Carolinas Medical Center
NorthEast

Uncompromising Excellence. Commitment to Care.

Medical Staff Bylaws

Approved by the Medical Executive Committee 01/17/2011
Approved by the Medical Staff 01/20/2011
Approved by Board of Commissioners 03/08/2011

Carolinas Medical Center NorthEast
Concord, North Carolina

Preamble

Whereas, Carolinas Medical Center NorthEast is a nonprofit hospital organized under the laws of the State of North Carolina;

Whereas, the purpose of the Hospital is to serve as a general community hospital providing patient care, education, community services, and research;

Whereas, the board requires that the Medical Staff be responsible for the quality of medical care in the Hospital and that the Hospital conduct review and evaluation activities to assess, preserve, and improve the overall quality and efficiency of patient care;

Whereas, the cooperative efforts of the Medical Staff, the Chief Executive Officer, and the Board are necessary to fulfill the Hospital's obligations to its patients; and

Whereas, the Board requires the input of the professionals practicing at the Hospital to aid in institutional policy formulation and the enforcement, planning, and coordination of services and governance.

Therefore, the Physicians practicing at the Hospital are hereby organized into a Medical Staff in conformity with these Bylaws.

Definitions

- "Board" shall mean the Board of Commissioners of Carolinas HealthCare System, which has the overall responsibility for the conduct of the Hospital.
- "Chief Executive Officer" or "CEO" means the individual appointed by the Board to act on its behalf in the overall administration and management of the Hospital, whose title is designated as President of Carolinas Medical Center NorthEast.
- "Clinical Privileges" or "Privileges" means the rights granted to a Staff member or Licensed Independent Practitioner to provide those diagnostic, therapeutic, medical, surgical, dental, or podiatry services specifically delineated to the applicant.
- "Delivered" means made available via mail, email, website (intranet or internet), facsimile, or other reasonable means.
- "Facility Credentials Committee" means the credentials committee of the Medical Staff of CMC-NorthEast.
- "Facility Medical Executive Committee" or "Facility MEC" means the committee composed of those members of the Medical Staff at CMC-NorthEast chosen pursuant to these Bylaws to represent and coordinate all activities and policies of the Medical Staff and its departments and committees. The Facility MEC is further defined in these Bylaws.
- "Fair Hearing Plan" means the Fair Hearing Plan attached to these Bylaws and incorporated herein by reference.
- "Governing Body" means the Board of Directors of the Hospital.
- "Hospital" means Carolinas Medical Center NorthEast of Concord, North Carolina.
- "Licensed Independent Practitioner Who is not a Medical Staff Member" means an individual other than a Physician who is qualified and licensed to exercise independent judgment and provide medical or surgical care within the areas of the individual's professional competence and who has been accorded Privileges to provide such care in the Hospital. Licensed Independent Practitioners who are not medical staff members include dentists who are not oral surgeons, podiatrists, doctorate level licensed clinical psychologists and optometrists.
- "Medical Staff" or "Staff" means the formal organization of all practitioners who have clinical privileges in the Hospital and who have been granted Medical Staff Membership by assignment to the Active, Courtesy, Coverage, Honorary, Emeritus, Silver, Affiliate or Telemedicine Medical Staff category. Only Active and Silver Staff members are voting members.

- “Oral Surgeon” means a licensed dentist with advanced training qualifying the dentist for board certification by the American Board of Oral and Maxillofacial Surgery.
- "Patient encounter" means any direct patient admission to CMC-NorthEast, any inpatient consultation performed at CMC-NorthEast or any procedure that requires or results in direct patient contact between the patient and the practitioner at any CMC-NorthEast facility, except for those procedures performed in the practitioner’s office.
- “Physician” means an individual with an M.D. or D.O. degree who is licensed to practice medicine.
- “Practitioner” except as specifically defined and applied in these Bylaws, and unless otherwise expressly provided in these Bylaws, means any individual applying for or exercising clinical privileges or providing other diagnostic, therapeutic, teaching or research services in the Hospital. It is hereby mutually understood that all such individuals, with respect to all work, duties and obligations, are at all times acting and performing services as independent contractors of the Hospital and its Governing Body; provided, however, bona fide employees of the Hospital shall not be considered independent contractors. All such independent contractors shall at all times render services in a manner consistent with all applicable laws, regulations and ethical standards.
- “Rules and Regulations” means those rules and regulations that may be adopted by the Medical Staff to implement the specific provisions of these Bylaws.
- “Submitted” means presented for vote at a duly called meeting or via printed or secure electronic ballots.
- “Voting Medical Staff” shall mean all Active and Silver Status members of the Medical Staff.

ARTICLE I
Purpose and Responsibilities of the Medical Staff

1.1
Purpose

The purpose of the Medical Staff is to bring qualified allopathic and osteopathic physicians and oral surgeons together into a cohesive body to promote good care and to offer advice, recommendations, and input to the Chief Executive Officer and the Board.

ARTICLE II

2.1
Responsibilities

To accomplish the above purpose, it is the obligation and responsibility of the Medical Staff:

A. To participate in the Hospital’s quality improvement program by:
    1. Evaluating practitioner and institutional performance through valid and reliable measurement systems;
    2. Monitoring patient care practices and enforcing Medical Staff and Hospital patient care policies
    3. Evaluating a practitioner’s credentials for the delineation or renewal of clinical privileges in a manner that is thorough, effective and timely;
    4. Establishing a continuing medical education program based upon the needs demonstrated by quality review and evaluation programs; and
    5. Developing an adequate system of utilization review.

B. To make recommendations to the Board regarding appointments and reappointment to the Medical Staff including appropriate membership category and department assignments and regarding the delineation of clinical privileges.

C. To participate in the Board’s planning activities, to assist in identifying community health needs, and to suggest to the Board appropriate institutional policies and programs to meet those needs.

D. To develop, administer, recommend amendments to, and enforce compliance with these Bylaws, the Medical Staff Rules and Regulations, Departmental Rules and Regulations, and the policies of the Medical Staff and the Hospital.

E. To establish, maintain, and enforce sound professional practices and initiate and pursue corrective action under these Bylaws to further quality patient care.

F. To meet the needs of a changing environment.

ARTICLE III
Qualifications for Medical Staff Membership

3.1
General Qualifications

Staff membership is a privilege extended only to professionally competent Physicians and Oral Surgeons who continuously meet the qualifications and requirements for membership set forth in these Bylaws. The Physician or Oral Surgeon who is currently a Staff member or who seeks Staff membership must continuously demonstrate to the satisfaction of the Medical Staff and the Board that he meets the following qualifications:

A. The individual currently maintains a valid license issued by the N.C. Medical Board.
B. The individual possesses the requisite professional education, training, experience, and demonstrated ability to provide patient services.
C. The individual demonstrates a willingness and capability to:
   1. Work with and relate to other Staff members, members of other health disciplines, Hospital management and employees, visitors, and the community in a cooperative, professional manner so as not to disrupt patient care or affect the Hospital's operations adversely;
   2. Discharge Medical Staff obligations appropriate to his particular Staff membership category; and
   3. Adhere to ethical standards generally recognized in his profession.
D. The individual must provide evidence of professional liability insurance coverage in such amounts and of such types as may be required as by the Hospital, such coverage to be maintained continuously throughout his appointment to the Staff.
E. The individual is free from any significant physical or behavioral impairment that would materially impair his ability to provide patient care consistent with the privileges requested of and approved by the Board.
F. The individual agrees to advise either the Chief Executive Officer or the Medical Staff Office of all medical malpractice lawsuits immediately when filed.

3.2
Nondiscrimination

No aspect of the granting of Medical Staff membership or particular clinical privileges shall be denied any applicant on the basis of age, sex, race, creed, color, national origin, religion, disability or any other criteria unrelated to the delivery of patient care in the Hospital.

3.3
Basic Responsibilities of Staff Membership

Each member of the Medical Staff, regardless of his/her assigned Staff category shall:

A. Provide patients with a level of care that meets the generally recognized professional standard of care;
B. Abide by these Bylaws, the Medical Staff Rules and Regulations of the Medical Staff Department to which he/she is assigned and others in which he/she may exercise clinical privileges, and all policies of the Medical Staff and the Hospital;
C. Discharge such Staff, department, committee, and Hospital functions for which he/she is responsible;
D. Prepare and complete in a timely fashion the medical and other required records for all patients he/she admits or to whom he/she provides care in the Hospital in a timely manner;
E. Abide by generally recognized standards of professional ethics;
F.Immediately informs the Chief of the Medical Staff of any voluntary or involuntary suspension, revocation, or termination of North Carolina license, DEA certification, professional liability insurance, or changes in staff membership or privileges at any other healthcare institution or managed care panel.
G. Each staff member must participate in the on-call coverage of the emergency service and other coverage programs as determined by the department or the Facility MEC.
H. All eligible members must be board certified by January 1, 2007. All members must meet board

certification admissibility requirements and obtain board certification within two cycles of eligibility.

l. Maintain continuous specialty board certification after initial certification. Any lapse of more than two years will automatically terminate medical staff membership and clinical privileges.

3.4
Effect of Other Affiliations

No Staff applicant shall automatically be entitled to membership on the Medical Staff or to exercise particular privileges solely because the applicant holds a certain degree, is licensed to practice in North Carolina or any other state, holds an administrative position, is a member of any professional organization, is certified by any clinical board, or has previously been a Staff member or granted privileges at the Hospital or at any other hospital.

