^{‡‡}

[§] Medical Staff Bylaws Credentialing Policy, Article III – Part B, Section 3.2.

^{**} Medical Staff Bylaws Credentialing Policy, Article III – Part B, Section 3.2.

^{††} Medical Staff Bylaws Credentialing Policy, Article III – Part B, Section 3.3.

^{‡‡} Medical Staff Bylaws Credentialing Policy, Article III – Part B, Section 3.5.

Approved:

December 17, 2008

Attachments:

New Technology/Procedure Briefing
New Technology/Procedure Assessment
Medical Staff Bylaws Credentialing Policy Excerpt

Signatures:



Director, Medical Support Services



Interim Medical Staff President & Chair, SHC Medical Executive
Committee

**MARY WASHINGTON HOSPITAL
NEW TECHNOLOGY/PROCEDURE BRIEFING**

Physician Name _____ Date _____

What new technology/procedure do you plan to use? _____

Will the nursing staff or other staffs need any special or additional education? _____

Will use of the technology/procedure require an operating room set-up that is different from the norm? _____

Please give us the name and location of three (3) hospitals that use this technology/procedure.

Name _____ City/State _____

Name _____ City/State _____

Name _____ City/State _____

When would you like to begin using this technology/procedure? _____

Will this technology/procedure require the attendance of any continuing medical education courses prior to its use? _____

Please outline the qualifications needed by a physician to use this technology/procedure safely. _____

If you have any of the following information, please submit them:

- a. Research concerning the proposed technology/procedure
- b. Course materials
- c. Manufacturer's materials
- d. FDA approvals (if any)

**MARY WASHINGTON HOSPITAL
NEW TECHNOLOGY/PROCEDURE ASSESSMENT**

Department: _____ Date: _____

New technology/procedure name and description: _____

Please see the attached materials for detailed information regarding this technology/procedure.

Please provide details if additional space is needed to implement this new technology/procedure.

Will the nursing staff or other staffs need any special or additional education? _____

Will any additional equipment/materials need to be purchased to implement this new technology/procedure?

Please estimate when the above-mentioned resources might be in place.

Please provide any additional information below that you feel would be relevant to the Hospital's decision to implement this new technology/procedure.

Signature of Department Director/Manager

Date

Name of Department Director/Manager (Typed or Printed)

EXCERPT FROM MEDICAL STAFF BYLAWS PART 2: CREDENTIALING POLICY

ARTICLE III – PART B: PROCEDURES FOR REQUESTING EXTENSION OF CLINICAL PRIVILEGES

Section 3. Clinical Privileges for New Procedures:

For the purposes of this section, the term “New Procedure or Service” is defined as those medical or surgical procedures for which competency criteria have not been established by the System. The Appointee’s Chief or Division Chairperson, as the case may be, initially shall determine whether the procedure or service requested is new. Whenever a Medical Staff Appointee requests Clinical Privileges to perform a New Procedure or Service not currently being performed at the Hospital (or a significant new technique to perform an existing procedure), the following process shall be followed:

1. The Appointee shall first be informed by the Chief Executive Officer (or designee) that the request will be processed after a determination has been made regarding whether the procedure or service will be offered within the System and, if so, the minimum qualifications that an Appointee must possess to be eligible to request the Clinical Privileges in question. The application shall be submitted to the Chief Executive Officer who shall refer the matter to the Board to determine whether to permit the New Procedure or Service to be performed at the Hospital.
2. The Credentials Committee or Executive Committee shall prepare a report that outlines the following:
 - a) how requests for similar privilege(s) have been processed in the past (if applicable),
 - b) the specialists/sub specialists who are likely to request this Clinical Privilege,
 - c) the positions of specialty societies or certifying Boards,
 - d) the training available in residency programs in the specialties likely to request this privilege,
 - e) in the case of new procedures, the training available outside of residency programs,
 - f) criteria required by other hospitals with similar resources, personnel, and facilities,
 - g) the ability of Medical Staff leaders and members to review the competency of practitioners who will perform the procedures,
 - h) availability of qualified Physicians to provide medical coverage for the practitioner in case of the applicant’s unavailability, and
 - i) other information deemed relevant by the committee.
3. The practitioner requesting privileges to perform the New Procedure or Service also may be asked to provide clinical information about the procedure, a list of training programs and evaluations for Medical Staff leaders to contact prior to making their report, and other information requested.
4. After receiving the Committee’s report and recommendations from the Executive and Credentials Committees, the Board (or its designee) shall make a preliminary determination as to whether the New Procedure or Service is one that will be offered to patients. One of the factors to be considered by the Board in reaching its determination is whether the System has the capabilities, including support services, space and equipment to perform the New Procedure or Service.
5. If the Board (or its designee) determines to offer the procedure or service, the Credentials Committee shall develop threshold credentialing criteria to guide in the determination of those individuals who are eligible to request the Clinical Privileges at the Hospital. In developing such criteria, the Credentials Committee shall conduct research and consult with experts, including those on the System’s Medical Staff and those outside the Hospital, and develop recommendations regarding:

- a) the minimum education, training and experience necessary to perform the procedure or service,
 - b) the extent of monitoring and supervision that should be required if privileges are granted, and
 - c) the criteria and/or indications for when the procedure or service is appropriate.
6. The Credentials Committee shall forward its recommendations to the Executive Committee, which shall review the matter and forward its recommendation to the Board (or its designee) for final action.
 7. The Board (or its designee) shall then establish the minimum threshold qualifications that an individual must demonstrate in order to be eligible to request the Clinical Privileges in question.
 8. Once the foregoing steps are completed, the specific requests from eligible Medical Staff Appointees who wish to perform the New Procedure or Service shall be processed in accordance with Article III, Part B, Section 2 of this policy.
 9. Procedures that are clinically or procedurally similar to or adaptations of an existing procedures and do not pose a greater risk to patients are not "New Procedures or Services" as that term is used in this Section. Accordingly, the Board may consider and approve criteria for Clinical Privileges to perform a new, but clinically similar procedure and also grant a qualified practitioner's request for such Clinical Privileges.

Mary Washington Hospital
PEER REVIEW GUIDELINES

Purpose

To ensure that the hospital, through the on-going review activities of its medical staff, assesses the performance of individuals granted clinical privileges and uses the results of such assessments to improve the practitioner's performance and patient care.

Goals

1. Improve the quality of patient care provided by individuals granted clinical privileges.
2. Monitor the performance of individuals who have clinical privileges.
3. Identify practitioner-specific opportunities for performance improvement.
4. Monitor significant trends by analyzing aggregate data.
5. Assure that the process for peer review is defined, fair, defensible, and useful.

Overview

"Peer review" is the evaluation of an individual practitioner's professional performance and includes the identification of opportunities to improve care. Peer review differs from other quality improvement processes in that it evaluates the strengths and weaknesses of an individual's performance rather than appraising the quality of care rendered by a group of professionals or the health system. Evaluation of an individual's performance may identify improvement opportunities applicable to other practitioners or hospital systems.

Peer review is conducted using multiple sources of information including evaluation of individual cases; review of aggregate data; compliance with medical staff and organizational rules, regulations and policies; and referrals from various hospital performance review and improvement activities.

Evaluations will be based on generally recognized standards of care. When possible, recognized best practices will be utilized. When clearly delineated standards of practice are not available, or conflicting standards exist, an evaluation will be performed by appropriate professional peer(s).

The objective for peer review is to provide practitioners with feedback for personal improvement and confirm personal achievement related to the effectiveness of their professional, technical, and interpersonal skills in providing patient care and interacting with other members of the health care team.

