

# **BYLAWS OF THE MEDICAL STAFF**

## **UNIVERSITY OF NORTH CAROLINA HOSPITALS**

Approved by the Executive Committee of the Medical Staff, November 5, 2001.

Approved by the Medical Staff, December 5, 2001.

Approved and adopted by the Board of Directors, University of North Carolina Health Care System, November 16, 2001, effective December 5, 2001.

Amended effective January 22, 2002.

Amended effective January 18, 2005.

Amended effective January 16, 2007.

Amended effective July 12, 2010.

Amended effective March 21, 2011.

Amended effective November 11, 2013.

Amended effective July 20, 2015.

Amended effective September 19, 2016.

Amended effective July 16, 2018.

Amended effective July 15, 2019.

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**BYLAWS OF THE MEDICAL STAFF  
THE UNIVERSITY OF NORTH CAROLINA HOSPITALS**

**Article I:  
Mission**

The mission of The University of North Carolina Hospitals is to provide high quality patient care, to educate health care professionals, to advance health research and to provide community service. Recognizing that the Medical Staff is responsible for the quality of medical and dental care in the Hospital, subject to the ultimate authority of the Board of Directors of The University of North Carolina Health Care System, and that the best interests of the patient are protected by a concerted effort, the physicians, dentists and other personnel in The University of North Carolina Hospitals hereby organize themselves in conformity with these *Bylaws*.

**Article II:  
Definitions**

The following definitions apply to terms used in these *Bylaws*:

**“Board of Directors”** and **“Board”** mean the Board of Directors of the University of North Carolina Health Care System.

**“Hospital”** means The University of North Carolina Hospitals and all the activities, services and programs thereof, including, as appropriate to the context, the outpatient clinics, services, and programs of the University of North Carolina School of Medicine and the University of North Carolina Health Care System.

**“Housestaff”** means all physicians and dentists who are in recognized residency training programs sponsored by The University of North Carolina Hospitals. Housestaff are eligible for Medical Staff committee membership and for participation in Medical Staff conferences, seminars, and teaching programs.

**“JCQAA Committee”** means the Joint Conference, Quality and Academic Affairs Committee of the Board of Directors.

**“Medical Staff”** means all physicians and dentists who are members of the Active Staff, Courtesy Staff, Affiliate Staff, or Honorary Staff.

**“Practitioner”** means: (1) a member of the Medical Staff, (2) an individual with Telemedicine, Visiting or Locum Tenens privileges, or (3) an Independent or Dependent Allied Health Professional with clinical or practice privileges at the Hospital.

**“President”** means the executive and administrative head of UNC Hospitals.

**“Physician”** includes both physicians and dentists, unless the context indicates otherwise.

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

### **Article III: Overview, Name and Purposes**

#### **Section 1. Overview**

These Bylaws describe the fundamental principles of Medical Staff self-governance and accountability to the Governing Body. Accordingly, the key standards for Medical Staff membership, appointment, reappointment and privileging are set out in these Bylaws. Additional provisions, including, but not limited to, procedures for implementing the Medical Staff standards may be set out in Medical Staff Rules, Policies or Manuals adopted or approved as described below. Upon proper adoption, as described below, all such Rules, Policies or Manuals shall be deemed an integral part of the Medical Staff Bylaws.

#### **Section 2. Name and Purposes**

The physicians and dentists with Active Staff, Courtesy Staff, Affiliate Staff or Honorary Staff membership as the “Medical Staff of The University of North Carolina Hospitals.”

At the direction of and as delegated by the Board of Directors, the Medical Staff has the following responsibilities:

1. To undertake that all patients admitted to or treated in any of the facilities, departments or services of the Hospital receive the best possible care;
2. To develop a high level of professional performance by all members of the Medical Staff through the appropriate delineation of clinical privileges and the continuous review and evaluation of the clinical activities of each member of the Medical Staff;
3. To provide the highest scientific and educational standards and to further the progress of all members of the Medical Staff in professional knowledge and skill;
4. To provide the highest scientific and educational standards for postgraduate, graduate, and undergraduate students in medicine;
5. To afford outstanding health care to the community;
6. To promulgate *Bylaws, Rules and Regulations* for the self-governance of the Medical Staff;
7. To provide an organized means whereby issues concerning the Hospital may be discussed by the Medical Staff with the Board of Directors and the President of the Hospital. Individual members of the Medical Staff have the right of attendance and voice at all meetings of the Board of Directors and its committees; and
8. To stimulate and carry out research.

**Article IV:  
Categories of the Medical Staff**

**Section 1. Membership**

Membership on the Medical Staff of the University of North Carolina Hospitals is a privilege extended only to physicians and dentists who continuously meet the qualifications, standards and requirements set forth in the *Bylaws*. Membership on the Medical Staff confers only those clinical privileges and prerogatives granted to the member by the Board of Directors in accordance with these Bylaws. Appointments to the Medical Staff are made without regard to race, religion, color, age, sex, national origin, disability, or sexual orientation, provided the individual is competent to render care consistent with the professional level of quality and competence established by the Medical Executive Committee and the Board of Directors. All appointments to the Medical Staff are made by the Board of Directors and are to one of the following categories of the staff. All appointees are assigned to a specific clinical department.

**Section 2. The Active Staff**

All members of the Active Staff must hold a faculty appointment in the School of Medicine or the School of Dentistry of the University of North Carolina at Chapel Hill. The Active Staff consists of physicians and dentists who have successfully completed an Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association (AOA), or Commission on Dental Accreditation (CODA) residency training program in the specialty in which the applicant seeks clinical privileges. Physicians or dentists who are certified by boards other than a member board of the ABMS or ADA recognized specialty, and/or who receive their specialty training in countries other than the United States or Canada, must be recommended by the Chair of the Department of that individual's specialty (or the Chair's designee) based on the Chair's determination that the physician or dentist possesses comparable competencies. The Credentials Committee will evaluate the physician or dentist for Active Staff membership according to criteria relative to education, current licensure, training, experience, and current competence. Each Department Chair must be certified in his/her specialty by a member board of the American Board of Medical Specialties (ABMS) or the American Dental Association (ADA) or possess comparable competence. In addition, after January 1, 2002, each new applicant to the Active Staff must be either certified, or in preparation for certification, by a member board of the ABMS or an ADA recognized specialty or subspecialty in which the applicant seeks clinical privileges. Physicians and dentists who apply for Active Staff membership prior to obtaining board certification may be granted Active Staff status not to exceed a period of two (2) years during which time the physician or dentist must successfully obtain board certification. If a specialty board requirement would preclude board certification within the two (2) year period, the physician or dentist must successfully obtain board certification within six (6) years of initial appointment, unless an earlier time period is identified by his/her board. If a member of the Active Staff fails to obtain board certification within these time limits, or is found to be ineligible for further preparation for board certification, the Active Staff appointment will terminate automatically and such physician or dentist will not be entitled to the Hearing and Appellate Review procedures of Article IX.

Following initial board certification, it is the expectation that Active Staff members will maintain board certification in the specialty area of granted privileges, including pursuing and passing subsequent required board certification examinations.

In exceptional circumstances and for good cause shown, a committee of the Chief Medical Officer, President of UNC Faculty Practice, and Department Chair may, for both initial appointments and reappointments, extend the time period during which board certification or recertification may be obtained or may waive the requirement of board certification entirely for an individual medical staff member.

Members of the Active Staff have primary responsibility for patient care and clinical education, and are entitled to exercise those clinical privileges granted to them by the terms of their appointment or reappointment. Within the scope of their clinical privileges, the Chair of the Department in which the Active Staff member holds privileges may administratively assign clinical responsibilities to Active Staff to best meet patient care and/or departmental needs at UNC Hospitals and the outpatient clinics, services and programs of the School of Medicine of the University of North Carolina at Chapel Hill and the University of North Carolina Health Care System.

All members of the Active Staff, except those who hold an appointment of Fellow or Clinical Instructor on the faculty of the School of Medicine or the School of Dentistry of the University of North Carolina at Chapel Hill, are entitled to vote, hold office and serve on Medical Staff committees. Those members of the Active Staff who hold such Fellow or Clinical Instructor faculty appointments are entitled to serve on Medical Staff committees, but may not vote or hold office.

### **Section 3. The Courtesy Staff**

A member of the Courtesy Staff must be a member of the Active Medical Staff of another hospital where s/he actively participates in quality improvement activities similar to those required of the Active Staff at UNC Hospitals. Appointment to the Courtesy Staff is intended to be a limited appointment for purposes of occasional inpatient admissions or outpatient care in accord with those clinical privileges as granted by the terms of the appointment, the goals of the Hospital, bed availability, and the needs of the Active Staff and their patients. The Courtesy Staff consists of physicians and dentists who are board certified or who possess all of the qualifications for board certification and are otherwise professionally qualified to attend patients in the Hospital. They are not required to hold a faculty appointment in the School of Medicine or the School of Dentistry of the University of North Carolina at Chapel Hill. (For purposes of these Bylaws, physicians and dentists who are certified or qualified for certification by a member board of the American Board of Medical Specialists (ABMS) or by the American Dental Association (ADA) satisfy the requirement for board certification.) Physicians and dentists who are certified or qualified for certification by boards other than a member board of the ABMS or the ADA are evaluated as to eligibility for Courtesy Staff based upon criteria relative to education, current licensure, training, experience, and current competence. Courtesy Staff may attend meetings of the Medical Staff and Department to which they are appointed, but are not eligible to vote, hold office, or serve on Medical Staff Committees.

### **Section 4. The Affiliate Staff**

The Affiliate Staff consists of physicians and dentists who have an office-based practice and refer patients to the inpatient services or procedural areas of UNC Hospitals. Appointment to the Affiliate Staff is intended for the purpose of coordination of care and appropriate follow-up of the Affiliate Staff's patients after treatment at UNC Hospitals. Members of the Affiliate Staff are not eligible for clinical privileges or admitting privileges, and are not entitled to vote on Medical Staff matters. Members of the Affiliate Staff may visit patients they have referred to UNC Hospitals.

## **Section 5. Term of Appointment**

All initial appointments and reappointments to the Active Staff, Courtesy Staff and Affiliate Staff, are for a period of two years from the date of appointment or reappointment.

## **Section 6. The Honorary Staff**

The Honorary Staff consists of physicians and dentists who were members of the Medical Staff but wished to transition to a less active role and are recognized by the Hospital for their professional eminence or their noteworthy contributions to the health and medical sciences. They are not eligible to admit patients, vote, hold office, have Hospital privileges, or serve on Medical Staff Committees. The Honorary Staff appointment is permanent, however, an Honorary Staff member may be dismissed from the Honorary Staff at the discretion of the Medical Staff Executive Committee. As of July 15, 2019, no further appointments to the Honorary Staff will be made.

## **Section 7. Basic Responsibilities**

Each member of the Active Staff, Courtesy Staff and Affiliate Staff will:

- a. Provide his/her patients with professional care that meets generally accepted standards of quality, provide for continuous care for his/her patients, and participate in all quality improvement activities of the Hospital and Medical Staff;
- b. Abide by the Medical Staff *Bylaws, Rules and Regulations*, and by all other Hospital and Departmental standards, policies, rules and regulations;
- c. Discharge such staff, department, service, committee and Hospital functions for which s/he is responsible by appointment, election or otherwise;
- d. Prepare and complete in a timely manner the medical records and all other required records of all patients s/he admits or in any way provides patient care services to in the Hospital;
- e. Participate in the teaching of fellows, housestaff, medical or dental students, nurses, student nurses and allied health personnel as required by his/her appointment;
- f. Encourage, promote, and when appropriate, participate in scientific investigation, as required by his/her appointment;
- g. Abide by the ethical principles of his/her profession; and
- h. Participate in continuing medical education.

