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.

Amended effective May 18, 2021.

TABLE OF CONTENTS

PAGE

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 Medical Staff of The University of North Carolina Hospitals hereby organize themselves in conformity with these *Bylaws of the Medical Staff of The University of North Carolina Hospitals ("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.

"**Chair**" or "**Department Chair**" means the Chair, duly appointed as set forth in these Bylaws, of a Department of The University of North Carolina as defined in the Medical Staff Organization Manual of these Bylaws. With the exception of the right to vote on Medical Staff corrective action matters, the Chair may delegate any of their rights, duties or responsibilities under these Bylaws to their designee. Such designee must be a member of the Medical Staff.

"**CMO**" means The University of North Carolina Hospitals' Chief Medical Officer. With the exception of the right to vote on Medical Staff corrective action matters, the CMO may delegate any of their rights, duties or responsibilities under these Bylaws to their designee. Such designee must be a member of the Medical Staff.

"**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.

"**JCUNCH Committee**" means the Joint Conference Committee for UNC Hospitals 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.

"**MSEC**" means the Executive Committee of the Medical Staff of The University of North Carolina Hospitals.

"**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 President of The University of North Carolina Hospitals. With the exception of the right to vote on Medical Staff corrective action matters, the President may delegate any of their rights, duties or responsibilities under these Bylaws to their designee. Such designee must be a member of the Medical Staff.

"**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 and Regulations, Policies, or Manuals adopted or approved as described below. Upon proper adoption, as described below, all such Rules and Regulations, 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 shall be known 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:

a. 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;

b. 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;

c. 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;

d. To provide the highest scientific and educational standards for postgraduate, graduate, and undergraduate students in medicine;

e. To afford outstanding health care to the community;

f. To promulgate *Bylaws*, *Rules and Regulations,* and an *Organization Manual* for the self-governance of the Medical Staff;

g. 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; and

h. To stimulate and carry out research

ARTICLE IV:
MEDICAL STAFF CATEGORIES, ALLIED HEALTH PROFESSIONALS, AND CLINICAL PRIVILEGES

Section 1. General

a. Overview. Hospital Medical Staff membership and the granting of clinical privileges are a privilege extended only to individuals who continuously meet the qualifications, standards, and requirements set forth in these Bylaws. The Board of Directors makes appointments to the Medical Staff, along with corresponding clinical privileges, to one of the categories listed below and grants clinical privileges without regard to race, religion, color, age, sex, gender, creed, national origin, disability, or sexual orientation. All appointments and granting of privileges are assigned to a specific clinical department.

b. Responsibilities. Each member of the Medical Staff and individual with clinical privileges will, as applicable:

(1) Provide their patients with professional care that meets generally accepted standards of quality, provide for continuous care for their patients, and participate in quality improvement activities of the Hospital and Medical Staff;

(2) Abide by the Medical Staff Bylaws, Rules and Regulations, and by all other Hospital and Departmental standards, policies, rules, and regulations;

(3) Discharge such staff, department, service, committee, and Hospital functions for which they are responsible by appointment, election or otherwise;

(4) Prepare and complete in a timely manner the medical records and all other required records of all patients they admit or in any way provides patient care services to in the Hospital;

(5) Participate in the teaching of fellows, housestaff, medical or dental students, nurses, student nurses and allied health personnel as required by their role;

(6) Encourage, promote, and when appropriate, participate in scientific investigation, as required by their role;

(7) Abide by the ethical principles of their profession; and

(8) Participate in continuing education.

c. Separate from Employment Matters. The rights granted to Practitioners under these bylaws are independent of any rights or obligations held by Practitioner as a result of any employment relationship. Any rights granted to Practitioners outside of these bylaws by virtue of their employment relationship shall not create additional rights under these bylaws.

Section 2. The Medical Staff

a. Categories and Qualifications of the Medical Staff.

(1) 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 American Board of Medical Specialties (ABMS), AOA, or American Dental Association (ADA), 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 based on the Chair's determination that the physician or dentist possesses comparable competencies.

Each Department Chair must be certified in their specialty by a member board of the ABMS, the AOA, the ADA, unless the exceptional circumstances and good cause shown referenced below have been identified.

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, AOA or an ADA 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 unless the exceptional circumstances and good cause shown referenced below have been identified. In such cases, the member of the Active Staff will not be entitled to the Hearing and Appellate Review procedures of Article VII.

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 CMO, President of UNC Faculty Physicians, 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 the Hospital 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. All members of the Active Staff have admitting privileges.

(2) 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 Hospital's Active Staff.

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 ABMS, AOA or 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, AOA 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.

(3) The Affiliate Staff. The Affiliate Staff consists of physicians and dentists who have an office-based practice and refer patients to the Hospital's inpatient services or procedural areas. 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 Hospital. 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 Hospital.

(4) 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 clinical privileges, or serve on Medical Staff Committees. As of July 15, 2019, no further appointments to the Honorary Staff will be made.

Section 3. Allied Health Professionals

a. Overview. Allied Health Professionals may obtain clinical privileges but do not qualify for Medical Staff membership. An Allied Health Professional who applies for Hospital privileges must be: 1) a member of the faculty or an employee of the School of Medicine of the University of North Carolina at Chapel Hill; 2) an employee of the University of North Carolina Health Care System; or 3) party to a contract with the Hospital (i.e., as locum tenens, telemedicine, or otherwise). An Allied Health Professional must fulfill all applicable requirements of these Bylaws and all applicable Medical Staff and Hospital rules, regulations, policies and procedures.

b. Categories and Rights of Allied Health Professionals.

(1) Independent Allied Health Professionals. The term "Independent Allied Health Professional" includes: licensed acupuncturists, 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.

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 their privileges, licensure/certification, and the rules, regulations, policies and procedures of the Medical Staff and the Hospital:

i Provide specified patient care services;
ii Exercise independent judgment in their areas of competence and participate directly in the management of patients, provided that a member of the Active Staff has overall responsibility for the care provided to each patient;

iii Enter reports and progress notes into the medical record and write certain treatment orders for specific patients;
iv Serve with voting rights on committees of the Medical Staff and attend Medical Staff or Department meetings, if so invited; and
v. Exercise other prerogatives, as specified by the Board.

(2) Dependent Allied Health Professionals. 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 designated by the Board.

