MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS OF EMORY HOSPITALS

CREDENTIALS POLICY

OF

EMORY JOHNS CREEK HOSPITAL, EMORY SAINT JOSEPH'S HOSPITAL, EMORY UNIVERSITY HOSPITAL, EMORY UNIVERSITY HOSPITAL MIDTOWN

Approved by the Board: August 19, 2021

CREDENTIALS POLICY

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ARTICLE 1

GENERAL

1.A. TIME LIMITS

Time limits referred to in this Policy and related policies and manuals are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

1.B. DELEGATION OF FUNCTIONS

(1) When a function is to be carried out by a Medical Staff Leader or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to one or more designees.

(2) When a Medical Staff Member is unavailable or unable to perform an assigned function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

1.C. CONFIDENTIALITY AND PEER REVIEW PROTECTION

1.C.1. Confidentiality:

All professional review activity and recommendations will be strictly confidential. No disclosures of any such information (discussions or documentation) may be made outside of the meetings of the committees charged with such functions, except:

(a) to another authorized individual and for the purpose of conducting professional review activity;

(b) as authorized by a policy; or

(c) as authorized by the Chief Executive Officer or by legal counsel to the Hospital.

Any breach of confidentiality may result in appropriate sanctions, including but not limited to a professional review action or appropriate legal action. Breaches of confidentiality will not constitute a waiver of any privilege. Any Member of the Medical Staff who becomes aware of a breach of confidentiality is encouraged to inform the Chief Executive Officer, the Chief Medical Officer, or the Chief of Staff (or the Vice Chief of Staff if the Chief of Staff is the person committing the claimed breach).

1.C.2. Peer Review Protection:

All professional review activity will be performed by the professional practice evaluation committees. Professional Practice Evaluation Committees include, but are not limited to:

(a) all standing and ad hoc Medical Staff and Hospital committees;

(b) all clinical services and sections;

(c) hearing and appellate review panels;

(d) the Board and its committees; and

(e) any individual or body acting for or on behalf of a professional committee, Medical Staff Leaders, and experts or consultants retained to assist in professional review activity.

All oral and written communications, reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and covered by the provisions of applicable law, including the protections offered by Ga. Code Ann. §31-7-15 and §31-7-131 et seq. or the corresponding provisions of any subsequent state statute providing protection to peer review or related activities, and are deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986 ("HCQIA"), 42 U.S.C. §11101 et seq.

1.D. DEFINITIONS

The following definitions apply to terms used in this Policy:

(1) "ADVANCED PRACTICE PROVIDER" ("APP") refers to an individual, other than a licensed Physician, Oral/Maxillofacial Surgeon, Dentist, Allied Health Professional, or Podiatrist, whose patient care activities require the authority to perform specified patient care services processed through the usual Medical Staff channels.

An APP is not a Member of the Medical Staff. APPs as defined in this policy will be credentialed pursuant to the Emory Healthcare Policy on Advanced Practice and Allied Health Professionals.

(2) "ALLIED HEALTH PROFESSIONAL" ("AHP") refers to an individual, other than a licensed Physician, Oral/Maxillofacial Surgeon, Dentist, Advanced Practice Provider or Podiatrist, whose patient care activities require the authority to perform specified patient care services processed through the usual Medical Staff channels.

An AHP is not a Member of the Medical Staff. AHPs as defined in this Policy will be credentialed pursuant to the Emory Healthcare Policy on Advanced Practice Provider and Allied Health Professionals.

(3) “APPLICANT” means a Practitioner who has completed and submitted an application for Medical Staff Membership, for Clinical Privileges, or for both.

(4) “BOARD” means the body designated as the governing body of the Hospital, and which has the authority for all Medical Staff, credentialing, and professional practice evaluation activities at the Hospital.

(5) “BOARD CERTIFICATION” is the designation conferred upon a Practitioner who has successfully completed an approved educational training program and an evaluation process, including passing an examination in the applicant’s area of clinical practice, and continues to be recognized by the board for maintaining Board Certification.

(6) “BYLAWS” or MEDICAL STAFF BYLAWS” means the Medical Staff Bylaws of the Hospital.

(7) “CHIEF MEDICAL OFFICER” (“CMO”) means the Medical Staff Member appointed to serve as the chief administrative official responsible for liaising between Hospital administration and the Medical Staff, engaging and aligning stakeholders to drive clinical quality, patient safety and Medical Staff Performance Improvement initiatives and partnering with Medical Staff Leaders to ensure efficient Medical Staff governance and operations.

(8) “CLINICAL PRIVILEGES” or “PRIVILEGES” means the authorization granted by the Board to render specific patient care services, for which the Medical Staff Leaders and Board have developed eligibility and other credentialing criteria and focused and ongoing professional practice evaluation standards.

(9) “CONTINUING MEDICAL EDUCATION” (“CME”) consists of educational activities which serve to maintain, develop or increase the knowledge, skills, and professional performance and relationships that a Physician uses to provide services for patients, the public or the profession. The content of CME is the body of knowledge and skills generally recognized and accepted by the profession as within the basic medical sciences, the discipline of clinical medicine, and the provision of health care to the public.

