Wellstar Health System

MEDICAL STAFF BYLAWS

OVERVIEW

These are the Medical Staff Bylaws for the Medical Staffs of Wellstar Health System, which includes Wellstar Cobb Medical Center, Wellstar Douglas Medical Center, Wellstar Kennestone Regional Medical Center, Wellstar North Fulton Medical Center, Wellstar Paulding Medical Center, Wellstar Spalding Medical Center, Wellstar Sylvan Grove Medical Center, Wellstar West Georgia Medical Center, Wellstar Windy Hill Hospital, and any other hospital which is or becomes part of Wellstar Health System. The Bylaws explain the rights of the Medical Staff; the qualifications for Medical Staff members, advanced practice professionals, and allied health professionals; and the basic steps in the appointment, reappointment and clinical privileging processes. They also describe how the Medical Staff governs itself and how it is organized by Medical Staff category and Clinical Departments. Finally, the Bylaws address how the Medical Staff reviews and investigates clinical competence and professional behavior concerns and the procedures used for hearings and appeals.

Organization of the Bylaws

The Bylaws are organized into the following articles:

Important Concepts

- Only Physicians, Oral and Maxillofacial Surgeons, Podiatrists, Dentists, and Psychologists who meet the qualifications in these Bylaws are eligible to be members of the Medical Staff. Others, such as CRNAs, certified nurse midwives, NPs and PAs, may hold clinical privileges but they are not eligible to be members of the Medical Staff.

- Being granted membership on the Medical Staff means the same thing as being appointed or reappointed to the Medical Staff.

- When the word "Practitioner" is used, it refers both to members of the Medical Staff and to those individuals who hold clinical privileges but are not members, such as CRNAs, certified nurse midwives, NPs and PAs.

- It is a privilege to serve on the Medical Staff and to exercise clinical privileges. Members and those holding clinical privileges must fulfill certain obligations and responsibilities such as providing quality care to patients and treating all patients, visitors and members of the healthcare team with respect, courtesy, and dignity.

- Terms of membership and clinical privileges cannot be for longer than two years, but they may be for two years or less. Members and those holding clinical privileges must apply for reappointment and renewal of clinical privileges at least every two years.

- Whenever the Hospital President deems it appropriate, s/he may delegate the performance of duties to a designee, and all references to the Hospital President include his/her designee.

- References to a "Clinical Department" or "Department" also include "sections" unless the context clearly requires otherwise.

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

- An abbreviated table of contents follows this overview. Detailed tables of contents are included at the beginning of each article.

- Definitions are set forth at the end of these Bylaws beginning on page 116.

- Adoption and approval dates for these Bylaws are listed on Appendix A.

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Wellstar Health System

MEDICAL STAFF BYLAWS

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ARTICLE I – GOVERNANCE

Section 1-1. Medical Staff Purpose and Authority

A. Purpose

The purpose of this Medical Staff is to organize the activities of Physicians and other clinical Practitioners who practice at Wellstar Health System in order to carry out, in conformity with these Bylaws, the functions delegated to the Medical Staff by the Board of Trustees.

B. Authority

Subject to the authority and approval of the Board of Trustees acting on behalf of the individual Hospital operating entities, the Medical Staff will exercise such power as is reasonably necessary to discharge its responsibilities under these Bylaws and associated Rules and Regulations, and policies and under the corporate Bylaws of the Wellstar Health System.

Section 1-2. Responsibilities of the Organized Medical Staff

The organized Medical Staff performs the following responsibilities through its officers, Medical Staff committees, Clinical Departments and sections:

A. Establish a framework for self-governance of the Medical Staff, and develop, follow and enforce Medical Staff Bylaws, Rules and Regulations, and policies;

B. Be accountable to the Board of Trustees for the safety, quality and efficiency of patient care provided by those authorized to practice in the Hospital and provide the Board of Trustees with regular reports and recommendations on quality improvement and outcome management processes;

C. Provide patients with safe, high-quality care that meets acceptable standards and available community resources;

D. Establish professional criteria and a process for appointment and reappointment to the Medical Staff and for granting delineated clinical privileges;

E. Evaluate and make recommendations to the Board of Trustees regarding the qualifications of an individual for appointment, reappointment and/or clinical privileges;

F. Maintain Medical Staff compliance with accreditation standards and applicable federal and state law;

G. Provide a means for communication and conflict management between the Medical Staff, Hospital and Board of Trustees;

H. Initiate and pursue collegial and remedial action when needed and establish a mechanism for fair hearing and appellate review;

I. Collaborate with the Hospital in providing uniform patient care processes throughout the Hospital and coordinate care with nursing and other patient care Departments;

J. Provide oversight for managing patient specific information, including but not limited to, review for completeness, timeliness and clinical pertinence of patient medical data and related records;

K. Establish an organizational structure and mechanisms that allow on-going monitoring, evaluation and improvement in patient care practices;

L. Provide leadership and participate in Hospital initiatives to measure and improve performance such as quality assessment, performance improvement, risk management, case management, utilization review and resource management;

M. Be actively involved in the measurement, assessment and improvement of medical assessment and treatment of patients; medication usage, the formulary and adverse drug reactions; blood and blood components utilization; surgical and invasive procedures; clinical practice patterns; autopsies and hospital-acquired infections;

N. Facilitate continuing education fashioned at least in part on the needs demonstrated through the quality improvement process, new state-of-the-art developments and other perceived needs, to assist in maintaining patient care standards and encourage continuous advancement in professional knowledge and skill; and

O. Promote the academic educational mission of residency training, where applicable, within Wellstar's Hospitals and clinics to provide outstanding clinical training that is patient-centered, academically rigorous and passionately delivered with uncompromising dedication and compassion; assist with career development of residents through mentorship; continually seek opportunities that afford scholarly inquiry for our trainees in an environment which fosters intellectual curiosity; support a culture that ensures the wellbeing of each and every trainee.

Section 1-3. Officers of the Medical Staff and MEC At-Large Members

A. Officers of the Medical Staff

1. Chief of Staff
2. Vice Chief of Staff

B. Qualifications of Officers

1. Officers must:
    a. Be members in good standing of the Active category and be actively involved in patient care in the Hospital;
    b. Indicate a willingness and ability to serve;
    c. Have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges;
    d. Have participated in Medical Staff leadership training and/or be willing to participate in such training during their term of office;
    e. Be in compliance with the professional conduct policies of the Hospital.

    Nominees that have some leadership experience by either chairing a committee or Department are preferred. The Nominating Committee will have discretion to determine if a staff member wishing to run for office meets the qualifying criteria.
2. Officers shall not simultaneously hold a MEC, Board, Department Chair, or equivalent position at a non-Wellstar hospital or health system. Noncompliance with this requirement may result in the officer being removed from office pursuant to Section 1-3, G.
3. Each Medical Staff officer shall disclose to the Medical Staff any leadership position at a non-Wellstar facility or ownership or financial interest that may conflict with, or have the appearance of conflicting with, the interests of the Medical Staff or Hospital.

C. Election of Officers

1. The Medical Staff shall receive notification of an election at least sixty (60) days prior to any such election.

2. The Nominating Committee is composed of the Chief of Staff, Vice-Chief of Staff, one or two past Chiefs of Staff (if available), the Vice President of Medical Affairs and the Hospital President. The VPMA and Hospital President are non-voting members.

3. The Nominating Committee shall offer at least one nominee for each available position. Nominations must be announced, and the names of the nominees distributed to all members of the Active staff at least thirty (30) days prior to the election.

4. A petition signed by at least ten percent (10%) of the members of the Active staff may add nominations to the ballot. The Medical Staff must submit such a petition to the Chief of Staff at least fourteen (14) days prior to the election for the nominee(s) to be placed on the ballot. The Nominating Committee must determine if the candidate meets the qualifications in Section 1-3, B above before s/he can be placed on the ballot.

5. Officers shall be elected prior to the expiration of the term of the current officers. Only members of the Active category shall be eligible to vote. The nominee(s) who receives the majority of votes cast will be elected. In the event of a lack of a majority vote, the MEC will arrange for a repeat vote between the two candidates receiving the most votes. Further, in the event that a nominee runs unopposed, no election will be required and the nominee shall be elected automatically.

D. Term of Office

All officers serve a term of two (2) years. They shall take office in the month of January. An individual may be reelected for two successive terms; an individual may be elected to further successive terms only if no other candidate is willing to run for the position. Officers cannot hold more than one Medical Staff office at the same time. Each officer shall serve in office until the end of his/her term of office or until a successor is appointed/elected or unless s/he resigns sooner or is removed from office.

E. Vacancies of Office

If there is a vacancy in a Medical Staff officer position during the Medical Staff year, except the office of the Chief of Staff, the MEC shall appoint a qualified Medical Staff member to serve the remainder of the term. If there is a vacancy in the office of the Chief of Staff, the Vice Chief of Staff shall serve the remainder of the term.

F. Duties of Officers

1. Chief of Staff

The Chief of Staff shall represent the interests of the Medical Staff to the MEC, Hospital administration, and the Board. The Chief of Staff is the primary elected officer of the Medical Staff and is the Medical Staff's advocate and representative in its relationships to the Board and Hospital administration. The Chief of Staff, jointly with the MEC, provides direction to and oversees Medical Staff activities related to assessing and promoting continuous improvement in the quality of clinical services and all other functions of the

Medical Staff as outlined in the Medical Staff Bylaws, Rules and Regulations, and policies. Specific responsibilities and authority are to:

a. Call and preside at all general and special meetings of the Medical Staff;

b. Serve as chair of the MEC and as ex officio member of all other Medical Staff committees without vote, and participate as invited by the Hospital President or the Board on Hospital or Board committees;

c. Enforce Medical Staff Bylaws, Rules and Regulations, and Medical Staff/Hospital policies;

d. Except as stated otherwise, appoint Medical Staff committee chairs and all members of standing and ad hoc Medical Staff committees; in consultation with Hospital administration, appoint Medical Staff members to appropriate Hospital committees or to serve as Medical Staff advisors or liaisons to carry out specific functions; as requested by and in consultation with the chair of the Board, appoint the Medical Staff members to appropriate Board committees when those are not designated by position or by specific direction of the Board or otherwise prohibited by state law;

e. Support and encourage Medical Staff leadership and participation on interdisciplinary clinical performance improvement activities;

f. Report to the Board or the appropriate Board subcommittee the MEC's recommendations concerning appointment, reappointment, delineation of clinical privileges or specified services, and corrective action with respect to Practitioners who are applying for appointment or privileges, or who are granted privileges or providing services in the Hospital;

g. Continuously evaluate and periodically report to the Hospital, MEC, and the Board regarding the effectiveness of the credentialing and privileging processes;

h. Review and enforce compliance with standards of ethical conduct and professional demeanor among the Practitioners on the Medical Staff in their relations with each other, the Board, Hospital administration, other professional and support staff, and the community the Hospital serves;

i. Communicate and represent the opinions and concerns of the Medical Staff and its individual members on organizational and individual matters affecting Hospital operations to Hospital administration, the MEC, and the Board;

j. Attend Board meetings and Board committee meetings as invited by the Board;

k. Ensure that the decisions of the Board are communicated and carried out within the Medical Staff;

l. Perform any duty of any Department Chair or Medical Staff committee chairperson if the chairperson is not available or otherwise fails to perform their duties; and

m. Perform such other duties and exercise such authority commensurate with the office as are set forth in the Medical Staff Bylaws.

2. Vice Chief of Staff

The Vice Chief of Staff or his/her designee shall serve as the chair of the Peer Review Committee. If the Chief of Staff is unavailable, the Vice Chief of Staff shall assume all the duties and have the authority of the Chief of Staff. S/he shall perform such further duties to assist the Chief of Staff as the Chief of Staff, the MEC, or the Board of Trustees may request from time to time.

G. Removal and Resignation from Office

1. Grounds for Removing a Medical Staff Officer

Grounds for removal shall be:

a. Failure to meet the responsibilities assigned within these Bylaws;

b. Failure to comply with the Rules and Regulations, and/or policies of the Medical Staff; or

c. For conduct or statements that are lower than the standards of the Medical Staff or Hospital or that is disruptive to the orderly operations of the Medical Staff or Hospital.

2. Process for Removal

A Medical Staff officer may be removed by the MEC and by the Active staff members. The Medical Staff may initiate the removal of any officer if at least ten percent (10%) of the Active members sign a petition advocating for such action and setting forth the ground(s) for removal. Removal of a Medical Staff officer may be approved by: (a) an affirmative vote by two-thirds (2/3) of the voting members of the Medical Staff and (b) an affirmative vote by two-thirds (2/3) of the MEC. Voting members of the Medical Staff must vote to remove a Medical Staff officer in-person at a specially called Medical Staff meeting; they cannot vote by proxy or ballot to remove a Medical Staff officer. Removal of a Medical Staff officer shall become effective upon approval by the Board.

3. Automatic Removal

If the MEC determines by a majority vote that an officer becomes noncompliant with any qualifying criteria for being an officer, the officer shall be automatically removed from office.

4. Resignation

Any elected officer may resign at any time by giving written notice to the MEC. Such resignation takes effect on the date specified in the written notice, and if no time is specified, then the resignation takes effect when a successor is elected.

H. MEC At-Large Members

MEC At-Large Members advise and support the Medical Staff officers and are responsible for representing the needs/interests of the entire Medical Staff, not simply representing the preferences of their own clinical specialty. MEC At-Large Members are subject to the provisions in this Section regarding qualifications, elections, term of office, vacancies, removal and resignation.

Section 1-4. Medical Staff Organization

A. Organization of the Medical Staff

The Medical Staff shall be organized into Departments. The Medical Staff may create clinical sections within a Department to facilitate Medical Staff activities. A list of Departments organized by the Medical Staff and formally recognized by the MEC is listed in the Rules and Regulations.

The MEC, with approval of the Board, may designate new Medical Staff Departments or clinical sections or dissolve current Departments or clinical sections as it determines will best promote the Medical Staff needs for promoting performance improvement, patient safety, and effective credentialing and privileging.

This Section 1-4 shall not apply to Wellstar Sylvan Grove Medical Center.

B. Assignment to Department

The MEC will, after consideration of the recommendations of the Chair of the appropriate Department, recommend Department assignments for all members in accordance with their qualifications. Each member will be assigned to one primary Department. Clinical privileges are independent of Department assignment. Practitioners who exercise clinical privileges within a Department are subject to its rules and regulations and to the authority of its Chair.

C. Qualifications, Selection, Term, and Removal of Department Chair

1. **Qualifications**: Each Department must have a Chair. All Chairs must be:

   a. Members of the Active Medical Staff in good standing;

   b. Members of and have relevant clinical privileges in the Department they are to lead;

   c. Board certified by an appropriate specialty board or have otherwise met the Threshold Eligibility Criterion related to board certification; and

   d. Able and willing to perform the responsibilities of the position.

   A Department Chair shall not simultaneously hold a MEC, Board, or equivalent position at a non-Wellstar hospital or health system; noncompliance with this requirement may result in the officer being removed from office by the MEC pursuant to Section 1-4, C.4.

   Each Department Chair shall disclose to the Medical Staff any leadership position at a non-Wellstar facility or ownership or financial interest that may conflict with, or have the appearance of conflicting with, the interests of the Medical Staff or Hospital.

2. **Selection**: The Active members of the Department will be queried for nominations for Department Chair. Unopposed candidates for Chair are elected automatically, and no voting is necessary. Where there are opposing candidates, Department Chairs shall be elected by majority vote of the Active members of the Department, subject to ratification by the MEC. If the post of Department Chair is vacated, the Department Vice Chair will serve out the remainder of the unexpired term.

3. **Term and Term Limits**: Each Department Chair shall serve a term of two (2) years commencing on January 1 and may be elected to serve successive terms. Each Department Chair shall serve in office until the end of his/her term of office or until a successor is appointed/elected or unless s/he resigns sooner or is removed from office.

4. **Removal and Resignation of the Department Chair**

   a. **Grounds for Removal:**

      Grounds for removal shall be:

      i. Failure to meet the responsibilities assigned within these Bylaws;

      ii. Failure to comply with Rules and Regulations, and policies of the Medical Staff; or

      iii. For conduct or statements that that are lower than the standards of the Medical Staff or Hospital or that is disruptive to the orderly operations of the Medical Staff or Hospital.

   b. **Process for Removal:** A Department Chair may be removed by the MEC, or by the Active staff members of the Department followed by ratification by the MEC. The members of the Department may initiate the removal of any Department Chair if at least twenty percent (20%) of the Active members of the Department sign a petition advocating for such action and setting forth the ground(s) for removal. Removal of a Department Chair may be approved by an affirmative vote by two-thirds (2/3) of those Active staff members of the Department voting in-person at a Department meeting followed by a majority vote of the MEC. The MEC may also remove the Department Chair by a two-thirds (2/3) vote of the MEC.

   c. **Automatic removal:** If the MEC determines by a majority vote that a Department Chair becomes noncompliant with any qualifying criteria for being a Department Chair, the Department Chair shall be automatically removed from office.

   d. **Resignation:** Any Department Chair may resign at any time by giving written notice to the MEC. Such resignation takes effect on the date specified in the written notice, and if no time is specified, then the resignation takes effect when a successor is elected.

D. Responsibilities of Department Chair

1. To oversee all clinically-related activities of the Department;

2. To oversee all administratively-related activities of the Department, unless otherwise provided by the Hospital;

3. To provide ongoing surveillance of the performance of all individuals in the Medical Staff Department who have been granted clinical privileges;

4. To recommend to the Credentials Committee the criteria for requesting clinical privileges that are relevant to the care provided in the Medical Staff Department;

5. To recommend clinical privileges for each member of the Department and other licensed independent Practitioners practicing with privileges within the scope of the Department;

6. To assess and recommend to the MEC and Hospital administration off-site sources for needed patient care services not provided by the Medical Staff Department or the Hospital;

7. To integrate the Department into the primary functions of the Hospital;

8. To coordinate and integrate interdepartmental and intradepartmental services and communication;

9. To develop and implement Medical Staff and Hospital policies and procedures that guide and support the provision of patient care services and review and update these, at least triennially, in such a manner to reflect required changes consistent with current practice, problem resolution, and standards changes;

10. To recommend to the Hospital President sufficient numbers of qualified and competent persons to provide patient care and service;

11. To provide input to the Hospital President regarding the qualifications and competence of Department or service personnel who are not licensed independent Practitioners (LIPs) but provide patient care, treatment, and services;

12. To continually assess and improve of the quality of care, treatment, and services;

13. To maintain quality control programs as appropriate;

14. To orient and continuously educate all persons in the Department; and

15. To make recommendations to the MEC and the Hospital administration for space and other resources needed by the Medical Staff Department to provide patient care services.

E. Qualifications, Selection, Term, and Removal of Department Vice Chair

The Department Vice Chair shall be subject to the same qualification, method of selection, term, and removal provisions as the Department Chair as set forth in Section 1-4, C.

Section 1-5. Committees

A. Designation and Substitution

Each Hospital shall have a Medical Executive Committee (MEC) and such other standing and ad hoc committees as established by the MEC and enumerated in the Rules and Regulations. Meetings of these committees will be either regular or special. Those functions requiring participation of, rather than direct oversight by the Medical Staff may be discharged by Medical Staff representation on such Hospital committees as are established to perform such functions. The Chief of Staff may appoint ad hoc committees as necessary to address time-limited or specialized tasks.