A Dependent Allied Health Professional may not independently admit patients to or discharge patients from the Hospital. A Dependent Health Professional may, within the scope of their privileges, licensure/certification, and the rules, regulations, policies and procedures of the Medical Staff and the Hospital:

i. Provide specified patient care services in collaboration with or under the supervision of Active Staff members;
ii. Enter reports and progress notes into the medical record and write certain treatment orders for specific patients;
iii. Serve with voting rights on committees of the Medical Staff and attend Medical Staff or Department meetings, if so invited; and
iv. Exercise other prerogatives, as specified by the Board.

c. Eligibility for Clinical Privileges. Allied Health Professionals may apply for clinical privileges as set forth in these Bylaws. Allied Health Professionals must meet those specific qualifications and may only request those specific practice privileges appropriate to and within the scope of their profession/license, and as further specified by the policies and procedures of the Credentials Committee and these Bylaws.

In addition, 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 the Dependent Allied Health Professional's patient care activities. In addition, for Dependent Allied Health Professionals 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 same site as the Dependent Allied Health Professional who has a valid license to practice medicine in North Carolina and any other necessary jurisdiction and who will supervise and assume responsibility for the Dependent Allied Health Professional's telemedicine patient care activities.

Section 4. Clinical Privileges

a. Overview. Medical Staff and Allied Health Professionals may be granted clinical privileges corresponding to the categories identified above and in accordance with their education, training, licensure/certification, experience and competence as set forth in these Bylaws and applicable Credentials Committee and Hospital rules and regulations and policies. In addition, the Board may grant other clinical privileges as set forth below.

Practitioners are entitled to only those clinical privileges delineated in: (1) the notice of appointment/reappointment to the Medical Staff, and/or (2) the notice of granting/renewal of privileges. The nature and scope of surgical procedures that a dentist may perform are specifically defined in those documents and in the application for privileges. The Credentials Committee obtains advice from the Dean of the School of Dentistry and the Chair of the Operating Room Committee or its equivalent) relative to the nature and scope of dental surgical privileges requested by applicants. 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 the provision of care at the Hospital.

The exercise of clinical privileges is subject to the rules and regulations of the Hospital, the relevant Department(s), and the authority of the relevant Department Chair(s).

Department Chairs determine whether the provision of telemedicine is consistent with commonly accepted quality standards and is an appropriate approach to the delivery of services within the Department. All Medical Staff appointments and categories of clinical privileges include the ability to provide clinical services via telemedicine link, as long as authorized by the Chair and in accordance with applicable law.

Practitioners 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, Drug Enforcement Administration registration, malpractice coverage, and involvement in any malpractice activity or disciplinary action by any licensing or certification board or health care facility.

Upon appointment to the Medical Staff and/or the granting of privileges, the Practitioner will be placed upon a Focused Professional Practice Evaluation in accordance with Hospital policy. In addition, when a Practitioner who is an existing member of the Medical Staff or has privileges at Hospital is granted new or additional privileges, the Practitioner will be placed on a Focused Professional Practice Evaluation in accordance with Hospital policy.

b. Additional Categories of Privileges. In addition to the clinical privileges that are granted in accordance with Medical Staff membership or to Allied Health Professionals as set forth above, the Board authorizes the following categories of privileges that are available to physicians, dentists, or Allied Health Professionals. None of the following categories of privileges shall entitle the Practitioner to Medical Staff membership, to vote on Medical Staff matters, or serve on Medical Staff Committees.

(1) Temporary Privileges. The President may grant Temporary Privileges upon the recommendation of the CMO for a limited period of time (not to exceed one hundred twenty (120) days) for qualified applicants. Temporary Privileges are granted only in the following two circumstances:

i. 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, evidence of current provisional liability coverage with individual limits in an amount not less than

$1,000,000.00 per claim/$3,000,000.00 annual aggregate, and any other documentation required by Credentials Committee policy. In this case, Temporary Privileges are granted only for the length of time needed to fulfill the important patient care, treatment and service need.

ii. When an applicant for new privileges with a complete application that raises no concerns is approved by an authorized subcommittee of the Credentials Committee (as designated by the Credentials Committee) and is awaiting review and approval by MSEC and the Board of Directors. In this case, the applicant must submit a complete application and all supporting documentation and satisfy any applicable policies of the Credentials Committee. Further, 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 subjection to involuntary termination of medical staff membership at another organization
h. No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges
i. Evidence of current provisional liability coverage with individual limits in an amount not less than $1,000,000.00 per claim/$3,000,000.00 annual aggregate
j. Peer reference

When exercising Temporary Privileges, the Practitioner acts under the supervision of the Chair of the Department in which the Practitioner holds privileges or the CMO.

(2) Emergency Privileges. In an emergency, any Practitioner, to the degree permitted by his/her license, may provide any type of patient care, treatment, and services necessary as a life-saving measure or to prevent serious harm. In such an emergency, a Practitioner may use all Hospital facilities, seek assistance from all Hospital personnel, and request any consultation.

(3) Disaster Privileges. In situations where the Hospital has activated its emergency management plan and the Hospital is unable to meet immediate patient needs, the President or CMO has the option to grant Disaster Privileges to volunteer health care providers. These individuals are not required to grant Disaster Privileges and can make such decisions on a case-by-case basis at their discretion. The President or CMO may grant Disaster Privileges upon completion of a brief information form and presentation of the volunteer health care provider's valid government-issued photo identification (for example, a driver's license or passport) and at least one of the following:

i. A current picture ID card from a health care organization that clearly identifies professional designation;
ii. A current license to practice;
iii. Primary source verification of licensure (if this cannot be completed within 72 hours of the volunteer health care provider's arrival, it shall be performed as soon as possible);
iv. Identification indicating that the volunteer health care provider 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;
v. Identification indicating that the volunteer health care provider has been granted authority by a government entity to render patient care in disaster circumstances; and/or
vi. Confirmation by an individual with clinical privileges at the Hospital or by a staff member with personal knowledge of the volunteer health care provider's ability to act as a Practitioner with privileges during a disaster.

The President or CMO 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 seventy-two (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 seventy-two (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 seventy-two (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.

