



PeaceHealth Southwest Medical Center MEDICAL STAFF CREDENTIALS POLICY

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MEDICAL STAFF CREDENTIALS POLICY

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APPENDIX A: CONFLICT OF INTEREST GUIDELINES

ARTICLE 1

GENERAL

1.A. DEFINITIONS

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

- (1) “ADVANCE PRACTICE PROFESSIONALS” (“APPs”) means individuals other than Medical Staff members who are authorized by law and by the Hospital to provide patient care services within the Hospital. All APPs are described as Category I, Category II, or Category III practitioners in the Medical Staff Bylaws documents:
 - “CATEGORY I PRACTITIONER” means a Licensed Independent Practitioner, a type of Advance Practice Professional who is permitted by law and by the Hospital to provide patient care services without direction or supervision, within the scope of his or her license and consistent with the clinical privileges granted. Certain Category I practitioners practice as part of a collaborative team with members of the Medical Staff. Category I practitioners also include those physicians not appointed to the Medical Staff who seek to exercise certain limited clinical privileges at the Hospital under the conditions set forth in the APP Policy (i.e., moonlighting residents). See Appendix A to the APP Policy.
 - “CATEGORY II PRACTITIONER” means an Advanced Practice Clinician, a type of Advance Practice Professional who provides a medical level of care or performs surgical tasks within the scope of his or her license and consistent with the clinical privileges granted, but who is required by law and/or the Hospital to exercise some or all of those clinical privileges under the supervision and direction of a Supervising Physician pursuant to a written supervision agreement. See Appendix B to the APP Policy.
 - “CATEGORY III PRACTITIONER” means a Dependent Practitioner, a type of Advance Practice Professional who is permitted by law or the Hospital to function only under the direction of a Supervising Physician, pursuant to a written supervision agreement and consistent with the scope of practice granted. Except as specifically indicated in Article 6 of the APP Policy, all aspects of the clinical practice of Category III practitioners at the Hospital shall be assessed and managed by Human Resources or Administration in accordance with Human Resources or Administrative policies and procedures, and the provisions of the APP Policy shall specifically **not** apply. Hereafter, as used in this Policy, the APP Policy, and the Medical Staff Bylaws, the term “Advance Practice Professional” shall mean Category I and Category II practitioners only (except for Article 6 of the APP Policy). See Appendix C to the APP Policy.
- (2) “BOARD” means the Community Health Board, which is responsible for the credentialing, privileging, and peer review activities at the Hospital, or its designated committee.
- (3) “CHIEF ADMINISTRATIVE OFFICER” (“CAO”) means the individual appointed to be responsible for the overall management of the Hospital. This position may also be referred to as the Chief Executive Officer (“CEO”) by a specific hospital.

- (4) "CHIEF MEDICAL OFFICER" ("CMO") means the individual appointed to act as the chief medical officer of the Hospital, in cooperation with the Chief of Staff. Use of the term CMO shall include both hospital-specific CMO as well as relevant network CMOs.
- (5) "CLINICAL PRIVILEGES" or "PRIVILEGES" means the authorization granted by the Board to render specific patient care services, for which the Medical Staff leaders and Board have developed eligibility and other credentialing criteria and focused and ongoing professional practice evaluation standards.
- (6) "COLLABORATION" means the communication and decision-making process among and between Category I practitioners and Medical Staff members who function as part of a patient care team related to the treatment and care of a patient and which may include (i) communication of data and information about the treatment and care of a patient, and (ii) development of an appropriate plan of care, including decisions regarding the health care provided, accessing and assessment of appropriate additional resources or expertise, and arrangement of appropriate referrals, testing, or studies.
- (7) "CORE PRIVILEGES" means a defined grouping of privileges for a specialty or subspecialty that includes the fundamental patient care services that are routinely taught in residency and/or fellowship training for that specialty or subspecialty and which have been determined by the Medical Staff Leaders and Board to require closely related skills and experience.
- (8) "DAYS" means calendar days.
- (9) "DENTIST" means a doctor of dental surgery ("D.D.S.") or doctor of dental medicine ("D.M.D.").
- (10) "HOSPITAL" means PeaceHealth Southwest Medical Center.
- (11) "MEDICAL EXECUTIVE COMMITTEE" ("MEC") means the Medical Staff Executive Committee.
- (12) "MEDICAL STAFF" means all physicians, dentists, oral surgeons, and podiatrists, who have been appointed to the Medical Staff by the Board.
- (13) "MEDICAL STAFF LEADER" means any Medical Staff Officer, department chair, and committee chair.
- (14) "MEMBER" means any physician, dentist, oral surgeon, and podiatrist, who has been granted Medical Staff appointment by the Board.
- (15) "NOTICE" means written communication by regular U.S. mail, Hospital mail, hand delivery, e-mail, facsimile, website, or other electronic method.
- (16) "ORAL AND MAXILLOFACIAL SURGEON" means an individual with a D.D.S. or a D.M.D. degree, who has completed additional training in oral and maxillofacial surgery.
- (17) "PATIENT CONTACTS" means any admission, consultation, procedure, physical response to emergency call, evaluation, treatment or service performed in the Hospital or its outpatient facilities. Patient contacts do not include referrals for diagnostic or laboratory tests or x-rays.
- (18) "PERMISSION TO PRACTICE" means the authorization granted to Advance Practice Professionals to exercise clinical privileges or scope of practice at the Hospital.
- (19) "PHYSICIAN" means both doctors of medicine ("M.D.s") and doctors of osteopathy ("D.O.s").

- (20) "SCOPE OF PRACTICE" means the authorization granted to a Category III practitioner by the Board to perform certain clinical activities and functions under the supervision of, or in collaboration with, a Supervising Physician.
- (21) "SPECIAL NOTICE" means hand delivery, certified mail (return receipt requested), or overnight delivery service providing receipt.
- (22) "SPECIAL PRIVILEGES" means privileges that fall outside of the core privileges for a given specialty, which require additional education, training, and/or experience beyond that required for core privileges in order to demonstrate competence.
- (23) "SUPERVISING PHYSICIAN" means a member of the Medical Staff with clinical privileges, who has agreed in writing to supervise a Category II or Category III practitioner and to accept full responsibility for the actions of the Category II or Category III practitioner while he or she is practicing in the Hospital.
- (24) "SUPERVISION" means the supervision of a Category II or Category III practitioner by a Supervising Physician that may or may not require the actual presence of the Supervising Physician, but that does require, at a minimum, that the Supervising Physician be readily available for consultation. The requisite level of supervision (general, direct, or personal) shall be determined at the time each Category II or Category III practitioner is credentialed and shall be consistent with any applicable written supervision agreement that may exist. ("General" supervision means that the physician is immediately available by phone, "direct" supervision means that the physician is on the Hospital's campus, and "personal" supervision means that the physician is in the same room.)
- (25) "TELEMEDICINE" means the exchange of medical information from one site to another via electronic communications for the purpose of providing patient care, treatment, and services.
- (26) "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.

1.B. DELEGATION OF FUNCTIONS

- (1) When a function under this Policy is to be carried out by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a practitioner or Hospital employee (or a committee of such individuals). Any such designee must treat and maintain all credentialing, privileging, and peer review information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of the Medical Staff Bylaws and related policies. In addition, the delegating individual or committee is responsible for ensuring that the designee appropriately performs the function in question. In addition, if the designee is performing ongoing functions, the delegation is subject to the review of the MEC.
- (2) When a Medical Staff member is unavailable or unable to perform a necessary function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

ARTICLE 2

QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

2.A. QUALIFICATIONS

2.A.1. Threshold Eligibility Criteria:

To be eligible to apply for initial appointment or reappointment to the Medical Staff, physicians, dentists, oral surgeons, and podiatrists must:

- (a) have a current, unrestricted license to practice in Washington and have never had a license to practice revoked or suspended by any state licensing agency;
- (b) where applicable to their practice, have a current, unrestricted DEA registration;
- (c) be available on a continuous basis, either personally or by arranging appropriate coverage, to (i) respond to the needs of any of their patients who have been admitted to the Hospital and (ii) respond to Emergency Department patients during those times when they are on call in a prompt, efficient, and conscientious manner. (“Appropriate coverage” means coverage by another credentialed practitioner with appropriate specialty-specific privileges as determined by the Credentials Committee.) Compliance with this eligibility requirement means that the practitioner must document that he or she is willing and able to:
 - (1) respond within 15 minutes, via phone, to an initial contact from the Hospital; and
 - (2) appear in person (or via technology-enabled direct communication and evaluation, i.e., telemedicine) to attend to a patient within 30 minutes of being requested to do so (or as otherwise required for a particular specialty as recommended by the MEC and approved by the Board);
- (d) have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Hospital;
- (e) have not been convicted of, or entered a plea of guilty or no contest to, Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil monetary penalties for the same;
- (f) have not been, and are not currently, excluded, precluded, or debarred from participation in Medicare, Medicaid, or other federal or state governmental health care program;
- (g) have not had Medical Staff appointment or clinical privileges denied, suspended, revoked, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct;
- (h) have not resigned Medical Staff appointment or relinquished privileges during a Medical Staff investigation or in exchange for not conducting such an investigation;
- (i) have not been convicted of, or entered a plea of guilty or no contest, to any felony; or to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, child abuse, elder abuse, or violence;

- (j) agree to personally fulfill all responsibilities regarding emergency service call coverage for their specialty or to obtain appropriate coverage (as determined by the Credentials Committee) by another member of the Medical Staff;
- (k) have or agree to make appropriate coverage arrangements (as determined by the Credentials Committee) with other members of the Medical Staff for those times when the individual will be unavailable;
- (l) demonstrate recent clinical activity in their primary area of practice during the last two years;
- (m) meet any current or future eligibility requirements that are applicable to the clinical privileges being sought;
- (n) if applying for privileges in an area that is covered by an exclusive contract, meet the specific requirements set forth in that contract;
- (o) document compliance with all applicable training and educational protocols as well as orientation requirements that may be adopted by the MEC or required by the Board, including, but not limited to, those involving electronic medical records, computerized physician order entry ("CPOE"), the privacy and security of protected health information, infection control, and patient safety;
- (p) document compliance with any health screening requirements (e.g., TB testing, mandatory flu vaccines, and infectious agent exposures);
- (q) have successfully completed:
 - (1) a residency or fellowship training program approved by the Accreditation Council for Graduate Medical Education ("ACGME"), the American Osteopathic Association ("AOA"), or the Canadian equivalent in the specialty in which the applicant seeks clinical privileges;
 - (2) a dental or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association ("ADA"); or
 - (3) a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association;
- (r) be certified in their primary area of practice at the Hospital by the appropriate specialty/subspecialty board of the American Board of Medical Specialties ("ABMS"), the AOA, the Royal College of Physicians or Surgeons of Canada, the American Board of Oral and Maxillofacial Surgery, the ADA, or the American Board of Podiatric Surgery, as applicable. Those applicants who are not board certified at the time of application but who have completed their residency or fellowship training within the last five years shall be eligible for Medical Staff appointment. However, in order to remain eligible, those applicants must achieve board certification in their primary area of practice within five years from the date of completion of their residency or fellowship training;* and
- (s) maintain board certification in their primary area of practice at the Hospital on a continuous basis, and satisfy all requirements of the relevant specialty/subspecialty board necessary to do so (board certification status will be assessed at reappointment).*

- * The requirements pertaining to board certification are applicable to those individuals who apply for initial staff appointment after September 20, 2006 and are not applicable to Medical Staff members who were appointed prior to the adoption date of these Bylaws. Those Medical Staff members shall be grandfathered and shall be governed by any board certification and residency training requirements that may have been in effect at the time of their initial appointments.

In addition, in exceptional circumstances, the five-year time frame for initial applicants and the time frame for recertification by existing members may be extended for one additional period not to exceed two years in order to permit an individual an additional opportunity to obtain certification. In order to be eligible to request an extension in these situations, an individual must, at a minimum, satisfy the following criteria:

- (1) the individual has been on the Hospital's Medical Staff for at least two full years;
- (2) there have been no significant documented peer review concerns related to the individual's competence or behavior at the Hospital during the individual's tenure;
- (3) the individual provides a letter from the appropriate certifying board confirming that the individual remains eligible to take the certification examination within the next two years; and
- (4) the appropriate department chair at the Hospital provides a favorable report concerning the individual's qualifications.

2.A.2. Waiver of Threshold Eligibility Criteria:

- (a) Any applicant who does not satisfy one or more of the threshold eligibility criteria outlined above may request that it be waived. The applicant requesting the waiver bears the burden of demonstrating (i) that he/she is otherwise qualified, and (ii) exceptional circumstances exist (e.g., when there is a demonstrated Hospital or Medical Staff need for the services in question). Exceptional circumstances generally do not include situations where a waiver is sought for the convenience of an applicant (e.g., applicants who wish to defer taking Board examinations).
- (b) A request for a waiver shall be submitted to the Credentials Committee for consideration. In reviewing the request for a waiver, the Credentials Committee may consider the specific qualifications of the applicant in question, input from the relevant department chair, and the best interests of the Hospital and the communities it serves. Additionally, the Credentials Committee may, in its discretion, consider the application form and other information supplied by the applicant. The Credentials Committee's recommendation will be forwarded to the MEC. Any recommendation to grant a waiver must include the specific basis for the recommendation.
- (c) The MEC shall review the recommendation of the Credentials Committee and make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the specific basis for the recommendation.
- (d) No applicant is entitled to a waiver or to a hearing if the Board determines not to grant a waiver. A determination that an applicant is not entitled to a waiver is not a "denial" of appointment or clinical privileges. Rather, that individual is ineligible to request appointment or clinical privileges. A determination of ineligibility is not a matter that is reportable to either the state board or the National Practitioner Data Bank.
- (e) The granting of a waiver in a particular case does not set a precedent for any other applicant or group of applicants.

- (f) If a waiver is granted that does not specifically include a time limitation, the waiver is considered to be permanent and the individual does not have to request a waiver at subsequent reappointment cycles.
- (g) An application for appointment that does not satisfy an eligibility criterion will not be processed until the Board has determined that a waiver should be granted.

2.A.3. Factors for Evaluation:

The six ACGME general competencies (patient care, medical knowledge, professionalism, system-based practice, practice-based learning, and interpersonal communications) will be evaluated as part of the appointment and reappointment processes, as reflected in the following factors:

- (a) relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, and clinical judgment, and an understanding of the contexts and systems within which care is provided;
- (b) adherence to the ethics of their profession, continuous professional development, an understanding of and sensitivity to diversity, and responsible attitude toward patients and their profession;
- (c) good reputation and character;
- (d) ability to safely and competently perform the clinical privileges requested;
- (e) ability to work harmoniously with others, including, but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families, and other members of health care teams; and
- (f) recognition of the importance of, and willingness to support, the Hospital's and Medical Staff's commitment to quality care and a recognition that interpersonal skills and collegiality are essential to the provision of quality patient care.

2.A.4. No Entitlement to Appointment:

No individual is entitled to receive an application or to be appointed or reappointed to the Medical Staff or to be granted particular clinical privileges merely because he or she:

- (a) is employed by the Hospital or its subsidiaries or has a contract with the Hospital;
- (b) is or is not a member or employee of any particular physician group;
- (c) is licensed to practice a profession in this or any other state;
- (d) is a member of any particular professional organization;
- (e) has had in the past, or currently has, Medical Staff appointment or privileges at any hospital or health care facility;
- (f) resides in the geographic service area of the Hospital; or

- (g) is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity.

2.A.5. Nondiscrimination:

No individual shall be denied appointment or reappointment on the basis of sex, race, religion, national origin, gender expression or identity, sexual orientation or any other status protected by applicable state or federal law.