## **Section 8. Leave of Absence**

If members appointed to the Active Staff, the Courtesy Staff, or the Affiliate Staff who are in good standing reasonably expect to be unavailable to fulfill their responsibilities for a period of longer than six (6) months, they shall take a leave of absence, except as otherwise determined in the discretion of the Chief Medical Officer or his/her designee. The member is responsible for notifying his/her Chair(s) of the leave of absence and shall state the expected duration of the leave of absence and the member's contact information during the leave of absence. Such notification shall be given at least thirty (30) days prior to such leave of absence unless excused

by the Chief Medical Officer for good cause. The Chair shall transmit the notification to the Credentials Committee. During the leave of absence, the member will not have privileges to admit or treat patients, nor have any of the other prerogatives or responsibilities of Medical Staff membership. Failure without good cause (to be determined in the discretion of the Chief Medical Officer or his/her designee) to submit a request for leave of absence when unable to fulfill Medical Staff responsibilities for more than six (6) months will be deemed a resignation from the Medical Staff and the member will not be entitled to the Hearing & Appellate Review Procedures of Article IX. Alternatively, if the member refuses or is unable to provide notification of a leave of absence, the Chair, in consultation with and approval by the Chief Medical Officer, may notify the member that he/she has been placed on a leave of absence based on information available to the Chair that the member is unable to engage in the practice of medicine at UNC Hospitals and is not expected to return to clinical practice at UNC Hospitals within six (6) months.

The leave of absence may be subject to conditions or limitations that the Chief Medical Officer, his/her designee, or the Credentials Committee may deem, in their discretion, to be appropriate.

If the member's privileges will expire during the leave of absence, the staff member must submit an application for reappointment to be processed in the ordinary manner, provided that the leave of absence may continue and be in effect at the beginning of the reappointment period, and provided further that the physician's reappointment will be conditioned on compliance with a focused professional practice evaluation. Failure to reapply will result in expiration of privileges, and a new application for privileges (to be processed in the ordinary manner) will be required to rejoin the medical staff.

At least thirty (30) days prior to termination of the leave of absence, the member must submit to the Chair a written request for the reinstatement of membership and privileges. The request must include a summary of any relevant clinical activities during the leave of absence. In addition, if the leave of absence was for medical reasons, the member must submit a report from the member's physician indicating that the individual is physically and/or mentally capable of resuming practice and safely exercising the member's clinical privileges. The Chair will submit the member's request, along with the Chair's recommendation regarding whether medical staff membership and privileges should be reinstated, to the Credentials Committee for review. A focused professional practice evaluation will be required as a condition of reinstating membership and privileges. The Credentials Committee will make a recommendation to the Medical Staff Executive Committee, and the Medical Staff Executive Committee will make a recommendation to the Board, who shall make the final decision regarding reinstating the member. If the reinstatement is approved, the Medical Staff member shall immediately be reinstated to membership on the Medical Staff and his or her privileges will be restored for the duration of the existing appointment cycle.

A determination that the member be denied reinstatement will be considered a denial of medical staff membership and privileges and entitles the member to the Hearing & Appellate Review Procedures of Article IX. However, failure without good cause (to be determined in the discretion of the Chief Medical Officer or his/her designee) to timely request reinstatement or submit the required documentation (i.e., at least thirty (30) days prior to the expiration of one year after going on voluntary leave) will be deemed a resignation from the Medical Staff and will not entitle the member to the Hearing & Appellate Review Procedures of Article IX.

## **Section 9. Termination of Appointment**

Appointments and reappointments to the Active Staff, Courtesy Staff, or Affiliate Staff may be terminated prior to the expiration of the period of appointment or reappointment only by one of the following means:

- a. Voluntary resignation , submitted in writing to the Office of Medical Staff Services;
- b. Administrative action, within the discretion of the CMO or his/her designee, due to the failure of the member of the Active Staff, Courtesy Staff, or Affiliate Staff to continuously meet the qualifications, standards and requirements set forth in the Bylaws, including by way of example and not limitation: failure to maintain a faculty appointment required for Active Staff appointment; failure to obtain or maintain licensure, board certification status, or medical malpractice insurance required for the staff category; involuntary exclusion from participation in Medicare, Medicaid, or other federally funded health care programs; Drug Enforcement Administration certificate revocation, suspension, stay, restriction, or probation; failure to comply with Hospital immunization, OSHA, CDC or other safety requirements; or conviction of a felony. Termination of privileges by administrative action does not entitle the member to the Hearing & Appellate Review Procedures of Article X; and
- c. Corrective action in accordance with Article IX.

## **Article V: Clinical Privileges**

### **Section 1. Delineation of Clinical Privileges**

- a. Practitioners are entitled to only those clinical privileges delineated in: (1) the notice of appointment/ reappointment to the Medical Staff, or 2) the notice of granting/renewal of privileges. The exercise of such privileges within any Department is subject to the rules and regulations of that Department and to the authority of that Department Chair or that Department Chair's designee. Department Chairs or designees determine whether the provision of telemedicine to distant sites is consistent with commonly accepted quality standards and is an appropriate approach to the delivery of services by the Practitioners within the department. All requests for clinical privileges are processed pursuant to the procedures for appointment and reappointment set forth in, respectively, Article VII, Sections 3 and 5.
- b. Every application for staff appointment and/or privileges contains a statement of the specific clinical privileges being requested by the applicant. A request for clinical privileges is evaluated based upon the criteria set forth in these bylaws, and other reasonable evidence of current ability to perform the privileges requested, including, but not limited to: peer recommendations; ethical character; and ability to work with others. It is also based upon an assessment, as appropriate, of an applicant's documented experience in categories of treatment areas or procedures, the results of treatment, and the conclusions drawn from relevant Practitioner-specific data compared to aggregate data, performance measurement data, and morbidity and mortality data, when available. The applicant has the burden of establishing his/her qualifications for the clinical privileges requested.
- c. An application by a Practitioner for a modification of clinical privileges pursuant to Article VII, Section 6 contains reasons for the request along with relevant information concerning training and experience.

- d. The renewal of clinical privileges is based upon the criteria set forth in these bylaws, and other information deemed relevant thereto, including, but not limited to: peer recommendations; ethical character; participation in continuing medical education; and the ability to work with others. It is also based upon an assessment, as appropriate, of an applicant's documented experience in categories of treatment areas or procedures, the results of treatment, and the conclusions drawn from quality improvement activities.
- e. The nature and scope of surgical procedures which a dentist may perform are specifically defined in the application for clinical privileges. The Credentials Committee obtains advice from the Dean of the School of Dentistry and the Chair of the Operating Room Committee relative to the nature and scope of dental surgical privileges requested by applicants. All dental surgical patients must undergo the same medical evaluation as patients admitted for other surgical services. A physician member of the Active Staff is responsible for the care of any medical problem present at the time of admission or that may arise during Hospitalization.
- f. A Practitioner with privileges shall promptly report to the Office of Medical Staff Services any significant change in information previously provided as part of prior applications for appointment or reappointment. This includes, but is not limited to: changes in professional licensure/certification, DEA, malpractice coverage, as well as involvement in any malpractice activity or disciplinary action by any licensing or certification board or healthcare facility.
- g. In the event that the certification or licensure of a Practitioner with Telemedicine, Visiting or Locum Tenens privileges is adversely affected in any manner, his/her practice privileges shall be immediately and automatically restricted, reduced, suspended, or revoked accordingly.
- h. In the event that the professional liability insurance of a Practitioner with Telemedicine, Visiting or Locum Tenens privileges is terminated for any reason, his/her practice privileges shall be immediately and automatically revoked.

## **Section 2. Temporary Privileges**

- a. When appropriate (as specified in this Section 2), the President, or his/her designee, may grant temporary clinical privileges upon the recommendation of the Chief Medical Officer, or his/her designee, for a limited period of time to qualified individuals.
- b. Temporary privileges are granted for a maximum of 120 days, only in the following two circumstances:
  - (1) To fulfill an important patient care, treatment, and service need. In this case, current licensure and current competence must be verified prior to granting temporary privileges, and the individual requesting temporary privileges must submit a current curriculum vitae, proof of licensure, and evidence of current professional liability coverage with individual limits in an amount not less than \$1,000,000 per claim / \$3,000,000 aggregate.
  - (2) When an applicant for new privileges with a complete application that raises no concerns is approved by the Credentials Committee and is awaiting review and approval by the Executive Committee and the Board of Directors. In this case, the applicant must submit a complete application and all supporting documentation, and the following must be verified prior to granting temporary privileges:

- A. Current licensure

- B. Relevant training or experience
  - C. Current competence
  - D. Ability to perform the privileges requested
  - E. A query and evaluation of the National Practitioner Data Bank (NPDB)
  - F. No current or previously successful challenge to licensure or registration
  - G. No subsection to involuntary termination of medical staff membership at another organization
  - H. No subsection to involuntary limitation, reduction, denial, or loss of clinical privileges
- c. In exercising temporary privileges, the Practitioner acts under the supervision of the Chair of the Department in which the Practitioner holds privileges or the Chief Medical Officer, or one of their designees.
- d. For good cause shown, the President, after consultation with the Department Chair of the Department in which the Practitioner holds privileges or designee and/or the Chief Medical Officer, may terminate the temporary privileges, or any part thereof, of any Practitioner to whom they have been granted. If, at the time of such termination, there are patients of the Practitioner admitted to the Hospital, those patients are assigned to another Practitioner by the Department Chair or Chief Medical Officer.
- e. A Practitioner is not entitled to the due process rights set forth in Articles VIII or IX relative to any matter concerning temporary privileges.

### **Section 3. Emergency Privileges**

In the case of an emergency, any Practitioner to the degree permitted by his/her license may do everything possible to save the life of a patient. In such an emergency, a Practitioner may use all Hospital facilities, seek assistance from all Hospital personnel, and request any consultation. For purposes of this section, an "emergency" is defined as a condition that is likely to result in serious or permanent harm 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.