(4) Telemedicine Privileges. In addition to the ability for all Medical Staff members and individuals with clinical privileges to provide clinical services via telemedicine link as set forth above, Telemedicine Privileges only may also be granted to physicians or dentists who are contracted by the Hospital to provide services to the Hospital's 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. 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, AOA or ADA satisfy the

requirement for board certification.) For the avoidance of doubt, all Medical Staff members and Practitioners with clinical privileges have privileges to provide telemedicine services, as long as authorized by the applicable Department Chair and in accordance with applicable law.

(5) Visiting Privileges. Visiting Privileges may be granted to physicians, dentists and Allied Health Professionals who have privileges at another hospital and whose purpose at the Hospital is for limited educational purposes. Unless otherwise expressly authorized by the CMO, individuals with Visiting Privileges may not independently treat patients and must work under the direct supervision of an Active Medical Staff member.

(6) 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, AOA or the ADA satisfy the requirement for board certification.) Locum Tenens Staff privileges must be delineated.

Section 5. Term of Medical Staff Membership and/or Clinical Privileges

a. Term. The term of Medical Staff Membership and/or Clinical Privileges is as follows:

(1) Active, Courtesy and Affiliate Staff. All initial appointments and reappointments to the Active Staff, Courtesy Staff and Affiliate Staff, and the corresponding granted clinical privileges, are for a two year term beginning on the date of appointment or reappointment.

(2) Honorary Staff. The Honorary Staff appointment is permanent subject to the termination provisions herein.

(3) Allied Health Professionals. Clinical privileges granted to Allied Health Professionals are initially granted for a two (2) year term and are renewable for additional two (2) year terms. Notwithstanding the foregoing, if an Allied Health Professional has clinical privileges in connection with a contract for services, the term of the clinical privileges may not exceed the duration of the contract (e.g., an Allied Health Professional who is granted clinical privileges in connection with a one year contract shall only be granted a one year term of clinical privileges).

(4) Temporary Privileges. Temporary Privileges granted to fulfill an important patient care, treatment and service need are limited to a term equal to the length of time needed to fulfill the important patient care, treatment and service need. Temporary privileges granted for complete applications with no concerns until review and approval of MSEC and the Board are limited to a term that lasts until MSEC and the Board are able to review and approve the application.

(5) Emergency Privileges. The term of Emergency Privileges is limited to the length of time of the emergency.

(6) Disaster Privileges. The term of Disaster Privileges is until the Practitioner can be granted Temporary Privileges to fulfill an important patient care, treatment and service need.

(7) Telemedicine Privileges. Telemedicine Privileges are initially granted for a two (2) year term and are renewable for additional two (2) year terms. Notwithstanding the foregoing, if Telemedicine Privileges are granted in connection with a contract to provide telemedicine services, the Telemedicine Privileges term may not exceed the duration of the contract (e.g., the term of Telemedicine Privileges granted in connection with a one (1) year contract shall not exceed one year).

(8) Visiting Privileges. Visiting Privileges are granted for a term equal to the time needed to fulfill the limited educational purposes.

(9) Locum Tenens Privileges. Locum Tenens Privileges are granted for a term equal to the time needed to temporarily fulfill the responsibilities of a member of the Active Staff, provided that the duration of the term shall not exceed one (1) year.

b. Termination, Revocation, Restriction, Reduction and Suspension. Medical Staff Membership and/or Clinical Privileges may be terminated, revoked, restricted, reduced or suspended as follows:

(1) Voluntary Resignation/Relinquishment. A Practitioner may, at any time, resign Medical Staff membership and/or relinquish any or all Clinical Privileges by giving written notice to the CMO, the applicable Department Chair and/or the Office of Medical Staff Services. A Practitioner who voluntarily resigns Medical Staff membership and/or relinquishes Clinical Privileges is not entitled to any hearing or appeal rights set forth in these Bylaws or elsewhere.

(2) Active, Courtesy or Affiliate Staff. An Active, Courtesy or Affiliate Staff Member's Medical Staff membership and corresponding privileges may be terminated or otherwise limited in accordance with the Corrective Action procedures in Article VI.

(3) Honorary Staff. An Honorary Staff Member's Medical Staff membership may be terminated at the discretion of MSEC.

(4) Allied Health Professional Privileges. If an Allied Health Professional has clinical privileges in connection with a contract with the Hospital, such clinical privileges shall automatically terminate at the time the contract is terminated. In addition, the President or CMO may terminate, restrict, suspend, revoke or reduce, in whole or in part, an Allied Health Professional's clinical privileges, either prior to the end of contract termination or when clinical privileges are granted independent of a contract with the Hospital, if the Allied Health Professional's activities or professional conduct are considered:

i. To be detrimental to patient care;
ii. To be lower than the standards or aims of the Hospital;

iii. To be disruptive to the operations of the Hospital.

Allied Health Professional Practitioners are not members of the Medical Staff and do not have recourse to the procedural rights specified in Articles VI and VII. However, in the event an Allied Health Professional's privileges are terminated, restricted, suspended, revoked or reduced as set forth in this subsection, the Allied Health Professional will be notified of the action and the reasons therefor, and may request that such action be reviewed by MSEC. At any such review meeting, the Allied Health Professional (and the Active Staff member who is a party to their collaborative practice or supervising physician agreement, if applicable) may be present and participate in the review. The Allied Health Professional 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.

(5) Temporary Privileges. Temporary Privileges granted to fulfill an important patient care, treatment and service need terminate once the important patient care, treatment and service need no longer exists. In addition, for good cause shown, the President (after consulting with the Department Chair of the Department in which the Practitioner holds privileges and/or the CMO) may terminate, revoke, suspend, restrict or reduce Temporary Privileges. 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 CMO. Practitioners with Temporary Privileges do not have recourse to the procedural rights specified in Articles VI and VII or any other fair hearing or due process rights relative to any matter concerning Temporary Privileges.

(6) Emergency Privileges. Emergency Privileges terminate at the time the emergency ends. The procedural rights specified in Articles VI and VII do not apply to any matter concerning Emergency Privileges, nor are there any other fair hearing or due process rights relative to any matter concerning Emergency Privileges.

(7) Disaster Privileges. Disaster privileges 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 may, after consultation with the CMO, 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 or CMO 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 or the CMO. The wishes of the patient(s) will be considered, where feasible, in choosing a substitute Practitioner. Practitioners with Disaster Privileges do not have recourse to the procedural rights specified in Articles VI and VII or any other fair hearing or due process rights relative to any matter concerning Disaster Privileges.