2.B. GENERAL CONDITIONS OF APPOINTMENT AND REAPPOINTMENT

2.B.1. Basic Responsibilities and Requirements:

As a condition of being granted appointment or reappointment, and as a condition of ongoing membership, every member specifically agrees to the following:

- (a) to provide continuous and timely quality care to all patients for whom the individual has responsibility;
- (b) to abide by all Bylaws, policies, and Rules and Regulations of the Hospital and Medical Staff in force during the time the individual is appointed;
- (c) to participate in the orientation process and the initial evaluation process for new members of the Medical Staff as may be requested;
- (d) to abide by PeaceHealth's ethical policies;
- (e) to participate in Medical Staff affairs through committee service, participation in quality improvement and professional practice evaluation activities, or by performing such other reasonable duties and responsibilities as may be assigned;
- (f) to participate in Root Cause Analyses and serious safety event activities as may be requested by Medical Staff Leaders and Hospital administration;
- (g) within the scope of his or her privileges, to provide emergency service call coverage, consultations, and care for unassigned patients (a member must complete all scheduled emergency service call obligations or arrange appropriate coverage);
- (h) to comply with clinical practice or evidence-based medicine protocols that are established by, and must be reported to, regulatory or accrediting agencies or patient safety organizations, including those related to national patient safety initiatives and core measures, or clearly document the clinical reasons for variance;
- (i) to comply with clinical practice or evidence-based medicine protocols pertinent to his or her medical specialty, as may be adopted by the Medical Staff or the Medical Staff leadership, or to clearly document the clinical reasons for variance;
- (j) to comply with all applicable training and educational protocols as well as orientation requirements that may be adopted by the MEC or required by the Board, including, but not limited to, those involving electronic medical records, computerized physician order entry ("CPOE"), the privacy and security of protected health information, infection control, and patient safety;

- (k) to inform Medical Staff Services, in writing and within 10 days, of any change in the practitioner's status or any change in the information provided on the individual's application form. This information shall be provided with or without request, at the time the change occurs, and shall include, but not be limited to:
- any and all complaints regarding, or changes in, licensure status or DEA controlled substance authorization,
 - adverse changes in professional liability insurance coverage,
 - the filing of a professional liability lawsuit against the practitioner,
 - changes in the practitioner's status (appointment, privileges, and/or scope of practice) at any other hospital or health care entity as a result of peer review activities or in order to avoid initiation of peer review activities,
 - knowledge of a criminal investigation involving the individual, arrest, charge, indictment, conviction, or a plea of guilty or no contest in any criminal matter other than a misdemeanor traffic citation,
 - exclusion or preclusion from participation in Medicare/Medicaid or any sanctions imposed,
 - any changes in the practitioner's ability to safely and competently exercise clinical privileges or perform the duties and responsibilities of appointment or permission to practice because of health status issues, including, but not limited to, a physical, mental, or emotional condition that could adversely affect the practitioner's ability to practice safely and competently, or impairment due to addiction, alcohol use, or other similar issue (all of which shall be referred for review under the Practitioner Health Policy),
 - any referral to a state board health-related program, and
 - any charge of, or arrest for, driving under the influence ("DUI") (Any DUI incident will be forwarded for review under the Practitioner Health Policy.);
- (l) to meet with Medical Staff Leaders and/or Hospital administration upon request, provide information regarding professional qualifications upon written request, and otherwise participate in collegial efforts as may be requested;
- (m) to immediately submit to an appropriate evaluation, which may include diagnostic testing (including, but not limited to, a blood and/or urine test) and/or a complete physical, mental, and/or behavioral evaluation, if at least two Medical Staff Leaders (or one Medical Staff Leader and one member of the Administrative team) are concerned with the individual's ability to safely and competently care for patients. The health care professional(s) to perform the testing and/or evaluations shall be determined by the Medical Staff Leaders and the Medical Staff member must execute all appropriate releases to permit the sharing of information with the Medical Staff Leaders;
- (n) to appear for personal or phone interviews in regard to an application for initial appointment or reappointment, if requested;

- (o) to maintain and monitor a current e-mail address with Medical Staff Services, which will be the primary mechanism used to communicate all Medical Staff information to the member;
- (p) to provide valid contact information in order to facilitate practitioner-to-practitioner communication (e.g., mobile phone number or valid answering service information);
- (q) to not engage in illegal fee splitting or other illegal inducements relating to patient referral;
- (r) to not delegate responsibility for hospitalized patients to any individual who is not qualified or adequately supervised;
- (s) to wear proper Hospital identification with name and status and to avoid deceiving patients as to the identity or clinical specialty of any individual providing treatment or services;
- (t) to seek consultation whenever required or necessary, and when responding to a request for a consultation, to personally see the patient and perform the requested consultation in accordance with the time frames set forth in the Medical Staff Rules and Regulations;
- (u) to complete in a timely and legible manner all medical and other required records, containing all information required by the Hospital, and to utilize the electronic medical record as required;
- (v) to cooperate with all utilization oversight activities;
- (w) to participate in an Organized Health Care Arrangement with the Hospital and abide by the terms of the Hospital's Notice of Privacy Practices with respect to health care delivered in the Hospital;
- (x) to perform all services and conduct himself/herself at all times in a cooperative and professional manner;
- (y) to promptly pay any applicable dues, assessments, and/or fines;
- (z) to satisfy continuing medical education requirements; and
- (aa) that, if there is any misstatement in, or omission from, the application, the Hospital may stop processing the application (or, if appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished). In either situation, there shall be no entitlement to a hearing or appeal. The individual will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response for the Credentials Committee's consideration. If the determination is made to not process an application or that appointment and privileges should be automatically relinquished pursuant to this provision, the individual may not reapply to the Medical Staff for a period of at least two years.

2.B.2. Burden of Providing Information:

- (a) Individuals seeking appointment and reappointment have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, character, ethics, and other qualifications and for resolving any doubts about an individual's qualifications. The information to be produced includes such quality data and other information as may be needed to assist in an appropriate assessment of overall qualifications for appointment, reappointment, and current clinical competence for any requested clinical privileges, including, but not limited to, information from other hospitals, information from the individual's office practice, information from insurers or managed care organizations in which the individual

participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians.

- (b) Individuals seeking appointment and reappointment have the burden of providing evidence that all the statements made and information given on the application are accurate and complete.
- (c) Complete Application: An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, all information has been verified from primary sources, and any required application fees and applicable fines have been paid. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time during the credentialing process. Any application that continues to be incomplete 30 days after the individual has been notified of the additional information required shall be deemed to be withdrawn.
- (d) The individual seeking appointment or reappointment is responsible for providing a complete application, including adequate responses from references. An incomplete application shall not be processed.

2.C. APPLICATION

2.C.1. Information:

- (a) Applications for appointment and reappointment shall contain a request for specific clinical privileges and shall require detailed information concerning the individual's professional qualifications. The applications for initial appointment and reappointment existing now and as may be revised are incorporated by reference and made a part of this Policy.
- (b) In addition to other information, the applications shall seek the following:
 - (1) information as to whether the applicant's medical staff appointment or clinical privileges have been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, subjected to probationary or other conditions, reduced, limited, terminated, or not renewed at any other hospital, health care facility, or other organization, or are currently being investigated or challenged;
 - (2) information as to whether the applicant's license to practice any relevant profession in any state, DEA registration, or any state's controlled substance license has been voluntarily or involuntarily suspended, modified, terminated, restricted, or relinquished or is currently being investigated or challenged;
 - (3) information concerning the applicant's professional liability litigation experience, including past and pending claims, final judgments, or settlements; the substance of the allegations as well as the findings and the ultimate disposition; and any additional information concerning such proceedings or actions as the Credentials Committee, the MEC, or the Board may request;
 - (4) current information regarding the applicant's ability to safely and competently exercise the clinical privileges requested; and
 - (5) a copy of a government-issued photo identification.
- (c) The applicant shall sign the application and certify that he or she is able to perform the privileges requested and the responsibilities of appointment.

2.C.2. Grant of Immunity and Authorization to Obtain/Release Information:

By requesting an application and/or applying for appointment, reappointment, or clinical privileges, the individual expressly accepts the conditions set forth in this Section:

(a) Immunity:

To the fullest extent permitted by law, the individual releases from any and all liability, extends immunity to, and agrees not to sue the Hospital or the Board, any member of the Medical Staff or the Board, their authorized representatives, and third parties who provide information for any matter relating to appointment, reappointment, clinical privileges, or the individual's qualifications for the same. This immunity covers any actions, recommendations, reports, statements, communications, and/or disclosures involving the individual that are made, taken, or received by the Hospital, its authorized agents, or third parties in the course of credentialing and peer review activities.

(b) Authorization to Obtain Information from Third Parties:

The individual specifically authorizes the Hospital, Medical Staff Leaders, and their authorized representatives (1) to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on his or her qualifications for initial and continued appointment to the Medical Staff, and (2) to obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of third parties that may be relevant to such questions. The individual also specifically authorizes third parties to release this information to the Hospital and its authorized representatives upon request. Further, the individual agrees to sign necessary consent forms to permit a consumer reporting agency to conduct a criminal background check on the individual and report the results to the Hospital.

(c) Authorization to Release Information to Third Parties:

The individual also authorizes Hospital representatives to release information to other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their agents when information is requested in order to evaluate his or her professional qualifications for appointment, privileges, and/or participation at the requesting organization/facility, and any licensure or regulatory matter.

(d) Authorization to Share Information Among PeaceHealth Entities:

The individual specifically authorizes PeaceHealth Entities (as defined below) to share credentialing, peer review, and other information and documentation pertaining to the individual's clinical competence, professional conduct and health. This information and documentation may be shared at any time, including, but not limited to, any initial evaluation of an individual's qualifications, any periodic reassessment of those qualifications, or when a question is raised about the individual. For purposes of this Section, a PeaceHealth Entity means:

- (i) any entity which, directly or indirectly, through one or more intermediaries, is controlled by PeaceHealth. This includes, but is not limited to, PeaceHealth hospitals, ambulatory surgery centers, and PeaceHealth affiliated physician groups. It also includes a joint venture in which PeaceHealth has an interest of 50 percent or more; and

(ii) any physician group not included in subsection (i) that has contracted with PeaceHealth or a PeaceHealth Entity to provide patient care services, provided:

(A) the physician group has a formal professional practice evaluation/peer review process, as evidenced by internal bylaws or policy; and

(B) the physician group has appropriate information sharing provisions consistent with this Policy either in a professional services contract or in a separate agreement with PeaceHealth or a PeaceHealth Entity consistent with this Policy.

(e) Hearing and Appeal Procedures:

The individual agrees that the hearing and appeal procedures set forth in this Policy are the sole and exclusive remedy with respect to any professional review action taken by the Hospital.

(f) Legal Actions:

If, despite this Section, an individual institutes legal action challenging any credentialing, privileging, peer review, or other action affecting appointment or privileges and does not prevail, he or she shall reimburse the Hospital and any member of the Medical Staff or Board involved in the action for all costs incurred in defending such legal action, including reasonable attorney's fees, expert witness fees, and lost revenues.

(g) Scope of Section:

All of the provisions in this Section 2.C.2 are applicable in the following situations:

(1) whether or not appointment or clinical privileges are granted;

(2) throughout the term of any appointment or reappointment period and thereafter;

(3) should appointment, reappointment, or clinical privileges be revoked, reduced, restricted, suspended, and/or otherwise affected as part of the Hospital's professional review activities; and

(4) as applicable, to any third-party inquiries received after the individual leaves the Medical Staff about his/her tenure as a member of the Medical Staff.

ARTICLE 3

PROCEDURE FOR INITIAL APPOINTMENT

3.A. PROCEDURE FOR INITIAL APPOINTMENT

3.A.1. Request for Application:

- (a) Applications for appointment shall be on approved forms.
- (b) An individual seeking initial appointment will be sent information that (i) outlines the threshold eligibility criteria for appointment outlined earlier in this Policy, (ii) outlines the applicable criteria for the clinical privileges being sought, and (iii) encloses the application form.
- (c) Applications may be provided to residents or fellows who are in the final six months of their training. Such applications may be processed, but final action on the applications shall not be taken until all applicable threshold eligibility criteria are satisfied.

3.A.2. Initial Review of Application:

- (a) A completed application form with copies of all required documents must be returned to the PeaceHealth Credentials Verification Office (“PHCVO”) accompanied by any required application fee.
- (b) As a preliminary step, the application shall be reviewed by the PHCVO and/or Medical Staff Services to determine that all questions have been answered and that the individual satisfies all threshold eligibility criteria. Incomplete applications shall not be processed. Individuals who fail to return completed applications or fail to meet the threshold eligibility criteria shall be notified that their applications shall not be processed. A determination of ineligibility does not entitle the individual to the hearing and appeal rights outlined in this Policy.
- (c) The PHCVO and/or Medical Staff Services shall oversee the process of gathering and verifying relevant information, and confirming that all references and other information or materials deemed pertinent have been received.

3.A.3. Steps to Be Followed for All Initial Applicants:

- (a) Evidence of the applicant’s character, professional competence, qualifications, behavior, and ethical standing shall be examined. This information may be contained in the application, and obtained from peer references and from other available sources in accordance with the PeaceHealth System Credentials Policy, including the applicant’s past or current department chairs at other health care entities, residency training director, and others who may have knowledge about the applicant’s education, training, experience, and ability to work with others.
- (b) An interview(s) with the applicant may be conducted. The purpose of the interview is to discuss and review any aspect of the applicant’s application, qualifications, and requested clinical privileges. This interview may be conducted by a combination of any of the following: the department chair, the Credentials Committee, a Credentials Committee representative, the MEC, the Chief of Staff, the CMO, and/or the CAO.

3.A.4. Department Chair Procedure:

- (a) Medical Staff Services shall transmit the complete application and all supporting materials to the chair of each department in which the applicant seeks clinical privileges. The department chair shall prepare a written report regarding whether the applicant has satisfied all of the qualifications for appointment and the clinical privileges requested on a form provided by Medical Staff Services.
- (b) The department chair shall be available to the Credentials Committee, the MEC, and the Board to answer any questions that may be raised with respect to the report and findings of that individual.

3.A.5. Credentials Committee Procedure:

- (a) The Credentials Committee shall review and consider the report prepared by the relevant department chair and shall make a recommendation.
- (b) The Credentials Committee may use the expertise of the department chair or any member of the department, or an outside consultant, if additional information is required regarding the applicant's qualifications.
- (c) After determining that an applicant is otherwise qualified for appointment and privileges, the Credentials Committee may require the applicant to undergo a physical, mental, and/or behavioral examination by a physician(s) satisfactory to the Credentials Committee or may request that the individual complete a separate Health Status Confirmation form if there is any question about the applicant's ability to perform the privileges requested and the responsibilities of appointment. The results of any examination shall be made available to the Committee for its consideration. Failure of an applicant to undergo an examination or complete a Health Status Confirmation form within a reasonable time after being requested to do so in writing by the Credentials Committee shall be considered a voluntary withdrawal of the application and all processing of the application shall cease. The cost of the health assessment will be borne by the applicant.
- (d) The Credentials Committee may recommend specific conditions on Medical Staff appointment and/or clinical privileges. These conditions may relate to behavior (e.g., personal code of conduct) or to clinical issues (e.g., general consultation requirements, appropriate documentation requirements, proctoring, completion of CME requirements). The Credentials Committee may also recommend that appointment be granted for a period of less than two years in order to permit closer monitoring of an individual's compliance with any conditions. Unless these matters involve the specific recommendations set forth in Section 7.A.1(a) of this Policy, such conditions do not entitle an individual to request the procedural rights set forth in Article 7 of this Policy.