### **Section 4. Disaster Privileges**

- a. During disasters in which the emergency management plan has been activated and where the Hospital is unable to meet immediate patient needs, the President or Chief Medical Officer or his/her designee(s) has the option to grant disaster privileges to volunteer licensed independent practitioners. These individuals are not required to grant disaster privileges and can make such decisions on a case-by-case basis at their discretion.
- b. The President, Chief Medical Officer, or his/her designee(s) may grant disaster privileges upon completion of a brief information form and presentation of the volunteer licensed independent practitioner's valid government-issued photo identification (for example, a driver's license or passport) and at least one of the following:
- (1) A current picture ID card from a health care organization that clearly identifies professional designation;
  - (2) A current license to practice;

- (3) Primary source verification of licensure;
  - (4) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group;
  - (5) Identification indicating that the individual has been granted authority by a government entity to render patient care in disaster circumstances; and/or
  - (6) Confirmation by a current Hospital or Medical Staff member(s) with personal knowledge regarding the volunteer licensed independent practitioner's ability to act as a licensed independent practitioner during a disaster.
- c. The President, Chief Medical Officer, or his/her designee(s) will assign a member of the Active Staff, in the Practitioner's specialty, if possible, to supervise the Practitioner who has been granted disaster privileges. Based on such supervision, the Hospital will determine within 72 hours of the Practitioner's arrival whether disaster privileges should continue. The Practitioner who has been granted disaster privileges will display a Hospital photo ID badge at all times to allow staff to readily identify him or her as a Practitioner with disaster privileges. As soon as the immediate situation is under control or within 72 hours of the Practitioner's arrival, whichever comes first, the Office of Medical Staff Services will verify the credentials via the same process as established under the *Bylaws of the Medical Staff* for granting temporary privileges to fulfill an important patient care, treatment and service need. If verification of credentials cannot be completed within 72 hours of the Practitioner's arrival due to extraordinary circumstances, the Hospital will document the reason verification could not be completed, evidence of the Practitioner's demonstrated ability to continue to provide adequate care, treatment and services, and evidence of the Hospitals' attempt to verify credentials as soon as possible.
- d. Disaster privileges will immediately terminate once the emergency has ended, as notified by the Hospital. Disaster privileges may also be terminated on the discovery of any information or the occurrence of any event of a professionally questionable nature about the Practitioner's qualifications or ability to exercise any or all of the disaster privileges granted. The President or his/her designee may, after consultation with the Chief Medical Officer, or his/her designee, terminate any or all of the Practitioner's disaster privileges provided that, where the life or well-being of a patient is determined to be endangered by continued treatment by the Practitioner the President, Chief Medical Officer, or his/her designee(s) may terminate immediately a Practitioner's disaster privileges. In the event of any such termination, the Practitioner's patient(s) then in the Hospital will be assigned to another Practitioner by the President, the Chief Medical Officer, or his/her designee(s). The wishes of the patient(s) will be considered, where feasible, in choosing a substitute Practitioner.
- e. A Practitioner is not entitled to the due process rights set forth in Articles VIII or IX relative to any matter concerning disaster privileges.

#### **Section 5. Telemedicine Privileges**

Telemedicine privileges may be granted to physicians or dentists who are contracted by UNC Hospitals to provide services to UNC Hospitals patients via telemedicine link. Telemedicine services shall include any of the following when provided via telemedicine link: consulting,

prescribing, rendering a diagnosis, or providing an official reading of images, tracings or specimens. A telemedicine link is defined as the use of electronic communication or other communication technology to exercise telemedicine privileges at a distance. Members of the Active Staff are not required to have Telemedicine privileges in order to provide telemedicine services. In order to qualify for Telemedicine privileges, a physician or dentist must be board certified or possess all of the qualifications for board certification and be otherwise professionally qualified to attend patients in the Hospital. (For purposes of these Bylaws, physicians and dentists who are certified or qualified for certification by a member board of the ABMS or by the ADA satisfy the requirement for board certification.) The terms of Telemedicine privileges and any renewal are for a period of two years from the date that privileges are granted or renewed. Individuals with Telemedicine privileges are not eligible for admitting privileges and are not entitled to vote on Medical Staff matters. Telemedicine privileges shall automatically terminate with the contract pursuant to which the individual with Telemedicine privileges provides services is terminated. Telemedicine privileges are granted as a courtesy and not as a right, and Telemedicine privileges may be restricted, reduced, suspended or revoked at the discretion of the Medical Staff Executive Committee or the Chief Medical Officer. Neither the granting, denial or termination of Telemedicine Staff membership shall entitle the individual concerned to any of the procedural rights provided in Article VIII, Article IX or any other right set forth in these Bylaws.

#### **Section 6. Visiting Privileges**

Visiting privileges may be granted to physicians and dentists who have privileges at another hospital and whose purpose at the Hospital is for limited educational purposes. Individuals with Visiting privileges may not independently treat patients and must work under the direct supervision of an Active Medical Staff member. They are not eligible to admit patients, vote on Medical Staff matters, hold office, or serve on Medical Staff Committees. The term of Visiting privileges shall not exceed the time period needed to fulfill the individual's limited educational purposes. Visiting privileges may be restricted, reduced, suspended or revoked at the discretion of the Medical Staff Executive Committee or Chief Medical Officer. Neither the granting, denial nor termination of Visiting privileges shall entitle the individual concerned to any of the procedural rights provided in Article VIII, Article IX or any other right set forth in these Bylaws. The granting of Visiting privileges requires the express approval of the Chief Medical Officer or his/her designee.

#### **Section 7. Locum Tenens Privileges**

Locum Tenens privileges may be granted to physicians and dentists appointed to assist or temporarily fulfill the responsibilities of a member of the Active Staff. In order to qualify for Locum Tenens privileges, a physician or dentist must be board certified or possess all of the qualifications for board certification and be otherwise professionally qualified to attend patients in the Hospital. (For purposes of these Bylaws, physicians and dentists who are certified or qualified for certification by a member board of the ABMS or by the ADA satisfy the requirement for board certification.) Locum Tenens Staff privileges must be delineated. Locum Tenens privileges shall have a duration of no more than one year and may not exceed the time period needed to fulfill the requisite patient care need. Individuals with Locum Tenens privileges are not eligible to vote on Medical Staff matters, hold office, or serve on Medical Staff Committees and Locum Tenens privileges may be restricted, reduced, suspended or revoked at the discretion of the Medical Staff Executive Committee or the Chief Medical Officer. Neither the granting, denial or termination of Locum Tenens privileges shall entitle the individual concerned to any of the procedural rights provided in Article VIII, Article IX or any other right set forth in these Bylaws.

**Article VI:  
Allied Health Professionals**

**Section 1. Qualifications**

An Independent or Dependent Allied Health Professional who applies for practice privileges must be a member of the faculty or an employee of the School of Medicine, an employee of the Hospital, or a party to a contract with the Hospital (i.e., as locum tenens or otherwise). An Allied Health Professional is not a member of the Medical Staff but must fulfill all other applicable requirements specified in these *Bylaws* and all Medical Staff and Hospital rules, regulations, policies, and procedures.

**Section 2. Independent Allied Health Professionals**

- a. The term "Independent Allied Health Professional" includes: licensed acupuncturists; certified clinical geneticists; clinical pharmacists; optometrists; podiatrists; psychologists; holders of doctoral degrees affiliated with the Department of Pathology and Laboratory Medicine, or other departments; and others as designated by the Board.
- b. An Independent Allied Health Professional must meet those specific qualifications and may request only those specific practice privileges appropriate to his/her category, as specified by the applicable policies and procedures of the Credentials Committee and these *Bylaws*.
- c. An application for practice privileges will be processed in accordance with the procedures specified in these bylaws for initial application for privileges. After initial privileges for two years, an Independent Allied Health Professional must apply for renewal of practice privileges every two years. Notwithstanding the foregoing, if an Independent Allied Health Professional has practice privileges in connection with a contract to provide services, the term of appointment shall automatically expire at the time the contract is terminated. In addition, an Independent Allied Health Professional's privileges may be terminated prior to the end of a contractual term in accordance with Section 4 of this Article VI.
- d. An Independent Allied Health Professional may not admit patients to or discharge patients from the Hospital. An Independent Allied Health Professional may, within the scope of his/her professional licensure or certification, his/her practice privileges, and the rules, regulations, policies and procedures of the Medical Staff and the Hospital:
  - (1) provide specified patient care services;
  - (2) exercise independent judgment in his/her areas of competence and participate directly in the management of patients, provided that a member of the Active Staff within the appropriate department or specialty has overall responsibility for the care provided to each patient;
  - (3) enter reports and progress notes into the medical record and write certain treatment orders for specific patients;
  - (4) serve with voting rights on committees of the Medical Staff and attend Medical Staff or department meetings, if invited; and
  - (5) exercise other prerogatives, as specified by the Board.

### **Section 3. Dependent Allied Health Professionals**

- a. The term “Dependent Allied Health Professional” includes: certified registered nurse anesthetists; certified nurse midwives; clinical pharmacist practitioners; nurse practitioners; physician assistants; radiologist assistants; anesthesia assistants; registered nurse first assistants; certified surgical first assistants; and others as designated by the Board.
- b. A Dependent Allied Health Professional must meet those specific qualifications and may request only those specific practice privileges within the scope of the licensing or certification requirements applicable to his/her profession, and as further specified by the policies and procedures of the Credentials Committee and these *Bylaws*. A Dependent Allied Health Professional must have a collaborative practice agreement or supervising physician agreement with one or more of the Active Staff who will supervise and assume responsibility for his/her patient care activities. However, for Dependent Allied Health Professionals at distant sites providing telemedicine services, the Dependent Allied Health Professional must have a collaborative practice agreement or supervising physician agreement with an attending physician located at the distant site who has a valid North Carolina license to practice medicine and who will supervise and assume responsibility for the Dependent Allied Health Professional’s patient care activities.
- c. An application for practice privileges will be processed in accordance with the procedures specified in these bylaws for initial application for privileges. After initial privileges for two years, a Dependent Allied Health Professional must apply for renewal of practice privileges every two years. Notwithstanding the foregoing, if a Dependent Allied Health Professional has practice privileges in connection with a contract to provide services, the term of appointment shall automatically expire at the time the contract is terminated. In addition, a Dependent Allied Health Professional’s privileges may be terminated prior to the end of a contractual term in accordance with Section 4 of this Article VI.
- d. A Dependent Allied Health Professional may not independently admit patients to or discharge patients from the Hospital. A Dependent Allied Health Professional may, within the scope of his/her professional licensure or certification, his/her practice privileges, and the rules, regulations, policies and procedures of the Medical Staff and the Hospital:
  - (1) provide specified patient care services in collaboration with or under the supervision of his/her sponsoring Active Staff member or members;
  - (2) enter reports and progress notes into the medical record and write certain treatment orders for specific patients;
  - (3) serve with voting rights on committees of the Medical Staff and attend Medical Staff or department meetings, if invited; and
  - (4) exercise other prerogatives, as specified by the Board.

### **Section 4. Restriction, Suspension, or Revocation of Practice Privileges**

- a. Allied Health Professionals are not members of the Medical Staff and accordingly shall have no recourse to the procedural rights specified in Articles VIII and IX.

- b. An Allied Health Professional shall promptly report to the Office of Medical Staff Services any significant change in information previously provided as part of prior applications for appointment or reappointment. This includes, but is not limited to: changes in professional licensure/certification, DEA, malpractice coverage, as well as involvement in any malpractice activity or disciplinary action by any licensing or certification board or healthcare facility.
- c. In the event that an Allied Health Professional's certification or licensure is adversely affected in any manner, his/her practice privileges shall be immediately and automatically restricted, suspended, reduced, or revoked accordingly.
- d. In the event that an Allied Health Professional's professional liability insurance is terminated for any reason, his/her practice privileges shall be immediately and automatically revoked.
- e. The practice privileges of a Dependent Allied Health Professional shall be automatically suspended or revoked if the clinical privileges of all his/her sponsoring or collaborative Active Medical Staff members are restricted, reduced, suspended or revoked for any reason.
- f. The President or Chief Medical Officer may restrict, reduce, suspend, or revoke any or all of the practice privileges of an Allied Health Professional without recourse to the procedural rights specified in Articles VIII and IX:

(1) An Independent Allied Health Professional whose practice privileges are restricted, reduced, suspended, or revoked will be notified of the action and the reasons for such action, and may request that such action be reviewed by the Medical Staff Executive Committee. At any such review meeting, the individual may be present and may participate in the review. The individual will be entitled to a written report at the conclusion of the review, but will not be entitled to any further internal review or appeal.