(8) Telemedicine Privileges. If Telemedicine Privileges are granted in connection with a contract to provide telemedicine services, the Telemedicine Privileges will automatically terminate upon termination of the contract. In addition, Telemedicine

Privileges may be restricted, reduced, suspended, terminated or revoked at the discretion of MSEC or CMO. Practitioners with Telemedicine Privileges do not have recourse to the procedural rights specified in Articles VI and VII or any other fair hearing or due process rights relative to any matter concerning Telemedicine Privileges.

(9) Visiting Privileges. Visiting Privileges terminate at the time period needed to fulfill the limited educational purposes ends. In addition, Visiting Privileges may be restricted, reduced, suspended, terminated or revoked at the discretion of MSEC or CMO. Practitioners with Visiting Privileges do not have recourse to the procedural rights specified in Articles VI and VII or any other fair hearing or due process rights relative to any matter concerning Visiting Privileges.

(10) Locum Tenens Privileges. Locum Tenens Privileges terminate at the earliest of: 1) once the time needed to temporarily fulfill the responsibilities of a member of the Active Staff ends; 2) the expiration of a corresponding contract to provide locum tenens services; or 3) after one (1) year. In addition, Locum Tenens Privileges may be restricted, reduced, suspended, terminated or revoked at the discretion of MSEC or CMO. Practitioners with Locum Tenens Privileges do not have recourse to the procedural rights specified in Articles VI and VII or any other fair hearing or due process rights relative to any matter concerning Locum Tenens Privileges.

c. Automatic Suspension. Medical Staff Membership and/or Clinical Privileges for all categories may be automatically suspended prior to the expiration of the period of appointment or term of privileges by administrative action. Such administrative action may be taken within the discretion of the CMO when the Practitioner fails to continuously meet the qualifications, standards, and requirements set forth in the Bylaws, including by way of example and not limitation:

(1) Failure to maintain a necessary faculty appointment;

(2) Failure to obtain or maintain required licensure, board certification, or professional liability insurance;

(3) Exclusion from participation in Medicare, Medicaid, or other federally funded health care programs;

(4) Drug Enforcement Administration certificate revocation, suspension, stay, restriction or probation;

(5) Failure to comply with Hospital immunization, OSHA, CDC, or other safety requirements;

(6) Restriction, reduction, suspension, revocation or termination of the clinical privileges of the Active Staff member who is a party to an Allied Health Professional Practitioner's collaborative practice or supervising physician agreement;

(7) Failure of an Allied Health Professional Practitioner to maintain a valid collaborative practice or supervising physician agreement;

(8) Conviction of a felony.

The CMO may reinstate automatically suspended Medical Staff Membership and/or Clinical Privileges when the reason for automatic suspension is resolved, or can proceed to termination as set forth herein. Automatic suspension is not corrective action within the meaning of Article VI and does not entitle a Practitioner to the procedural rights specified in Articles VI and VII or any other fair hearing or due process rights relative to any matter concerning automatic suspension.

Section 6. Leave of Absence.

If Practitioners who are in good standing and who are Active Staff, Courtesy Staff, Affiliate Staff, are Allied Health Professionals, or have Telemedicine Privileges 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 CMO.

The Practitioner 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 Practitioner'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 CMO for good cause. The Chair shall transmit the notification to the Credentials Committee.

During the leave of absence, the Practitioner will not have clinical privileges, nor have any of the other prerogatives or responsibilities of their Medical Staff membership or clinical privileges, as applicable.

Failure without good cause (to be determined in the discretion of the CMO or his/her designee) to submit a request for leave of absence when unable to fulfill responsibilities for more than six (6) months will be deemed a resignation from the Medical Staff and/or of clinical privileges, as applicable, and Medical Staff members will not be entitled to the Hearing & Appellate Review Procedures of Article VII. Alternatively, if the Practitioner refuses or is unable to provide notification of a leave of absence, the Chair, in consultation with and approval by the CMO, may notify the Practitioner that they have been placed on a leave of absence based on information available to the Chair that the Practitioner is unable to fulfill their responsibilities at the Hospital and is not expected to return to clinical practice at the Hospital within six (6) months.

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

If the Practitioner's Medical Staff membership and/or clinical privileges will expire during the leave of absence, the Practitioner must submit an application for reappointment 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/renewal period, and provided further that the Practitioner's reappointment/renewal will be conditioned on compliance with a focused professional practice evaluation. Failure to reapply will result in a resignation of Medical Staff membership/expiration of clinical privileges, and a new application for appointment and/or for clinical privileges (to be processed in the ordinary manner) will be required to rejoin the Medical Staff and/or to obtain clinical privileges.

At least thirty (30) days prior to returning from the leave of absence, the Practitioner must submit to the Chair a written request for the reinstatement of membership and/or clinical 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 Practitioner must submit a report from the Practitioner's physician indicating that the individual is physically and/or mentally capable of resuming practice and safely exercising the Practitioner's clinical privileges.

The Chair will submit the Practitioner's request, along with the Chair's recommendation regarding whether medical staff membership and/or clinical 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/or privileges. The Credentials Committee will make a recommendation to MSEC, and MSEC will make a recommendation to the Board, who shall make the final decision regarding reinstating the Practitioner's membership and/or clinical privileges.

If the reinstatement is approved, the Practitioner shall immediately be reinstated to membership on the Medical Staff and/or clinical privileges will be restored for the duration of the existing appointment cycle.

A determination that the Practitioner be denied reinstatement will be considered a denial of medical staff membership and/or privileges. Medical Staff members shall be entitled to the Hearing & Appellate Review Procedures of Article VII and Allied Health Professionals shall be entitled to the process set forth in Article IV, Section 5(b)(4).

Failure without good cause (to be determined in the discretion of the CMO) to timely request reinstatement or submit the required documentation (i.e., at least thirty (30) days prior to returning from the leave of absence) will be deemed a resignation from the Medical Staff and/or of clinical privileges. As such Medical Staff members shall not be entitled to the Hearing & Appellate Review Procedures of Article VII and Allied Health Professionals shall not be entitled to the process set forth in Article IV, Section 5(b)(4).