3.A.6. MEC Recommendation:

- (a) At its next regular meeting after receipt of the written findings and recommendation of the Credentials Committee, the MEC shall:
 - (1) adopt the findings and recommendation of the Credentials Committee, as its own; or
 - (2) refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the MEC prior to its final recommendation; or

- (3) state its reasons in its report and recommendation, along with supporting information, for its disagreement with the Credentials Committee's recommendation.
- (b) If the recommendation of the MEC is to appoint, the recommendation shall be forwarded to the Board.
- (c) If the recommendation of the MEC is unfavorable and would entitle the applicant to request a hearing in accordance with Section 7.A.1(a) of this Policy, the MEC shall forward its recommendation to the CAO, who shall promptly send Special Notice to the applicant. The CAO shall then hold the application until after the applicant has completed or waived a hearing and appeal.

3.A.7. Board Action:

- (a) Upon receipt of a recommendation that the applicant be granted appointment and clinical privileges, the Board, or its designated committee, may:
 - (1) appoint the applicant and grant clinical privileges as recommended; or
 - (2) refer the matter back to the Credentials Committee or MEC or to another source inside or outside the Hospital for additional research or information; or
 - (3) reject or modify the recommendation.
- (b) If the Board determines to reject a favorable recommendation, it should first discuss the matter with the Chair of the Credentials Committee and the Chair of the MEC. If the Board's determination remains unfavorable to the applicant, the CAO shall promptly send Special Notice to the applicant that the applicant is entitled to request a hearing.
- (c) Any final decision by the Board to grant, deny, revise or revoke appointment and/or clinical privileges will be disseminated to appropriate individuals and, as required, reported to appropriate entities.

3.A.8. Time Periods for Processing:

Once an application is deemed complete, it is expected to be processed within 90 business days, unless it becomes incomplete. This time period is intended to be a guideline only and shall not create any right for the applicant to have the application processed within this precise time period.

ARTICLE 4

CLINICAL PRIVILEGES

4.A. CLINICAL PRIVILEGES

4.A.1. General:

- (a) Appointment or reappointment shall not confer any clinical privileges or right to admit or treat patients at the Hospital. Each individual who has been appointed to the Medical Staff is entitled to exercise only those clinical privileges specifically granted by the Board.
- (b) For privilege requests to be processed, the applicant must satisfy any applicable threshold eligibility criteria.
- (c) Requests for clinical privileges that are subject to an exclusive contract will not be processed except as consistent with the contract.
- (d) Requests for clinical privileges that have been grouped into core privileges will not be processed unless the individual has applied for the full core and satisfied all threshold eligibility criteria (or has obtained a waiver in accordance with Section 4.A.2).
- (e) The clinical privileges recommended to the Board shall be based upon consideration of the following factors:
 - (1) education, relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal and communication skills, and professionalism with patients, families, and other members of the health care team and peer evaluations relating to these criteria;
 - (2) appropriateness of utilization patterns;
 - (3) ability to perform the privileges requested competently and safely;
 - (4) information resulting from ongoing and focused professional practice evaluation and other performance improvement activities, as applicable;
 - (5) availability of other qualified staff members with appropriate privileges (as determined by the Credentials Committee) to provide coverage in case of the applicant's illness or unavailability;
 - (6) adequate professional liability insurance coverage for the clinical privileges requested;
 - (7) the Hospital's available resources and personnel;
 - (8) any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration;
 - (9) any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another hospital;

- (10) practitioner-specific data as compared to aggregate data, when available;
 - (11) morbidity and mortality data related to the specific individual, and when statistically and qualitatively significant and meaningful, when available; and
 - (12) professional liability actions, especially any such actions that reflect an unusual pattern or excessive number of actions.
- (f) Core privileges, special privileges, privilege delineations, and/or the criteria for the same shall be developed by the relevant department chair and shall be forwarded to the Credentials Committee for review and recommendation. The Credentials Committee will forward its recommendations to the MEC, which will review the matter and forward its recommendations to the Board for final action.
 - (g) The applicant has the burden of establishing his or her qualifications and current competence for all clinical privileges requested.
 - (h) The report of the chair of the clinical department in which privileges are sought shall be forwarded to the Chair of the Credentials Committee and processed as a part of the initial application for staff appointment.

4.A.2. Privilege Modifications and Waivers:

- (a) Scope. This Section applies to all requests for modification of clinical privileges during the term of appointment (increases and relinquishments), resignation from the Medical Staff, and waivers related to eligibility criteria for privileges or the scope of those privileges.
- (b) Submitting a Request. Requests for privilege modifications, waivers, and resignations must be submitted in writing or electronically to Medical Staff Services.
- (c) Increased Privileges.
 - (1) Requests for increased privileges must state the specific additional clinical privileges requested and provide information sufficient to establish eligibility, as specified in applicable criteria, and current clinical competence.
 - (2) If the individual is eligible and the application is complete, it will be processed in the same manner as an application for initial clinical privileges.
- (d) Waivers.
 - (1) Any individual who does not satisfy one or more eligibility criteria for clinical privileges may request that it be waived. The individual requesting the waiver bears the burden of demonstrating **exceptional** circumstances, and that his or her qualifications are equivalent to, or exceed, the criterion in question.
 - (2) If the individual is requesting a waiver of the requirement that each member apply for the full core of privileges in his or her specialty, the process set forth in this paragraph shall apply.
 - (i) Formal Request: The individual must forward a written or electronic request to Medical Staff Services, which must indicate the specific patient care services

within the core that the member does not wish to provide, state a good cause basis for the request, and include evidence that the individual does not provide the patient care services at issue in any health care facility.

- (ii) On-Call Obligations: By applying for a waiver related to limiting the scope of core privileges, the individual nevertheless agrees to participate in the general on-call schedule for the relevant specialty and to maintain sufficient competency to assist other physicians on the Medical Staff in assessing and stabilizing patients who require services within that specialty, if this call responsibility is required by the Medical Staff leadership after review of the specific circumstances involved. If, upon assessment, a patient needs a service that is no longer provided by the individual pursuant to the waiver, the individual shall work cooperatively with the other physicians in arranging for another individual with appropriate clinical privileges to care for the patient or, if such an individual is not available, in arranging for the patient's transfer.
- (iii) Review Process: A request for a waiver shall be submitted to the Credentials Committee for consideration. In reviewing the request for a waiver, the Credentials Committee shall specifically consider the factors outlined in Paragraph (f) below and may obtain input from the relevant department chair. The Credentials Committee's recommendation will be forwarded to the MEC, which shall review the recommendation of the Credentials Committee and make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the specific basis for the recommendation.

(e) Relinquishment and Resignation of Privileges.

- (1) Relinquishment of Individual Privileges. A request to relinquish any individual clinical privilege, whether or not part of the core, must provide a good cause basis for the modification of privileges. All such requests will be processed in the same manner as a request for waiver, as described above.
- (2) Resignation of Appointment and Privileges. A request to resign Medical Staff appointment and relinquish all clinical privileges must specify the desired date of resignation, which must be at least 30 days from the date of the request, and be accompanied by evidence that the individual will be able to accomplish the following by the specified end date:
 - (i) completion of all medical records;
 - (ii) appropriate discharge or transfer of responsibility for the care of any hospitalized patient who is under the individual's care at the time of resignation; and
 - (iii) completion of scheduled emergency service call or formal arrangement for appropriate coverage to satisfy this responsibility.

After consulting with the Chief of Staff, the CMO or CAO will act on the resignation request with a report on the matter forwarded to the MEC.

- (f) Factors for Consideration. The Medical Staff Leaders and Board may consider the following factors, among others, when deciding whether to recommend or grant a modification (increases and/or relinquishments) or waiver related to privileges:
- (1) the Hospital's mission and ability to serve the health care needs of the community by providing timely, appropriate care within its facilities;
 - (2) whether sufficient notice has been given to provide a smooth transition of patient care services;
 - (3) fairness to the individual requesting the modification or waiver, including past service and the other demands placed upon the individual;
 - (4) fairness to other Medical Staff members who serve on the call roster in the relevant specialty, including the effect that the modification would have on them;
 - (5) the expectations of other members of the Medical Staff who are in different specialties but who rely on the specialty in question in the care of patients who present to the Hospital;
 - (6) any perceived inequities in modifications or waivers being provided to some, but not others;
 - (7) any gaps in call coverage that might/would result from an individual's removal from the call roster for the relevant privilege and the feasibility and safety of transferring patients to other facilities in that situation; and
 - (8) how the request may affect the Hospital's ability to comply with applicable regulatory requirements, including the Emergency Medical Treatment and Active Labor Act.
- (g) Effective Date. If the Board grants a modification or waiver related to privileges, it shall specify the date that the modification or waiver will be effective. Failure of a member to request privilege modifications or waivers in accordance with this Section shall, as applicable, result in the member retaining Medical Staff appointment and clinical privileges and all associated responsibilities.
- (h) Procedural Rights. No individual is entitled to a modification or waiver related to privileges. Individuals are also not entitled to a hearing or appeal or other process if a waiver or a modification related to a relinquishment of privileges is not granted.

4.A.3. Clinical Privileges for New Procedures:

- (a) Requests for clinical privileges to perform either a procedure not currently being performed at the Hospital or a new technique to perform an existing procedure (hereafter, "new procedure") shall not be processed until (1) a determination has been made that the procedure shall be offered by the Hospital and (2) criteria to be eligible to request those clinical privileges have been established as set forth in this Section.
- (b) As an initial step in the process, the individual seeking to perform the new procedure will prepare and submit a report to Medical Staff Services addressing the following:
 - (1) appropriate education, training, and experience necessary to perform the new procedure safely and competently;

- (2) clinical indications for when the new procedure is appropriate;
- (3) whether there is empirical evidence of improved patient outcomes with the new procedure or other clinical benefits to patients;
- (4) whether proficiency for the new procedure is volume-sensitive and if the requisite volume would be available;
- (5) whether the new procedure is being performed at other similar hospitals and the experiences of those institutions; and
- (6) whether the Hospital currently has the resources, including space, equipment, personnel, and other support services, to safely and effectively perform the new procedure.

Hospital administration and/or the Health Technology Assessment Committee (or functional equivalent and only where applicable) shall review this report and consult with the Chief of Staff, the department chair, and the Credentials Committee (any of which may conduct additional research as may be necessary) and shall make a preliminary determination as to whether the new procedure should be offered to the community.

- (c) If the preliminary determination of the Hospital is favorable, the Credentials Committee will determine whether the request constitutes a “new procedure” as defined by this Section or if, instead, it is an extension of an existing privilege. If it is determined that it does constitute a “new procedure,” the Credentials Committee will then develop threshold credentialing criteria to determine those individuals who are eligible to request the clinical privileges at the Hospital. In developing the criteria, the Credentials Committee may conduct additional research and consult with experts, as necessary, and develop recommendations regarding:
 - (1) the appropriate education, training, and experience necessary to perform the procedure or service;
 - (2) the clinical indications for when the procedure or service is appropriate;
 - (3) the manner of addressing the most common complications that arise in the performance of the new procedure;
 - (4) the extent (time frame and mechanism) of focused monitoring and supervision that should occur if the privileges are granted in order to confirm competence; and
 - (5) the manner in which the procedure would be reviewed as part of the Hospital’s ongoing and focused professional practice evaluation activities.
- (d) The Credentials Committee will forward its recommendations to the MEC, which will review the matter and forward its recommendations to the Board for final action.
- (e) The Board will make a reasonable effort to render the final decision within 60 days of receipt of the MEC’s recommendation. If the Board determines to offer the procedure or service, it will then establish the minimum threshold qualifications that an individual must demonstrate in order to be eligible to request the clinical privileges in question.

- (f) Once the foregoing steps are completed, specific requests from eligible Medical Staff members who wish to perform the procedure or service may be processed.

4.A.4. Clinical Privileges That Cross Specialty Lines:

- (a) Requests for clinical privileges that previously at the Hospital have been exercised only by individuals from another specialty shall not be processed until the steps outlined in this Section have been completed and a determination has been made regarding the individual's eligibility to request the clinical privileges in question.
- (b) As an initial step in the process, the individual seeking the privilege will prepare and submit a report to the Credentials Committee that specifies the minimum qualifications needed to perform the procedure safely and competently, whether the individual's specialty is performing the privilege at other similar hospitals, and the experiences of those other hospitals in terms of patient care outcomes and quality of care.
- (c) The Credentials Committee shall then conduct additional research and consult with experts, as necessary, including those on the Medical Staff (e.g., department chairs, individuals on the Medical Staff with special interest and/or expertise) and those outside the Hospital (e.g., other hospitals, residency training programs, specialty societies).
- (d) The Credentials Committee may or may not recommend that individuals from different specialties be permitted to request the privileges at issue. If it does, the Committee may develop recommendations regarding:
 - (1) the appropriate education, training, and experience necessary to perform the clinical privileges in question;
 - (2) the clinical indications for when the procedure is appropriate;
 - (3) the manner of addressing the most common complications that arise which may be outside of the scope of the clinical privileges that have been granted to the requesting individual;
 - (4) the extent (time frame and mechanism) of focused monitoring and supervision that should occur if the privileges are granted in order to confirm competence;
 - (5) the manner in which the procedure would be reviewed as part of the Hospital's ongoing and focused professional practice evaluation activities (which may include assessment of both long-term and short-term outcomes for all relevant specialties); and
 - (6) the impact, if any, on emergency call responsibilities.
- (e) The Credentials Committee shall forward its recommendations to the MEC, which shall review the matter and forward its recommendations to the Board for final action. The Board shall make a reasonable effort to render the final decision within 60 days of receipt of the MEC's recommendation.
- (f) Once the foregoing steps are completed, specific requests from eligible Medical Staff members who wish to exercise the privileges in question may be processed.

4.A.5. Clinical Privileges for Dentists:

- (a) For any patient who meets the classification of ASA 1 (normal, healthy patients) or ASA 2 (patients with mild systemic disease with no functional limitations), dentists may admit such patients, perform a complete admission history and physical examination, and assess the medical risks of any surgical procedure to be performed or the medical management of the patient's condition, if they are deemed qualified to do so by the Credentials Committee and MEC. They must, nevertheless, have a relationship with a physician on the Medical Staff (established and declared in advance) who is available to respond and become involved with that individual's care should any medical issue arise with the patient that is outside of their scope of practice.
- (b) For any patient who meets ASA 3 or 4 classifications, a medical history and physical examination of the patient shall be made and recorded by a physician who is a member of the Medical Staff before dental surgery may be performed. In addition, a designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization.
- (c) The dentist shall be responsible for the oral surgery care of the patient, including the appropriate history and physical examination, as well as all other appropriate elements of the patient's record. Dentists may write orders within the scope of their licenses and consistent with relevant Hospital policies and rules and regulations.

4.A.6. Clinical Privileges for Podiatrists:

- (a) For any patient who meets the classification of ASA 1 (normal, healthy patients) or ASA 2 (patients with mild systemic disease with no functional limitations), podiatrists may admit such patients, perform a complete admission history and physical examination, and assess the medical risks of any surgical procedure to be performed or the medical management of the patient's condition, if they are deemed qualified to do so by the Credentials Committee and MEC. They must, nevertheless, have a relationship with a physician on the Medical Staff (established and declared in advance) who is available to respond and become involved with that individual's care should any medical issue arise with the patient that is outside of their scope of practice.
- (b) For any patient who meets ASA 3 or 4 classifications, a medical history and physical examination of the patient shall be made and recorded by a physician who is a member of the Medical Staff before podiatric surgery may be performed. In addition, a designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization.
- (c) The podiatrist shall be responsible for the podiatric surgery care of the patient, including the appropriate history and physical examination, as well as all other appropriate elements of the patient's record. Podiatrists may write orders within the scope of their licenses and consistent with relevant Hospital policies and rules and regulations.

4.A.7. Physicians in Training:

- (a) Physicians in residency training shall not hold appointments to the Medical Staff and shall not be granted clinical privileges. The program director, clinical faculty, and/or attending staff member shall be responsible for the direction and supervision of the on-site and/or day-to-day patient care activities of each trainee, who shall be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements, and/or training protocols approved by the Hospital and the MEC or their designee(s). The applicable program director shall be responsible for verifying and evaluating the qualifications of each physician in training.