(2) A Dependent Allied Health Professional whose practice privileges are restricted, reduced, suspended, or revoked will be notified of the action and the reasons for such action, and may request that such action be reviewed by the Medical Staff Executive Committee. At any such review meeting, the individual and his/her sponsoring or collaborative Active Staff member or members may be present and may participate in the review. The individual will be entitled to a written report at the conclusion of the review, but will not be entitled to any further internal review or appeal.

#### **Article VII:**

#### **Procedure for Appointment and Reappointment or to Apply for or Renew Privileges**

#### **Section 1. Application for Appointment or for Privileges**

- a. Applicants for: (1) membership on the Active Staff, the Courtesy Staff, or the Affiliate Staff, (2) Telemedicine privileges or Locum Tenens privileges, or (3) for privileges as an Allied Health Professional, must submit a Uniform Application for Medical/Allied Health Professionals form (Uniform Application) along with all required supporting information as set forth in the Uniform Application.
- b. Applicants for Visiting privileges must submit an Application for Visiting Privileges, along with a current curriculum vitae, proof of licensure, letter signed by the Chair of the sponsoring Department and supervising physician, and evidence of current professional liability coverage with individual limits in an amount not less than \$1,000,000 per claim / \$3,000,000 aggregate.

- c. All applications are submitted as set forth in Section 3(b) below. A decision by the Credentials Committee, the Executive Committee of the Medical Staff and the Board of Directors is made within a time period not to exceed 180 days from the receipt by the Office of Medical Staff Services of a complete application.
- d. Applicants have the burden of providing the information required in the application form, and any additional information reasonably required by the Credentials Committee to document or verify the applicant's qualifications and suitability for appointment to the Medical Staff. The Office of Medical Staff Services will promptly notify the applicant if any information is incomplete or missing, and the applicant will have the obligation of obtaining the requested information.
- e. As part of the application, the applicant signs a statement that s/he has received and read the current *Bylaws of the Medical Staff, Rules and Regulations of the Medical Staff, and Organization Manual* and agrees to be bound by the terms thereof in all matters relative to his/her activities as a Medical Staff member or individual with privileges and relative to consideration of his/her application without regard to whether s/he is granted membership and/or clinical privileges.

## **Section 2. Effect of Application**

By submitting an application, the applicant thereby consents to the inspection by Hospital representatives of records and documents pertinent to his/her current licensure, specific training and experience, current competence, and ability to perform the privileges requested, and agrees to appear for interviews with regard to his/her application. The applicant further authorizes Hospital representatives to consult with others who may have information bearing on his/her application, and releases from liability the Hospital, its representatives, and all other individuals and organizations for disclosing otherwise privileged or confidential information in good faith and without malice in connection with the evaluation of his/her application.

## **Section 3. Evaluation Process**

- a. The applicant has the burden of producing information sufficient for the proper evaluation of his/her application.
- b. The application is submitted to the Chair of each department in which the applicant requests privileges. If an applicant is seeking privileges in a department outside of the applicant's specialty, the application should be submitted to the Chair of the department of both the applicant's specialty and to the Chair(s) of the department(s) in which the applicant seeks privileges, or the Chairs' designees. The Chair of each such department reviews the application and supporting documentation and transmits to the Office of Medical Staff Services a written report with a recommendation to the Credentials Committee to either grant the application, deny the application, or defer the application for further consideration. Where granting an application is recommended, the Chair(s) further recommend(s) the clinical privileges to be granted and any special conditions. The Office of Medical Staff Services verifies from primary sources, whenever feasible, the applicant's references, education and training, board certification, licensure, insurance information, health status, and any other relevant information, and promptly notifies the applicant of any problems relative to verification efforts. The Credentials Committee, through the Office of Medical Staff Services, will seek confirmation of the Chair recommendation(s) upon receipt during the verification process of

new or additional information that was not available to the Chair(s) upon first review of the application.

In addition, when considering an application for Telemedicine privileges or an application by a Dependent Allied Health Professional wishing to provide telemedicine services from a distant site, the Office of Medical Staff Services may, in accordance with UNC Hospitals policy:

- i. Use credentialing information from the distant site, if the distant site is a Joint Commission-accredited organization, and the distant site practitioner has a license issued or recognized by the state of North Carolina; and/or
- ii. Choose to use the credentialing and privileging decision from the distant site to make a final privileging decision if all of the following requirements are met:
  - a) The distant site is a Joint Commission-accredited hospital, and UNC Hospitals has verified that the distant site's credentialing and privileging processes meet 42 C.F.R. 482.12(a)(1)-(a)(9) and 482.22(a)(1)-(a)(4).
  - b) The distant site practitioner is privileged at the distant site for those services to be provided at UNC Hospitals.
  - c) The distant site provides UNC Hospitals with a current list of the distant site practitioner's privileges.
  - d) UNC Hospitals performs an internal review of the distant site practitioner's performance of privileges at UNC Hospitals, and sends to the distant site information that is useful to assess the distant site practitioner's quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes related to sentinel events considered reviewable by The Joint Commission that result from the telemedicine services provided and complaints about the distant site practitioner from patients or other staff or providers at UNC Hospitals.
  - e) The distant site practitioner has a license issued or recognized by the state of North Carolina.
- c. When verification by the Office of Medical Staff Services is complete, the Credentials Committee reviews the application, the supporting documentation, the Department Chair (or designee) report(s) and recommendation(s), and such other information relevant to the staff category (if applicable), department and service affiliation, and clinical privileges requested by the applicant. The Credentials Committee then recommends that the Executive Committee either grant the application, deny the application, or the Credentials Committee defers the application for further consideration. Where granting the application is recommended, the Credentials Committee further recommends the staff category (if applicable), department, and service affiliations, the clinical privileges (core and/or special, or office practice only) to be granted, and any limitations to the privileges or conditions to be attached to the appointment (if applicable).
- d. The Executive Committee, acting upon the recommendation of the Credentials Committee, determines whether to recommend to the Board of Directors that the application be granted,

denied, or that the application be deferred for further consideration. All recommendations for granting the application shall further recommend the clinical privileges to be granted and any conditions to be attached to the appointment (if applicable). In addition, the Executive Committee determines when the application contains issues that require presentation to the full Board at its next meeting.

- e. When the recommendation of the Executive Committee is to defer the applicant for further consideration, a recommendation on the application is made by the Executive Committee to the Board of Directors within sixty (60) days.
- f. When the recommendation of the Executive Committee is, in all respects, favorable to the applicant, it is forwarded together with all supporting documentation to the Board of Directors.
- g. When the recommendation of the Executive Committee is adverse to the applicant and entitles the applicant to a Hearing as provided in these bylaws, the applicant shall be so notified, and in accordance with Article IX if applicable. An adverse recommendation by the Executive Committee is not forwarded by the President to the Board of Directors until after, if applicable, the applicant has exercised, or has been deemed to have waived, his/her rights to a Hearing as provided in Article IX.

If, after a Hearing as provided in Article IX, the recommendation of the Hearing Panel is favorable to the applicant, the application and supporting documentation is forwarded to the Board of Directors for final action. If it is deemed appropriate, the Board may direct that a further Hearing be conducted to consider matters still in question. At its next regular meeting following receipt of the record of the Hearing and the subsequent recommendation by the Executive Committee, the Board of Directors makes a decision whether to appoint the applicant to the Medical Staff and/or deny his/her application for privileges.

- h. At its next regular meeting following its receipt of the recommendation of the Executive Committee, the Board of Directors acts on the matter. However, applications may be acted on by the Board of Directors before its next regular meeting through the Credentialing Subcommittee of the JCQAA Committee (which Subcommittee is composed of at least two voting members of the Board of Directors), as long as the following requirements are met:
  - The application is complete;
  - The Executive Committee has not made a recommendation that is adverse or has limitations;
  - The applicant's license or registration is not currently challenged, and has not previously been successfully challenged;
  - The applicant has not previously received an involuntary limitation, reduction, denial or loss of clinical privileges; and
  - The applicant does not have an unusual pattern or excessive number of professional liability actions resulting in a final judgment against the applicant.
- i. If the Board's decision is adverse to the applicant, the Board of Directors will take no final action until the applicant has had an opportunity to exercise and/or waive his/her right to a Hearing.
- j. The Board of Directors' decision with regard to staff membership and/or clinical privileges is final, except that the Board may defer final action by referring the matter back to the Executive Committee for further reconsideration. Any such referral back states the reasons therefore

and establishes a time period within which a subsequent recommendation to the Board of Directors shall be made. All decisions to appoint specify the nature and scope of the clinical privileges granted to the applicant, including any conditions to be attached to the appointment.

- k. When the decision of the Board of Directors is final, the President or his/her designee sends written notice of the Board's decision to the applicant.

#### **Section 4. Application for Reappointment or Renewal of Privileges**

- a. Applications for reappointment to the Active Staff, Courtesy Staff, or Affiliate Staff or for the renewal of privileges are distributed to Practitioners at least ninety (90) days prior to the expiration of a term of appointment or privileges. All such applications are submitted to the Office of Medical Staff Services on the prescribed form and signed by the Practitioner applicant. As part of the application, the applicant signs a statement that s/he has received and read the current *Bylaws of the Medical Staff*, and *Rules and Regulations of the Medical Staff*, and related Policies and Manuals, and agrees to be bound by the terms thereof in all matters relative to his/her activities as a Medical Staff member and/or individual with privileges and relative to consideration of his/her application without regard to whether s/he is granted membership and/or clinical privileges.
- b. A complete application provides detailed information concerning: the Practitioner's current staff status or privileges; specific clinical privileges requested; ability to perform the privileges requested; current faculty status; current licensure; physical and mental health status; involvement in any professional liability action, claim or suit; currently pending challenges to any licensure or registration or the voluntary relinquishment of any such licensure or registration; voluntary or involuntary relinquishment of membership in a professional society; voluntary or involuntary termination of Medical Staff membership at another Hospital; voluntary or involuntary limitation, reduction or loss of clinical privileges at another Hospital; and any other qualifications set forth in these *Bylaws*. Practitioners must also provide proof of professional liability insurance coverage in an amount of not less than \$1,000,000 per claim.
- c. If an application for reappointment or for renewal of privileges is not received by the Office of Medical Staff Services at least sixty (60) days prior to the expiration of a Practitioner's term of appointment or privileges, the Practitioner and the Practitioner's clinical Department Chair or designee (and the Chair of the Department of the Practitioner's specialty or designee, if applicable) are notified in writing by the President that the Practitioner's Medical Staff membership and/or clinical privileges will be terminated unless a completed application is received by the deadlines identified by the Office of Medical Staff Services.