ARTICLE IV
Medical Staff Categories

4.1
Categories

Medical Staff membership shall be divided into **eight (8)** categories: Active Staff, Courtesy Staff, Coverage Staff, Honorary Staff, Emeritus Staff, Silver Staff, Affiliate Staff or Telemedicine Staff.

4.2
Active Staff

A. Qualifications

1. Meet qualifications outlined in Article 3.1 and 3.3;
2. Maintain availability for patient care and consultation within time guidelines determined by the Medical Staff department in which he exercises clinical privileges and the rules and regulations of the medical staff.
3. Practitioner must ensure the provision of continuous care to his/her patients as determined by the practitioner's department; and
4. Have twenty (**20) or more** patient encounters, be employed by a CMC-NorthEast medical facility, refer more than twenty (20) or more patients for direct admission to the Active Medical Staff at CMC-NorthEast, or have a professional services agreement with CMC-NorthEast. "Patient encounter" means any direct patient admission to CMC-NorthEast, any inpatient consultation performed at CMC-NorthEast or any procedure that requires or results in direct patient contact between the patient and the practitioner at any CMC-NorthEast facility, except for those procedures performed in the practitioner's office.

B. Prerogatives

Active Staff members may:

1. Admit patients within the scope of his/her delineated clinical privileges and as may be provided in these Bylaws, Medical Staff Rules and Regulations, and Rules and Regulations of the Medical Staff Department to which he/she is assigned and others in which he/she may exercise clinical privileges;
2. Vote on all matters presented at general and special meetings of the Medical Staff and at meetings of all departments and committees of which they are a member;
3. Hold office at the Staff, department, or committee level after one (1) year of staff membership, except as otherwise provided in these Bylaws, Rules and Regulations or departmental Rules and Regulations. Physicians who do not have at least twenty-one (21) inpatient encounters per year may not hold or be eligible for a position as a Medical Staff Officer; and
4. Exercise those clinical privileges that are recommended by the Medical Staff and granted to them by the Board.

C. Responsibilities

Active staff members shall:

1. Actively participate in and carry out the organizational and administrative functions of the Medical Staff;
2. Assume Emergency Services coverage duties and consultation responsibilities and assignments as determined by the Facility MEC.
3. Actively participate in other recognized functions of Staff membership, including quality improvement and utilization review activities and the discharge of other Staff functions as may be required from time to time.
4. Attend regular and special meetings of the Medical Staff and meetings of all departments and committees of which they are a member.
5. Promptly pay when due all Staff membership dues and assessments.
6. Provide documentation on the Staff application for renewal of privileges that he has had at least 50 hours of postgraduate medical education each year or 100 hours over the previous two (2) year period. A minimum of 35 hours per year (or 70 hours in two (2) years) must be from Category 1. Renewal of privileges will be contingent upon achieving this goal. Exceptions may be made upon the recommendation by the CMC-NorthEast Facility MEC, if approved by the Governing Body.
7. Maintain continuous BLS certification, ACLS certification, PALS certification, ATLS certification, NALS certification or NPR certification.
8. Arrange for continuous coverage by an individual comparably credentialed at the Hospital in relevant skills when member is out of town or otherwise unavailable.

4.3
Courtesy Staff

A. Qualifications

Courtesy Staff members are those who have a practice volume at CMC-NorthEast sufficient to allow monitoring of the quality of care and who have at least one (1) inpatient encounter per year but no more than twenty (20) inpatient encounters per year or be employed by a CMC-NorthEast facility or have a professional services agreement with CMC-NorthEast. To qualify for Courtesy Staff membership, the applicant must:

1. Meet the qualifications outlined in Article 3.1 and 3.3;
2. Maintain availability for patient care and consultation within time guidelines determined by each Medical Staff Department in which he exercises clinical privileges. Practitioner must ensure the provision of continuous care to his/her patients as determined by the practitioner's department.
3. Have at least one (1) inpatient encounter per year at CMC-NorthEast. The inpatient encounter must be of sufficient depth or frequency to allow direct observation by the Department Chairman or an Active Staff member who can comment knowledgeably to the Department Chairman about the quality of care rendered; and
4. If needed or requested by the Department Chairman for purposes of determining quality of patient care, the practitioner will provide the Chairman with a complete and accurate list of institutions where the practitioner has trained and/or worked. In addition, if requested to do so by the Department Chairman, the practitioner will sign a statement allowing Medical Staff representatives to obtain verification of activities, details of care provided and statistics or details on outcomes from any institution or office listed.

B. Prerogatives

Courtesy Staff members may:

1. Admit patients within the scope of their delineated clinical privileges and subject to available facilities and staff. During periods of shortages of facilities or staff as determined by the CEO or

the Facility MEC, this prerogative of Courtesy Staff members to admit patients shall be subordinate to that of Active Staff members;

2. Exercise those Clinical Privileges that have been recommended by the Medical Staff and granted to them by the Board; and
3. Attend general and special meetings of the Medical Staff and meetings of all departments and committees of which they are a member. They shall not; however, be entitled to vote at such meetings.
4. Courtesy Staff members shall be eligible to serve on committees but shall not be eligible to hold office or vote in the Medical Staff organization.

C. Responsibilities

Courtesy Staff members shall:

1. Pay when due all Staff assessments;
2. Arrange for continuous coverage by an individual comparably credentialed at the Hospital in relevant skills when not available to provide care for hospitalized patients; and
3. Maintain continuous BLS certification or ACLS Certification, or PALS certification, or ATLS or NALS or NPR certification. The annual assessment and the life support certification requirement may be waived by the Chief of the Medical Staff for those physicians asked to visit CMC-NorthEast or any of its affiliates for the purpose of providing an educational contribution to CMC-NorthEast.
4. Provide documentation on the Staff application for renewal of privileges that he/she has had at least 50 hours of postgraduate medical education each year or 100 hours over the previous two (2) year period. A minimum of 35 hours per year (or 70 hours in two (2) years) must be from Category 1. Renewal of privileges will be contingent upon achieving this goal. Exceptions may be made upon the recommendation by the CMC-NorthEast Facility MEC, if approved by the Governing Body.

D. Required Change in Category

If a Courtesy Staff provider exceeds twenty (20) inpatient encounters in any one year, the Chief of Staff or his/her designee will notify him/her that he/she must apply to be reclassified as Active Staff and fulfill the responsibilities for Active Staff membership.

4.4
Honorary, Emeritus and Silver Medical Staff

A. Qualifications

Honorary Staff members are those who may or may not be physicians but, in the judgment of the Medical Staff and at the recommendation of the Facility MEC, are deemed deserving of Honorary Staff membership by virtue of their outstanding reputation or their exceptional contributions to CMC-NorthEast. Emeritus Staff members are those who have been members of the Active Medical Staff of CMC-NorthEast for at least ten (10) years and who are retired from active medical practice and, subject to the determination of the Facility MEC have demonstrated exceptional contributions with outstanding reputation to the medical staff, and therefore deserve to be Emeritus Staff. Silver status may be applied for by any Active medical staff member who has served as Active staff for 25 years and who is 60 or more years of age. Silver status allows the Active member to continue to have the rights of Active status, but to discontinue unassigned Emergency Department call. This status is awarded in appreciation for years of service.

B. Prerogatives

Honorary or Emeritus Staff members are not eligible to admit patients to CMC-NorthEast or to exercise clinical privileges at CMC-NorthEast. They are members of the Medical Staff but are not eligible to vote or hold office. Emeritus Staff may; however, at the discretion of the Facility MEC attend Medical Staff meetings, committee meetings and/or department meetings.

4.5
Coverage Staff

A. Qualifications

1. Meet qualifications outlined in Article 3.3;
2. Provide coverage for a sponsoring member in good standing of the Active Medical Staff on a contractual, voluntary or fee for service basis.
3. Practitioner must apply for appointment in the same manner as any Staff member applying for regular Staff appointment and must be granted delineated clinical privileges at least equal to the sponsoring Staff member.
4. Must be located to or arrange to be close enough (office/residence) to the Hospital to provide continuous care to patients.
5. Must be a member of the Active or Associate (or comparable) Staff of another hospital where he or she actively participates in a patient care audit program and other quality review, evaluation, and monitoring activities similar to those required of the Active Staff of this Hospital or have enough activity at CMC-NorthEast to monitor quality.
6. Must be sponsored by and provide coverage to at least one (1) member of the Active Staff.

B. Prerogatives

1. The prerogatives of a Coverage Staff Member shall be to exercise the clinical privileges as are granted to provide services to the patients of specified member(s) of the Active Staff during the period of coverage. Coverage Staff members shall not be eligible to admit patients to the hospital except that Coverage Staff members may admit the patients of a sponsoring physician on the covering physician's service during the period of coverage.
2. Coverage Staff members shall not be eligible to vote on matters presented to meetings of the Staff, departments, divisions or section; to hold office in the Medical Staff organization; or to serve on committees. Coverage Staff members shall not be required to attend meetings.

C. Responsibilities

1. Discharge the basic responsibilities specified in Section 3.3.
2. Pay dues and assessments as determined by the Medical Staff.

D. Rights of the Practitioner

A practitioner's Coverage Staff membership is dependent upon the sponsorship of at least one (1) member of the Active Staff of CMC-NorthEast. If at any time, and for any or no reason, a Coverage Staff member loses or terminates all such sponsorship, his or her medical staff membership and clinical privileges shall automatically terminate without any entitlement to the procedural rights and the Fair Hearing Plan.