ARTICLE V:
PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT TO THE MEDICAL STAFF AND/OR TO APPLY FOR CLINICAL PRIVILEGES

Section 1. Applications

a. All Applications. Every application for staff appointment and/or clinical privileges, whether an initial application, an application for reappointment or renewal, or an application for modification of clinical privileges, is governed by this Article V. Each application must include, at a minimum, the applicant's:

(1) Signature;

(2) Date of birth;

(3) Year and school of graduation;

(4) Date of current licensure;

(5) Statement of postgraduate or special training and experience; and

(6) Statement of the scope of clinical privileges sought by the applicant.

All applicants shall also sign a statement attesting to: 1) their receipt and review of the current Bylaws, Rules and Regulations, and Organization Manual; and 2) that they agree to abide by and be bound by the terms thereof, as well as all Hospital policies, in all matters relative to their activities as a Medical Staff member or individual with privileges and relative to consideration of their application, without regard to whether they are granted membership and/or clinical privileges.

b. Application for Staff Appointment and/or Clinical Privileges.

(1) Uniform Application. All applicants (either initial or for renewal/reappointment) for Active, Courtesy or Affiliate Staff membership, Telemedicine Privileges, Locum Tenens Privileges, or privileges as an Allied Health Professional must submit a Uniform Application for Medical/Allied Health Professionals form (the "Uniform Application") along with all required supporting information set forth in the Uniform Application or as required by Credentials Committee policy.

(2) Application for Visiting Privileges. 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, evidence of current professional liability coverage with individual limits in an amount not less than $1,000,000 per claim / $3,000,000 aggregate, and anything else required as set forth in the Application for Visiting Privileges.

c. Applications for Modification. Applications for modification of privileges shall include a completed Privilege form, a letter from the Chair recommending the modification, and a Collaborative Practice Agreement if applicable.

d. Applicants' Responsibility. 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, verify or evaluate the applicant's qualifications and suitability for appointment to the Medical Staff and/or clinical privileges. 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. 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 2. Procedure for Submission of Initial Applications for Medical Staff Membership or Clinical Privileges

a. Submission to Chair. 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.

b. Review by Chair. The Chair reviews the application and supporting documentation and drafts a written report to the Credentials Committee with a recommendation to either grant the application, deny the application, or defer the application for further consideration. Where granting an application is recommended, the Chair further recommends the clinical privileges to be granted and any special conditions. The Chair submits the written recommendation to the Office of Medical Staff Services.

c. Verification by the Office of Medical Staff Services. Upon receipt of a complete application together with a Chair's recommendation, the Office of Medical Staff Services verifies from primary sources, whenever feasible, the applicant's references, education and training including required continuing education, board certification, licensure, competence, 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, the Office of Medical Staff Service may, in accordance with Hospital policy:

(1) Use credentialing information from the distant site, if the distant site is a Joint Commission-accredited (or, beginning July 1, 2021, a Medicare-participating) organization, and the applicant has a license issued or recognized by the state of North Carolina; and/or

(2) 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:

i. The distant site is a Joint Commission-accredited (or, beginning July 1, 2021, a Medicare-participating) organization, and Hospital has verified that the distant site's credentialing and privileging processes meet 42 C.F.R. §§ 482.12(a)(1)-(a)(9) and 42 C.F.R. §§ 482.22(a)(1)-(a)(4).
ii. The applicant is privileged at the distant site for those services to be provided at the Hospital.
iii. The distant site provides Hospital with a current list of the applicant's privileges.
iv. Hospital performs an internal review of the applicant's performance of privileges at Hospital, and sends to the distant site information that is useful to assess the applicant'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 Hospital.
v. The applicant has a license issued or recognized by the state of North Carolina.

Section 3. Procedure for Submission of Applications for Reappointment or Renewal of Clinical Privileges

a. Distribution of Application. Applications for reappointment to the Medical 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.

   In the event that a Practitioner's privileges are scheduled to expire while the Practitioner is on a leave of absence pursuant to Article IV, Section 6, 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 the CMO. 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.

b. Chair Review. 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 (and the Chair of the Department of the Practitioner's specialty, if applicable) to review all pertinent information relative to each Practitioner eligible for reappointment or renewal of privileges.

c. Chair Recommendation.

   (1) Relevant Criteria. 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; peer recommendations; 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 (if applicable); contributions towards the Hospital's objectives of patient care, education and research; and general attitude towards patients, the Hospital, and the public.

   (2) Chair's Evaluation Form. The Department Chair (or the CMO 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.

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 as set forth in Article V, Section 4(d) below and require presentation of identified issues to MSEC.

When the overall evaluation is satisfactory, individual unsatisfactory evaluations of specific elements do not necessarily require presentation to MSEC. The Credentials Committee, working with the CMO and the applicant's Department Chair(s), 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 VI.

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 MSEC, pursuant to Article VI, Section 1(d), that the Practitioner's medical staff membership and/or privileges be suspended, revoked, restricted, or terminated.

(3) Procedure for Evaluation of Application. The completed application, Chair recommendation, and Chair Evaluation form are evaluated in accordance with Section 4 below.

Section 4. Procedure for Evaluation of Applications

a. Timeline for Consideration. A decision by the Credentials Committee, MSEC and the Board of Directors on an application is made within a time period not to exceed one hundred eighty (180) days from the Office of Medical Staff Services' receipt of a complete application.

b. Review by Credentials Committee. When verification by the Office of Medical Staff Services is complete, the Credentials Committee reviews: the application, the supporting documentation, the Department Chair report(s) and recommendation(s), relevant Focused Professional Practice Evaluation and Ongoing Professional Practice Evaluation data (if applicable), , department and service affiliation, and clinical privileges requested by the applicant, and such other information relevant to the staff category (if applicable). In its review of each application, the Credentials Committee evaluates the applicant according to criteria relevant to, as applicable:

(1) Current licensure and/or certification;

(2) Specific relevant training, experience and competence;

(3) Evidence of physical ability to perform the requested privilege;

(4) Data from professional practice review by an organization that currently privileges the applicant (if available);

(5) Peer and/or faculty recommendation regarding the applicant's current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills and professionalism;

(6) Challenges to any licensure or registration;

(7) Voluntary and involuntary relinquishment of any license or registration;

(8) Voluntary and involuntary termination of medical staff membership;

(9) Voluntary and involuntary limitation, reduction, or loss of clinical privileges;

(10) Any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant;

(11) Documentation as to the applicant's health status;

(12) Relevant practitioner-specific data as compared to aggregate data, when available;

(13) Morbidity and mortality data, when available; and

(14) Individual character and judgment.

