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BYLAWS
OF THE MEDICAL STAFF OF
VIDANT MEDICAL CENTER

The physicians practicing in the Hospital organize themselves into a Medical Staff under these Bylaws. The medical staff is responsible for the quality of medical care in the hospital and must accept and discharge this responsibility, subject to the ultimate authority of the hospital governing body, and that the cooperative efforts of the medical staff, the hospital president and the governing body are necessary to fulfill the hospital's obligations to its patients.

The purposes of this organization are:

- To ensure that all patients admitted to or treated in any of the facilities, or clinical services of the hospital shall receive quality care;

- To ensure a high level of professional performance of all practitioners authorized to practice in the hospital through the appropriate delineation of the clinical privileges that each practitioner may exercise in the hospital and through an ongoing review and evaluation of each practitioner's performance in the hospital;

- To provide an appropriate educational setting that will maintain scientific standards and that will lead to continuous advancement in professional knowledge and skill;

- To initiate and maintain rules and regulations for self-government of the medical staff; and

- To provide a means whereby issues concerning the medical staff and the hospital may be discussed by the medical staff with the governing body and the Chief Executive Officer.

ROBERT'S RULES OF ORDER

Medical Staff business will be conducted pursuant to Robert's Rules of Order, unless otherwise specified.
ARTICLE I: MEDICAL STAFF MEMBERSHIP

A. Qualifications for Membership
Only doctors of medicine, doctors of dental surgery, doctors of osteopathy and doctors of podiatric medicine, excluding residents, who hold an unrestricted license to practice medicine or dentistry in North Carolina who can sufficiently document their: (1) background, experience, training and demonstrated competence; (2) adherence to the ethics of their profession; and (3) good reputation and ability to work with others to assure the Governing Body and Medical Staff that patients treated by them in the Hospital will receive appropriate medical care, are qualified for membership on the Medical Staff. No physician is entitled to medical staff membership or to exercise particular clinical privileges in the Hospital simply because he/she has a license to practice medicine, osteopathy, dental surgery, or podiatry.

By accepting medical staff membership, each physician agrees to strictly abide by the VMC Policy on Physician Health and the code of behavior therein, and either the Principles of Medical Ethics of the American Medical Association, the Code of Ethics of the American Dental Association, or by the Code of Ethics of the American Osteopathic Association, whichever is applicable. These individuals who continuously meet the qualifications, standards and requirements set forth in these Bylaws shall constitute the members of the medical staff.

B. Conditions and Duration of Appointment
1. The Governing Body makes initial appointments, reappointments and revocations of appointments to the Medical Staff after there has been a Medical Staff recommendation, as provided in these Bylaws.

2. Initial appointments and reappointments are for no more than two years.

3. Each Medical Staff member must ensure that the Hospital has a current certificate of insurance from an insurance company licensed to do business in North Carolina verifying malpractice liability coverage with a minimum of $1,000,000 per claim or medical incident and an aggregate limit of $3,000,000. It is the responsibility of each medical staff member to notify the VMC Medical Staff Support office immediately when insurance has been cancelled.

4. Upon approval of these Bylaws, each new medical staff member shall be certified or shall become certified, in the area of clinical practice, within three (3) years of eligibility or within three testing cycles, whichever is longer, by an appropriate board of the American Board of Medical Specialists or its equivalent board as recommended by the Chief of Service. Medical Staff members, whose board certificates bear an expiration date, shall successfully complete recertification no later than three (3) years following such date. For members whose certifying board requires maintenance of certification in lieu of renewal, maintenance of certification requirements must be met,
with a lapse in continuous maintenance of no greater than (3) years. Those medical staff members without clinical privileges or holding Refer and Follow privileges will not be required to maintain board certification requirements. Initial applicants with lapsed board certification at the time of their application are ineligible for appointment to the medical staff.

5. Every application must be signed by the applicant and contain his specific acknowledgment of his obligation to provide continuous care to, and supervision of, his patients; to abide by the Medical Staff Bylaws and policies; to accept consultation and emergency call duties as required by the medical staff bylaws and as assigned by the Chief of the Service pursuant to medical staff policy; and to abide by the Hospital’s policies and procedures.

6. Each appointee to the Medical Staff, regardless of category shall be responsible for maintenance of his/her professional competence.

7. Every practitioner practicing at this Hospital by virtue of Medical Staff membership or otherwise, shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted to him by the Governing Body, except as provided in Article V.

8. Active medical staff members must be current in staff dues as a condition for promotion and reappointment.

9. A physician who has ever been convicted of, pled guilty to, or pled nolo contendre to a felony, health care related crime, or any other crime involving moral turpitude or who has been sanctioned by any state or federal governmental authority for civil or criminal health care related misconduct is not generally eligible for medical staff membership, unless he/she shows by clear and convincing evidence that the nature of the crime poses no threat to patient safety and welfare, or to the reputation or effective operation of the Hospital, and that he/she is otherwise in compliance with the standards established by these Bylaws and North Carolina law.

10. A physician who is currently involuntarily excluded from participation in any federally funded healthcare program is not eligible for medical staff membership.

11. Medical Staff members must maintain current registration with the US Drug Enforcement Agency, if applicable to his or her privileges in the hospital.

12. Physicians must provide demonstration of clinical performance and competence within the last twelve (12) months with an active clinical practice in the area in which Clinical Privileges are sought, for the purpose of ascertaining current clinical competence;
13. Physicians must ensure that their physical and mental health does not impair the fulfillment of responsibilities of Medical Staff membership and the specific requested clinical privileges.

14. Each appointee to the Medical staff, regardless of category shall notify the Chief of Staff, or designee, immediately, in writing, of the occurrences referenced in Article VII, Section 7b-f of these bylaws. Failure to provide this notification within seventy-two (72) hours will result in an automatic seven (7) day suspension.

Rewritten/Adopted June 19, 2007; July 22, 2014
ARTICLE II: MEDICAL STAFF CATEGORIES

The Medical Staff categories are: active, consulting, honorary and inactive.

A. Active Medical Staff

1. Active medical staff members must be doctors of medicine, dental surgery or osteopathy, who hold a current unrestricted license to practice medicine or dental surgery in North Carolina. They must reside in the 29 county hospital service region and provide professional services to patients in the hospital. Their primary site of patient care delivery must be Pitt County, or they must be a member of a medical practice group having its primary site of patient care delivery in Pitt County. Members are appointed to a specific clinical service. Members may admit patients to the hospital within the scope of their delineated privileges and are eligible to vote on matters brought before the Medical Staff, hold office, and serve on committees. All members of the Active Staff with privileges shall accept assignment for emergency call duties. Active medical staff members without privileges are excluded from the requirements to maintain liability insurance coverage, participate in on call responsibilities, and the need to be in Pitt County. Additionally, these members may not hold any Medical Staff office.

2. Active medical staff members must be physically present in Pitt County at all times to provide continuous care to their patients or designate an active medical staff member physically present in Pitt County who agrees to do so. Clinical service coverage policy, if approved by the Medical Executive Committee, may allow for exceptions. Designated coverage must be provided by a qualified active medical staff member, as determined by the affected Chiefs of Service.

3. Meetings: The active medical staff shall meet annually in November or December and at other times as the Chief of Staff may determine and announce. Election of officers and at large members to the Medical Executive Committee shall be held at the annual meeting. Attendance is not mandatory but is highly recommended. Those active staff members present at a meeting of the medical staff shall constitute a quorum. The action of a majority of members present at a meeting shall be the action of the medical staff. The Chief of Staff shall convene a meeting of the medical staff upon request of 10% of the active membership.

4. Special Active Staff Considerations:
   - After serving 25 years in good standing as a member of the active medical staff of this hospital and having performed all the duties and obligations of active membership, a member may request withdrawal of service functions and emergency department duties in part or in total without otherwise losing status as an active staff member. He/she shall continue to vote, hold office, serve on committees, and be entitled to all other benefits of active staff membership.
   - Exemptions from Bylaws requirements for Active Medical Staff members may be requested by the Chief of Service, through the Credentials committee, approved by the Medical Staff Executive Committee and the Governing Body. All requests shall indicate the duration of exemption, not to exceed the next reappointment cycle.
Denial of exemptions does not allow access to the appellate process outline in the Bylaws.

B. Consulting Medical Staff
Consulting medical staff members are doctors of medicine, doctors of dental surgery, doctors of osteopathy and doctors of podiatric medicine, who hold a current unrestricted license to practice medicine or dental surgery in North Carolina. Consulting medical staff members cannot vote or hold office and are excused from payment of annual staff dues. Members are appointed to a specific clinical service.

Members provide their services in the care of patients upon request of an active medical staff member. Consulting medical staff members cannot admit patients to the hospital. Each Consulting medical staff member must identify a member or practice group of the active medical staff, who is qualified by credentials and privileges, available, and has agreed to care for and admit patients seen by the consulting medical staff member, if necessary. Designated coverage must be provided by a qualified active medical staff member, as determined by the affected Chiefs of Service. Provision for emergency medical consultation shall be mutually agreed upon by both parties.

C. Affiliate Medical Staff
Affiliate medical staff members are doctors of medicine, dental surgery, osteopathy and podiatric medicine who hold a current unrestricted license to practice medicine or dental surgery in North Carolina. Affiliate medical staff members must be sponsored by a member of the active medical staff who has admitting privileges and who is not subject to any special consideration set out in paragraph A.4 of this Article II. Affiliate medical staff members are not eligible for any exception to the requirements of members contained in these Medical Staff Bylaws, including, but not limited to, the requirement to take call. Members are appointed to a specific clinical service. Affiliate medical staff members are not required to reside in the 29 county hospital service area. An Affiliate medical staff member may admit patients to the hospital within the scope of his or her delineated privileges, but only for his or her sponsor’s patients or patients of his or her sponsor’s group. Their primary site of patient care delivery is not required to be Pitt County, provided however, while on call, Affiliate medical staff members must be physically in Pitt County or have his or her call obligations covered by his or her sponsor or a member of his or her sponsor’s group. In the event that the Affiliate medical staff member no longer has a sponsoring physician, the medical staff membership and clinical privileges of the Affiliate medical staff member are automatically revoked. Affiliate staff who lose their privileges due to the loss of a sponsor are not allowed to appeal and this is not reportable to the Medical Board. Affiliate medical staff members are subject to the peer review process. The maximum appointment to the Affiliate medical staff is one (1) year. Affiliate medical staff members cannot vote or hold office and are excused from payment of annual staff dues.

D. Honorary Medical Staff
Honorary medical staff members are doctors of medicine, doctors of dental surgery, and doctors of osteopathy who are not active in the hospital, or who have served as active or

Revised 10/27/15
consulting medical staff. Honorary staff members have no hospital privileges; they cannot admit patients, vote, hold office or serve on committees.

E. Inactive Medical Staff
A Medical Staff member, in good standing, planning a leave of absence not exceeding two (2) years, may request placement on the Inactive Medical Staff during their absence. The request shall be made in writing to the Chief of Staff for approval within forty-five days of the start of the leave. An Inactive Staff member will be automatically reinstated, pursuant to the Medical Staff’s Leave of Absence Policy, upon written notice of his return, provided that he/she continues to meet medical staff qualifications.

Rewritten/Adopted June 19, 2007
Revised 9/20/11, 7/22/14, 10/27/15
ARTICLE III: MEDICAL STAFF OFFICERS

The officers of the Medical Staff are: Chief of Staff, Chief of Staff-Elect, Immediate Past Chief of Staff and Treasurer.

A. Qualifications
Officers must be members of the active medical staff.

B. Elections
The Chief of Staff-Elect and Treasurer are elected at the Medical Staff’s Annual Meeting. Elections are by secret ballot and are determined by a plurality of the votes cast rather than requiring a majority. No votes by proxy or absentee ballots are allowed. Upcoming elections and the members of the nominating committee, which consists of the three (3) immediate past Chiefs of Staff, are announced to the medical staff in September. A preliminary ballot is distributed to medical staff members eligible to vote prior to the annual meeting. Nominations may also be made from the floor at the annual meeting.

C. Term of Office
Officers serve a one year term, coincident with the calendar year, with the Chief of Staff and immediate Past Chief of Staff automatically succeeding to their offices on January 1.

D. Vacancies in Office
If the Chief of Staff is unable to serve any or all of his term, he is replaced for the duration of the vacancy by the Chief of Staff-Elect. If both the Chief of Staff and the Chief of Staff-Elect are unable to serve, an emergency meeting of the Medical Staff will be called within one month and a Chief of Staff Pro Tem elected. The Chief of Staff Pro Tem has all the privileges and responsibilities of the Chief of Staff and serves during the vacancy. In the event neither the Chief of Staff or Chief of Staff Elect can resume their duties, elections will be held for both offices at the next Medical Staff Annual Meeting. If the Chief of Staff or Chief of Staff-Elect is able to resume the duties of Chief of Staff, the Chief of Staff Pro Tem will step down.

In the event the Chief of Staff-Elect is unable to serve at the time of his accession to Chief of Staff, an emergency meeting of the Medical Staff will be called within one month and another Chief of Staff elected to serve the remainder of the term. If the Treasurer is unable to serve, his duties will be assumed by the Chief of Staff Elect.

E. Removal from Office
An officer may be removed from office by a three fourths vote of the medical staff present at any regular or special called medical staff meeting for failure to perform the duties outlined in these Bylaws.
F. Duties of Officers

1. Chief of Staff: The Chief of Staff will:
   a. Represent the medical staff and act in coordination and cooperation with the Hospital President and health system CEO in all matters of mutual concern;
   b. Attend all meetings of the governing body as an ex-officio, non-voting member;
   c. Call, preside at, and be responsible for the agenda for medical staff general meetings;
   d. Serve as Chair of the Medical Executive Committee;
   e. Serve as ex-officio member of all other medical staff committees without vote;
   f. Enforce these Bylaws, implement corrective action where indicated, and ensure Medical Staff compliance with procedural safeguards related to corrective action;
   g. Appoint committee members to all standing, special, and multidisciplinary Medical Staff committees, except for the Medical Staff Executive and Credentials Committees, and committees on unique clinical skills;
   h. Present the views, policies, actions, needs and grievances of the Medical Staff to the Governing Body, Hospital President, and health system CEO:
      i. The report to the Governing Body and Hospital President will emphasize the impact of Board and administrative policies on the Medical Staff’s ability to provide safe, efficient medical care, on the resources necessary to render the medical care expected in a tertiary medical center, and on compliance with accrediting and regulatory bodies and agencies;
      ii. The report will include statements on the Medical Staff’s fulfillment of its responsibility to provide medical care and on other matters, including credentialing, quality improvement; and
      iii. The report will include other matters as may arise or may be specified from time to time by the Medical Staff or the Governing Body;
   i. Receive and communicate the Governing Body’s policies to the Medical Staff;
   j. Be the spokesperson for the Medical Staff; and
   k. Be responsible for coordinating ongoing education on the Joint Commission for the Medical Staff. With the support of the Medical Executive Committee and the Chiefs of Service, he will ensure Medical Staff compliance with Joint Commission guidelines and all pertinent laws and regulations, consistent with instructions and interpretations given during the educational and preparation process.

2. Chief of Staff-Elect: The Chief of Staff-Elect will:
   a. Assist the Chief of Staff in the performance of his duties and assume the duties of the Chief of Staff in the Chief of Staff’s absence;
   b. Attend all meetings of the Governing Body as an ex-officio, non-voting member;
c. Assume the role of Chief of Staff at the end of the Chief of Staff’s term of office. In the event of the Chief of Staff’s death, resignation, or removal from the Medical Staff, the Chief of Staff-Elect will succeed the Chief of Staff; and
d. Be a member of the Medical Staff Executive and Credentials Committees.