B. Medical Executive Committee (MEC)

1. Committee Membership:

a. Composition of voting members:

i. Wellstar Cobb Medical Center: The MEC shall be a standing committee consisting of the following voting members: Officers, Credentials Chair, Department Chairs, Hospitalist, medical director of the burn service line, medical director of the critical care unit, and a Department representative for Departments with greater than 50 members.

ii. Wellstar Douglas Medical Center: The MEC shall be a standing committee consisting of the following voting members: Officers, Department Chairs, section chairs not already represented, Credentials Chair, and a Hospitalist appointed by the Chief of Staff.

iii. Wellstar North Fulton Medical Center: The MEC shall be a standing committee consisting of the following voting members: Officers, Department Chairs, Department Vice Chairs, and up to four (4) at-large members.

iv. Wellstar Paulding Medical Center: The MEC shall be a standing committee consisting of the following voting members: Officers, Credentials Chair, Department Chairs, nursing center medical director, anesthesia representative, critical care/pulmonary representative, emergency medicine representative, Hospitalist representative, pathology representative, pediatrics emergency medicine representative, outpatient primary care representative, radiology representative, and five (5) at-large members.

v. Wellstar Spalding Medical Center: The MEC shall be a standing committee consisting of the following voting members: Officers, Department Chairs, and two (2) at-large members.

vi. Wellstar Sylvan Grove Medical Center: The MEC shall be a standing committee consisting of the following voting members: Officers, one (1) at-large member, and the Immediate Past Chief of Staff.

vii. Wellstar West Georgia Medical Center: The MEC shall be a standing committee consisting of the following voting members: Officers, Department Chairs, Immediate Past Chief of Staff, one (1) at-large member designated as the Secretary for the MEC, one (1) Hospital-based representative elected by the MEC (if not already represented), and one (1) internal/family medicine hospitalist representative elected by the MEC (if not already represented).

viii. Wellstar Windy Hill Hospital: The MEC shall be a standing committee consisting of the following voting members: Officers, Department Chairs, anesthesia representative, pathology representative, hospitalist representative, two (2) orthopedics representatives, and three (3) at-large members appointed by the Chief of Staff.

ix. Wellstar Kennestone Regional Medical Center: The MEC shall be a standing committee consisting of the following voting members: Officers, Credentials Chair, Department Chairs, a Hospitalist appointed by the Chief of Staff, a Neurosciences member appointed by the Chief of Staff, a representative from Graduate Medical Education, and one additional member from each Department for every twenty-five (25) Active staff members, up to maximum of three (3) additional Department members, appointed by the Department Chair.

In the event that a Department Chair is unavailable to attend a meeting of the MEC, the Department Vice Chair may attend as a voting member of the MEC.

b. Composition of the Nonvoting Members: The non-voting attendees to the MEC shall consist of the Hospital President (or his/her designee), and the VPMA, and may include other Hospital representatives as determined by the Chief of Staff, including, but not limited to, the Chief Nursing Officer (CNO), an Advanced Practice Professional (APP) representative, and, where applicable, a representative of the Graduate Medical Education (GME) program.

c. Removal from MEC: Voting MEC members may be removed by the Chief of Staff or the MEC Chair when good cause is demonstrated, such as excessive absence. Non-voting MEC members may only be removed by the Hospital President. An officer, MEC At-Large Member, or Department Chair who is removed from his/her position in accordance with Section 1-3, G and/or Section 1-4, C above will automatically lose his/her membership on the MEC. When the chair of either a committee or a Department resigns or is removed from these positions, his/her replacement will serve on the MEC.

2. **Duties:** The duties of the MEC, as delegated by the Medical Staff, shall be to:

   a. Serve as the final decision-making body of the Medical Staff in accordance with the Medical Staff Bylaws and provide oversight for all Medical Staff functions;

   b. Coordinate the implementation of policies adopted by the Board;

   c. Submit recommendations to the Board concerning all matters relating to appointment, reappointment, staff category, Department assignments, clinical privileges, and corrective action;

   d. Report to the Board and to the Medical Staff for the overall quality and efficiency of professional patient care services provided by individuals with clinical privileges and coordinate the participation of the Medical Staff in organizational performance improvement activities;

   e. Take reasonable steps to encourage and monitor professionally ethical conduct and competent clinical performance on the part of Practitioners with privileges including collegial and educational efforts and investigations, when warranted;

   f. Make recommendations to the Board on medical administrative and Hospital management matters;

   g. Keep the Medical Staff up-to-date concerning the licensure and accreditation status of the Hospital;

   h. Participate in identifying community health needs and in setting Hospital goals and implementing programs to meet those needs;

   i. Review and act on reports from Medical Staff committees, Departments, and other assigned activity groups;

   j. Formulate and recommend to the Board Medical Staff Rules and Regulations and Medical Staff policies;

   k. Request evaluations of Practitioners privileged through the Medical Staff process when there is question about an Applicant or Practitioner's ability to perform privileges requested or currently granted;

   l. Make recommendations concerning the structure of the Medical Staff, the mechanism by which Medical Staff membership or privileges may be terminated, and the mechanisms for fair hearing procedures;

   m. Consult with administration on the quality, timeliness, and appropriateness of contracts for patient care services provided to the Hospital by entities outside the Hospital;

n. Oversee that portion of the corporate compliance plan that pertains to the Medical Staff;

o. Hold Medical Staff leaders, committees, and Departments accountable for fulfilling their duties and responsibilities;

p. Make recommendations to the Medical Staff for changes or amendments to the Medical Staff Bylaws; and

q. The MEC is empowered to act for the organized Medical Staff between meetings of the organized Medical Staff.

3. **Meetings:** The MEC shall meet at least four (4) times per year and more often as needed to perform its assigned functions. Permanent records of its proceedings and actions shall be maintained.

C. Medical Staff Credentials Committee

1. Composition

Membership of the Medical Staff Credentials Committee shall consist of at least five (5) members of the Active Medical Staff who are experienced leaders that are not Department Chairs as appointed by the Chief of Staff. The Credentials Committee shall also include at least one (1) advanced practice registered nurse (APRN) or physician assistant (PA) (or both whenever practicable), who shall be appointed by the membership of the committee. Any APRN or PA who serves on the Credentials Committee shall be entitled to vote on matters involving APP/AHPs, but shall not be entitled to vote on matters involving Physicians, Dentists, Podiatrists, Oral and Maxillofacial Surgeons, or Psychologists. Members will be appointed for two (2) year terms with the initial terms staggered such that approximately one third of the members will be appointed each year. The Credentials Chair will be appointed for a two (2) year term. The Credentials Chair and members may be reappointed for additional terms without limit. The committee may also invite non-voting attendees such as representatives from Hospital administration and the Board.

2. Meetings

The Medical Staff Credentials Committee shall meet at least ten (10) times per year and on call of the Credentials Chair.

3. Duties

a. To review and recommend action on all applications and reapplications for membership on the Medical Staff including assignments of Medical Staff category;

b. To review and recommend action on all requests regarding privileges from eligible Practitioners;

c. To recommend eligibility criteria for the granting of Medical Staff membership and privileges;

d. To develop, recommend, and consistently implement policy and procedures for all credentialing and privileging activities;

e. To review, and where appropriate act on, reports that are referred to it from other Medical Staff committees, Medical Staff, or hospital leaders;

f. To perform such other functions as requested by the MEC.

4. Confidentiality

a. The Credentials Committee shall function as a peer review committee consistent with federal and state law. All members of the committee shall, consistent with the Medical Staff and Hospital confidentiality policies, keep in strict confidence all papers, reports, and information obtained by virtue of membership on the committee.

b. The credentials file is the property of the Hospital and will be maintained with strictest confidence and security. The files will be maintained by the designated agent of the Hospital in locked file cabinets or in secure electronic format. Medical Staff and administrative leaders may access credential files for appropriate peer review and institutional reasons. Files may be shown to accreditation and licensure agency representatives with permission of the Hospital President or his/her designee.

c. Individual Practitioners may review their credentials file only upon written request approved by the Chief of Staff, Hospital President, Credentials Chair or VPMA. Review of such files will be conducted in the presence of the Medical Staff service professional, Medical Staff leader, or a designee of Hospital administration. Confidential letters of reference may not be reviewed by Practitioners and will be sequestered in a separate file and removed from the formal credentials file prior to review by a Practitioner. Nothing may be removed from the file. Only items supplied by the Practitioner or directly addressed to the Practitioner may be copied and given to the Practitioner. The Practitioner may make notes for inclusion in the file. A written or electronic record will be made and placed in the file confirming the dates and circumstances of the review.

5. Hospitals Without a Credentials Committee

The following Hospitals currently do not have a Medical Staff Credentials Committee: Wellstar Spalding Medical Center, Wellstar Sylvan Grove Medical Center, and Wellstar Windy Hill Hospital. For these Hospitals, the Medical Executive Committee shall assume and perform all duties and responsibilities that have been delegated to the Credentials Committee under these Bylaws. For purposes of the appointment and privileging process

set forth in Section 3-2, the Department Chairs, as applicable, shall review applications in accordance with Section 3-2, B and make recommendations on applications directly to the MEC for review in accordance with Section 3-2, D. Notwithstanding the foregoing, the MEC may utilize any of the methods for reviewing an application that are available to the Credentials Committee set forth in Section 3-2, C.1.

Section 1-6. Medical Staff Meetings

A. Medical Staff Meetings

1. An annual meeting and other general meetings, if any, of the Medical Staff shall be held at a time determined by the MEC. Notice of the meeting shall be given to all Medical Staff members via appropriate media (including, but not limited to, electronic mail) and posted conspicuously.

2. Except for Bylaws amendments or as otherwise specified in these Bylaws, all other items to be voted on may be done solely by electronic voting. The voting period will be closed ten (10) business days after presentation of the issue to the Active members either at a meeting or through electronic communication. The meeting will be considered closed when the voting is closed.

3. **Special Meetings of the Medical Staff**

   a. The Chief of Staff may call a special meeting of the Medical Staff at any time. The Chief of Staff must call a special meeting if so directed by resolution of the MEC. Such request or resolution shall state the purpose of the meeting. The Chief of Staff shall designate the time and place of any special meeting.

   b. Written or electronic notice stating the time, place, and purposes of any special meeting of the Medical Staff shall be conspicuously posted and shall be sent to each member of the Medical Staff at least three (3) days before the date of such meeting. No business shall be transacted at any special meeting, except that stated in the notice of such meeting.

B. Regular Meetings of Medical Staff Committees and Departments

Committees and Departments shall meet at least annually and more often as needed to perform its assigned functions; meeting notices may be given in any manner determined appropriate by the Chair. Committees and Departments may, by resolution, provide the time for holding regular meetings without notice other than such resolution.

C. Special Meetings of Committees and Departments

A special meeting of any committee or Department may be called by the applicable committee chair, Department Chair, or by the Chief of Staff.

D. Quorum

1. Medical Staff Meetings: Those eligible Medical Staff members present and voting on an issue.

2. MEC, Credentials Committee, and Medical Staff Peer Review Committee: A quorum will exist when fifty percent (50%) of the members are physically present. When dealing with Category 1 requests for expedited credentialing, the MEC quorum will consist of at least two (2) members.

3. Department meetings or Medical Staff committees other than those listed in Section 1-6, D.2 above: Those present and eligible Medical Staff members voting on an issue.

E. Attendance Requirements

1. Members of the Medical Staff are encouraged to attend meetings of the Medical Staff.

2. MEC, Credentials Committee, and Medical Staff Peer Review Committee meetings: Members of these committees are expected to attend in-person at least fifty percent (50%) of the meetings held.

3. Special meeting attendance requirements: Whenever there is a reason to believe that a Practitioner is not complying with Medical Staff or Hospital policies or has deviated from standard clinical or professional practice, the Chief of Staff or the applicable Department Chair or Medical Staff committee chair may require the Practitioner to confer with him/her or with a standing or ad hoc committee that is considering the matter. The Practitioner will be given special notice of the meeting at least five (5) business days prior to the meeting. This notice shall include the date, time, place, issue involved, and that the Practitioner's appearance is mandatory. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. The Practitioner shall not have the right to be accompanied by legal counsel at this meeting. Failure of the Practitioner to appear at any such meeting after two notices, unless excused by the MEC in its discretion for good cause shown, will result in an automatic relinquishment of the Practitioner's membership and privileges. Such termination does not give rise to a fair hearing but would automatically be rescinded if and when the Practitioner participates in the previously referenced meeting.

4. Nothing in the foregoing paragraph shall preclude the initiation of an investigation or a precautionary suspension of clinical privileges as outlined in Article IV of these Bylaws.

F. Participation by the Hospital President

The Hospital President or his/her designee may attend any general, committee, or Department meetings of the Medical Staff as an ex-officio member without vote.

G. Robert's Rules of Order

Medical Staff and committee meetings shall be run in a manner determined by the chair of the meeting. When parliamentary procedure is needed, as determined by the chair or evidenced

by a majority vote of those attending the meeting, the latest abridged edition of Robert's Rules of Order shall determine procedure.

H. Notice of Meetings

Written or electronic notice stating the place, day, and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be delivered or sent to each member of the Department or committee not less than three (3) business days before the time of such meeting by the person or persons calling the meeting. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

I. Action of Committee or Department

The recommendation of a majority of its members present at a meeting at which a quorum is present shall be the action of a committee or Department. Such recommendation will then be forwarded to the MEC for action. The chair of a committee or meeting shall vote only to cause or break a tie.

J. Rights of Ex Officio Members

Except as otherwise provided in these Bylaws, persons serving as ex officio members of a committee shall have all rights and privileges of regular members, except that they shall not vote, be able to make motions, or be counted in determining the existence of a quorum.

K. Minutes

Minutes of each regular and special meeting of a committee or Department shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The presiding committee chair or Department Chair shall authenticate the minutes and copies thereof shall be submitted to the MEC or other designated committee. A permanent file of the minutes of each meeting shall be maintained.

Section 1-7. Conflict Resolution

A. In the event the Board acts in a manner contrary to a recommendation by the MEC, involving issues of patient care or safety, the matter may (at the request of the MEC) be submitted to a Joint Conference Committee composed of the officers of the Medical Staff and an equal number of members of the Board for review and recommendation to the full the Board. The Joint Conference Committee will submit its recommendation to the Board within thirty (30) days of its meeting.

B. To promote timely and effective communication and to foster collaboration between the Board, management, and Medical Staff, the Chair of the Board, Hospital President, or the Chief of Staff may call for a meeting between appropriate leaders, for any reason, to seek direct input, clarify any issue, or relay information directly.

C. Any conflict between the Medical Staff and the Medical Executive Committee will be resolved using the mechanisms noted in Sections 2-5, A through D of these Bylaws.

Section 1-8. Review, Revision, Adoption, and Amendment

A. Medical Staff Responsibility

1. The Medical Staff shall have the responsibility to formulate, review at least biennially, and recommend to the Board any Medical Staff Bylaws, Rules and Regulations, policies, and amendments as needed. The Medical Staff can exercise this responsibility through a centralized ad hoc Bylaws Committee comprised of the Chiefs of Staff of each Hospital or their designee(s). The Medical Staff must be provided notice of the biennial review at least sixty (60) days prior to such review.

2. Such responsibility shall be exercised in good faith and in a reasonable, responsible, and timely manner. This applies equally to the review, adoption, and amendment of the related rules, policies, and protocols developed to implement the various sections of these Bylaws.

B. Methods of Adoption and Amendment to These Bylaws

1. Proposed amendments to these Bylaws may be originated by the Board of Trustees, the MEC, the centralized ad hoc Bylaws Committee, or by a petition signed by at least ten percent (10%) of Active members. All proposed amendments to these Bylaws must be reviewed by the centralized ad hoc Bylaw Committee prior to voting.

2. Each Active member of the Medical Staff will be eligible to vote on the proposed amendment via printed or secure electronic ballot in a manner determined by the MEC. All Active members of the Medical Staff shall receive at least thirty (30) days advance notice of the proposed changes. The amendment shall be considered approved by an affirmative vote by two-thirds (2/3) of votes cast by those members eligible to vote with at least twenty percent (20%) of Active members voting.

3. Bylaw amendments are not effective until they are approved by the Board.

C. Methods of Adoption and Amendment to Any Medical Staff Rules and Regulations and Policies

1. The Medical Staff may adopt Rules and Regulations and policies as necessary to carry out its functions and meet its responsibilities under these Bylaws. Rules and Regulations and policies cannot be inconsistent with these Bylaws, and any of the Rules and Regulations or policies that are inconsistent with these Bylaws are null and void.

2. Except as noted in Section 1-8, C.4 below, the MEC shall vote on the proposed language changes to the Rules and Regulations at a regular meeting, or at a special meeting called for such purpose. If the MEC proposes to adopt Rules and Regulations, or amendment thereto, the MEC must communicate the proposal to the Medical Staff prior to vote. Following an affirmative vote by the MEC, Rules and Regulations may be adopted,

amended, or repealed, in whole or in part. Any such changes shall be effective when approved by the Board.

3. Any proposed changes to the Medical Staff Rules and Regulations regarding required days of emergency call service and/or exemptions to emergency call service (*see* Section 2-2, E.4-5) are subject to the same process as amendments to these Bylaws as set forth in Section 1-8, B above. This paragraph does not apply to Wellstar Sylvan Grove Medical Center and Wellstar Windy Hill Hospital.

4. Adoption of or amendments to system-wide Medical Staff policies shall be effective when approved by the Board. All other Medical Staff policies will become effective upon approval of the MEC.

D. Technical Modifications or Compliance with Law or Accreditation Standards

1. Except as specified in this Section 1-8, D, neither the organized Medical Staff nor the Board may unilaterally amend the Medical Staff Bylaws or Rules and Regulations.

2. Either the Board or the MEC may adopt such amendments to these Bylaws, Rules and Regulations, and policies that are, in the Board or MEC's judgment, technical or legal modifications, or clarifications. Such modifications may include reorganization or renumbering, punctuation, spelling, or other errors of grammar or expression. Any such amendments adopted by the MEC shall be effective when approved by the Board.

3. In cases of a documented need for an urgent amendment to Rules and Regulations necessary to comply with law or regulation, the MEC may provisionally adopt and the Board may provisionally approve an urgent amendment without prior notification to the Medical Staff. In such cases, the MEC immediately informs the Medical Staff. The Medical Staff has the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the organized Medical Staff and the MEC, the provisional amendment stands. If there is conflict over the provisional amendment, the process for resolving conflict between the organized Medical Staff and the MEC is implemented (see Section 1-7, C). If necessary, a revised amendment is then submitted to the Board for action.

Wellstar Health System

MEDICAL STAFF BYLAWS

Article II: Membership & Categories of the Medical Staff

ARTICLE II – MEMBERSHIP & CATEGORIES OF THE MEDICAL STAFF

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ARTICLE II – MEMBERSHIP & CATEGORIES OF THE MEDICAL STAFF

Section 2-1. Basic Qualifications for Membership

Medical Staff membership is a privilege. Only Physicians, Oral and Maxillofacial Surgeons, Podiatrists, Dentists, and Psychologists who continuously meet the qualifications, standards and requirements set forth in these Bylaws and in policies adopted by the Board of Trustees are eligible to be Medical Staff members. The basic qualifications for Medical Staff membership that Applicants must meet (Threshold Eligibility Criteria) are described in Section 3-1 of these Bylaws, and Medical Staff members must continuously meet these qualifications in order to maintain their membership and clinical privileges.

Being granted membership on the Medical Staff means the same thing as being appointed or reappointed to the Medical Staff. Individuals who are granted membership on the Medical Staff are not automatically granted clinical privileges, and individuals who are granted clinical privileges are not automatically granted membership on the Medical Staff. Some individuals, such as telemedicine Physicians, locum tenens, CRNAs, certified nurse midwives, nurse practitioners, and physician assistants hold and exercise clinical privileges but are *not* members of the Medical Staff.

Section 2-2. Categories of the Medical Staff

The Medical Staff membership categories are: Active and Courtesy.

The Board of Trustees, based on the MEC's recommendation, assigns each Medical Staff member to a Medical Staff category at initial appointment and at reappointment. The rights associated with any category may be limited by special conditions attached to a member's membership by these Bylaws, the Medical Staff's Rules and Regulations or policies, or by Hospital policy.

For purpose of evaluating a Practitioner's qualification for the Active staff category, a Patient Encounter is defined as admitting or attending a patient, in-facility consultation on an inpatient, or performing an inpatient or outpatient procedure; provided that, for emergency department Practitioners, hospitalists, pathologists, radiologists, anesthesiologists, or Practitioners in a hospital-based clinic, each shift performed shall constitute a Patient Encounter. Patient Encounters are monitored periodically, and members are reassigned to an appropriate category as needed (see Section 2-2, D for requests to transfer to another Medical Staff category).

Assignments and reassignments to a Medical Staff category are final and do not entitle a member to exercise the hearing and appeal provisions of these Bylaws.

A. Active Staff

Members of this category must have served on the Medical Staff for at least one (1) year and either:

1. Had at least twelve (≥ 12) Patient Encounters per year; or
2. Attended in-person (unless a meeting is only held telephonically) at least four (4) Medical Staff or Hospital meetings per year at that Hospital or as an MEC-authorized representative for the Hospital at any System meetings; or
3. Served on the Hospital's emergency department on-call roster, in an uncompensated capacity, for at least twelve (≥ 12) days per year.