E. Termination of Sponsoring Relationship

If the sponsor or the coverage staff member wishes to terminate a coverage relationship, he or she must notify the other party to the coverage arrangement and must inform, in writing, within ten (10) business days, the Chief of the Medical Staff of the termination of a coverage relationship.

4.6
Affiliate Staff

A. Qualifications

1. Meet the basic qualifications for Medical Staff appointment; and
2. Desire to be associated with, but do not intend to establish a practice at, the Hospital.

B. Responsibilities and Prerogatives

1. May visit their hospitalized patients and review their medical records but may not admit patients, consult on patients, exercise any clinical privileges, write orders or progress notes, make notations in the medical record, or actively participate in the provision or management of care to patients at the Hospital.

4.7
Telemedicine Staff

Telemedicine privileges are defined as privileges for the use of electronic communication or other communication technologies to provide or support clinical care at a distance. Telemedicine privileges shall include consulting, prescribing, rendering a diagnosis or otherwise providing clinical treatment to a patient using Telemedicine. Appointees to other categories of the Medical Staff are not required to apply for Telemedicine privileges in order to use electronic communication or other communication technologies to provide or support clinical care at a distance.

A. Qualifications

1. Meet the basic qualifications for Medical Staff appointment; and
2. Have expressed an interest in providing services using Telemedicine.

B. Responsibilities

1. Be responsible for providing services by Telemedicine at the request of Appointees of the Medical Staff;
2. Not assume the functions and responsibilities of Appointees of other categories;
3. Not be responsible for the care of unassigned patients, including the care of staff cases or emergency service care;
4. Not be required to attend quarterly medical staff meetings;
5. Not be required to attend departmental meetings;
6. Participate in quality assessment and monitoring activities as assigned by the department or committee chairs; and

C. Prerogatives

1. Not be entitled to admit patients;
2. Be entitled to treat patients within the limits of their assigned clinical privileges provided, however, another qualified Appointee of the Medical Staff of the same department admits the patient, serves as the attending physician for the patient, and is responsible for responding to patient needs and emergencies that may arise. The admitting physician shall identify at the time of the admission any Telemedicine practitioner who will be providing treatment to the patient; and
3. Not be entitled to vote at Medical Staff or Department meetings and not be eligible to hold office.

D. Exception for Privileges for Telemedicine Status

The CREDENTIALS POLICY shall not apply to practitioners who are granted privileges to participate, via Telemedicine, in the medical care of patients. A Practitioner who has Telemedicine Status may not act as the primary Practitioner responsible for the patient's care. The attending or primary Practitioner shall be responsible for the patient's care and the actions of the Telemedicine Practitioner. The attending or primary Practitioner shall inform the patient of the Telemedicine Practitioner's participation in the patient's care and secure patient consent to same. Patient consent to the participation of the Telemedicine Practitioner should be recorded in the patient's medical record.

Applicants for Telemedicine privileges must provide the following:

1. An application for Telemedicine privileges and relevant Delineation of Privileges form;
2. A copy of current DEA certificate, if applicable;
3. A certificate of insurance evidencing current, valid professional liability insurance coverage from an insurance company licensed or approved to do business in this state, in the amount of a minimum of $1 million, unless the Board specifies otherwise;
4. A letter confirming medical staff appointment in good standing and documentation of privileges as requested at a facility accredited by The Joint Commission; and
5. Such additional information as may be requested.

An Applicant for Telemedicine privileges shall provide the Hospital adequate information upon which to make a recommendation for Telemedicine privileges. It shall be the responsibility of the Applicant to provide a complete application for privileges.

E. Processing Requests for Telemedicine Privileges

Applications for Telemedicine privileges shall be processed as follows:

1. Application, Delineation of Privileges form and required documentation shall be submitted to the Medical Staff Office;
2. The Medical Staff Office shall (a) submit a query to the National Practitioner Data Bank, the Federation of State Medical Boards, The American Medical Association Physician Profile, and the OIG's List of Excluded Providers (if not contained in the AMA Profile); (b) verify current licensure(s); and (c) shall verify the Applicant's status at his/her primary hospital;
3. The documentation, results of queries and information from the Applicant's primary hospital shall be reviewed by the relevant Department Chair, who shall forward a report to the Facility Credentials Committee; thereafter, the Applicant's request for Telemedicine Status shall be processed in accordance with the CREDENTIALS POLICY.

4.8
Disaster Privileges

During disaster(s) in which the emergency operations plan has been activated, the President (or designee) or the Chief of Staff (or designee) may, if the medical center is unable to handle immediate and emergency patient needs, grant disaster privileges to Licensed Independent Practitioner(s) deemed qualified and competent, for the duration of the disaster situation. Granting of these privileges will be handled on a case by case basis and are not a "right" of the requesting provider and may be revoked at any time.

If the President or Chief of Staff is unable to fulfill these duties (or to name a designee), the responsibility will pass in the following order to the Facility Credentials Committee Chair, Vice-Chief of Staff, and/or Vice-Chief Elect.

ARTICLE V
Medical Staff Active Member Rights

5.1

A. Each Active member of the Medical Staff has the right to an audience with the Facility MEC. In the event a practitioner is unable to resolve a difficulty working with his/her respective department chair, that physician may, upon presentation of a written notice, meet with the Facility MEC to discuss the issue.

B. Any medical staff officer has a right to call a meeting with administrative and/or board officers to discuss any issue of importance as long as they agree to a mutually acceptable time.

C. Any Active member has the right to initiate a recall election of a medical staff officer and/or department chairman. A petition for such recall must be presented to the Facility MEC and signed by at least 30% of

the Active medical staff. Upon presentation of such valid petition, the Facility MEC will schedule a special general staff meeting for the purposes of discussing the issues and (if appropriate) entertain a no-confidence vote.

D. Any Active member may call a general staff meeting. Upon presentation of a petition signed by 20% of the members of the Active staff, the Facility MEC will schedule a general staff meeting for the specific purpose addressed by the petitioners. No business other than that detailed in the petition may be transacted.

E. Any Active member may raise a challenge to any rule or policy established by the Facility MEC. In the event that a rule, regulation, or policy is felt to be inappropriate, any Active member may submit a petition signed by at least 10% of the Active staff members. When such petition has been received by the Facility MEC, it will either provide the petitioners with information clarifying the intent of such rule, regulation, or policy; or schedule a meeting with the petitioners to discuss the issues. The results will be reported to the medical staff.

F. Any clinical section or subspecialty group may request a department meeting when a majority of that group believes that the department has not acted in an appropriate manner.

G. The above sections A-E do not pertain to issues involving disciplinary action, denial of request for appointment or clinical privileges, or any other matter relating to individual membership or privileging sections. The Fair Hearing Plan provides recourse in these matters.

H. Any member has a right to a hearing/appeal pursuant to the institution's Fair Hearing Plan in the event that any of the following actions are taken or recommended:
1. denial of initial staff appointment
2. denial of reappointment
3. revocation of staff appointment
4. denial or restriction of requested clinical privileges
5. reduction in clinical privileges
6. revocation of clinical privileges
7. individual application of, or individual changes in, the mandatory concurring consultation requirement
8. suspension of staff appointment or clinical privileges if such suspension is for more than 14 days.

ARTICLE VI
Organization of the Medical Staff

6.1
Medical Staff Officers

A. Identifications - The officers of the medical staff shall consist of a Chief of Staff, Vice Chief of Staff and Vice Chief Elect, and such other officer or officers as the medical staff may from time to time elect.

B. Qualifications – Only Active Staff members in good standing shall be eligible to serve as officers of the medical staff. If, at any time during the terms of his/her office, the individual fails to remain in good standing as an Active Staff member, such failure immediately shall result in his/her termination as an officer and the creation of a vacancy in the office involved.

C. Nomination – Candidates for office shall be nominated pursuant to any of the following methods:
1. By Nominating Committee – The Nominating Committee shall consist of the immediate past Chief of Staff (chair), two other past Chiefs who are members of the Active medical staff and two (2) physicians at large as appointed by the current Chief of Staff. The Nominating Committee shall convene at least sixty (60) days prior to the annual meeting of the Medical Staff and shall submit to the Vice Chief Elect one (1) or more qualified nominees for each office. The names of such nominees shall be reported to the staff members at least thirty (30) days prior to the annual meeting.
2. By Petition Nomination – Nominations may also be made by a petition signed by at least 5% of the members of the Active medical staff. Such petitions must be submitted to the immediate Past Chief of the Medical Staff at least 45 days prior to the election. The Nominating Committee will then

confirm the nominee's interest and willingness in fulfilling the role, responsibilities, and duties for which they are being nominated.

D. Election – Except as provided in subsection E of this section, officers shall be elected bi-annually at the annual meeting of the medical staff. Only staff members accorded the prerogative to vote under Article IV shall be eligible to vote for officers. Voting shall be by secret written ballot, or by a show of hands or voice vote. Method of voting will be determined by the Facility MEC. A nominee shall be elected to office upon receiving over fifty percent (50%) of the total number of votes cast for such office. If no nominee for such office receives such a majority vote on the first ballot, a runoff election shall be held between the two nominees receiving the highest number of votes, and the nominees receiving over fifty percent (50%) of the total number of votes cast in such runoff election shall be elected to such office.