3. **Immediate Past Chief of Staff:** The Immediate Past Chief of Staff will:
   a. Prepare the Chief of Staff-Elect for the office of Chief of Staff and serve in other capacities as directed by the Chief of Staff;
   b. Act in cooperation and coordination with the Chief of Staff in matters of mutual concern between the Hospital and Medical Staff;
   c. Assume the duties of the Chief of Staff in the temporary absence of the Chief of Staff and Chief of Staff-Elect;
   d. Serve as the Chairman of the Joint Policy Committee;
   e. Serve as an ombudsman for Hospital and Medical Staff leadership in maintaining appropriate rapport between private practice groups and faculty utilizing hospital facilities; and
   f. Be a member of and act as parliamentarian for the Medical Executive Committee.

4. **Treasurer:** The Treasurer will:
   a. Be a member of the Medical Executive Committee and be responsible for collecting annual staff dues as established by the Medical Executive Committee, disbursing those funds as directed by the Chief of Staff or the Medical Executive Committee, being accountable for those funds, and reporting to the Medical Executive Committee.

5. **Past Past Chief of Staff:** While not a current officer, this previous officer shall preside over the past chiefs of staff committee.

G. **Medical Staff Legal Counsel**
The medical staff may retain legal counsel to represent the interests of the entire medical staff. The Chief of Staff will authorize utilization of legal counsel, and may consult with the Medical Executive Committee as needed.

Rewritten/Adopted June 19, 2007
ARTICLE IV: CLINICAL SERVICES

A. Organization of Clinical Services
Each Clinical Service is organized as a separate part of the Medical Staff and has a Chief of Service who is responsible for the overall supervision of the clinical work within that Service. The Hospital has the following Clinical Services: Internal Medicine, Surgery, Obstetrics and Gynecology, Pediatrics, Psychiatry, Pathology, Radiology, Family Medicine, Anesthesiology, Emergency Medicine, Rehabilitation Medicine, Radiation Oncology, and Cardiovascular Sciences.

The Medical Executive Committee will consider the recommendations of the Clinical Service as transmitted through the Credentials Committee and recommend initial Clinical Service assignments for all Medical Staff members and all other approved practitioners with clinical privileges.

B. Chiefs of Clinical Services
Each Chief of Service must be an active medical staff member and must be certified by an appropriate specialty board. Under the Affiliation Agreement between the Hospital and the School of Medicine, the chairperson of a clinical department in the School of Medicine, or such other person from that department the Dean of the School of Medicine may designate, shall be appointed the Chief of the corresponding Clinical Service. Appointments are of an indefinite duration, subject to review by the Governing Body and the Dean of the School of Medicine.

1. Duties: Each Chief of Clinical Service will:
   a. Be accountable for all clinically and administratively related activities within the clinical service and maintain quality control programs as appropriate, including peer review;
   b. Continually monitor the professional performance of all individuals with clinical privileges in that clinical service and report regularly to the Medical Executive Committee through the credentialing process;
   c. Recommend to the Medical Executive Committee the criteria for clinical privileges relevant to the care provided in the clinical service, as determined by the members of the clinical service;
   d. Recommend clinical privileges for each member of the service;
   e. Enforce Hospital and Medical Staff Bylaws and policies;
   f. Implement actions taken by the Medical Executive Committee within the service;
   g. Relay to the Medical Executive Committee recommendations from the Service on staff classification, delineation of clinical privileges, and reappointments for all practitioners in the Service;
   h. Assess and recommend to the appropriate hospital authority off-site sources needed for patient care services but not provided by the service;
   i. Be responsible for the teaching, education and research programs in the service that are conducted in the Hospital;
   j. Participate in every phase of administration of the clinical service through cooperation with the nursing service and Hospital administration in matters
affecting patient care and be responsible for the integration of the clinical service into primary functions of the hospital and for the coordination and integration of interdepartmental and intradepartmental services;

k. Work collaboratively with Administration, department managers, and governing body to make recommendations for: a sufficient number of qualified and competent persons to provide care, treatment and service; space and other resources needed by the clinical service; orientation and continuing education of all persons in the service; the determination of the qualifications and competence of department personnel who are not licensed, independent practitioners and who provide patient services;

l. Develop and implement policies and procedures that guide and support the provision of care, treatment and services;

m. Provide continuous assessment and improvement of the quality of care, treatment and services;

n. Be responsible for providing a mechanism for representation from all members of the clinical service in developing patient care policies of the service; and

o. Participate actively in the Hospital’s strategic planning work.

C. Clinical Service Functions
Each clinical service will establish its own mechanism, consistent with medical staff and governing body policies, for providing representation by all members of the service in granting clinical privileges and in developing patient care and other policies of the service.

Each clinical service will establish a quality improvement mechanism in order to continuously assess and improve the quality of care, treatment, and services. Priorities for review are based on high volume, high risk, and problem-prone areas. Presentations, at least quarterly, at the clinical service meetings will include conclusions, recommendations, actions, and effectiveness of action. Reports are submitted consistent with the Hospital’s quality plan. Each clinical service will conduct peer review of its clinical work, consistent with the peer review policy.

D. Meetings
Clinical services will meet at least quarterly. Attendance is not mandatory but is highly recommended; however, each clinical service may develop and enforce its own meeting attendance requirements. Those active medical staff members present shall constitute a quorum. Minutes of each meeting will be prepared and include a record of attendance and the vote taken on each matter. Minutes are forwarded to the Medical Executive Committee. Each clinical service shall maintain a permanent record of its meeting minutes.

Rewritten/Adopted June 19, 2007
Credentialing and Privileging Process

Vidant Medical Center
Medical Staff
ARTICLE V: APPLICATION PROCEDURE FOR APPOINTMENT

Section 1. Application for Appointment

a. Clinical privileges are granted to those practitioners who meet the qualifications for medical staff membership as stipulated in Article I, and Article II of the bylaws of the medical staff.

b. The Medical Staff is committed to a culture of safety, accountability, and performance improvement. In its comprehensive evaluation of each practitioner’s professional practice, the Medical Staff considers outcomes of patient care, medical and clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, health status, professionalism and systems-based practice.

c. A potential applicant will be provided with an application package containing a Medical Staff application form, a privileges request form, a copy of the Medical Staff Bylaws, Rules and Regulations, and a detailed list of required supporting documentation.

d. Every initial application for staff appointment must contain a request for the specific clinical privileges desired by the applicant. The evaluation of such requests shall be based upon the applicant’s education, training, experience, demonstrated competence, references and other relevant information, including an appraisal by the clinical service in which such privileges are sought. Applicants shall have the burden of establishing their qualifications and competency in the clinical privileges they request.

e. Each application for Medical Staff appointment is submitted on the format approved by the Governing Body. If the applicant is a member of the Medical Staff of another Vidant Health hospital, an abbreviated application form may be utilized, with the additional information provided from the applicant’s original credentials file maintained by the VH Centralized Verifications Office (CVO).

f. At the time of initial application, all members of the medical staff and advanced practice professionals must attest that, to the best of their knowledge, they are free from any reportable, communicable disease which may present a hazard to those patients under their care. If the medical staff member or advanced practice professional cannot attest to that fact because of known reportable communicable disease in himself, his application will be reviewed by the Chief of Staff, their private physician and the physician representative of the Infection Control Committee. This group will make recommendations as to possible restrictions of that medical staff member’s or advanced practice professional’s privileges. No medical staff member or advanced practice professional should have their privileges restricted unless there is clear and convincing evidence that such restrictions are necessary to prevent harm to a patient or the medical staff member or advanced practice professional.
g. The applicant shall have the burden of producing adequate information of a proper evaluation of competence, character, physical and mental health status, ethics and other qualifications, and for resolving any doubts about such qualifications. The applicant is responsible for insuring that the questionnaire mailed to the previous Chief of Service is completed and returned to the hospital for entry into the application. Clinical privileges may be withheld until such information is made available and verified.

h. All applicants for medical staff membership will select a sponsor physician, who will be a member of the active medical staff. The Medical Staff Support office will confirm that the physician is willing to accept the sponsorship role prior to the award of the temporary or provisional staff privileges. The duties of the sponsor physician will be:

1) To review the performance of the provisional staff member until full promotion to full staff privileges. If at any time the sponsor believes the activities or professional conduct of the temporary or provisional staff member is considered to be lower than the standards of the medical staff, disruptive to the operation of the hospital, or could affect adversely the health or welfare of a patient, the sponsor should report it to the Chief of Service or Chief of Staff.

2) To perform a review of random sampling of records at the end of the provisional period, and

3) To complete a questionnaire for the Chief of Service regarding provisional member's compliance with the Medical Staff Bylaws, professional knowledge, skill, judgment, and attitude, any observed or informed problems regarding physical and mental health, and the appropriateness of the advancement of the provisional staff member to full status. The sponsor physician may recommend an extension of the provisional period as deemed appropriate in accordance with the Medical Staff Bylaws.

Section 2. Process for Initial Application for Clinical Privileges

a. An application which is not complete shall not qualify for a credentialing recommendation. If the applicant fails to complete the application after 90 days and has not requested an extension, it will be deemed to have been withdrawn. Termination of the credentialing process shall not entitle the applicant to review or appeal pursuant to Article VIII.

b. The Medical Staff support professional will use their best efforts in ensuring that the Vidant Health CVO will in a timely manner, verify information contained in the completed application with confirmation of licensure, insurance, DEA registration, education and training, work history, clinical competence, occupational health compliance, board certification status, identification of the applicant, criminal background history and reports
from the National Practitioner Data Bank and the Federal Healthcare Exclusion Database. All information will be primary source verified when possible.

c. As a part of the assessment of a provider for initial medical staff membership and clinical privileges at Vidant Medical Center, an inquiry of the National Practitioner Data Bank shall be made, asking for information about the provider. Information from this inquiry shall be forwarded to the Chief of the Service or services in which the provider is seeking membership and privileges and to the Chairperson of the Credentials Committee of the Vidant Medical Center Medical Staff. Confidentiality of this information shall be maintained in accordance with guidelines currently in effect for credentials files of providers.

d. The complete application will be sent to the Credentials Committee within sixty (60) days.

e. **Chief of Service.** The complete and fully verified application will be forwarded to the appropriate Chief of Service.

1) The Chief of Service will promptly review the application and supporting materials and prepare a report and recommendation, stating whether the applicant is recommended for Medical Staff appointment, and if so the staff category and specific Clinical Privileges recommended.

2) The Chief of Service will have sixty (60) days following the receipt of the application, to forward any recommendation, along with the entire file to the credentials committee.

3) During the initial appointment process for advanced nurse practitioners, the Chief Nursing Officer will review the application for privileges, and forward a formal, specific, written recommendation for appointment to the Chair of the Credentials Committee.

f. **Credentials Committee.** Following receipt of the completed application for membership, the credentials committee at its next scheduled meeting shall:

1) The credentials committee shall examine the evidence of the character, professional competence, qualifications and ethical standing of the practitioner, and whether the practitioner has established and meets all of the necessary qualifications for the category of staff membership and the clinical privileges requested by him or her.

2) Obtain from every clinical service in which the practitioner seeks clinical privileges specific, written recommendations for delineating the practitioner's clinical privileges, and these recommendations shall be made a part of the report.

3) Together with its written report, the credentials committee shall transmit to the Medical Executive Committee, in a timely manner, the completed application and
a recommendation that the practitioner be either provisionally appointed to the medical staff, rejected for medical staff membership, or that the application be deferred for further consideration.

g. **Medical Executive Committee.** At its next regular meeting after receipt of the application and the report and recommendation of the credentials committee, the Medical Executive Committee shall determine whether to recommend to the governing body that the practitioner be provisionally appointed to the medical staff, that he be rejected for medical staff membership, or that his application be deferred for further consideration. All recommendations to appoint must also specifically recommend the clinical privileges to be granted, which may be qualified by probationary conditions relating to such clinical privileges.

1) When the recommendation of the Medical Executive Committee is to defer the application for further consideration, it must be followed up within 60 days with a subsequent recommendation for provisional appointment with specified clinical privileges, or for rejection for staff membership.

2) When the recommendation of the Medical Executive Committee is favorable to the practitioner, the Chief of Staff shall promptly forward said recommendation, together with all supporting documentation, through the Vidant Medical Center’s President, to the governing body.

3) When the recommendation of the Medical Executive Committee is adverse to the practitioner either in respect to appointment or clinical privileges:

   i) The Chief of Staff shall promptly so notify the practitioner by certified mail, return receipt requested.

   ii) No such adverse recommendation shall be forwarded to the governing body until after the practitioner has exhausted or has been deemed to have waived his right to a hearing as provided in Article VIII of these bylaws.

   iii) If the practitioner exercises his right to a hearing as provided in Article VIII of these bylaws, then the Medical Executive Committee shall consider the report and recommendation of the hearing committee and the hearing record at the next regularly scheduled meeting after the conclusion of the hearing procedures, including notice requirements, as described in Article VIII.

   iv) If the Medical Executive Committee's reconsidered recommendation is favorable to the practitioner, the Chief of Staff shall promptly forward said recommendation, together with all supporting documentation, through the Vidant Medical Center’s President, to the governing body.

   v) If such recommendation continues to be adverse, the Chief of Staff shall promptly so notify the practitioner, by certified mail, return receipt requested.
The Chief of Staff shall also forward such recommendation and documentation to the governing body.

h. **Governing Body.** At its next regular meeting after receipt of a favorable recommendation, it is expected that the governing body or its executive committee shall act in the matter. If the Chief of Staff receives notice that the governing body's decision is adverse to the practitioner in respect to either appointment or clinical privileges, the Chief of Staff shall promptly notify the practitioner of such adverse decision by certified mail, return receipt requested.

1) The decision of the Governing Body is final and shall be communicated to the applicant within 30 days of action.

2) An applicant whose application is denied will not have the right to reapply for a period of one (1) year following the final decision of the Governing Body. An applicant whose application is approved, but who is denied some of the Clinical Privileges requested may reapply for the denied privileges upon completion of additional education or experience relevant to the denied privileges.

3) The recommendations at any level may include special conditions be attached to the appointment, to any privilege, or that an application be deferred pending receipt of additional information. The reasons for each recommendation will be stated and supported with reference to the relevant portion of the application or supporting materials.

4) At any point in this initial appointment process, a personal interview may be conducted with the applicant.

i. **Provisional Status.** All initial appointments to any category of the medical staff shall be provisional for a minimum of a six-month period.

1) At the end of this six-month period the candidate is eligible for permanent staff appointment.

2) Appointment to provisional medical staff membership may not exceed one full year, at which time the failure to advance an appointee from provisional to a regular staff shall be deemed a termination of his staff appointment.

3) A provisional appointee whose membership is so terminated shall have the rights accorded by these bylaws to a member of the medical staff who has failed to be reappointed.

4) Provisional staff members shall be assigned to a clinical service where their performance shall be observed by the Chief of Service or his representative to determine the eligibility of such provisional members for regular staff membership and for exercising the clinical privileges provisionally granted to them.
5) Advancement to regular staff privileges shall be done after six months and before twelve months service upon the recommendation of the Chief of Service.

Section 3. Process for Reappointment

a. Before the end of the previous biennial reappraisal or two years after initial appointment, the medical staff member will be required to complete a medical staff reappointment application.

   1) Only completed applications for reappointment shall qualify for consideration.

   2) A completed application for reappointment must include all the information requested on the application form.