- (b) A physician in training at the fellowship level may request clinical privileges in an area for which he or she has already completed residency training if he or she can demonstrate that all necessary eligibility criteria as set forth in this Policy have been met. Requests for privileges shall be reviewed in accordance with the initial credentialing process outlined in this Policy and, if granted, shall be subject to all relevant oversight provisions, including ongoing and focused professional practice evaluation. Physicians in training at the fellowship level may not be granted clinical privileges in the specialty area in which they are currently in training as part of their fellowship.

4.A.8. Telemedicine Privileges:

- (a) Qualified individuals may be granted telemedicine privileges, but shall not be appointed to the Medical Staff.
- (b) Requests for initial or renewed telemedicine privileges shall be processed through one of the options set forth below, as determined by the CAO and/or CMO, in consultation with the Chief of Staff. Additional guidance regarding telemedicine privileges is found in the System Credentials Policy.
 - (1) A request for telemedicine privileges may be processed through the same process for Medical Staff applications, as set forth in this Policy. In such case, the individual must satisfy all qualifications and requirements set forth in this Policy, except those relating to geographic location, coverage arrangements, and emergency call responsibilities.
 - (2) If the individual requesting telemedicine privileges has been granted the same privileges at a distant hospital that participates in Medicare or a telemedicine entity (as that term is defined by Medicare), a request for telemedicine privileges may be processed using an abbreviated process that relies on the credentialing and privileging decisions made by the distant hospital or telemedicine entity. In such cases, the Hospital must ensure, through a written agreement, that the distant hospital or telemedicine entity will comply with all applicable Medicare regulations and accreditation standards. The distant hospital or telemedicine entity must provide:
 - (i) confirmation that the practitioner is licensed in Washington;
 - (ii) a current list of privileges granted to the practitioner; and
 - (iii) any other attestations or information required by the agreement or requested by the Hospital.

This information shall be provided to the MEC for review and recommendation to the Board for final action. Notwithstanding the process set forth in this subsection, the Hospital may determine that an applicant for telemedicine privileges is ineligible for appointment or clinical privileges if the applicant fails to satisfy the threshold eligibility criteria set forth in this Policy.

- (c) Telemedicine privileges, if granted, shall be for a period of not more than two years.
- (d) Individuals granted telemedicine privileges shall be subject to the Hospital's peer review activities. The results of the peer review activities, including any adverse events and complaints filed about the practitioner providing telemedicine services from patients, other practitioners or staff, will be shared with the hospital or entity providing telemedicine services.

- (e) Telemedicine privileges granted in conjunction with a contractual agreement shall be incident to and coterminous with the agreement.

4.B. TEMPORARY CLINICAL PRIVILEGES

4.B.1. Eligibility to Request Temporary Clinical Privileges:

- (a) Applicants. Temporary privileges for an applicant for initial appointment may be granted by the CAO or CMO under the following conditions:
 - (1) the applicant has submitted a complete application, along with any application fee;
 - (2) the verification process is complete, including verification of current licensure, relevant training or experience, current competence, ability to exercise the privileges requested, and current professional liability coverage; compliance with privileges criteria; and consideration of information from the National Practitioner Data Bank, from a criminal background check, and from OIG queries;
 - (3) the applicant demonstrates:
 - (i) successful completion of a residency and/or fellowship in the specialty for which privileges are requested, with no disciplinary actions taken or conditions imposed during residency or fellowship training;
 - (ii) all references contain favorable evaluations;
 - (iii) claims activity (including past malpractice claims, judgments and settlements) that is reasonable in light of the applicant's specialty, with no unusual pattern or excessive number of liability actions resulting in a judgment against the applicant;
 - (iv) no reports of disciplinary actions on licensure or registration; and
 - (v) no investigation into, and no disciplinary action taken, including but not limited to involuntary termination, limitation, restriction, reduction, probation, denial or loss of employment, medical staff appointment or clinical privileges at any hospital or other entity;
 - (4) the application is pending review by the MEC and the Board, following a favorable recommendation by the Chief of Staff and the Credentials Committee or its Chair, and after considering the evaluation of the department chair; and
 - (5) temporary privileges for a Medical Staff applicant will be granted for a maximum period of 120 consecutive days.
- (b) Important Patient Care Need. Temporary privileges may also be granted in other limited situations by the CAO or CMO when there is an important patient care, treatment, or service need.
 - (1) Important patient care need temporary privileges may be granted under the following circumstances:
 - (i) the care of a specific patient;

- (ii) when a consulting physician is needed, but is not available on the Medical Staff;
 - (iii) for a physician who is either proctoring a member of the Medical Staff or being proctored by another physician;
 - (iv) when necessary to prevent a lack or lapse of services in a needed specialty area; or
 - (v) to an individual serving as a locum tenens for a member of the Medical Staff who is on vacation, attending an educational seminar, or ill, and/or otherwise needs coverage assistance for a period of time.
- (2) The following factors will be considered and/or verified prior to the granting of temporary privileges in these situations: a favorable recommendation of the Chief of Staff and evaluation by the department chair, current licensure, current competence (verification of good standing in at least one hospital in which the individual practiced in the previous year), current professional liability coverage acceptable to the Hospital, and results of a query to the National Practitioner Data Bank, from a criminal background check, and from OIG queries.
- (3) In addition, the applicant must demonstrate:
- (i) successful completion of a residency and/or fellowship in the specialty for which privileges are requested, with no disciplinary actions taken or conditions imposed during residency or fellowship training;
 - (ii) all references contain favorable evaluations;
 - (iii) claims activity (including past malpractice claims, judgments and settlements) that is reasonable in light of the applicant's specialty, with no unusual pattern or excessive number of liability actions resulting in a judgment against the applicant;
 - (iv) no reports of disciplinary actions on licensure or registration; and
 - (v) no investigation into, and no disciplinary action taken, including but not limited to involuntary termination, limitation, restriction, reduction, probation, denial or loss of employment, medical staff appointment or clinical privileges at any hospital or other entity.
- (4) The grant of clinical privileges in these situations will not exceed 120 days. In exceptional situations, this period of time may be extended in the discretion of the CAO or CMO and the Chief of Staff.
- (c) Automatic Expiration. All grants of temporary privileges shall automatically expire upon the date specified at the time of initial granting unless further affirmative action is taken by the relevant department chair, the Chair of the Credentials Committee, the Chief of Staff, and the CMO or the CAO with approval of the Board to renew such temporary privileges.
- (d) Compliance with Bylaws and Policies. Prior to any temporary privileges being granted, the individual must agree in writing to be bound by the bylaws, rules and regulations, policies, procedures, and protocols of the Medical Staff and the Hospital.

4.B.2. Supervision Requirements:

Special requirements of supervision and reporting may be imposed on any individual granted temporary clinical privileges.

4.B.3. Withdrawal of Temporary Clinical Privileges:

- (a) The CAO or CMO may withdraw temporary admitting privileges at any time, after consulting with the Chief of Staff, the Chair of the Credentials Committee, or the department chair. Clinical privileges shall then expire as soon as patients have been discharged or alternate care has been arranged.
- (b) If the care or safety of patients might be endangered by continued treatment by the individual granted temporary privileges, the CAO, the department chair, the Chief of Staff, or the CMO may immediately withdraw all temporary privileges. The department chair or the Chief of Staff shall assign to another member of the Medical Staff responsibility for the care of such individual's patients until they are discharged or an appropriate transfer arranged. Whenever possible, consideration shall be given to the wishes of the patient in the selection of a substitute physician.

4.C. EMERGENCY SITUATIONS

- (1) For the purpose of this section, an "emergency" is defined as a condition which could result in serious or permanent harm to a patient(s) and in which any delay in administering treatment would add to that harm.
- (2) In an emergency situation, a member of the Medical Staff may administer treatment to the extent permitted by his or her license, regardless of department status or specific grant of clinical privileges.
- (3) When the emergency situation no longer exists, the patient shall be assigned by the department chair or the Chief of Staff to a member with appropriate clinical privileges, considering the wishes of the patient.

4.D. DISASTER PRIVILEGES

- (1) When the disaster plan has been implemented and the immediate needs of patients in the facility cannot be met, the CAO, the CMO, or the Chief of Staff may use a modified credentialing process to grant disaster privileges to eligible volunteer licensed independent practitioners ("volunteers"). Safeguards must be in place to verify that volunteers are competent to provide safe and adequate care.
- (2) Disaster privileges are granted on a case-by-case basis after verification of identity and licensure.
 - (a) A volunteer's identity may be verified through a valid government-issued photo identification (i.e., driver's license or passport).
 - (b) A volunteer's license may be verified in any of the following ways: (i) current Hospital picture ID card that clearly identifies the individual's professional designation; (ii) current license to practice; (iii) primary source verification of the license; (iv) identification indicating that the individual has been granted authority to render patient care in disaster circumstances or is a member of a Disaster Medical Assistance Team, the Medical Resource Corps, the Emergency System for Advance Registration of

Volunteer Health Professionals, or other recognized state or federal organizations or groups; or (v) identification by a current Hospital employee or Medical Staff member who possesses personal knowledge regarding the individual's ability to act as a volunteer during a disaster.

- (3) Primary source verification of a volunteer's license will begin as soon as the immediate situation is under control and must be completed within 72 hours from the time the volunteer begins to provide service at the Hospital.
- (4) In extraordinary circumstances when primary source verification cannot be completed within 72 hours, it should be completed as soon as possible. In these situations, there must be documentation of the following: (a) the reason primary source verification could not be performed in the required time frame; (b) evidence of the volunteer's demonstrated ability to continue to provide adequate care; and (c) an attempt to obtain primary source verification as soon as possible. If a volunteer has not provided care, then primary source verification is not required.
- (5) The Medical Staff will oversee the care provided by volunteer licensed independent practitioners. This oversight shall be conducted through direct observation, mentoring, clinical record review, or other appropriate mechanism developed by the Medical Staff and Hospital.

4.E. CONTRACTS FOR SERVICES

- (1) From time to time, the Hospital may enter into contracts with practitioners and/or groups of practitioners for the performance of clinical and administrative services at the Hospital. All individuals providing clinical services pursuant to such contracts will obtain and maintain clinical privileges at the Hospital, in accordance with the terms of this Policy.
- (2) To the extent that:
 - (a) any such contract confers the exclusive right to perform specified services to one or more practitioners or groups of practitioners, or
 - (b) the Board by resolution limits the practitioners who may exercise privileges in any clinical specialty to employees of the Hospital or its affiliates,no other practitioner except those authorized by or pursuant to the contract or resolution may exercise clinical privileges to perform the specified services while the contract or resolution is in effect. This means that only authorized practitioners are eligible to apply for appointment or reappointment to the Medical Staff and for the clinical privileges in question. No other applications will be processed.
- (3) Prior to the Hospital signing any exclusive contract and/or passing any Board resolution described in paragraph (2) in a specialty service and/or specialty area that has not previously been subject to such a contract or resolution, the Board will request the MEC's review of the matter. The MEC (or a subcommittee of its members appointed by the Chief of Staff) will review the quality of care and service implications of the proposed exclusive contract or Board resolution, and provide a report of its findings and recommendations to the Board within 30 days of the Board's request. As part of its review, the MEC (or subcommittee) may obtain relevant information concerning quality of care and service matters from (i) members of the applicable specialty involved, (ii) members of other specialties who directly utilize or rely on the specialty in question, and (iii) Hospital administration. However, the actual terms of any such exclusive arrangement or employment contract, and any financial information related to them, including

but not limited to the remuneration to be paid to Medical Staff members who may be a party to the arrangement, are not relevant and shall neither be disclosed to the MEC nor discussed as part of the MEC's review. (Note: If more than one physician in a relevant specialty area will be affected by the determination of the Board, the following procedures will be coordinated to address all requested meetings in a combined and consolidated manner.)

- (4) After receiving the MEC's report, the Board shall determine whether or not to proceed with the exclusive contract or Board resolution. If the Board determines to do so, and if that determination would have the effect of preventing an existing Medical Staff member from exercising clinical privileges that had previously been granted, the affected member is entitled to the following notice and review procedures:
 - (a) The affected member shall be given at least 30 days' advance notice of the anticipated effective date of the exclusive contract or Board resolution and shall have the right to meet with the Board or a committee designated by the Board to discuss the matter prior to the contract in question being signed by the Hospital or the Board resolution becoming effective. Any such meeting must be requested by the affected member and held within 30 days of the notice, unless this time frame is extended by mutual agreement.
 - (b) At the meeting, the affected member shall be entitled to present any information that he or she deems relevant to the Board's initial determination to enter into the exclusive contract or enact the resolution.
 - (c) If, following this meeting, the Board confirms its initial determination to enter into the exclusive contract or enact the Board resolution, the affected member shall be notified that he or she is ineligible to continue to exercise the clinical privileges covered by the exclusive contract or Board resolution. In that circumstance, the ineligibility begins as of the effective date of the exclusive contract or Board resolution and continues for as long as the contract or Board resolution is in effect.
 - (d) The affected member shall not be entitled to any procedural rights beyond those outlined above with respect to the Board's decision or the effect of the decision on his or her clinical privileges, notwithstanding the provisions in Article 7 of this Policy.
 - (e) The inability of a physician to exercise clinical privileges because of an exclusive contract or resolution is not a matter that requires a report to the state licensure board or to the National Practitioner Data Bank.
- (5) Except as provided in paragraph (1), in the event of any conflict between this Policy or the Medical Staff Bylaws and the terms of any contract, the terms of the contract shall control.

ARTICLE 5

PROCEDURE FOR REAPPOINTMENT

5.A. PROCEDURE FOR REAPPOINTMENT

All terms, conditions, requirements, and procedures relating to initial appointment shall apply to continued appointment and clinical privileges and to reappointment.

5.A.1. Eligibility for Reappointment:

To be eligible to apply for reappointment and renewal of clinical privileges, an individual must have, during the previous appointment term:

- (a) completed all medical records and be current at time of reappointment;
- (b) completed all continuing medical education requirements;
- (c) satisfied all Medical Staff responsibilities, including payment of dues, fines, and assessments;
- (d) continued to meet all qualifications and criteria for appointment and the clinical privileges requested, including those set forth in Section 2.A.1 of this Policy;
- (e) if applying for clinical privileges, had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. Any individual seeking reappointment who has minimal activity at the Hospital must submit such information as may be requested (such as a copy of his/her confidential quality profile from his/her primary hospital, clinical information from the individual's private office practice, and/or a quality profile from a managed care organization or insurer), before the application shall be considered complete and processed further; and
- (f) paid the reappointment processing fee, if any.

5.A.2. Factors for Evaluation:

In considering an individual's application for reappointment, the factors listed in Section 2.A.3 of this Policy will be considered. Additionally, the following factors may be evaluated as part of the reappointment process:

- (a) compliance with the Bylaws, rules and regulations, and policies of the Medical Staff and the Hospital;
- (b) participation in Medical Staff duties, including committee assignments, emergency call, consultation requests, quality of medical record documentation, cooperation with case management, participation in quality improvement, utilization activities, and professional practice evaluation activities, and such other reasonable duties and responsibilities as assigned;
- (c) the results of the Hospital's performance improvement and professional practice evaluation activities, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that, other practitioners will not be identified);

- (d) any focused professional practice evaluations;
- (e) verified complaints received from patients, families, and/or staff; and
- (f) other reasonable indicators of continuing qualifications.