E. Term – Each officer shall serve a term of two (2) years or until a successor is elected, commencing on the first day of the medical staff year, January 1st, unless the officer shall resign sooner or be removed from office. The officers shall be eligible for re-election.

F. Resignation or Removal from Office

1. Conditions for Removal of Officer
If any of the following conditions exist, the removal of a medical staff officer from office shall be considered:
   a. Attendance by the medical staff officer at general medical staff and Facility MEC meetings is less than seventy five (75%) percent during the year
   b. The health of an officer prevents him/her from carrying out his/her duties
   c. Suspension, revocation or annulment of professional license by the N.C. Medical Board
   d. Suspensions from the medical staff
   e. Failure to perform the required duties of the office
   f. Failure to adhere to professional ethics
   g. Failure to comply with or support enforcement of the CMC-NorthEast Medical Staff Bylaws, Rules and Regulations and policies
   h. Failure to maintain adequate professional liability insurance
   i. Failure to maintain Active medical staff membership

2. Mechanism for Removal of Officer
   a. Removal of a medical staff officer during his/her term of office may be initiated and approved by a two-thirds (2/3) majority vote of the Facility MEC and a two-thirds (2/3) vote of the Active staff members. The removal shall not be recognized as being official until it has been ratified by the Board.

3. Resignation: Any elected officer of the medical staff may resign at any time by giving written notice to the Facility MEC. Such resignation, which may or may not be made contingent upon acceptance, takes effect on the date of receipt or any time specified therein.

G. Conflict of Interest

1. In any instance where an officer, department chairperson, section chief, committee chairperson, or member of any Medical Staff committee has or reasonably could be perceived as having a conflict of interest or a bias in any matter involving another Medical Staff member that comes before the individual or committee, or in any instance where the individual brought a complaint against that Appointee, such individual shall not participate in the discussion or vote on the matter and shall be excused from the meeting; however, prior to being excused from the meeting, the individual may be asked, and may answer, any questions concerning the matter.

2. As a matter of procedure, the chairperson of the committee designated to make such a review shall inquire, prior to any discussion of the matter, whether any member has any conflict of interest or bias. The existence of a potential conflict of interest or bias on the part of any committee member may be

called to the attention of the chairperson by any committee member with knowledge of the matter.

3. A department chairperson shall have a duty to delegate review of applications for appointment, reappointment, or clinical privileges, or questions that may arise, to a vice-chair or other member of the department, if the department chairperson has a conflict of interest with the individual under review or could be reasonably perceived to be biased.

H. Vacancies

Vacancies in office shall be filled by the Facility MEC. If there is a vacancy in the office of the Chief of Staff, the Vice Chief shall serve out the remaining term.

6.2
Duties of Officers

Chief of the Medical Staff

Reporting
The Chief of the Medical Staff reports directly to the Facility MEC and the Board. He or she must also report to the CEO, as necessary.

The Chief of the Medical Staff communicates the opinions and concerns of the medical staff and its individual members, and recommendations of the Facility MEC (Facility MEC) to the hospital Board and the President of the hospital. As chairperson of the Facility MEC, the Chief of the Medical Staff reports the views and decisions of the hospital's Board and President of the hospital to the Facility MEC and the medical staff membership.

Position purpose
The Chief of the medical staff provides leadership and guidance to the medical staff and promotes effective communication among and between the medical staff, Facility MEC, administration, and the Board.

This individual serves, as the chief medical officer of the organization and is responsible for:
- ensuring bylaws implementation
- securing and maintaining JCAHO accreditation
- providing information to the Board concerning the care and treatment of patients
- facilitating positive relationships among administration, the medical staff and other organizational support services**.**

Accountability & functions
- communicate and represent opinions, policies, concerns, needs and grievances of the medical staff and hospital Board.
- communicate the views and decisions of the hospital's Board and the hospital President to the Facility MEC and the medical staff membership;
- ensure medical staff compliance with procedural standards and the rights of individual staff members in all stages of the hospital's credentialing process, and in all instances where corrective action has been recommended in regard to a practitioner;
- direct the efficient operation and organization of the administrative policymaking and representative aspects of the medical staff organization, and evaluate the effectiveness of the organization;
- assist the President of the hospital in coordinating the activities and concerns of the administration, nursing, and other patient care services and personnel with those of the medical staff,
- oversee the quality activities of the medical staff and reports such to the Facility MEC and the hospital Board;
- enforce compliance with the Bylaws, rules, regulations, policies and procedures of the medical staff ;
- call, preside at, and develop agenda for all general and special meetings of the medical staff and the

Facility MEC;
- serve as chairperson of the Facility MEC, as an ex officio member without vote on all other standing staff committees;
- unless otherwise provided in the hospital or staff bylaws, appoint medical staff members and chairpersons to staff committees formed to accomplish staff administrative, environmental, or representative functions.
- review and enforce compliance with standards of ethical conduct and professional demeanor among the members of the medical staff in their relations with each other, the board, hospital administration, other professional and support staff, and the community the hospital serves.

Position Requirements

This individual must:

- be an Active physician member of the medical staff, having held that status for at least five (5) years;
- be board certified or board admissible;
- have prior experience as a department chair, credentials committee member, board member, Facility MEC member, or in a similar medical staff leadership position;
- have received or be willing to receive out-of-hospital education and training in medical administrative activities and medical staff leadership.

Recognition and benefits

The Chief of the Medical Staff is encouraged to attend two (2) external continuing education programs per year. Due to the significant time commitment this position demands and the possibility for significant family and practice disruption, this organization also reimburses the Chief of the Medical Staff for participation and expenses - including spousal expenses, if applicable - in the continuing education programs.

He or she is exempt from all other medical administrative requirements of the staff, such as attendance at staff and departmental meetings and the payment of staff assessments.

Occupational hazards

The Chief of the Medical Staff should anticipate some degree of stress, significant practice disruption, and some degree of strain on professional relations and friendships. This position requires dedicated time for committee meetings and related work. Due to the possibility of legal entanglements, the institution provides protection to the individual holding this position, in the form of indemnification and a pledge to support the actions of the Chief of the Medical Staff-provided those actions relate directly to the performance of the functions described in this position description or other documents - such as when he or she advises the Board on specific competence-related issues.

Vice Chief of the Medical Staff

Reporting

The Vice Chief of the Medical Staff reports directly to the Chief of the Medical Staff and the Facility MEC. He or she also reports to the CEO, when necessary.

Position Purpose

The Vice Chief of the Medical Staff provides continuity in leadership when the Chief of the Medical Staff is absent or otherwise unable to perform his or her assigned functions. The Vice Chief of the Medical Staff is expected to stay informed of all medical staff issues at all times.

Accountability and functions

The Vice Chief of the Medical Staff assists in performing any functions specified by the president of the medical staff and has the responsibilities and authority:

- to chair the MSQIC (Medical Staff Quality Improvement Committee) and report findings of the MSQIC to the Facility MEC;
- to assume all of the duties and responsibilities and authority of the Chief when the latter is unable - temporarily or permanently - to accomplish the same by reason of illness, absence, other incapacity or

unavailability, or refusal;
- to serve as an ex-officio member, with voting rights, of the Medical Executive Committee (Facility MEC);
- to coordinate the medical staff education program related to medical staff activities;
- to perform such additional duties as may be assigned by the Chief of the Staff, the Facility MEC, or the hospital Board.

Position requirements
This individual must:
- be an Active member of the medical staff organization, having held that status for at least five (5) years;
- be board certified or board admissible;
- have prior experience as a department chair, credentials committee member, board member, Facility MEC member, or in a similar physician leadership position;
- have received or commit a willingness to receive out-of-hospital education and training on medical administrative activities and physician leadership.

In addition to the above requirements, the Vice Chief of the Medical Staff may not, during his or her term of office, hold a physician leadership position at any other hospital and must abide by the conflict of interest policy.

Recognition and benefits
The benefits of this position include participation in one (1) external continuing education event per year.

Due to the significant time commitment this position demands and the possibility for significant family and practice disruption, the organization will reimburse the Vice Chief of the Medical Staff for participation and expenses - including spousal expenses, if applicable - in the continuing education programs.

Serving as Vice Chief of the Medical Staff automatically fulfills all other medical administrative requirements, such as service on other committees and payment of staff assessments. This individual is also exempt from attending departmental meetings.

Occupational hazards
The Vice Chief of the Medical Staff should anticipate the challenge of resolving difficult credentialing issues, which are likely to require significant time and patience.

Vice Chief Elect of the Medical Staff

Reporting
The Vice Chief Elect of the Medical Staff reports directly to the Medical Staff Chief of Staff and the Facility MEC.

Position Purpose
The primary focus of the Vice Chief Elect is to learn the major responsibilities of the medical staff, including credentialing and privileging and quality improvement. The Vice Chief Elect also oversees the medical staff budget which is maintained by the Medical Staff Office. The Vice Chief Elect will Chair the Bylaws Committee.

Accountability and Functions
The Vice Chief Elect is a voting member of Facility MEC, Medical Staff Quality Improvement Committee and the Facility Credentials Committee. He/She may be asked to perform such other duties as assigned by the Chief or Vice Chief of Staff, the Facility MEC, or the Board. In the absence of the Chief and Vice Chief, he/she shall assume the duties and have the authority of the absent leaders.