#### **Section 5. Reappointment Process**

- a. At least ninety (90) days prior to the expiration of each Practitioner's appointment, reappointment, and/or privileges the Office of Medical Staff Services requests the Department Chair in which the Practitioner has clinical privileges or designee (and the Chair of the Department of the Practitioner's specialty or designee, if applicable) to review all pertinent information relative to each Practitioner eligible for reappointment or renewal of privileges.
- b. Each Department Chair's recommendation concerning the reappointment of a Practitioner and/or the nature and scope of the clinical privileges to be renewed is based upon such Practitioner's professional performance, including, as applicable: relevant Practitioner-specific data compared to aggregate data, performance measurement data and morbidity and

mortality data, when available; ethics and conduct; attendance and participation in staff affairs; relevant training and/or experience; compliance with the *Bylaws of the Medical Staff and Rules and Regulations of the Medical Staff*; cooperation with Hospital personnel; use of the Hospital's facilities for patients; relations with other Practitioners and ability to work with others; satisfactory completion of such continuing education requirements as may be imposed by the North Carolina licensing boards, the Hospital, or applicable accreditation agencies; physical and mental capabilities; continuing status on the faculty of the School of Medicine or the School of Dentistry of the University of North Carolina at Chapel Hill; contributions towards the Hospital's objectives of patient care, education and research; and general attitude towards patients, the Hospital and the public.

- c. The Department Chair (or the Chief Medical Officer when a Department Chair applies for reappointment) forwards his/her written recommendations regarding reappointment and/or renewal of privileges to the Credentials Committee via the Chair's Evaluation Form (a key part of the Practitioner's ongoing professional practice evaluation), which references each of the above elements of performance to at least one of the six general competencies (Patient Care/Clinical Skills, Medical Knowledge, Interpersonal and Communication Skills, Professionalism, Practice-Based Learning and Improvement, and Systems-Based Practice). Thereafter, the procedures set forth in Article VII are followed relative to applications for reappointment and/or renewal of, or changes in clinical privileges granted in connection therewith.

The Chair's Evaluation Form requires the Chair to evaluate each of multiple elements of the Practitioner's performance as being satisfactory or unsatisfactory, provide an evaluation of overall performance as satisfactory or unsatisfactory, and then recommend in favor of or against reappointment and/or renewal of requested privileges. Any overall unsatisfactory evaluations and any recommendation for less than the full requested term of reappointment and/or all requested privileges disqualify the applicant from expedited consideration and require presentation of identified issues to the Executive Committee.

When the overall evaluation is satisfactory, individual unsatisfactory evaluations of specific elements do not necessarily require presentation to the Executive Committee. The Credentials Committee, working with the Office of the Chief Medical Officer and the applicant's Department Chair or designee (and the Chair of the Department of the Practitioner's specialty or designee, if applicable), may establish a focused professional practice evaluation. When focused professional practice evaluations are approved by the Board as conditions or terms for reappointment or continued appointment but do not limit the requested scope of clinical privileges or category of appointment, such counseling or practice evaluation or other requirements do not constitute corrective action as defined in Article VIII.

When Practitioners fail to meet the requirements or conditions of focused professional practice evaluations, the Chair of the Credentials Committee may make a recommendation to the Medical Staff Executive Committee, pursuant to Article VIII, Section 1(d), that the Practitioner's medical staff membership and/or privileges be suspended, revoked, restricted or terminated.

- d. In the event that a Practitioner's privileges are scheduled to expire while the Practitioner is on a leave of absence, the Practitioner must submit an application for reappointment and/or renewal to be processed in the ordinary manner, provided that the leave of absence may continue and be in effect at the beginning of the reappointment and/or renewal period, and provided further that the Practitioner's reappointment and/or renewal may be conditioned on

compliance with a focused professional practice evaluation as determined in the discretion of the Practitioner's Department Chair or Chief Medical Officer or their designees. Failure to reapply will result in the expiration of privileges, and a new application for privileges (to be processed in the ordinary manner) will be required for reappointment and/or renewal of privileges.

## **Section 6. Modification of Appointment or Privileges**

A Practitioner may, at any time, request modification of his or her Medical Staff category or clinical privileges by submitting to the Department Chair(s) or designee a written application on the prescribed form. Such application is processed by the Office of Medical Staff Services.

### **Article VIII: Corrective Action**

#### **Section 1. Procedure**

- a. The proceedings under this Article VIII are administrative matters and not an adversarial hearing process; none of the procedural rules set forth in Article IX apply. The initiation of these proceedings shall be considered an investigation by the Medical Staff; the investigation is concluded when the process has been completed (including any hearing or appeal permitted under Article IX) or the Medical Staff member concurs in any actions taken (including by waiver).
- b. Any documents, reports, requests, and written notices referenced in this Article VIII may be delivered in person, by email, or by certified mail (return receipt requested) to the designated recipient.
- c. If the deadline pursuant to which an action must be taken under this Article VIII falls on a weekend or holiday, the deadline will be extended to the next work day. In addition, any deadline or time period in this Article VIII may be extended by the Chief Medical Officer or his/her designee upon good cause shown, either upon request or his/her own accord.
- d. Whenever the activities or professional conduct of any member of the Medical Staff are considered to be detrimental to patient care, to be lower than the standards or aims of the Medical Staff or to be disruptive to the operations of the Hospital, corrective action against such Medical Staff member may be requested by an Officer of the Medical Staff, the Chair of any clinical department, the Chair of the Credentials Committee, the President, or the Chair of the JCQAA Committee. All requests for corrective action are made in writing to the Executive Committee and set forth the activities or conduct which constitute the grounds for the request. Within five (5) calendar days of its receipt of the request, the Executive Committee forwards the request for corrective action to the Chair of the department in which the Medical Staff member has privileges (or to the Chief Medical Officer if the request involves a Department Chair).
- e. The Chair of the Executive Committee promptly forwards to the President all requests for corrective action and continues to keep the President informed of all action taken in connection therewith.
- f. The Chief Medical Officer, or his/her designee, appoints an Ad Hoc committee within seven (7) calendar days of the Executive Committee's receipt of the request for corrective action.

The Ad Hoc Committee shall meet within seven (7) calendar days of being appointed to investigate the corrective action request, and shall provide a written report to the Executive Committee within fifteen (15) calendar days of the Ad Hoc Committee's first meeting. Absent special circumstances as determined in the sole discretion of the Chief Medical Officer or his/her designee, the Ad Hoc Committee should be composed of at least three Medical Staff members and may include members of the department of the Medical Staff member under review.

- g. The scope and format of the investigation shall be determined in the sole discretion of the Ad Hoc committee. At a minimum, however, the Ad Hoc committee should: 1) conduct interviews of individuals with direct knowledge of the issues under review (unless unnecessarily cumulative), including the Medical Staff member under investigation (as described more fully below) 2) review and consider any documentation relied upon by the individual requesting the corrective action, 3) review and consider relevant medical records, 4) review and consider any available and relevant personnel records of the Medical Staff member under investigation, and 5) review and consider any written materials provided by the Medical Staff member at under investigation (as described more fully below). If the Ad Hoc committee determines that it needs expert review of medical records or clinical issues, the Chief Medical Officer or the Chair of the Credentials Committee will assist the committee in identifying an internal or external resource, as appropriate to the circumstances. If the Chief Medical Officer agrees that an external expert is required under the circumstances, the expense will be charged to the Medical Staff member's department unless otherwise agreed by the Chief Medical Officer.
- h. As part of the Ad Hoc committee's investigation, the Medical Staff member against whom corrective action has been requested will be offered at least one opportunity to meet with the Ad Hoc committee to discuss, explain or refute the charges against him/her and/or to provide a written response. The Chief Medical Officer, within his/her discretion, shall determine what or whether information or documents being considered or created by the Ad Hoc committee as part of its investigation are shared with the Medical Staff member under investigation. Any information or documents provided to the Ad Hoc committee by the Medical Staff member may be shared with the Executive Committee or the Credentials Committee for consideration. Neither the Medical Staff member nor the Ad Hoc committee have the right to have legal counsel present for this meeting. The Medical Staff member's failure to cooperate with the committee in scheduling this meeting shall constitute a waiver of the right to meet with the Ad Hoc committee.
- i. At the conclusion of its investigation, the Ad Hoc committee submits a report to the Executive Committee describing its process and summarizing its findings, conclusions and recommendations. A copy of the report will be delivered to the Medical Staff member by the Chair of the Executive Committee. The Chair of the Executive Committee, within his/her discretion, shall determine what or whether other information or documents considered or created by the Ad Hoc committee or the Executive Committee are shared with the Medical Staff member under investigation. Information or documents considered or created by the Ad Hoc committee or the Executive Committee that are not shared with the Medical Staff member shall be maintained as confidential and peer review privileged material.
- j. At the next regularly scheduled Executive Committee meeting, or at an earlier meeting if deemed appropriate within the discretion of the Chief Medical Officer, the Executive Committee considers the report of the Ad Hoc committee acts upon the request for corrective action. At least one representative of the Ad Hoc committee will attend this meeting for the purpose of answering any questions about the process or the findings, but that representative

will not be present at or participate in the Executive Committee's deliberations or any vote on the matter. The Chair of the Credentials Committee may designate another member of the Credential Committee who participated in the Committee's deliberation to attend in his/her place or to accompany him/her in order to offer information and answer any questions, but that member will not participate in the Executive Committee's deliberations or vote on the matter. The Chair of the Department to which the Medical Staff member belongs may designate another member of the Department to attend, offer information, and answer any questions, but that member will not be present at or participate in the Executive Committee's deliberations or vote on the matter. The Medical Staff member has the right to either: (i) meet with the Executive Committee at the meeting at which it considers the Ad Hoc committee report and prior to the Executive Committee's action on that report; or (ii) submit a written statement to the Executive Committee at least three (3) calendar days prior to the meeting at which the Executive Committee considers the Ad Hoc committee report. Neither the Medical Staff member nor the Ad Hoc committee have the right to have legal counsel present for this meeting. The Medical Staff member's failure to cooperate with the Executive Committee in scheduling this meeting shall constitute a waiver of the right to meet with the Executive Committee. If the Medical Staff member meets with the Executive Committee at the meeting at which it considers the Ad Hoc committee report, the Chair of the Executive Committee will introduce the Medical Staff member and briefly describe the circumstances of the request for corrective action. The Medical Staff member may then address the Executive Committee, after which the Chair of the Executive Committee offer Executive Committee members the opportunity to ask the Medical Staff member questions, and the Medical Staff member may respond.

- k. The Executive Committee may adopt, reject or modify the recommendations of the Ad Hoc committee or may request additional information before action is taken. Possible actions include, but are not limited to: issuing a warning, a letter of admonition, or a letter of reprimand; imposing terms of probation or a requirement for consultation; recommending reduction, suspension or revocation of clinical privileges; recommending that an already imposed suspension of clinical privileges be terminated, modified or sustained; or recommending that the Medical Staff member's staff membership and/or clinical privileges be suspended or revoked. The Chair of the Executive Committee or his/her designee shall prepare a written summary of the Executive Committee's findings and conclusions.
- l. The recommendation and written summary of the Executive Committee shall be provided by the Chair of the Executive Committee to the Board of Directors, the President, the Medical Staff Member, and the Chair of the Medical Staff member's department.
- m. Any recommendation by the Executive Committee for the reduction, suspension or revocation of clinical privileges, or for the suspension or revocation of Medical Staff membership, may become effective immediately if the Executive Committee determines that the failure to act may result in imminent danger to the health of any individual, subject to reversal by the Board of Directors through the Hearing and Appellate Procedure set forth in Article IX. In the event the Chair of the JCQAA Committee has initiated the corrective action process and recommends the reduction, suspension or revocation of clinical privileges, or for the suspension or revocation of Medical Staff membership, the Medical Staff member is entitled to the rights set forth in Article IX. If the Medical Staff member chooses not to exercise his/her rights under Article IX, the Executive Committee's recommendation will go to the Board of Directors for final action.