   3) The applicant must also pledge by signature to continue to abide by the Bylaws, Rules, and Regulations of the Medical Staff.

b. As a part of the assessment of a provider for reappraisal-reappointment, the Authorized Practitioner shall make an inquiry of the National Practitioners Data Bank, asking for information about the provider. Results from this inquiry shall be forwarded to the Chief of the Service or services in which the provider is seeking reappointment and privileges and to the Chairperson of the Credentials Committee of the Vidant Medical Center Medical Staff. Confidentiality of this information shall be maintained in accordance with guidelines currently in effect for credentials files of physicians and dentists.

c. Upon receipt of a complete application, the information contained in the application will be verified with confirmation of licensure, insurance, DEA registration, occupational health compliance, board certification status, and reports from the National Practitioner Data Bank and the Federal Healthcare Exclusion Database. The Medical Staff Support professional will verify the information contained in the application.

d. The applicant shall have the burden of producing adequate information for a proper evaluation of his competence, character, health status, ethics, professionalism and other qualifications, and for resolving any doubts about such qualifications.

e. Continuing education requirements vary among disciplines of practitioners of the medical staff. The medical staff continuing education credit requirement for reappointment is the same as the requirement established by the practitioner’s licensing agency. Maintenance of a full and unrestricted license is sufficient evidence to meet the reappointment requirement for CME.

f. At the time of reappointment, all members of the medical staff and advanced practice professionals must attest that, to the best of their knowledge, they are free from any reportable, communicable disease which may present a hazard to those patients under their
care. If the medical staff member or advanced practice professional cannot attest to that fact because of known reportable communicable disease in himself, his reappointment would be reviewed by the Chief of Staff, their private physician and the physician representative of the Infection Control Committee. This group will make recommendations as to possible restrictions of that medical staff member’s or advanced practice professionals privileges. No medical staff member or advanced practice professional should have their privileges restricted unless there is clear and convincing evidence that such restrictions are necessary to prevent harm to a patient or the medical staff member or advanced practice professional.

g. An application which is not complete shall not qualify for a credentialing recommendation. If the applicant fails to complete the application without good cause within the stated deadline, the term of appointment and clinical privileges shall expire and the applicant will be required to reapply for appointment and privileges.

h. Should the application be complete, a reappointment profile will be initiated regarding the staff member's performance during the past two years. Included in the profile will be collected information regarding the applicant's utilization of hospital resources, compliance with Medical Staff Bylaws, Rules, and Regulations, and findings from quality improvement/performance activities, and at a minimum should encompass organizational improvement activities which may include medication use, blood use, operative and invasive procedures, mortality, medical records, utilization review, and nosocomial infections. Verification of information supplied in the reappointment application will also be undertaken.

i. Once the application is complete, a reappointment profile will be initiated regarding the staff member's clinical performance since prior appointment. Included in the profile will be collected peer review information, CME activity, clinical competence assessment, and information from external sources as necessary.

j. **Chief of Service.** The completed reappointment application along with the reappointment profile will be submitted to the applicant's Chief of Service.

1) The Chief of Service will promptly review the reappointment application and supporting materials and prepare a report and recommendation, stating whether the applicant is recommended for Medical Staff appointment, and if so the staff category and specific Clinical Privileges recommended.

2) The Chief of Service will have sixty (60) days following the receipt of the reappointment application to forward any recommendation, along with the entire file, to the credentials committee.
3) During the re-credentialing process for advanced nurse practitioners, the Chief Nursing Officer will review the application for privileges, and forward a formal, specific, written recommendation for appointment to the Chair of the Credentials Committee.

k. **Credentials Committee.** Following receipt of the completed application for membership, the credentials committee at its next scheduled meeting shall:

1) The credentials committee shall examine the evidence of the character, professional competence, qualifications and ethical standing of the practitioner, and whether the practitioner has established and meets all of the necessary qualifications for the category of staff membership and the clinical privileges requested by him or her.

2) Obtain from every clinical service in which the practitioner seeks clinical privileges specific, written recommendations for delineating the practitioner's clinical privileges, and these recommendations shall be made a part of the report.

3) Together with its written report, the credentials committee shall transmit to the Medical Executive Committee, in a timely manner, the completed application and a recommendation that the practitioner be either re-appointed to the medical staff or rejected for medical staff membership, or that the application be deferred for further consideration.

l. **Medical Executive Committee.** At its next regular meeting after receipt of the reappointment application and the report and recommendation of the credentials committee, the Medical Executive Committee shall determine whether to recommend to the governing body that the reappointment, non-reappointment or modification of the practitioner’s clinical privileges.

1) When the recommendation of the Medical Executive Committee is to defer the application for further consideration, it must be followed up within 60 days with a subsequent recommendation for reappointment with specified clinical privileges, or for rejection for reappointment.

2) When the recommendation of the Medical Executive Committee is favorable to the practitioner, the Chief of Staff shall promptly forward said recommendation, together with all supporting documentation, through the Vidant Medical Center’s President, to the governing body.

3) When the recommendation of the Medical Executive Committee is adverse to the practitioner either in respect to appointment or clinical privileges:

i. The Chief of Staff shall promptly so notify the practitioner by certified mail, return receipt requested.
ii. No such adverse recommendation shall be forwarded to the governing body until after the practitioner has exhausted or has been deemed to have waived his right to a hearing as provided in Article VIII of these bylaws.

iii. If the practitioner exercises his right to a hearing as provided in Article VIII of these bylaws, then the Medical Executive Committee shall consider the report and recommendation of the hearing committee and the hearing record at the next regularly scheduled meeting after the conclusion of the hearing procedures, including notice requirements, as described in Article VIII.

iv. If the Medical Executive Committee's reconsidered recommendation is favorable to the practitioner, the Chief of Staff shall promptly forward said recommendation, together with all supporting documentation, through the Vidant Medical Center’s President, to the governing body.

v. If such recommendation continues to be adverse, the Chief of Staff shall promptly so notify the practitioner, by certified mail, return receipt requested. The Chief of Staff shall also forward such recommendation and documentation to the governing body.

m. Governing Body. At its next regular meeting after receipt of a favorable recommendation, it is expected that the governing body or its executive committee shall act in the matter. If the Chief of Staff receives notice that the governing body's decision is adverse to the practitioner in respect to either appointment or clinical privileges, the Chief of Staff shall promptly notify the practitioner of such adverse decision by certified mail, return receipt requested.

n. The decision of the Governing Body is final.

o. A written record of all matters considered in each practitioner's periodic reappointment appraisal must be made a part of the permanent files of the hospital.

Section 4. Expedited Governing Body Approval

The Chief of Staff and the Hospital President may request expedited approval by the Governing Body for eligible applications for initial appointment to the Medical Staff, granting of Privileges, reappointment to the Medical Staff, or renewal or modification of Privileges. Only complete and verified applications that raise no concerns and have received favorable recommendations from both the Credentials Committee and the Medical Executive Committee, without limitations, are eligible for this expedited Governing Body approval process.

Section 5. Special Privileging Situations

While the routine process for approval of initial appointments require review and recommendation by the Chief of Service, Credentials Committee and the Medical Executive Committee, with final approval by the Governing Body, alternate approval processes may be used in the situations described below:
a. **Temporary Privileges.**

1) Upon receipt of a verified application for medical staff membership, the hospital president or his designee, with the written concurrence of the Chief of Service concerned and of the Chief of the Medical Staff, may grant temporary clinical privileges to the applicant. The applicant shall act under the supervision of the Chief of Service to which he/she is assigned. Temporary privileges for new applicants may be granted for no more than 120 days.

2) An applicant is usually ineligible for temporary appointment if any of the following has occurred: a current or previously successful challenge to licensure or registration, the applicant has been subject to involuntary termination of medical staff membership at any organization, or has been subject to involuntary limitation, reduction, denial, or loss of clinical privileges or there has been a final judgment adverse to the applicant in a professional liability action. If there has been a final judgment adverse to the applicant in a professional liability action and the Chief of Service and Chief of Staff believe the liability action should not affect the applicant’s ability to gain temporary privileges, the Chief of Staff may proceed in issuing temporary privileges.

3) Special requirements of supervision and reporting may be imposed by the Chief of Service concerned on any practitioner granted temporary privileges.

4) Temporary Privileges may not be renewed or extended.

5) Temporary Privileges may be terminated at any time, with or without cause, by the applicable Chief of Service, the Chief of Staff, the Hospital President or his designee.

6) A Practitioner who is denied Temporary Privileges or whose Temporary Privileges are terminated shall not be entitled to a hearing or other review of such denial or termination. Unless otherwise required by law, such denial or termination shall not constitute an adverse action reportable to any governmental body or to another institution.

b. **Locum Tenens Privileges.**

Locum Tenens Privileges may be granted to a practitioner who is serving as a locum tenens for a member of the Medical Staff or an Advanced Practice Professional during a practitioner’s absence. The application components, eligibility criteria, approval process and time period for Locum Tenens Privileges are the same as for Temporary Privileges. Appointment to the medical staff should be considered for Locum Tenens Practitioners providing recurring Locum Tenens coverage.
c. **Visiting Professor Privileges.**

Visiting professor privileges may be granted to distinguished practitioners for no more than thirty (30) days at the discretion of the Chief of Service with the approval of the Chief of Staff. The Chief of Service will be responsible for notifying the Chief of Staff by letter of the purpose of the appointment, the expected duration of the visitor's stay, and the active staff member who will be responsible for this individual. Visiting professors will be required to provide a current curriculum vitae and a valid medical license from North Carolina. Verification of current competence will be accomplished before the award of visiting professor privileges. Visiting professors may not admit patients to the hospital. They may be granted privileges for procedures in the hospital during a single visit not exceeding 30 days. The physician must show evidence of $1 million malpractice insurance coverage applicable in North Carolina and the patient should be informed of the visiting professor's involvement in the case. This should be documented as part of the informed consent for the procedure.

d. **Emergency Privileges.**

1) **Emergency Coverage.** Emergency Privileges are reserved strictly for emergency situations when there is an extreme patient care, treatment, or service need that mandates an urgent authorization to practice, for a limited period of time, and there is insufficient time to complete the entire application verification process.

   i) Documentation must be provided from the Chief of Service, Hospital President or other appropriate individual outlining the critical need for the Practitioner to be issued Emergency Privileges. Refer to Vidant Health CVO Policy and Procedure – Credentialing Elements for the issuance of Emergency Privileges.

   ii) Upon the written concurrence of the Chief of Service in which the Privileges are to be exercised, the Chief of Staff and the Hospital President, Emergency Privileges are granted for a time-limited period for the specific need identified.

   iii) Emergency Privileges may be terminated at any time, with or without cause, by the applicable Chief of Service, the Chief of Staff, or the Hospital President. A Practitioner who is denied Emergency Privileges or whose Emergency Privileges are terminated shall not be entitled to a hearing or other review of such denial or termination.

   iv) Unless otherwise required by law, such denial or termination shall not constitute an adverse action reportable to any governmental body or to another institution.

   v) The full verification process will be initiated by the Vidant Health Credentials Verifications Office (CVO) to enable further processing of the application for full or locum tenens privileges.

2) **Individual Patient Emergency.** In case of emergency, any provider of the medical staff, to the degree permitted by his license and regardless of service or staff status
or lack of it, shall be permitted and assisted to do everything possible to save the
life of a patient, using every facility of the hospital necessary, including the calling
for any consultation necessary or desirable.

i) Emergency care may also be provided by a resident physician.

ii) When an emergency situation no longer exists, such provider must request the
privileges necessary to continue to treat the patient. In the event such privileges
are denied or he/she does not desire to request privileges, the patient shall be
assigned to an appropriate member of the medical staff.

iii) For the purpose of this section, an "emergency" is defined as a condition in
which serious permanent harm would result to a patient or in which the life of
a patient is in immediate danger and any delay in administering treatment would
add to that danger.

e. Disaster Privileges.

1) Disaster privileges may be granted by the Chief of Staff, the hospital President or
their designee to physicians and dentists when the Vidant Medical Center
Emergency Management Plan has been activated or the organization cannot meet
immediate patient care needs.

2) Decisions for granting disaster privileges will be made on a case-by-case basis.

3) Every effort will be made to insure individuals are properly identified prior to the
award of privileges.

4) The first step towards issuance of disaster privileges begins when the individual
requesting privileges presents a valid picture ID issued by a US state, federal or
regulatory agency and one of the following forms of identification:

i) A current picture hospital identification card that clearly identifies professional
designation,

ii) A copy of current license to practice medicine or primary source verification,

iii) Identification indicating that the individual is a member of a Disaster Medical
Assistance Team (DMAT), or has been granted authority to render patient care
in emergency circumstances, such authority having been granted by a federal,
state, or municipal entity, or

iv) Or in the absence of one of the three forms of verification above, a current
hospital or medical staff member(s) with personal knowledge regarding
practitioner’s identity and ability to act as a licensed independent practitioner
during a disaster may be accepted.
5) Once proper identification has been obtained and validated, the individual will be logged in an emergency privileges log book to denote method of identification, all other possible identification data, and the date privileges were issued.

6) The individual will be issued temporary identification to insure other employees can readily identify the individual with emergency privileges.

7) Each Chief of Service or his designee will be responsible for making a recommendation for emergency privileges if possible and for oversight of the individuals who work in their department with emergency privileges.

8) The Medical Staff Support office will begin the process of verifying the credentials and privileges of those with disaster privileges, within 72 hours of granting the privileges. The minimum verifications will include: Verification of current licensure, criminal background check, query of the National Practitioner Data Bank, verification of board certification status, and verification that current hospital privileges are in good standing without issues.

9) Disaster Privileges may be terminated at any time, with or without cause, by the applicable Chief of Service, the Chief of Staff, or the Hospital President.

10) A Practitioner who is denied Disaster Privileges or whose Disaster Privileges are terminated shall not be entitled to a hearing or other review of such denial or termination. Unless otherwise required by law, such denial or termination shall not constitute an adverse action reportable to any governmental body or to another institution.

11) A practitioner’s privileges granted under an Emergency or Disaster situation will be terminated when the situation no longer exists.
ARTICLE VI: APPLICATION AND AWARD OF CLINICAL PRIVILEGES

Section 1. Credentialing Procedures and the Award of Clinical Privileges

a. Each Clinical Service shall establish its own criteria for the award of general and special privileges for its members. Race, color, creed, gender or national origin shall not be a factor in the award or denial of clinical privileges.

1) Requested special privileges must be reasonably related to the field of practice and documented expertise of the applicant.

2) Requests for all general and special privileges must be accompanied by credible written documentation of training and experience.

3) The Chief of Service is responsible for the initial evaluation of the applicant’s credentials and request for general and special privileges. It is the further duty of the Chief of Service to initiate the recommendation, with supporting data, that an applicant be granted or denied clinical privileges.

4) The following considerations may affect the granting of clinical privileges:

   i. The ability of the hospital to provide facilities and support services for the applicant and her/his patients.

   ii. The current need for additional medical staff with the applicant’s skills and training.

5) All Clinical Service credentialing and privileging criteria must be approved by the Medical Executive Committee and Governing Body prior to implementation.

Section 2. Application Process for Clinical Privileges

a. Requests for additional clinical privileges or modification of privileges must be in writing. To assure uniformity, they should be submitted on a prescribed form, on which the type of clinical privileges desired and the applicant's relevant recent training and/or experience must be stated and meet the requirements in accordance with established policies.

b. Privileges for Active and Consulting staff will require meaningful involvement with at least 25 patients during the 2-year period immediately preceding reappointment. If activity falls below this threshold during the reappointment period, suitable clinical activity or quality data from other facilities may be supplied for consideration of ongoing privileges.

c. Refer and Follow privileges may be granted to those active medical staff members who anticipate minimal or no clinical activity in the facility and/or rely on the services of other active medical staff members for inpatient management of their patients. Access to review the medical record of patients with an active patient-physician relationship will not be limited. Entries into the medical record are limited by privileges.
d. Physicians with no clinical privileges or with Refer and Follow privileges for 2 years or more, who wish to request additional privileges, may be required to participate in a reentry program developed by the Chief of Service.

e. Privileges granted to dental surgeons shall be based on their training, experience, and demonstrated competence and judgment. The scope and extent of surgical procedures that each dental surgeon may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by dental surgeons shall be under the overall supervision of the Chief of Surgery. All dental patients shall receive the same basic medical appraisal as patients admitted to other surgical services. A physician member of the medical staff shall be responsible for the care of any medical problem that may be present at that time of admission or that may arise during hospitalization.