Position Requirements
This individual must be a physician member of the Active staff and must have held that position for at least three (3) years. He/she may not, at any time while holding this position, be an officer or leader in any other hospital medical staff organization. Prior successful service within the medical staff structure as chairperson of a medical staff committee, member at large of the Facility MEC, or service on a Board subcommittee is desirable but not required.

Recognition and Benefits
The Vice Chief Elect will be entitled to participate, as an officer of the medical staff, in at least one (1) continuing education opportunity per year devoted to medical administrative activities.

The Vice Chief Elect is entitled to utilize the services of the Medical Staff Office staff for assistance in performing his/her duties. Prior medical staff leaders and members of the Facility MEC will provide personal recognition when appropriate. This position also offers an individual member of the medical staff the opportunity to develop the leadership skills necessary to become a recognized leader of the medical staff.

6.3
Other Officials of the Staff

Other officials of the Staff shall include department chairmen, section chiefs, and such other officials as may be created by the medical staff. Such officials shall perform their duties consistent with these Bylaws, Rules and Regulations, and all policies of the hospital.

ARTICLE VII
Clinical Departments

7.1
Organization of Departments

Departments shall be organized by medical specialty to promote the effective delivery of patient care services. Accordingly, each department shall be organized as a separate administrative unit of the medical staff and shall have a chairman who is selected and who has the authority, duties, and responsibilities as defined in this Article. Each department shall be directly responsible for providing clinical services and overseeing the quality of care rendered by all practitioners within their specialties.

7.2
Creation and Current Designation

A. The Facility MEC and the Board shall be authorized jointly to create and organize such departments as shall be deemed necessary and appropriate. In addition, the Facility MEC and the Board jointly may eliminate, subdivide, or combine departments as necessary and appropriate. The current departments of the Medical Staff are designed as follows: Medicine, Surgery, Anesthesiology & Pain Management, Pathology & Laboratory Medicine, Obstetrics/Gynecology, Emergency Medicine, Radiology, Family Medicine, Pediatrics, and Psychiatry.

B. The following factors shall be considered in determining whether the creation of a department or a section is warranted:

1. there are at least six (6) Medical Staff Appointees, who are available for appointment to the department or section; and

2. the level of clinical activity that will be affected by the new department or section is substantial enough to warrant imposing the responsibility to accomplish departmental and sectional functions on a routine basis.

C. The following factors shall be considered by the Facility MEC in determining whether the elimination of a department or section is warranted:

1. there is no longer an adequate number of Medical Staff Appointees in the department or section to

enable it to accomplish the functions set forth in these Bylaws;

2. there are an insubstantial number of patients or an insignificant amount of clinical activity to warrant the imposition of the designated duties on the Appointees in the department or section;

3. the department or section fails to meet on at least a quarterly basis;

4. the department or section fails to fulfill all designated responsibilities and functions; or

5. no qualified individual is willing to serve as Department Chairman or section chief.

7.3
Assignment to Departments

Each staff member and each Licensed Independent Practitioner shall be assigned to one (1) department, but may be granted clinical privileges in one (1) or more additional departments. The Facility MEC shall, after consideration of the recommendations of the clinical departments, as transmitted through the Facility Credentials Committee, make one (1) departmental assignment for each medical staff member. The exercise of clinical privileges within any department shall be subject to these Bylaws, the Rules and Regulations, and the rules, regulations and policies of that department as administered and enforced by its department chairman.

7.4
Functions of the Departments

The primary function of each department is to implement and conduct specific review and evaluation activities to preserve and improve the quality and efficiency of patient care provided in that department. To further this function, each department shall:

A. Establish guidelines for the granting of clinical privileges and the exercise thereof within the department, as well as for the holding of office in that department.
B. Conduct ongoing monitoring and evaluation of patient care and clinical performance relating to the quality of patient care.
C. Meet a minimum of six times per year, or more frequently as necessary to consider findings from the ongoing monitoring activities of the medical staff. Each department shall meet separately at least six (6) times per year to review and analyze on a quality review basis the clinical work of the department.

7.5
Department Chairman

A. Qualifications

Each Chairman shall be a member of the Active staff and qualified by training, experience and demonstrated ability for the position. The Chairman of each medical staff department must be certified by an appropriate specialty board or affirmatively established through the privilege delineation process that the person possesses comparable competence. The Facility MEC will decide which specialty board(s) is relevant to the Chairman's competency and responsibilities. If the Chairman is not certified by an appropriate Board, the Facility MEC will determine the knowledge and skills expected of a diplomat of a board relevant to the individual responsibilities as Department Chairman.

B. Selection and Appointment

The Chairman shall be selected by members of the department.

C. Term of Office; Removal –

Each Department Chairman shall serve a term of two (2) years commencing with the date of his/her appointment. A Department Chairman may serve successive terms. Removal of a Department Chairman from office may be accomplished by the Board upon recommendation of the Facility MEC, or a two-thirds (2/3) vote of the department members eligible to vote on departmental matters.

D. Duties and Responsibilities

Each Department Chairman, in conjunction with appropriate personnel, is responsible for ensuring that the following functions are carried out:

1. Coordinate the clinical and administrative activities of the department, and appoint such members as necessary to conduct these activities;
2. Coordinate and integrate department functions with those of the other clinical departments and the Medical Staff;
3. Participate in credentialing procedures for appointment and reappointment to the Medical Staff and for the delineation of clinical privileges, as required by the procedures specified in the Credentialing Policy Manual;
4. Recommend clinical privileges, as appropriate, for each member of their respective departments;
5. Recommend to their respective departments criteria for clinical privileges within the specialty fields for which the department is responsible;
6. Determine the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment and services;
7. Regularly assess and assist in the improvement of the quality of patient care provided by members of the department, and by dependent practitioners associated with the department, and provide performance review reports to the department periodically;
8. Submit written reports to the Facility MEC as required concerning department performance review activities and consequent recommendations for the maintenance and improvement of the quality of patient care; maintaining quality control programs where necessary.
9. Assess and recommend to Administration any off-site sources for needed patient care treatment, and services not provided by the department or the organization;
10. Coordinate and integrate interdepartmental and intradepartmental services;
11. Develop and implement policies and procedures that guide and support the provision of care, treatment and services;
12. Recommend a sufficient number of qualified and competent persons to provide care, treatment and services;
13. Provide, when appropriate, orientation and continuing education for members of the department;
14. Recommend space and other resources needed by the department.

ARTICLE VIII
Medical Staff Committees

8.1
General

There shall be a Facility MEC and such other standing and special committees of the medical staff as may from time to time be necessary or appropriate to perform the duties and responsibilities of the medical staff set forth in these Bylaws. The Facility MEC may itself establish such committees to perform such duties and responsibilities. Each member of the Active medical staff may be given committee appointment by the Chief of the Medical Staff. The CEO may attend every medical staff committee or department meeting in an ex-officio capacity.

8.2
Facility MEC

A. Composition – The Facility MEC shall consist of officers of the medical staff, a representative from Graduate Medical Education and the medical staff department chairs. Departments with Active medical staff membership equal to or greater than 1/6 of the total Active medical staff membership shall be eligible to have their Vice Chair attend Facility MEC as a voting member. This requires application to and approval

of the Facility MEC. The Hospital's CEO and the most recent past Chief of Staff shall serve as ex-officio members without vote. The Chief of the Medical Staff shall serve as Chairman of the Facility MEC.

B. General Purposes – Acting pursuant to its delegated authority from the Governing Body, the Facility MEC shall be charged with overseeing all of the principal functions for which the Medical Staff is responsible, including making recommendations concerning Medical Staff structure, establishing mechanisms for reviewing and delineating clinical privileges, and establishing quality assurance mechanisms, staff membership criteria, corrective actions procedures, Fair Hearing mechanisms, and continuing medical education programs. The Facility MEC shall also be responsible for receiving and acting on reports and programs. The Facility MEC shall also be responsible for receiving and acting on reports and recommendations from any Medical Staff or department committees. Finally, the Facility MEC shall be authorized to act on behalf of the Medical Staff during periods between Staff meetings. No action of the Facility MEC shall be binding or constitute final action until approved by the Governing Body.

C. Specific Duties

The Facility MEC shall perform the following specific duties:

1. Receive and act upon reports and recommendations from the departments, committees, and officers of the Staff.
2. Coordinate the activities and policies of the Medical Staff, departments, and committees, and to serve as liaison between the Medical Staff, the governing body and the CEO.
3. To make recommendations on hospital management matters to the governing body through the CEO.
4. Make recommendations to the governing body, based upon recommendations received from the Facility Credentials Committee, concerning staff appointments and reappointments, staff category assignments, department assignments, delineation of clinical privileges, and corrective action. Any disputed policy changed shall be resolved by the Facility MEC.
5. Report to the governing body and the medical staff concerning the overall quality and efficiency of patient care.
6. Initiate and implement medical staff policies.
7. Assume responsibility for medical staff compliance with hospital accreditation standards.
8. Represent the medical staff in matters before the governing body.
9. To provide for the preparation of all meeting programs, either directly or through delegation to a program committee or other suitable agent.
10. To report to each general medical staff meeting.
11. To recommend, administer and maintain a dues structure for the Active medical staff which has been approved by the medical staff for the continuation of staff programs and projects.
12. To serve as a screening committee that will submit names and candidates for physician vacancies on the hospital's Board. The following procedure will be followed:

    a. The medical staff members may submit names of candidates to the Facility MEC.
    b. The Facility MEC will interview the candidates and determine the candidates' eligibility and commitment to adhere to the duties and responsibilities of the Board.
    c. The Facility MEC will select two candidates and present those names to the full medical staff for approval at the Medical Staff Quarterly meeting.
    d. Upon approval by a majority of the medical staff, the candidates' names will be subsequently submitted to the Nominating Committee of the Board for vacancies on the Board. Candidates, if elected to the Board, will serve in a corporate capacity without a vested interest.