Definitions

1. *"Peer"* is an individual practicing in the same profession and who has expertise in the appropriate subject matter. The level of subject matter expertise required to provide a meaningful evaluation of a practitioner's performance will determine what "practicing in the same profession" means on a case-by-case basis. For example, for issues related to general medical care, any practitioner in the same professional discipline may review the care. For specialty/privilege-specific issues, a peer is an individual with training and experience relevant to the clinical issue(s) being considered.
2. *"Routine/Informal/Collegial"* peer review includes the review of individual cases and other performance data by the Medical Staff department, clinical division/section, intra/multi-disciplinary team, or Physician Quality Management Committee (PQM-C). Data may be obtained from a variety of internal or external sources. The

process is ongoing and a routine component of medical staff operations. Voluntary actions by the affected practitioner taken as a result of collegial reviews including, but not limited to, participation in educational activities, proctoring, participating in practice conditions, and modification of clinical privileges shall not be considered adverse actions with respect to reporting to external agencies.

3. *"Focused peer review"* is a process whereby an in-depth review is conducted of an individual practitioner's performance. The focused evaluation may be general in scope or specific to a particular aspect of the practitioner's performance. The evaluation process may include record review, aggregate data analysis, observation, and interviews. Focused reviews conducted under the direction of a Department Chief, Division Chair, or the PQM-C are considered informal collegial peer review.
4. *"Formal peer review"* procedures include investigations conducted by or under the direction of the Credentials Committee conducted pursuant to the procedures defined in the Medical Staff Bylaws Part II (Credentialing Policy). Once formal investigative procedures have been initiated, actions taken may be subject to state and/or federal reporting requirements. Legal counsel will interpret regulations related to reporting obligations. All reports to external agencies shall be prepared and coordinated with assistance of legal counsel.

General Peer Review Guidelines

1. The practitioner(s) being reviewed will be afforded the opportunity to provide input throughout the process.
2. Conclusions from the peer review process will be considered during the re-credentialing and re-privileging process.
3. Recognizing the inherent limitations of data derived directly from ICD-9 coding and Uniform Billing data, especially with respect to allocation of responsibility to a particular practitioner, ICD-9-based data will be used primarily as reference and screening tools rather than a definitive data source. This type of data will not be used as the sole or primary basis for an adverse action.
4. Peer review information is available only to authorized individuals who have a legitimate need to know based upon their responsibilities as medical staff leaders or hospital staff supporting the peer review process.
5. Peer review information includes, but is not limited to, quality and utilization review data; SAFE (incident) reports; sentinel events; patient or staff complaints; and case-based reviews by internal or external reviewers.
6. The medical staff is committed to achieving performance improvement through voluntary collegial interventions.
7. If the involved practitioner is unresponsive to collegial intervention or action must be taken immediately in order to protect the public or maintain the orderly and efficient operation of the hospital, formal procedures will be instituted.

Physician Quality Management Committee (PQM-C)

1. The Physician Quality Management Committee (PQM-C), established in accordance with the Medical Staff Bylaws, is accountable to the Medical Executive Committee for providing leadership and oversight for the Medical Staff Peer Review program.
2. The PQM-C Chair shall serve as the physician advisor for the Medical Support Services nurse reviewers and shall serve as a resource regarding data analysis and interpretation.

Department / Specialty-Specific Peer Review Structure & Process

1. Department/Service Chiefs have overall responsibility for the continuing surveillance of the professional performance of all individuals assigned to their department. The Chief may delegate peer review responsibilities to other medical staff leaders in his department including Division Chairs and Clinical Medical Directors. If the designated leader(s) do not have the clinical expertise required, other medical staff appointees will be requested to assist with the review.
2. As noted in Medical Staff Bylaws Part 2 (Credentialing Policy), all medical staff appointees, as a condition of staff appointment, are expected to participate in monitoring and evaluation activities. When assisting in quality and peer review activities, practitioners shall be indemnified to the fullest extent permitted by law.
3. The healthcare organization will provide resources to assist the medical staff carry out their peer review responsibilities. In recognition of the need to be judicious with resources, particularly human resources and physician time, the medical staff in collaboration with the healthcare system will strive to establish peer review procedures that are efficient for medical and hospital staff. This includes helping the organization prioritize data collection and analysis.
4. Nurse reviewers in the Medical Support Services Department (MSS) will serve as the primary resource for peer review and will perform data abstraction, event screening and case review coordination under the direction of the appropriate Department Chief, Division Chair and Physician Quality Management Committee (PQM-C). Nurse reviewers will maintain communication with other hospital departments and services collecting data that may be beneficial to the peer review process including but not limited to medical records, risk management, patient safety, information services and national registries.
5. If the initial review of case by a nurse reviewer does not identify a concern, the nurse reviewer conclusion will be documented in the peer review data base for the purpose of verifying that the case was reviewed with no issues forwarded for physician level review.
6. When physician level review is indicated, the nurse reviewer will refer the cases for physician review based on instructions by the appropriate Department Chief/Division Chair. The Chief/Chair may personally perform the review, delegate the review to a standing Department/Division peer review committee, appoint specific Department/Division appointees to serve as an ad-hoc peer review committee, or require that all appointees serve as reviewers on a rotating basis. Department/Division meetings may be used as a peer review forum. If the Chief/Division Chair/Medical Director has not provided Medical Support Services with specific directions, the case will be referred to the Service Chief, or an appropriate Division Chair/Medical Director, if one exists.
7. The Medical Staff will make good faith efforts to complete the review in a timely manner. It's expected that physician level review will be completed within approximately 90 days of referral by the nurse reviewer. Issues that represent serious performance concerns will be reviewed on an expedited basis.
8. The Department Chief/Division Chair may request assistance from the PQM-C Chair and/or Committee when there is concern a pattern of undesired performance may be developing. The PQM-C shall assist with developing a plan of action. The PQM-C may meet with involved practitioner in an effort to gain an understanding of the issues involved.

Medical Staff Department / Division Responsibility

1. Each Medical Staff Department shall appoint/elect physician(s) to the Physician Quality Management Committee in accordance with the provisions outlined in the Medical Staff Bylaws. It is the responsibility of the Department Chief to determine how to appoint/elect their PQM-C designee(s). All PQM-C members are subject to review and approval of the Medical Executive Committee and Board of Directors. Division staff appointees not appointed to the PQM-C will be available to the PQM-C on a consulting basis.
2. Division level reviews will be considered “educational case conferences” (i.e., mortality and morbidity conference). The objective of the case review process is to use traditional case-specific review as a mechanism to initiate collegial dialogue at the medical specialty level for the purpose of sharing knowledge so the medical staff may continually improve professional performance and improve patient care.
3. Following presentation, the Department Chief / Division Chair will document the disposition of the case on the confidential peer review form. The peer review form will be maintained in the practitioner’s confidential peer review file in Medical Support Services with data entered into the Peer Review data base.

Management of Multi-disciplinary Differences

1. There may be instances when patient care issues or concerns involve practitioners from multiple medical specialties. In such cases the nurse reviewer will refer the case to the Physician Quality Management Committee Chair who shall determine the best plan of action.

Communicating Peer Review Results

1. If a practitioner-specific improvement opportunity is identified, the appropriate medical staff leader, or his/her designated representative, shall inform the affected practitioner. The Chief/Chair, or other appropriate medical staff leader, may exercise discretion in determining whether the communication process is verbal or by written correspondence. To promote collegial interaction, direct verbal communication is preferred. The involved practitioner should be informed of the basis for the concern and provided opportunity for input prior to a final peer review conclusion. If a practitioner requested to perform a case review identifies improvement opportunities or deficiencies and does not feel it's appropriate to address the issue directly with the affected practitioner, the peer reviewer should discuss the matter with the appropriate Department Chief or Division Chair. The Chief/Chair may review the case him/herself or, if the Chief/Chair does not have the required clinical expertise to conduct the review, may request a review of the case by another staff appointee with appropriate clinical knowledge.
2. If a practitioner does not participate in peer review meetings or is unresponsive to a request to meet to discuss an issue of concern, the Chief or Division Chair may exercise the option of calling a mandatory meeting in accordance with Medical Staff Bylaws Part 1 Article III, Part D Section 2. It is unacceptable for the communication process to be delegated to a non-physician.