(10) “CORE PRIVILEGES” means a defined grouping of Privileges for a specialty or subspecialty that includes the fundamental patient care services that are routinely taught in residency and/or fellowship training for that specialty or subspecialty and which have been determined by the Medical Staff Leaders and Board to require closely related skills and experience.

(11) “CORPORATE DIRECTOR OF ADVANCED PRACTICE PROVIDERS” means the individual appointed by Emory Healthcare to provide oversight and coordination of APP practice.

(12) “CHIEF EXECUTIVE OFFICER” means the individual appointed by the Board to act on its behalf in the overall management of the Hospital.

(13) “CREDENTIALS COMMITTEE” means the Medical Staff committee that is charged with reviewing the credentials of all applicants for appointment/reappointment and/or privileges and forwarding its recommendations to the Medical Executive Committee for review, among other responsibilities set forth in this Policy and the Organization Manual.

(14) “DAYS” means calendar days.

(15) “DELEGATING/SUPERVISING PHYSICIAN” refers to a Medical Staff Member in good standing who is responsible for the Supervision and direction of an APP or AHP under applicable law. The Sponsoring Physician for an APP or AHP performs the duties of the Supervising Physician as stipulated in the rules of the appropriate State Board of Medical or Nurse Examiners.

(16) “DENTIST” means a doctor of dental surgery (“D.D.S.”) or doctor of dental medicine (“D.M.D.”).

(17) “EX OFFICIO” means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means with voting rights.

(18) “FOCUSED PROFESSIONAL PRACTICE EVALUATION” (“FPPE”) means a time-limited period of evaluating a Practitioner’s privilege-specific competence, if the Practitioner a) does not have documented evidence of competency performing the required privilege at the Hospital; or b) a question has arisen regarding the Practitioner's ability to provide safe, high quality patient care. This type of Focused Evaluation is implemented for all initially requested Privileges, and it can include chart review, monitoring, simulation, proctoring, external peer review and discussion with individuals involved in patient care.

(19) “HEARING OFFICER” means the individual described in Section 7.A.6 (c).

(20) “HEARING PANEL” means those individuals described in Section 7.A.6 (a).

(21) “HOSPITAL” refers to Emory Johns Creek Hospital, Emory Saint Joseph’s Hospital, Emory University Hospital, and/or Emory University Hospital Midtown, as applicable.

(22) “MEDICAL EXECUTIVE COMMITTEE” (“MEC”) means the Medical Executive Committee of the Hospital.

(23) “MEDICAL STAFF” means all Physicians, Dentists, Podiatrists, and oral/maxillofacial surgeons who have been appointed to the Medical Staff by the Board.

(24) “MEDICAL STAFF LEADER” means any Medical Staff officer, chief of service, section chief, or committee chair.

(25) “MEDICAL STAFF OFFICE” means the Medical Staff Office at the Hospital or the Emory Healthcare Credentialing Verification Office (CVO).

(26) “MEDICAL STAFF SERVICES DEPARTMENT” means the department at Emory Healthcare responsible for assisting the medical staff in fulfilling their responsibilities as required

by local, state, and federal regulations and accrediting bodies. The department is tasked with ensuring an efficient and confidential credentialing and privileging process, and maintaining documentation of those members of the Medical Staff who meet the qualifications, standards, and requirements, set forth in the Medical Staff bylaws.

(27) “MEDICAL STAFF YEAR” means January 1st through December 31st.

(28) “MEMBER” means any Physician, Dentist, Oral Surgeon, and Podiatrist who has been granted Medical Staff appointment by the Board.

(29) “NOTICE” means written communication by regular U.S. mail, email, facsimile, or Hospital mail.

(30) “ONGOING PROFESSIONAL PRACTICE EVALUATION” (“OPPE”) means ongoing review and identification of professional practice trends. This type of ongoing evaluation can include chart review, direct observation, monitoring, and discussions. This information is used to determine a) whether to continue, limit, or revoke existing Privileges; and b) whether a period of Focused Professional Practice Evaluation for a particular Practitioner should occur.

(31) “ORAL/MAXILLOFACIAL SURGEON” means an individual with a D.D.S. or a D.M.D. degree, who has completed additional training in oral and maxillofacial surgery.

(32) "ORGANIZED HEALTH CARE ARRANGEMENT” (“OHCA”) means the term used by the HIPAA Privacy Rule which permits the Hospital and Medical Staff to use joint notice of privacy practices information when patients are admitted to the Hospital. Practically speaking, being part of an OHCA allows the Members of the Medical Staff to rely upon the Hospital notice of privacy practices and therefore relieves Medical Staff Members of their responsibility to provide a separate notice when Members consult or otherwise treat Hospital inpatients.

(33) “PATIENT CONTACTS” includes any admission, consultation, procedure, response to emergency call, evaluation, treatment, or service performed in any facility operated by the Hospital or affiliate, including outpatient facilities. It shall not include referrals for diagnostic or laboratory tests or x-rays.