Active staff:

1. Have the right to attend and vote at meetings of the Medical Staff;
2. Are eligible to serve as a Medical Staff officer, if the member meets the qualifications for the office and is nominated and elected as provided in these Bylaws;
3. Have the right to attend and vote at meetings of the Clinical Department or specialty section to which they have been assigned;
4. Are eligible to serve as the chairperson of a Clinical Department, if the member meets the qualifications for the position and is nominated and elected as provided in these Bylaws; and
5. May serve and vote on those Medical Staff committees to which they have been appointed.

B. Courtesy Staff

Members are assigned to the Courtesy staff when they do not meet the requirements for the Active Staff Category. The prerogatives and responsibilities of the Courtesy staff are listed below.

Courtesy staff:

1. May attend meetings of the Medical Staff, but they do not have the right to vote;
2. May attend meetings of the Clinical Department or specialty section to which they have been assigned, but they do not have the right to vote;
3. Are not eligible to serve as the chairperson of a Clinical Department or specialty section; and
4. May serve and vote on those Medical Staff committees, other than the MEC, to which they have been appointed.

C. Emeritus Recognition

Emeritus Recognition is restricted to those individuals who have retired from active Hospital practice, who are of outstanding reputation, have provided distinguished service to the Hospital, and have been recommended by the MEC and approved by the Board for this Medical Staff recognition. This recognition is entirely discretionary and may be rescinded at any time. Emeritus Recognition is not a Medical Staff category. Emeritus members may attend Medical Staff, Department, or section meetings, continuing medical education activities, and may be appointed to committees. They may not hold clinical privileges, hold office, or be eligible to vote.

D. Requests to Transfer to Another Medical Staff Category

Requests to transfer to another Medical Staff category must be provided to the Medical Staff Office. The Credentials Committee and the MEC consider the request and make a recommendation on the request to the Board of Trustees, which takes final action.

Decisions on requests for transfers are final and do not entitle a member to exercise the hearing and appeals provisions of these Bylaws.

Section 2-3. Basic Obligations of Practitioners

When an Applicant applies for membership and/or clinical privileges, and for as long as a Practitioner is a Medical Staff member and/or holds clinical privileges, the Applicant or Practitioner automatically agrees to fulfill the following obligations:

A. Treat all patients, visitors and members of the healthcare team with respect, courtesy, and dignity;

B. Provide continuous care and supervision to his/her patients, seek consultation whenever necessary and per the Medical Staff's Rules and Regulations on consultations, and only delegate to those Practitioners qualified to care for patients;

C. Abide by these Bylaws, Rules and Regulations, and the policies and procedures of the Medical Staff and the Hospital, as well as the generally recognized ethics of his/her profession;

D. Each staff member and Practitioner with privileges must abide by the Medical Staff Code of Conduct and Professional Conduct Policy;

E. Each staff member and Practitioner with privileges must have current and valid professional liability insurance coverage as specified by the Board of Trustees from time to time. In addition, staff members shall comply with any financial responsibility requirements that apply under state law to the practice of their profession. Each staff member and Practitioner with privileges shall notify the Hospital President or designee immediately of any and all malpractice claims filed in any court of law against the Medical Staff member;

F. Each staff member, consistent with his/her granted clinical privileges, must participate in the on-call coverage of the emergency department, unassigned patient call, or in other Hospital coverage programs as determined by the MEC and the Board and documented in the Medical Staff Rules and Regulations, after receiving input from the appropriate clinical specialty, to assist in meeting the patient care needs of the community;

G. Successfully complete:

1. Infection control and patient safety education training approved by the MEC;

2. Health screening requirements;

3. Orientation; and

4. Any electronic health record training and associated competency validation, and use the electronic health record for all patient care documentation and order entry;

H. Appear for any requested interview about an application, clinical performance or professional behavior and permit the Medical Staff and hospital to obtain evaluations about clinical performance, health status, or behavior by a consultant;

I. Each staff member and Practitioner with privileges must submit to any pertinent type of health evaluation: (1) as requested by the officers of the Medical Staff, Hospital President, and/or Department Chair when it appears necessary to protect the well-being of patients and/or staff;

(2) when requested by the MEC or Credentials Committee as part of an evaluation of the member's or Practitioner's ability to exercise privileges safely and competently, including when there is a reasonable suspicion of impairment; or (3) as part of a post-treatment monitoring plan consistent with the provisions of any Medical Staff and Hospital policies addressing Practitioner health or impairment;

J. Each staff member and Practitioner with privileges must participate in any type of competency evaluation when determined necessary by the MEC and/or Board in order to properly delineate that member's clinical privileges;

K. Participate in on-going professional practice evaluations (OPPE), focused professional practice evaluations (FPPE) and peer review, as well as clinical improvement, risk management, patient safety, case/resource management and other improvement activities as requested;

L. Each Applicant for privileges or staff member or Practitioner with privileges agrees to release from any liability performed or made without malice, to the fullest extent permitted by law, all persons for their conduct in connection with investigating and/or evaluating the quality of care or professional conduct provided by the Medical Staff member and his/her credentials;

M. Cooperate with the Hospital in matters involving accreditation, licensure surveys and the Hospital's fiscal responsibilities and policies, including those relating to payment or reimbursement by governmental and third-party payers;

N. Disclose conflicts of interest regarding relationships with pharmaceutical companies, device manufacturers, or other vendors in accordance with the Wellstar policy on conflicts of interest and any additional policies that may be adopted by the MEC and/or required by the Board, including, but not limited to, disclosure of financial interests in any product, service, or medical device not already in use at the Hospital that a Medical Staff member may request the Hospital purchase;

O. Pay annual Medical Staff dues, if any, as determined by the MEC. The MEC may pass policies from time to time which exempt from dues payment certain categories of membership or members holding specified leadership positions;

P. Notify the Medical Staff office in writing within five (5) business days if s/he is charged with any felony or misdemeanor, including DUI (but excluding minor traffic citations such as parking or speeding tickets); or is named as a defendant in a False Claims Act lawsuit.

Q. Notify the Medical Staff office in writing immediately, and in no case more than 24 hours, if s/he:

1. Is the subject of a complaint to, or under investigation by, his/her licensing board and of any actual or proposed disciplinary actions;

2. Has a medical condition that could adversely affect his/her ability to care for patients safely and competently;

3. Is notified by his/her professional liability insurance carrier that it intends to cancel, reduce, not renew or impose any conditions on professional liability insurance coverage;

4. Loses DEA registration;

5. Is under investigation by Medicare or Medicaid or is excluded, voluntarily or involuntarily, from participating in Medicare, Medicaid or any other federally-funded healthcare program;

6. Is the subject of any adverse determination by an external peer review organization;

7. Voluntary or involuntary loss or restriction of staff membership or clinical privileges at another hospital or health care facility;

8. Suspension or summary suspension of Medical Staff membership or clinical privileges at another hospital or health care facility;

9. Is under investigation by another hospital or health care facility; or

10. Is referred to, contacts or enters into a contract or agreement with any individual, group, program or impaired physician committee because of substance abuse or other disease.

Section 2-4. History and Physical Examinations

Each staff member and Practitioner with privileges shall prepare and complete in timely fashion, according to Medical Staff and Hospital policies, the medical and other required records for all patients to whom the Practitioner provides care in the Hospital, or within its facilities, clinical services, or Departments. A history and physical examination (H&P) must be completed and documented by a Physician, Oral and Maxillofacial Surgeon, or podiatric surgeon, consistent with his/her delineated clinical privileges, or by a APP/AHP, consistent with his/her delineated clinical privileges and upon the request of his/her supervising Physician, for each patient no more than 30 days before, or 24 hours after, admission or registration, but before surgery or a procedure requiring anesthesia services. If an H&P was performed outside the hospital and completed within 30 days before admission or registration, an updated examination of the patient, including any changes in the patient's condition, must be completed and documented within 24 hours after admission or registration, but before surgery or a procedure requiring anesthesia services. All H&P documentation shall be in accordance with the terms and provisions of the Wellstar Medical Information Policy as may be in effect from time to time and with applicable state law.

Section 2-5. Medical Staff Member Rights

A. Each Active staff member has the right to a meeting with the MEC on matters relevant to the responsibilities of the MEC that may affect patient care or safety. In the event such Practitioner is unable to resolve a matter of concern after working with his/her Department Chair or other appropriate Medical Staff leader(s), that Practitioner may, upon written notice to the Chief of Staff two (2) weeks in advance of a regular meeting, meet with the MEC to discuss the issue.

B. Each staff member in the Active category has the right to initiate a recall election of a Medical Staff officer by following the procedure outlined in Section 1-3 of these Bylaws, regarding removal and resignation from office.

C. Each staff member in the Active category may initiate a call for a general staff meeting to discuss a matter relevant to the Medical Staff by presenting a petition signed by ten percent (10%) of the members of the Active category. Upon presentation of such a petition, the MEC shall schedule a general staff meeting for the specific purposes addressed by the petitioners. No business other than that detailed in the petition may be transacted.

D. Each staff member in the Active category may challenge any rule, regulation, or policy established by the MEC. In the event that a rule, regulation, or policy is thought to be inappropriate, any Medical Staff member may submit a petition signed by ten percent (10%) of the members of the Active category. Upon presentation of such a petition, the adoption procedure outlined in Section 1-8 will be followed.

E. Each staff member in the Active category may call for a Department meeting by presenting a petition signed by ten percent (10%) of the Active members of the Department. Upon presentation of such a petition the Department Chair will schedule a Department meeting.

F. The above Sections 2-5, A through E do not pertain to issues involving individual peer review, formal investigations of professional performance or conduct, denial of requests for appointment or clinical privileges, or any other matter relating to individual membership or privileges. Articles IV (Reviews and Investigations) and Article V (Hearings and Appeals) of these Bylaws provide recourse in these matters.

G. Any Practitioner eligible for Medical Staff appointment has a right to a hearing/appeal pursuant to the conditions and procedures described in Article V (Hearings and Appeals) of these Bylaws.

H. Unified Medical Staff

   1. Formation – A "unified medical staff" is created by integrating separately certified hospitals that are members of a multi-hospital system. If the Wellstar Health System Board of Trustees elects to have a unified medical staff, then the medical staff of each affected separately certified hospital must vote, by majority, in accordance with Medical Staff Bylaws, either to accept a unified and integrated medical staff structure or to opt out of such a structure and to maintain a separate and distinct medical staff for their respective hospital.

2. Dissolution – Once there is a unified medical staff, the voting members at each facility in which the member has clinical privileges, has the ability to vote to "opt out" of the unified medical staff. This would require a petition signed by ten percent (10%) of the members who would qualify for voting privileges at that campus. Upon presentation of such a petition, a medical staff meeting will be scheduled. Each voting member who would qualify for voting privileges at that campus will be eligible to vote on the proposed "opt out" amendment only if present at the meeting; no proxy ballots will be accepted. All voting members of the medical staff shall receive at least fourteen (14) days advance notice of the proposed changes. The amendment shall be considered approved by the medical staff if the medical staff receives a simple majority of the votes cast by those members eligible to vote.

Section 2-6. Leaves of Absence

The term "leave of absence" or "LOA" automatically includes "administrative leave of absence" or "ALOA," which is a category of LOA, unless the context clearly requires otherwise.

Practitioners must request a leave of absence ("LOA"), or will be placed on LOA, if they:

- Are away from patient care responsibilities for more than 90 days (> 90);
- Develop a physical or mental health condition (*e.g.,* seizure, MI, TIA/stroke, addiction or substance abuse) that may affect their ability to care for patients safely and competently; or
- Otherwise meet one of the LOA criteria described in Section 2-6, B, below.

LOAs are matters of courtesy, not of right. Determinations that a Practitioner has not demonstrated good cause for an LOA or not to grant an extension are final and do not entitle the Practitioner to exercise the hearing and appeals provisions of these Bylaws.

A. Requesting an LOA

Requests for an LOA must be submitted in writing to the Medical Staff office and include the reason for the requested LOA and the proposed duration of LOA. LOA requests may *not* be for more than one year, except as noted in Section 2-6, B.2. The Credentials Committee forwards its recommendation on the LOA request to the MEC and the Board of Trustees for final action. Practitioners cannot exercise clinical privileges and are excused from membership responsibilities (*e.g.,* committee service, etc.) during LOA, but Practitioners whose reappointment or renewal of clinical privileges period occurs during a LOA *must* complete the reappointment and clinical privileges renewal requirements if they wish to remain on the Medical Staff and/or hold clinical privileges.

B. LOA Categories

The LOA categories are described below.

1. Administrative LOA

Practitioners are placed automatically on administrative leave of absence ("ALOA") for up to 90 days when they do not meet an administrative requirement of membership or holding clinical privilege (*e.g.*, requirements that are not part of the Threshold Eligibility Criteria set forth in Section 3-1, A). The ALOA period cannot be renewed or extended. ALOAs automatically end when the Practitioner resolves the technical issue or at the end of the 90-day period, whichever occurs first. If the Practitioner has not resolved the administrative issue by the end of the 90 days, s/he must request to move to another LOA category or s/he will be deemed to have automatically and voluntarily relinquished membership and/or clinical privileges and is not entitled to exercise the hearing and appeal provisions of these Bylaws. A request for membership or clinical privileges subsequently received from the Practitioner is processed as an initial application.

APPs and AHPs are placed on ALOA for up to 90 days when: (1) their Primary Supervising Physician goes on LOA or ALOA, (2) they lose their Primary Supervising Physician, or (3) their Primary Supervising Physician resigns Medical Staff membership or clinical privileges or has his/her Medical Staff membership or clinical privileges terminated. The APP/AHP will be reinstated if s/he secures an alternate or new Primary Supervising Physician. If the APP/AHP has not secured an alternate or new Primary Supervising Physician who is a current member of the Medical Staff by the end of the 90-day period, s/he must request to move to another LOA category or will be deemed to have automatically and voluntarily relinquished clinical privileges and is not entitled to the hearing and appeals provisions of these Bylaws.

2. Military LOA

A Practitioner may request, and be granted, an LOA to fulfill military service obligations. If the Practitioner is on active military duty for more than one year, the LOA will be extended automatically until the Practitioner's active duty is completed.

3. Personal or Professional LOA

A Practitioner may request an LOA for a variety of personal and professional reasons (*e.g.,* for medical reasons, to pursue additional education, or to serve as a volunteer with Doctors without Borders, etc.). If a Practitioner does not or is not able to request LOA because of a physical or psychological condition or health issue, the Chief of Staff, in consultation with the VPMA or MEC, may place the Practitioner on LOA and inform the Practitioner of this action.

C. Reappointment During LOA

If a Practitioner's reappointment or renewal of clinical privileges period occurs during an ALOA or LOA, he/she still must complete the reappointment and/or renewal of clinical privileges application and otherwise comply with all the requirements in these Bylaws.

D. Requests for Reinstatement

This subsection does not apply to ALOAs; ALOAs automatically end when the Practitioner resolves the technical issue or at the end of the 90-day period, whichever occurs first (except for Practitioners who are placed on ALOA for failure to comply with the Medical Staff's policy on influenza vaccinations; those Practitioners may remain on ALOA for more than 90 days and will be removed from ALOA per that policy).

Requests for reinstatement must be submitted in writing to the Medical Staff office at least thirty (30) days before the end of the LOA and include a summary of the Practitioner's relevant clinical activities, if any, during the LOA. The Practitioner must provide any other information requested by the Hospital. If the reason for the LOA was related to the Practitioner's physical or mental health (including impairment due to addiction) or the ability to care for patients safely and competently, the Practitioner must submit an appropriate report from his/her healthcare provider indicating that he/she is physically and/or mentally capable of resuming a Hospital practice and safely exercising the clinical privileges requested and that answers any

questions that the MEC or Board of Trustees may have as part of its consideration of the request for reinstatement.

The Department Chair reviews the request and forwards his/her reinstatement recommendation to the Credentials Committee, which forwards its recommendation to the MEC and the Board of Trustees for final action. Reinstatement may be to the same, or different, Medical Staff category and clinical privileges may be limited, modified or be subject to monitoring or proctoring conditions.

E. Requests for an Extension

This subsection does not apply to those on military LOA or ALOA.

Except for military leave and ALOA, requests for an LOA extension must be submitted in writing to the Medical Staff office and include the reason for, and the dates of, the requested extension. Extension requests may not be for more than one additional year. The Credentials Committee forwards it recommendation on the LOA extension to the MEC and the Board of Trustees for final action. Practitioners cannot exercise clinical privileges during the extension and must complete the reappointment and clinical privileges renewal requirements if they wish to remain on the Medical Staff and/or hold clinical privileges.

F. Failure to Request an Extension or Reinstatement

Practitioners who, without good cause, do not request an extension or reinstatement are deemed to have automatically and voluntary relinquished their membership and/or clinical privileges and do not have the right to the hearing and appeal provisions in these Bylaws. A request for membership or clinical privileges subsequently received from the Practitioner is processed as an initial application.

Section 2-7. Exclusive Contracts

A. From time to time, the Hospital may enter into contracts with Practitioners and/or groups of Practitioners for the performance of clinical and administrative services at the Hospital. To the extent that any such contract confers the exclusive right to perform specified services to one or more Practitioners or groups of Practitioners, no other Practitioner except those authorized by or pursuant to the contract or resolution may exercise clinical privileges to perform the specified services while the contract or resolution is in effect. This means that only authorized Practitioners are eligible to apply for appointment or reappointment to the Medical Staff and for the clinical privileges in question. No other applications will be processed. Practitioners who have previously been granted privileges, which then become covered by an exclusive contract, will not be able to exercise those privileges unless they become authorized by or pursuant to the contract or resolution. The ineligibility to apply for appointment or reappointment or the loss of the ability to exercise previously granted privileges pursuant to this Section 2-7 does not entitle the Practitioner to exercise the hearing and appeals provisions of these Bylaws.

B. The Medical Executive Committee may review the quality-of-care ramifications of continued exclusivity or of imposition of exclusivity on any Department/service or privileges and make a recommendation to Hospital administration as to whether exclusivity is appropriate for a particular Department or specialty. The Medical Executive Committee shall collect information from the members of medical specialties that would be affected, from Hospital administration, and from other interested parties, in order to make an informed recommendation; however, the final decision to enter into an exclusive arrangement is reserved by the Hospital.

C. The effect of expiration or other termination of a contract upon a Practitioner's staff appointment and clinical privileges will be governed solely by the terms of the Practitioner's contract with the Hospital. If the contract or the employment agreement is silent on the matter, then contract expiration or other termination alone will not affect the Practitioner's staff appointment status or clinical privileges.

Section 2-8. Resigning Membership & Clinical Privileges

To resign membership and/or clinical privileges in good standing, a Practitioner must:

A. Submit a written or emailed letter of resignation to the Medical Staff office;

B. Complete all clinical, billing and record-keeping responsibilities;

C. Allow for the orderly transfer of his/her clinical responsibilities, including satisfying any unassigned patient call responsibilities;

D. Not be under an investigation as described in Article IV, have a significant case under peer review, or be subject to a Performance Improvement Plan; and

E. Not have refused to participate in collegial efforts.

Practitioners who do not meet these criteria and resign their membership or clinical privileges are deemed to have resigned not in good standing. The Credentials Committee and the MEC will forward their recommendations on the Practitioner's resignation status to the Board of Trustees for final approval.

Wellstar Health System

MEDICAL STAFF BYLAWS

Article III: Appointment, Reappointment & Clinical Privileges

ARTICLE III – APPOINTMENT, REAPPOINTMENT & CLINICAL PRIVILEGES

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ARTICLE III – APPOINTMENT, REAPPOINTMENT & CLINICAL PRIVILEGES

Being granted membership on the Medical Staff means the same thing as being appointed or reappointed to the Medical Staff. Individuals who are granted membership on the Medical Staff are not automatically granted clinical privileges, and individuals who are granted clinical privileges are not automatically granted membership on the Medical Staff. Some individuals, such as telemedicine Physicians, locum tenens, CRNAs, certified nurse midwives, nurse Practitioners and physician assistants hold and exercise clinical privileges but are *not* members of the Medical Staff.

Individuals will not be denied membership or clinical privileges based on race, creed, religion, gender, national origin, veteran's status or any other status protected by law. Individuals also are not entitled to receive an application, to be appointed to the Medical Staff or to be granted any particular clinical privileges because s/he is licensed to practice in this, or any other, commonwealth or state; is a member of any particular professional organization; has had, or currently has, Medical Staff appointment or privileges at any hospital or health care facility; resides in the geographic service area of the Hospital; or is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity.