Focused Review & Investigative Review Panels

1. When a serious performance issues raises concern with respect to patient safety or the orderly operation of the hospital, the matter should be referred to Medical Staff President who shall proceed in accordance with Article III, Part C of the Medical Staff Bylaws Part 2 (Credentialing Policy) or Chair, Physician Quality Management Committee. These leaders, individually or collectively, will make sufficient inquiry to determine if a formal or informal review process is appropriate.
2. If the basis for the referral is questionable or leadership does not feel there is an immediate threat to patient safety or the orderly operations of the hospital and the matter can likely be addressed via informal mechanisms,

the matter will be referred to the appropriate Department Chief(s) for evaluation. The Chief may review the matter him/herself, request that other Department/Division appointees with appropriate clinical knowledge assist in the review or refer that matter to the Physician Quality Management Committee. If referred to the PQM-C, the Department Chief / Division Chair shall provide the Committee with the basis for referral.

3. A "focused review" may be conducted to gain a better understanding of a specific practitioner's performance. The affected appointee shall be afforded the opportunity to participate in the review process. Recommendations resulting from the focused review process are considered collegial in nature with the goal of achieving voluntary compliance by the affected practitioner. If serious performance concerns are identified during the focused review process, the matter shall be referred to the Medical Staff President.
4. If a determination is made that the situation is serious and has the potential to affect the practitioner's appointment and/or clinical privileges, the matter will be referred to the Credentials Committee. The Committee will proceed in accordance with the procedures described in Medical Staff Bylaws Part 2 (Credentialing Policy) Article III, Part C.

External Peer Review

1. Participation in peer review activities is an expectation of staff appointment. Knowledge of internal policies and procedures is beneficial to the peer review process. As such, external review should be limited to situations when the existing medical staff does not have the clinical expertise required or there are significant concerns regarding conflict of interest. All external reviews will be coordinated with assistance of legal counsel to ensure peer review privilege and appropriate agreements with external reviewers. No practitioner can require the hospital to obtain external peer review. Appropriate indications for external peer review include:
 - a. Litigation when dealing with the potential for a lawsuit.
 - b. Ambiguity when dealing with vague or conflicting recommendations from internal reviewers or medical committees and conclusions from the review will directly impact a practitioner's membership or privileges.
 - c. Lack of internal expertise when no one on the medical staff has adequate expertise in the specialty under review, or when the only practitioners on the medical staff with expertise are direct competitors of the practitioner under review.
 - d. New technology or new specialty and the medical staff Credentials or Medical Executive Committee needs help assessing the credentials of an applicant or to address a performance concern.
 - e. To assist with a focused review, formal investigation and/or fair hearing.

Peer Review Documents

1. Peer review conclusions should be documented on a peer review form. If peer review is documented in a letter, it shall be handled in the same manner as the peer review form. If the letter does not contain sufficient detail to determine a conclusion regarding peer review, the nurse reviewer may request clarification.
2. Peer review documents will be maintained in practitioner-specific file(s) in the Medical Support Services Department. Information referred from the Physician Health Resource Group (PHRG) will be forwarded to the confidential peer review file and maintained in a clearly identified section of the file. Documents that are extremely sensitive, such as health assessments, may be sealed.
3. The peer review file is separate from the credentials file. The hospital will keep hard copy practitioner-specific peer review information in locked files. Electronic access to peer review data will be restricted in the same manner as hard copy information.

4. Peer review results will be considered during the re-appointment and re-privileging process. Information may be maintained in hard copy, microfilm or computerized files.
5. Peer review information is available only to authorized individuals who have a legitimate need to know based on their responsibilities as a medical staff leader or hospital employee/representative. They shall have access to the information only to the extent necessary to carry out their assigned responsibilities. The following individuals shall have access to practitioner-specific peer review information:
 - a) Medical Staff Officers
 - b) Medical Staff Department Chiefs and Division Chairs (for members of their department/division only).
 - c) Members of the Medical Staff department/division level peer review committees and Medical Staff Committees including the PQM, Credentials, and Medical Executive Committees when a matter is referred to them for review and action.
 - d) The Board of Directors when a matter has been referred to the Board for action.
 - e) Medical Support Services staff who support the Medical Staff peer review process and Physician Quality Management Committee.
 - f) The Chief Executive Officer, Vice President Medical Affairs, and Hospital Legal Counsel.
 - g) Individuals surveying for accrediting and licensing bodies (e.g., JCAHO and state/federal regulatory bodies) to the extent required by law. Legal counsel shall provide direction regarding access.
6. A practitioner may review the contents of his peer review file upon request
7. No copies of peer review documents will be created and distributed unless authorized by Hospital legal counsel. However, a practitioner may have a copy of any material that she or he previously provided to the Hospital or that the Hospital previously sent to the practitioner.

Suspected Health or Impairment Issues

1. The Physician Health Resource Group should be consulted when health and/or impairment issues are suspected. (Refer to the "*Practitioner Conduct and Wellness Policy*").

Conflict of Interest

1. All individuals involved in the peer review shall be sensitive to concerns related to conflict of interest and shall adhere to the guidelines related to conflict of interest as outlined in Medical Staff Bylaws Part I, Article III, Part A.

Confidentiality Of Peer Review

1. All information obtained in support of the peer review process is considered absolutely confidential. Persons participating in or supporting the peer review process do so with the belief that all relevant information they may provide, both oral and written, shall be protected as confidential as stated in Virginia Health Codes. Disclosure of peer review information to persons not involved in or supporting the peer review process is inappropriate. Individuals who breach confidentiality shall be subject to disciplinary procedures.

Authority To Institute Precautionary Suspension

1. Nothing in these guidelines shall be interpreted to restrict the authority as defined in Medical Staff Bylaws Part 2 (Credentialing Policy) as pertains to imposition of a precautionary suspension of clinical privileges

Approved: Medical Executive Committee:

Adopted: April 1992
Revised: January 1995
January 1997
July 2002, September 2002
March 2004
February 2006 (*reflecting creation of the Physician Quality Management Committee*)
January 2007 (*to conform to revision in Medical Staff Bylaws Part II, Article III, Part C*)

Related Documents:

- Medical Staff Bylaws Part I - Medical Staff Structure
- Medical Staff Bylaws Part 2 - Credentialing Policy
- Practitioner Conduct and Wellness Policy
- Peer Review Referral Cover Memo (Side 1 & Side 2)
- Peer Review Referral Form (Master in MIDAS System: Quality Management Module)
- Medical Staff Quality Event/Indicators (Master in MIDAS System: Quality Management Module)
- Virginia Codes Relevant To Peer Review



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MediCorp Health System / Mary Washington Hospital
Medical Staff & Allied Health Professionals Conduct Policy

A. POLICY STATEMENT

1. The goal of this policy is to create a culture of respect between all members of the health provider team that promotes the provision of safe and competent patient care. Achievement of this goal requires collaboration, communication, and collegiality among all members of the health provider team. As such, all Medical Staff members and Allied Health Professionals practicing in the Hospital must conduct themselves in a professional and cooperative manner.
2. This Policy outlines collegial and educational efforts that will be used by Medical Staff leaders to evaluate and address conduct that does not meet this standard. The goal of these efforts is to arrive at voluntary, responsive actions by the affected individuals to resolve the concerns that have been raised, and thus avoid the necessity of proceeding through the disciplinary process.
3. Compliance with the law and provision of an environment free from sexual/unlawful harassment is critical. This Policy also addresses sexual/unlawful harassment of Hospital associates, patients, guests and other members of the Medical Staff, which will not be tolerated. Unlawful harassment as defined in Section B(6) includes unwelcome behaviors that are sexual in nature or related to personal characteristics of the individual to whom the behavior is directed including race, national origin, religion, age, or disability.
4. All efforts undertaken pursuant to this Policy shall be part of the Medical Staff peer review activities and confidential pursuant to applicable federal and state laws. The organization will assert privilege to the extent appropriate and legally permissible.
5. Individuals are encouraged to first attempt to resolve conduct issues in a collegial manner, including informing the offending individual that the conduct is unwelcome and/or discussing the incident with a Hospital Manager or Department Chief.