Section 3. Interservice Privileging

a. Requests for special privileges that are provided by or within another Clinical Service will be considered on a case by case basis. Upon the award of interservice privileges, a participating Clinical Service shall provide a process that permits physician members of other clinical services to exercise approved interservice privileges within its area or facility. The requirements for granting these special interservice privileges may not be more restrictive than a Clinical Service requires for its own members. It shall not be necessary to have all of the membership qualifications of each Clinical Service in order to exercise interservice privileges. Specialty Board Certification or Eligibility in more than one clinical discipline shall likewise not be required. Physicians holding interservice privileges are expected to meet the relevant duty schedules of both Clinical Services. The award of clinical privileges shall generally conform to those existing in similar medical centers.

b. When special procedures or services are performed by two or more Clinical Services, an interservice practice committee may be established by the Medical Executive Committee. The interservice committee's responsibilities shall include, but are not necessarily limited to:

1) The establishment of processes and schedules by which all physician members will have reasonable and equitable access to necessary facilities and equipment.

2) The establishment of duties by which all physician members can discharge their responsibilities to that unit, including attendance at required Clinical Service meetings and committees.

3) The establishment of a quality improvement program specific to the shared services. Physician specific quality improvement data shall be provided to the appropriate Chief of Service for consideration in biennial reappointments.

c. Interservice practice committees shall make regular reports of their activities to the Chiefs of Service of the participating Clinical Services.
d. **Interservice Credentialing and Privileging Dispute Resolution.**

At the request of the Executive Committee, the Chief of Staff, in consultation with the Chairperson of the Credentials Committee will appoint five members from the Active medical staff to an Ad Hoc dispute resolution committee. The members will be selected from Clinical Services or areas of practice that are removed from the issue to be resolved. The medical staff attorney will provide advice and guidance to the Ad Hoc Committee. After suitable notification, a designated spokesperson for each side will make a presentation to the Ad Hoc committee. Following the presentations, the committee will deliberate the issues and clarify any questions individually with the advocates. At the conclusion of the deliberations, a vote of the committee will be received by the committee chair. The majority vote of the Ad Hoc committee shall be its recommendation to the full Credentials Committee of the Medical Staff. The Credentials Committee shall present this recommendation to the Medical Executive Committee at its next regularly scheduled meeting. The Executive Committee shall then forward its recommendation to the Governing Body within thirty days.

e. **New Technology.** A new technology group shall be named by the Medical Executive Committee when several Clinical Services are jointly involved in the development of a significant new technology. The group shall develop appropriate standards of training and expertise, and review the credentials of physicians requesting such privileges for the Credentials Committee of the Medical Staff. Its recommendations regarding privileges in the new technology shall be made to the Credentials Committee of the Medical Staff. In other respects the group shall function as a temporary interservice practice committee.

A new technology group shall be dissolved twenty four (24) months after inception unless extended for additional twelve (12) month periods, or established as a permanent interservice practice committee by the Medical Executive Committee. Upon dissolution, as new technology becomes an integral part of specialty practice, the established credentialing and privileging procedures of the Clinical Service will be followed.
Corrective Action Process

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Vidant Medical Center
Medical Staff

Rewritten and Adopted 12/19/06
Revised 9/21/10, 9/20/11, 4/16/13, 10/22/13, 7/22/14
ARTICLE VII: CORRECTIVE ACTION FOR MEDICAL STAFF MEMBERS

Section 1: Definitions

For the purposes of Articles VII and VIII the following definitions shall apply:

For purposes of Article VII and Article VIII of these Bylaws, Rules and Regulations, the term “Practitioner” shall include medical staff members and Advanced Practice Professionals who, by holding privileges at VMC, are subject by these Bylaws, Rules and Regulations to the Corrective Action Process contained in this Article.

Professional Standards Committee (PSC): A medical staff committee with membership comprised of six most recent past chiefs of staff, excluding the immediate past chief of staff (the most recent past chief shall include any past chiefs of staff preferably in the order of recent service). The most recent past chief, exclusive of the immediate past chief, shall serve as chair. The chair and two other committee members will accomplish the duties of the PSC described in Article VII. In the event the Hearing and Appellate Review process is initiated, the remaining three members will function as the hearing committee described in Article VIII. The medical staff attorney will attend all meetings of this committee.

The members of the PSC must not be physicians who are in direct economic competition with the practitioner or party to any activity which led to the request for investigation. Physicians who practice in the same specialty/subspecialty as the affected practitioner are considered for these purposes to be in direct economic competition. If one of the designated former past chiefs is no longer a member of the medical staff or unavailable to serve on the PSC, the Chief of Staff will appoint another previous past chief to serve on this committee.

Being a member of a multi-specialty practice that has the same specialty/subspecialty of the affected practitioner is not considered as being in direct economic competition and does not disqualify an individual from serving on the PSC.

For purposes of computing time under these Bylaws, when the time period being computed is seven days or less, Saturdays, Sundays and state holidays are excluded from the calculation. When the time period being computed is more than seven days, Saturdays, Sundays and state holidays are included in the calculation.

For purposes of this Section of these Bylaws, “conduct that warrants Intermediate Corrective Action” is conduct that does not comply with these Bylaws and the Medical Staff Policies but is also non-repetitive human error, non-reckless conduct, does not present an immediate or imminent risk of harm to a patient, and is not otherwise subject to an automatic suspension or other automatic corrective action by the terms of the Medical Staff Bylaws and Policies.

“The Elected Medical Staff Leadership” refers to the Chief of Staff, the Chief of Staff Elect and the Past Chief of Staff.
Section 2. Request for Investigation Prior to Corrective Action

a. Whenever the Chief of any Clinical Service, the Chief Medical Officer, the Chair of the Credentials Committee, the Chief of Staff, the Hospital President or the Governing Body believes the activities or professional conduct of any practitioner is considered to be lower than the standards of the medical staff, disruptive to the operation of the hospital or could affect adversely the health or welfare of a patient, any of these individuals or the Governing Body may request an investigation. The request must be made in writing to the VMC Chief of Staff, and shall contain an explanation of the specific activities or conduct which constitutes the grounds for the request. The written request shall be processed as outlined in Sections 2 through 5 inclusive of this Article VII.

b. Immediately upon receipt of the request, the Chief of Staff shall consult with the Chief of the Clinical Service in which the practitioner has clinical privileges and at least one other active staff member in the same clinical service, who must be a person other than the person initiating the request for action, regarding the possible need for summary suspension as described in Article VII, Section 6. The Chief of Staff may, after this consultation elect summary restriction of privileges or suspension. If summary suspension/restriction is invoked, further action shall take place as described in Article VII, Section 6.

c. In event the subject of the investigation is the Chief of Staff or Chief of Staff-Elect, the other of the two will act as "Chief of Staff" in this matter only.

d. If a practitioner has been subjected to action adversely affecting his license imposed by the State Medical or Dental Board, whether or not such action is stayed by a court of law, the Board's action will be treated as a request for investigation prior to Corrective Action as described in this Article VII. A copy of the Board's ruling shall be considered a written request to the VMC Medical Executive Committee for investigation prior to Corrective Action as described in subsection (a) of this Section 2. Nothing in this paragraph shall supersede the provisions of Section 7(b) of this Article VII.

e. If the Chief of Staff and the Chief of Service shall make a determination that the practitioner’s alleged conduct warrants Intermediate Corrective Action, then practitioner shall be subject to Article VII, Section 3 of these Bylaws, otherwise the practitioner shall be subject to Article VII, Section 4 of these Bylaws.

Section 3. Intermediate Corrective Action

a. Upon determination that the practitioner’s alleged conduct warrants Intermediate Corrective Action, the practitioner’s Chief of Service shall notify the affected practitioner, in writing, of the alleged conduct and give the affected practitioner the opportunity to meet with the Chief of Service to dispute, explain or otherwise discuss the alleged conduct. The Chief of Service shall meet with the provider within 10 days of the notification.

b. Subsequent to meeting with the provider, the Chief of Service has the sole discretion, to
institute one or more of the following corrective actions:

1. Dismiss the proceeding with no corrective action;
2. Issue a letter of warning, a letter of admonition, and/or a letter of reprimand;
3. Require the affected practitioner to pay fine not to exceed $500.00, with said funds being payable to the ECU Residents Emergency Needs Fund;
4. Require the affected practitioner to attend no more than 6 hours of directed education, at the practitioner’s own expense, in a topic to be decided at the discretion of the Chief of Service;
5. Any other form of intermediate corrective action, of similar characteristics to those listed above, to be determined in the sole discretion of Chief of Service;
6. Any other corrective action mutually agreed upon by the Chief of Service and the affected practitioner.

c. The Chief of Service shall notify the affected practitioner and Chief of Staff of corrective action(s) in writing. The affected practitioner may, within 14 days after the notice, request a review and hearing of the matter by The Elected Medical Staff Leadership.

1. If this review is requested, the corrective action shall be held in abeyance until final decision is rendered by The Elected Medical Staff Leadership;
2. The Chief of Service shall schedule the matter to be heard by The Elected Medical Staff Leadership within 14 days;
3. The Chief of Service shall provide the affected practitioner at least 7 days written notice of the time, date and location of this meeting;
4. Both the Chief of Service and the affected practitioner shall have the opportunity to address The Elected Medical Staff Leadership;
5. The decision rendered by the Chief of Service will be upheld unless, by majority vote, The Elected Medical Staff Leadership decide to institute different corrective action, subject to the limitations set forth in Article VII, Section 3 (b) (with “The Elected Medical Staff Leadership” being substituted for “the Chief of Service”);
6. The Chief of Service shall notify the affected practitioner of the final decision of the Elected and the final corrective action within 3 days in writing.

d. If the Practitioner fails to abide by the final corrective action within a reasonable amount of time, as determined by and in the sole discretion of the Chief of Service, the Chief of Service may refer the matter to Professional Standards Committee as described in Article VII, Section 4 of these Bylaws

e. The Chief of Service shall make or submit a report to the Medical Executive Committee, for informational purposes only, during a closed session of their next regularly scheduled meeting.

f. The written notices from a finalized Intermediate Corrective Action shall be available for consideration in future corrective actions in regards to the affected practitioner.

g. At any time during the Intermediate Corrective Action process, the Chief of Service or the affected practitioner may, upon written notice, terminate the Intermediate Corrective Action process and refer the matter to Professional Standards Committee as described in Article VII, Section 4 of these Bylaws
h. All written communication described in this Section may be accomplished using email.

Section 4. Referral to Professional Standards Committee (PSC)

a. Upon receipt of the Request for Investigation by PSC, the Chief of Staff will immediately notify the affected practitioner and forward the request to the chair of the PSC. The chair of the PSC will keep the Chief of Staff informed at each phase of the committee’s activity.

b. Within 30 days of receipt of the request for investigation, the PSC chair and two of the members of the PSC will conduct and complete an informal investigation into the matter including an interview of witnesses and the affected practitioner.

c. The PSC may recommend the Medical Executive Committee issue a warning, a letter of admonition, or a letter of reprimand, impose terms of probation or require consultation, recommend reduction, suspension or revocation of clinical privileges, recommend that an already imposed summary suspension or reduction of clinical privileges be terminated, modified or sustained, or recommend that the practitioner's staff membership be suspended or revoked, or such other disciplinary action as may be justified by the facts and circumstances. Recommendations should include a timeframe for completion.

d. The Chair of the PSC will invite the affected practitioner to confer with him for the purpose of reviewing the committee’s recommendation, prior to delivering the recommendation of the PSC to the VMC Medical Executive Committee. During this conference, the Chair of the PSC shall also inform the affected practitioner that the practitioner may accept or decline the committee’s recommendation. If he accepts the recommendation, he waives his right to the fair hearing process. If he declines the committee’s recommendation, he exercises his right to a hearing on the proposed action as described in Article VIII.

e. If the affected practitioner fails to confer with the Chair of the PSC, it is deemed that he accepts the PSC’s recommendation and waives his right to the fair hearing process.

f. The affected practitioner must notify the chair of his decision to accept or decline the PSC’s recommendation within 5 days following his meeting with the Chair of the PSC. Upon notification of acceptance, the Chair of the PSC will confirm in writing to the affected practitioner, the terms of the recommendations from the PSC to the VMC Medical Executive Committee.

g. At least 5 days prior to the meeting of the Medical Executive Committee, the Chief of Staff shall notify the affected practitioner of his right to appear before the VMC Medical Executive Committee at the time the PSC’s report is presented to the VMC Medical Executive Committee. At this meeting the affected practitioner shall have the right to make a brief statement to the committee, but may not ask questions, call witnesses or be represented by another member of the active staff or by counsel (having previously waived his rights to a “Fair Hearing” provided in Article VIII of these bylaws, this appearance shall not constitute a hearing). The minutes shall reflect the appearance.
If the VMC Medical Executive Committee is scheduled to meet less than 5 days from the affected practitioner’s acceptance of the recommendation, the PSC may report at this meeting, with the written approval of the affected practitioner.

If no response is received from the affected practitioner, he is deemed to have accepted the PSC’s recommendation and waived his right to the fair hearing process. If the PSC’s recommendation is declined by the affected practitioner, no recommendation is forwarded to the VMC Medical Executive Committee until the conclusion of the fair hearing process.

Major extenuating circumstances affecting either the practitioner under investigation or other essential participants may be cause for the PSC chair to postpone or otherwise reschedule the activities of the committee in this matter. The definition of “major extenuating circumstances” is to be made by the chair of the PSC in consultation with the Chief of Staff.

Section 5. Actions of VMC Medical Executive Committee

The VMC Medical Executive Committee shall hear the PSC’s report at its next regularly scheduled meeting.

If the practitioner under investigation fails to appear, he shall be deemed to have waived his right to appear. Major extenuating circumstances affecting either the practitioner under investigation or other essential participants may be cause for the Chief of Staff to postpone or otherwise reschedule the activities of the VMC Medical Executive Committee in this matter. The definition of “major extenuating circumstances” is to be made by the Chief of Staff in consultation with the members of the VMC Medical Executive Committee.

The VMC Medical Executive Committee, in executive session, shall take action on the recommendation of the PSC. A written record of the meeting shall be made by the VMC Medical Executive Committee.

Acceptance, rejection or modification of the PSC’s recommendation requires a majority vote by the Medical Executive Committee.

In the event the VMC Medical Executive Committee modifies the recommendation of the PSC, the Chief of the Staff or his designee shall immediately notify and confer with the affected practitioner and advise him of the changes in the recommendations by the VMC Medical Executive Committee.

Within 5 days of the notification, the affected practitioner shall indicate, in writing, whether he accepts or declines the VMC Medical Executive Committee’s modification of the PSC’s recommendation. The Chief of Staff in consultation with the Chair of the PSC shall have the authority to make minor modifications to the VMC Medical Executive Committee’s recommendation upon request of the affected practitioner. If the VMC Medical Executive Committee’s recommendation is declined by the affected practitioner, the matter moves to
the Fair Hearing Process under Article VIII of these Bylaws and no recommendation is forwarded to the Governing Body until the conclusion of the process.

g. In the event the affected practitioner accepts the modifications of the VMC Medical Executive Committee, The Chief of Staff or his designee shall, within 5 days of the action taken by the VMC Medical Executive Committee, inform the affected practitioner in writing of the action taken by the VMC Medical Executive Committee. Such notification shall be sent by certified mail, with receipt notification or hand delivered.

h. Any restrictions imposed by the VMC Medical Executive Committee become effective immediately and remain in effect pending the Governing Body's decision on the matter.