5.A.3. Reappointment Application:

- (a) An application for reappointment shall be furnished to members approximately five months prior to the expiration of their current appointment term. A completed reappointment application must be returned to the PHCVO within 30 days.
- (b) Failure to return a completed application within 30 days may result in the assessment of a reappointment late fee, which must be paid prior to the application being processed. In addition, failure to submit a complete application at least two months prior to the expiration of the member's current term may result in the automatic expiration of appointment and clinical privileges at the end of the then current term of appointment unless the application can still be processed in the normal course, without extraordinary effort on the part of Medical Staff Services and the Medical Staff Leaders. If an individual's privileges lapse due to a processing delay, subsequent Board action may be to grant reappointment and renewal of clinical privileges using the filed application.
- (c) Reappointment shall be for a period of not more than two years.
- (d) The application shall be reviewed by Medical Staff Services to determine that all questions have been answered and that the individual satisfies all threshold eligibility criteria for reappointment and for the clinical privileges requested.
- (e) The PHCVO and/or Medical Staff Services shall oversee the process of gathering and verifying relevant information and shall also be responsible for confirming that all relevant information has been received.

5.A.4. Processing Applications for Reappointment:

- (a) Medical Staff Services shall forward the application to the relevant department chair and the application for reappointment shall be processed in a manner consistent with applications for initial appointment.
- (b) Additional information may be requested from the applicant if any questions or concerns are raised with the application or if new privileges are requested.

5.A.5. Conditional Reappointments:

- (a) Recommendations for reappointment and renewed privileges may be contingent upon an individual's compliance with certain specific conditions that have been recommended. These conditions may relate to behavior (e.g., personal code of conduct) or to clinical issues (e.g., focused assessment of quality outcomes, general consultation requirements, appropriate documentation requirements, including timely completion of medical records, proctoring, completion of CME requirements). Unless the conditions involve the matters set forth in Section 7.A.1(a) of this Policy, such conditions do not entitle an individual to request the procedural rights set forth in Article 7 of this Policy.

- (b) Reappointments may be recommended for periods of less than two years in order to permit closer monitoring of an individual's compliance with any conditions that have been recommended. A recommendation for reappointment for a period of less than two years does not, in and of itself, entitle an individual to the procedural rights set forth in Article 7.
- (c) In addition, in the event the applicant for reappointment is the subject of an unresolved professional practice evaluation concern, a formal investigation, or a hearing at the time reappointment is being considered, a conditional reappointment for a period of less than two years may be granted pending the completion of that process.

5.A.6. Potential Adverse Recommendation:

- (a) If the Credentials Committee and/or the MEC is considering a recommendation to deny reappointment or to reduce clinical privileges, the committee chair will notify the member of the possible recommendation and invite the member to meet prior to any final recommendation being made.
- (b) Prior to this meeting, the member will be notified of the general nature of the information supporting the recommendation contemplated.
- (c) At the meeting, the member will be invited to discuss, explain, or refute this information. A summary of the interview will be made and included with the committee's recommendation.
- (d) This meeting is not a hearing, and none of the procedural rules for hearings will apply. The member will not have the right to be accompanied by legal counsel at this meeting and no recording (audio or video) of the meeting shall be permitted or made.

5.A.7. Time Periods for Processing:

Once an application is deemed complete and verified, it is expected to be processed within 120 days, unless it becomes incomplete. This time period is intended to be a guideline only and shall not create any right for the applicant to have the application processed within this precise time period.

ARTICLE 6

QUESTIONS INVOLVING MEDICAL STAFF MEMBERS

6.A. COLLEGIAL EFFORTS AND PROGRESSIVE STEPS

- (1) This Policy encourages the use of collegial efforts and progressive steps by Medical Staff Leaders and Hospital management to address questions relating to an individual's clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised.
- (2) Collegial efforts and progressive steps include, but are not limited to:
 - (a) informal mentoring, coaching, or counseling by a Medical Staff Leader (e.g., advising an individual of policies regarding appropriate behavior, communication issues, emergency call obligations, or the timely and adequate completion of medical records);
 - (b) sharing comparative data, including any variations from clinical practice or evidence-based protocols or guidelines, in order to assist the individual with conforming his or her practice to appropriate norms;
 - (c) addressing minor performance issues through an Informational Letter;
 - (d) sending an Educational Letter that describes opportunities for improvement and provides guidance and suggestions;
 - (e) facilitating a formal Collegial Intervention (i.e., a planned, face-to-face meeting between an individual and one or more Medical Staff Leaders) in order to directly discuss a matter and the steps needed to be taken to resolve it; and
 - (f) developing a Performance Improvement Plan, which may include a wide variety of tools and techniques that can result in a constructive and successful resolution of the concern.
- (3) All of these efforts are fundamental and integral components of the Hospital's professional practice evaluation activities, and are confidential and protected in accordance with state law.
- (4) Copies of any formal documentation that is prepared by a Medical Staff Leader regarding such collegial efforts, including letters that follow a formal Collegial Intervention, will be included in an individual's confidential file. The individual shall have an opportunity to review any such documentation and respond in writing. The response shall be maintained in that individual's file along with the original documentation.
- (5) Collegial efforts and progressive steps are encouraged, but are not mandatory, may be taken in any order or skipped in whole or in part and shall be within the discretion of the appropriate Medical Staff Leaders and Hospital management. When a question arises, the Medical Staff and/or Hospital Leaders may:
 - (a) address it pursuant to the collegial efforts and progressive steps provisions of this Section;

- (b) refer the matter for review in accordance with the Professional Practice Evaluation Policy, Professionalism Policy, Practitioner Health Policy, and/or other relevant policy; or
 - (c) refer it to the MEC for its review and consideration in accordance with Section 6.D of this Article.
- (6) Should any recommendation be made or an action taken that entitles an individual to a hearing in accordance with this Policy, the individual is entitled to be accompanied by legal counsel at that hearing. However, Medical Staff members do not have the right to be accompanied by counsel when the Medical Staff Leaders and Hospital management are engaged in collegial efforts or other progressive steps. These efforts are intended to resolve issues in a constructive manner and do not involve the formal hearing process. In addition, there shall be no recording (audio or video) or transcript made of any meetings that involve collegial efforts or progressive steps activities.

6.B. PROFESSIONAL PRACTICE EVALUATION ACTIVITIES

Professional practice evaluation activities shall be conducted in accordance with the Professional Practice Evaluation Policy, the Professionalism Policy, the Practitioner Health Policy, and/or other relevant policy. Matters that are not satisfactorily resolved through collegial - efforts or through one of these policies shall be referred to the MEC for its review in accordance with Section 6.D below. Such interventions and evaluations, however, are not mandatory prerequisites to MEC review.

6.C. PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

6.C.1. Imminent Danger: Precautionary Suspension or Restriction/Requests to Voluntarily Refrain:

- (a) Whenever, in their sole discretion, failure to take such action may result in imminent danger to the health and/or safety of any individual, the MEC OR any Medical Staff Officer or chair of a clinical department, acting in conjunction with the CMO or the CAO, shall have the authority to proceed as follows:
 - (1) request that the individual agree to voluntarily refrain from exercising privileges pending further review of the circumstances; or
 - (2) if the individual is unwilling to voluntarily refrain from practicing pending further review, to suspend or restrict all or any portion of the individual's clinical privileges as a precaution.
- (b) The above actions can be taken at any time, including, but not limited to, immediately after the occurrence of an event that causes concern, following a pattern of occurrences that raises concern, or following a recommendation of the MEC that would entitle the individual to request a hearing.
- (c) Precautionary suspension or restriction, or an agreement to refrain, is an interim step in the professional review activity, but it 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, restriction, or agreement.
- (d) These actions shall become effective immediately, shall promptly be reported in writing to the CAO, the CMO, and the Chief of Staff, and shall remain in effect unless the action is modified by the CAO or MEC.

- (e) The individual in question shall be provided a letter via Special Notice that memorializes the individual's agreement to voluntarily refrain from practicing or the imposition of a precautionary suspension and terms related to the same. The correspondence shall also contain a brief written description of the reason(s) for the action, including the names and medical record numbers of the patient(s) involved (if any), within three days of the action.

6.C.2. MEC Review Process for Precautionary Suspensions or Restrictions:

- (a) The MEC shall review the matter resulting in a precautionary suspension or restriction within a reasonable time under the circumstances, not to exceed 14 days. As part of this review, the individual shall be given an opportunity to meet with the MEC. The individual may propose ways other than precautionary suspension or restriction to protect patients and/or employees, depending on the circumstances. Neither the MEC nor the individual shall be accompanied by legal counsel at this meeting, and no recording (audio or video) or transcript of the meeting shall be permitted or made; however, minutes of the meeting shall be prepared.
- (b) After considering the matters resulting in the suspension or restriction and the individual's response, if any, the MEC shall determine the appropriate next steps, which may include, but not be limited to, commencing a focused review or a formal investigation, or recommending some other action that is deemed appropriate under the circumstances. The MEC shall also determine whether the precautionary suspension or restriction should be continued, modified, or terminated pending the completion of the focused review or investigation (and hearing and appeal, if applicable).
- (c) There is no right to a hearing based on the imposition or continuation of a precautionary suspension or restriction.

6.C.3. Leadership Council Review Process for an Agreement to Voluntarily Refrain from Practicing:

- (a) The Leadership Council shall review the matter resulting in an individual's agreement to voluntarily refrain from exercising clinical privileges within a reasonable time under the circumstances, not to exceed 14 days. As part of this review, the individual shall be given an opportunity to meet with the Leadership Council. Neither the Leadership Council nor the individual shall be accompanied by legal counsel at this meeting, and no recording (audio or video) or transcript of the meeting shall be permitted or made; however, minutes of the meeting shall be prepared.
- (b) After considering the matter resulting in an individual's agreement to voluntarily refrain and the individual's response, if any, the Leadership Council shall determine the appropriate next steps, which may include, but not be limited to, commencing a focused review, referring the matter for review pursuant to another policy, referring the matter to the MEC with a recommendation to initiate a formal investigation, or to take some other action that is deemed appropriate under the circumstances. The Leadership Council shall also determine whether the agreement to voluntarily refrain from practicing should be continued throughout any further review process.
- (c) There is no right to a hearing based on an individual's agreement to voluntarily refrain from practicing in accordance with this Section.

6.C.4. Care of Patients:

- (a) Immediately upon the imposition of a precautionary suspension or restriction or an individual's agreement to voluntarily refrain from practicing, the department chair or the Chief of Staff shall assign to another individual with appropriate clinical privileges responsibility for care of the

individual's hospitalized patients, or to otherwise aid in implementing the precautionary suspension, restriction, or agreement to refrain from practicing, as appropriate. The assignment shall be effective until the patients are discharged. The wishes of the patient shall be considered in the selection of a covering physician.

- (b) All members of the Medical Staff have a duty to cooperate with the Chief of Staff, the department chair, the MEC, the CMO, and the CAO in enforcing precautionary suspensions, restrictions, or agreements to voluntarily refrain from practicing.

6.D. INVESTIGATIONS

6.D.1. Initial Review:

- (a) Where collegial efforts or actions under one or more of the policies referenced in this Article have not resolved an issue, and/or when there is a single instance of such severity that in the discretion of Medical Staff Leaders it requires further review, regarding:
 - (1) the clinical competence or clinical practice of any member of the Medical Staff, including the care, treatment or management of a patient or patients;
 - (2) the safety or proper care being provided to patients;
 - (3) the known or suspected violation by any member of the Medical Staff of applicable ethical standards or the Bylaws, rules and regulations, and policies of the Hospital or the Medical Staff; and/or
 - (4) conduct by any member of the Medical Staff 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 member to work harmoniously with others,

the matter may be referred to the Chief of Staff, the chair of the department, the chair of a standing committee, the CMO, or the CAO.

- (b) In addition, if the Board becomes aware of information that raises concerns about any Medical Staff member, the matter shall be referred to the Chief of Staff, the chair of the department, the chair of a standing committee, the CMO, or the CAO for review and appropriate action in accordance with this Policy.
- (c) The person to whom the matter is referred shall conduct or arrange for an inquiry to determine whether the question raised has sufficient credibility to warrant further review and, if so, shall forward it in writing to the MEC.
- (d) No action taken pursuant to this Section shall constitute an investigation.

6.D.2. Initiation of Investigation:

- (a) When a question involving the qualifications, competence, conduct or health of a member is referred to, or raised by, the MEC, the MEC shall review the matter and determine whether to conduct a formal investigation, to direct the matter to be handled pursuant to another policy (e.g., Professionalism Policy; Practitioner Health Policy; Professional Practice Evaluation Policy), or to proceed in another manner that the MEC believes is appropriate. Prior to making its determination, the MEC may discuss the matter with the individual involved. An investigation

shall begin only after a formal determination by the MEC to do so. The MEC's determination shall be recorded in the minutes of the meeting where the determination is made.

- (b) The MEC shall inform the individual that an investigation has begun. The notification shall include:
 - (1) the date on which the investigation was commenced;
 - (2) the committee that will be conducting the investigation, if already identified; and
 - (3) a statement that the physician will be given the opportunity to meet with the committee conducting the investigation before the investigation concludes; and
 - (4) a copy of Section 6.D.3 of the Credentials Policy, which outlines the process for investigations.

This notification may be delayed if, in the MEC's judgment, informing the individual immediately would compromise the investigation or disrupt the operation of the Hospital or Medical Staff.

6.D.3. Investigative Procedure:

- (a) Selection of Investigating Committee.

Once a determination has been made to begin an investigation, the MEC shall either investigate the matter itself or appoint an ad hoc committee to conduct the investigation, keeping in mind the conflict of interest guidelines outlined in Article 8. Any ad hoc committee may include individuals not on the Medical Staff. Whenever the questions raised concern the clinical competence of the individual under review, the ad hoc committee shall include a peer of the individual (e.g., physician, dentist, podiatrist, or oral surgeon).

- (b) Investigating Committee's Review Process.

- (1) The committee conducting the investigation ("investigating committee") shall have the authority to review relevant documents and interview individuals. A summary of each interview will be prepared and the interviewee will be asked to review, revise, and sign his or her summary, which will then be included as an attachment to the investigating committee's report.
- (2) The investigating committee shall also have available to it the full resources of the Medical Staff and the Hospital, including the authority to arrange for an external review, if needed. An external review may be used whenever the Hospital and investigating committee determine that:
 - (i) there are ambiguous or conflicting findings by internal reviewers;
 - (ii) the clinical expertise needed to conduct the review is not available on the Medical Staff;
 - (iii) an external review is advisable to prevent allegations of bias, even if unfounded; or
 - (iv) the thoroughness and objectivity of the investigation would be aided by such an external review.

If a decision is made to obtain an external review, the individual under investigation shall be notified of that decision and the nature of the external review. Upon completion of the external review, the individual shall be provided a copy of the reviewer's report.

- (3) The investigating committee may require a physical, mental, and/or behavioral examination of the individual by health care professional(s) acceptable to it. The individual being investigated shall execute a release (in a form approved or provided by the investigating committee) allowing (i) the investigating committee (or its representative) to discuss with the health care professional(s) conducting the examination the reasons for the examination; and (ii) the health care professional(s) conducting the examination to discuss and provide documentation of the results of such examination directly to the investigating committee. The cost of such health examination shall be borne by the individual.

(c) Meeting with the Investigating Committee.

- (1) The individual under investigation shall have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the individual shall be informed of the general questions being investigated. The investigating committee may also ask the individual to provide written responses to specific questions related to the investigation and/or a written explanation of his or her perspective on the events that led to the investigation for review by the investigating committee prior to the meeting.
- (2) This meeting is not a hearing, and none of the procedural rules for hearings shall apply. No recording (audio or video) or transcript of the meeting shall be permitted or made. Neither the individual being investigated nor the investigating committee will be accompanied by legal counsel at this meeting.
- (3) At the meeting, the individual shall be invited to discuss, explain, or refute the questions that gave rise to the investigation or that have been identified by the investigating committee during its review. A summary of the interview shall be prepared by the investigating committee and included with its report. The interview summary will be shared with individual prior to the investigating committee finalizing its report, so that he or she may review it and recommend suggested changes. A suggested change should only be accepted if the investigating committee believes it more accurately reflects what occurred at the meeting.