Section 3-1. Applications for Membership and Clinical Privileges

To be eligible for membership and/or clinical privileges, a prospective Applicant must meet the Threshold Eligibility Criteria set out below; applications will not be accepted or processed from anyone who does not meet the Criteria. Prospective Applicants are not entitled to the hearing and appeal provisions in these Bylaws because of a refusal to accept or process an application for membership and/or privileges for failure to meet the criteria.

Prospective Applicants who have applications *in process* for a license, professional liability insurance or a DEA registration (*see* Sections 3-1, A.1, A.7, and A.9 below) may receive an application for membership and/or clinical privileges if they otherwise meet the criteria listed below, but membership and/or clinical privileges will not be granted until the license, insurance coverage and/or DEA registration has been issued.

A. Threshold Eligibility Criteria

1. Licensure

Applicants must have a current, active license to practice medicine, oral surgery, podiatry, general dentistry, or clinical psychology in Georgia. APP and AHP Applicants must have a current, active license/registration in Georgia, where appropriate. The license must be unrestricted for initial appointment applications.

2. Training and Certification

Applicants must demonstrate training and certification, as applicable, as follows:

a. Demonstrate that s/he has successfully graduated from an approved school of medicine, osteopathy, dentistry, podiatry, clinical psychology, or applicable recognized course of training in a clinical profession eligible to hold privileges;

b. A Physician Applicant (MD or DO) must have successfully completed an allopathic or osteopathic residency program, approved by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA) and be currently board certified or board eligible and become board certified within the time period specified by the appropriate specialty board but no longer than (7) seven years of completing formal training as defined by the appropriate specialty board of the American Board of Medical Specialties or the American Osteopathic Association, the National Board of Physicians and Surgeons (NBPAS), the American Board of Physicians and Surgeons (only for emergency medicine certification), or any boards accepted by the American Board of Medical Specialties or accepted by these bylaws. This requirement shall not apply to moonlighting residents or fellows in their final year of training.

c. A Dentist must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation;

d. An Oral and Maxillofacial Surgeons must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation and successfully completed an American Dental Association approved residency program and be board certified or become board certified within seven (7) years of completing formal training as defined by the American Board of Oral and Maxillofacial Surgery;

e. A Podiatrist (DPM) must have successfully completed a two-year (2) residency program in surgical, orthopedic, or podiatric medicine approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association (APMA), and be board certified or become board certified within seven (7) years of completing formal training as determined by the American Board of Foot and Ankle Surgery or the American Board of Podiatric Medicine;

f. A Psychologist must have an earned a doctorate degree, (PhD or Psy.D in psychology) from an educational institution accredited by the American Psychological Association and have completed at least two (2) years of clinical experience in an organized healthcare setting, supervised by a licensed Psychologist, one (1) year of which must have been post doctorate, and have completed an internship endorsed by the American Psychological Association (APA), and be board certified as appropriate to the area of clinical practice;

g. A certified registered nurse anesthetist (CRNA) must have graduated from an approved program of anesthesia accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs or a predecessor or successor agency and be currently certified by the National Board on Certification and Recertification for Nurse Anesthetists (NBCRNA), or by a predecessor or successor agency to either. Applicants may be actively seeking initial certification but must obtain the same on the first examination for which eligible.

h. A certified nurse midwife (CNM) must have successfully completed an Accreditation Commission for Midwifery Education (ACME) (formerly the American College of Nurse Midwives – ACNM) accredited nurse midwifery program and be currently certified by the American Midwifery Certification Board (AMCB). Applicants may be actively seeking initial certification but must obtain the same on the first examination for which eligible.

i. A nurse practitioner (NP) must have completed a masters, post-masters, or doctorate degree in a nurse practitioner program [acute care is preferred] accredited by the Commission on Collegiate of Nursing Education (CCNE) or the Accreditation Commission for Education in Nursing (ACEN) and be currently certified by the American Nurses Credentialing Center (ANCC) or the American Association of Critical Care Nurses (AACN) or an equivalent body. Applicants may be actively seeking initial certification but must obtain the same on the first examination for which eligible.

j. A physician assistant (PA) must have completed an Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) approved program (prior to January 2001 – Commission on Accreditation of Allied Health Education Programs) and be currently certified by the National Commission on Certification of Physician Assistants (NCCPA) as a PA-C.

k. A physician assistant anesthetist (PAA) must have completed a graduate level degree program accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP), or any of the commission's successor organizations, which qualifies the candidate to sit for the National Commission for Certification of Anesthesiologist Assistants (NCCAA) examination and be currently certified by the National Commission for the Certification of Anesthesiologist Assistants (NCCAA) as an Anesthesiologist Assistant-Certified (AA-C) is required for initial Applicants and reapplicants.

l. A certified surgical assistant must have successful completion of a surgical assistant education program accredited by the Association of Surgical Technologists or the Commission on Accreditation of Allied Health Education Programs and be currently certified by the National Board of Surgical Technology and Surgical Assisting (NBSTSA), the National Surgical Assistants Association (NSAA), or the American Board of Surgical Assistants (ABSA).

m. A radiology assistant (RA) must have current certification and registration in radiography by the American Registry of Radiologic Technologists (ARRT). Successful completion of a radiologist assistant educational program that is recognized by ARRT is required for initial Applicants and reapplicants.

n. A pathology assistant must have successfully completed an NAACLS-accredited pathologist assistant training program and be currently certified as a pathologists' assistant by the American Society of Clinical Pathology (ASCP).

o. A registered nurse first assistant (RNFA) must have successfully completed an approved AORN RNFA training program that meets the AORN standards for RNFA education programs (including a Bachelor of Science in Nursing) and be currently certified in perioperative nursing (CNOR) by the Association of Operating Room Nurses (AORN). Current RNFA certification or active participation in the certification process to be achieved within 9 months of eligibility is required for initial Applicants. Current certification is required for reapplicants. A Bachelor of Science in Nursing is required for those entering into an RNFA program after January 1, 2020.

3. Board Eligibility and Board Certification

Physicians, Oral and Maxillofacial Surgeons, and Podiatrists who apply for Medical Staff membership and/or clinical privileges must be board eligible or board certified. When recertification is required by the specialty board and an Applicant's certification has lapsed, recertification must be obtained within two years.

Current members who have met prior qualifications for membership and/or privileges on the dates listed below shall be exempt from these board certification requirements: Wellstar

Cobb Medical Center – November 9, 2007; Wellstar Douglas Medical Center – November 9, 2007; Wellstar North Fulton Medical Center – January 1, 2006; Wellstar Paulding Medical Center – November 9, 2007; Wellstar Spalding Medical Center – March 24, 1998; Wellstar Sylvan Grove Medical Center – January 1, 2020; Wellstar West Georgia Medical Center – March 1, 2020; Wellstar Windy Hill Hospital – November 9, 2007; Wellstar Kennestone Regional Medical Center – November 9, 2007. Those Medical Staff members shall be grandfathered and shall be governed by the board certification requirement in effect at the time of their initial appointments.

a. Physicians

MD Applicants must be board certified or board eligible in their primary specialty or subspecialty by an American Board of Medical Specialties (ABMS) member board, the National Board of Physicians and Surgeons (NBPAS), or the American Board of Physicians and Surgeons only for emergency medicine certification. DO Applicants must be board certified or board eligible in their primary specialty or subspecialty by the American Osteopathic Association (AOA), an ABMS member board, or the National Board of Physicians and Surgeons (NBPAS). This requirement shall not apply to residents in their final year of training.

b. Oral and Maxillofacial Surgeons

Oral and Maxillofacial Surgeon Applicants must be board certified or board eligible by the American Board of Oral and Maxillofacial Surgery (ABOMS).

c. Podiatrists

DPM Applicants must be board certified or board eligible by the American Board of Podiatric Medicine or the American Board of Foot and Ankle Surgery.

d. Psychologists

Psychologist Applicants must be board certified by the American Board of Professional Psychology (ABPP) or American Board of Medical Psychology (ABMP) in at least one (1) of the following specialties: Clinical Neuropsychology (Adult or Pediatrics), Clinical Health Psychology, Geropsychology, Addiction Psychology, Severe Mental Illness, Medical Psychology, Rehabilitation Psychology, Clinical Psychology, or Clinical Child & Adolescent Psychology within seven (7) years of the initial appointment date (or if the appointment date was prior to January, 1, 2020, then by January 1, 2027).

4. Current Competence, Experience, Ethics and Character

Applicants must provide sufficient documentation of their current clinical competence and experience to perform all privileges requested; adherence to the ethics of their profession; good reputation and character, including physical health and mental and emotional stability; have appropriate written and verbal communication skills; and show their ability to work harmoniously with others to convince the Medical Staff that all Hospital patients

treated by them will receive quality care and that the Medical Staff and Hospital will be able to operate in an orderly manner.

5. Health Status and Ability to Perform Clinical Privileges

Applicants must be able to perform the clinical privileges requested.

6. Ability to Provide Continuous and Timely Patient Care

Applicants who are requesting admitting privileges must demonstrate the capability to continuous and timely care of their patients by providing documentation of: (i) appropriate backup coverage by another member of the Medical Staff with appropriate specialty-specific privileges and (ii) an office location close enough to fulfill their Medical Staff responsibilities.

7. Professional Liability Insurance

Applicants must have current and valid individual or group professional liability insurance coverage with a qualified Georgia licensed malpractice carrier in minimum amounts of $1,000,000 per occurrence/$3,000,000 aggregate (per physician if a group policy) with defense costs written outside of, and not included within the limits and meet all other requirements as specified by the Board of Trustees from time to time. Such insurance must provide continuous, uninterrupted coverage for the entire period that the Practitioner maintains clinical privileges at the Hospital. If a Practitioner changes insurance carriers for any reason or discontinues his/her practice, s/he must maintain either: (1) prior Acts coverage on the new policy or (2) an Extended Reporting Endorsement ("Tail Coverage") on the expired policy.

8. Federally-Funded/State Healthcare Programs

Applicants cannot be excluded, suspended, debarred or otherwise declared ineligible to participate in Medicare, Medicaid or other federal or state funded healthcare program.

9. Controlled Substance Registration

Applicants, where applicable to their practice, must have a current valid Federal Drug Enforcement Administration (DEA) registration. The registration must be unrestricted for initial appointment applications.

10. Membership and Privileges at Other Healthcare Facilities

Applicants must not have had Medical Staff membership or clinical privileges suspended or terminated from a Wellstar Hospital or from any other health facility for reasons related to clinical competence or professional conduct within the last ten (10) years. Applicants also must not have had Medical Staff membership or clinical privileges automatically resigned or terminated at any Wellstar Hospital for any reason within the last twelve (12) months.

11. Clinical Activity

Applicants must demonstrate recent clinical activity in their primary area of practice in which clinical privileges are sought during the last two years;

12. Felony

Applicants must not have, in any jurisdiction within the last ten (10) years, been convicted of, or entered a plea of guilty or no contest, to any felony relating to controlled substances, illegal drugs, insurance or healthcare fraud or abuse, abuse (physical, sexual, child, or elder), or violence or been required to register as a sex offender.

13. Health Requirements

Applicants must document compliance with any current health screening and vaccination requirements (*e.g*., TB testing, mandatory vaccines, etc.).

14. Training and Education

Applicants must document compliance with all applicable training as required by the MEC or Board of Trustees, including, but not limited to, those involving electronic medical records, computerized physician order entry (CPOE), the privacy and security of protected health information, infection control, and patient safety.

15. Supervising Physician for APP/AHP

APP/AHP Applicants must have a primary supervising Physician who is a current member of the Medical Staff in good standing and must submit a copy of his/her current collaborative practice agreement that has been signed by the primary supervising Physician and any back-up supervising Physicians to the Medical Staff Services Office.

B. Waiver of Threshold Eligibility Criteria

1. Any Applicant who does not satisfy one or more of the Threshold Eligibility Criteria outlined above may request that it be waived. The Applicant requesting the waiver bears the burden of demonstrating exceptional circumstances, and that his or her qualifications are equivalent to, or exceed, the criterion in question.

2. A request for a waiver shall be submitted to the Credentials Committee for consideration. In reviewing the request for a waiver, the Credentials Committee may consider the specific qualifications of the Applicant in question, input from the relevant Department Chair, and the best interests of the Hospital and the communities it serves. Additionally, the Credentials Committee may, in its discretion, consider the application form and other information supplied by the Applicant. The Credentials Committee's recommendation will be forwarded to the MEC. Any recommendation to grant a waiver must include the specific basis for the recommendation.

3. The MEC shall review the recommendation of the Credentials Committee and make a recommendation to the Board (or a Board Proxy Committee, as defined in Section 3-2, A) regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the specific basis for the recommendation.

4. No Applicant is entitled to a waiver or to a hearing if the Board or Board Proxy Committee determines not to grant a waiver. A determination that an Applicant is not entitled to a waiver is not a "denial" of appointment or clinical privileges. Rather, that individual is ineligible to request appointment or clinical privileges. A determination of ineligibility is not reportable to either the State of Georgia or the National Practitioner Data Bank.

5. The granting of a waiver in a particular case does not set a precedent for any other Applicant or group of Applicants.

6. An application for appointment that does not satisfy a Threshold Eligibility Criterion will not be processed until the Board or Board Proxy Committee has determined that a waiver should be granted.

C. Application Form and Content

Applications for membership and/or clinical privileges must be completed in full, signed and dated by the Applicant and be submitted to the Medical Staff Services Office on approved forms. Applications must include a request for the specific clinical privileges sought and require detailed information about the Applicant's professional qualifications, which will include, but not be limited to:

1. Peer references from practitioners who can provide adequate information about the Applicant's current professional competence and character.

    a. An Applicant for initial appointment must provide at least three (3) peer references; an Applicant for reappointment must provide at least one (1) peer reference (except for active staff members who meet the minimum patient encounters).

    b. At least one peer reference must be in the same specialty area as the Applicant, and at least one peer reference should preferably be from the Applicant's Department Chair, program director or someone in a supervisory role or supervisory capacity to the applicant.

    c. Peer references cannot be from anyone who is personally related to the Applicant.

2. Information about the Applicant's:

    a. Medical staff membership and/or clinical privileges at other hospitals or health care facilities, including any denial, voluntary or involuntary relinquishment, termination, suspension, limitation or reduction of medical staff membership or clinical privileges and whether the Applicant has ever withdrawn an application for membership or privileges or resigned before a final decision was made by the Board of Trustees;

    b. Licenses or registrations to practice any profession in any state, commonwealth or territory;

c. DEA registration, where applicable to the Applicant's practice;

d. Professional liability insurance coverage, professional liability litigation and settlement experience, and whether professional liability insurance coverage has ever been denied, refused or not renewed;

e. Practice location;

f. Membership in professional societies;

g. Ability to participate in Medicare, Medicaid or any other government sponsored program or any private or public medical insurance program;

h. Physical and mental health ability to perform the clinical privileges requested within applicable standards of care;

i. Criminal background history;

j. Citizenship and/or visa status information and valid identification to confirm the Applicant's identity; and

k. Plan for qualified Physicians or other appropriate Practitioners at the Hospital to provide back-up medical coverage for the Applicant.

3. Documentation of health requirements as required by the Board.

D. Burden to Provide Required Information

1. The burden is on the Applicant to produce all information deemed adequate by the Medical Staff to properly evaluate the Applicant's qualifications for membership and/or clinical privileges, to resolve any doubts about the application and to establish that s/he is competent to exercise the clinical privileges requested. The Applicant is responsible for answering all questions on the application; providing accurate, up-to-date information and for ensuring that all supporting information and verifications, including information from training programs, peer references, and other health care facilities, are submitted as requested.

2. Any misrepresentation or misstatement in, or omission from, the application (whether intentional or not) is grounds for withdrawing the application from further consideration. If membership or clinical privileges were granted before discovering a misrepresentation, misstatement or omission, the Practitioner's membership or clinical privileges may be summarily dismissed and, depending on the circumstances, the Practitioner may be reported to the National Practitioner Data Bank.

3. An application shall be complete when all question on the application form have been answered, all supporting documentation has been supplied, all information has been verified from primary sources, and all applicable application fees and applicable fines have been paid.

4. The Medical Staff, Hospital, and any of their committees or representatives may request additional information from the Applicant at any time, and the application will not be processed further or considered until the information needed to resolve the doubt or concern is received; neither the Medical Staff nor the Board of Trustees is obligated to review or consider such an application.

5. Applications are deemed voluntarily withdrawn if the Applicant has not provided the requested information or otherwise resolved the doubt or concern thirty (30) calendar days after being notified in writing, addressed to the e-mail address Applicant provided for communication, of the need for further information, and the Applicant is not entitled to exercise the hearing and appeal rights in these Bylaws. The Applicant may reapply for membership and clinical privileges, but if the application is deemed voluntarily withdrawn again under this subsection, the Applicant cannot apply again for a period of one year.

Section 3-2. Initial Appointment and Privileging Process

This Section explains the basic steps in the initial appointment and clinical privileging process.

An individual term of appointment and/or granting of clinical privileges cannot be for more than two (2) years but may be for two years or less. Practitioners aged seventy (70) and above shall be appointed for a term of not more than one (1) year. Practitioners are not entitled to the hearing and appeals procedures in these Bylaws because of a decision to appoint or grant clinical privileges for less than two years.

A. Application Categories and Expedited Review

An expedited review and approval process may be used for initial appointment or for reappointment. All initial applications for membership and/or privileges will be designated Category 1 or Category 2 as follows:

Category 1: A completed application that does not raise concerns as identified in the criteria for Category 2 shall be designated as Category 1. Applicants in Category 1 will be granted Medical Staff membership and/or privileges after review and action by the following: Department Chair, Credentials Chair acting on behalf of the Credentials Committee, the MEC, and a committee consisting of at least two individuals as delegated by the Board (the "Board Proxy Committee").

Category 2: If one or more of the following criteria are identified while reviewing a completed and verified application, the application will be treated as Category 2. Applications in Category 2 must be reviewed and acted on by the Department Chair, Credentials Committee, MEC, and the Board Proxy Committee. The Credentials Committee may request that an appropriate subject matter expert assess selected applications. At all stages in this review process, the burden is upon the Applicant to provide evidence that s/he meets the criteria for membership on the Medical Staff and for the granting of requested privileges.

Criteria for Category 2 applications include, but are not necessarily limited to, the following:

1. The application is deemed to be incomplete;
2. The final recommendation of the MEC is adverse or with limitation;
3. The Applicant is found to have experienced an involuntary termination of medical staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges at another organization or has a current challenge or a previously successful challenge to licensure or registration;
4. Applicant is under investigation by a state medical board or has prior disciplinary actions, legal sanctions, or probation;
5. Applicant has had either an unusual pattern of or two (2) or more malpractice cases filed or settled within the last ten (10) years, excluding dismissals, or one final adverse judgment or settlement in a professional liability action in excess of $100,000.00;

6. Applicant changed medical schools or residency programs or has gaps in training or practice;

7. Applicant has changed practice affiliations more than four (4) times in the past ten (10) years, excluding telemedicine and locum tenens Practitioners;

8. Applicant has practiced or been licensed in five (5) or more states post residency/fellowship, excluding telemedicine and locum tenens Practitioners;

9. Applicant has one or more reference responses that raise concerns or questions;

10. Discrepancy is found between information received from the Applicant and references or verified information;

11. Applicant has an adverse National Practitioner Data Bank report unrelated to professional liability actions;

12. The request for privileges are not reasonable based upon Applicant's experience, training, and demonstrated current competence, and/or is not in compliance with applicable criteria;

13. Applicant has been removed from a managed care panel for reasons of professional conduct or quality;

14. Applicant has been sanctioned by CMS or any State in connection with Medicare, Medicaid or other federal or state funded healthcare program;

15. Applicant has potentially relevant physical, mental, and/or emotional health problems;

16. Other reasons as determined by a Medical Staff leader or other Hospital representative which raise questions about the qualifications, competency, professionalism, or appropriateness of the Applicant for membership or privileges.

B. Department Chair Recommendation

Applications are submitted to the Chair of each Department in which the Applicant requests privileges. Each Department Chair reviews the application and supporting documentation and makes a recommendation on (a) the Applicant's request for appointment and/or clinical privileges, including any limitations to privileges or conditions on appointment, and (b) whether the application is forwarded as a Category 1 or Category 2. The immediate past Department Chair may perform these duties if the current Department Chair is unavailable, and either may obtain input if necessary from an appropriate subject matter expert. The Department Chair has the right to meet with the Applicant to discuss any aspect of the application.