Section 6. Notification of Practitioner of Action of VMC Medical Executive Committee

a. The Chief of Staff shall promptly notify the Hospital President or his designee of any action taken by the VMC Medical Executive Committee and will keep him fully informed of all actions in connection therewith and of the recommendation of any restriction of privileges.

b. The Chief of Staff will within 5 days of the action taken by the VMC Medical Executive Committee, inform in writing the Chief of the respective Clinical Service or his designee of the actions taken by the VMC Medical Executive Committee and will specifically instruct that Chief of the Clinical Service of what measures that he will undertake in order to carry out the directives of the VMC Medical Executive Committee. Any restrictions imposed by the VMC Medical Executive Committee become effective immediately and remain in effect pending the Governing Body's decision on the matter. The Chief of Staff will be responsible for monitoring compliance with the recommendations and delegate duties, as appropriate, to the Chief of Service.

c. The event the practitioner does not adhere to the recommendations adopted by the Governing Body, the Chief of Staff, in consultation with the Chief of Service shall, be responsible for enacting the terms set forth in the recommendations.

d. The Governing Body shall hear the recommendation of the VMC Medical Executive Committee report at its next regularly scheduled meeting.

e. The Chief of Staff or his designee shall, within 5 days of the action taken by the Governing Body, inform the affected practitioner in writing of the action taken by the Governing Body. Such notification shall be hand delivered or sent by certified mail, with receipt notification.

f. The Chief of Staff will within 5 days of the action taken by the Governing Body, inform in writing the Chief of Staff, the Chief of the respective Clinical Service or his designee of the actions taken by the Governing Body. The Chief of Staff will specifically instruct that Chief of the Clinical Service of what measures that he will undertake in order to carry out the directives of the Governing Body. Any restrictions imposed by the VMC Board of Trustees become effective immediately and remain in effect for the time prescribed in the adopted recommendations.
Section 7. Summary Suspension/Restriction

a. Following request for investigation according to Article VII, Section 2, paragraph b, whenever action must be taken immediately in the best interest of patient care in the hospital or of the public welfare, the Chief of Staff or hospital President may summarily suspend all or any portion of the clinical privileges of a practitioner and such summary suspension/restriction shall become effective immediately.

b. A practitioner whose clinical privileges have been summarily suspended shall be notified immediately of the action taken and within 24 hours, he shall be informed in writing by the Chief of Staff (with a copy to the Hospital President or his designee) of the reason(s) for the suspension, including a list of allegations which led to the suspension. Thereupon, the Chief of Staff will direct the PSC to investigate the allegations immediately and present their findings to the VMC Medical Executive Committee within 7 business days of the suspension. Although this investigation is informal, the PSC shall allow the practitioner to appear before the PSC, be represented by counsel and call and cross examine witnesses. A called meeting of the VMC Medical Executive Committee may be necessary.

c. The affected practitioner may be present at the meeting of the VMC Medical Executive Committee at which the findings of the PSC are presented. He may be represented by a member of the then active medical staff or by counsel. He shall be notified in writing of the meeting and shall be provided a copy of the findings of the PSC at least 48 hours prior to the meeting before the VMC Medical Executive Committee. The Chief of Staff shall be responsible for assuring that the written findings and notice have been delivered to the affected practitioner. In executive session, the VMC Medical Executive Committee, upon receiving the report of the PSC, will recommend modification, continuance or termination of the terms of the summary suspension. The affected practitioner may appeal the decision of the PSC and request a hearing upon the decision of the VMC Medical Executive Committee as described in Article VIII of these Bylaws but the suspension/restriction shall remain in effect throughout the appeals process.

d. Immediately upon the imposition of the summary suspension/restriction, the Chief of Staff or the responsible Chief of Service shall have the authority to provide for alternative medical coverage for the patients of the suspended practitioner still in the hospital at the time of such suspension. The wishes of the patients shall be paramount in the selection of such alternative practitioner.
Section 8. Automatic Suspension

a. A temporary suspension may be imposed automatically after notice of non-compliance with applicable medical staff bylaws, rules, regulations and policies.

b. Action by the State Medical or Dental Board revoking or suspending a practitioner's license, shall automatically result in suspension of all his hospital privileges.

c. A member of the medical staff shall automatically be suspended from practice in the hospital upon failure to maintain professional liability insurance as required by these Bylaws.

d. Practitioners who have their Drug Enforcement Agency (DEA) registration revoked or suspended shall automatically be suspended from practicing in the hospital.

e. The privileges of practitioners who have been excluded from participation in Medicare, Medicaid or other Federal health care programs shall be automatically suspended.

f. Health care providers who have been newly convicted of, pled guilty to, or pled nolo contendere to a felony, health care related crime, or any other crime involving moral turpitude or who have been sanctioned by any state or federal governmental authority for civil or criminal health care related misconduct shall have their hospital and staff membership privileges suspended. A health care provider whose privileges have been suspended for a felony conviction may subsequently have his or her privileges reinstated or may apply for privileges as described in these bylaws.

g. A practitioner under automatic suspension by operation of this Section shall not be entitled to the procedural rights provided in Article VIII of these Bylaws, since such suspension is not the result of any corrective action.

h. In the event a practitioner, who has been automatically suspended pursuant to this Section, corrects the problem that gives rise to the automatic suspension, he may be reinstated by the Chief of Staff or his designee within 24 hours. Upon failure to reinstate as herein provided the practitioner shall be entitled to procedural rights set forth in Article VIII of these bylaws.

i. A provider who fails to remedy the underlying basis of the automatic suspension within 45 days will automatically convert to inactive status.

j. Any patients hospitalized in the care of a suspended health provider shall be managed in accordance with Article VII, Section 6, and Paragraph d of these bylaws.

Revised 09-16-2008, 07-20-10, 04-16-13, 10-22-13, 7-22-14, 2-2015, 4-2016
Fair Hearing

and

Appellate Review Process

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Vidant Medical Center
Medical Staff

Rewritten and Adopted 12/19/06
ARTICLE VIII: HEARING AND APPELLATE REVIEW PROCEDURE

Section 1. Right to Hearing and to Appellate Review

a. When any practitioner receives notice of a recommendation of the PSC or Medical Executive Committee that, if ratified by decision of the Governing Body, will result in denial of privileges or adversely affect his clinical privileges by reduction, suspension or revocation of those privileges, he shall be entitled to a hearing before the PSC, serving as the hearing committee of the medical staff. The three members of the PSC who have not previously reviewed the matter will comprise the hearing committee.

b. When any practitioner has been summarily suspended/restricted as described in Article VII, Section 6, paragraph a, he shall have been afforded an invitation to appear before a meeting of the Medical Executive Committee, as described in Article VII, Section 6, paragraph c. If the Medical Executive Committee affirms any or all the suspension/restriction, that action shall remain in effect during the ensuing hearing and appeals process unless removed by the appropriate authority. (Appropriate authority in this case shall be the Medical Executive Committee or the Governing Body.) If the Medical Executive Committee removes the summary suspension/restriction but imposes any other corrective action, that corrective action will be held in abeyance until the appeals process outlined herewith has been exhausted. If the Chief of Staff or the Medical Executive Committee has taken action that involves neither suspension nor summary restriction, the process to be followed is defined in Article VII, Section 1 through 5, inclusive, and in the appeals process in this Article VIII.

Section 2. Notice of Hearing

a. The practitioner will have been notified in writing by the chair of the PSC (as provided by Article VII, Section 4) of the action recommended to the Medical Executive Committee or in the case of a summary suspension or restriction (as provided in Article VII, Section 6) by the Chief of Staff. The practitioner may waive his right to a hearing by providing the written notification as provided in Article VII, Section 4 or 6, or by his failure to request such hearing, in writing, within time period established therein.

b. If the affected practitioner requests a hearing, he is entitled to written notice from the chair of the PSC, or Chief of Staff in the case of summary suspension or restriction, of the time, date and place of the hearing. The hearing shall be scheduled for no less than 30 days from the date of the practitioner's written request for the hearing. The chair of the PSC, or Chief of Staff in the case of summary suspension or restriction, shall provide the practitioner with notice of the time and date of the hearing and a list of witnesses expected to testify at the hearing on behalf of the hearing committee. The notice of the hearing shall state the acts or omissions for which the practitioner is being subjected to Corrective Action, including a list of specific or representative charts, and/or other subject matter that was considered in making the recommendation for Corrective Action.
Section 3. Composition of the Hearing Committee

a. The three members of the PSC who have not previously reviewed the matter will comprise the hearing committee. The members of the hearing committee must not be physicians who are in direct economic competition with the practitioner or party to any activity which led to the request for investigation. Physicians who practice in the same specialty/subspecialty are considered for these purposes to be in direct economic competition.

Section 4. Rights of the Affected Practitioner at the Hearing

a. The practitioner shall have the right to be represented by counsel or other person of his choice, to have a record made of the proceedings, to call, examine and cross-examine witnesses, to present evidence determined to be relevant by the Chair of the hearing committee, without regard to its admissibility in a court of law and to submit a statement at the close of the hearing. Any or all of these procedural requirements may be waived voluntarily by the affected practitioner.

Section 5. Conduct of Hearing

a. All members of the hearing committee must be present when the hearing takes place, and no member may vote by proxy.

b. An accurate record of the hearing must be kept. The mechanism shall be established by the hearing committee, and may be accomplished by use of a court reporter, electronic recording unit, detailed transcription or by the taking of adequate minutes.

c. The personal presence of the practitioner for whom the hearing has been scheduled shall be required. A practitioner who fails to appear without good cause shall be deemed to have waived his right to appeal.

d. The chair of the hearing committee shall preside over the hearing to determine the order of procedure during the hearing, to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence, and to maintain decorum.

e. The chair of the hearing committee is responsible for designating the witnesses, along with the appropriate documentary material, who are to appear before the hearing committee to present the evidence upon which the PSC’s recommendation was based.

f. The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible over objection in civil or criminal action. The practitioner for whom
the hearing is being held shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of procedure or of fact and such memoranda shall become a part of the hearing record. In reaching a decision, official notice may be taken by the hearing committee, either before or after submission of the matter for decision, of any generally accepted technical or scientific matter relating to the issues under consideration at the hearing and of any facts which may be judicially noticed by the courts of the state where the hearing is held. Participants in the hearing shall be informed of the matters to be noticed and those matters shall be noted in the record of the hearing. The practitioner for whom the hearing is being held shall be given the opportunity, on request, to refute the officially noticed matters by evidence or by written or oral presentation of authority, the manner of such refutation to be determined by the hearing committee. The committee shall also be entitled to consider any pertinent material contained on file in the hospital, and all other information which can be considered in connection with applications for appointment to the medical staff and for clinical privileges pursuant to these bylaws.

g. The hearing committee may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The hearing committee may thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the practitioner for whom the hearing was convened.

h. Within 21 days of the close of the hearing or at the next regularly scheduled meeting of the Medical Executive Committee, whichever is later, the hearing committee shall make a written and oral report and recommendation to the Medical Executive Committee. The report may recommend confirmation, modification or rejection of the original adverse recommendation of the Medical Executive Committee.

Section 6. Rights of the practitioner following the hearing

a. Following conclusion of the hearing, the affected practitioner has the right to receive the written recommendation of the hearing committee, including a statement of the basis for the recommendation, within 21 days of the conclusion of the hearing.

b. The affected practitioner shall have the right to appear before the Medical Executive Committee when the recommendations of the hearing committee concerning himself are presented. He shall have the right to be present to hear the report of the hearing committee and he shall have the right to present a written statement and to read that statement to the assembled Medical Executive Committee. He shall not be present during further deliberations of the Medical Executive Committee.

Section 7. Actions of the Medical Executive Committee

a. The Medical Executive Committee shall hear the hearing committee’s report at its next regularly scheduled meeting.
b. At least 7 days prior to the meeting of the Medical Executive Committee, the affected practitioner shall be notified in writing by the Chief of the Medical Staff of his right to appear personally before the Medical Executive Committee at the time the hearing committee’s report is presented to the Medical Executive Committee. At this meeting the affected practitioner shall have the right to make a brief statement to the committee, but may not ask questions, call witnesses or be represented by another member of the active staff or by counsel. Having previously waived or exercised hearing rights, this appearance shall not constitute a hearing. A record shall be made of the appearance.

c. Failure to appear by the practitioner under investigation shall be deemed a waiver of the right to appear. Major extenuating circumstances affecting either the practitioner under investigation or other essential participants may be cause for the Chief of Staff to postpone or otherwise reschedule the activities of the Medical Executive Committee in this matter. The definition of "major extenuating circumstances" is to be made by the Chief of Staff in consultation with the members of the Medical Executive Committee.

d. The Medical Executive Committee, in executive session, shall take action on the recommendation of the hearing committee. A written record of the meeting shall be made by the Medical Executive Committee.

e. Rejection or modification of the hearing committee’s recommendation requires a 2/3 majority vote by the Medical Executive Committee.

f. The Chief of Staff will notify the affected practitioner of the final decision of the Medical Executive Committee within four business days of the day of the decision of the Medical Executive Committee. The action of the Medical Executive Committee will be implemented within 30 days of notification of the affected practitioner. Such notification shall be sent in writing, by certified mail, with receipt and a copy to the Hospital President or his designee.

Section 8. Appeal to the Governing Body

a. If the affected practitioner elects to appeal the final decision of the Medical Executive Committee, he must notify in writing the Hospital President, within 30 days, from the date of notification of the action of the Medical Executive Committee. Failure to notify the Hospital President in that time shall be considered to be a waiver of that right to appeal and the proceedings shall have been concluded. The affected practitioner may elect in writing to waive his right of appeal.

b. Procedure for appeal beyond written notification of the Hospital President by the affected practitioner shall follow the guidelines contained in the Hospital Board of Trustees Constitution and Bylaws.

c. Within 30 days after receipt of a notice by an affected practitioner of an adverse recommendation or decision made or adhered to after a hearing as above provided, he may,
by written notice to the governing body delivered through the hospital president by certified mail, request an appellate review by the governing body. Such appellate review may be held only on the record on which the adverse recommendation or decision is based, including the practitioner's written statement.

d. If such appellate review is not requested within 30 days, the affected practitioner shall be deemed to have waived his right, and to have accepted such adverse recommendation or decision, and it shall become effective immediately.

e. Within 10 days after receipt of such notice of request for appellate review, the governing body shall schedule a date for such review, including a time and place for oral argument if such has been requested, and shall, through the hospital president, by written notice sent by certified mail, notify the affected practitioner of the date. The date of the appellate review shall not be less than 30 days, nor more than 60 days, from the date of receipt of the notice of request for appellate review, except that when the practitioner requesting the review is under a suspension which is then in effect, such review shall be scheduled as soon as the arrangements for it may reasonably be made, but not more than 60 days from the date of receipt of such notice.

f. The appellate review shall be conducted by the governing body or by a duly appointed appellate review committee of the governing body of not less than 5 members.

g. The affected practitioner shall have 14 days after he has requested an appellate review to submit a written statement in his own behalf, in which those factual and procedural matters with which he disagrees, and his reasons for such disagreement, shall be specified. This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted to the governing body through the hospital president by certified mail, return receipt requested, at least 10 days prior to the scheduled date for the appellate review. A similar statement may be submitted by the Medical Executive Committee or by the chair of the hearing committee appointed by the governing body, and if submitted, the hospital president shall provide a copy thereof to the practitioner at least 10 days prior to the date of such appellate review by certified mail, return receipt requested.

h. The governing body or its appointed review committee shall act as an appellate body. It shall review the record created in the proceedings, and shall consider the written statements submitted pursuant to subparagraph e. of this Section 10, for the purpose of determining whether the adverse recommendation or decision against the affected practitioner was justified and was not arbitrary or capricious. The review committee or the governing body, whichever is appropriate, shall also be represented by an individual who shall be permitted to speak in favor of the adverse recommendation or decision, and who shall answer questions put to him by any member of the appellate review body. The affected practitioner with or without counsel shall have the right to be present to speak against the adverse recommendation or decision and to answer questions put to him by any member of the appellate review body.

i. New or additional matters not raised during the original hearing or in the hearing committee
report, nor otherwise reflected in the record, shall not be introduced at the appellate review.

j. If the appellate review is conducted by the governing body, it may affirm, modify or reverse any prior decision, or, in its discretion, refer the matter back to the Medical Executive Committee for further review and recommendation within 30 days. Such referral may include a request that the Medical Executive Committee arrange for a further hearing to resolve specified disputed issue.

k. If the appellate review is conducted by a committee of the governing body, such committee shall, within 10 days after the scheduled or adjourned date of the appellate review, either make a written report recommending that the governing body affirm, modify or reverse its prior decision, or refer the matter back to the Medical Executive Committee to arrange for a further hearing to resolve disputed issues. Within 10 days after receipt of such recommendation after referral or at its next regularly scheduled session, the governing body committee shall make its recommendation to the entire governing body as above provided.

l. The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Section 10 have been completed or waived. Where permitted by the hospital bylaws, all action required of the governing body may be taken by a committee of the governing body duly authorized to act.