B. EXAMPLES OF INAPPROPRIATE CONDUCT

The general expectation related to professional conduct is set forth in the Medical Staff Bylaws/Credentialing Policy. To aid in the education of Medical Staff and Allied Health Professionals and enforcement of this Policy, examples of "inappropriate conduct" include, but are not limited to:

1. threatening, abusive, or offensive language directed at patients, nurses, Hospital associates, allied health professionals or other physicians with intent to harm or undermine patient care (e.g., belittling, berating, and/or non-constructive criticism with the intent to intimidate, undermine confidence, or imply incompetence);
2. degrading or demeaning comments regarding patients, families, nurses, physicians, Hospital personnel, or the Hospital in the presence of the patient;
3. physical contact with another individual that is inappropriate, threatening or intimidating;
4. inappropriate medical record entries impugning the quality of care provided by the Hospital, Medical Staff members, or any other individual.
5. "sexual/unlawful harassment," which is defined as any verbal and/or physical conduct a reasonable person would consider unwelcome and offensive or severe and pervasive enough to

create a hostile or intimidating work environment to those individuals who are subjected to it. Examples include, but are not limited to, the following:

- a) Verbal: epithets, derogatory slurs, off-color jokes, sexual propositions, sexually graphic commentaries, threats, and/or suggestive or insulting sounds;
- b) Visual/Non-Verbal: derogatory posters, cartoons, or drawings, suggestive objects or pictures, and/or obscene gestures;
- c) Physical: unwanted physical contact, including touching, interference with an individual's normal work movement, and/or assault; and
- d) Other: engaging in or threatening retaliation as a result of an individual's reporting or other response to harassing conduct.

C. GENERAL GUIDELINES/PRINCIPLES

1. Unprofessional conduct by Medical Staff appointees and Allied Health Professionals authorized to practice in the Hospital will be addressed in accordance with this Policy. Inappropriate conduct by Hospital Associates, volunteers, others providing services to the organization or visitors shall be addressed in other policies.
2. This Policy outlines collegial steps (i.e., counseling, warnings, and meetings with a practitioner) that may be taken to address complaints about inappropriate conduct by practitioners. However, a single incident of inappropriate conduct or a pattern of inappropriate conduct may be so unacceptable that immediate disciplinary action is required. Therefore, nothing in this Policy precludes an immediate referral of a matter being addressed through this Policy to the Medical Executive Committee or the elimination of any particular step in the Policy.
3. To effectuate the objectives of this Policy, the MediCorp and Mary Washington Hospital Board of Directors delegates to the Medical Staff, through the Medical Staff Executive Committee (MEC), responsibility for educating medical staff appointees regarding the importance of appropriate professional conduct and for evaluating and addressing conduct issues in a timely manner.
4. To provide for a timely and efficient evaluation and intervention process, the Credentialing Committee and Medical Executive Committee (MEC) delegate responsibility for evaluating and addressing conduct concerns to the Medical Staff President, Chiefs of Service, and, when deemed appropriate by the Medical Staff President and appropriate Department Chief, a "Professional Conduct Committee" (PCC).
5. The PCC shall be composed of the Medical Staff President (who shall serve as Chair), Medical Staff Vice President and one (1) member from each of the four (4) Medical Staff Departments. The Department members shall not be currently serving on the Medical Executive, Credentials, or Physician Quality Management Committee(s). Each of the four (4) Medical Staff Departments will also select an alternate PCC member who shall serve in the absence of the primary Department member. All members will be approved by the MEC and Mary Washington Hospital Board of Directors. The Chief of the involved practitioner's Department and Medical Staff President are delegated responsibility by the MEC to jointly review all professional conduct concerns and develop an action plan in accordance with this Policy. The Director of Human Resources, or his/her designee, shall be an ad-hoc PCC representative and available to the Chief and President on a consulting basis. The Human Resource Director will routinely be involved in all allegations involving sexual/unlawful harassment and/or hostile work environment claims. In all other matters the Human Resource Director will be invited to participate at the discretion of the Medical Staff President or his/her designee.
6. Legal counsel shall not attend any of the meetings described in this Policy.

7. PCC members shall avoid actual or perceived conflicts of interest utilizing the conflict of interest guidelines described in Medical Staff Bylaws, Article III, Part A, Section 8, "Conflict of Interest".
8. Medical Staff leadership and Hospital Administration shall make Associates, Medical Staff, Allied Health Professionals and other personnel in the Hospital aware of this Policy and procedures for reporting conduct concerns. Hospital Administration shall provide resources to the Department Chiefs, PCC and MEC including education related to managing conduct issues and staff resources to assist the PCC and MEC in carrying out their responsibilities pursuant to this policy.
9. Patient complaints involving significant professional conduct concerns will be handled in accordance with this Policy. Documentation from the Hospital's patient relations specialist or other hospital representative shall serve as the documentation of record.
10. All individuals and committees charged with the responsibility of reviewing allegations of inappropriate conduct shall make reasonable efforts to obtain all relevant information. All conclusions related to professional conduct shall consider the work environment and other relevant issues affecting the practitioner involved at the time the conduct in question occurred.

D. REPORTING CONDUCT CONCERNS

1. To avoid misinterpretation, conduct concerns should be submitted in writing. If an individual does not wish to do so, the individual's supervisor or PCC member (or the PCC's designated representative) may document the concern, after attempting to ascertain the individual's reasons for declining and encouraging the individual to do so.
2. Documentation may be submitted on a Conduct Concern Report, or documented (typed or legibly written) on plain paper. E-mail should not be used as the mechanism for communicating conduct concerns. The following should be documented:
 - a) the name of the practitioner(s) whose conduct is in question
 - b) the date and time of the incident;
 - c) a factual description of the questionable behavior;
 - d) the name of any patient or patient's family member who may have been involved in the incident, including any patient or family member who may have witnessed the incident;
 - e) the circumstances which precipitated the incident;
 - f) the names of other witnesses to the incident;
 - g) consequences, if any, of the behavior as it relates to patient care, personnel, or Hospital operations;
 - h) any action taken to intervene in, or remedy, the incident;
 - i) the name and signature of the individual reporting the matter; and
 - j) if a Hospital Manager intervened in an attempt to resolve the matter and, if so, if the parties involved arrived at a mutually acceptable response.
3. All Reports involving conduct concerns shall be sent directly to the Medical Support Services/Medical Staff Office.
4. Nothing in this Policy is intended to prevent individuals who have concerns regarding practitioner conduct to work directly with the involved practitioner. Direct interaction provides an opportunity for all parties to understand factors in the work environment that increase stress for the health care

team. When offered an opportunity to discuss issues related to conduct, practitioners are encouraged to participate.