## **Section 2. Summary Suspension**

- a. The President, the Chief Medical Officer, the Chair of the department in which the Medical Staff member has clinical privileges, or the Chair of the Credentials Committee has the authority, whenever immediate action must be taken because a failure to act may result in imminent danger to the health of any individual, to summarily suspend, for cause, all or any portion of the clinical privileges of a Medical Staff member with delineated clinical privileges. Such suspension shall become effective immediately upon imposition by individuals so empowered, and the Medical Staff member shall be notified promptly.
- b. Upon the imposition of a summary suspension, the Chief Medical Officer shall promptly convene an Ad Hoc committee to investigate the matter pursuant to Section 1(c) through (i) above, and a single Ad Hoc committee may investigate both a summary suspension and a recommendation for the limitation or revocation of privileges.
- c. If the Medical Staff member requests a hearing under Article IX for any actions taken or recommended by the Executive Committee under Article VIII, Section 1, the Medical Staff member shall be entitled to include in that hearing any challenges to the imposition of a summary suspension under this Section 2. Only one hearing is allowed; the Medical Staff member may request a hearing under Article IX solely on the imposition of the summary suspension only if no other actions or recommendations of the Executive Committee are the subject of a hearing. However, in the event a summary suspension exceeds fourteen (14) calendar days, the Medical Staff member shall be given notice of a right to hearing asset forth in Article IX, Section 3.

## **Article IX: Hearing and Appellate Review Procedure**

### **Section 1. Procedure**

- a. Any documents, reports, requests, and written notices referenced in this Article IX may be delivered in person, by email, or by certified mail (return receipt requested) to the designated recipient.
- b. If the deadline pursuant to which an action must be taken under this Article IX falls on a weekend or holiday, the deadline will be extended to the next work day. In addition, any deadline or time period in this Article IX may be extended by the Hearing Chair (as defined below) in his/her sole discretion and upon good cause shown, either upon request or his/her own accord.

### **Section 2. Right to Hearing**

A Medical Staff member is entitled to a Hearing before a committee of the Medical Staff when s/he receives notice that the Executive Committee or the JCQAA Committee is recommending that any of the following actions be taken against him/her:

- a. The denial of Medical Staff appointment or reappointment;
- b. The suspension or revocation of Medical Staff membership; and/or
- c. The restriction, denial, reduction, suspension or revocation of clinical privileges.

### **Section 3. Notice of Recommendation**

When a recommendation is made, which, according to these bylaws, entitles a Medical Staff member to a Hearing prior to a final decision by the Board of Directors, the affected Medical Staff member will promptly be given written notice by the President. The notice will contain:

- a. A statement of the recommendation made and the general reasons for it;
- b. Notice that the Medical Staff member has the right to request a Hearing on the recommendation within fifteen (15) calendar days of receipt of this notice; and
- c. A copy of this Article outlining the rights in the Hearing.

### **Section 4. Request for Hearing**

The Medical Staff member has fifteen (15) calendar days following his/her receipt of such notice to file a written request for a Hearing with the President. The failure of the Medical Staff member to request a Hearing constitutes a waiver of his/her right to such a Hearing and to any appellate review to which s/he might otherwise be entitled. If such a right to a Hearing is waived, the recommendation becomes effective against the Medical Staff member immediately.

### **Section 5. Notice of Hearing**

- a. The President will schedule a Hearing as soon as practicable. The Hearing date will not be less than thirty (30) calendar days from the date on which the notice of Hearing is forwarded to the Medical Staff member, unless an earlier date is agreed upon in writing by the parties.
- b. The President will forward the written notice of Hearing to the Medical Staff member. The notice of Hearing will include:
  - (1) the date, time, and location of the Hearing;
  - (2) a proposed list of witnesses, as known at the time, who are expected to give testimony or present evidence at the Hearing in support of the Executive Committee or the JCQAA Committee, provided that the list may be revised or amended; and
  - (3) the names of the Hearing Panel members/Hearing Officer, if known.

### **Section 6. Appointment of Hearing Panel, Presiding Officer, or Hearing Officer**

- a. When a Hearing is requested, the President, after consulting with the Chief Medical Officer, may appoint: 1) a Hearing Panel that will be composed of not less than three (3) members; or 2) one person to serve as Hearing Officer. As determined within the sole discretion of the President, the Hearing Officer or the Hearing Panel will be composed of Medical Staff members, or other physicians or laypersons not connected with the Hospitals, or any combination of the above, none of whom will have actively participated in the consideration of the matter at any previous level or are in direct economic competition with the Medical Staff member requesting the hearing. Knowledge of the matter will not preclude any individual from serving as Hearing Officer or a member of the Hearing Panel.

- b. The Hearing Officer or Hearing Panel may be advised by an attorney in the UNC Hospitals' Legal Department. In addition, the Executive Committee or the JCQAA Committee (depending on whose recommendation prompted the Hearing initially) may be advised by a separate attorney in the UNC Hospitals' Legal Department. The attorney representing the Hearing Officer/Hearing Panel and the attorney representing the Executive Committee/JCQAA Committee will take reasonable measures to ensure confidentiality and avoid conflicts of interest.
- c. In the case of the appointment of a Hearing Panel, the President will designate one member of the Hearing Panel as Chair or appoint an attorney at law as Presiding Officer. The Presiding Officer may participate in the private deliberations of the Hearing Panel and be a legal advisor to it, but will not be entitled to vote on its recommendations.
- d. The Hearing Panel Chair, the Hearing Officer, or the Presiding Officer, as applicable (hereinafter referenced as "Hearing Panel Chair") retains the discretion to determine the structure, format and procedure of the hearing, (including the discretion to make rulings on all questions that pertain to matters of procedure and to the admissibility of evidence), with the goals of:
  - (1) Ensuring that all participants in the Hearing have a reasonable opportunity to be heard and to present oral and documentary evidence, but subject to limitation based on a reasonable number of witnesses and duration of direct and cross examination, applicable to both sides as may be necessary to avoid excessive or irrelevant testimony or to prevent undue delay or abuse of the Hearing process; and
  - (2) Maintaining decorum throughout the Hearing.

### **Section 7. Hearing Procedure**

- a. There is no right to discovery in connection with the Hearing. However, the Medical Staff member is entitled to obtain or review the following documents, provided that: (1) the Medical Staff member makes a specific, written request for the documents at least two (2) weeks prior to the date of the pre-Hearing conference described more fully below; and (2) the Medical Staff member executes a stipulation that such documents will be maintained as confidential and will not be disclosed or used for any purpose outside of the Hearing and any subsequent appeal:
  - (1) copies of, or reasonable access to, all patient records identified in the notice of Hearing, as revised or supplemented, at the Medical Staff member's expense;
  - (2) non-privileged reports of experts or other documents relied upon to support the recommendation or action by the Chair, the Credentials Committee, any Ad Hoc committee, the Executive Committee, or the JCQAA Committee; and
  - (3) non-privileged, redacted copies of relevant committee or department minutes.

The Executive Committee or the JCQAA Committee (depending on whose recommendation prompted the Hearing initially) shall produce the requested documents within one (1) week of receiving such request.

- b. The Hearing Chair will require the Medical Staff member (or his/her counsel), the Executive Committee or the JCQAA Committee (depending on whose recommendation prompted the Hearing initially), and counsel for the Executive Committee or the JCQAA Committee to participate in a pre-Hearing conference for the purpose of resolving all procedural questions in advance of the Hearing. The pre-Hearing conference shall be scheduled for a date that permits the Medical Staff member to submit a request for documents as set forth above at least two weeks prior to the pre-Hearing conference. The Hearing Chair shall specifically require the parties to present at the pre-Hearing conference: the names of their respective counsel who will appear at the Hearing; copies of all documentary evidence reasonably known at the time to be submitted at the Hearing and any objections to such documents reasonably known at the time; the names of all witnesses and a brief statement of their anticipated testimony; and the time granted to each witnesses' testimony and cross-examination. Witnesses and documents not provided and agreed upon pursuant to the pre-Hearing conference will be excluded from the Hearing unless admitted for good cause shown (and subject to any conditions that may be impose) in the sole discretion of the Hearing Chair.
- c. The parties may have counsel present at the Hearing for advice and assistance only. The parties are expected to present their case on their own behalf, including by making any opening or closing statements, presenting evidence, and examining witnesses.
- d. Each party must give the other party copies of all documentary evidence and a list of final witnesses and expected testimony at least one (1) week prior to the Hearing. Any objections to such evidence or witnesses must be submitted to the Hearing Chair at least three (3) calendar days prior to the Hearing.
- e. A Medical Staff member who fails to appear at the Hearing is deemed to have waived his/her rights as set forth in this Article IX and to have voluntarily accepted the recommendation or decision in question, which thereupon becomes final and effective.
- f. The Hearing shall be recorded as determined by the Hearing Chair, and may include the use of a court reporter, electronic recording unit, or any other method that ensures a fair and complete record. The cost of a court reporter or other electronic recording will be borne by the Hospital, but a copy of the transcript or a recording will be provided to the Medical Staff member requesting the Hearing at the Medical Staff member's expense. Oral evidence will be taken only on oath or affirmation administered by any person entitled to notarize documents in this State.
- g. The Executive Committee or the JCQAA Committee, depending on whose recommendation prompted the Hearing initially, will first present evidence in support of its recommendation. Thereafter, the burden then shifts to the Medical Staff member or his/her representative to present evidence.
- h. Subject to reasonable limits determined by the Hearing Chair, each party has the right to: be represented by an attorney or other person of his/her choice; call and examine witnesses; introduce documentary evidence; cross-examine witnesses on any relevant matters; rebut any evidence; and submit a written statement at the close of the Hearing. If the Medical Staff member does not testify on his/her own behalf, s/he may be called as a witness by the Executive Committee's representative and examined as if under cross-examination. Hearing Panel members or the Hearing Chair may question the witnesses, call additional witnesses, or request additional documentary evidence.

- i. The Hearing need not be conducted in accordance with any rules of evidence. Any relevant evidence, if it is the sort of evidence upon which reasonable persons customarily rely in the conduct of serious affairs, may be considered in the sole discretion of the Hearing Chair, regardless of the admissibility of such evidence in a court of law. Prior to or at any time during the Hearing, each party is entitled to submit memoranda concerning any issue of law, procedure or fact, and such memoranda will become a part of the Hearing record.

### **Section 8. Hearing Conclusion, Deliberations, and Recommendations**

- a. The Hearing Chair may recess the Hearing and reconvene at a later date for the convenience of the participants or for purposes of obtaining new or additional evidence or consultation, in the sole discretion of the Hearing Chair. Upon conclusion of the presentation of all the evidence or upon a decision by the Hearing Chair that the remaining evidence will be cumulative or irrelevant, the Hearing will be closed.
- b. The Hearing Panel's or Hearing Chair's, as applicable, recommendation will uphold the recommendation of the Executive Committee or the JCQAA Committee unless it finds that the Medical Staff member who requested the Hearing has proved, by clear and convincing evidence, that the recommendation of the Executive Committee or the JCQAA Committee (depending on whose recommendation prompted the Hearing initially) was without reasonable basis.
- c. The recommendation of the Hearing Panel or Hearing Chair will be based on the evidence produced at the Hearing, including oral testimony of witnesses, memoranda presented in connection with the Hearing, all applications, references, and accompanying documents, medical records, and any other evidence that has been accepted.
- d. Within fifteen (15) calendar days after final adjournment of the Hearing (which will be designated as the time the Hearing Chair receives the Hearing transcript or any post-Hearing memoranda, whichever is later; provided that the Hearing Panel or Hearing Officer may determine that the Hearing transcript is not necessary in order to adjourn the Hearing), the Hearing Panel will conduct its deliberations and will render a recommendation, accompanied by a report, that will contain a concise statement of the reasons for the recommendation. At a minimum, the written report shall contain a summary of the evidence submitted by both parties and the Hearing Panel's key decisions.
- e. The Hearing Chair will deliver the written report and recommendation to the President who will forward it, along with all supporting documentation, to the Board of Directors for further action. The President will also deliver a copy of the report and recommendation to the Medical Staff member and to the Executive Committee for information.