After its review, the Credentials Committee then recommends that MSEC either grant the application, deny the application, or the Credentials Committee defers the application for further consideration or evaluation. 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).

Temporary Privileges may be granted by the Credentials Committee prior to MSEC and Board review and approval in accordance with Article IV, Section 4(b)(1). In addition, see Article V, Section 4(d) for when expedited approval by the Board is permitted.

c. Review by MSEC. MSEC, 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 or evaluation. In addition, MSEC determines when the application contains issues that require presentation to the full Board at its next meeting.

(1) Recommendation for granting. When the recommendation of MSEC is, in all respects, favorable to the applicant, it is forwarded together with all supporting documentation to the Board of Directors. 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).

(2) Recommendation for deferring. When the recommendation of MSEC is to defer the applicant for further consideration, a recommendation on the application is made by the MSEC to the Board of Directors within sixty (60) days of such deferral provided that the one hundred eighty (180) time limit set forth above for a decision on an application is not exceeded.

(3) Adverse recommendation.

i. When the recommendation of MSEC is adverse to the applicant and the applicant is entitled to a Hearing under these Bylaws, the applicant shall be so notified, and in accordance with Article VII if applicable. An adverse recommendation by MSEC in these cases 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 VII.

If, after a Hearing as provided in Article VII, 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 the recommendation of the Hearing Panel is not favorable to the applicant, the procedures in Article VII are followed.

ii. When the recommendation of MSEC is adverse to the applicant but the applicant is not entitled to a Hearing under these Bylaws, the applicant shall be so notified and the recommendation by MSEC will be forwarded to the Board of Directors.

d. Review by the Board.

(1) Favorable Recommendation by MSEC; Expedited Decision. At the next regular meeting following its receipt of the recommendation of MSEC, the Board of Directors acts on the matter. However, applications may be acted on by the Board of Directors on an expedited basis before its next regular meeting through the Credentialing Subcommittee of the JCUNCH Committee (which Subcommittee is composed of at least two voting members of the Board of Directors), as long as the following requirements are met:

i. The application is complete;
ii. MSEC has not made a recommendation that is adverse or has limitations;
iii. The applicant's license or registration is not currently challenged, and has not previously been successfully challenged;
iv. The applicant has not previously received an involuntary limitation, reduction, denial or loss of clinical privileges; and

v. The applicant does not have an unusual pattern or excessive number of professional liability actions resulting in a final judgment against the applicant.

(2) Favorable Recommendation by a Hearing Panel. At the next regular meeting following its receipt of the recommendation of a Hearing Panel, the Board of Directors acts on the matter. If it is deemed appropriate, the Board may direct that a further Hearing be conducted to consider matters still in question.

(3) Unfavorable Recommendation by MSEC. When the recommendation of MSEC is adverse to the applicant but the applicant is not entitled to a Hearing under these Bylaws, the Board will consider the matter at the next regular meeting following its receipt of the recommendation of MSEC.

(4) Board Decision Adverse to Applicant. If the Board's decision is adverse to an applicant, no final action will be taken until an applicant entitled to the Hearing and Appellate Rights set forth in Article VII has had the opportunity to exercise and/or waive their right to a Hearing.

(5) Finality of Board Decisions. The Board's decision on applications is final, subject to the Hearing rights set forth in Article VII, and except that the Board may defer final action by referring the matter back to MSEC for further consideration. Any such referral for further consideration shall state the reasons therefor and establishes a time period within which a subsequent recommendation to the Board shall be made. All decisions to grant an application shall specify the nature and scope of the clinical privileges granted to the applicant, including any conditions to be attached to the appointment.

(6) Notice of Board Decisions. When the decision of the Board of Directors is final, the President shall send written notice of the Board's decision to the applicant. Upon appointment to the Medical Staff and/or the granting of privileges, the Practitioner will be placed upon a Focused Professional Practice Evaluation in accordance with Hospital policy. In addition, when a Practitioner who is an existing member of the Medical Staff or has privileges at Hospital is granted new or additional privileges, the Practitioner will be placed on a Focused Professional Practice Evaluation in accordance with Hospital policy.

ARTICLE VI:
CORRECTIVE ACTION

Section 1. Procedure

a. The proceedings under this Article VI are administrative, non-adversarial matters and do not include a hearing; none of the procedural rules set forth in Article VII 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 VII) 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 VI 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 VI 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 VI may be extended by the CMO 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 MSEC, an Officer of the Medical Staff, the Chair of any clinical department, the Chair of the Credentials Committee, the President, or the Chair of JCUNCH. All requests for corrective action are made in writing to MSEC and should set forth the activities or conduct which constitute the grounds for the request. Within five (5) calendar days of its receipt of the request, MSEC forwards the request for corrective action to the Chair of the department in which the Medical Staff member has privileges (or to the CMO if the request involves a Department Chair).

e. The CMO 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 CMO appoints an Ad Hoc committee within seven (7) calendar days of MSEC'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 MSEC within fifteen (15) calendar days of the Ad Hoc Committee's first meeting. Absent special circumstances as determined in the sole discretion of the CMO, 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 under investigation (as described more fully below).

(6) If the Ad Hoc committee determines that it needs expert review of medical records or clinical issues, the CMO 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 CMO 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 CMO.