(d) Time Frames for Investigation.

The investigating committee shall make a reasonable effort to complete the investigation and issue its report within 30 days of the commencement of the investigation, provided that an external review is not necessary. When an external review is necessary, the investigating committee shall make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the results of the external review. 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.

(e) Investigating Committee's Report.

- (1) At the conclusion of the investigation, the investigating committee shall prepare a report of the investigation. The report should include a summary of the review process (e.g., a list of documents that were reviewed, any individuals who were interviewed, etc.), specific findings and conclusions regarding each concern that was under review, and the investigating committee's recommendations.
- (2) In making its recommendations, the investigating committee 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 individual, recognizing that fairness does not require that the individual agree with the recommendation. Specifically, the committee may consider:
 - (i) relevant literature and clinical practice guidelines, as appropriate;
 - (ii) all of the opinions and views that were expressed throughout the review, including report(s) from any external review(s);
 - (iii) any information or explanations provided by the individual under review; and
 - (iv) other information as deemed relevant, reasonable, and necessary by the investigating committee.

6.D.4. Recommendation:

- (a) The MEC may accept, modify, or reject any recommendation it receives from an ad hoc investigating committee if one was appointed by the MEC. In either case, at the conclusion of the investigation, the MEC may:
 - (1) determine that no action is justified;
 - (2) issue a letter of guidance, counsel, warning, or reprimand;
 - (3) impose conditions for continued appointment;
 - (4) impose a requirement for monitoring, proctoring, or consultation;
 - (5) impose a requirement for additional training or education;
 - (6) recommend reduction of clinical privileges;
 - (7) recommend suspension of clinical privileges for a term;
 - (8) recommend revocation of appointment and/or clinical privileges; or
 - (9) make any other recommendation that it deems necessary or appropriate.
- (b) A recommendation by the MEC that would entitle the individual to request a hearing shall be forwarded to the CAO, who shall promptly inform the individual by Special Notice. The CAO shall hold the recommendation until after the individual has completed or waived a hearing and appeal.

- (c) If the determination of the MEC does not entitle the individual to request a hearing, it shall take effect immediately and shall remain in effect unless modified by the Board.
- (d) In the event the Board considers a modification to the recommendation of the MEC that would entitle the individual to request a hearing, the CAO shall inform the individual by Special Notice. No final action shall occur until the individual has completed or waived a hearing and appeal.
- (e) When applicable, any recommendations or actions that are the result of an investigation or hearing and appeal shall be monitored by Medical Staff Leaders on an ongoing basis through the Hospital's performance improvement activities or pursuant to the applicable policies regarding conduct, as appropriate.

6.E. AUTOMATIC RELINQUISHMENT/ACTIONS

6.E.1. Failure to Complete Medical Records:

Failure to complete medical records, after notification by the medical records department of delinquency, may result in automatic relinquishment of all clinical privileges in accordance with the time frames as set forth in the Medical Staff Rules and Regulations (except that the individual must complete all scheduled emergency service obligations or arrange appropriate coverage). Relinquishment shall continue until all delinquent records are completed and reinstatement accomplished in accordance with applicable policies and rules and regulations. Failure to complete the medical records that caused relinquishment within the time required by applicable policies and rules and regulations shall result in automatic resignation from the Medical Staff.

6.E.2. Action by Government Agency or Insurer and Failure to Satisfy Threshold Eligibility Criteria:

- (a) Any action taken by any licensing board, professional liability insurance company, court or government agency regarding any of the matters set forth below, or any failure to satisfy any of the threshold eligibility criteria set forth in this Policy, must be promptly reported by the Medical Staff member to Medical Staff Services.
- (b) An individual's appointment and clinical privileges shall be automatically relinquished, without the right to the procedural rights outlined in this Policy, if an individual fails to satisfy any of the threshold eligibility criteria set forth in Section 2.A.1 of this Policy on a continuous basis (except for board certification requirements, which shall be assessed at time of reappointment). This includes, but is not limited to, the following occurrences:
 - (1) Licensure: Revocation, expiration, suspension, the placement of restrictions on an individual's license.
 - (2) Controlled Substance Authorization: Revocation, expiration, suspension or the placement of restrictions on an individual's DEA controlled substance authorization.
 - (3) Insurance Coverage: Termination or lapse of an individual's professional liability insurance coverage, or other action causing the coverage to fall below the minimum required by the Hospital or cease to be in effect, in whole or in part.
 - (4) Medicare and Medicaid Participation: Debarment, proposed debarment, termination, exclusion, or preclusion by government action from participation in the Medicare/Medicaid or other federal or state health care programs.

- (5) Criminal Activity: Arrest, charge, indictment, conviction, or a plea of guilty or no contest pertaining to any felony; or to any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; (iv) child abuse; (v) elder abuse; or (vi) violence against another. (DUIs will be addressed in the manner outlined in Section 2.B.1(k).)

- (c) Automatic relinquishment shall take effect immediately upon written notice to the individual provided via Special Notice, and shall continue until the matter is resolved and the individual is reinstated, if applicable.

- (d) If the underlying matter leading to automatic relinquishment is resolved within 60 days, the individual may request reinstatement. Failure to resolve the matter within 60 days of the date of relinquishment shall result in an automatic resignation from the Medical Staff.

- (e) Request for Reinstatement.
 - (1) Requests for reinstatement following the expiration or lapse of a license, controlled substance authorization, and/or insurance coverage will be processed by Medical Staff Services. If any questions or concerns are noted, Medical Staff Services will refer the matter for further review in accordance with (e)(2) below.

 - (2) All other requests for reinstatement shall be reviewed by the Leadership Council. If the Leadership Council makes a favorable recommendation on reinstatement, the Medical Staff member may immediately resume clinical practice at the Hospital. This determination shall then be forwarded to the Credentials Committee, MEC, and the Board for ratification. If, however, the Leadership Council has any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the full Credentials Committee, MEC, and Board for review and recommendation.

6.E.3. Failure to Provide Requested Information:

- (a) Failure to provide information pertaining to a Medical Staff member's qualifications for continued appointment or clinical privileges, in response to a written request from the CAO, the CMO, the Credentials Committee, the MEC, the Leadership Council, the Committee for Professional Enhancement, or any other committee authorized to request such information, shall result in a requirement that the individual meet with the Leadership Council to discuss why the requested input was not provided.

- (b) Failure of the Medical Staff member to either meet with the Leadership Council or provide the requested information prior to the meeting will result in the automatic relinquishment of the individual's clinical privileges until the information is provided to the satisfaction of the requesting party. If the individual fails to provide input requested within thirty (30) days of the automatic relinquishment, the individual's Medical Staff membership and clinical privileges will be deemed to have been automatically resigned.

6.E.4. Failure to Complete or Comply with Training or Educational Requirements:

- (a) Failure to complete or comply with training, educational, or orientation requirements that are adopted by the MEC or required by the Board, including, but not limited to, those pertinent to electronic medical records, computerized physician order entry ("CPOE"), the privacy and security of protected health information, infection control, or patient safety, shall result in a

requirement that the individual meet with the Leadership Council to discuss why the requirement was not met.

- (b) Failure of the individual to either meet with the Leadership Council or complete or comply with the pertinent requirement prior to the meeting will result in the automatic relinquishment of the individual's clinical privileges until the individual demonstrates completion or compliance with the relevant requirement. If the individual fails to do so within thirty (30) days of the automatic relinquishment, the individual's Medical Staff membership and clinical privileges will be deemed to have been automatically resigned.

6.E.5. Failure to Attend Special Meeting:

- (a) Whenever there is a concern regarding the clinical practice or professional conduct involving any individual, a Medical Staff Leader may require the individual to attend a special meeting with one or more of the Medical Staff Leaders and/or with a standing or ad hoc committee of the Medical Staff.
- (b) No legal counsel shall be present at this meeting, and no recording (audio or video) or transcript shall be permitted or made.
- (c) The notice to the individual regarding this meeting shall be given by Special Notice at least three days prior to the meeting and shall inform the individual that attendance at the meeting is mandatory.
- (d) Failure of the individual to attend the meeting shall result in the automatic relinquishment of all clinical privileges until such time as the individual does attend the special meeting. If the individual does not attend the special meeting within 30 days of the date of relinquishment, it shall result in automatic resignation from the Medical Staff.

6.F. LEAVES OF ABSENCE

6.F.1. Initiation:

- (a) A Medical Staff member may request a leave of absence by submitting a written request to the Chief of Staff. The request must state the beginning and ending dates of the leave, which shall not exceed one year, and the reasons for the leave. Except in extraordinary circumstances, this request will be submitted at least 30 days prior to the anticipated start of the leave in order to permit adjustment of the call roster and assure adequate coverage of clinical and/or administrative activities.
- (b) The Chief of Staff shall forward the request for a leave of absence to the relevant department chair, Leadership Council, Credentials Committee, MEC, and Board for recommendation and approval. The granting of a leave of absence, or reinstatement, as appropriate, may be conditioned upon the individual's completion of all medical records.
- (c) Except for maternity leaves, members of the Medical Staff must report to the Chief of Staff any time they are away from Medical Staff and/or patient care responsibilities for longer than 30 days and the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. Under such circumstances, the Chief of Staff, in consultation with the CMO and/or CAO, may or may not trigger a medical leave of absence.

6.F.2. Duties of Member on Leave:

During the leave of absence, the individual shall not exercise any clinical privileges. In addition, the individual shall be excused from all Medical Staff responsibilities (e.g., meeting attendance, committee service, emergency service call obligations) during this period.

6.F.3. Reinstatement:

- (a) Individuals requesting reinstatement shall submit to the Chief of Staff a written summary of their professional activities during the leave, evidence demonstrating that they continue to maintain current licensure, DEA registration, and adequate malpractice coverage, and any other information that may be requested by the Hospital. Following review by the Chief of Staff, requests for reinstatement shall then be reviewed by the Leadership Council. If the Leadership Council makes a favorable recommendation on reinstatement, the Medical Staff member may immediately resume clinical practice at the Hospital. This determination shall then be forwarded to the Credentials Committee, the MEC, and the Board for ratification. If, however, the Leadership Council has any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the full Credentials Committee, MEC, and Board for review and recommendation. If a request for reinstatement is not granted, for reasons related to clinical competence or professional conduct, the individual shall be entitled to request a hearing and appeal.
- (b) If the leave of absence was for health reasons (except for maternity leave), the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges requested and the request for reinstatement shall be processed in accordance with the Practitioner Health Policy.
- (c) Absence for longer than one year shall result in automatic relinquishment of Medical Staff appointment and clinical privileges unless an extension is granted by the CAO or CMO. Extensions shall be considered only in extraordinary cases where the extension of a leave is in the best interest of the Hospital.
- (d) If an individual's current appointment is due to expire during the leave, the individual must apply for reappointment, or appointment and clinical privileges shall lapse at the end of the appointment period.
- (e) Failure to request reinstatement from a leave of absence in a timely manner shall be deemed a voluntary resignation of Medical Staff appointment and clinical privileges.
- (f) Leaves of absence are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination shall be final, with no recourse to a hearing and appeal.

6.G. ACTION AT ANOTHER PEACEHEALTH HOSPITAL

- (1) Each PeaceHealth Hospital will share information regarding the implementation or occurrence of any of the following actions with all other PeaceHealth Hospitals at which an individual maintains Medical Staff appointment, clinical privileges, or any other permission to care for patients:
 - (a) ***automatic relinquishment or resignation*** of appointment or clinical privileges for any reason set forth in the Credentials Policy or other Medical Staff policies (except for

those relinquishments or resignations that result from incomplete medical records or the failure to provide requested information in a timely manner);

- (b) **voluntary agreement to modify clinical privileges or to refrain from exercising** some or all clinical privileges for a period of time for reasons related to the individual's clinical competence, conduct or health;
 - (c) participation in a **Performance Improvement Plan** under the Professional Practice Evaluation Policy or Medical Staff Professionalism Policy;
 - (d) a grant of **conditional membership or privileges** (either at initial appointment or reappointment), or conditional continued membership or clinical privileges; and/or
 - (e) any **denial, suspension, revocation, or termination** of appointment and/or clinical privileges.
- (2) Upon receipt of notice that any of the actions set forth in Paragraph (1) have occurred at any PeaceHealth Hospital, that action will automatically and immediately take effect at the PeaceHealth Hospital receiving the notice, unless the PeaceHealth Hospital receiving the notice determines that the individual no longer satisfies the eligibility criteria set forth in this Policy and has therefore automatically relinquished his or her appointment and privileges.

The automatic effectiveness of any such action, or an automatic relinquishment based on such action, will not entitle the individual to any additional procedural rights (including advance notice, additional peer review, formal investigation, hearing, or appeal) other than what occurred at the PeaceHealth Hospital taking the original action.

- (3) The Board may waive the automatic effectiveness of an action or an automatic relinquishment at the receiving PeaceHealth Hospital based on a recommendation to do so from the MEC at that Hospital. However, the automatic effectiveness or relinquishment will continue until such time as a waiver has been granted and the practitioner has been notified in writing of such. Waivers are within the discretion of the Board and are final. They will be granted only as follows:
- (a) after a full review of the specific circumstances and any relevant documents (including peer review documents) from the PeaceHealth Hospital where the action first occurred. The burden is on the affected practitioner to provide evidence showing that a waiver is appropriate; and
 - (b) based on a finding that the granting of a waiver will not affect patient safety, quality of care, or Hospital operations.

The denial of a waiver pursuant to this Section will not entitle the individual to any procedural rights, including advance notice, additional peer review, formal investigation, hearing, or appeal.

ARTICLE 7

HEARING AND APPEAL PROCEDURES

7.A. INITIATION OF HEARING

7.A.1. Grounds for Hearing:

- (a) An individual is entitled to request a hearing whenever the MEC makes one of the following recommendations:
 - (1) denial of initial appointment to the Medical Staff;
 - (2) denial of reappointment to the Medical Staff;
 - (3) revocation of appointment to the Medical Staff;
 - (4) denial of requested clinical privileges;
 - (5) revocation of clinical privileges;
 - (6) suspension of clinical privileges for more than 30 days (other than precautionary suspension);
 - (7) mandatory concurring consultation requirement (i.e., the consultant must approve the course of treatment in advance); or
 - (8) denial of reinstatement from a leave of absence if the reasons relate to clinical competence or professional conduct.
- (b) No other recommendations shall entitle the individual to a hearing.
- (c) If the Board makes any of these determinations without an adverse recommendation by the MEC, an individual would also be entitled to request a hearing. For ease of use, this Article refers to adverse recommendations of the MEC. When a hearing is triggered by an adverse recommendation of the Board, any reference in this Article to the "MEC" shall be interpreted as a reference to the "Board."

7.A.2. Actions Not Grounds for Hearing:

None of the following actions shall constitute grounds for a hearing, and they shall take effect without hearing or appeal, provided that the individual shall be entitled to submit a written explanation to be placed into his or her file:

- (a) determination that an applicant for membership fails to meet the threshold eligibility qualifications or criteria for membership;
- (b) ineligibility to request membership or privileges, or to continue privileges, because a relevant specialty is closed under a Medical Staff development plan or is covered under an exclusive provider agreement;

- (c) failure to process a request for a privilege when the individual does not meet the eligibility criteria to hold the privilege;
- (d) determination that an application is incomplete or untimely;
- (e) determination that an application shall not be processed due to a misstatement or omission;
- (f) change in assigned staff category or a determination that an individual is not eligible for a specific staff category;
- (g) expiration of membership and privileges as a result of failure to submit an application for reappointment within the allowable time period;
- (h) issuance of a letter of guidance, counsel, warning, or reprimand;
- (i) determination that conditions, monitoring, supervision, proctoring, or a general consultation requirement (i.e., the individual must obtain a consult but need not get prior approval for the treatment) is appropriate for an individual;
- (j) determination that a requirement for additional training or continuing education is appropriate for an individual;
- (k) the voluntary acceptance of a Performance Improvement Plan;
- (l) any requirement to complete a health assessment, diagnostic testing, a complete physical, mental or behavioral evaluation, or a clinical competency evaluation pursuant to any Bylaws-related document;
- (m) conducting an investigation into any matter or the appointment of an ad hoc investigating committee;
- (n) grant of conditional appointment or reappointment or of an appointment or reappointment period that is less than two years;
- (o) refusal of the Hospital to consider a request for appointment, reappointment, or privileges within five years of a final adverse decision regarding such request;
- (p) precautionary suspension;
- (q) automatic relinquishment of appointment or privileges or automatic resignation;
- (r) denial of a request for leave of absence, for an extension of a leave or for reinstatement from a leave if the reasons do not relate to clinical competence or professional conduct;
- (s) removal from the on-call roster or any other reading panel;
- (t) withdrawal of temporary privileges;
- (u) requirement to appear for a special meeting; and
- (v) termination of any contract with or employment by the Hospital.