Section 9. Final Decision by Governing Body

a. Within 30 days after the conclusion of the appellate review, the governing body shall make its final decision in the matter and shall send notice thereof to the Medical Executive Committee and, through the hospital president, to the affected practitioner, by certified mail. If this decision is in accordance with the Medical Executive Committee's last recommendation in the matter, it shall be immediately effective and final, and shall not be subject to further hearing or appellate review. If this decision is contrary to the Medical Executive Committee's last such recommendation, the governing body shall refer the matter to the Chief of Staff, Chief of Staff-Elect, Secretary, and Chair of the Credentials Committee of the Medical Staff for further review and recommendation within 30 days, and shall include in such notice of its decision a statement that a final decision will not be made until the Chief of Staff, Chief of Staff-Elect, Secretary, and Chair of the Credentials Committee of the Medical Staff's recommendation has been received. At their next meeting after receipt of the Chief of Staff, Chief of Staff-Elect, Secretary, and Chair of the Credentials Committee of the Medical Staff's recommendation, the governing body shall make its final decision with like effect and notice as first above provided in this Section 10.

b. Notwithstanding any other provision of these bylaws, no practitioner shall be entitled as a right to more than one hearing and one appellate review on any matter which shall have been the subject of action by the Medical Executive Committee, or by the governing body, or by a duly authorized committee of the governing body, or by both.
Section 10. Reporting Adverse Actions

a. The hospital must report any professional review action that adversely affects the clinical privileges of a practitioner or dentist for a period longer than thirty (30) days. It is the duty for the Authorized Representative of the hospital to report adverse actions taken against clinical privileges of a practitioner, or dentist to the applicable licensing agency within fifteen (15) days of the date the adverse professional review action was taken. Any revisions in adverse professional review actions are to be reported in like manner. Before a report is submitted by the Authorized Representative, it shall be reviewed by the Chief of the Medical Staff and the Chief of the Service in which the affected practitioner or dentist has the majority of his privileges. The Chief of Staff and Chief of Service shall attest to the accuracy of the report on behalf of the Medical Staff. The affected practitioner or dentist is to receive a copy of the report for information only.

b. Voluntary surrender or reduction of clinical privileges is to be reported as described above when, at the time of surrender or reduction of privileges, the affected practitioner or dentist is under investigation by the medical staff for possible incompetence or improper professional conduct or if surrender or reduction is in lieu of an investigation.

c. "Investigation" is defined in Article VII of the Medical Staff Bylaws and is defined here as being in process when the steps as outlined in Article VII, Section 2, paragraphs a and b or Article VII, Section 8 have been accomplished.

d. Confidentiality of this report shall be maintained in accordance with guidelines currently in effect for practitioners' and dentists' credentials files.
Medical Staff Organizational Structure

Medical Staff Committees

Rewritten and Adopted 06-17-08; Revised 10-22-13, 7-22-14
ARTICLE XI: MEDICAL STAFF COMMITTEES

A. General Nature of Medical Staff Committees

As a self-governing entity, the organized medical staff has several responsibilities in its relationship to the governing body. The medical staff’s responsibilities, among others, are as follows:

1. Oversight of care provided by physicians and other licensed independent practitioners in the hospital.
2. A role in graduate medical education programs, when the hospital has one or more programs.
3. A leading role in performance improvement activities to improve the quality of care and patient safety.
4. Collection, verification, and evaluation of each licensed independent practitioner’s credentials.
5. Recommending to the governing body that an individual be appointed to the medical staff and be granted clinical privileges, based on his/her credentials.

To meet these responsibilities, medical staff committees have been formed as an interdisciplinary mechanism of monitoring and evaluating the quality of patient care and to improve organizational performance, under the direction of the governing body. Unless otherwise stated, standing medical staff committees will include a broad representation of the medical staff; however committees will consist of an appropriate number of individuals to be an effective, yet manageable size. Committees will meet on a regular basis as determined by the Chair of the committee.

Ad hoc committees are formed by the Medical Executive Committee or by another medical staff committee. They confine their work to the purpose and term for which they are appointed and report as directed. They do not have power of action unless specifically granted by the motion that created the committee. Upon completing their assignment, ad hoc committees are dissolved.

When a medical staff committee is functioning as a medical review committee, they are formed for the purpose of evaluating the quality, cost of, or necessity for hospitalization or health care, including medical staff credentialing, pursuant to North Carolina General Statutes 131E-76, 131E-95 and/or 90-21.22A, and each may act on behalf of the Hospital in connection with the credentialing and peer review of persons having or applying for credentials pursuant to North Carolina General Statute 131E-97.2.

All medical review functions are strictly confidential and materials are marked “Confidential” and segregated from the committee minutes or other records of the committee. Any information generated or considered by a medical staff committee that is shared with another committee, the governing body or the hospital president must be presented by a member of the medical staff committee or by a contact person designated as such by the committee. All members of medical review committees shall comply with and strictly adhere to policies and procedures regarding access and storage of medical review committee
Medical Executive Committees may propose policy development and or revisions to the Medical Executive Committee via established reporting mechanisms.

B. Committee Membership and Chairs

Medical staff committees are chaired by an active medical staff member. Medical Staff Committee Chairs will be appointed by the Chief of Staff unless otherwise indicated. Active medical staff members are the only voting members on medical staff committees except as otherwise permitted in these Bylaws. VMC resident physicians may attend the meeting as observers. Nonvoting members are encouraged to be active participants.

C. Medical Staff Committee Meetings

Committees will meet on a schedule to be determined by each committee. Attendance is not mandatory but is highly recommended; however, each committee may develop and enforce its own meeting attendance requirements. Those active medical staff members present shall constitute a quorum. Minutes of each meeting are forwarded to the Medical Executive Committee. The Committees are as follows:

1. Medical Executive Committee
   a. Composition: All members of the active medical staff are eligible for membership. It is a standing committee, and its membership is as follows:
      i. The Officers of the Medical Staff: Chief of Staff, who serves as Chair; Chief of Staff Elect; Past Chief of Staff; and Treasurer;
      ii. One member and one or more alternate recommended for appointment by each clinical service and approved and appointed by the Chief of Staff. Alternates serve and carry the clinical service votes only in the absence of the appointed member. It is the responsibility of the appointed member to ensure that the alternate is invited to be present in his absence. If neither the member nor the alternate are in attendance for a vote, then the Chief of Service may also cast the vote for the Service.
      iii. Four at-large members (two from the private practicing physician group and two from the full-time faculty of the School of Medicine) to be elected by the Medical Staff at its annual meeting;
      iv. One dental representative elected annually by the dental practitioners from the active medical staff.
      v. Each Chief of Service
      vi. The Chairman of the Patient Safety/Quality Improvement Committee as an ex-officio member without vote to present monthly reports of quality improvement findings;
      vii. Past Chiefs of Staff in their second, third, and fourth years after the Chief of Staff year as ex-officio members without vote, at their pleasure; and
      viii. The Hospital President, or designee, as an ex-officio member, without vote;
b. **Removal of Members:**  
   i. Members may be removed from office by a three fourths vote of the medical staff present at any regular or special called medical staff meeting for failure to perform the duties outlined in these Bylaws.

c. **Voting:**  
   i. Each Clinical Service shall have a number of votes based on total members of the Active Medical Staff in the respective Service as of January 1 of each year:  
      - 1-5 members: 1 vote;  
      - 6-10 members: 2 votes;  
      - 11-15 members: 3 votes;  
      - 16-20 members: 4 votes, etc.;  
   ii. Each chief of service, medical staff officer, at-large member and dental practitioner shall have one vote.  
   iii. When the total number of possible votes by the MSEC is considered, members who are full-time academic physicians shall not have more than 1/3 voting power. At any given meeting, for any specific motion or vote cast by the MSEC, the members present who may vote shall vote.

d. **Duties:** The duties of the Medical Executive Committee are to:  
   i. Represent and act on behalf of the medical staff, subject to the limitations of these Bylaws;  
   ii. Coordinate the activities and general policies of the clinical services;  
   iii. Adopt such policies as may be necessary to implement more specifically the general principles found within these bylaws. These shall relate to the proper conduct of medical staff clinical and operational activities, including but not limited to administrative, patient care, and medical record policies.  
   iv. Serve as liaison between the medical staff, hospital executive staff and governing body;  
   v. Recommend action to the hospital executive staff on medical-administrative matters;  
   vi. Make recommendations on hospital management matters (for example, long range planning) to the governing body through the hospital president and health system CEO;  
   vii. Fulfill the medical staff's accountability to the governing body for the medical care rendered to patients in the hospital;  
   viii. Ensure that the medical staff is kept abreast of the accreditation program and informed of the accreditation status of the hospital;  
   ix. Review the credentials of all applicants and make recommendations to the governing body for medical staff membership, assignments to clinical service and delineation of clinical privileges, acting on the recommendation of the Credentials Committee;  
   x. Periodically review the performance and clinical competence of medical staff members and other practitioners with clinical privileges, and as a result of such reviews, make recommendations for reappointments and renewal or changes in clinical privileges, acting on the recommendation of the Credentials Committee;  
   xi. Ensure professional and ethical conduct and competent performance of all members of the Medical Staff, including the initiation of and/or participation in Medical Staff corrective action with review by the Professional Standards Committee.
Committee or peer review measures when warranted;

xii. Report at each full medical staff meeting;

xiii. Receive and act upon reports and recommendations from Clinical Service and committee meetings; approval of minutes from clinical service and committee meetings shall confer endorsement of reports and recommendations therein; and

xiv. Evaluate the quality, cost of, or necessity for hospitalization or health care services, including medical staff credentialing.

xv. Duties may be altered or removed by amendment to these Bylaws.

2. **Credentials Committee**

   a. **Composition:** The Credentials Committee consists of an elected representative and an elected alternate from each Clinical Service, to be elected by January 1 of each year to ordinarily serve a four (4) year term. The elected alternate will only serve and carry the clinical service vote in the absence of the elected representative. It is the responsibility of the elected representative to ensure that the alternate is invited to be present in his absence. The Hospital President or designee and the Chief of Staff-Elect serve as ex-officio members without vote. Hospital and Medical Staff Legal Counsel serve on an advisory basis. The Chair is appointed by the Chief of Staff.

   b. **Duties:** At the time of initial appointment, promotion or reappointment, review the credentials of all applicants, including specific consideration of the recommendations from the Clinical Service(s) in which such applicant requests privileges, and make recommendations to the Medical Executive Committee for membership, delineation of clinical privileges and assignment to the Clinical Service(s) as provided in these Bylaws:

   i. Evaluate the quality, cost of, or necessity for hospitalization or health care, including medical staff credentialing;

   ii. Review and make a recommendation to the Medical Executive Committee on all changes in clinical service delineation of clinical privilege documents.

   iii. Maintain the credentialing policies manual

   iv. With regard to Advanced Practice Professionals:

   a) Review the credentials of all advanced practice professional applicants and make recommendations for delineation of clinical duties or privileges as governed by the rules and regulations of the State of North Carolina governing the employment and use of advanced practice professionals;

   b) Ensure that the advanced practice professional functions under the supervision of a specified member of the Medical Staff and is registered or licensed with the appropriate State regulatory agency;

   c) Ensure that the supervising physician and advanced practice professional abide by State statutes, rules and regulations governing the employment and use of advanced practice professionals;

   d) Make a recommendation to the Medical Executive Committee on each applicant for advanced practice professional duties and responsibilities, including specific consideration of the recommendations from the Clinical Service of the applicant's supervising physician;

   e) Review, at the time of promotion and recredentialing, all information
available regarding the competence of the advanced practice professional, and make recommendations to the Medical Executive Committee for the promotion and reappointment of the advanced practice professional.

3. **Patient Safety/Quality Improvement Committee**
   a. **Composition:** Membership shall consist of active medical staff members and representatives from the hospital board of trustees, administration, quality management, patient care services and medical records. Appropriate other individuals and professionals from relevant programs, services and departments also will participate as appointed by the Chief of Staff. The members and chairperson shall be appointed by the Chief of Staff.

   b. **Duties:** The Patient Safety/Quality Improvement Committee shall:
      i. Coordinate all patient safety/quality improvement activities.
      ii. Review all submitted patient safety/quality improvement reports and other topics appropriate for this committee.
      iii. Recommend patient safety/quality improvement priorities, in coordination with the Quality Management Department, for Hospital Executive Staff, Medical Executive Committee, and Board of Trustees review and action.
      iv. Assign tasks to and receive reports from appropriate individuals and subcommittees pursuant to the goals of the committee:
      v. Report the findings and actions of the committee to other appropriate committees and individuals.
      vi. Conduct an annual appraisal of the patient safety/quality improvement program.

4. **Utilization Management Committee**
   a. **Composition:** The Utilization Management Committee is comprised of a physician chairperson and physician representatives appointed by the Chief of Staff from each of the major clinical services. Physician representatives serve 2-year terms, which are staggered allowing half of the membership to rotate annually. Additional committee members include Vice-President and staff representatives from other areas, such as Patient Access Services, Clinical Information Management, Quality Management, Behavioral Health, Rehabilitation, Finance and Patient Care Services. Members may be reappointed.

   b. **Duties:**
      i. Review reports from hospital committee members about utilization management issues
      ii. Review operational statistics, length of stay trends, outliers and problems identified through the utilization review process
      iii. Review reports and communications from all outside review organizations for consideration and action, as appropriate
      iv. Monitor provider denials related to inappropriate admission, treatment, resource utilization or length of stay
      v. Monitor medical necessity for hospital admission and continued hospital services
      vi. Provide oversight and support for operational improvement related to access,
vii. Give written notice when it is determined that an admission to the hospital or continued stay are not medically necessary. Notice shall be served to the patient and or their representative, Attending Physician, Administration and Financial Services. As appropriate, notice may be given to the Chief of Service, Medical Executive Committee and fiscal intermediaries.