E. INITIAL PROCEDURE AND PROFESSIONAL CONDUCT COMMITTEE PROCESS

1. Upon receipt of the conduct Report, the Medical Staff Office/Medical Support Services Department Associates assigned responsibility for supporting the peer review program will review the confidential peer review file of the practitioner in question to determine if there have been prior conduct Reports and prepare a summary. The summary shall outline if and what prior actions have been taken.
2. The Medical Staff President (President) and affected appointee's Department Chief (Chief), or his/her designee(s) will be contacted by Medical Support Services and are responsible for reviewing the information and developing a course of action. If additional information is required, Medical Support Services will work with other organizational representatives, including but not limited to the Human Resources Department, to obtain the information requested.
3. The President and Chief will proceed as follows:
 - a) Handle the matter personally utilizing the approaches outlined in paragraph 4 of this section; or
 - b) Consult with, or refer the matter to, the Physician Health Resource Group (PHRG). If the PHRG agrees to accept the referral, the matter will be handled in accordance with the Practitioner Wellness Policy; or
 - c) Refer the matter to the PCC.

The Medical Staff President and Chief, PHRG and/or PCC may meet with the individual(s) who submitted the report and/or any witnesses to the incident to ascertain additional details of the incident.

4. If, following an evaluation, which shall include an opportunity for the affected practitioner to discuss the matter with the President and Chief or PCC, it is determined that the practitioner's conduct was inappropriate, the President and Chief or the PCC will determine a course of action, including but not limited to, any or a combination of the following:
 - a) Inform the practitioner of the specific concern and afford the practitioner the opportunity to review the written conduct Report and submit a response to the allegation of inappropriate conduct.
 - b) Send the practitioner a letter of guidance for the purpose of educating the practitioner regarding conduct expectations and/or relevant Bylaws, Rules & Regulations, etc. relating to the conduct concern and future conduct expectations. The practitioner may be required to attest in writing of his/her willingness to abide by the conduct expectations. Refusal to attest in writing, if requested, shall result in an automatic referral of the matter to the Medical Executive Committee;
 - c) Educate the practitioner about administrative channels that are available for registering complaints or concerns about quality or services, if the practitioner's conduct suggests that such concerns led to the behavior. A practitioner's concerns regarding the quality or efficiency of Hospital Operations will not be accepted as justification for conduct considered inappropriate as defined in Section B of this Policy.
 - d) Send the practitioner a letter of warning or reprimand, particularly if there have been prior Conduct Reports;
 - e) Notify the practitioner that a Conduct Report has been received and schedule a meeting with the practitioner. The practitioner may be informed that this meeting is mandatory and that

refusal to attend the meeting shall result in automatic referral of the matter to the Medical Executive Committee (MEC).

- f) Refer the matter to the MEC.
 - g) Issue a precautionary suspension in accordance with the procedures and timeline outlined in the Credentialing Policy Article III–Part D except that the immediate review of the matter shall be conducted by the Medical Executive Committee rather than the Credentials Committee.
5. Letters of guidance, warning, reprimand, etc. will be copied to the practitioner's confidential peer review file. The letter shall afford the practitioner the opportunity to submit documentation for his/her confidential file. Any documentation submitted by the practitioner will be reviewed by the President and Chief, and/or PCC, if the PCC was involved in a review of the conduct in question. The conclusion and/or expectations set forth in the President's and Chief's or PCC's letter to the practitioner shall stand unless modified by the Medical Staff President and Chief or PCC. Letters of guidance or warning, or actions taken pursuant to Section 4(b) above, shall not be considered a reprimand or an adverse event.
 6. If additional Conduct Reports are received concerning a practitioner, the President and Chief, or PCC may continue to utilize the collegial and educational steps noted in this Section as long as they believe there is still a reasonable likelihood that those efforts will resolve the concerns.
 7. Conduct shall be considered at the time of biennial reappointment or privileges review. The MEC shall be informed whenever three (3) Conduct Reports have been received for a specific practitioner. The MEC may also be notified sooner depending upon the nature of the inappropriate conduct. The MEC shall be informed of the nature of the conduct and actions taken.
 8. Whenever a practitioner is being counseled regarding conduct, the practitioner shall be advised that any actual or threatened retaliation against the person reporting a concern, whether the specific identity is disclosed or not, will be grounds for immediate referral to the Medical Executive Committee for disciplinary action.
 9. If the President and Chief, PCC, or MEC determine that a practitioner's concerns regarding hospital operations are credible, the matter will be referred to the Senior Vice President for Hospital Operations.
 10. If the President and Chief, PCC, or MEC substantiate that allegations of inappropriate conduct raised by an Associate are false or unreasonable, the matter will be referred to the Director of Human Resources. A dated notation will be placed in the Practitioner's file stating that the Conduct Report was investigated and found to be wholly without merit.

F. REFERRAL TO THE MEDICAL EXECUTIVE COMMITTEE

1. At any point, the President and Chief, or PCC may refer the matter to the MEC. The MEC shall be fully apprised of actions previously taken to address the practitioner's conduct. When a referral is made, the referring party should submit a recommended course of action to the MEC. The MEC may adopt, reject, or modify the recommendation.
2. The MEC may take additional steps to address the concerns including, but not limited to, any or a combination of the following:
 - a) Require the practitioner meet with MEC representatives or the entire MEC. The MEC may invite the Chair of the Mary Washington Hospital Board Medical Affairs Committee or his his/her designee to participate in the meeting;
 - b) Issue a letter of warning or reprimand;

- c) Notify the practitioner that receipt of another Conduct Report will result in the MEC's recommendation that the Mary Washington Hospital Board restrict, suspend, or terminate the appointee's staff appointment and/or clinical privileges.
3. Prior to the MEC taking action pursuant to Section F(2)(a-e), the MEC shall provide the practitioner written notice of the conduct concern and shall extend an invitation to the practitioner to discuss the matter with the MEC. The notice shall indicate the meeting is mandatory and that failure to attend the meeting, unless excused by the MEC upon showing of good cause, shall constitute a voluntary relinquishment of all clinical privileges until the matter is resolved.
4. At any point, the MEC may also make a recommendation regarding the practitioner's continued appointment and clinical privileges that if upheld by the Medical Affairs Committee entitles the practitioner to a hearing as outlined in the Credentialing Policy. If the practitioner is entitled to a hearing, the hearing shall be conducted in accordance with the procedures outlined in the Credentialing Policy.

G. SEXUAL/UNLAWFUL HARASSMENT CONCERNS

As previously stated in this Policy, The Director of Human Resources will assist the President and Chief or the PCC in the investigation, evaluation and development of actions related to Conduct Reports of sexual/unlawful harassment or hostile work environment claims. Because of the unique legal implications surrounding sexual/unlawful harassment or hostile work environment claims, a single confirmed incident requires the following actions:

1. A meeting shall be held with the practitioner to discuss the incident. If the practitioner agrees to stop the conduct thought specifically to constitute unlawful harassment, the meeting shall be followed up with a formal letter of admonition and warning to be placed in the confidential portion of the practitioner's peer review file. This letter shall also set forth those additional actions, if any, which result from the meeting.
2. If the practitioner refuses to stop the inappropriate conduct immediately and take all other actions recommended, or if the conduct is sufficiently egregious that a warning is not sufficient, the matter will be referred to the MEC.
3. Any reports of threatened or actual retaliation or any further reports of sexual/unlawful harassment, after the practitioner has agreed to stop the improper conduct, shall result in an immediate evaluation by the PCC and report to the MEC.
4. If the Conduct Report alleging sexual/unlawful harassment is found to be false, a notation shall be placed in the Practitioner's file stating that a Conduct Report was investigated and found to be wholly without merit.