### **Section 9. Appellate Review**

- a. Within fifteen (15) calendar days after receipt of notice of the written report and recommendation, either: 1) the Medical Staff member; or 2) the Executive Committee or the JCQAA Committee (depending on whose recommendation prompted the Hearing initially) may request an appellate review. The request will be in writing to the President and will include a statement of the grounds for appeal and the specific facts or circumstances that justify further review. If an appellate review is not requested in this manner, both parties will be deemed to have waived appellate review and accepted the written report and recommendation as final.

- b. The grounds for appeal are:
  - (1) that during or prior to the Hearing there was substantial and material failure to comply with these Bylaws of the Medical Staff so as to deny due process or a fair Hearing; or
  - (2) the recommendation was arbitrary, capricious, a result of prejudice, or not supported by substantial evidence.
- c. The Chair of the Board of Directors may appoint a Review Panel composed of not less than three (3) persons, either members of the Board or others, including but not limited to reputable persons outside the Hospital, to consider the record upon which the recommendation before it was made, or the Board may hear the appeal as a whole.
- d. The Review Panel will base its decision solely on the record of the proceedings below, and the Medical Staff member has no right to appear before the Review Panel. Additional evidence will not be considered, absent (as determined in the sole discretion of the Chair of the Board of Directors, a compelling demonstration that such evidence was not developed at the time of the Hearing or that any opportunity to admit it at the Hearing was inappropriately denied. Each party has the right to present a written statement in support of its position on appeal, to be submitted by a date determined by the Chair of the Board or the Review Panel. The Review Panel will recommend final action to the Board.

#### **Section 10. Final Decision of the Board**

- a. Within thirty (30) calendar days after receipt of the Review Panel's recommendation, the Board of Directors will render a final decision in writing, including specific reasons, and will deliver copies to the Executive Committee and, through the President, to the Medical Staff member, provided that the time period may be extended in the discretion of the Chair of the Board upon good cause shown. The Board of Directors may affirm, modify or reverse the recommendation of the Review Panel, refer the matter for further review and recommendation, or make its own decision in light of the Board of Directors' ultimate legal responsibility to make appointments and grant clinical privileges.
- b. Except where the matter is referred for further action and recommendation, the final decision of the Board of Directors will be immediately effective and not subject to further Hearing or appellate review. If the matter is referred for further action and recommendation, such recommendation will be promptly made to the President and Chief Medical Officer in accordance with the instructions given by the Board of Directors. This further review process and the report back to the Board of Directors will not exceed thirty (30) calendar days except as the parties may otherwise stipulate or as extended in the discretion of the Chair of the Board of Directors upon good cause shown.
- c. Notwithstanding any other provision set forth in these Medical Staff Bylaws, no Medical Staff member shall be entitled as a matter of right to more than one Hearing and one appellate review on any matter which has been considered by either the Executive Committee of the Medical Staff or the Board of Directors.

**Article X:  
Organization of Departments and Services**

**Section 1. General Organization**

An up-to-date list of the Departments of the Medical Staff is set forth in the *Medical Staff Organization Manual*.

**Section 2. Organization of Departments and Services**

- a. The Chief Medical Officer is responsible for the clinical operations of the Hospital. The Chief Medical Officer calls and presides over all regular and special meetings of the Medical Staff.
- b. Each department or service shall be organized as a division of the staff and shall have a Department Chair or Service Head who is responsible to the Chief Medical Officer for the ongoing, effective operation of his Department or Service, for improving patient safety, and for continually assessing and improving its activities. Each Department Chair and Service Head is appointed by the Board of Directors upon the recommendation of the Dean of the School of Medicine, except that the Chair of the Department of Dentistry is appointed upon recommendation of the Dean of the School of Dentistry.
- c. A Department Chair or Service Head may be removed from that position by the Board of Directors for unsatisfactory performance of his/her responsibilities as set forth in these *Bylaws*. The Chief Medical Officer or the President may recommend to the Board of Directors the removal of a Department Chair or Service Head and shall give a Department Chair or Service Head notice and the grounds upon which such recommendation is based. The Department Chair or Service Head may request a discussion with the Chair of the Board's JCQAA Committee to be held within five (5) days of such notice. Following such discussion, the Board of Directors renders a final decision. A Department Chair or Service Head so removed shall have no further appeal rights under these *Bylaws*. Without further action taken pursuant to these *Bylaws*, removal as Department Chair or Service Head does not affect the Medical Staff appointment or clinical privileges of the physician.
- d. The Hospital may, from time to time, contract with physicians, dentists or other allied health professionals to perform various administrative duties and responsibilities on its behalf. Individuals in such administrative positions who desire Medical Staff membership or clinical privileges are subject to the same procedures as all other applicants for membership or privileges. All matters relative to the membership and/or privileges of such individuals are governed by these *Bylaws*.

**Article XI:  
Departments and Services**

**Section 1. Functions of Departments and Services**

- a. Each department establishes its own written criteria relative to clinical or practice privileges consistent with the policies of the Hospital, the Board of Directors and the Medical Staff.
- b. Each department and service establishes and maintains a systematic process for monitoring and evaluating all of its major clinical activities for the purpose of improving the quality of the care provided. In all such evaluation and monitoring activities, each department and service

is specifically designated and will conduct such activities as a Medical Review Committee, as defined by the Board of Directors. Each department and service meets at least monthly to review selected cases that contribute to the continuing education of every Practitioner and to the process of identifying opportunities for improvement in patient care. Such reviews may include an evaluation of deaths, selected unimproved patients, patients with infections, complications in care, errors in diagnosis and treatment, and other matters deemed to be appropriate. In addition, departments and services may review or participate in the review of patient incidents identified by the Risk Management Department.

- c. Each patient admitted for inpatient care or outpatient surgery shall have a history taken and a comprehensive physical examination (H&P) performed by an attending physician or by a Housestaff physician or Allied Health Professional with such privileges and authenticated by the attending physician. Qualified oral surgeons who admit patients without medical problems may perform the history and physical examination on those patients. An H&P shall be completed for the electronic medical record no more than twenty-four (24) hours prior to a scheduled admission or outpatient surgery or within twenty-four (24) hours after emergency surgery (the "Required Period"). In an emergency when there is no time to record a complete H&P, a progress or admission note describing a brief history and appropriate physical findings and the preoperative diagnosis is recorded in the medical record before surgery. If all or part of the H&P is dictated, then a brief note shall be written in the record on the progress notes or typed directly in the electronic medical record upon admission to provide pertinent information until the dictated H&P is transcribed. An H&P may be performed outside the Required Period, but within thirty (30) days prior to a scheduled admission or outpatient surgery, if an updated assessment is subsequently both performed and documented during the Required Period that identifies any changes in the patient's medical status or that no changes have occurred.

## **Section 2. Responsibilities of Department Chairs**

Each Department Chair is responsible for:

- a. All clinically related activities of the department/service;
- b. All administratively related activities of the department/service, unless otherwise provided for by the Hospital or University;
- c. Continuing surveillance of the professional performance of all individuals who have delineated clinical or practice privileges in the department/ service;
- d. Recommending to the Medical Staff the criteria for clinical or practice privileges that are relevant to the care provided in the department/service;
- e. Recommending clinical or practice privileges for each Practitioner within the department/service, including the provision of services by telemedicine if applicable;
- f. Assessing and recommending off-site resources for needed patient care services not provided by the Department/Service or the Hospital;
- g. The integration of the department/service into the primary functions of the organization;
- h. The coordination and integration of interdepartmental and intradepartmental services;

- i. The development and implementation of policies and procedures that guide and support the provision of services;
- j. Recommendations for a sufficient number of qualified and competent persons to provide care/service;
- k. The determination of the qualifications and competence of department/service personnel who are not licensed independent practitioners and who provide patient care services;
- l. The continuous assessment and improvement of the quality of care and services provided;
- m. The maintenance of quality control programs, as appropriate;
- n. The orientation and continuing education of all persons in the department/service; and
- o. Recommendations for space and other resources needed by the department/service.

Each Department Chair is certified by an appropriate specialty board or comparable competence affirmatively established through the credentialing process.

## **Article XII: Officers**

### **Section 1. Officers**

- a. Officers of the Medical Staff must be members of the Active Staff.
- b. The officers of the Medical Staff are the Chief Medical Officer, such Associate Chief Medical Officers as may be deemed appropriate and appointed by the Chief Medical Officer, and six Members-at-Large.
- c. The Chief Medical Officer is appointed by the Board of Directors upon the recommendation of the Dean of the School of Medicine, with the approval of the Executive Committee of the Medical Staff.
- d. Selection of Members-at-Large to serve on the Executive Committee: The Chief Medical Officer will seek nominations for Members-at-Large from the Medical Staff membership. All nominees will be asked to confirm their nomination and prepare a short statement of interest. The slate of nominees, with each person's statement of interest, will be distributed as a ballot to all voting members of the Medical Staff for selection of the Members-at-Large. The Chief Medical Officer will report the results of the election and selection of the Members at Large to the Executive Committee and the Medical Staff.

### **Section 2. Term of Office**

The Members-at-Large will serve staggered two year terms or until a successor is appointed or elected.

### **Section 3. Duties of Officers**

- a. **Chief Medical Officer.** The Chief Medical Officer serves as the Chief Administrative Officer of the Medical Staff. His/her responsibilities are as follows:

- (1) To work with the President relative to all matters of mutual concern between the Medical Staff and the Hospital;
- (2) To call and preside at all meetings of the Medical Staff and keep complete and accurate minutes of all meetings;
- (3) To appoint the membership of all standing, special and multidisciplinary Medical Staff Committees, except the Executive Committee, subject to the approval of the Executive Committee. Unless otherwise set forth in these Bylaws, the Chief Medical Officer names all committee Chairs;
- (4) To serve as an ex-officio member of all Medical Staff Committees;
- (5) To represent the views, policies, needs and grievances of the Medical Staff to the Board of Directors and the President;
- (6) To serve as the public spokesperson for the Medical Staff;
- (7) To report at the annual Medical Staff meeting regarding Medical Staff affairs;
- (8) To enforce the Bylaws of the Medical Staff, the Rules and Regulations of the Medical Staff and related Policies and Manuals and implement and monitor sanctions or corrective action taken pursuant to these Bylaws; and
- (9) To serve as the Chair of the Executive Committee.

b. **Associate Chief Medical Officers.** An Associate Chief Medical Officer, in the absence of the Chief Medical Officer, assumes all of the authority and duties of the Chief Medical Officer. The Associate Chief Medical Officers also perform such other duties as may be assigned by the Chief Medical Officer.

c. **Members-at-Large.** The Members-at-Large are responsible for reflecting the views of the membership in Medical Staff affairs.