7.B. THE HEARING

7.B.1. Notice of Recommendation:

The CAO shall promptly give Special Notice of a recommendation which entitles an individual to request a hearing. This notice shall contain:

- (a) a statement of the recommendation and the general reasons for it;
- (b) a statement that the individual has the right to request a hearing on the recommendation within 30 days of receipt of this notice; and
- (c) a copy of this Article.

7.B.2. Request for Hearing:

An individual has 30 days following receipt of the notice to request a hearing. The request shall be in writing to the CAO and shall include the name, address, and telephone number of the individual's counsel, if any. Failure to request a hearing shall constitute waiver of the right to a hearing, and the recommendation shall be transmitted to the Board for final action.

7.B.3. Notice of Hearing and Statement of Reasons:

- (a) The CAO shall schedule the hearing and provide, by Special Notice to the individual requesting the hearing, the following:
 - (1) the time, place, and date of the hearing;
 - (2) a proposed list of witnesses who shall give testimony at the hearing and a brief summary of the anticipated testimony;
 - (3) the names of the Hearing Panel members (or Hearing Officer) and Presiding Officer, if known; and
 - (4) a statement of the specific reasons for the recommendation, including a list of patient records (if applicable), and a general description of the information supporting the recommendation. This statement does not bar presentation of additional evidence or information at the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications and the individual has a sufficient opportunity to review and rebut the additional information.
- (b) The hearing shall begin no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to in writing by the parties.

7.B.4. Hearing Panel, Presiding Officer, and Hearing Officer:

- (a) Hearing Panel:

The CAO, after consulting with the Chief of Staff, shall appoint a Hearing Panel in accordance with the following guidelines:

- (1) The Hearing Panel shall consist of at least three members, a majority of which must hold the same or similar degree type as the affected individual, and may include any combination of:
 - (i) any member of the Medical Staff, provided the member has not actively participated in the matter at any previous level; and/or
 - (ii) physicians or laypersons not connected with the Hospital (i.e., physicians not on the Medical Staff or laypersons not affiliated with the Hospital).
 - (2) Knowledge of the underlying peer review matter, in and of itself, shall not preclude the individual from serving on the Panel.
 - (3) Employment by, or other contractual arrangement with, the Hospital or an affiliate shall not preclude an individual from serving on the Panel.
 - (4) The Panel shall not include any individual who is in direct economic competition with the individual requesting the hearing.
 - (5) The Panel shall not include any individual who is demonstrated to have an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter.
 - (6) In addition, the appointment of the Hearing Panel shall comply with the guidelines set forth in the conflict of interest provisions found in Article 8 of this Policy.
- (b) Presiding Officer:
- (1) The CAO, after consulting with the Chief of Staff, shall appoint a Presiding Officer who shall be an attorney. The Presiding Officer may not be, or represent clients who are, in direct competition with the individual who requested the hearing and may not currently represent the Hospital in any legal matters. The Presiding Officer shall not act as an advocate for either side at the hearing.
 - (2) The Presiding Officer shall:
 - (i) allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination;
 - (ii) prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant or abusive or that causes undue delay;
 - (iii) maintain decorum throughout the hearing;
 - (iv) determine the order of procedure;
 - (v) rule on all matters of procedure and the admissibility of evidence; and
 - (vi) conduct argument by counsel on procedural points within or outside the presence of the Hearing Panel at the Presiding Officer's discretion.

- (3) The Presiding Officer may be advised by legal counsel to the Hospital with regard to the hearing procedure.
 - (4) 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.
- (c) Hearing Officer:
- (1) As an alternative to a Hearing Panel, for matters limited to issues involving professional conduct, the CAO, after consulting with the Chief of Staff, may appoint a Hearing Officer, preferably an attorney, to perform the functions of a Hearing Panel. The Hearing Officer may not be, or represent clients who are, in direct economic competition with the individual requesting the hearing.
 - (2) If 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 to the Hearing Officer.
- (d) Objections:
- Any objection to any member of the Hearing Panel, to the Presiding Officer, or to the Hearing Officer, shall be made in writing, within 10 days of receipt of notice, to the CAO. A copy of such written objection must be provided to the Chief of Staff and must include the basis for the objection. The Chief of Staff shall be given a reasonable opportunity to comment. The CAO shall rule on the objection and give notice to the parties. The CAO may request that the Presiding Officer make a recommendation as to the validity of the objection.
- (e) Compensation:
- The Hearing Panel, Presiding Officer, and/or Hearing Officer may be compensated by the Hospital, but the individual requesting the hearing may participate in any such compensation should the individual wish to do so.

7.B.5. Counsel:

The Presiding Officer, Hearing Officer, and counsel for either party may be an attorney at law who is licensed to practice, in good standing, in any state.

7.C. PRE-HEARING PROCEDURES

7.C.1. General Procedures:

- (a) The pre-hearing and hearing processes shall be conducted in an informal manner. Formal rules of evidence or procedure shall not apply.
- (b) Neither party has the right to issue subpoenas, depose, interrogate, or interview witnesses or other individuals prior to the hearing or to otherwise compel any individual to participate in the hearing or pre-hearing process.
- (c) Neither the individual who has requested the hearing, nor any other person acting on behalf of the individual, may contact Hospital employees or Medical Staff members whose names appear on the MEC's witness list or in documents provided pursuant to this Article concerning the subject matter of the hearing, until the Hospital has been notified and has contacted the

individuals about their willingness to be interviewed. The Hospital will advise the individual who has requested the hearing once it has contacted such employees or Medical Staff members and confirmed their willingness to meet. Any employee or Medical Staff member may agree or decline to be interviewed by or on behalf of the individual who requested a hearing.

7.C.2. Time Frames:

The following time frames, unless modified by mutual written agreement of the parties, shall govern the timing of pre-hearing procedures:

- (a) the pre-hearing conference shall be scheduled at least 14 days prior to the hearing;
- (b) the parties shall exchange witness lists and proposed documentary exhibits at least 10 days prior to the pre-hearing conference; and
- (c) any objections to witnesses and/or proposed documentary exhibits must be provided at least five days prior to the pre-hearing conference.

7.C.3. Witness List:

- (a) At least 10 days before the pre-hearing conference, the individual requesting the hearing shall provide a written list of the names of witnesses expected to offer testimony on his or her behalf.
- (b) The witness list shall include a brief summary of the anticipated testimony.
- (c) The witness list of either party may, in the discretion of the Presiding Officer, be amended at any time during the course of the hearing, provided that notice of the change is given to the other party.

7.C.4. Provision of Relevant Information:

- (a) Prior to receiving any confidential documents, the individual requesting the hearing must agree that all documents and information shall be maintained as confidential and shall not be disclosed or used for any purpose outside of the hearing. The individual must also provide a written representation that his/her counsel and any expert(s) have executed Business Associate agreements in connection with any patient Protected Health Information contained in any documents provided.
- (b) Upon receipt of the above agreement and representation, the individual requesting the hearing shall be provided with a copy of the following:
 - (1) copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the individual's expense;
 - (2) reports of experts relied upon by the MEC;
 - (3) copies of relevant minutes (with portions regarding other physicians and unrelated matters deleted); and
 - (4) copies of any other documents relied upon by the MEC.

The provision of this information is not intended to waive any privilege under the state peer review protection statutes.

- (c) The individual shall have no right to discovery beyond the above information. No information shall be provided regarding other practitioners on the Medical Staff.
- (d) At least 10 days prior to the pre-hearing conference (or as otherwise agreed upon by both sides), each party shall provide the other party with its proposed exhibits. All objections to documents or witnesses shall be submitted in writing at least five days in advance of the pre-hearing conference. The Presiding Officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.
- (e) Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges shall be excluded.

7.C.5. Pre-Hearing Conference:

The Presiding Officer shall require the individual and the MEC or their representatives (who may be counsel) to participate in a pre-hearing conference, which shall be held no later than 14 days prior to the hearing. At the pre-hearing conference, the Presiding Officer shall resolve all procedural questions, including any objections to exhibits or witnesses. The Presiding Officer shall establish the time to be allotted to each witness's testimony and cross-examination. It is expected that the hearing shall last no more than 15 hours, with each side being afforded approximately seven and a half hours to present its case, in terms of both direct and cross-examination of witnesses. Both parties are required to prepare their case so that a hearing shall be concluded after a maximum of 15 hours. The Presiding Officer may, after considering any objections, grant limited extensions upon a demonstration of good cause and to the extent compelled by fundamental fairness.

7.C.6. Stipulations:

The parties and their counsel, if applicable, shall use their best efforts to develop and agree upon stipulations, so as to provide for a more orderly and efficient hearing by narrowing the issues on which live testimony is reasonably required.

7.C.7. Provision of Information to the Hearing Panel:

The following documents shall be provided to the Hearing Panel in advance of the hearing: (a) a pre-hearing statement that either party may choose to submit; (b) exhibits offered by the parties following the pre-hearing conference, (without the need for authentication); and (c) any stipulations agreed to by the parties.

7.D. HEARING PROCEDURES

7.D.1. Rights of Both Sides and the Hearing Panel at the Hearing:

- (a) At a hearing, both sides shall have the following rights, subject to reasonable limits determined by the Presiding Officer:
 - (1) to call and examine witnesses, to the extent they are available and willing to testify;
 - (2) to introduce exhibits;
 - (3) to cross-examine any witness on any matter relevant to the issues;

- (4) to have representation by counsel who may call, examine, and cross-examine witnesses and present the case; and
 - (5) to submit proposed findings, conclusions and recommendations to the Hearing Panel as part of the Post-Hearing statement referenced in this Article, following the close of the hearing session(s).
- (b) If the individual who requested the hearing does not testify, he or she may be called and questioned.
 - (c) The Hearing Panel may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

7.D.2. Record of Hearing:

A stenographic reporter shall be present to make a record of the hearing. The cost of the reporter shall be borne by the Hospital. Copies of the transcript shall be available at the individual's expense. Oral evidence shall be taken only on oath or affirmation administered by any person entitled to notarize documents in this state.

7.D.3. Failure to Appear:

Failure, without good cause, to appear and proceed at the hearing shall constitute a waiver of the right to a hearing and the matter shall be transmitted to the Board for final action.

7.D.4. Presence of Hearing Panel Members:

A majority of the Hearing Panel shall be present throughout the hearing. In unusual circumstances when a Hearing Panel member must be absent from any part of the hearing, he or she shall read the entire transcript of the portion of the hearing from which he or she was absent.

7.D.5. Persons to Be Present:

The hearing shall be restricted to those individuals involved in the proceeding, the Chief of Staff, and the CAO. In addition, administrative personnel may be present as requested by the CAO or the Chief of Staff.

7.D.6. Order of Presentation:

The MEC shall first present evidence in support of its recommendation. Thereafter, the burden shall shift to the individual who requested the hearing to present evidence.

7.D.7. Admissibility of Evidence:

The hearing shall not be conducted according to rules of evidence. Evidence shall not be excluded merely because it is 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. The guiding principle shall be that the record contains information sufficient to allow the Board to decide whether the individual is qualified for appointment and clinical privileges.

7.D.8. Post-Hearing Statement:

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

7.D.9. Postponements and Extensions:

Postponements and extensions of time may be requested by anyone, but shall be permitted only by the Presiding Officer or the CAO on a showing of good cause.

7.E. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

7.E.1. Basis of Hearing Panel Recommendation:

Consistent with the burden on the individual to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial appointment, reappointment and clinical privileges, the Hearing Panel shall recommend in favor of the MEC unless it finds that the individual who requested the hearing has proved, by clear and convincing evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

7.E.2. Deliberations and Recommendation of the Hearing Panel:

Within 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 statements, whichever is later), the Hearing Panel shall conduct its deliberations outside the presence of any other person except the Presiding Officer. Thereafter, the Hearing Panel shall render a recommendation, accompanied by a report, which shall contain a concise statement of the basis for its recommendation.

7.E.3. Disposition of Hearing Panel Report:

The Hearing Panel shall deliver its report to the CAO. The CAO shall send by Special Notice a copy of the report to the individual who requested the hearing. The CAO shall also provide a copy of the report to the MEC.

7.F. APPEAL PROCEDURE

7.F.1. Time for Appeal:

- (a) Within 10 days after notice of the Hearing Panel's recommendation, either party may request an appeal. The request shall be in writing, delivered to the CAO either in person or by certified mail, return receipt requested, and shall include a statement of the reasons for appeal and the specific facts or circumstances which justify further review.
- (b) If an appeal is not requested within 10 days, an appeal is deemed to be waived and the Hearing Panel's report and recommendation shall be forwarded to the Board for final action.

7.F.2. Grounds for Appeal:

The grounds for appeal shall be limited to the following:

- (a) there was substantial failure by the Hearing Panel to comply with this Policy and/or the Medical Staff Bylaws during the hearing, so as to deny a fair hearing; and/or

- (b) the recommendations of the Hearing Panel were made arbitrarily or capriciously and/or were not supported by credible evidence.

7.F.3. Time, Place and Notice:

Whenever an appeal is requested as set forth in the preceding Sections, the Chair of the Board (or the CAO on behalf of the Chair) shall schedule and arrange for an appeal. The individual shall be given Special Notice of the time, place, and date of the appeal. The appeal shall be held as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved.

7.F.4. Nature of Appellate Review:

- (a) The Board may serve as the Review Panel or the Chair of the Board may appoint a Review Panel composed of not less than three 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 and recommend final action to the Board.
- (b) Each party shall have the right to present a written statement in support of its position on appeal. The party requesting the appeal shall submit a statement first and the other party shall then have ten days to respond. In its sole discretion, the Review Panel may allow each party or its representative to appear personally and make oral argument not to exceed 30 minutes.
- (c) When requested by either party, the Review Panel may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination provided at the Hearing Panel proceedings. Such additional evidence shall be accepted only if the Review Panel determines that the party seeking to admit it has demonstrated that it is relevant, new evidence that could not have been presented at the hearing, or that any opportunity to admit it at the hearing was improperly denied.

7.G. BOARD ACTION

7.G.1. Final Decision of the Board:

- (a) Within 30 days after the Board (i) considers the appeal as a Review Panel, (ii) receives a recommendation from a separate Review Panel, or (iii) receives the Hearing Panel's report and recommendation when no appeal has been requested, the Board shall consider the matter and take final action.
- (b) The Board may review any information that it deems relevant, including, but not limited to, the findings and recommendations of the MEC, Hearing Panel, and Review Panel (if applicable). The Board may adopt, modify, or reverse any recommendation that it receives or, in its discretion, refer the matter to any individual or committee for further review and recommendation, or make its own decision based upon the Board's ultimate legal authority for the operation of the Hospital and the quality of care provided.
- (c) The Board shall render its final decision in writing, including specific reasons, and shall send Special Notice to the individual. A copy shall also be provided to the MEC for its information.