C. Credentials Committee Recommendation

If the application is designated Category 1, it is presented to the Credentials Chair, or designee, for review and recommendation. The Credentials Chair reviews the application to ensure that it fulfills the established standards for membership and/or clinical privileges. The Credentials Chair determines whether the application is forwarded as a Category 1 or may change the

designation to a Category 2. If forwarded as a Category 1, the Credentials Chair acts on behalf of the Medical Staff Credentials Committee and the application is presented to the MEC for review and recommendation. If the Credentials Chair changes the designation to a Category 2, then the application is reviewed by the full Credentials Committee as described below.

If designated Category 2, the Credentials Committee reviews the Applicant's application and supporting documentation and the recommendation from each Department Chair to determine whether the Applicant has established and satisfied all the necessary qualifications for appointment and/or clinical privileges.

1. As part of its evaluation, the Credentials Committee may:

    a. Use the expertise of the Department Chair, any other Department member or an outside consultant;

    b. Require the Applicant to meet with the Credentials Committee to discuss any aspect of the application; and/or

    c. Require the Applicant to undergo physical or mental examination by a Physician or other provider acceptable to the Credentials Committee in order to determine the Applicant's ability to perform the privileges requested. The Applicant must make the examination results available to the Credentials Committee for its consideration. If an Applicant does not have the examination or provide the results to the Credentials Committee within a reasonable time, the application is deemed voluntarily withdrawn. Applicants who are deemed to have voluntarily withdrawn an application do not have the right to exercise the hearing and appeal provisions in these Bylaws.

2. No more than 90 days after the Applicant has provided all required information, the Credentials Committee will make a written recommendation to the MEC either to:

    a. Appoint the Applicant to the Medical Staff and/or grant clinical privileges. A recommendation to appoint an Applicant to the Medical Staff must include the Medical Staff category and Clinical Department to which the Applicant should be assigned, and a recommendation to grant clinical privileges must include the specific clinical privileges to be granted, including any limitations on privileges or conditions on appointment;

    b. Defer the application for further consideration; or

    c. Deny appointment and/or clinical privileges. The hearing and appeals procedures in these Bylaws are not triggered by a recommendation from the Credentials Committee to deny appointment and/or clinical privileges.

D. MEC Recommendation

If an application has been designated Category 1, the MEC may meet in accordance with quorum requirements established for expedited credentialing. If forwarded from the Credentials Committee as a Category 2 application, the MEC reviews the Applicant's application and supporting documentation, the recommendations from the Credentials

Committee and the Department Chair, and decides whether to defer the application for further consideration or whether to recommend that the Board act on the application as a Category 1 or Category 2 and grant or deny membership and/or clinical privileges.

1. Deferring an Application

If the MEC defers the application for further consideration, it must make a written recommendation to the Board to grant or deny membership and/or clinical privileges within 60 days after the MEC has received all information needed for its decision.

2. Recommendations That Are Different from the Credentials Committee

When the MEC's recommendation is different from the Credentials Committee's recommendation, the MEC will either:

a. Send the application back to the Credentials Committee for further evaluation and responses to the MEC's specific questions; or

b. Provide clear and convincing reasons, along with supporting information, for its disagreement with the Credentials Committee's recommendation and forward its recommendation along with the Credentials Committee's findings and recommendation to the Board Safety and Quality Committee.

3. MEC Recommendations That Entitle an Applicant to Request a Hearing

MEC recommendations that are adverse to the Applicant entitle the Applicant to request a hearing per Article V (*see* Section 5-1, A, for recommendations that are adverse). The MEC forwards the adverse recommendation to the Hospital President rather than the Board of Trustees, and the Hospital President sends written notice of the adverse recommendation to the Applicant per Section 5-1, C. The MEC's recommendation will be held and will not be sent to the Board of Trustees for final action until (a) the hearing and appeals process in Article V is complete, or (b) the Practitioner has waived his/her right to a hearing and appeal.

4. MEC Recommendations That Do Not Entitle an Applicant to Request a Hearing

MEC recommendations that are not adverse are forwarded to the Board Safety and Quality Committee and the Board for final action, and the Applicant is not entitled to request a hearing. A recommendation to appoint an Applicant to the Medical Staff must include the Medical Staff category and Clinical Department to which the Applicant should be assigned, and a recommendation to grant clinical privileges must include the specific clinical privileges to be granted, including any conditions on appointment.

E. Board of Trustees Final Action

1. If the application is designated by the MEC as Category 1, it is presented to the Board or Board Proxy Committee where the application is reviewed to ensure that it fulfills the established standards for membership and clinical privileges. If the Board or Board Proxy Committee agrees with the recommendations of the MEC, the application is approved and the requested membership and/or privileges are granted for a period not to exceed 24

months. If a Board Proxy Committee takes the action, such actions shall be reported to the entire Board. If the Board or Board Proxy Committee disagrees with the MEC's recommendation, then the procedure for processing Category 2 applications will be followed.

2. For a Category 2 application, the Board or Board Proxy Committee will act on the application at its next regular meeting following receipt of the MEC's recommendation. The Board or Board Proxy Committee may:

   a. Adopt, reject, or modify the MEC's recommendation; or

   b. Refer the matter back to the MEC with instructions for further review and a time frame for responding to the Board or Board Proxy Committee.

3. Decisions to appoint an Applicant to the Medical Staff must include the Medical Staff category and Clinical Department to which the Applicant should be assigned, and decisions to grant clinical privileges must include the specific clinical privileges to be granted, including any limitations on privileges or conditions on appointment, and the timeframe of the appointment. Applicants will be notified in writing of the Board's final decision within thirty (30) days.

4. When the MEC's recommendation to the Board is not adverse, but the Board or Board Proxy Committee considers modifying it such that it is adverse per Section 5-1, A, the Practitioner is entitled to a hearing, and the Hospital President will send the Practitioner written notice of the adverse recommendation as explained in Section 5-1, C, and the Board or Board Proxy Committee will not take final action until (a) the hearing and appeals process in Article V is complete, or (b) the Practitioner has waived his/her right to a hearing and appeal.

Section 3-3. Reappointment and Renewal of Clinical Privileges

Members of the Medical Staff are reappointed and Practitioners with clinical privileges must renew clinical privileges at least every two years. Applications for reappointment and/or renewal of privileges must be processed and approved before the current appointment and/or privileges term expires.

A. Applications for Reappointment and Renewal of Clinical Privileges

The Medical Staff Services Office will provide Practitioners who meet the Threshold Eligibility Criteria in Section 3-1, A with electronic access to an application for reappointment and/or renewal of clinical privileges at least 120 days before the Practitioner's current appointment or privileges term expires. Applications must include a request for the specific clinical privileges sought and require detailed information concerning the Practitioner's professional qualifications, which will include, but not be limited to, those items listed in Section 3-1, C, and must be returned to the Medical Staff Services Office within sixty (60) days before the Practitioner's current appointment or privileges term expires.

Applications for reappointment and/or renewal of clinical privileges are processed in the same manner as applications for initial appointment and clinical privileges. Recommendations for reappointment are based on the Applicant's:

1. Ethical behavior, current clinical competence, and clinical judgment in the treatment of patients, including any professional performance evaluations;
2. Participation in Medical Staff duties, as required by the Bylaws, Rules and Regulations, and policies;
3. Compliance with the Medical Staff's Bylaws, Rules and Regulations, policies, and the Hospital's policies and procedures;
4. Professional behavior;
5. Physical, mental, and emotional health;
6. Capacity to satisfactorily treat patients as indicated by the results of the Hospital's quality assessment activities or other reasonable indicators of continuing qualifications;
7. Satisfactory completion of continuing education requirements that directly relate to the Practitioner's area of practice per the appropriate licensure board;
8. Current professional liability insurance status and pending malpractice challenges, including claims, lawsuits, judgments and settlements;
9. Current licensures and registrations, including pending challenges to any license or registration or any voluntary or involuntary relinquishment of any license or registration;
10. Voluntary or involuntary termination of appointment or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital or health care facility;

11. Criminal background history; and

12. Other reasonable indicators of continuing qualifications and relevant findings from the Hospital's quality assessment activities.

In the event an application is received prior to the expiration of such Practitioner's appointment and the Practitioner meets the Threshold Eligibility Criteria, the membership and/or clinical privileges of such Practitioner shall be automatically extended until final action on the Practitioner's application is taken by the Board of Trustees pursuant to Section 3-2, E, provided that no extension can exceed two (2) years from the effective date of the Practitioner's most recent reappointment.

B. Burden to Provide Required Information

Practitioners are responsible for submitting an application and all required information per Section 3-1, D, to the Medical Staff Services Office by the due date. Practitioners who fail to submit the required information by the due date will not be processed, and membership and/or clinical privileges will be deemed voluntarily relinquished.

Practitioners whose membership and/or clinical privileges are deemed voluntarily relinquished under this subsection are not entitled to the hearing and appeals procedures in these Bylaws. These Practitioners may reapply but must do so as new Applicants.

Section 3-4. Clinical Privileges

Being appointed or reappointed to the Medical Staff does not automatically grant clinical privileges. Clinical privileges are delineated on an individual basis and will include any limitations or restrictions, where necessary. Practitioners are only able to exercise those clinical privileges that have been specifically granted to them by the Board of Trustees, except in an emergency per Section 3-4, G. Practitioners who exercise clinical privileges within a Department are subject to the rules and regulations of that Department and to the authority of the Department Chair.

Applicants for clinical privileges and Practitioners who hold clinical privileges agree to fulfill the basic obligations contained in Section 2-3.

A. Eligibility for an Application for Clinical Privileges

Prospective Applicants for initial clinical privileges and Practitioners renewing clinical privileges must meet the Threshold Eligibility Criteria in Section 3-1, A.

B. Applications for Clinical Privileges Content and Processing

The requirements on application forms, content and the burden to provide required information in Section 3-1, C and D, apply to Applicants for initial clinical privileges and Practitioners renewing clinical privileges.

Applications for initial clinical privileges are processed in the same manner as applications for initial appointment per Section 3-2 and applications for renewal of clinical privileges are processed in the same manner as applications for reappointment per Section 3-3.

C. Requests for Additional Clinical Privileges

Practitioners may request additional clinical privileges at any time, but the request must be in writing on approved forms, detail the specific additional clinical privileges desired, and be supported by documentation of training and experience that justify the additional privileges. Requests for additional privileges made during a current appointment or privileges term are processed in the same manner as an application for initial clinical privileges (see Section 3-2).

Recommendations for additional clinical privileges are based on the Practitioner's relevant recent training; ongoing professional practice evaluation (OPPE); observation of patient care provided; reviews of the records of patients treated in this or other hospitals, if available; results of the Hospital's quality assessment activities; and other reasonable indicators of the Practitioner's continuing qualifications for the privileges requested, including any professional performance evaluations. Recommendation for additional clinical privileges may include requirements for supervision, consultation or other conditions for such periods of time as are thought necessary.

D. Clinical Privileges for New Procedures and Techniques

1. Requests for clinical privileges to perform a significant procedure not currently being performed at the Hospital or a significant new technique for performing an existing procedure will not be processed until the MEC, in conjunction with Hospital administration and relevant Hospital Departments (nursing, pharmacy, etc.), determines that the procedure

or technique is consistent with the Hospital's mission, values, strategic, operating, capital, and staffing plans, that the procedure will be offered, and that the Medical Staff has established eligibility criteria for requesting those clinical privileges.

2. The Credentials Committee will work in conjunction with the Department Chair and the Practitioner requesting permission to perform the new procedure or technique to make a preliminary recommendation to the MEC about whether the new procedure or technique should be offered to the community. Factors to be considered will include, but are not limited to, whether:

    a. There is empirical evidence of improved patient outcomes or other clinical benefits to patients;

    b. The new procedure or technique is being performed at other similar hospitals and the experiences of those hospitals; and

    c. The Hospital has the resources, including space, equipment, personnel and other support services, to safely and effectively perform the new procedure or technique.

3. If the recommendation is to offer the new procedure or technique, the Credentials Committee will partner with the Department Chair and the Medical Staff Services Office to develop recommendations regarding the minimum education, training, and experience necessary to perform the new procedure or technique, as well as the extent of monitoring and supervision that should occur if the privileges are granted. The Credentials Committee may also develop criteria and/or indications for when the new procedure or technique is appropriate.

4. The Credentials Committee forwards its recommendations to the MEC, which will review the matter and forward its recommendation to the Board of Trustees for final action.

E. Clinical Privileges that Cross Specialty Lines

1. Requests for clinical privileges that previously have been exercised at a Wellstar Hospital only by individuals from another specialty shall not be processed until the steps outlined in this Section have been completed and a determination has been made regarding the individual's eligibility to request the clinical privileges in question.

2. As an initial step in the process, the individual seeking the privilege will prepare and submit a report to the Credentials Committee that specifies the minimum qualifications needed to perform the procedure safely and competently, whether the individual's specialty is performing the privilege at other similar hospitals, and the experiences of those other hospitals in terms of patient care outcomes and quality of care.

3. The Credentials Committee shall then conduct additional research and consult with experts, as necessary, including those on the Medical Staff (*e.g.*, Department Chairs, individuals on the Medical Staff with special interest and/or expertise) and those outside the Hospital (*e.g.*, other hospitals, residency training programs, specialty societies).

4. The Credentials Committee may or may not recommend that individuals from different specialties be permitted to request the privileges at issue. If it does, the Credentials Committee may develop recommendations regarding:

    a. The appropriate education, training, and experience necessary to perform the clinical privileges in question;

    b. The clinical indications for when the procedure is appropriate;

    c. The manner of addressing the most common complications that arise which may be outside of the scope of the clinical privileges that have been granted to the requesting individual;

    d. The extent (time frame and mechanism) of focused monitoring and supervision that should occur if the privileges are granted in order to confirm competence;

    e. The manner in which the procedure would be reviewed as part of the Hospital's ongoing and focused professional practice evaluation activities (which may include assessment of both long-term and short-term outcomes for all relevant specialties); and

    f. The impact, if any, on emergency call responsibilities.

5. The Credentials Committee shall forward its recommendations to the MEC, which shall review the matter and forward its recommendations to the Board for final action. The Board shall make a reasonable effort to render the final decision within 60 days of receipt of the MEC's recommendation.

6. Once the foregoing steps are completed, specific requests from eligible Medical Staff members who wish to exercise the privileges in question may be processed

F. Temporary Clinical Privileges

1. The Hospital President or his/her designee may grant temporary privileges to fulfill an important patient care, treatment or service need. Temporary privileges must be specifically delineated and may include the privilege to admit patients; special requirements for supervision and reporting may be imposed by the Department Chair. Temporary privileges automatically terminate at the end of the specific period for which they were granted.

2. The Hospital President or his/her designee, on the recommendation of the Chief of Staff or his/her designee, may grant temporary privileges to a provider who does not have such clinical privileges at the Hospital, under the following circumstances:

    a. There is an important patient care, treatment, or service need for a specific patient or patients; and

    b. The individual's current licensure and current competence are verified.

3. A provider is ineligible for temporary privileges if the provider:

    a. Submits an incomplete application; or

b. The provider's application is designated as Category 2.

4. The individual must sign a statement acknowledging that s/he agrees to be bound by these Medical Staff Bylaws and by the Medical Staff's Rules and Regulations. Temporary privileges granted under this subsection may only be for a limited period of time, not to exceed 120 days. The provider must apply for membership and/or clinical privileges in order to attend patients beyond the period initially granted for temporary privileges.

5. Granting temporary privileges is a courtesy and not a right. The Hospital President or his/her designee, after consultation with the Department Chair, the Credentials Committee Chair and/or the Chief of Staff, may withdraw an individual's temporary privileges at any time. If the individual has patients admitted to the Hospital, the Chief of Staff or the Department Chair will reassign the patients to members of the Medical Staff with appropriate privileges. The patient's wishes will be considered. This assignment will be effective until the patients are discharged. Individuals do not have the right to the hearing and appeal provisions in these Bylaws because of their inability to obtain temporary privileges or because temporary privileges are terminated based on reasons unrelated to the Practitioner's professional competence or conduct.

G. Emergency Privileges

For the purposes of this subsection, an emergency is a condition that could reasonably be expected to jeopardize the life or health of the person affected or could reasonably result in disfigurement or impaired faculties and any delay in administering treatment would add to that harm or danger.

In an emergency, any provider, regardless of membership status, Medical Staff category or clinical privileges, is permitted to do everything possible within the scope of his/her license to save the life of a patient or prevent serious harm. When the emergency situation no longer exists, the patient's care will be assigned to a Medical Staff member with appropriate privileges. If the provider who provided the emergency care to the patient wants to continue to care for the patient, s/he must apply for membership and/or privileges per these Bylaws. Emergency temporary privileges do not grant or imply membership on the Medical Staff, do not entitle the provider to the hearing and appeal provisions set forth in these Bylaws, and do not afford the provider any of the rights outlined in these Bylaws.

H. Disaster Privileges

1. The Hospital President, or his/her designee, or the Chief of Staff, or his/her designee, may grant Disaster Privileges to eligible volunteer licensed independent Practitioners (LIPs) and/or APPs upon declaration of a major disaster and activation of the Wellstar Emergency Management Plan. These LIPs/APPs must present a valid government-issued photo identification issued by a state or federal agency (*e.g.*, driver's license or passport) and at least one of the following:

   a. A current license;

   b. Primary Source verification of licensure;

c. A current hospital picture identification card that identifies professional designation;

d. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group;

e. Identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state, or municipal authority; or

f. Confirmation by current Hospital or Medical Staff member(s) with personal knowledge regarding the individual's identity and ability to act as an LIP/APP.

2. Individuals granted Disaster Privileges will be given patient care assignments and identification as outlined in the Wellstar Emergency Management Plan.

3. The Medical Staff oversees the professional performance of volunteer Practitioners who have been granted disaster privileges by direct observation or clinical record review. The organization decides based on its oversight within 72 hours of the LIP/APP's arrival and issuance of Disaster Privileges whether disaster recovery privileges should be continued for the LIP/APP.

4. Primary source verification of licensure will begin as soon as the immediate situation is under control or within seventy-two (72) hours from the time the volunteer Practitioner presents to the organization, whichever first occurs. If primary source verification cannot be completed in seventy-two (72) hours, there is documentation of the following:

   a. Why primary source verification could not be performed in seventy-two (72) hours;

   b. Evidence of LIP/APP's demonstrated ability to continue to provide adequate care, treatment, and services; and

   c. An attempt to perform primary source verification as soon as possible.

5. Once the immediate situation has passed and such determination has been made consistent with the Wellstar Emergency Management Plan, the Practitioner's disaster privileges will terminate immediately.

6. Any individual with the authority to grant disaster privileges pursuant to these Bylaws will also have the authority to terminate disaster privileges. Such authority may be exercised in the sole discretion of the hospital and will not give rise to a right to a fair hearing or an appeal.

I. Telemedicine Privileges

1. Requests for initial or renewed telemedicine privileges shall be processed through one of the following options, as determined by the Hospital President or VPMA in consultation with the Chief of Staff:

a. A request for telemedicine privileges may be processed through the same process for Medical Staff applications, as set forth in these Bylaws. In such case, the individual must satisfy all qualifications and requirements set forth in these Bylaws, except those relating to geographic location, coverage arrangements, and emergency call responsibilities.

b. The Hospital privileges Practitioners using credentialing information from the distant site if the distant site is a Joint Commission accredited hospital or telemedicine entity and the information is then processed through the routine Medical Staff credentialing and privileging process. The distant-site Practitioner must have a license that is issued or recognized by the State of Georgia.

2. Telemedicine privileges granted in conjunction with a contractual agreement shall be incident to and coterminous with the agreement.

J. Residents or Fellows in Training

1. Upon recommendation of the MEC, the Board may grant clinical privileges to Practitioners who are not members of the Medical Staff, such as residents moonlighting in the Hospital. Residents or fellows in training in the Hospital shall not normally hold membership on the Medical Staff and shall not normally be granted specific clinical privileges. Rather, they shall be permitted to function clinically only in accordance with the written training protocols developed by the Graduate Medical Education Committee in conjunction with the residency training program. The protocols must delineate the roles, responsibilities, and patient care activities of residents and fellows including which types of residents may write patient care orders, under what circumstances why they may do so, and what entries a supervising Physician must countersign. The protocol must also describe the mechanisms through which resident directors and supervisors make decisions about a resident's progressive involvement and independence in delivering patient care and how these decisions will be communicated to appropriate Medical Staff and Hospital leaders.