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 CMO, 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 MSEC 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 MSEC 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 CMO. The CMO, within his/her discretion, shall determine what or whether other information or documents considered or created by the Ad Hoc committee or MSEC are shared with the Medical Staff member under investigation. Information or documents considered or created by the Ad Hoc committee or MSEC that are not shared with the Medical Staff member shall be maintained as confidential and peer review privileged material.

j. Upon request for corrective action, MSEC, at the next regularly scheduled meeting, or at an earlier meeting if deemed appropriate within the discretion of the CMO, considers the Ad Hoc committee report. 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 MSEC'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 MSEC'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 MSEC's deliberations or vote on the matter. The Medical Staff member has the right to either: (1) meet with MSEC at the meeting at which it considers the Ad Hoc committee report and prior to MSEC's action on that report; or (2) submit a written statement to MSEC at least three (3) calendar days prior to the meeting at which MSEC 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

MSEC in scheduling this meeting shall constitute a waiver of the right to meet with MSEC. If the Medical Staff member meets with MSEC at the meeting at which it considers the Ad Hoc committee report, the Chair of MSEC will introduce the Medical Staff member and briefly describe the circumstances of the request for corrective action. The Medical Staff member may then address MSEC, after which the Chair of MSEC offer MSEC members the opportunity to ask the Medical Staff member questions, and the Medical Staff member may respond.

k. The MSEC 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 CMO shall prepare a written summary of MSEC's findings and conclusions.

l. The recommendation and written summary of MSEC shall be provided by the Chair of MSEC 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 MSEC for the reduction, suspension, or revocation of clinical privileges, or for the suspension or revocation of Medical Staff membership, may become effective immediately if MSEC 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 VII. In the event the Chair of JCUNCH 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 VII. If the Medical Staff member chooses not to exercise his/her rights under Article VII, MSEC's recommendation will go to the Board of Directors for final action.

Section 2. Summary Suspension

a. The President, the CMO, 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 CMO 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 VII for any actions taken or recommended by MSEC under Article VI, 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 (1) hearing is allowed; the Medical Staff member may request a hearing under Article VII solely on the imposition of the summary suspension only if no other actions or recommendations of MSEC 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 as set forth in Article VII.

ARTICLE VII:
HEARING AND APPELLATE REVIEW PROCEDURE

Section 1. Procedure

a. Any documents, reports, requests, and written notices referenced in this Article VII may be delivered in person, by email, or by certified mail (return receipt requested) to the designated recipient.

b. The Hearing contemplated herein may be held remotely via telecommunication if circumstances warrant, as determined in the sole discretion of the CMO.

c. If the deadline pursuant to which an action must be taken under this Article VII 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 VII 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 MSEC or JCUNCH 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 MSEC or JCUNCH, 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 CMO, may appoint: 1) a Hearing Panel that will be composed of not less than three (3) members; or (2) one (1) 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 Hospital's Legal Department or other attorney of the Hospital's choosing. In addition, MSEC or JCUNCH (depending on whose recommendation prompted the Hearing initially) may be advised by a separate attorney of the Hospital's choosing, including a different attorney within the Hospital's Legal Department. The attorney representing the Hearing Officer/Hearing Panel and the attorney representing MSEC/JCUNCH 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, MSEC, or JCUNCH; and

(3) Non-privileged, redacted copies of relevant committee or department minutes.

The MSEC or JCUNCH (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), MSEC or JCUNCH (depending on whose recommendation prompted the Hearing initially), and counsel for MSEC or JCUNCH 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 (2) 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 VII 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 MSEC or JCUNCH, 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 MSEC'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, in their sole discretion, 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. 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 MSEC or JCUNCH unless it finds that the Medical Staff member who requested the Hearing has proved, by clear and convincing evidence, that the recommendation of MSEC or JCUNCH (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 MSEC 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) MSEC or JCUNCH (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 MSEC 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 CMO 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 (1) Hearing and one (1) appellate review on any matter which has been considered by either MSEC of the Medical Staff or the Board of Directors.

ARTICLE VIII:
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 CMO is responsible for the clinical operations of the Hospital. The CMO 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 CMO for the ongoing, effective operation of his Department or Service, for improving patient safety, and for continually assessing and improving its activities.

c. A Department Chair or Service Head may be removed from that position by the President for unsatisfactory performance of his/her responsibilities as set forth in these *Bylaws*. The CMO 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 JCUNCH 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 IX:
DEPARTMENTS AND SERVICES

Section 1. Functions of Departments and Services; History and Physical Requirements

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. History and physical (H&P) examination requirements shall be satisfied as set forth in the Rules and Regulations.

Section 2. Responsibilities of Department Chairs

Each Department Chair serves as the Hospital Clinical Service Chief for the applicable service line and is responsible for performing the following duties on behalf of the Hospital, in addition to and as independent from any duties to or responsibilities on behalf of the University:

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 Hospital;

h. The coordination and integration of Hospital 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 all department/service personnel 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 X:
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 CMO, such Associate CMOs as may be deemed appropriate and appointed by the CMO, and six (6) Members-at-Large.

c. The CMO is appointed by the Board of Directors upon the recommendation of the Dean of the School of Medicine, with the Medical Staff delegating approval of such appointment to MSEC of the Medical Staff. The CMO shall serve as the formal liaison between the medical staff and the Board.

d. Selection of Members-at-Large to serve on MSEC: The CMO will seek nominations for Members-at-Large from the Active 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 with a ranked-choice voting system to all voting members of the Medical Staff for selection of the Members-at-Large. The CMO will report the results of the election and selection of the Members at Large to MSEC and the Medical Staff. In the event of a vacancy due to the departure or transition of a Member-at-Large, the open Member-at-Large seat shall be filled by the nominee with the next largest number of votes who remains willing to fill the role.

Section 2. Term of Office

The Members-at-Large will serve staggered two (2) year terms or until a successor is appointed or elected.

Section 3. Duties of Officers

a. **CMO**. The CMO 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 MSEC, subject to the approval of MSEC. Unless otherwise set forth in these Bylaws, the CMO 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, 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 MSEC.

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

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 CMO (or the Dean of the School of Medicine if the CMO 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 CMO (or with the Dean of the School of Medicine if the CMO is the subject of removal) to be held within five (5) days of the date of such request. Following such meeting, the CMO (or the Dean of the School of Medicine, if the CMO is the subject of removal) consults with MSEC before rendering a final decision. An officer so removed has no further appeal rights or any hearing 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 XI: 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 MSEC, are appointed by the CMO subject to approval by MSEC, 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 CMO. 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 MSEC. Robert's Rules of Order will govern all committee meetings.