7.G.2. Further Review:

Except where the matter is referred by the Board for further action and recommendation by any individual or committee, the final decision of the Board shall be effective immediately and shall not be subject to further review. If the matter is referred for further action and recommendation, such

recommendation shall be promptly made to the Board in accordance with the instructions given by the Board.

7.G.3. Right to One Hearing and One Appeal Only:

No member of the Medical Staff shall be entitled to more than one hearing and one appellate review on any matter. If the Board denies initial appointment to the Medical Staff or reappointment or revokes the appointment and/or clinical privileges of a current member of the Medical Staff, that individual may not apply for staff appointment or for those clinical privileges for a period of five years unless the Board provides otherwise.

ARTICLE 8

CONFLICT OF INTEREST GUIDELINES FOR CREDENTIALING, PRIVILEGING, AND PROFESSIONAL PRACTICE EVALUATION ACTIVITIES

8.A.1. General Principles:

- (a) All those involved in credentialing, privileging, and professional practice evaluation activities (referred to collectively as “Medical Staff Functions” in this Article) must be sensitive to potential conflicts of interest (“COI”) in order to be fair to the individual whose qualifications are under review, to protect the individual with the potential conflict, and to protect the integrity of the review processes.
- (b) It is also essential that peers participate in Medical Staff Functions in order for these activities to be meaningful and effective. Therefore, whether and how an individual can participate must be evaluated reasonably, taking into consideration common sense and objective principles of fairness.
- (c) A potential conflict of interest depends on the situation and not on the character of the individual. To promote this understanding, any individual with a potential conflict of interest shall be referred to as an “Interested Member.”
- (d) No Medical Staff member has a right to compel the disqualification of another member based on an allegation of conflict of interest. Rather, that determination is within the discretion of the Medical Staff Leaders or Board chair, guided by this Article.
- (e) The fact that any Medical Staff member chooses to refrain from participation, or is excused from participation, in any Medical Staff Function shall not be interpreted as a finding of an actual conflict that inappropriately influenced the review process.
- (f) **Appendix A** to this Policy is a chart that outlines the conflict of interest guidelines that are applicable to Medical Staff Functions at the Hospital. The remainder of this Article is intended to supplement **Appendix A** and expand upon the guidelines that are summarized in the chart.

8.A.2. Process for Identifying Conflicts of Interest:

- (a) Self-Disclosure. Any individual involved in Medical Staff Functions must disclose all personal conflicts of interest relevant to those activities to the committee chair, CAO, or CMO.
- (b) Identification by Others. Any individual who is concerned about a potential conflict of interest on the part of any other individual who is involved in Medical Staff Functions should inform the committee chair, CAO, or CMO.
- (c) Identification by Individual under Review. An individual who is the subject of review during any Medical Staff Functions is obligated to notify the committee chair, CAO, or CMO of any known or suspected conflicts of interest by others who are involved in such activities. Any potential conflict of interest that is not raised timely by the individual under review shall be deemed waived.

8.A.3. Implementation of Conflict of Interest Guidelines in **Appendix A**:

This section describes how to implement the Conflict of Interest Guidelines found in **Appendix A** of this Policy:

- Paragraph (a) identifies the three COI situations that require special treatment and rules during the performance of Medical Staff Functions, irrespective of the Interested Member's level of participation in the process (e.g., individual reviewer, CPE member, MEC member);
- Paragraph (b) describes the other common situations that raise COI issues during the performance of Medical Staff Functions; and
- Paragraph (c) describes how to apply the guidelines in **Appendix A** to the common COI situations outlined in (b) at each level of the review processes.

(a) Three COI Situations That Require Special Treatment and Rules, Irrespective of an Interested Member's Level of Participation:

- (1) Employment or Contractual Arrangement with the Hospital. Because Medical Staff Functions are performed on behalf of the Hospital, the interests of those who are employed by, or under contract with, the Hospital are aligned with the Hospital's interest in seeing that those activities are performed effectively, efficiently, and lawfully. As such, employment by, or other contractual arrangement with, the Hospital or any of its affiliated entities does not, in and of itself, preclude an Interested Member from participating in Medical Staff Functions.
- (2) Self or Family Member. While Interested Members may provide information to other individuals involved in the review process, an Interested Member should not otherwise participate in the review of his or her own application or the professional practice evaluation of the care he or she provided or in any such activities involving an immediate family member (spouse or domestic partner, parent, child, sibling, or in-law).
- (3) Relevant Treatment Relationship. As a general rule, an Interested Member who has provided professional health services to a practitioner whose application or provision of care is under review should not participate in the review process regarding the practitioner. However, if the patient-physician relationship has terminated and the review process does not involve the health condition for which the practitioner sought professional health services, the Interested Member may participate fully in all Medical Staff Functions.

Furthermore, even if a current patient-physician relationship exists, the Interested Member may provide information to others involved in the review process if:

- (i) the information was not obtained through the treatment relationship, or
- (ii) the information was obtained through the treatment relationship, but the disclosure was authorized by the practitioner under review through the execution of a HIPAA-compliant authorization form.

(b) Other Common Situations That Raise COI Issues During the Performance of Medical Staff Functions:

Participation by any Interested Member who is in one of the following situations – as it relates to the practitioner under review – will be evaluated under the guidelines outlined in Paragraph (c) and **Appendix A**:

- (1) Significant Financial Relationship (e.g., when the Interested Member and other practitioners: are members of a small, single specialty group; maintain a significant referral relationship; are partners in a business venture; or, are individuals practicing in a specialty for which a policy matter – such as clinical privileging criteria – is being considered);
- (2) Direct Competitor (e.g., practitioners in the same specialty, but in different groups);
- (3) Close Friendships;
- (4) History of Personal Conflict (e.g., former partner, ex-spouse, or where there has been demonstrated animosity);
- (5) Personal Involvement in the Care That Is Subject to Review (e.g., where the Interested Member provided care in the case under review, but is not the subject of the review);
- (6) Active Involvement in Certain Prior Interventions with the Individual Under Review (e.g., where the Interested Member was involved in the development of a prior Performance Improvement Plan or in a disciplinary action involving the individual under review. This situation does not include participation in initial education or collegial intervention activities (e.g., sending an Educational Letter; meeting collegially with a colleague and sending a follow-up letter)); and/or
- (7) Formally Raised the Concern about Another Individual (e.g., where the Interested Member's concern triggered the review of another practitioner, as evidenced by the Interested Member's written report regarding the concern (i.e., sent a written concern to a Medical Staff Officer, CAO, or CMO, or filed a report through the Hospital's electronic reporting system)).

(c) Application of the Guidelines in **Appendix A** to the Performance of Medical Staff Functions:

(1) Individual Reviewers in Credentialing and Professional Practice Evaluation Activities

An Interested Member may participate as an individual reviewer so long as a check and balance is provided by subsequent review by a Medical Staff committee. This includes, but is not limited to, the following:

- (i) participation in the review of applications for initial and renewed membership and clinical privileges (which is subsequently reviewed by the Credentials Committee and/or MEC); and
- (ii) participation as a case reviewer in professional practice evaluation activities (which is subsequently reviewed by the Leadership Council, Committee on Professional Enhancement, Investigating Committee, and/or MEC).

(2) Credentials Committee, Leadership Council, and Committee on Professional Enhancement Members

As a general rule, an Interested Member may fully participate as a member of the Credentials Committee, Leadership Council, and Committee on Professional Enhancement because these committees do not possess any disciplinary authority and do not make any final recommendation that could adversely affect the membership or clinical privileges of a practitioner, which is only within the authority of the MEC and Board.

However, the chairs of these committees always have the discretion to recuse an Interested Member if they determine that the Interested Member's presence or participation would inhibit full and fair discussion of the issue, would skew the recommendation or determination of the committee, or would otherwise be unfair to the practitioner under review.

(3) Medical Executive Committee

As a general rule, an Interested Member may fully participate as a member of the MEC when it is approving routine and favorable recommendations regarding the granting of initial appointment, reappointments, and clinical privileges.

However, an Interested Member should be recused from the MEC when that committee is considering a matter that could result in an adverse professional review action affecting the Medical Staff membership or clinical privileges of a practitioner. The Interested Member's participation in MEC meetings will be governed by the guidelines regarding recusal that are set forth in **Appendix A**.

(4) Investigating Committees

Once a formal investigation has been initiated by the MEC, additional steps to manage conflicts of interest should be taken as a precaution. Therefore, an Interested Member should not be appointed as a member of an investigating committee and should not participate in the committee's deliberations or decision-making, but may be interviewed and provide information if necessary for the committee to conduct a full and thorough investigation.

(5) Hearing Panel

An Interested Member should not be appointed as a member of a Hearing Panel and should not participate in the Panel's deliberations or decision-making.

(6) Board

As a general rule, an Interested Member may fully participate as a member of the Board when it is approving routine and favorable recommendations regarding the granting of initial appointment, reappointments, and clinical privileges.

However, an Interested Member should be recused from the Board when the Board is considering action that will adversely affect Medical Staff membership or clinical privileges of a practitioner. The Interested Member's participation in Board meetings will be governed by the guidelines regarding recusal that are set forth in **Appendix A**.

ARTICLE 9

CONFIDENTIALITY AND PEER REVIEW PROTECTION

9.A. CONFIDENTIALITY

Actions taken and recommendations made pursuant to this Policy shall be strictly confidential. Individuals participating in, or subject to, credentialing and professional practice evaluation activities shall make no disclosures of any such information (discussions or documentation) outside of committee meetings, except:

- (1) when the disclosures are to another authorized member of the Medical Staff or authorized Hospital employee and are for the purpose of researching, investigating, or otherwise conducting legitimate credentialing and professional practice evaluation activities;
- (2) when the disclosures are authorized by a Medical Staff or Hospital policy; or
- (3) when the disclosures are authorized, in writing, by the CAO, CMO, or by legal counsel to the Hospital.

Any breach of confidentiality may result in a professional review action and/or appropriate legal action. Such breaches are unauthorized and do not waive the peer review privilege. Any member of the Medical Staff who becomes aware of a breach of confidentiality must immediately inform the CAO, CMO, or the Chief of Staff (or the Vice Chief of Staff if the Chief of Staff is the person committing the claimed breach).

9.B. PEER REVIEW PROTECTION

- (1) All credentialing and professional practice evaluation activities pursuant to this Policy and related Medical Staff documents shall be performed by “peer review committees” in accordance with the relevant state law. These committees include, but are not limited to:
 - (a) all standing and ad hoc Medical Staff and Hospital committees;
 - (b) all departments *and service lines*;
 - (c) hearing panels;
 - (d) the Board and its committees; and
 - (e) any individual acting for or on behalf of any such entity, including but not limited to department chairs, committee chairs and members, *service line leads*, officers of the Medical Staff, the CMO, all Hospital personnel, and experts or consultants retained to assist in peer review activities.

All oral or written communications, reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and covered by the applicable provisions of the relevant state law.

- (2) All peer review committees shall also be deemed to be “professional review bodies” as that term is defined in the Health Care Quality Improvement Act of 1986, 42 U.S.C. §11101 *et seq.*

ARTICLE 10

AMENDMENTS

- (A) This Policy may be amended by a majority vote of the members of the MEC, which may consult with any other Medical Staff leader or leadership body as may be necessary.
- (B) Prior to initiating the formal notice process below, the MEC shall submit all proposed amendments to the PeaceHealth Legal Department for review and comment. Proposed amendments that are determined to be relevant to other PeaceHealth hospitals will be forwarded by the PeaceHealth Legal Department to those hospitals for consideration by their respective MECs.
- (C) Notice of all proposed amendments shall be provided to each voting member of the Medical Staff at least seven days prior to the MEC meeting. Any voting member of the Medical Staff may submit written comments to the MEC.
- (D) No amendment shall be effective unless and until it has been approved by the Board.

ARTICLE 11

ADOPTION

This Policy is adopted and made effective upon approval of the Board, superseding and replacing any and all other Bylaws, Rules and Regulations of the Medical Staff or Hospital policies pertaining to the subject matter thereof.

Adopted by the Medical Staff: 8/2/2018
Reviewed by the Medical Staff: 5/11/2021
Reviewed by the Medical Staff: 4/9/2024

Approved by the Board: 8/27/2018
Reviewed by the Board: 5/19/2021
Reviewed by the Board: 4/15/2024

APPENDIX A
CONFLICT OF INTEREST GUIDELINES

Potential Conflicts	Levels of Participation								
	Provide Information	Individual Reviewer Application/ Case	Committee Member					Hearing Panel	Board
			Credentials	Leadership Council	CPE	MEC	Investigating Committee		
Employment/contract relationship with Hospital	Y	Y	Y	Y	Y	Y	Y	Y	Y
Self or family member	Y	N	R	R	R	R	N	N	R
Relevant treatment relationship*	Y	N	R	R	R	R	N	N	R
Significant financial relationship	Y	Y	Y	Y	Y	R	N	N	R
Direct competitor	Y	Y	Y	Y	Y	R	N	N	R
Close friends	Y	Y	Y	Y	Y	R	N	N	R
History of conflict	Y	Y	Y	Y	Y	R	N	N	R
Provided care in case under review (but not subject of review)	Y	Y	Y	Y	Y	R	N	N	R
Involvement in prior PIP or disciplinary action	Y	Y	Y	Y	Y	R	N	N	R
Formally raised the concern	Y	Y	Y	Y	Y	R	N	N	R

Y – (Green “Y”) means the Interested Member may serve in the indicated role; no extra precautions are necessary.

Y – (Yellow “Y”) means the Interested Member may generally serve in the indicated role. It is legally permissible for Interested Members to serve in these roles because of the check and balance provided by the multiple levels of review and the fact that the Credentials Committee, Leadership Council, and CPE have no disciplinary authority.

In addition, the Chair of the Credentials Committee, Leadership Council, or CPE always has the authority and discretion to recuse a member in a particular situation if the Chair determines that the Interested Member’s presence would (i) inhibit the full and fair discussion of the issue before the committee, (ii) skew the recommendation or determination of the committee, or (iii) otherwise be unfair to the practitioner under review.

N – (Red “N”) means the Interested Member should not serve in the indicated role.

R – (Red “R”) means the Interested Member should be recused, in accordance with the guidelines on the next page.

* Special rules apply both to the provision of information and participation in the review process in this situation. See Section 8.A.3 of the Credentials Policy.

RULES FOR RECUSAL	
STEP 1 Confirm the conflict of interest	The Committee Chair or Board Chair should confirm the existence of a conflict of interest relevant to the matter under consideration.
STEP 2 Participation by the Interested Member at the meeting	<p>The Interested Member may participate in any part of the meeting that does not involve the conflict of interest situation.</p> <p>When the matter implicating the conflict of interest is ready for consideration, the Committee Chair or Board Chair will note that the Interested Member will be excused from the meeting prior to the group’s deliberation and decision-making.</p> <p>Prior to being excused, the Interested Member may provide information and answer any questions regarding the following:</p> <ul style="list-style-type: none"> (i) any factual information for which the Interested Member is the original source; (ii) clinical expertise that is relevant to the matter under consideration; (iii) any policies or procedures that are applicable to the committee or Board or are relevant to the matter under consideration; (iv) the Interested Member’s prior involvement in the review of the matter at hand (for example, an Investigating Committee member may describe the Investigating Committee’s activities and present the Investigating Committee’s written report and recommendations to the MEC prior to being excused from the meeting); and (v) how the committee or Board has, in the past, managed issues similar or identical to the matter under consideration.
STEP 3 The Interested Member is excused from the meeting	The Interested Member will then be excused from the meeting (i.e., physically leave the meeting room and/or disconnect from any telephone or other electronic connection) prior to the committee’s or Board’s deliberation and decision-making.
STEP 4 Record the recusal in the minutes	The recusal should be documented in the minutes of the committee or Board. The minutes should reflect the fact that the Interested Member was excused from the meeting prior to deliberation and decision-making.