2. The post-graduate education program director or committee must communicate periodically with the MEC and the Board about the performance of its residents, patient safety issues, and quality of patient care and must work with the MEC to assure that all supervising Physicians possess clinical privileges commensurate with their supervising activities

Section 3-5. Clinical Competency Evaluation

A. Focused Professional Practice Evaluation (FPPE)

All initially requested privileges shall undergo a period of focused professional practice evaluation (FPPE). The Credentials Committee, after receiving a recommendation from the Department Chair, will define the circumstances which require monitoring and evaluation of the clinical performance of each Practitioner following his or her initial grant of clinical privileges at the Hospital. Such monitoring may utilize prospective, concurrent, or retrospective proctoring, including, but not limited to: chart review, the tracking of performance monitors/indicators, external peer review, simulations, morbidity and mortality reviews, and discussion with other healthcare individuals involved in the care of each patient. The Credentials Committee will also establish the duration for such FPPE and triggers that indicate the need for performance monitoring.

B. Ongoing Professional Practice Evaluation (OPPE)

The Medical Staff will also engage in OPPE to identify professional practice trends that affect quality of care and patient safety. Information from this evaluation process will be factored into the decision to maintain existing privileges, to revise existing privileges, or to revoke an existing privilege prior to or at the time of reappointment. OPPE shall be undertaken as part of the Medical Staff's evaluation, measurement, and improvement of Practitioner's current clinical competency. In addition, each Practitioner may be subject to FPPE when issues affecting the provision of safe, high quality patient care are identified through the OPPE process. Decisions to assign a period of performance monitoring or evaluation to further assess current competence must be based on the evaluation of an individual's current clinical competence, practice behavior, and ability to perform a specific privilege.

C. Practitioner Re-Entry

A Practitioner who has not provided acute inpatient care within the past four (4) years who requests clinical privileges at the Hospital must arrange for a preceptorship, that is acceptable to the Credentials Committee and MEC, either with a current member in good standing of the Medical Staff who practices in the same specialty or with a training program or other equivalently competent Physician practicing outside of the Hospital. If a Practitioner has not provided any clinical care within the past six (6) years as determined by the Georgia medical licensing board or the MEC, s/he may be required to go through a formal re-entry process through an ACGME or AOA accredited residency program or other formal process to assess and confirm clinical competence. The Practitioner must assume responsibility for any financial costs required to fulfill these requirements. A description of the preceptorship or training program, including details of monitoring and consultation must be written and submitted for approval to the Department Chair and/or Credentials Committee and MEC. At a minimum, the preceptorship or training program description must include the following:

1. The scope and intensity of the required activities;

2. The requirement for submission of a written report from the preceptor or training program prior to termination of the preceptorship period assessing, at a minimum, the Applicant's demonstrated clinical competence related to the privileges requested, ability to get along with others, the quality and timeliness of medical records documentation, ability to perform the privileges requested, and professional ethics and conduct.

D. Special Conditions for the Aging Practitioner

At the age of seventy (70) Practitioners shall be required to undergo FPPE of his/her clinical performance as part of the assessment of his/her capacity to perform the requested privileges. Such focused review may be required in the absence of any previous performance concerns. The scope and duration of the focused review shall be determined by the MEC upon recommendation of the Department Chair and Credentials Committee. In addition to the focused review, a Practitioner must complete an annual examination that addresses his/her physical and mental capacity to perform the privileges requested. The physical and mental exams must be conducted by a Physician acceptable to the Credentials Committee/MEC, and the outcome shall be documented on the approved form and submitted to the Credentials Committee/MEC by the date requested. The physical exam is a "fitness to work" evaluation and must indicate that the Practitioner has no physical or mental problem that may interfere with the safe and effective provision of care permitted under the privileges granted.

Section 3-6. Automatic Relinquishment

A Practitioner's membership and/or clinical privileges are automatically and voluntarily relinquished if the Practitioner:

A. Loses his/her license to practice or license to prescribe, provided further that:

   1. Whenever a Practitioner's license or other legal credential authorizing practice in this state is limited or restricted by an applicable licensing or certifying authority, any clinical privileges that the Practitioner has been granted at the Hospital that are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term;

   2. Whenever a Practitioner is placed on probation by the applicable licensing or certifying authority, his/her membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term;

B. Is excluded or terminated from participating in Medicare, Medicaid, Tricare, or any other federally-funded healthcare program. Any Practitioner listed on the United States Department of Health and Human Services Office of the Inspector General's List of Excluded Individuals/Entities or the Georgia Department of Community Health/Office of Inspector General's Medicaid Exclusion List will be considered to have automatically relinquished his/her privileges;

C. Has his/her Medical Staff membership and clinical privileges suspended or terminated at any other Wellstar Hospital;

D. Practitioner's previously granted privileges become covered by an exclusive contract, unless such Practitioner becomes authorized by or pursuant to the contract.

E. Has been convicted of or entered a plea of "guilty" or "no contest" or its equivalent to a felony relating to controlled substances, illegal drugs, insurance or healthcare fraud or abuse, abuse (physical, sexual, child, or elder), or violence or been required to register as a sex offender in any jurisdiction;

F. Is on leave of absence ("LOA") and does not request an extension or reinstatement by the end of the LOA period (see Section 2-6, D and E for requesting an LOA extension and reinstatement);

G. Is on administrative leave of absence ("ALOA") and has not resolved the issue or requested a transfer to another LOA category at the end of the 90-day ALOA period (see Section 2-6, B.1);

H. Fails to complete the reappointment and/or renewal of clinical privileges process per Section 3-3;

I. Is subject to automatic termination for failure to complete medical records in accordance with the Medical Staff Rules and Regulations; such automatic termination shall take effect immediately;

J. Fails to promptly pay Medical Staff dues or any special assessment;

K. Fails to complete or comply with training or educational requirements that are adopted by the MEC or required by the Hospital or the Board of Trustees, including, but not limited to, those pertinent to electronic medical records, computerized physician order entry ("CPOE"), the privacy and security of protected health information, infection control, or patient safety;

L. Fails to satisfy any of Minimum Threshold Criteria set forth in Section 3-1, A of these Bylaws on a continuous basis unless the Board has granted a waiver pursuant to Section 3-1, B;

M. Fails to provide information pertaining to an individual's qualifications for appointment, reappointment, or clinical privileges, in response to a written request from the Credentials Committee, the MEC, the Peer Review Committee, the VPMA, the Hospital President, or any other committee authorized to request such information. The information must be provided within the time frame established by the requesting party;

N. Fails to execute a general or specific release of information and/or provide documents when requested by the Chief of Staff or designee, the MEC, an Investigating Committee, the Peer Review Committee, Credentials Committee, or as otherwise required by these Bylaws, to evaluate the competency and credentialing/privileging qualifications of the Practitioner. If the Practitioner does not execute the release and/or provide requested documents within thirty (30) calendar days of notice of the automatic relinquishment, it shall result in automatic resignation from the Medical Staff and/or withdrawal of the Practitioner's application, as applicable;

O. Fails without good cause to appear at a meeting where his/her special appearance is required in accordance with Section 1-6, E.3. Failure of the individual to attend the meeting shall result in the automatic relinquishment of all clinical privileges until the individual does attend the special meeting. If the individual does not attend the special meeting within 30 days of the date of relinquishment, it shall result in automatic resignation from the Medical Staff; or

P. Does not undergo a physical or mental examination within a reasonable time as requested by the MEC, an Investigating Committee, or the Credentials Committee and make the examination results available to the requesting committee (*see* Section 3-2, B and Section 4-2, C).

Q. Failure to comply with the annual health screening and vaccination requirements as set forth in the Medical Staff General Rules and Regulations.

When any of the triggering circumstances in this Section 3-6 occur, the MEC through the Chief of Staff or his/her designee, shall notify the Practitioner in writing that his/her membership and/or clinical privileges have been deemed automatically relinquished. The Chief of Staff, with the approval of the Hospital President, may reinstate the Practitioner's privileges or membership after determining that the triggering circumstances have been resolved. Unless a different timeframe is specified above, failure to resolve the underlying matter leading to automatic relinquishment within 60 days from the date Practitioner received notice of relinquishment shall result in an automatic resignation from the Medical Staff and the Practitioner will have to reapply for membership and/or privileges. Practitioners whose membership and/or clinical privileges are automatically and voluntarily relinquished or resigned under this Section are not entitled to

exercise the hearing and appeals procedures in these Bylaws. Further, nothing in this Section shall preclude the MEC from imposing further corrective action as deemed appropriate.

Section 3-7. Authorization to Obtain and Release Information

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

A. Immunity

To the fullest extent permitted by law, the individual releases from any and all liability, extends immunity to, and agrees not to sue the Hospital, the Board, or any other Wellstar Hospital, any member of the Medical Staff or the Board, their authorized representatives, and third parties who provide information for any matter relating to appointment, reappointment, clinical privileges, or the individual's qualifications for the same. This immunity covers any actions, recommendations, reports, statements, communications, and/or disclosures involving the individual that are made, taken, or received by the Hospital, its authorized agents, or third parties in the course of credentialing, privileging, and peer review activities or any activities authorized in accordance with this Section 3-7.

B. Authorization to Obtain Information from Third Parties

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

C. Authorization to Release Information to Third Parties

The individual also authorizes Hospital representatives to release information to other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their agents when information is requested in order to evaluate his/her professional qualifications for appointment, privileges, and/or participation at the requesting organization/facility, and any licensure or regulatory matter, unless otherwise privileged under state and/or federal law and unless a separate authorization has been obtained where required.

D. Authorization to Share Information within Wellstar Health System

The individual specifically authorizes all the Hospitals within Wellstar Health System to share credentialing, privileging, and peer review information pertaining to the individual's clinical competence and/or professional conduct. This information may be shared only with appropriate personnel at initial appointment, reappointment, and/or any other time during the individual's appointment and shall otherwise be treated as privileged and confidential under applicable state and federal laws.

E. Hearing and Appeal Procedures; Legal Actions

1. The individual agrees that the hearing and appeal procedures set forth in these Bylaws are the sole and exclusive remedy with respect to any professional review action taken by the Hospital and that the individual will not institute legal action challenging any credentialing, privileging, peer review, or other action affecting appointment or privileges without first pursuing and exhausting the hearing and appeal procedures set forth in these Bylaws.

2. If, despite this Section, an individual institutes any such legal action without first pursuing and exhausting the hearing and appeal procedures set forth in these Bylaws, s/he shall reimburse the Hospital and any member of the Medical Staff or Board involved in the action for all costs incurred in defending such legal action, including reasonable attorney's fees, and expert witness fees.

F. Scope of Section

All of the provisions in this Section 3-7 are applicable in the following situations:

1. Whether or not appointment or clinical privileges are granted;

2. Throughout the term of any appointment or reappointment period and thereafter;

3. If a Practitioner's appointment, reappointment, or clinical privileges be denied, revoked, reduced, restricted, suspended, and/or otherwise affected as part of the Hospital's credentialing, privileging, and/or professional review activities; and

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

Section 3-8. Immunity and Indemnification

A. State and Federal Protections

All minutes, documents, reports, communications, recommendations and actions made or taken pursuant to these Bylaws are deemed to be covered by the provisions of O.C.G.A. §31-7-15, §§31-7-130 *et seq*., §§31-7-140 *et seq*. ("Georgia Statutes"), the federal Health Care Quality Improvement Act of 1986, 42 U.S.C. §§11101 *et seq*. ("HCQIA"), and the federal Patient Safety and Quality Improvement Act of 2005, 42 U.S.C. §§299 *et seq*. ("PSQIA"), and/or the corresponding provisions of any other federal or state statute providing privilege and confidentiality protections to peer review, medical review, credentialing, privileging, patient safety, professional practice evaluation activities, or related activities. Furthermore, the committees, individuals and/or panels charged with making reports, findings, recommendations or investigations pursuant to the Bylaws are acting on behalf of the Hospital and its Board of Trustees when engaged in such professional review activities and are deemed to be "professional review bodies" and/or "medical review committees" as those terms are defined in HCQIA and/or the Georgia Statutes.

B. Indemnification

Subject to applicable law, the Hospital shall indemnify against reasonable and necessary expenses, costs, and liabilities incurred by a Medical Staff member in connection with the defense of any pending or threatened action, suit, or proceeding to which s/he is made a party because of having acted in an official capacity in good faith on behalf of the Hospital or Medical Staff. However, no member shall be entitled to such indemnification if the acts giving rise to the liability constituted willful misconduct, breach of a fiduciary duty, self-dealing or bad faith.

Wellstar Health System

MEDICAL STAFF BYLAWS

Article IV: Reviews & Investigations

ARTICLE IV – REVIEWS & INVESTIGATIONS

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ARTICLE IV – REVIEW & INVESTIGATIONS

Section 4-1. Reviews

It is the policy of the Medical Staff leadership of the Hospital to work collegially with Practitioners to assist them in delivering high quality and safe medical care, to continually improve their clinical skills, to comply with Medical Staff and Hospital policies, and to meet all performance expectations as established from time to time by the Medical Staff. Concerns related to clinical competence or professional behavior may be reviewed and addressed collegially with the Practitioner without conducting an investigation or recommending adverse actions (see Section 4-2 for information on investigations and Section 5-1, A for adverse recommendations). The goal of these efforts is to promote a collegial and educational approach to resolve the concerns through voluntary action by the Practitioner. Examples of collegial efforts include, but are not limited to:

1. Letters of education, warning or reprimand;
2. Requirements for additional education or training;
3. Retrospective reviews and prospective monitoring;
4. Proctoring or consultation with another provider when the consultant's approval is *not* needed to proceed with clinical care; and
5. Requirements for outside assessment, examination or screening.

While collegial efforts are encouraged, they are not mandatory, and an investigation may be requested per Section 4-2 if a Practitioner does not wish to participate in the collegial process or in the discretion of the appropriate Medical Staff leader or committee.

Collegial efforts are part of the Hospital's professional review and patient safety activities, but they are not adverse actions or recommendations and do not entitle the Practitioner to the hearing and appeal provisions in these Bylaws.

Section 4-2. Investigations

A. Grounds for Requesting Investigation

The Chief of Staff, a Department Chair, a Medical Staff committee chairperson, a majority of the members of a Medical Staff committee, the Hospital President, the VPMA, the Chief Executive Officer, or the Board of Trustees Chair may request an investigation when, on information and belief, there is cause to question a Practitioner's:

1. Clinical competence;
2. Care and treatment of patients or management of a case;
3. Known or suspected violation of applicable ethical standards;
4. Known of suspected violation of Medical Staff, Hospital or Board of Trustees Bylaws, Rules and Regulations, or policies (including, but not limited to, the Hospital's quality assessment, risk management and utilization review programs); and/or
5. Behavior or conduct that is considered lower than the standards of the Hospital or disruptive to the orderly operations of the Medical Staff or the Hospital, including the inability of the Practitioner to work harmoniously with others.

The request for the investigation must be in writing, submitted to the MEC and specific reference to the activity or conduct forming the basis of the request. The MEC also may initiate an investigation on its own motion. The matter may also be referred to the Chief of Staff, the Department Chair, the service line chief, the chair of a standing committee, the VPMA, Wellstar Health System administration, or the Hospital President for concurrent review and appropriate action.

B. Initial Review by MEC

The MEC will meet as soon as possible after receiving a request for an investigation to discuss the issue(s) raised in the request. In its discretion, the MEC may, among other actions:

1. Determine the matter is unfounded and take no further action;
2. Address the matter through collegial efforts;
3. Proceed under an applicable Medical Staff policy;
4. Refer the matter to an appropriate Medical Staff committee; and/or
5. Conduct a formal investigation.

In making its determination, the MEC may discuss the matter with the Practitioner but is not required to do so. The MEC's initial review of a request for an investigation shall not constitute an investigation.

If the MEC decides to conduct a formal investigation, the meeting minutes will specifically recite that a formal resolution to conduct an investigation has been adopted, the MEC will

appoint an Investigating Committee per Section 4-2, C.2, and the investigation procedures set out below will be followed. If the MEC decides not to conduct a formal investigation, the MEC shall notify the Board of such determination. In the event the Board believes the MEC has incorrectly determined that an investigation is unnecessary, it may direct the MEC to proceed with an investigation.

C. Investigation Procedures

1. Notice of the Investigation

When the MEC decides to conduct a formal investigation into a matter, the Chief of Staff or the VPMA will send the Practitioner written notice that the MEC has opened an investigation and advise the Practitioner that s/he will have an opportunity to meet with the Investigating Committee before it makes a final recommendation (*see* Section 4-2, C.2.c, below). Despite the status of any investigation, the MEC shall at all times retain the authority and discretion to take whatever action may be warranted by the circumstances, including suspension, termination of the investigative process, or other action.

2. Investigating Committee

a. Creation of the Investigating Committee

The MEC may decide to:

i. Conduct the investigation by the full MEC;

ii. Appoint a subcommittee of the MEC to conduct the investigation; or

iii. Appoint an ad hoc committee to conduct the investigation. An ad hoc committee cannot have more than three (3) members, who may or may not be members of the Medical Staff, and cannot include direct economic competitors or partners, associates, or relatives of the Practitioner being investigated.

The composition of the Investigating Committee shall comply with the conflict of interest guidelines set forth in the Medical Staff Rules and Regulations.

b. Authority of the Investigating Committee

The Investigating Committee shall have the authority to review relevant documents and interview individuals. It shall also have available to it the full resources of the Medical Staff and the Hospital, as well as the authority to seek external review, if needed. An external reviewer or agency may be used whenever a determination is made by the Hospital and Investigating Committee that:

i. The clinical expertise needed to conduct the review is not available on the Medical Staff;

ii. The individual under review is likely to raise, or has raised, questions about the objectivity of other Practitioners on the Medical Staff;

iii. The individuals with the necessary clinical expertise on the Medical Staff would not be able to conduct a review without risk of allegations of bias, even if such allegations are unfounded; or

iv. The thoroughness and objectivity of the investigation would be aided by such an external review.

The Investigating Committee may require a physical, mental, and/or behavioral examination of the individual by health care professional(s) acceptable to it. The individual being investigated shall execute a release (in a form approved or provided by the Investigating Committee) allowing: (1) the Investigating Committee (or its representative) to discuss with the health care professional(s) conducting the examination the reasons for the examination; and (2) the health care professional(s) conducting the examination to discuss and provide documentation of the results of such examination directly to the Investigating Committee. The cost of such health examination shall be borne by the individual. If a Practitioner does not undergo the examination within a reasonable time, his/her membership and/or clinical privileges will be deemed to have been voluntarily relinquished, and the Practitioner does not have the right to exercise the fair hearing and appeal provisions in these Bylaws.

c. Practitioner's Opportunity to Respond

The individual shall have an opportunity to meet with the Investigating Committee before it makes its report to discuss, explain, or refute the questions that gave rise to the investigation. Prior to this meeting, the individual shall be informed of the specific questions being investigated, including the relevant underlying facts known to the Investigating Committee. No recording (audio or video) or transcript of the meeting shall be permitted or made. A summary of the interview shall be prepared by the Investigating Committee and included with its report. This meeting is not a hearing, none of the procedural rules for hearings shall apply, and individual being investigated shall not have the right to be accompanied by legal counsel at this meeting.

d. Recommendations and Report

The Investigating Committee will prepare a report for the MEC that includes its findings, conclusions and recommendations and a summary of its meeting with the Practitioner. In making its recommendations, the Investigating Committee shall strive to achieve a consensus as to what is in the best interests of patient care and the safe and orderly operation of the Hospital, while balancing fairness to the individual, recognizing that fairness does not require that the individual agree with the recommendation.

3. MEC Action

The MEC will review the Investigating Committee's recommendations and may accept, modify or reject them. A representative of the Investigating Committee will be available to the MEC to answer questions. After the conclusion of the investigation, the MEC shall take action that may include, without limitation:

a. Determine that no action is justified;

b. Issue a letter of guidance, counsel, warning, or reprimand, although nothing herein shall be deemed to preclude appropriate committee chairs or Department Chairs from issuing informal written or oral warnings prior to an investigation. If such letters are issued, the affected Practitioner may submit a written response, which shall be placed in the Practitioner's file;

c. Impose conditions for continued appointment;

d. Impose a requirement for monitoring, proctoring, or consultation;

e. Impose a requirement for additional training or education;

f. Recommend reduction of clinical privileges;

g. Recommend suspension of clinical privileges for a term based on a reasonable belief that failure to take such an action may result in an imminent danger to the health of any individual;

h. Recommend revocation of appointment and/or clinical privileges; or

i. Make any other recommendation that it deems necessary or appropriate.