H. APPLICANT'S AGREEMENT TO ABIDE BY PROFESSIONAL CONDUCT EXPECTATIONS

As a part of the application process, individuals applying for medical staff appointment, clinical privileges, or permission to practice as an allied health professional will be required to sign an Acknowledgement & Agreement stating that he/she has received, read, and understands the conduct expectations and procedures set forth in the Conduct Policy and will abide by the Policy and any modifications to the Policy approved during the appointee's term. Failure to sign the Acknowledgement will constitute an incomplete application and the application will not be processed. Modifications/revisions to the Conduct Policy and/or Acknowledgement by the applicant will not be accepted.

I. ACKNOWLEDGING RECEIPT OF CONDUCT CONCERN AND ACTIONS TAKEN

Upon receipt of a conduct concern, the Medical Support Services Department will send a confidential acknowledgement to the individual(s) initiating the concern. When appropriate, the Medical Staff President or Chief of Service will inform the initiating party that the issue has been addressed. Specific details regarding the actions shall be privileged committee communications in accordance with Virginia Statute §8.01-581.17.

J. HUMAN RESOURCES ACCESS TO CONDUCT INFORMATION OF EMPLOYED PRACTITIONERS

The Director of Human Resources, or his designee, shall have access to all Conduct Reports related complaints and actions taken relating to employed practitioners and actions relating to Conduct Reports raised by Hospital Associates, and Hospital volunteers/students.

K. REPORTING CONDUCT ISSUES TO OUTSIDE ENTITIES

The Hospital shall report conduct issues and actions taken in accordance with all applicable regulatory requirements including, but not limited to, reports to the State Board of Medicine and National Practitioner Data Bank.

Approved:

Medical Executive Committee: February 15, 2007

Board Medical Affairs Committee: February 28, 2007



Dr. Daniel Hoffman, Medical Staff President & Chair Medical Executive Committee



Mr. Fred M. Rankin, III, President & Chief Executive Officer, MediCorp Health System / MWH

Sections of Medical Staff Bylaws / Credentialing Policy Reference in Conduct Policy

Medical Staff Credentialing Policy: Article II – Part B: Section 2. Professional Conduct:

Individuals appointed to the Medical Staff shall be expected to relate in a positive and professional manner to other health professionals, and to cooperate and work collegially with the Medical Staff leadership and hospital management and personnel. Professional conduct shall also include, but not be limited to, each appointee's obligation to present him or herself at the hospital physically and mentally capable of providing safe and competent care to his or her patients.

Medical Staff Bylaws Article III – PART A: Section 8. Conflict of Interest:

1. In any instance where an officer, or Service Chief, division chairperson, Clinical Medical Director or committee chairperson, or member of any Medical Staff committee has or reasonably could be perceived to have a conflict of interest or to be biased in any matter involving another Medical Staff appointee that comes before such individual or committee, or in any instance where any such individual or committee member initiated the request for review involving that appointee, such individual or member shall not participate in the discussion or voting on the matter, and shall be excused from any meeting during that time, although that individual or committee member may be asked, and may answer, any questions concerning the matter before leaving. As a matter of procedure, the chairperson of that committee designated to make such a review shall inquire, prior to any discussion of the matter, whether any member has any conflict of interest or bias. The existence of a potential conflict of interest or bias on the part of any committee member may be called to the attention of the chairperson by any committee member with knowledge of the matter.
2. A Service Chief or division chairperson, as the case may be, shall have a duty to delegate review of applications for appointment, reappointment or clinical privileges, or questions that may arise to another member of the department, if the service chief or division chairperson has a conflict of interest with the individual under review, or could be reasonably perceived to be biased.

Acknowledgement & Agreement

I acknowledge that I have received the Conduct Policy read and understand the professional conduct expectations and medical staff intervention process set forth in this Policy and agree to conduct myself in accordance with these expectations. I understand that failure to adhere to professional conduct expectations could result in disciplinary action including termination of appointment and/or clinical privileges.

Signature

Date

Printed Name

Practitioner Health & Wellness Policy

Mary Washington Hospital (MWH) and Stafford Hospital Center (SHC)

1) POLICY STATEMENT

- a) This Policy applies to all practitioners who provide patient care services at Mary Washington Hospital (MWH) and Stafford Hospital Center (SHC). For purposes of this Policy, a "practitioner" is defined as a member of the Medical Staff or an Allied Health Professional who has been granted clinical privileges.
- b) Mary Washington Hospital and Stafford Hospital Center and its Medical Staffs are committed to providing quality care, which can be compromised if a practitioner is suffering from a health issue.
- c) "Health issue" means any physical, mental, or emotional condition, including alcohol or substance abuse and use of prescription medications that could adversely affect an individual's ability to practice safely and competently.
- d) "Hospital" means the facility where the practitioner holds appointment and/or clinical privileges,
- e) The Mary Washington Hospital and Stafford Hospital Center Medical Staffs have established a Practitioner Health Resource Group (PHRG) to assist the Medical Executive Committees with issues related to practitioner health and wellness. The composition and duties of the Physician Health Resource Group are outlined in Medical Staff Bylaws Part I (Medical Staff Structure), Section VI, Part D.
- f) To the extent possible, and consistent with quality of care and patient safety concerns, the PHRG will manage health related reviews and interventions in a confidential fashion.
- g) The Chief Medical Officer (CMO) shall serve as the PHRG Chair. The CMO shall keep the Department Chief Executive Officer, Medical Staff President(s) and Department Chief(s) at the Hospital(s) where the practitioner has been granted appointment and/or clinical privileges apprised of matters under review and actions taken.

2) MECHANISM FOR REPORTING AND REVIEWING POTENTIAL HEALTH ISSUES

- a) Practitioners who have a health issue that could affect their ability to safely and competently exercise their clinical privileges are required to report it to the CMO or their Department Chief. The CMO and/or Department Chief will meet with the involved practitioner and will collaborate on an action plan which may include consultation with or intervention by the PHRG. If the practitioner holds appointment and/or clinical privileges at MWH and SHC, the Chiefs at both Hospitals will be notified.
- b) Any individual who observes behavior or otherwise has reason to believe a practitioner has a health issue that could affect the ability of the practitioner to practice safely and competently shall report their concern to the CMO or the practitioner's Department Chief or their assigned coverage. If the CMO and Department Chief or their coverage is unavailable, the concerned individual shall contact any of the following: MWH Vice President Medical Affairs, SHC Sr. Medical Director, or Medical Staff President at the Hospital where the practitioner holds staff appointment and/or clinical privileges.
 - i) The Medical Staff Leader may inform the individual who filed the report that follow-up action was taken, however, the specifics of any action shall not be shared in light of their confidential nature.

3) CONCERNS REQUIRING AN IMMEDIATE RESPONSE

- a) Any individual who is concerned that a practitioner has a health issue that may result in an imminent danger to the health and/or safety of any individual shall immediately notify the CMO (Executive Vice President Medical Affairs), the practitioner's Department Chief, Medical Staff President, or Chief Executive Officer who shall have the authority to suspend all or any portion of the clinical privileges of the practitioner consistent with Medical Staff Bylaws Part 2 / Credentialing Policy, Article III, Part D, Precautionary Suspension of Clinical Privileges. If the practitioner holds appointment and/or clinical privileges at MWH and SHC, the precautionary suspension shall apply to both Hospitals.
- b) In the event of a precautionary suspension, the affected practitioner's hospitalized patients may be assigned to another practitioner with appropriate clinical privileges or to the appropriate practitioner on unassigned call. The affected practitioner may be authorized permission to talk with the patient and or family and write a transfer note in the medical record to help with the orderly transfer of care. If the practitioner is unable or not authorized to interact with the patient or family, the affected patients shall be informed that their practitioner is unable to proceed with their care due to illness. The wishes of the patient(s) shall be considered in the selection of a covering practitioner. The CMO or the affected practitioner's Department Chief(s) shall assist with the orderly transfer of patient care including talking with the patient and family members.