#### **Section 4. Removal of Officers**

a. An officer of the Medical Staff may be removed from office for causes unrelated to professional capabilities or the exercise of clinical privileges. Such causes may include failing to perform the duties of the position, exhibiting conduct detrimental to the interests of the Hospital, or suffering from a physical or mental infirmity that renders the individual incapable of fulfilling the duties of the office. The Chief Medical Officer (or the Dean of the School of Medicine if the Chief Medical Officer is the subject of removal) will give an officer notice and the grounds upon which such removal is proposed. The officer may request a meeting with the Chief Medical Officer (or with the Dean of the School of Medicine if the Chief Medical Officer is the subject of removal) to be held within five (5) days of the date of such request. Following such meeting, the Chief Medical Officer (or the Dean of the School of Medicine, if the Chief Medical Officer is the subject of removal) consults with the Executive Committee of the Medical Staff before rendering a final decision. An officer so removed has no further appeal rights under these *Bylaws*.

- b. Without further action pursuant to these *Bylaws*, removal from office does not affect the Medical Staff appointment or clinical privileges of the physician.

### **Article XIII: Committees**

#### **Section 1. General**

Committees are either standing or special. All committee members, regardless of whether they are members of the Medical Staff, are eligible to vote on committee matters unless otherwise set forth in these *Bylaws* or the *Medical Staff Organization Manual*. The presence of twenty-five (25) percent of a committee's members will constitute a quorum. The members of all standing committees, other than the Executive Committee, are appointed by the Chief Medical Officer subject to approval by the Executive Committee, unless otherwise stated in these *Bylaws* or the *Medical Staff Organization Manual*. Unless otherwise set forth in these *Bylaws* or the *Medical Staff Organization Manual*, the Chair of each committee is appointed by the Chief Medical Officer. Each standing committee meets at least quarterly unless otherwise set forth in these *Bylaws* or the *Medical Staff Organization Manual*. Minutes of each meeting are recorded and forwarded to the Executive Committee. Robert's Rules of Order will govern all committee meetings.

#### **Section 2. Executive Committee**

- a. The Executive Committee consists of the Officers of the Medical Staff, the Department Chairs, the Chief Nursing Officer, the President of UNC Faculty Physicians, the Deans of the Schools of Medicine and Dentistry or their designees, the President of the Housestaff Council, two Allied Health Professionals (consisting of the Director of the UNC Health Care Advanced Practice Provider Center and an individual elected by the body of Allied Health Professionals), and the President of UNC Hospitals. All members are entitled to vote; however, the two Allied Health Professional members may not vote on matters relating to physician corrective action. The Chief Medical Officer is a member and Chair of the Committee.
- b. The Medical Staff delegates to the Medical Staff Executive Committee authority to oversee the operations of the Medical Staff. With the assistance of the Chief Medical Officer, and without limiting this delegation of authority, the Medical Executive Committee is responsible for making recommendations to the Board of Directors for its approval concerning:
  - 1. The structure of the Medical Staff;
  - 2. The mechanisms used to review credentials and to delineate individual clinical or practice privileges;
  - 3. Recommendations of individuals for Medical Staff membership;
  - 4. Recommendations for delineated clinical or practice privileges for eligible individuals;
  - 5. Participation of the Medical Staff in performance improvement activities;
  - 6. The mechanisms for terminating Medical Staff membership; and
  - 7. The mechanisms for Fair Hearing procedures.

The Executive Committee receives and acts on reports and recommendations from Medical Staff Committees, departments and assigned activity groups, and is empowered to act for the Medical Staff in the intervals between Medical Staff meetings, within the scope of its responsibilities.

- a. The authority delegated pursuant to this Article XIII, Section 2 may be removed by amendment of these *Bylaws*, or by resolution of the Medical Staff, approved by a 2/3 vote of the voting members of the Medical Staff, taken at a general or special meeting noticed to include the specific purpose of removing specifically-described authority of the Medical Executive Committee.
- b. A member of the Medical Executive Committee may be removed from the Medical Executive Committee for the reasons described in and pursuant to the process outlined in Article XII, Section 4 (herein), provided however, that the member of the Medical Executive Committee who is the subject of removal not participate in any discussions between the Chief Medical Officer (or with the Dean of the School of Medicine if the Chief Medical Officer is the subject of removal) and the Medical Executive Committee. A member of the Medical Executive Committee so removed has no further appeal rights under these *Bylaws*.

### **Section 3. Creation of Committees**

The Executive Committee may, by resolution and upon approval of the Board of Directors, without amendment of these *Bylaws*, establish additional standing or special committees to perform one or more Medical Staff functions. In the same manner, the Executive Committee may, by resolution and upon approval of the Board of Directors, dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical Staff functions.

#### **Article XIV: Meetings**

Meetings of the Medical Staff may be called at any time by the Chief Medical Officer or at the request of the Board of Directors, or the Executive Committee. At any such meeting, only that business set forth in the notice thereof will be transacted. Notice of any such meeting shall be deemed sufficient if it is given in writing to the Medical Staff at least forty-eight (48) hours prior thereto. The Chief Medical Officer, in his/her discretion, may declare a quorum at any regular or special meeting of the Medical Staff.

#### **Article XV: Rules and Organization Manual**

### **Section 1. General Rules and Organization Manual**

The Medical Staff may initiate and adopt such Rules and an Organization Manual as it may deem necessary and periodically review and revise its Rules and Organizational Manual to comply with current Medical Staff practice and to implement more specifically the general principles found in these *Bylaws*. Proposed Rules or Manual amendments may emanate from any responsible committee, department, medical staff officer, or by petition signed by at least 100 members of the Active Staff. Additionally, Hospital administration may develop and recommend proposed Rules or Manual amendments, and in any case should be consulted as to the impact of any such proposed changes or amendments on Hospital operations and feasibility. Proposed Rules or Manual amendments are submitted to the Medical Staff Executive Committee for review and action, as follows:

## **Section 2. Process for Adoption or Amendment**

- a. Except as provided at Section 2d. below, with respect to circumstances requiring urgent action, the Medical Staff Executive Committee will not act on the proposed Rule or Manual amendment until the Medical Staff has had a reasonable opportunity to review and comment on such amendment. This review and comment opportunity may be accomplished by posting proposed Rules on the Medical Staff website or by sending the proposed Rules via electronic mail to the members of the Medical Staff at least 15 days prior to the scheduled Medical Staff Executive Committee meeting, together with instructions on how interested members may communicate comments during this review and comment period. All comments will be summarized and provided to the Medical Staff Executive Committee prior to Medical Staff Executive Committee action on the proposed Rule or Manual amendment.
- b. Medical Staff Executive Committee approval is required for amendments to the Rules or Organizational Manual, unless the proposed Rule or Manual amendment is one generated by petition of at least 100 members of the Active Staff. In this latter circumstance, if the Medical Staff Executive Committee fails to approve the proposed Rule or Manual amendment, it will notify the Medical Staff. The Medical Staff Executive Committee and the Medical Staff each has the option of invoking or waiving the conflict management provisions of Article XVIII.
  - (1) If conflict management is not invoked within 25 days it will be deemed waived. In this circumstance, the Medical Staff's proposed Rule or Manual amendment will be forwarded to the Governing Body for action. The Medical Executive Committee may forward comments to the Medical Staff and the Governing Body regarding the reasons it declined to approve the proposed Rule.
  - (2) If conflict management is invoked, the proposed Rule will not be voted upon or forwarded to the Board of Directors until the conflict management process has been completed, and the results of the conflict management process are communicated to the Medical Staff and the Board of Directors.
  - (3) With respect to proposed Rules or Manual amendments generated by petition of the Medical Staff, approval requires the affirmative vote of a majority of the votes of at least 25% of the Active Staff members, provided at least 14 days' advance written notice, accompanied by the proposed Rule or Manual amendment, has been given.
- c. Following approval by the Medical Staff Executive Committee as described above, a proposed Rule or Manual amendment is forwarded to the Board of Directors for approval, which approval shall not be withheld unreasonably. The Rule or Manual amendment becomes effective immediately following approval of the Board of Directors.
- d. Where urgent action is required to comply with law or regulation, the Medical Staff Executive Committee is authorized to provisionally adopt a Rule or Manual amendment and forward it to the Board of Directors for approval and immediate implementation, subject to the following: if the Medical Staff did not receive prior notice of the proposed Rule, the Medical Staff will be notified of the provisionally-adopted and approved Rule or Manual amendment, and may, by petition signed by at least 100 members of the Active Staff, require the Rule or Manual amendment to be submitted for possible recall; provided, however, the approved Rule or Manual amendment will remain effective until such time as a superseding Rule or Manual amendment meeting the requirements of the law or regulation that precipitated the initial urgency has been approved pursuant to any applicable provision of this Section 3.

## **Article XVI: Amendment**

These *Bylaws*, are reviewed no less than once every three years by the Bylaws Committee. At any time, the Executive Committee of the Medical Staff may make recommendations for amendment of these *Bylaws*. Additionally, the Medical Staff may make recommendations for amendment of these *Bylaws* by submitting to the Executive Committee of the Medical Staff a petition signed by at least 10% of the Active Staff members entitled to vote. Hospital administration also may recommend amendments to these *Bylaws*.

To be adopted, amendments require approval by a majority of the Medical Staff members voting on the matter, provided that at least twenty-five (25) percent of the Active Staff entitled to vote cast votes. Active Staff members entitled to vote may vote at any regular or special meeting of the Medical Staff or by delivering a completed ballot to the Office of the Chief Medical Officer, provided at least 14 days' advance written notice, accompanied by the proposed amendments, has been given to the Active Staff members. The ballot may be submitted electronically, through U.S. mail, or by hand. Any member of the Medical Staff entitled to vote who does not submit a vote within the 14-day period shall have his or her vote counted in favor of the amendment.

Amendments that have been passed by a majority vote of the Medical Staff, as described above, become effective when approved by the Board of Directors. If approval is withheld, the reasons for doing so will be specified by the Board of Directors in writing and forwarded to the Chief Medical Officer, the Executive Committee of the Medical Staff and the Bylaws Committee.

## **Article XVII: Conflict Management**

In the event of conflict between the Medical Staff Executive Committee and the Medical Staff (as represented by written petition signed by at least 100 of the voting members of the Medical Staff) regarding a proposed or adopted Rule or Organizational Manual provision, or other issue of significance to the Medical Staff, the Chief Medical Officer will convene a meeting with the petitioners' representative(s). The foregoing petition will include a designation of up to five members of the voting Active Staff to serve as the petitioners' representative(s). The Medical Staff Executive Committee will be represented by an equal number of Medical Staff Executive Committee members. The Medical Executive Committee's and the petitioners' representative(s) will exchange information relevant to the conflict and work in good faith to resolve differences in a manner that respects the positions of the Medical Staff, the leadership responsibilities of the Medical Staff Executive Committee, and the safety and quality of patient care at the Hospital. Resolution at this level requires a majority vote of the Medical Staff Executive Committee's representatives at the meeting and a majority vote of the petitioners' representatives. Unresolved differences will be submitted to the Board of Directors for its consideration in making its final decision with respect to the proposed Rule or Organizational Manual issue.