4. Subsequent Action

a. A recommendation by the MEC that would entitle the individual to request a hearing shall be forwarded to the Hospital President, who shall promptly inform the individual by special notice. The Hospital President shall hold the recommendation until after the individual has completed or waived a hearing and appeal.

b. If the determination of the MEC does not entitle the individual to request a hearing, the MEC shall notify the Board of such determination. The MEC's action shall take effect immediately and shall remain in effect unless modified by the Board.

c. In the event the Board makes a preliminary decision that is different from the recommendation of the MEC, which preliminary decision would entitle the individual to request a hearing, the Hospital President shall inform the individual by special notice. No final action shall occur until the individual has completed or waived a hearing and appeal.

d. When applicable, any recommendations or actions that are the result of an investigation or hearing and appeal shall be monitored by Medical Staff leaders on an ongoing basis through the Hospital's performance improvement activities or pursuant to the applicable policies regarding conduct, as appropriate.

Section 4-3. Precautionary Suspensions

A. Grounds for Precautionary Suspension of Privileges

1. Any combination of one (1) Medical Staff Leader (Chief of Staff, Vice Chief of Staff, or Department Chair of the affected Practitioner) and one (1) administrator (Hospital President, VPMA, or administrator-on-call) shall have the authority to suspend or restrict all or any portion of a Practitioner's clinical privileges as a precaution pending an investigation whenever, in their sole discretion, failure to take such action may result in imminent danger to the health and/or safety of any individual or to the safe and orderly operations of the hospital. As an alternative, the Practitioner may also be afforded an opportunity to voluntarily refrain from exercising privileges pending an investigation.

2. A precautionary suspension or restriction can be imposed at any time, including, but not limited to, immediately after the occurrence of an event that causes concern, following a pattern of occurrences that raises concern, or following a recommendation of the MEC that would entitle the individual to request a hearing.

3. Precautionary suspensions are effective immediately and remain in effect until lifted or modified by the MEC, the Hospital President, or the Board of Trustees. Precautionary suspensions must be reported immediately in writing to the Chief of Staff, the Hospital President, and the Wellstar System Executive Vice President responsible to the Board Safety and Quality Committee. When a precautionary suspension is imposed at a Wellstar Hospital, the Practitioner's clinical privileges shall be suspended under the same terms at all other Wellstar Hospitals where the Practitioner maintains clinical privileges.

4. Precautionary suspensions are interim precautionary steps in a professional review activity, but they are not complete professional review actions in and of themselves and do not imply any final finding of responsibility for the situation that caused the suspension or restriction.

B. Investigation Following Precautionary Suspension

1. The MEC shall review the matter resulting in a precautionary suspension or restriction (or the individual's agreement to voluntarily refrain from exercising clinical privileges) within a reasonable time under the circumstances, not to exceed 30 days. There is no right to a hearing based solely on the imposition or continuation of a precautionary suspension or restriction.

2. Prior to, or as part of, this review, the individual shall be given an opportunity to meet with the MEC. Prior to this meeting, the individual will be informed of the specific questions being investigated, including the relevant underlying facts known to the MEC. At the meeting, the individual will be invited to discuss, explain, or refute the questions that gave rise to the investigation. No recording (audio or video) or transcript of the meeting shall be permitted or made. A summary of the interview will be prepared. This meeting is not a hearing, and none of the procedural rules for hearings will apply.

3. After considering the matters resulting in the suspension or restriction and the individual's response, if any, the MEC shall determine the appropriate next steps, which may include,

but not be limited to, the options outlined in Section 4-2, C.3 or any other action that is deemed appropriate under the circumstances. The MEC shall also determine whether the precautionary suspension or restriction should be continued, modified, or terminated pending the completion of the focused review or investigation (and hearing and appeal, if applicable).

C. Care of Practitioner's Patients

The Department Chair or Chief of Staff will assign the suspended Practitioner's Hospital patients to another member of the Medical Staff with appropriate clinical privileges. The patient's wishes will be considered. This assignment will be effective until the patients are discharged. All Medical Staff members have a duty to cooperate in enforcing suspensions and in caring for a suspended Practitioner's Hospital patients.

Section 4-4. Action at Another Wellstar Hospital

A. Notice of Action

Each Wellstar Hospital will share information regarding the implementation or occurrence of any of the following actions with all other Wellstar Hospitals at which an individual applies for and/or maintains Medical Staff appointment, clinical privileges, or any other permission to care for patients:

1. Automatic relinquishment of appointment or clinical privileges;

2. Precautionary suspension or restriction of all or any portion of an individual's clinical privileges;

3. Voluntary agreement to refrain from exercising some or all clinical privileges for a period of time;

4. Any involuntary modification of appointment or clinical privileges, including any restriction, revocation, or termination of clinical privileges;

5. A conditional appointment, a conditional continued appointment, or a conditional reappointment;

6. Imposition of a Performance Improvement Plan or similar plan; and/or

7. Initiation of a formal investigation.

B. Effect of Action at Another Wellstar Hospital

Upon receipt of notice that any of the actions set forth in Section 4-4, A.1 through A.5 have occurred at any Wellstar Hospital, that same action will automatically and immediately take effect at each Wellstar Hospital receiving such notice. A Performance Improvement Plan or similar plan shall not automatically take effect at other Wellstar Hospitals receiving such notice, but may be imposed at other Hospitals, in whole, in part, or as modified, in the discretion of the MEC(s) of the receiving Hospital(s).

C. Waiver of Automatic Action

An affected Practitioner may request a waiver of the automatic effectiveness of such an action. The burden is on the affected Practitioner to provide evidence showing that a waiver is appropriate. Waivers will be granted only as follows:

1. In exceptional circumstances;

2. Based on a finding that the granting of a waiver will not affect patient safety, quality of care, or operations at the receiving Wellstar Hospital; and

3. After a full review of the specific circumstances and any relevant documents (including peer review documents) from the Wellstar Hospital where the action first occurred.

The MEC at the receiving Wellstar Hospital shall consider the request and, in its full discretion, may recommend a waiver of the automatic effectiveness of such an action. Upon receipt of a recommendation from the MEC at a receiving Wellstar Hospital, the Board may waive the automatic effectiveness of such an action at that Hospital. However, the automatic effectiveness of the action, as set forth in Section 4-4, B, will continue until the Board has granted a waiver and the Practitioner has been notified in writing of such. Waivers are within the sole discretion of the Board and are final.

D. Finality of Automatic Action

Neither the automatic effectiveness of any action set forth in Section 4-4, A at any Wellstar Hospital, nor the denial of a waiver pursuant to Section 4-4, C, will entitle any individual to any additional procedural rights (including advance notice or additional peer review), formal investigation, hearing, or appeal.

Section 4-5. Confidentiality and Peer Review Protection

A. Confidentiality

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

1. When the disclosures are to another authorized member of the Medical Staff or authorized Hospital employee and are for the purpose of researching, investigating, or otherwise conducting legitimate credentialing, privileging, and professional practice evaluation activities;

2. When disclosures are permitted under these Bylaws, including, but not limited to Section 3-7;

3. When the disclosures are authorized by a Medical Staff or Hospital policy or contract or by law;

4. When the disclosures are authorized, in writing, by legal counsel to the Hospital; or

5. When the disclosures are authorized, in writing, by the individual Practitioner who is the subject of the requested disclosure.

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

B. Peer Review Protection

All Peer Review activities pursuant to these Bylaws and related Medical Staff documents shall be performed by "Peer Review Committees," "Review Organizations," and "Medical Review Committees" (referred to collectively as "peer review committees") in accordance with O.C.G.A. §31-7-15, §§31-7-130 *et seq*., §§31-7-140 *et seq*. ("Georgia Statutes"), the federal Health Care Quality Improvement Act of 1986, 42 U.S.C. §§11101 *et seq*. ("HCQIA"), and the federal Patient Safety and Quality Improvement Act of 2005, 42 U.S.C. §§299 *et seq*. ("PSQIA"), and/or the corresponding provisions of any other federal or state statute providing privilege and confidentiality protections to peer review, medical review, credentialing, privileging, patient safety, professional practice evaluation activities, or related activities. Committees that conduct Peer Review activities may include, but are not limited to:

1. All standing and ad hoc Medical Staff and Hospital committees;

2. All Departments and services;

3. Hearing panels;

4. The Board and its committees; and

5. Any individual acting for or on behalf of any such entity, including but not limited to Department Chairs, service line chiefs, committee chairs and members, officers of the Medical Staff, the VPMA, legal counsel, all Hospital personnel, and experts or consultants retained to assist in such activities.

Wellstar Health System

MEDICAL STAFF BYLAWS

Article V: Hearings & Appeals

ARTICLE V – HEARINGS & APPEALS

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ARTICLE V – HEARINGS & APPEALS

Section 5-1. Hearings

A. Adverse Recommendations

The following Practitioners who are the subject of an Adverse Recommendation are entitled to request a hearing:

1. Medical Staff members;
2. Physicians or Dentists with clinical privileges without membership; and
3. Applicants who are Physicians or Dentists.

An individual is entitled to request a hearing whenever the MEC makes one of the following Adverse Recommendations for reasons related to professional competence or other actions that require a report to the National Practitioner Data Bank:

1. Denial of initial appointment to the Medical Staff;
2. Denial of reappointment to the Medical Staff;
3. Revocation of appointment to the Medical Staff;
4. Denial of requested clinical privileges;
5. Termination or revocation of clinical privileges;
6. Suspension of clinical privileges for more than 30 days (other than precautionary suspension);
7. Imposition of a mandatory concurring consultation requirement (*i.e.*, the consultant must approve the course of treatment in advance) that lasts more than 30 days;
8. A proctoring requirement (such that the Practitioner cannot perform certain procedures without proctor approval or without the proctor being present and watching the Practitioner) that lasts more than 30 days;
9. Precautionary suspension of clinical privileges for more than 14 days;
10. Denial of reinstatement from a leave of absence if the reasons relate to clinical competence or professional conduct; or
11. Any other recommendation that requires notification to the National Practitioner Data Bank.

No other recommendations shall entitle the individual to a hearing.

If the Board makes any of these determinations without an adverse recommendation by the MEC, an individual would also be entitled to request a hearing. For ease of use, this Article refers to adverse recommendations of the MEC. When a hearing is triggered by an adverse recommendation of the Board, any reference in this Article to the "MEC" shall be interpreted as a reference to the "Board."

B. Actions Not Grounds for Hearing

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

1. Determination that an Applicant for membership fails to meet the threshold eligibility qualifications or criteria for membership;

2. Ineligibility to request membership or privileges, or to continue privileges, because a relevant specialty is closed under a Medical Staff development plan or is covered under an exclusive provider agreement;

3. Failure to process a request for a privilege when the individual does not meet the eligibility criteria to hold the privilege;

4. Determination that an application is incomplete or untimely;

5. Determination that an application shall not be processed due to a misstatement or omission;

6. Change in assigned staff category or a determination that an individual is not eligible for a specific staff category;

7. Expiration of membership and privileges because of failure to submit an application for reappointment within the allowable time period;

8. Issuance of a letter of guidance, counsel, warning, or reprimand;

9. Determination that conditions, monitoring, supervision, or a general consultation requirement (*i.e.*, the individual must obtain a consult but need not get prior approval for the treatment) is appropriate for an individual;

10. A proctoring requirement (such that the Practitioner cannot perform certain procedures without proctor approval or without the proctor being present and watching the Practitioner) that does not last more than 30 days;

11. Determination that a requirement for additional training or continuing education is appropriate for an individual;

12. The voluntary acceptance of a Performance Improvement Plan;

13. Any requirement to complete a health assessment, diagnostic testing, a complete physical, mental or behavioral evaluation, or a clinical competency evaluation pursuant to any Bylaws-related document;

14. Conducting an investigation into any matter or the appointment of an ad hoc Investigating Committee;

15. Grant of conditional appointment or reappointment or of an appointment or reappointment period that is less than two years;

16. Refusal of the Hospital to consider a request for appointment, reappointment, or privileges within five years of a final adverse decision regarding such request;

17. Precautionary suspension that does not last more than 14 days;

18. Automatic relinquishment of appointment or privileges or automatic resignation;

19. Denial of a request for leave of absence, for an extension of a leave or for reinstatement from a leave if the reasons do not relate to clinical competence or professional conduct;

20. Removal from the on-call roster or any other reading panel;

21. Withdrawal of temporary privileges for reasons unrelated to professional competence or conduct;

22. Requirement to appear for a special meeting; and

23. Termination of any contract with or employment by the Hospital.

C. Notice of an Adverse Recommendation

When the MEC or Board of Trustees has made an adverse recommendation as explained in Section 5-1, A, the Hospital President will inform the Applicant or Practitioner of the adverse recommendation in writing by certified mail, return receipt requested. The notice must include:

1. The adverse recommendation made and the specific reasons for it;

2. A statement that the Applicant or Practitioner has the right to request a hearing within 30 days of receipt of the notice;

3. A statement that the failure to request a hearing is a waiver of the hearing and appeal rights in this Article V and that the adverse recommendation will become final;

4. Notice that the recommendation, if finally adopted by the Board, may result in a report to the state licensing authority (or other applicable state agencies) and the National Practitioner Data Bank; and

5. A copy of this Article V on hearings and appeals.

D. Requesting a Hearing

1. The Applicant or Practitioner has 30 days from the date or receipt of the notice of adverse recommendation to request a hearing. The request for a hearing must be in writing and delivered to the Hospital President either in person or by certified mail, return receipt

requested. If a hearing is not requested as described within the 30 days, the Applicant or Practitioner is deemed to have waived the right to a hearing and to have accepted the adverse recommendation. The adverse recommendation will be transmitted to the Board of Trustees and become effective when the Board of Trustees takes final action.

2. When adverse recommendations are taken by more than one MEC which are based on common circumstances or events, the Applicant or Practitioner shall be entitled to a single hearing ("Consolidated Hearing") before a joint hearing panel comprised of members from each of the affected Medical Staffs as set forth in Section 5-1, F.1.b. below. A Consolidated Hearing shall otherwise be conducted in accordance with the procedures set forth in this Article V.

E. Scheduling a Hearing

When a hearing has been requested as required by Section 5-1, D, the Hospital President will schedule the hearing to begin as soon as practical, but no sooner than 30 days after the notice of the hearing. The hearing may be scheduled earlier if both parties specifically agree to an earlier date in writing. The Hospital President will send a written notice to the Applicant or Practitioner by certified mail, return receipt requested that includes:

1. The time and date of the hearing and where it will be held;

2. A proposed list of witnesses who may testify or present evidence in support of the MEC (the Applicant or Practitioner must provide his or her witness list within 10 days of receiving the notice of the hearing as explained in Section 5-1, G.1)

3. The names of the hearing panel members and presiding officer or the hearing officer, if known (see Section 5-1, F); and

4. A statement of the specific reasons for the adverse recommendation and a list of patient records and information that support the recommendation. This statement does not bar presentation of additional evidence or information at the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications and the individual has a sufficient opportunity to review and rebut the additional information.

F. Appointing Either a Hearing Panel and Presiding Officer or a Hearing Officer

When a hearing has been properly requested, the Hospital President, in consultation with the Chief of Staff (and the Chair of the Board of Trustees if the hearing is the result of a Board of Trustees adverse recommendation), will appoint either a hearing panel or a hearing officer (see Section 5-1, E.1 directly below for the hearing panel and Section 5-1, E.2 for the hearing officer). If a hearing panel is appointed, the Hospital President also will select a presiding officer. In the case of a Consolidated Hearing, "Hospital President" shall mean the Hospital President of the Medical Staff which made the initial adverse recommendation unless otherwise indicated.

1. Hearing Panel

a. A hearing panel must have at least three (3) members of the Medical Staff who have not actively participated in the matter at issue at any previous level. If three such members cannot be found, then Medical Staff members of other Wellstar Hospitals may be appointed, subject to meeting the requirements of this Section 5-1, F.1.

b. In the case of a Consolidated Hearing, a joint hearing panel shall be appointed as follows:

   i. Three (3) or fewer Hospitals – not less than seven (7) Medical Staff members;

   ii. Four (4) Hospitals – not less than nine (9) Medical Staff members; and

   iii. More than four (4) Hospitals – not less than eleven (11) Medical Staff members.

   A minimum of two (2) Medical Staff members of each affected Medical Staff shall be appointed to serve on the joint hearing panel by the respective Hospital Presidents in accordance with this Section 5-1, F. References to "hearing panel" throughout this Article V shall include and apply to any joint hearing panel appointed for a Consolidated Hearing.

c. Knowledge of the underlying matter does not prohibit anyone from serving as a hearing panel member.

d. Employment by, or a contract with, Wellstar, a Hospital, or any affiliated entity shall not preclude any individual from serving on the hearing panel.

e. The hearing panel shall not include any individual who is in direct economic competition with the individual requesting the hearing.

f. The hearing panel shall not include any individual who is professionally associated with, related to, or involved in a significant referral relationship with, the individual requesting the hearing.

g. The hearing panel shall not include any individual who is demonstrated to have an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter.

h. In addition, the appointment of the hearing panel shall comply with the guidelines set forth in the conflict of interest provisions found in Article V of the Medical Staff Rules and Regulations.

When a hearing panel is appointed, the Hospital President also will select a presiding officer.

2. Presiding Officer

The Hospital President shall appoint an attorney at law or other qualified person to serve as a presiding officer. The presiding officer will:

a. Ensure all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence, with reasonable limits on the number of witnesses and duration of direct and cross examination that are applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process;

b. Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, or abusive, or that causes undue delay. The presiding officer may, in his/her discretion, limit the duration of the hearing to a reasonable time under the circumstances, including reasonable time limits on the presentation of evidence;

c. Maintain decorum throughout the hearing;

d. Determine the order of procedure throughout the hearing;

e. Make rulings on all questions that relate to procedural matters and the admissibility of evidence;

f. Act so that all information reasonably relevant to the appointment or clinical privileges of the individual requesting the hearing is considered by the hearing panel in formulating its recommendations; and

g. Conduct argument by counsel on procedural points outside the presence of the hearing panel, unless the panel members wish to be present.

The presiding officer may not be, or represent clients who are, in direct economic competition with the individual requesting the hearing, employed by the Hospital, or a member of the hearing panel. The presiding officer must not act as a prosecuting officer or as an advocate for either side at the hearing. The presiding officer may participate in the private deliberations of the hearing panel and be a legal advisor to it but is not entitled to vote on the recommendations. The presiding officer may thereafter continue to advise the Board of Trustees on the matter as legal counsel.

3. Objections to the Hearing Panel

Any objection to any member of the hearing panel, to the presiding officer, or to the hearing officer, shall be made in writing, within 10 days of receipt of notice, to the Hospital President. A copy of such written objection must be provided to the Chief of Staff and must include the basis for the objection. The Chief of Staff shall be given a reasonable opportunity to comment. The Hospital President shall rule on the objection and give notice to the parties. The Hospital President may request that the Presiding Officer make a recommendation as to the validity of the objection.

G. Pre-Hearing Discovery

Except as specifically provided in this Section 5-1, G, there is no right to pre-hearing discovery. All objections to documents and/or witnesses, to the extent then reasonably known, must be submitted in writing to the presiding officer and ruled upon before the hearing. The presiding officer will not entertain later objections, unless the party offering the objection demonstrates

good cause. Applicants and Practitioners are not entitled to, will not be given access to, and will not be allowed to introduce, any evidence of any peer review records, minutes or other documents or information that relate to other applicants or Practitioners or actions taken or not taken with respect to other applicants or Practitioners.

1. Witness Lists

Within ten (10) days of receiving the notice of the hearing, the Applicant or Practitioner must provide a written list of the names and addresses of the individuals expected to offer testimony or present evidence on his or her behalf. The proposed list of witnesses who will testify or present evidence in support of the MEC is provided to the Applicant or Practitioner in the notice of hearing as explained in Section 5-1, E. Hospital employees appearing on the MEC's witness list cannot be contacted by the Applicant or Practitioner, his/her attorney, or anyone else acting on the Applicant or Practitioner's behalf, unless specifically agreed to by Hospital counsel.

The witness list of either party may be supplemented or amended at any time up to ten (10) calendar days prior to the hearing. In the discretion of the presiding officer, the witness list of either party may be supplemented or amended at any time during the hearing, provided that notice of the change is given to the other party. The presiding officer also has the authority to limit the number of witnesses (see Section 5-1, F.2.a).