4) REVIEW BY CMO, DEPARTMENT CHIEF, AND PRACTITIONER HEALTH GROUP (PHRG)

- a) The CMO and the practitioner's Department Chief(s) shall act expeditiously in reviewing concerns regarding a potential health issue. The CMO and Department Chief may initially review the issue of concern without convening the PHRG. The CMO and Department Chief(s) may but are not obligated to, proceed with review and development of an action plan consistent with Section 4 and Section 5 of this Policy without convening the PHRG.
- b) The CMO and Department Chief(s) and PHRG, if convened, shall act expeditiously. The review process may include a meeting with the individual(s) who initially reported the concern. The CMO, Department Chief, and/or PHRG, or its designated representative(s), are encouraged to review the practitioner's central confidential peer review file located in the Mary Washington Hospital Medical Support Services Department (Medical Staff Office).
- c) If the reviewing party believes the practitioner has or might have a health issue as defined in this Policy, it shall meet with the practitioner. At this meeting, the practitioner should be told there is a concern that his or her ability to practice safely and competently may be compromised by a health issue and advised of the nature of the concern, but should not be told who initially reported the concern.
- d) The reviewing party may request that the individual undergo a physical or mental examination, submit to an alcohol or drug screening test, or be evaluated by a physician or organization specializing in substance abuse and have the results of the examination or evaluation provided to it. The CMO, or his/her designee, will be available to help coordinate the evaluation and provide the practitioner with the names of health care providers approved by the PHRG. The Hospital will pay for the initial evaluation. The Hospital will not pay for any other evaluation or, if recommended, treatment.
 - i) A form authorizing the Hospital to release information to the examining physician or the physician or organization conducting the evaluation is attached as Appendix A. A form authorizing the examining physician or the physician or organization conducting the evaluation to disclose information about the practitioner to the Practitioner Health Committee is attached as Appendix B.
- e) If the reviewing party believes the behavior of the physician is not related to a health issue but represents a professional conduct issue, they will confer with the Medical Staff President at the

appropriate Hospital(s) who shall determine if the issue should be handled in accordance with Medical Staff and Allied Health Professional Conduct Policy.

5) INTERVENTIONS FOR HEALTH CONCERNS

- a) Based on the severity and nature of the health issue, the reviewing party (CMO and Department Chief or PHRG) may recommend to the practitioner that he or she:
 - i) take a voluntary leave of absence, consistent with the Leave of Absence procedures outlined in Medical Staff Bylaws Part 2 / Credentialing Policy, to receive appropriate medical treatment or participate in a rehabilitation program, as applicable; or
 - ii) voluntarily refrain from exercising some or all privileges until an accommodation can be made to ensure that the practitioner is able to practice safely and competently; or
 - iii) voluntarily agree to specific conditions or restrictions on his or her practice.

If the PHRG recommends that the practitioner receive medical treatment or participate in a rehabilitation program, it shall assist the practitioner in identifying appropriate resources, as necessary.
- b) If the practitioner agrees to the recommendations, this shall be documented by the CMO (or his or her designee) and delivered to the Mary Washington Hospital Medical Support Services Department for inclusion in the practitioner's central confidential peer review file.
- c) If the practitioner does not agree to the recommendations, the matter shall be referred to the PHRG, if not previously involved, and/or the Medical Executive Committee MEC. If referred to the MEC, the MEC may review the matter or request an investigation be conducted pursuant to the Medical Staff Bylaws Part 2/Credentials Policy, Article III, Part C.
- d) In the event the Chief is concerned that the action of the PHRG is not sufficient to protect patients or other health care workers, the matter will be referred back to the PHRG with specific recommendations on how to revise the action plan or it will be referred to the Medical Executive Committee for review and possible investigation.

6) REINSTATEMENT/RESUMPTION OF PRACTICE

- a) A written request for reinstatement of clinical privileges or removal of conditions or restrictions on clinical privileges must be submitted to the practitioner's Department Chief(s) at the Hospital(s) where the practitioner hold(s) appointment and/or clinical privileges or the CMO along with evidence that the practitioner is able to safely and competently resume practice. At a minimum, that evidence shall consist of the Health Status Assessment form attached as Appendix C or a letter from the practitioner's treating physician or substance abuse treatment program addressing the following issues:
 - i) the practitioner's current condition;
 - ii) whether the practitioner is continuing to receive medical treatment and, if so, the treatment plan, or is continuing to participate in a substance abuse rehabilitation or in an after-care program, a description of that program and whether the practitioner is in compliance with all aspects of the program;
 - iii) to what extent, if any, the practitioner's behavior and clinical practice need to be monitored;

- iv) whether the practitioner is capable of resuming clinical practice and providing continuous, competent care to patients as requested; and
 - v) if any conditions or restrictions are required to allow the practitioner to safely resume practicing.
- b) Before acting on a request for reinstatement or lifting of conditions or restrictions, the CMO and Department Chief or PHRG may request that the practitioner undergo an examination by a physician of its choice to obtain a second opinion on the practitioner's ability to practice safely and competently. If the second opinion is requested the Hospital will pay for the exam.
 - c) Before the practitioner's clinical privileges are reinstated or conditions or restrictions removed, the practitioner may be required to identify at least one practitioner who is willing to assume responsibility for the care of his or her patients in the event of the practitioner's inability or unavailability.
 - d) If the practitioner was granted a formal leave of absence, the final decision to reinstate a practitioner's clinical privileges must be approved pursuant to the process set forth in the Medical Staff Bylaws Part 2/Credentials Policy, Part III, Part E, Section 6.
 - e) After reinstatement or removal of conditions or restrictions, the practitioner's exercise of clinical privileges may be subject to monitoring by an individual appointed by the Chief. The nature of that monitoring shall be recommended by the PHRG in consultation with Chief.
 - f) If the practitioner is continuing to receive medical treatment or to participate in a substance abuse treatment or after-care program, the PHRG may require the practitioner to submit periodic reports from his or her treating physician or the substance abuse treatment/after-care program.
 - g) As a condition of reinstatement, a practitioner who has undergone treatment for substance abuse may be required to agree to submit to random alcohol or drug screening tests at the request of the CMO or other PHRG member, the President of the Medical Staff, or Department Chief.

7) DOCUMENTATION AND CONFIDENTIALITY

- a) The initial report and a description of any recommendations made by the PHRG shall be included in the practitioner's central confidential peer review file maintained in the Medical Support Services Department at Mary Washington Hospital. If the review reveals that there was no merit to the initial report this shall be so documented. If the review reveals there may be some merit to the report, but does not rise to the level of seriousness to require immediate action, this shall be documented in the report. The practitioner shall be afforded the opportunity to provide a written response to the concern about the potential health issue and this shall also be included in his or her confidential file.
- b) Throughout this process, all parties should avoid speculation, conclusions, gossip, and any discussions of this matter with anyone other than those described in this Policy.
- c) All minutes, reports, recommendations, communications, and actions made or taken pursuant to this Policy are intended to be covered by the provisions of the Health Care Quality Improvement Act and prevailing Virginia prevailing laws governing peer review or the corresponding provisions of any subsequent federal or state statute providing protection to peer review or related activities. Furthermore, the committees, panels, or individuals charged with making reports, findings, recommendations or investigations pursuant to this Policy shall be considered to be acting on behalf of the Hospital and its Board of Trustees when engaged in such review activities and thus are "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986.
- d) All requests for information concerning a practitioner with a health issue shall be forwarded to the CMO.





- e) Nothing in this Policy precludes immediate referral to the Medical Executive Committee or the elimination of any particular step in the Policy in dealing with conduct that may compromise patient care.