5. **Quality Executive Committee**
   a. **Composition**: The QEC will be comprised of the Chief of Service for each clinical service.
   
   b. **Duties**:
      i. Provide oversight of the peer review process.
      ii. Provide broad oversight of the quality process and organization, including priority setting.
      iii. Focus on specific issues, receiving information and recommending action to HPS/QIC, VMC Executive Staff, or other effected organizations
      iv. Become educated on quality topics and methods, and disseminate that education among the medical staff.
      v. Create, nurture, and effect culture change, particularly around behavioral expectations and a patient safety culture, in VMC.

6. **Medical Ethics Committee**
   a. **Composition**: The Medical Ethics Committee shall be composed of members of the medical staff and others that are appointed by the Chief of Staff and hospital President. Appointments shall be for one-year terms, and members may serve more than one term. The Chair of the Committee shall be appointed by the Chief of Staff. If the Chair is unable to attend a meeting, he or she will designate another Committee member to chair the meeting in his or her absence.
   
   b. **Purpose and Activities**: The purpose of the committee is to provide a forum for interdisciplinary discussions of general and specific ethical issues which affect the care and treatment of patients within Vidant Medical Center. The committee is educational and advisory in purpose. It shall not interfere with the primary responsibility of physicians and the relationship between physicians and their patients. Activities of the committee may include, but are not limited to, clinical ethics consultation, medical staff education, and policy development and review. The committee may engage in other activities when requested to do so by the Chief of Staff or hospital president.
      i. The Medical Ethics Committee shall sponsor regular continuing education programs for physicians and other health professionals. Such interdisciplinary sessions should promote sensitivity to the difficult and complex issues which face health care providers in making bioethical decisions.
      ii. The committee shall provide clinical ethics consultation upon request. Any patient,
a patient's family member, guardian, or health care agent, or any medical or hospital staff member caring for the patient may request a consultation. The committee's advice is not binding. Typical issues may include withholding and withdrawal of life-sustaining treatment, patient decision-making capacity, and surrogate decision-making. The committee shall inform medical and hospital staff about how to use its clinical ethics consultation service.

iii. The committee may discuss and formulate bioethical policy recommendations for the staff and hospital, whenever requested by the Chief of Staff and/or hospital administration. If the Committee identifies a need for institutional policy regarding a bioethical issue, it may propose to the Chief of Staff or to hospital administration that policy be developed to address that need.

7. **Graduate Medical Education Committee**

The Graduate Medical Education Committee (GMEC) is responsible for advising on and monitoring all aspects of graduate medical education. It is responsible directly to the Medical Executive Committee for all medical staff issues related to graduate medical education trainees. The Graduate Medical Education Committee (GMEC) is directly responsible to the dean of the School of Medicine and the Chief Executive Officer of Vidant Medical Center for all other issues as required by the Accreditation Council for Graduate Medical Education (ACGME). A director of medical education may be provided for in the same manner as the salaried Chief of Staff. He shall supervise programs of graduate medical training and of continuing education for hospital personnel and for the medical staff.

a. **Composition:** The committee shall be constituted as required by the ACGME to include at least the following voting members: the Designated Institutional Official, a representative sample of program directors from its ACGME-accredited programs, a minimum of two peer-selected residents/fellows; and, (a quality improvement/safety officer or his or her designee. The committee chair shall be a physician member of the active medical staff appointed jointly by the Dean of the Medical School and the Chief Executive Officer of the hospital.

b. **Purpose and Duties:** The GMEC Chair shall report to the Medical Executive Committee and to the medical staff yearly. The GMEC shall review credentials of graduate medical education trainees and recommend resident physician privileges to the Medical Executive Committee through the Credentials Committee. The committee shall through its policies and procedures and at the direction of the Medical Executive Committee oversee resident physician activities of graduate medical education trainees in this institution. The committee shall advise on and monitor the following:

i. establishment of institutional policies for graduate medical education;

ii. establishment and maintenance of appropriate liaison with residency directors and with the administrators of other institutions participating in programs sponsored by the institution;

iii. regular review of all residency training programs in relation to their compliance
with institutional policies and the requirements of the relevant ACGME Review Committee;
iv. establishment and implementation of policies and procedures for the selection, evaluation, promotion and dismissal of residents.
v. establishment and implementation of institutional policies and procedures for discipline and the adjudication of complaints and grievances relevant to the graduate medical programs; these policies and procedures must satisfy the requirements of fairness and of due process. They must apply equally to all residents, faculty, and residency programs in the sponsoring and participating institutions.
vi. assurance of appropriate and equitable funding for resident positions, including benefits and support services;
vii. appropriate working conditions and duty hours of residents;
viii. regular review of ethical, socioeconomic, medical/legal, and cost containment issues that affect graduate medical education; and
ix. other duties as may be described by the ACGME.

8. **Bylaws and Policy Committee**
a. **Composition:** Physician members will be selected by chiefs of service, hospital leaders, and others involved with patient care activities at VMC with final appointment made by the Chief of Staff. The committee will also include medical staff, the medical staff attorney and representation from the hospital legal affairs department.

b. **Purpose and Duties:** The Bylaws Committee shall be responsible for making recommendations relating to revision to and updating of the bylaws, rules and regulations of the medical staff, as necessary, based on standards and recommendations of accreditation agencies as well as requests from the medical staff.

9. **Committee on Physician Health**
a. **Composition:** Physician members will be selected by chiefs of service, medical staff leadership and hospital leaders, with final appointment made by the Chief of Staff.

b. **Purpose and Duties:** The Committee on Physician Health is a medical review committee where proceedings, records and materials produced or considered are confidential. The committee will serve as a physician advocate in matters concerning health and wellbeing including:

i. provide confidential non-punitive information and help

ii. serve as an advisory group to medical staff leadership

iii. serve as an avenue of peer review for issues related to physician health, disruptive behavior and impairment, in which case the processes are governed by the VMC Medical Staff Peer Review Policy.
10. **Infection Control Committee**

   a. **Composition:** The committee shall consist of medical staff members appointed by the Chief of Staff. Hospital representatives and ad hoc members will serve on the committee as needed.

   b. **Duties:** The duties of the Infection Control Committee shall be:

      i. Coordinate ongoing, comprehensive and systematic infection surveillance, prevention, and control program for patient care through the routine collection of data, data analysis, initiation of action, and evaluation of action taken.

      ii. Develop and maintain an ongoing review of policies and procedures that prevent and control the spread of infection in all patient care service areas in the hospital and in affiliated agencies.

      iii. Establish priorities for investigation through review of collected data and through analysis of specific demographic and descriptive information specific to the VMC patient population to guide the process for corrective actions.

      iv. Review and evaluate pertinent infection control studies done interdepartmentally and interdepartmentally.

      v. Ensure compliance with the policies, standards, regulations, and laws set forth by the Board of Trustees and accrediting and governing agencies.

      vi. Initiate appropriate control measures or studies when there is felt to be a danger to the patients, visitors, or personnel of the hospital.

      vii. Ensure that the infection control program works together with the organization-wide process for assessing and improving organizational performance.

      viii. Ensure confidentiality and integrity of infection control data by issuing policies and guidelines for the management and dissemination of the data to internal and external agencies and departments.

   

   Rewritten & Approved June 17, 2008, rev. 10/22/13, 7/22/14
ARTICLE XII: IMMUNITY FROM LIABILITY

To the extent permitted by law, the following shall be express conditions to any practitioner's application for, or exercise of, clinical privileges at this hospital:

First, that any act, communication, report, recommendation or disclosure, with respect to any such practitioner, performed or made in good faith and without malice and at the request of an authorized representative of this or any other health care facility, for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged to the fullest extent permitted by law.

Second, that such privilege shall extend to members of the hospital's medical staff and of its governing body, its other practitioners, its chief executive officer and his representatives, and to third parties, who supply information to any of the foregoing authorized representative of the governing body or of the medical staff.

Third, that there shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure, even where the information involved would otherwise be deemed privileged.

Fourth, that such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care institution's activities related, but not limited to: (1) applications for appointment of clinical privileges, (2) periodic reappraisals for reappointments or clinical privileges, (3) corrective action, including summary suspension, (4) hearings and appellate reviews, (5) quality improvement activities, (6) utilization reviews and (7) other hospital, clinical service, or committee activities related to quality patient care and interprofessional conduct.

Fifth, that the acts, communications, reports, recommendations and disclosures referred to in this Article may relate to a practitioner's professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly have an effect on patient care.

Sixth, that in furtherance of the foregoing, each practitioner shall upon request of the hospital execute releases in accordance with the tenor and import of this Article in favor of the individuals and organizations specified in paragraph Second, subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of this State.

Seventh, that the consents, authorizations, releases, rights, privileges, and immunities provided in these bylaws for the protection of this hospital's practitioners, other appropriate hospital officials and personnel and third parties, in connection with applications for initial appointment, shall also be fully applicable to the activities
for initial appointment, shall also be fully applicable to the activities and procedures covered by this Article.

Eighth. any information transmitted to third parties must be made available to the concerned individual upon his request.
ARTICLE XIII: RULES AND REGULATIONS

The medical staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found within these bylaws, subject to the approval of the governing body. These shall relate to the proper conduct of medical staff organizational activities as well as embody the level of practice that is to be required of each practitioner in the hospital. Such rules and regulations shall be a part of these bylaws, except that they may be amended or repealed at any regular meeting at which a quorum is present and without previous notice or at any special meeting on notice, by a two-thirds vote of those present of the active medical staff. Such changes shall become effective when approved by the governing body. It is expected that clinical service rules and regulations (and amendments thereto) usually will be adopted by each clinical service and will be submitted for approval to the Medical Executive Committee and to the governing body.

The Medical Executive Committee may provisionally adopt, and the governing body may provisionally approve, an amendment to the rules and regulations without prior notification of the medical staff, if an urgent need arises to comply with law or regulation. After such approval by the governing body, the Medical Executive Committee will immediately notify the medical staff. The medical staff then has the opportunity for retrospective review of and vote approval or disapproval on the provisional amendment.

ARTICLE XIV: AMENDMENTS

These bylaws, rules and regulations shall be reviewed by the Constitution and Bylaws Committee at least biannually. The bylaws may be amended and revised in a manner to reflect the hospital's current practices with respect to medical staff organization and functions after submission of the proposed amendment at any regular or special meeting of the medical staff. A proposed amendment shall be referred to a special committee which shall report on it at the next regular meeting of the medical staff or at a special meeting called for such purpose. To be adopted, an amendment shall require a two-thirds vote of the active medical staff present. Amendments so made shall be effective when approved by the governing body.

ARTICLE XV: AMENDING A PROPOSED AMENDMENT

While amendments to a proposed bylaw amendment can be made in both the first and second degrees (as applicable) and can be adopted by a majority vote without notice, they are subject to restrictions on the extent of the changes they propose. No amendment is in order that increases the modification of the article or rule to be amended. The same principle applies to an amendment in the nature of a substitute for sections or articles; the proposed substitution is open to amendments that diminish the amount of change, but not to amendments that increase it or that introduces new changes. Amendments to strike out a sentence, paragraph, or section deserve special care. In such cases, the existing bylaw is not itself open to consideration, only the amendment.

Revised 3-19-85
Rules and Regulations

Vidant Medical Center
Medical Staff

Reviewed: 4/2016
PART TWO: MEDICAL STAFF

A. Admission and Discharge of Patients

1. The hospital shall accept patients for care and treatment without limitations.

2. A patient may be admitted to the hospital only by a member of the medical staff. All practitioners shall be governed by the official admitting policy of the hospital. A practitioner whose admitting privileges are under suspension may not assume the care of any patient admitted by another practitioner.

3. A member of the medical staff shall be responsible for the timely medical care and treatment of each patient in the hospital, for the prompt completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring practitioner and to relatives of the patient. Whenever these responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered into the medical record.

4. No patient shall be admitted to the hospital until an admission status order is entered. In the case of an emergency such order shall be recorded as soon as possible. The admitting practitioner will designate the appropriate level of care warranted.

5. Upon request of the utilization review committee, the attending practitioner must provide in writing:
   (a) justification of the necessity for continued hospitalization of any patient;
   (b) the estimated period of time the patient will need to remain in the hospital;
   (c) plans for post hospital care.
   This report must be submitted within 24 hours of receipt of such request. Failure of compliance with this policy will be brought to the attention of the Medical Executive Committee for action.

6. Patients shall be discharged only on an order. Should a patient leave the hospital against the advice of the treatment team, there should be a reasonable attempt to have Against Medical Advice paperwork obtained.

B. Medical Records

History and Physical
Patients receive a medical history and physical examination no more than 30 days prior to, or 24 hours after registration or admission, but prior to surgery or a procedure requiring anesthesia services;

For a medical history and physical examination that was completed within 30 days prior to registration or inpatient admission, an update documenting any changes in the patient’s
condition is completed within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring moderate sedation, deep sedation, or anesthesia.

The history and physical examination and the updated examination, must be completed and documented by a physician or other qualified licensed individual who has been granted the appropriate privileges in accordance with state law and Medical Staff Policies and Procedures.

Revised 10-28-14

When the history and physical examination or an admission summary are not recorded before an operation or any potentially hazardous invasive procedure, requiring moderate sedation, deep sedation or anesthesia, the procedure shall be canceled, unless the attending practitioner states in writing that such delay would be detrimental to the patient.

Clinical Entries
Clinical entries into the medical record may be recorded by a credentialed and privileged attending physician, qualified non-physician, a medical student, or a resident physician working under the attending practitioner's direction. However, the attending practitioner shall be responsible for reading all such entries. All formal entries (such as history and physical examination, consultations, operative reports, and discharge summaries) shall be authenticated by the attending practitioner. A medical student entry cannot be used in lieu of those of a member of the medical staff.

C. General Conduct of Care

1. A general consent form, signed by or on behalf of every patient admitted to the hospital, must be obtained at the time of admission. The admitting office should notify the attending practitioner whenever such consent has not been obtained. When so notified, it shall, except in emergency situations, be the practitioner's obligation to obtain proper consent before the patient is treated in the hospital. In addition to obtaining the patient's general consent to treatment, it shall be the responsibility of the provider performing the procedure to obtain consent that informs the patient of the nature of risks, benefits, and alternatives inherent in any special treatment, operative or invasive procedure. An appropriate consent form may be signed by any provider on the treatment team. Consent forms obtained by resident physicians and advanced practice professionals should indicate the supervising attending physician. If the performing provider is not the signatory of the form, the performing provider shall record the consent in the medical record.

2. Residents physicians may write patient care orders for patients assigned to their care. This policy does not prohibit a member of the medical staff from writing orders. Medical staff members who choose not to participate in the teaching program are not subject to denial or limitation of privileges for this reason alone.

3. Transfer orders must be written within an appropriate time following transfer from a critical care unit. The use of "Renew", and "Continue orders" are not acceptable.
4. Fourth year medical students serving as acting interns shall be permitted to write physician orders which must then be countersigned by a physician prior to implementation or telephone order obtained from a physician.

5. All drugs and medications should be administered to patients only when ordered by a practitioner having clinical privileges. All drugs and medications administered to patients shall be those listed in the latest edition of: United States Pharmacopoeia, National Formulary, American Hospital Formulary Service or A.M.A. Drug Evaluations.

Revised 10-28-14

6. Standing orders for laboratory testing must include a date of termination. Standing orders without a date of termination are to be executed one occasion only and the physician writing the order is to be contacted for clarification.

7. The attending physician is primarily responsible for requesting consultation. Any practitioner with clinical privileges in this hospital can be called for consultation within their area of expertise. A recorded history and physical examination and stated reason for consultation should be available on the chart prior to request. An order for consultation should be written. The attending practitioner shall inform the patient before requesting the consultation.