D. Meetings

The Facility MEC must meet at least ten (10) times per year and a permanent record of all proceedings and actions shall be maintained.

8.3
Facility Credentials Committee

A. General Purposes

Acting pursuant to authority from the governing body, the Facility Credentials Committee shall oversee the credentialing process. It shall review and make recommendations to the Facility MEC concerning applications for appointment and reappointment to the medical staff and for initial and renewal of clinical privileges.

B. Composition

The Facility Credentials Committee shall be appointed annually by the Chief of the Medical Staff. The committee shall include a member from each department of the medical staff and one (1) from Hospital Administration.

C. Specific Duties

The Facility Credentials Committee shall perform the following:

1. Review and evaluate the qualifications of each practitioner applying for initial appointment, reappointment, or modification of clinical privileges.
2. Submit to the Facility MEC required reports and information on the qualifications of each practitioner applying for staff membership or particular clinical privileges, as well as recommendations with respect to appointment, membership category, department affiliation, clinical privileges, and special conditions.
3. Submit other periodic reports to the Facility MEC as it may require from time to time.

D. Meetings

The committee shall meet at least quarterly, and a report of all committee minutes, findings and/or recommendations shall be forwarded to the Facility MEC of the medical staff.

8.4
Bylaws Committee

A. General Purpose

Acting pursuant to authority from the governing body, the Bylaws Committee shall oversee the process of revising the medical staff bylaws, and associated policies, while considering recommendations from the governing body and/or medical staff members. It shall review and make recommendations to the Facility MEC concerning such revisions.

B. Composition

The Bylaws Committee shall be appointed annually by the Chief of the Medical Staff. The committee shall include at least one (1) member from each department of the medical staff and one (1) from Hospital Administration.

C. Specific Duties

The Bylaws Committee shall perform the following:

1. Review and evaluate the bylaws at least annually, and as necessary, based on recommendations from the governing body and/or medical staff members. These changes may be based on general

recommendations of the governing body and/or medical staff members, or as required to maintain compliance with any and all applicable regulatory bodies.

2. Submit to the Facility MEC recommendations for Bylaw revisions in a timely manner pursuant to any existing deadlines necessary for approval by the Board.
3. Submit other periodic reports to the Facility MEC as it may require from time to time.

8.5
Cancer Committee

A. Composition

Physician members must include at least one member from each diagnostic and treatment service listed: diagnostic radiologist, pathologist, general surgeon, medical oncologist, and radiation oncologist. Additional physician members are included at the discretion of the chairperson and cancer committee members. Non-physician members must include at least one representative from each service listed: hospital administration, oncology nursing, social or case work, cancer registry, quality assurance, and hospice or pain/palliative care. Additional non-physician members are included at the discretion of the chairperson and cancer committee members.

B. Duties and Responsibilities

The committee responsibilities include the following:

- Develop and evaluate the annual goals and objectives for the clinical, educational, and programmatic activities related to cancer
- Promote a coordinated multidisciplinary approach to patient management
- Ensures that education and consultative cancer conferences cover all major sites and related issues
- Ensures that an active supportive care system is in place for patients, families and staff
- Monitors quality management and improvement through completion of quality management studies that focus on quality, access to care and outcomes
- Promotes clinical research
- Supervises the cancer registry and ensures accurate and timely abstracting, staging and follow-up reporting
- Performs quality control of registry data
- Encourages data usage and regular reporting
- Ensures content of the annual report meets requirements
- Publishes the annual report by December 31 of the following year
- Promotes utilization of ethics committee for cancer related issues

C. Meetings

The Committee shall meet at least quarterly with a report of all committee minutes, findings, and all recommendations to be reported to the Facility MEC for appropriate action.

8.6
Medical Staff Review Committees

The Medical Staff Quality Improvement Committee and the Trauma Outcomes Committee shall be medical staff review committees. Other review committees may be assigned as necessary.

8.7
Other Committees

The Facility MEC may establish other committees. In addition, and subject to approval by the Facility MEC, the Chief of the Medical Staff may appoint special or ad hoc committees to undertake specific projects as he may assign. Reports by such committees shall be made directly to the Chief of the Medical Staff.

ARTICLE IX
Meetings

9.1
Medical Staff Meetings

A. Annual Meeting – There shall be an annual meeting of the Medical Staff held at the fall quarterly meeting each year. The Chief of the Medical Staff and such other officers, department or division heads or committee chairmen as the CEO or the Facility MEC may designate shall present reports on actions taken during the preceding year and on other matters of interest and importance to the staff members. Medical staff officers shall be elected at the annual meeting. Notice of the annual meeting shall be given as described in this section.

B. Special Meetings – Special meetings of the medical staff may be called at any time by the Chief of the Medical Staff or the Facility MEC and shall be called upon the written request of at least **20%** of the members of the Active staff. The person or persons calling or requesting the special meeting shall state the purpose of such in writing. The meeting shall be scheduled by the Chief of the Medical Staff within seven (7) days after receipt of such request. No business shall be transacted at any special meeting except that is stated in the notice of the meeting.

9.2
Committee and Department Meetings

A. Regular Meetings – Except as otherwise specified in these Bylaws, the chairmen of committees or departments may establish the times for the holding of regular meetings of the members of their respective entities. Committees may, by resolution, specify the time for holding regular meetings without notice other than by resolution. Departments shall hold regular meetings to review and evaluate the clinical work of practitioners with privileges in the department. At the departmental meetings, emphasis must be placed on morbidity and mortality analysis with detailed consideration of selected deaths, unimproved hospitalized patients, infections, complications, errors in diagnosis, results of treatment and analytical reports relative to patient care within the hospital.

B. Special meetings – Special meetings of committees or departments may be called by the chairman thereof, the Facility MEC or the Chief of the Medical Staff.

C. Attendance Requirements – Department Meetings

Department Chiefs, Vice-Chiefs, and sections chiefs shall be required to attend at least fifty percent (50%) of all applicable department meetings in each year unless excused for just cause such as sickness, absence from the community, or attending medical emergencies.

D. Attendance Requirements – Committee Meetings

Committee Chairpersons shall be required to attend at least fifty percent (50%) of all applicable committee meetings in each year unless excused for just cause such as sickness, absence from the community, or attending medical emergencies.

9.3
Quorum

A. Medical Staff meetings – Those members of the medical staff present and entitled to vote at any regular or special meeting shall constitute a quorum.

B. Department and Committee meetings – Those members of the departments and committees of the medical staff present and entitled to vote at any regular or special meeting shall constitute a quorum.

9.4
Manner of Acting

A. General – Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall constitute action of that group.

B. Action by Mail – The Facility MEC may authorize the submission by mail of any medical staff matter to the membership entitled by vote. Ballots and other information deemed appropriate by the Facility MEC shall be provided to all members eligible to vote. Only ballots received by the secretary within ten (10) calendar days of the date that such ballots and other materials were postmarked shall be counted.

C. Rights of Ex-Officio Members – Persons serving under these Bylaws as "Ex-Officio" members of a committee shall have all rights and privileges of regular members except they shall not be counted in determining the existence of a quorum. In addition, the Ex-Officio members serve without right to vote.

9.5
Minutes

Except as otherwise provided in these Bylaws, minutes of all meetings shall be prepared and retained. They shall include, at a minimum, a record of the attendance of members and the vote taken on significant matters and conclusions, recommendations or actions. A copy of minutes shall be signed by the presiding officer of the meeting and forwarded to the Facility MEC. Copes of all minutes shall be maintained by the Facility MEC. Each committee and department shall maintain a file on the minutes of each meeting.

9.6
Attendance

A. Requirements – At a minimum, each active medical staff member is encouraged to attend at least 50% of Medical Staff AND 50% of Department/Section meetings each year.

B. Attendance at meetings – Successful compliance with the minimum attendance stated above will result in the members' medical staff reappointment dues being waived for the next scheduled reappointment cycle.

9.7
Meeting Procedures

A. Order of Business and Agenda

The order of business at all Staff, department, or committee meetings shall be determined by the Chief of Staff or the chairman of the department or committee. The agenda at all regular meetings shall include at least:

1. Approval of the minutes of the last regular meeting and all special meetings held since the last regular meeting.
2. Old business
3. The presentation of any administrative reports or other communications
4. Report for the Chief Executive Officer or Administrative representative of hospital
5. The election of officers and other representatives as required by Bylaws
6. The presentation of any reports by Staff officers or department or committee officials on the overall results of patient care quality evaluations, and other staff, department, or committee functions
7. The presentation of new business

The Department Chairman shall be responsible for the agenda and the order of business, as well as the scheduling of meetings.

B. Notice of meeting

Except as otherwise provided in these Bylaws, a notice of all Staff, department and committee meetings shall consist of written notification stating the place, day, and hour of such meeting. Notice of special department or committee meetings may be given orally, not less than three (3) days before the meeting.