2. Documents

The Applicant or Practitioner is entitled to copies of, or reasonable access to, the following documents, upon specific request, if a stipulation is signed by both parties that the documents and their content will be maintained as confidential and not be disclosed or used for any purpose outside of the hearing:

a. All patient medical records referred to in the statement of reasons (these are provided at the Practitioner's expense);

b. Reports of experts relied on by the Credentials Committee or the MEC;

c. Copies of relevant minutes (with portions regarding other Physicians and unrelated matters deleted); and

d. Any other documents relied on by the Credentials Committee or the MEC.

The following documents shall <u>not</u> be disclosed or used as part of the hearing:

a. Information regarding other Practitioners; and

b. Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges.

Disclosure of any document per this subsection shall not constitute a waiver of the protections provided by state or federal peer review, medical review, credentialing, privileging, or quality review statutes. Intentional disclosure of documents by the Applicant, Practitioner or his/her representative contrary to these procedures or applicable

law constitutes independent grounds for disciplinary action, up to and including termination of Medical Staff membership and/or clinical privileges. Any and all documents produced hereunder shall be returned to the Hospital or destroyed upon the completion of the hearing and appeals process and under all circumstances shall remain privileged and confidential.

3. Exhibit Lists

Either ten (10) calendar days before the hearing, or on the date set by the presiding officer or the date agreed to by counsel for both sides, each party must provide the other party with a list of proposed exhibits.

H. Pre-Hearing Conference

The presiding officer may require a representative for the individual and for the MEC to participate in a pre-hearing conference. At the pre-hearing conference, the presiding officer shall resolve all procedural questions, including any objections to exhibits or witnesses, and determine the time to be allotted to each witness's testimony and cross-examination.

I. Hearing Procedure

1. Failure of the Applicant or Practitioner to Appear and Proceed

The Applicant or Practitioner's personal appearance at the hearing is required. If the Applicant or Practitioner fails to appear personally and proceed at the hearing without good cause, s/he is deemed to have waived the right to a hearing and to have accepted the adverse recommendation. Good cause for failure to appear will be determined by the presiding officer in his/her sole discretion. The recommendation will become effective when the Board of Trustees takes final action on the matter.

2. Record of the Hearing

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

3. Rights of Both Sides

Subject to reasonable limits as determined by the presiding officer, both sides have the right to:

a. Be represented by an attorney or other person of choice. Both sides shall notify the other of the name of their counsel, if any, as soon as practicable and at least ten (10) days prior to the hearing;

b. Have a record made of the proceedings, copies of which may be obtained by the Applicant or Practitioner upon payment of any reasonable charges associated with its preparation;

c. Call, examine, and cross-examine witnesses;

d. Present evidence determined to be relevant by the presiding officer, regardless of its admissibility in a court of law; and

e. Submit a written statement or memorandum of points and authorities at the close of the hearing session(s).

An Applicant or Practitioner who does not testify on his/her own behalf may be called and examined as if under cross-examination.

The hearing panel may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

4. Admissibility of Evidence

The hearing does not have to be conducted strictly according to the rules of law or evidence on examining witnesses or presenting evidence. Any relevant evidence will be admitted if it is the sort of evidence upon which responsible people are accustomed to relying in the conduct of serious affairs, regardless of whether the evidence would be admissible in a court of law. The concern of the hearing panel is with the truth of the matter, providing adequate safeguards for the rights and fairness of both parties. The hearing panel is entitled to consider all other information that may be considered, pursuant to these Bylaws, in connection with applications for appointment or reappointment and for clinical privileges.

5. Burden of Proof

The MEC or the Board of Trustees, depending upon whose recommendation prompted the hearing, bears the initial burden of presenting evidence that the recommendation is supported by a preponderance of the evidence.

Consistent with the burden on the individual to demonstrate that s/he satisfies, on a continuing basis, all criteria for initial appointment, reappointment, and clinical privileges, the individual who requested the hearing must prove that the recommendation: (1) is not supported by the preponderance of the evidence, or (2) is arbitrary and capricious by clear and convincing evidence.

6. Postponements

Requests for postponements or extensions of time beyond any time limit in this Article V may be granted by the presiding officer on a showing of good cause.

7. Presence of Hearing Panel Members

All members of the hearing panel shall be present, absent good cause, for all stages of the hearing and deliberations. A majority of the hearing panel shall be present throughout the hearing. In unusual circumstances when a hearing panel member must be absent from any part of the hearing, he or she shall read the entire transcript of the portion of the hearing from which s/he was absent.

8. Other Persons to be Present

The hearing shall be restricted to those individuals involved in the proceeding. Administrative personnel may be present as requested by the Chief of Staff or Hospital President.

9. Order of Presentation

The Board or the MEC, depending on whose recommendation prompted the hearing initially, shall first present evidence in support of its recommendation. Thereafter, the individual who requested the hearing shall present evidence.

10. Recesses and Adjournment

The presiding officer may recess and reconvene the hearing for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing will be finally adjourned.

11. Post Hearing Statements

Each party shall have the right to submit a written statement within timeframes and page limits as required by the hearing panel, following the parties' receipt of the transcript of the hearing. Written statements shall be submitted by both parties on the same date.

J. Hearing Panel Deliberations and Written Report

1. Deliberations and Recommendation of the Hearing Panel

Within 20 days after final adjournment of the hearing (which may be designated as the time the hearing panel receives the hearing transcript or any post-hearing statements, whichever is later), the hearing panel shall conduct its deliberations outside the presence of any other person except the presiding officer. Thereafter, the hearing panel shall render a recommendation, accompanied by a report, which shall contain a concise statement of the basis for its recommendation in accordance with the burden of proof set forth in Section 5-1, I.5. The hearing panel's decision must be based on the evidence produced at the hearing and in the record, including:

- Oral testimony of witnesses;
- Post-hearing written statements;
- Any information regarding the Applicant or Practitioner that was admitted into evidence at the hearing and the Applicant or Practitioner had an opportunity to comment on and refute it;
- Any applications, references and accompanying documents;
- Other documented evidence, including medical records; and

- Any other evidence that was admitted into evidence at the hearing.

2. Disposition of Hearing Panel Report

The hearing panel shall deliver its report to the Hospital President who shall forward it, along with all supporting documentation, to the Board for further action. The Hospital President shall also send a copy of the report and recommendation, certified mail, return receipt requested, to the individual who requested the hearing, and to the MEC for information.

Either party may request an appeal within ten (10) days of receiving the hearing panel's report as described more fully in Section 5-2, B.

Section 5-2. Appeals

A. Grounds for an Appeal

Either party may request an appeal from a decision of a hearing panel or hearing officer for the grounds listed below:

1. There was substantial failure to comply with these Bylaws; and/or

2. The hearing panel's recommendations were made arbitrarily, capriciously or with prejudice and/or were not supported by a preponderance of the evidence.

B. Requesting an Appeal

An appeal must be requested for the grounds listed above in Section 5-2, A, within 10 days of receiving the hearing panel's report (see Section 5-1, J for the hearing panel's report). The request for an appeal must be in writing and delivered to the Hospital President either in person or by certified mail. The request must include a brief statement of the reasons for appeal. If an appeal is not requested within ten (10) days as described, both parties are deemed to have waived the right to request an appeal and to have accepted the recommendation in the hearing panel's report, and the recommendation will take effect immediately and become final upon adoption by the Board of Trustees.

C. Scheduling an Appeal

When an appeal has been properly requested, the Chair of the Board of Trustees shall schedule and arrange for the appellate review. The Applicant or Practitioner will be given written notice of the time, date and place of the appellate review by certified mail, return receipt requested. The appeal shall be held as soon as arrangements can reasonably be made, considering the schedules of all the individuals involved.

D. Appointing an Appeals Panel

The Board of Trustees Chair will appoint an appeals panel that is composed of at least three (3) Board of Trustees members to consider the record upon which the hearing panel's recommendation was made and to recommend final action to the Board of Trustees. At least one member of the appeals panel must be a Physician. Members of the appeal panel may not be direct competitors of the Practitioner under review and should not have participated in any formal investigation leading to the recommendation for corrective action that is under consideration.

E. Appeal Procedure

1. Each party has the right to present a written statement to the appeals panel in support of its position on appeal, subject to reasonable page limits as required by the appeals panel. The party requesting the appeal shall submit a statement first and the other party shall then have ten (10) days to submit a written statement in response.

2. The appeals panel may, in its sole discretion, allow each party or its representative to appear personally and make a time-limited thirty (30) minute oral presentation.

3. When requested by either party, the appeals panel may, in its sole discretion, accept additional oral or written evidence, subject to the same rights of cross-examination, not provided at the hearing panel proceedings. Additional evidence may be accepted only if the party seeking to admit it can demonstrate: (a) that it is relevant, new evidence that could not have been presented at the hearing, or (b) that any opportunity to admit it at the hearing was improperly denied.

4. If the appeals panel allows for oral argument, a stenographic reporter shall be present to make a record of the appeal. The cost of the reporter shall be borne by the Hospital. Copies of the transcript shall be available at the individual's expense.

F. Appeals Panel Written Report

The appeals panel will send a written report of its recommendation on the matter, including the specific reasons for its recommendation, to the Board of Trustees Chair.

G. Final Decision of the Board of Trustees

1. Within 30 days after the Board (i) receives a recommendation from the appeals panel, or (ii) receives the Hearing Panel's report and recommendation when no appeal has been requested, the Board shall consider the matter and take final action.

2. The Board may review any information that it deems relevant, including, but not limited to, the findings and recommendations of the MEC, hearing panel, and appeals panel (if applicable). The Board may adopt, modify, or reverse any recommendation that it receives or, in its discretion, refer the matter to any individual or committee for further review and recommendation, or make its own decision based upon the Board's ultimate legal authority for the operation of the Hospital and the quality of care provided.

3. The Board shall render its final decision in writing, including specific reasons, and shall send special notice to the individual. A copy shall also be provided to the MEC for its information.

H. Further Review

The Board of Trustees may refer the matter for further review and recommendation, or it may affirm, modify or reverse the appeal panel's recommendation. Except where referred for further review and recommendation, the Board of Trustees decision is final, effective immediately, and is not subject to further review. If referred for further review and recommendation, the recommendation must be made promptly to the Board of Trustees per its instructions.

I. Right to One Appeal Only

No Applicant or Practitioner is entitled as a matter of right to more than one appellate review on any single matter which may be the subject of an appeal. If the Board ultimately determines to deny Medical Staff appointment or reappointment to an Applicant, or to revoke or terminate the Medical Staff appointment and/or clinical privileges of a current member or a Physician or Dentist with privileges without membership, that individual may not apply within ten (10)

years for Medical Staff appointment or for those clinical privileges at the Hospital unless the Board provides otherwise.

Section 5-3. Hearings & Appeals for Practitioners with Privileges Without Medical Staff Membership and Who Are Not Physicians or Dentists

Advanced Practice Professionals (APPs) and Allied Health Professionals (AHPs) are not entitled to the hearing and appeals procedures set forth in the Medical Staff Bylaws. However, if the Hospital will voluntarily report such Practitioner to the NPDB, the Practitioner must have the full fair hearing and appeal process as set forth in Sections 5-1 and 5-2 above. If the Practitioner will not be voluntarily reported to the NPDB, the Practitioner shall be entitled to the review process set forth below.

A. If an APP or AHP receives notice of a recommendation by the MEC that will adversely affect his/her exercise of clinical privileges, the Practitioner and his/her supervising Physician, if applicable, shall have the right to request an in-person meeting (a "Review Meeting") with two Physicians and two peers from the same professional discipline who are not financial competitors with the affected Practitioner assigned by the Chief of Staff (the "Review Body") to discuss the recommendation.

B. The request for a Review Meeting must be made in writing to the Hospital President within ten (10) business days from the date of receipt of notice of an adverse recommendation. Failure to request a Review Meeting within ten (10) business days shall result in a waiver of the remainder of the review process in this Section 5-3 and the adverse recommendation shall be forwarded to the Board for final action.

C. At the Review Meeting, the Practitioner and the supervising Physician, if applicable, must be present to discuss, explain, or refute the recommendation. A Review Meeting shall not constitute a hearing and none of the procedural rules set forth in the Medical Staff Bylaws with respect to hearings shall apply. Neither the Practitioner nor his/her supervising Physician, if applicable, shall have the right to be accompanied by legal counsel at this meeting. The Review Body shall make written findings regarding the adverse recommendation and forward those findings to the affected Practitioner and the MEC.

D. Upon receipt and review of the Review Body's written findings, the MEC shall make a final recommendation regarding the Practitioner's clinical privileges.

E. If the MEC's final recommendation adversely affects the Practitioner's exercise of his/her clinical privileges, the Practitioner and the supervising Physician, if applicable, may request an appeal in writing to the Hospital President within ten (10) days of receipt of the findings of the Review Body. Two members of the Board assigned by the chair of the Board (the "Appeal Body") shall hear the appeal from the Practitioner and the supervising Physician. A representative from the Medical Staff leadership may be present.

F. Upon completion of the review, the Appeal Body will provide a report and recommendation to the full Board for action. The Board will then make its final decision based upon the Board's ultimate legal responsibility to grant privileges and to authorize the performance of clinical activities at the Hospital. The Practitioner and the supervising Physician will be notified within ten (10) days of the final decision of the Board. A copy of the Board's final action will also be sent to the MEC for information.

Wellstar Health System

MEDICAL STAFF BYLAWS

Definitions

DEFINITIONS

Advanced Practice Professionals (APPs) – APPs perform delegated medical acts *under the supervision of a Physician* (MD/DO) and include certified nurse midwives, certified registered nurse anesthetists (CRNAs), clinical pharmacist practitioners, certified nurse practitioners (CNPs), certified nurse specialists, physicians' assistants (PAs), and physician assistant anesthetists (PAAs). APPs are granted clinical privileges, but they are not members of the Medical Staff.

Allied Health Professionals (AHPs) – AHPs are credentialed by the Medical Staff to the extent that they perform delegated medical acts (*i.e.*, actively ligate, retract, incise, and/or close) *under the supervision of a Physician* (MD/DO) and include registered nurses, licensed practical nurses, registered nurse first assistants (RNFA), certified surgical assistants (CSA), and other medical assistants. AHPs are granted clinical privileges if they incise, ligate, actively retract, or close. AHPs are not members of the Medical Staff.

Applicant – an individual who is applying for Medical Staff membership and/or clinical privileges.

Board of Trustees or **Board** – the Board of Trustees for Wellstar Health System, Inc. that has been delegated by the subsidiary operating entities the overall fiduciary responsibility for the conduct of the Hospitals, except for the West Georgia Medical Center, Inc. Board of Trustees, which acts as the governing body on behalf of Wellstar West Georgia Medical Center. The Board of Trustees serves as the governing body for each Hospital as described in The Joint Commission standards and the CMS Medicare Conditions of Participation.

Board Safety and Quality Committee – the Board Safety and Quality Committee established pursuant to the Bylaws of the Board of Trustees.

Collaborative Practice Agreement – the job description or nurse protocol between an APP/AHP and his/her supervising Physician(s) that is required by Georgia law and describes those medical acts, tasks and functions delegated to the APP/AHP by the primary supervising Physician that are appropriate to the APP/AHP's education, qualification, training, skills, and competence.

Days – calendar days, unless it is specifically noted to be business days.

Dentist – an individual with a DDS or DMD degree who is fully licensed to practice dentistry in Georgia.

Federal Health Care Program – any plan or program that provides health benefits that are funded directly, in whole or in part, by the federal government or a state health care program (except for the Federal Employees Health Benefits Program). The most significant federal health care programs are Medicare, Medicaid, Blue Cross Federal Employee Program (FEP)/Tricare and the Veterans programs.

Hospital – a Wellstar Health System affiliate hospital, including Wellstar Atlanta Medical Center, Wellstar Cobb Medical Center, Wellstar Douglas Medical Center, Wellstar Kennestone Regional Medical Center, Wellstar North Fulton Medical Center, Wellstar Paulding Medical Center,

Wellstar Spalding Medical Center, Wellstar Sylvan Grove Medical Center, Wellstar West Georgia Medical Center, Wellstar Windy Hill Hospital, and any other hospital which is directly or indirectly controlled by or becomes part of Wellstar Health System.

Hospital President – the individual appointed by the Board of Trustees to act on its behalf in the overall administrative management of the Hospital. The term also includes the Hospital President's designated representative.

Investigation – a formal investigation opened by the Medical Executive Committee per Article IV, as reflected in the MEC's meeting minutes, regarding a Practitioner's clinical competence; care and treatment of patients or management of a case; known or suspected violation of applicable ethical standards; known of suspected violation of Medical Staff, Hospital or Board of Trustees Bylaws, rules regulations or policies (including, but not limited to, the Hospital's quality assessment, risk management and utilization review programs); and/or behavior or conduct that is considered lower than the standards of the Hospital or disruptive to the orderly operations of the Medical Staff or the Hospital, including the inability of the Practitioner to work harmoniously with others. All other actions and/or reviews are routine peer review.

Investigating Committee – the committee appointed by the Medical Executive Committee to conduct a formal investigation per Article IV, Section 4-2.

Medical Staff – the formal organization of Physicians, Oral and Maxillofacial Surgeons, Dentists, Podiatrists, and Psychologists who have been appointed to the Medical Staff by the Board of Trustees.

Medical Staff Bylaws – Bylaws of the Medical Staff that have been adopted by the Medical Staff and approved by the Board of Trustees, as explained in these Bylaws.

Medical Staff Year – the period from January 1 to December 31 of each year.

Nominating Committee – the nominating committee is composed of the Chief of Staff, Vice-Chief of Staff, one or two past Chiefs of Staff (if available), the Vice President of Medical Affairs and the Hospital President. The VPMA and Hospital President are non-voting members.

Oral and Maxillofacial Surgeon – an individual with a DDS or DMD degree who is fully licensed to practice oral surgery in Georgia.

Patient Encounter – admitting or attending a patient, in-facility consultation on an inpatient, or performing an inpatient or outpatient procedure; provided that, for emergency department Practitioners, hospitalists, pathologists, radiologists, anesthesiologists, or Practitioners in a Hospital-based clinic, each shift performed shall constitute a patient encounter.

Patient Safety Evaluation System (PSES) – the collection, management or analysis of information for reporting to or by a patient safety organization for patient safety activities including, but not limited to, efforts to improve patient safety and the quality of patient safety delivery, the collection and analysis of patient safety work product, the development and discrimination of information, maintenance of confidentiality and security measures and all other activities relating to improving patient safety.

Patient Safety Work Product – any data, reports, records, memoranda, analyses, including root cause analyses, or oral or written statements which are assembled or developed by or on behalf of the Hospital for reporting to a patient safety organization or are developed by a patient safety organization for the conduct of patient safety activities and which could result in improved patient safety, healthcare quality or healthcare outcomes or which identify the fact of reporting to a patient safety organization.

Physician – an individual with an MD or DO degree who is fully licensed to practice medicine in Georgia.

Podiatrist – an individual with a DPM degree who is fully licensed to practice podiatry in Georgia.

Practitioner – a collective term used to refer to all the members of the Medical Staff and to all individuals who hold clinical privileges at the Hospital.

Primary Supervising Physician – the Physician who is accountable to the Georgia Composite Medical Board for an APP/AHP's medical activities and professional conduct at all times, whether the Physician personally is providing supervision or the supervision is being provided by a back-up supervising Physician.

Psychologist – an individual with a PsychD or PhD degree who is fully licensed to practice psychology in Georgia.

Rules and Regulations – the Rules and Regulations of the Medical Staff that have been adopted by the Medical Executive Committee and approved by the Board of Trustees, as explained in these Bylaws.

Unassigned Patient Call – the call schedule for patients who do not have a Physician on the Medical Staff with appropriate privileges to manage the patient's condition.

Vice President of Medical Affairs (VPMA) – the Vice President of Medical Affairs for a Hospital employed by Wellstar Health System, Inc. or one of its subsidiaries or affiliates.

Voting Members of a Department – the voting members of a Department are the Department Chair and the active Medical Staff members who are assigned to the Department.

Wellstar Health System

MEDICAL STAFF BYLAWS

Appendix

APPENDIX A

APPROVAL & EFFECTIVE DATES

Wellstar Board of Trustees approved December 12, 2019 – Effective January 1, 2020

Wellstar West Georgia Board of Trustees approved February 17, 2020 – Effective March 1, 2020

As amended by:

- Wellstar West Georgia Board of Trustees effective November 20, 2023
- Wellstar Board of Trustees and Wellstar West Georgia Board of Trustees effective January 1, 2025