8. If a nurse has a doubt or question about the care provided to any patient they are encouraged to bring the matter to the attending physician. The nurse may use the nursing chain of command to validate the concerns. If there is insufficient response the nurse may contact the Chief of Service. When circumstances justify the action, the Chief of Service may intervene in the medical care.

9. There is coordination of care, treatment and services among the practitioners involved in the patient’s care.

D. Policies Regarding Surgical Care

There shall be formed an operating room committee composed of representatives of different surgical specialties, anesthesia and nursing services and of hospital management. This committee shall meet quarterly or as deemed necessary by Chief of Surgery to review the functions within the surgical area and to recommend additions or changes in policy of rules when indicated. The policies, regulations and rules for the surgical suite should be determined by the clinical service of surgery, ob-gyn, and anesthesiology with recommendations by the operating room committee. The institution and performance of policy will be the responsibility of the operating room committee.
E. Tissue and Cytologic Examination

1. All surgical specimens removed during surgery will be submitted for pathological examination, except incidentally removed vaginal tissue, cataracts, foreign bodies (including synthetic materials, orthopedic appliances, and bullets), residual portions of tissue used as graft, therapeutic radioactive sources, newborn infant foreskin, normal placentas, teeth, toenails, fingernails, gallstones, urinary calculi, traumatically amputated extremities, debrided tissue from traumatic wounds, directional coronary atherectomy specimens, and blood clot material from any vascular access performed for dialysis in end stage renal disease patients.

2. All fluid specimens will be submitted for cytologic examination except in cases where there is an established diagnosis and fluid removal is therapeutic.

3. Any specimen eligible for exemption is also eligible for pathological examination at the discretion of the operating surgeon. Removed specimens that are not submitted for pathological examination will be described and/or documented in the operative record.

4. The extent of the pathological examination shall be determined by the pathologist.

F. Policies Regarding Obstetrical Care

1. Sterilization and abortions will be done in accordance with North Carolina state law.

2. Other rules and regulations shall be a requirement of the clinical service of obstetrics and gynecology as specified in these bylaws.

G. Policies for the Determination of Brain Death

Section I. Determination of Death: Neurologic Criteria

A. Only attending physicians shall apply accepted neurologic criteria to determine if a person is dead. "Brain death" can be used as the sole basis of the determination of death of a person.

1. Cessation is recognized when evaluation discloses that:
   a. cerebral functions are absent, and
   b. brain stem functions are absent

2. Irreversibility is recognized when:
   a. the cause of coma is established and sufficient to account for the loss of brain functions, and
   b. the possibility of recovery of any brain functions is excluded, and
c. the cessation of all brain functions persists for an appropriate period of observation and/or trial of therapy.

B. Complicating conditions, e.g., drug and metabolic intoxication and hypothermia should be ruled out before applying neurologic criteria to determine death.

C. Extra caution should be exercised when applying neurologic criteria to determine death in children less than five years old and in patients in shock.

D. A second opinion regarding determination of death may be obtained at the discretion of the attending physician.


Revised 9-20-94

H. Patient Self-Determination Rights and End-of-Life Decisions

The DNR policy and Patient Directive policy, which are set forth in the Medical Staff Policy manual and Patient Care Services manual are incorporated into these Medical Staff Bylaws by reference.

I. Guidelines for Post-Mortem Examination:

It shall be the duty of all staff members to secure meaningful autopsies whenever possible. An autopsy may be performed only with consent, in accordance with state law. All autopsies shall be performed by the hospital pathologist, or by a practitioner delegated this responsibility. The attending physician shall be notified when an autopsy is performed. Provisional anatomic diagnoses shall be recorded on the medical record within 72 hours and the complete protocol should be made a part of the medical record within sixty (60) days.

After the death of a patient, it shall be the responsibility of the attending physician to make a judgment as to the need for a post-mortem examination. Below are guidelines to assist in this process; but, except for medical examiner regulations and statutory requirements, these guidelines are not intended to impede the attending physician from seeking a post-mortem examination on any patient to whom he has rendered medical care.

Medical Examiner Cases:
After the death of a patient, the attending physician must first determine whether or not the case should be referred to the medical examiner for further investigation. Listed below are characteristics which place a death in the jurisdiction of the medical examiner. The medical examiner must be notified of all deaths that have at least one of these
characteristics. No other authority for post-mortem examination is to be sought after the medical examiner has made a determination as to whether he will conduct such an investigation and until the medical examiner has determined the extent of the investigation, including whether or not an autopsy will be performed. In some cases where the attending physician is uncertain as to medical examiner jurisdiction, consultation with the medical examiner must be obtained for clarification of jurisdiction.

**Medical Examiner Jurisdiction:**
The following types of deaths in North Carolina must be reported to a medical examiner:

a) Homicide  
b) Suicide  
c) Accident  
d) Trauma  
e) Disaster  
f) Violence  
g) Unknown, unnatural or suspicious circumstances  
h) In police custody, jail or prison  
i) Poisoning or suspicion of poisoning  
j) Public health hazard (such as acute contagious disease or epidemic)  
k) Deaths during surgical or anesthetic procedures  
l) Sudden unexpected deaths not reasonably related to known previous disease  
m) Deaths without medical attendance

Revised 3-18-08

**Hospital (Non-Medical Examiner Cases):**
In deaths where the medical examiner has no jurisdiction or chooses to exercise his jurisdiction in a limited manner, the attending physician may seek a post-mortem examination by obtaining permission for autopsy examination from the legally appropriate person or entity, in accordance with state statute. Since this authority is gained through a process of consent, opportunity for refusal of consent and opportunity for limiting the autopsy examination must be afforded. (The definition of the chain of authority is published on the back of the VMC autopsy consent form.)

**Characteristics of Non-Medical Examiner Case (Hospital Autopsies) in Which Authority for Autopsy Should be Pursued:**

a) All unanticipated deaths.  
b) Death during treatment under an experimental regimen.  
c) Death related or possibly related to pregnancy.  
d) All unexpected pediatric deaths.  
e) Deaths from high risk or contagious diseases.  
f) Deaths from known or suspected occupational hazards.  
g) Any death in which the representative authorized by the state statute requests that an autopsy be performed.

The attending physician's prerogative to pursue authority for autopsy examination in "hospital cases" is not limited to cases with these characteristics.
The attending physician shall document his actions related to a post-mortem investigation and examination in the form of a progress note in the patient's medical record.

Revised 6-15-82, 12-18-90, 9-17-91, 12-19-95

J. Resident Physicians

Applicants who are receiving a residency position at Vidant Medical Center are required to sign a waiver of release of information to the medical staff credentials committee when he or she submits a completed application to the East Carolina University (Brody) School of Medicine. After the waiver has been signed, the application shall be reviewed by the medical staff credentials committee and processed through the regular course of any other staff application. The resident physician will only practice under the direction of the Chief of Service or his delegate. Each Chief of Service is responsible for the action of the resident physicians in the service.

Revised 12-18-90, 12-99,01-2015,2-2016
Advanced Practice Professionals

of

Vidant Medical Center

Advanced Practice Nurses
Physician Assistants
Anesthesiologist Assistants
Nurse Midwives
Clinical Psychologists

Rewritten September 2011
Revised April 2014
Part III. ADVANCED PRACTICE PROFESSIONALS (APP)

A. CATEGORIES OF ADVANCED PRACTICE PROFESSIONALS

CATEGORY I: ADVANCED PRACTICE REGISTERED NURSE
“Advanced Practice Registered Nurse” (APRN) is an umbrella title for RNs who are Certified Registered Nurse Anesthetists, Certified Nurse Midwives, Clinical Nurse Specialists or Nurse Practitioners. Completion of an advanced formal education program is required for recognition to practice in any of these categories. The specific scopes of practice and requirements for recognition to practice in North Carolina for each APRN category are defined in Administrative Rules, which may be obtained from the North Carolina Board of Nursing. (NC Board of Nursing, 2011)

A. Certified Nurse Midwife (CNM)
The CNM is a RN that has completed a post-graduate certificate midwifery program, or has a Master’s in Nursing Degree midwifery program. CNMs provide well-woman and gynecological care for women of all ages (including family planning, infertility, preconception, menopause, and treatment of common health problems), obstetrical care including prenatal, postpartum, intrapartum, and newborn care. The CNM may perform the acts authorized by the Midwifery Practice Act under the supervision of a physician who is actively engaged in the practice of obstetrics in North Carolina (NC Board of Nursing, 2011).

B. Nurse Practitioner (NP)
The NP is a RN that has completed a post-graduate certificate NP program, with a Masters Degree in Nursing NP program, or Postmaster’s NP program. As of January 1, 2005, all new NP graduates must have a Master’s Degree and National Certification required after January 1, 2000 (NC Board of Nursing, 2011). Nurse Practitioners function at the direction of or under the supervision of a physician licensed to practice medicine by the North Carolina Board of Medicine and who perform medical acts traditionally performed by the physician, such as physical examinations, diagnosis and treatment. Only individuals approved by the Joint Subcommittee of the Medical Board and the Board of Nursing may legally identify themselves as nurse practitioners (NC Board of Nursing, 2011).

C. Certified Registered Nurse Anesthetists (CRNA)
The CRNA is a RN who has completed a Masters of Science Degree in Nursing or another appropriate Master’s degree program. Mandatory national certification examination; continuing education and recertification are required (NC Board of Nursing, 2011).

Anesthesia duties are granted to certified registered nurse who are qualified to render patients insensible to pain and emotional stress during surgical, obstetrical, and certain invasive medical procedures. These practitioners use general or regional anesthesia or conscious sedation.
1. A CRNA is defined as a nurse anesthetist who has been certified (or is eligible for certification) by the Board of Directors of the American Association of Nurse Anesthetists (AANA).

2. A CRNA may provide and administer anesthesia for surgical procedures only under the direct supervision and medical direction of the designated anesthesiologist of Vidant Medical Center, who shall be immediately available if needed. An Anesthesiologist is ‘immediately available’ when the anesthesiologist supervises a CRNA consistent with generally accepted standards of anesthesia care, which may be evidenced by compliance with the requirements for medical direction or supervision of CRNAs under Chapter 12, Section 50 of the Medicare Physician Claims Processing Manual.

3. Any other special procedure request must be approved by the Chief of Service of Anesthesia.

**CATEGORY II: PHYSICIAN ASSISTANT**
A Physician Assistant (PA) is an auxiliary, paramedical person who functions under the supervision of a physician licensed by the North Carolina Board of Medicine, and who performs tasks traditionally performed by the physician, such as history taking, physical examination, diagnosis and treatment. They must be of good moral character and give evidence that he/she has successfully completed a physician assistants' training program recognized by the North Carolina Board of Medicine. If a physician assistant was licensed in North Carolina after June 1, 1994, he/she must also show successful completion of the Physician Assistant National Certifying Examination (NC Board of Medicine, PA Regulations, Subchapter 32S; 2011).

**CATEGORY III: ANESTHESIOLOGIST ASSISTANT**
An Anesthesiologist Assistant (AA) is a paraprofessional who specifically assists the anesthesiologist and is certified by the American Academy of Anesthesiologist Assistants to provide anesthesia related patient care in the perioperative setting under the supervision of an Anesthesiologist. Anesthesia duties are granted to Anesthesiologist Assistants (AA) who are qualified to render patients insensible to pain and emotional stress during surgical, obstetrical, and certain invasive medical procedures. This practitioner uses general or regional anesthesia or conscious sedation. The AA may provide and administer anesthesia for surgical procedures only under the direct supervision and medical direction of a credentialed anesthesiologist at Vidant Medical Center.

**CATEGORY IV: CLINICAL PSYCHOLOGISTS**
Clinical activities for Psychologists involve the provision of psychological services, including assessment, treatment planning, treatment, and consultation. Psychologists shall be licensed by the State of North Carolina. The clinical activities of a psychologist will be based on education, training, and demonstrated competence. The specific services to, or in behalf of, a patient within the hospital to be provided by a psychologist shall be documented as an order within the patient's medical record, authenticated by that physician. Criteria for performance standards will be determined by the Credentials Committee. Application will be made to the Chief of Psychiatric Medicine and the Chief of Service will forward said application with a recommendation or comments to the Credentials Committee of the medical staff.
B. SCOPE OF RESPONSIBILITY

Advanced Practice Professionals (APPs) shall retain appropriate responsibility within their area of professional competence for the care and supervision of each patient in the hospital for whom they are providing services. APPs are members of the APP staff and are not eligible to vote, hold office, or serve on standing medical staff committees unless otherwise noted in Article XI of these bylaws. Duties granted to APPs shall be based on their documented education, training, experience, demonstrated competence, judgment, current licensure, and health status. The applicant shall submit a completed application to the Medical Staff Support office.

During the initial appointment and re-credentialing process for advanced practice registered nurses, the Chief Nursing Officer and the Director of Advanced Clinical Practice will review the application and forward a written recommendation for appointment to the Chairman of the Credentials Committee. Every initial application for staff appointment must contain a request for the specific clinical privileges desired by the applicant. The applicant shall meet the qualifications required of their specific category and work within that scope of practice as recommended by the Chief of Service, subject to approval by the Medical Staff Credentials Committee, the Medical Executive Committee, and Board of Trustees.

1. No APP shall practice at VMC without a supervising physician. It shall be the responsibility of the supervising physician and the APP to be familiar with, and abide by the applicable statutes and the rules and regulations governing the employment and use of APPs.

2. The APP shall, through a qualified medical staff member, apply through the Credentials Committee for authorization to provide patient care, not to exceed the limits approved by the applicable state licensing board(s). The Medical Executive Committee may establish particular qualifications for APPs provided said qualifications are not arbitrary or discriminatory and comply with applicable laws.

3. Corrective action with regard to APPs shall be accomplished in accordance with Article VII and Article VIII of these Bylaws, Rules and Regulations. Any Request for Investigation Prior to Corrective Action that is initiated in relation to an APP pursuant to Article VII, Section 2 (a) shall automatically be deemed to also be a Request for Investigation of that APP’s primary supervising physician Medical Staff member for the purpose of investigating the primary supervising physician Medical Staff member’s supervision of, instructions to, or other conduct related to the action(s) of the APP. The APP and the primary supervising physician Medical Staff member will be subject to the same Professional Standards Committee formed under Article VII, Section 3, but the investigations regarding the APP and the primary supervising physician Medical Staff member (including the PSC’s recommendations, the appeal rights, etc.) shall otherwise be treated separately.

4. A qualified member of the Medical Staff must be responsible for the care of each patient seen by the APP. The APP is responsible to this Medical Staff member, and upon
change of sponsorship, must reapply through the Credentials Committee. All APP activities within the scope of their authority as granted by regulatory agencies and by approved hospital privileges shall be deemed to have been authorized by a physician approved by the North Carolina Medical Board.

C. INACTIVE ADVANCED PRACTICE PROFESSIONAL

An Advanced Practice Professional, in good standing, planning a leave of absence not exceeding two (2) years, may request placement on the Inactive Advanced Practice Professional Staff during their absence. The request shall be made in writing to the Chief of Staff for approval within forty-five days of the start of the leave. An Inactive Advanced Practice Professional Staff member will be automatically reinstated to the APP Staff upon written notice of his/her return, provided that he/she continues to meet qualifications for appointment and privileges.
ADOPTION

These bylaws together with the appended rules and regulations, were adopted at a regular meeting of the active medical staff, shall replace any previous bylaws, rules and regulations and became effective when approved by the governing body of the hospital.

ADOPTED by the active medical staff on August 23, 2016

_________________________________
Chief of Staff*

__________________________________
Secretary of the Staff*

APPROVED by the governing body on October 25, 2016

_________________________________
Secretary of the Governing Body*

*Signature page on file in the Medical Staff Support Office.