Section 2. MSEC

a. MSEC 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 (2) 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 Hospital President. All members are entitled to vote; however, the two (2) Allied Health Professional members may not vote on matters relating to physician corrective action. The CMO is a member and Chair of the Committee. All members of MSEC who are members by virtue of their holding of another office, including the Hospital President, are ex-officio members with voting rights.

b. The Medical Staff delegates to MSEC authority to oversee the operations of the Medical Staff. With the assistance of the CMO, and without limiting this delegation of authority, MSEC 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 MSEC 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. In addition, MSEC receives and acts on an annual report from the Chief Nursing Officer and CMO on data and recommendations relating to patient satisfaction scores. MSEC makes recommendations to the Board of Directors on all of these matters.

c. The authority delegated by the Medical Staff to MSEC in these Bylaws 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 MSEC.

d. A member of MSEC may be removed from MSEC for the reasons described in and pursuant to the process outlined in Article X, Section 4 (herein), provided however, that the member of MSEC who is the subject of removal not participate in any discussions between the CMO (or with the Dean of the School of Medicine if the CMO is the subject

of removal) and MSEC. A member of MSEC so removed has no further appeal rights under these *Bylaws*.

Section 3. Creation of Committees

The MSEC 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, MSEC 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 XII: MEETINGS

Meetings of the Medical Staff may be called at any time by the CMO, or at the request of the Board of Directors, or MSEC. 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 CMO, in his/her discretion, may declare a quorum at any regular or special meeting of the Medical Staff.

ARTICLE XIII: POLICIES, RULES AND REGULATIONS AND ORGANIZATION MANUAL

Section 1. General: Policies, Rules and Regulations, and Organization Manual

The Medical Staff may initiate and adopt such Rules and Regulations, and an Organization Manual as it may deem necessary and periodically review and revise them to comply with current Medical Staff practice and to implement more specifically the general principles found in these Bylaws. The Medical Staff may also adopt policies regarding the Medical Staff's organizational structure or rules for self-governance ("Policies") as it may deem necessary. Proposed Policies, Rules or Manual amendments, as well as new Policies (collectively, "Proposals"), may emanate from any responsible committee, department, medical staff officer, or by petition signed by at least one hundred (100) members of the Active Staff. Additionally, Hospital administration may develop and recommend Proposals, and in any case should be consulted as to the impact of any such proposed changes or amendments on Hospital operations and feasibility. Proposals are submitted to MSEC 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, MSEC will not act on Proposals until the Medical Staff has had a reasonable opportunity to review and comment on such Proposals. This review and comment opportunity may be accomplished by posting Proposals on the Medical Staff website or by sending the Proposals via electronic mail to the members of the Medical Staff at least fifteen (15) days prior to the scheduled MSEC 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 MSEC prior to MSEC action on Proposals.

b. MSEC approval is required for Proposals, unless the Proposals are generated by petition of at least one hundred (100) members of the Active Staff. In this latter circumstance, if MSEC fails to approve Proposals, it will notify the Medical Staff. The MSEC and the Medical Staff each has the option of invoking or waiving the conflict management provisions of Article XV.

   (1) If conflict management is not invoked within twenty-five (25) days it will be deemed waived. In this circumstance, the Medical Staff's Proposals will be forwarded to the Governing Body for action. The MSEC may forward comments to the Medical Staff and the Governing Body regarding the reasons it declined to approve the Proposals.

   (2) If conflict management is invoked, the Proposals 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 Proposals generated by petition of the Medical Staff, approval requires the affirmative vote of a majority of the votes of at least twenty-five (25) percent of the Active Staff members, provided at least fourteen (14) days' advance written notice, accompanied by the Proposals, has been given.

c. Following approval by MSEC as described above, Proposals are forwarded to the Board of Directors for approval, which approval shall not be withheld unreasonably. Proposals become effective immediately following approval of the Board of Directors.

d. Where urgent action is required to comply with law or regulation, MSEC is authorized to provisionally adopt Proposals and forward them to the Board of Directors for provisional approval and immediate implementation. However, if the Medical Staff did not receive prior notice of a provisionally adopted and approved Proposal, the Medical Staff will be notified of the provisionally adopted and approved Proposal and given the opportunity for retrospective review of and comment on the same. If there is no conflict, the provisionally adopted and approved Proposal stands. However, if there is conflict, the Conflict Management provisions of Article XV shall be implemented; provided, however, a provisionally adopted and approved Proposal will remain effective until such time as superseding Proposals meeting the requirements of the law or regulation that precipitated the initial urgency has been approved pursuant to any applicable provision of these Bylaws.

ARTICLE XIV:
AMENDMENT

These *Bylaws* are reviewed no less than once every three (3) years by the Bylaws Committee. At any time, MSEC may make recommendations for amendment of these *Bylaws.* Additionally, the Medical Staff may make recommendations for amendment of these *Bylaws* by submitting to MSEC a petition signed by at least ten (10) percent 10% of the Active Staff members entitled to vote. Hospital administration also may recommend amendments to these *Bylaws*. Amendments shall comply with applicable State and Federal law and regulations.

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 CMO, provided at least fourteen (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 fourteen (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 CMO, MSEC of the Medical Staff and the Bylaws Committee.

ARTICLE XV:
CONFLICT MANAGEMENT

In the event of conflict between MSEC and the Medical Staff (as represented by written petition signed by at least one hundred (100) of the voting members of the Medical Staff) regarding a proposed or adopted Policy, Rule or Organizational Manual provision, or other issue of significance to the Medical Staff, the CMO will convene a meeting with the petitioners' representative(s). The foregoing petition will include a designation of up to five (5) members of the voting Active Staff to serve as the petitioners' representative(s). The MSEC will be represented by an equal number of MSEC members. The MSEC'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 MSEC, and the safety and quality of patient care at the Hospital. Resolution at this level requires a majority vote of MSEC'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. Nothing in the foregoing is intended to prevent medical staff members from communicating with the governing body on a proposed or adopted Policy, Rule or Organizational Manual provision; however, the medical staff members shall initiate such communication through the CMO.

ARTICLE XVI:
CHIEF MEDICAL OFFICER'S AUTHORITY

The CMO may waive or suspend any of the requirements of these Bylaws in an emergency circumstance, to the extent permitted by applicable law, regulation, or applicable accreditation standard. For the purposes of this Article XVI, an "emergency circumstance" means a situation of urgency that justifies immediate action and when there is not sufficient time to follow the applicable provisions and procedures of these Bylaws. Examples include, but are not limited to, an immediate threat to the life or health of an individual or the public, a natural disaster, or a judicial or regulatory order. The duration of the waiver or suspension shall not exceed the time that the emergency circumstance exists.