ARTICLE X
Corrective Action

10.1
Reporting Requirements

A. General – Every member of the staff shall be required to report any direct knowledge that he may have concerning the commission or omission of any act by another member of the staff or any other person directly involved in the care of patients that is or may constitute the conduct specified in Section 10.2 of this Article.

B. Method of Reporting – All reports pursuant to this Section shall be submitted to the Chief of the Medical Staff, the Performance Improvement Department, the Director of Risk Management, or the President of the Hospital who shall act according to the quality inquiry policy.

10.2
Criteria

Corrective action may be taken when an individual's conduct is (1) detrimental to a patient's safety or to the delivery of quality patient care within the hospital; (2) contrary to Medical Staff Bylaws, the Rules and Regulations, or policies of the Hospital; or (3) below applicable professional standards.

10.3
Investigation

When reliable information indicates that an individual may have exhibited acts, demeanor, or conduct falling within the criteria specified in section 10.2 of this Article, the Facility MEC shall direct that an investigation be undertaken. The Facility MEC may conduct the investigation itself, or may assign the task to an appropriate staff officer, department, or committee. The investigation shall be conducted in a prompt manner and a written report shall be prepared as soon thereafter as practical. The report may include recommendations for appropriate corrective action. The affected individual shall be notified that an investigation is being conducted and shall be given the opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. Interviews with such individuals may be conducted. Such investigation shall not constitute a hearing nor shall the procedural rules with respect to hearings or appeals set forth in these Bylaws be applicable. No investigation shall be considered to preclude the Facility MEC from taking any action as may be warranted by the circumstances or the incidents involving the individual under investigation.

When peer review investigation is deemed appropriate by the Facility MEC, an investigation will begin. An external review will occur if, in the judgment of the Chief of the Medical Staff, one of the following situations exists.

1. Department members available for internal review are in a significantly competitive situation such that objectivity may be jeopardized.
2. Department members available for internal review are in a business arrangement with the physician in question such that objectivity may be jeopardized.
3. The peer review issue is of such a specialized nature that there is no internal expert with sufficient knowledge to conduct the review.
4. Other circumstances that are deemed appropriate.

10.4
Facility MEC Action

Within seven (7) days following the receipt of a request for corrective action or following receipt of a report pursuant to a departmental investigation or Facility MEC investigation, the Facility MEC shall take action upon the request. If the corrective action could involve a reduction or a suspension of clinical privileges, or a suspension or expulsion from the Medical Staff, the affected practitioner shall be permitted to appear before the Facility MEC prior to its taking action. This appearance shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect shall apply. A record of such Facility MEC action may include but shall be limited to the following:

A. A determination that no corrective action need to be taken.
B. A determination to defer any corrective action for a reasonable time when circumstances warrant.
C. The issuance of a letter of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude department chairmen from issuing written or oral warnings outside of the mechanism for corrective action.
D. A recommendation to the Board imposing terms of probation or special limitation upon continued Medical Staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or proctoring.
E. A recommendation to the Board for the reduction, modification, suspension or revocation of clinical privileges.
F. A recommendation to the Board for the reduction of membership status or the limitation of any prerogatives directly relation to the member’s delivery of patient care.
G. A recommendation to the Board for the suspension, revocation, or probation of medical staff membership. The Chief of the Medical Staff shall promptly notify the CEO in writing of all requests for corrective action received by the Facility MEC and shall continue to keep the Chief Executive Officer fully informed of all action taken in connection therewith.

10.5
Summary Suspension

A. Criteria – Whenever an individual who has been granted clinical privileges: (1) displays conduct which necessitates that immediate action be taken to protect the life or well-being of any patient or to reduce a substantial and imminent likelihood of significant impairment of the life, health, or safety of any patient, prospective patient, or other person; or (2) the individual is excluded by the Federal or State government from participation in Medicare, State health care programs, or other Federal non-procurement programs based on the authority contained in Sections 1128 and 1156 of the Social Security Act, the CEO or designee in conjunction with the Chief of the Medical Staff or designee, the Board, or at least two members of the Facility MEC may summarily suspend the clinical privileges of such individual. Such summary suspension shall become effective immediately upon imposition, and written notice shall be promptly provided to such individual. The summary suspension shall remain in effect for the period stated in the notice, or if none, until resolved as set forth in Subsection B and C of this section 10.5 In the event such individual is a Staff member, and unless otherwise indicated by the terms of the summary suspension, such member’s patients shall be promptly assigned to another Staff member by the department chairman or by the Chief of the Medical Staff. The wishes of the patient shall be considered in the assignment.

B. Facility MEC – Not later than thirty (30) calendar days after the imposition of such summary suspension, a meeting of the Facility MEC shall be convened to review and consider the action. Upon request of the Facility MEC, the affected individual may attend the meeting and make a statement concerning the issues under investigation, on such terms and conditions as the Facility MEC may impose, provided, in no event shall such meeting of the Facility MEC, whether with or without the presence of such individual, constitute a hearing within the meaning of Article XI of these Bylaws or the Fair Hearing Plan. The Facility MEC shall modify, continue, or terminate the summary suspension, in all such events furnishing written notice of its decision to the individual.

C. Procedural Rights – Following the Facility MEC's decision, unless the Facility MEC terminates the summary suspension within thirty (30) calendar days after its imposition, the affected individual shall be entitled to the procedural rights afforded by Article XI and the Fair Hearing Plan.

10.6
Automatic Suspension

In the following instances, the individual's privileges or membership shall be suspended automatically, which action shall be final without a right to hearing or further review:

A. Revocation or suspension of licensure – Whenever an individual's license authorizing practice in the state of N.C. is revoked or suspended, clinical privileges and, if the individual is a staff member, staff membership automatically shall be revoked as of the date such action becomes effective. Whenever an individual's licensure authorizing practice in the State of N.C. is limited or restricted by the applicable licensing authority, any clinical privileges granted to the individual within the scope of such limitation or restriction automatically shall be limited or restricted in a similar manner, as of the date such action becomes effective and throughout its duration.

B. Controlled substances – Whenever an individual practitioner's DEA certificate is revoked or suspended, this action will automatically result in a review of the practitioner's clinical privileges and Staff membership as of the date such action became effective. Whenever an individual's DEA certificate is limited or restricted, any clinical privileges granted to the individual within the scope of such limitation or restriction automatically shall be limited or restricted in a similar matter as of the date such action became effective and throughout its duration.

C. Medical Records – Staff members shall be required to complete medical records within such reasonable time periods as are described by the Medical Staff Rules and Regulations. A limited suspension in the form of withdrawal of admitting privileges until medical records are completed shall be imposed after notice of delinquency for failure to complete medical records or other violations as outlined in the medical record policy.

D. Out of Date Requirements - When recurring and standard credentials requirements expire (including but not limited to: PPD, BLS, CME), the practitioner will be notified and will be allowed 30 days to submit proof of compliance. Failure to do so may result in automatic suspension until such proof is submitted.

10.7
Impaired Physician
A policy on the regulations concerning the Impaired Physician is attached to these Bylaws.

ARTICLE XI
Confidentiality, Immunity, and Release

11.1
Special Definitions

For the purposes of this Article, the following definitions shall apply.

A. "Information" means record of proceedings, minutes, interviews, records, reports, forms, memoranda, statements, recommendations, findings, evaluations, opinions, conclusions, actions, data, and other disclosures or communications in written or oral form relating to any subject matter specified in Section 12.3 of this Article.

B. "Practitioner" means a medical staff member or applicant and all individuals applying for or exercising clinical privileges at the hospital.

C. “Representatives” means the Board and any director of committee thereof; the CEO or his designee; the medical staff and any organization, officer, clinical unit, department, or committee thereof which, in connection with its credentialing duties under these Bylaws, if a “medical review committee” under Chapter 131E of the General Statutes of North Carolina and a “professional review body” under the Health Care Quality Improvement Act of 1986; and any individual authorized by any of the foregoing to perform specific information gathering, analysis, use, or dissemination functions.

D. “Third parties” mean both individuals and organization providing Information and Representatives.

11.2
Authorization and Conditions

By submitting an application for staff membership or by applying for or exercising clinical privileges at the hospital, a practitioner:

A. Authorized representatives of the hospital and the medical staff to solicit, provide, and act upon information bearing on his professional ability and qualifications.

B. Agrees to be bound by the provision of this Article and that he shall have no claim against any representative who acts in accordance with the provisions of this Article.

11.3
Confidentiality of Information

Information with respect to any practitioner submitted, collected, or prepared by any representatives for the purposes of evaluating and improving the quality and efficiency of patient care, reducing morbidity and mortality, contributing to teaching or clinical research, and determining the health care services are professionally indicated and performed in compliance with applicable standards of care shall, to the fullest extent permitted by law, be confidential and privileged and shall not be used in any way except as provided herein or except as otherwise provided by law. Such confidentiality shall also extend to information of the kind that may be provided by Third Parties. Information shall not become a part of any particular patient’s record or of the general hospital records. The filing of reports under the Health Care Quality Improvement Act of 1986 shall not be deemed a breach of confidentiality.

11.4
Immunity from Liability

A. Each practitioner agrees that no representative shall be liable for damages or other relief for any decision, opinion, action, statement, or recommendation made within the scope of his duties as a representative, if such representative acts in good faith and without malice after reasonable effort under the circumstances to ascertain the truthfulness of the facts and in reasonable belief that the decision, opinion, action, statement, or recommendation is warranted by such facts.