8) ILLEGAL CONDUCT

- a) If the review process identifies conduct which may be illegal or in violation in the practitioner’s license to practice, the Hospital will contact law enforcement authorities, licensing board, or other appropriate authorities.

9) LEGAL COUNSEL

- a) In order to achieve the objective of this Policy, and except as otherwise may be determined by the Chief Medical Officer and Chief Executive Officer, legal counsel shall not attend any of the meetings described above.

<u>Mary Washington Hospital</u>	<u>Stafford Hospital Center</u>
Adopted: September 09, 2002	Adopted: March 10, 2009
Reviewed Without Revision: January 2004, April 2007, February 2009	
Revised:	
	
Dr. Cindy Marrow Chair, Medical Executive Committee	Chair, Medical Executive Committee
	
Fred M. Rankin, III Chief Executive Officer	Fred M. Rankin, III Chief Executive Officer

APPENDIX A

**CONSENT FOR DISCLOSURE OF INFORMATION
AND
RELEASE FROM LIABILITY**

I hereby authorize the Hospital (Mary Washington Hospital and/or Stafford Hospital Center) to provide _____ [the facility or physician performing health assessment] OR [my treating physician] all information, both written and oral, relevant to an evaluation of my health status.

I understand that the purpose of this Authorization and Release is to allow [the facility or physician performing health assessment] OR [my treating physician] to conduct a full and complete evaluation of my health status so that the Hospital can determine if I am able to care for patients safely and competently.

I also understand that the information being disclosed is considered confidential and privileged and that my treating physician(s) and facilities providing assessment and/or treatment and others involved in the peer review process are required to maintain the confidentiality of peer review information, pursuant to applicable federal and state laws.

I release from any and all liability, and agree not to sue, the Hospital, any of its officers, directors, or employees, any physician on the Hospital's Center's Medical Staff, or any authorized representative of the Hospital, for any matter arising out of the release of information by the Hospital to [the facility or physician performing health assessment] OR [my treating physician].

I also release from any and all liability, and agree not to sue [the facility or physician performing health assessment, or any of its officers, directors, employees or authorized representatives] OR [treating physician], for any matter arising out of [the facility's] OR [my treating physician's] provision of an evaluation of my health status to the Hospital.

Date

Signature of Practitioner

**APPENDIX B
AUTHORIZATION FOR RELEASE
OF PROTECTED HEALTH INFORMATION**

I hereby authorize _____ [facility performing health assessment and/or practitioner overseeing treatment or treatment program OR my treating physician] to provide all information, both written and oral, relevant to an assessment of my health status and my ability to safely practice, to the Physician Health Resource Group, Credentials Committee, Medical Executive Committee(s) and Board(s) of Trustees where I have been granted appointment and/or clinical privileges. The information to be released includes, but is not limited to, answers to the questions on the attached Health Status Assessment Form, along with the following:

- a. my current condition;
- b. whether I am [continuing to receive medical treatment and, if so, the treatment plan] OR [continuing to participate in a substance abuse rehabilitation program or in an after-care program, a description of that program and whether the practitioner is in compliance with all aspects of the program];
- c. to what extent, if any, my behavior and clinical practice need to be monitored;
- d. whether I am capable of resuming clinical practice and providing continuous, competent care to patients as requested; and
- e. any conditions or restrictions that are required to allow me to safely resume practicing.

I understand that the purpose of this Authorization is to allow to the Hospital to obtain information that is relevant to my qualifications for medical staff appointment and clinical privileges, including, but not limited to, my ability to care for patients safely and competently and to relate cooperatively with others in the Hospital.

I understand that the willingness of the Facility to conduct this assessment or provide treatment does not depend on my signing this Authorization.

I understand that my health information is protected by federal law and that, by signing this Authorization, the information will be disclosed to the parties hereby authorized to receive it and could be disclosed to other parties responsible for making recommendations and decisions regarding staff appointment and/or clinical privileges. However, I also understand that the information being disclosed is protected by state peer review laws and that [the facility performing the health assessment and/or practitioner overseeing treatment or treatment program] OR [my treating physician], the Hospital, and others involved in the peer review process are required to maintain the confidentiality of peer review information pursuant to those state laws.

I understand that I may revoke this Authorization at any time, in writing, except to the extent that the Facility has already relied upon it in making a disclosure to the Hospital. My written revocation will become effective when [the facility performing the health assessment and/or practitioner overseeing treatment or treatment program] OR [my treating physician] has knowledge of it.

This Authorization expires when my medical staff appointment and clinical privileges at the Hospital end. Once this Authorization has expired, the Facility may no longer use or disclose my health information for the purpose listed in this Authorization, unless I sign a new Authorization form.

Date

Signature of Practitioner

APPENDIX C

**HEALTH STATUS ASSESSMENT
CONFIDENTIAL PEER REVIEW DOCUMENT**

Please respond to the following questions based upon your assessment of _____'s (referred to as the "practitioner" below) current health status. (If using this form please attach a separate sheet if additional space is needed. You may respond in letter format conditioned on all questions being addressed):

1. Does the practitioner have any medical, psychiatric, or emotional condition that could affect his/her ability safely to exercise the clinical privileges set forth on the attached list and/or perform the duties of appointment, including response to emergency call? **Yes** **No**

If yes, please provide the diagnosis/diagnoses and prognosis: _____

2. Is the practitioner currently taking any medication that may affect either clinical judgment or motor skills? **Yes** **No**

If yes, please specify medications and any side effects: _____

3. Is the practitioner currently under any limitations concerning activities or work load?
 Yes **No**

If yes, please specify: _____

4. Is the practitioner currently under the care of a physician? **Yes** **No**

If yes, please describe treatment plan: _____

5. In your opinion, are any conditions or restrictions on the practitioner's clinical privileges or other accommodations necessary to permit the practitioner to exercise privileges safely and/or to fulfill medical staff responsibilities appropriately? **Yes** **No**

If yes, please explain any such restrictions, conditions or accommodations: _____

Date

Signature of Physician Examiner

**Medical Staff & Allied Health Professionals Conduct Policy
Conduct Concern Report**

**This report is submitted in accordance with the Medical Staff & Allied Health Professionals Conduct Policy
and is considered privileged communication pursuant to VA statute 8.01-581.17**

Guidelines for Report Completion:

To avoid misinterpretation, the Professional Conduct Committee (PCC) prefers that conduct concerns be submitted in writing by the individual observing the conduct of concern. If the individual observing the conduct does not wish to do so, the report may be completed by another hospital representative such as an Associate's supervisor, member of the PCC, or the PCC's designated representative. Conduct concerns should be brought to the attention of the Medical Staff President or the involved practitioner's Department Chief as soon as possible. Conduct reports /concerns should be forwarded to the MWH Medical Support Services Department (MSS).

Description of Conduct Concern:

1. Name(s) of Practitioner(s) Whose Conduct is in Question

2. Date and Time of Incident(s)

3. Description of Questionable Conduct

4. Witnesses to Conduct of Concern

**Medical Staff & Allied Health Professionals Conduct Policy
Conduct Concern Report**

**This report is submitted in accordance with the Medical Staff & Allied Health Professionals Conduct Policy
and is considered privileged communication pursuant to VA statute 8.01-581.17**

5. Consequences of Behavior to Patient Care, Hospital Staff, or Hospital Operations

6. Actions Taken or Planned

7. Management Intervention

Report Completed/Update By: _____

Date: _____

8. Medical Support Services Department Processing

MSS Instructions: Upon receipt of the Conduct Concern Report, review the involved practitioner's confidential performance / peer review file. Document if the practitioner's file contains any prior conduct concerns. Summarize prior conduct issues and what, if any, actions were taken. Sign and date the document/summary and append to the Conduct Concern Report.