B. Each practitioner agrees that no representative and no Third Party shall be liable for damages or other relief by reason of providing information to another representative or to an appropriate state or federal regulatory agency, concerning any practitioner who is or has been applicant to or a member of the staff or who did not does exercise clinical privileges or provide specific patient care services at the hospital, provided that such representative acts in good faith and without malice, provided such information is reported in a factual manner, and provided further that such information will not be disclosed to any other hospital, health care facility, organization of health professionals, or individuals without that practitioners express written consent.

11.5
Activities and Information Covered

A. Activities: The confidentiality and immunity provided by this Article applies to all acts, communications, proceedings, interviews, reports, records, minutes, forms, memoranda, statements, recommendations, findings, evaluations, opinion, conclusions, or disclosures performed or made in connection with any of the hospital’s activities, including but not limited to applications for appointments or clinical privileges, periodic reappraisals for reappointment or for clinical privileges, corrective action, hearings and appellate reviews,

quality improvement plan activities, utilization review plan activities, and/or other hospital and staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct.

B. Information: Information as defined in this Article may relate to a practitioner's professional qualifications, clinical ability, judgment, character, physical or mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care.

11.6
Authorizations

Each practitioner shall, upon written request of the hospital, execute general and specific authorizations in accordance with the tenor and import of this Article. Execution of such authorizations is not a prerequisite to the effectiveness of this Article.

11.7
Cumulative Effect

Provisions in these Bylaws and in application forms relating to authorization, confidentiality of information, or immunities from liability are in addition to other protections provided by law and not in limitation thereof.

ARTICLE XII
General Provisions

12.1
Staff Rules and Regulations

A. Adoption – Subject to approval by the governing body, the Facility MEC may adopt such Rules and Regulations necessary to implement more specifically the general principles set forth in these Bylaws. These shall relate to the proper conduct of medical staff organizational activities as well as embody the level of practice that is to be required for each practitioner in the hospital.

B. Amendment – Such Rules and Regulations shall be a part of these Bylaws, except that they may be amended or repealed by the Facility MEC. Such changes shall become effective when approved by the governing body.

12.2
Department Rules and Regulations

Subject to the approval of the Facility MEC, each department may formulate its own rules and regulations for the conduct of its affairs. Such rules and regulations shall be consistent with these Bylaws, the Rules and Regulations, if any, of the medical staff, and other policies of the hospital.

12.3
Staff Assessments

The Facility MEC will establish the amount of the annual staff assessment Assessments shall be payable at the beginning of each new medical staff year. Failure, unless excused by the Facility MEC for good cause, to render payment within two (2) months following the commencement of the medical staff year, shall, after special notice of delinquency, result in summary suspension of staff membership (including all prerogatives) and clinical privileges until the delinquency is remedied.

12.4
Special Assignments

If funds of the medical staff are insufficient for any expenditure authorized by the Facility MEC, additional funds may be obtained through a special assessment of the medical staff. Approval of such assessment shall be by at least a two-thirds (2/3) vote of those present at any regularly scheduled or called medical staff meeting.

Article XIII
Medical Staff Bylaws Amendment Process

13.1
Proposal of Amendments

Amendments to any Section of the Medical Staff Bylaws may be proposed for consideration by the Voting Medical Staff as follows:

A. The Facility MEC may propose amendments to the Medical Staff Bylaws, provided that the following must occur before the proposal shall be considered by the Voting Medical Staff:

1. Copies of the proposed amendments must be delivered to the Bylaws Committee and the Facility Credentials Committee (when deemed appropriate by the facility MEC), each of which shall independently review the proposed amendments and provide a report of its recommendations to the Facility MEC.

2. Copies of the proposed amendments must be delivered to all members of the Medical Staff at least thirty (30) days prior to being voted upon by the Facility MEC. Any member of the Medical Staff wishing to submit written comments to the Facility MEC regarding the proposed amendments must do so at least fifteen (15) days prior to the proposed amendments being voted upon by the Facility MEC.

B. Members of the Medical Staff may propose amendments to the Medical Staff Bylaws, provided that the following must occur before the proposal shall be considered by the Voting Medical Staff:

1. The proposed amendments must be endorsed by at least ten percent (10%) of the Voting Medical Staff.

2. Copies of the proposed amendments and a document evidencing endorsement by the requisite percentage of the Voting Medical Staff must be delivered to the Bylaws Committee and the Facility Credentials Committee (when deemed appropriate by the facility MEC) each of which shall review the proposed amendments and provide a report of its recommendations to the Facility MEC.

3. Copies of the proposed amendments and a document evidencing endorsement by the requisite percentage of the Voting Medical Staff must be delivered to the Facility MEC. The Facility MEC shall review the proposed amendments, together with the recommendations of the Bylaws Committee and the Facility Credentials Committee, prior to taking a vote.

13.2
Voting On Amendments

Any proposed amendments that have satisfied the requirements set forth in Part A above shall be submitted to the Voting Medical Staff in a manner determined by the Facility MEC. The Facility MEC shall simultaneously deliver to the Voting Medical Staff a copy of any written report prepared by the Facility MEC in accordance with Section 13.1 above. To be adopted, the proposed amendments must receive a majority of the votes cast by the Voting Medical Staff. Typically any proposed amendments will be considered at the next quarter medical staff meeting following a final adoption by the Facility MEC. However, on the rare occasion that a proposed amendment is time-sensitive and a meeting cannot be called, the Facility MEC reserves the right to submit the proposed amendments to the medical staff electronically and in return consider an electronic vote (email, web-based survey, etc.).

13.3
Governing Body Approval

All amendments to the Medical Staff Bylaws adopted by the Voting Medical Staff pursuant to the procedures in Part B above shall be submitted to the Board and shall become effective only after approval by the Board.

13.4
Resolution of conflict between the Medical Staff and Facility MEC

In the event of any conflict between the Medical Staff Body, the Facility MEC and/or Administration, including but not limited to any conflict involving amendments to these Bylaws or the adoption or amendment of any rule, regulation or policy, the conflict resolution process set forth in this section shall be followed.

A. In the event of a conflict, any member of the Medical Staff or any member of the Facility MEC may request a meeting to discuss the conflict. The request must be submitted in writing to the Chief of Staff, and copied to the hospital Administrator, and must generally describe the conflict between the Medical Staff and the Facility MEC. The Chief of Staff shall set the time and place for the meeting, which shall be held within ten (10) days of receipt of the written request for the meeting. The Medical Staff shall be represented at the meeting by three (3) members of the Active Medical Staff (the "Medical Staff Representatives"). The Medical Staff Representatives shall be selected by the Medical Staff members who are entitled to vote at any meeting of the Medical Staff. The meeting shall be attended by the Medical Staff Representatives, the members of the Facility MEC, Chief of Staff and a representative from Administration.

B. The Chief of Staff and Facility Administrator will co-chair the meeting. Each person attending the meeting (an "Attendee") shall acknowledge the conflict and the different perspectives shall be shared in an environment of respect. Each Attendee shall have the opportunity to ask questions of the other Attendees and to gather information to better understand the basis of the conflict, as well as the perspective of the other Attendees. Each Attendee shall engage active listening skills when discussing the conflict and the Attendees shall have the opportunity to discuss the positions without judgment, with the intent of protecting the safety of patients and improving the quality of care. The Attendees are encouraged to resolve the issue informally at this meeting.

C. However, in the event the Attendees are unable to reach a resolution of the conflict, one or more objective and appropriate third party representatives, jointly agreed upon by the Chief of Staff, the Facility Administrator and the Medical Staff Representative may be consulted. Examples of a third party may include, but is not limited to, the CMC-NorthEast Advisory Board, an outside mediator, or an appropriate leadership representation from another CHS facility. All Attendees may attend the meeting and shall have an opportunity to be heard regarding the conflict. The third party shall resolve the conflict within thirty (30) days and shall transmit a decision to the Medical Staff Representatives, the Facility MEC and the Administrator. The decision made by the third party shall be binding.

13.5
Exclusivity

The mechanism described herein shall be the sole method for amendment of these Bylaws. These Bylaws may not be unilaterally amended by either the governing body or the medical staff and should be reviewed annually.

13.6
Construction of Terms and Headings
Except as otherwise expressly stated herein, words used in these Bylaws shall be read as the masculine or feminine gender and the singular or the plural, as the context requires. The captions and headings in these Bylaws are for convenience only and are not intended to limit or define the scope or effect of any provision of these Bylaws.

ARTICLE XIV
Financial Distribution

14.1
Net Earnings

No part of the organization's net earnings will inure to the benefit of any member.

14.2
Dissolution

In the event of the dissolution of the medical staff, the assets will be distributed to a successor organization qualified under Federal Regulation 501(c)(6) or to CMC-NorthEast if it is qualified under Section 501 (c)(3), or to some other 501(c)(3) organization providing health care services in Cabarrus County.

ARTICLE XV
Adoption

These Bylaws shall be adopted and made effective upon their approval by the governing body and shall supersede and replace any and all previous Bylaws, and henceforth, all activities and actions of the medical staff and of each individual exercising clinical privileges in the hospital shall be taken pursuant to the requirements of these Bylaws, and these bylaws should be reviewed annually by the Facility MEC.