(34) “PERFORMANCE IMPROVEMENT” (“PI”) refers to the coordinated, systematic, Hospital wide approach to improving patient care and health outcomes. Components of Performance Improvement include planning, monitoring, continuous assessment, and improvement of the quality of care and services provided.

(35) “PERMISSION TO PRACTICE” means the authorization granted to Advanced Practice and Allied Health Professionals to exercise Clinical Privileges or a Scope of Practice.

(36) “PHYSICIAN” includes both doctors of medicine (“M.D.s”) and doctors of osteopathy (“D.O.s”).

(37) “PODIATRIST” means a doctor of podiatric medicine (“D.P.M.”).

(38) "PRACTITIONER" means, unless otherwise expressly defined, a Physician, Oral/Maxillofacial Surgeon, Podiatrist, Dentist, APP or AHP who has been granted Clinical Privileges or a Scope of Practice in the Hospital through the usual Medical Staff channels.

(39) "PRESIDING OFFICER" means the individual described in Section 7.A.6 (b).

(40) "PROFESSIONAL PRACTICE EVALUATION COMMITTEE(S)" means those committees that perform professional review activity and include, but are not limited to, those committees listed in Section 1.C.2

(41) "RESTRICTION" means a professional review action that:

(a) is recommended by the Medical Executive Committee as part of an investigation or agreed to by the Practitioner while he or she is under investigation or in exchange for the Medical Executive Committee not conducting an investigation or taking an adverse professional review action; and

(b) limits the individual's ability to independently exercise his or her clinical judgment (i.e., a mandatory concurring consulting requirement in which the consultant must approve the course of treatment in advance or a proctoring requirement in which the proctor must be present for the case and has the authority to intervene in the case, if necessary).

Restrictions do not include the following, whether recommended by the Medical Executive Committee or by any other Medical Staff committee:

(a) general consultation requirements, in which the Practitioner agrees to seek input from a consultant prior to providing care;

(b) observational proctoring requirements, in which the Practitioner agrees to have a proctor present to observe his or her provision of care; and

(c) other collegial Performance Improvement efforts, including informational letters, educational letters, or voluntary Performance Improvement plans that are suggested by the Medical Staff leadership and voluntarily agreed to by the Practitioner as a part of the routine professional practice evaluation process.

(42) "REVIEW PANEL" means those individuals who participate in appellate review of a Medical Staff hearing as set forth in Section 7.E.4.

(43) "SCOPE OF PRACTICE" means the authorization granted to a Category III Practitioner to perform certain clinical activities and functions under the supervision of, or in collaboration with, a Supervising Physician.

(44) "SPECIAL NOTICE" means hand delivery, certified mail (return receipt requested), or overnight delivery service providing receipt.

(45) “SUPERVISION” means the supervision of (or collaboration with) a Category II or Category III Practitioner by a Delegating or Supervising Physician, that may or may not require the actual presence of the Delegating or Supervising Physician, but that does require, at a minimum, that the Delegating or Supervising Physician be readily available for consultation. The requisite level of Supervision (general, direct, or personal) shall be determined at the time each Category II or Category III Practitioner is credentialed and shall be consistent with any applicable written supervision or collaboration agreement that may exist. (“General” Supervision means that the Physician is immediately available by phone, “direct” Supervision means that the Physician is on the Hospital’s campus, and “personal” Supervision means that the Physician is in the same room.)

(46) “SYSTEM” or “EHC” means Emory Healthcare.

(47) “TELEMEDICINE” means the exchange of medical information from one site to another via electronic communications for the purpose of providing patient care, treatment, and services.

(48) “UNASSIGNED PATIENT” means any individual who comes to the Hospital for care and treatment who does not have an attending Physician or specialist for the need required, or whose attending Physician or designated alternate is unavailable to attend the patient, or who does not want the prior attending Physician to provide him/her care while a patient at the Hospital.

ARTICLE 2

QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

2.A. QUALIFICATIONS

2.A.1. Threshold Eligibility Criteria:

To be eligible to apply for initial appointment, reappointment and/or Clinical Privileges and as a condition of maintaining ongoing appointment and/or Clinical Privileges, individuals must satisfy the applicable eligibility criteria unless in exceptional circumstances the Board has determined that a waiver will serve the best interests of the patients and of the Hospital[1]:

(a) Have a current, unrestricted license to practice in Georgia[2] that is not subject to any Restrictions, probationary terms, or conditions not generally applicable to all licensees, and have never had a license to practice revoked, restricted or suspended by any state licensing agency;

(b) As applicable to relevant practice, have a current, unrestricted DEA registration;

(c) Be available on a continuous basis, either personally or by arranging appropriate coverage, to respond to the needs of inpatients and Emergency Department patients in a prompt, efficient, and conscientious manner;

(d) Have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Hospital. Minimum coverage and sufficient amounts and terms will be established from time to time by the Board after consulting with the MEC. Generally, applicants shall carry prior acts or tail coverage required per the applicable Georgia statute of limitations, with a company licensed or authorized to do business in the State of Georgia, or participate in the Professional Liability Program of Emory Healthcare, Inc.;

(e) Have never been, and not currently be, excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care program;

(f) Have never had Medical Staff appointment, Clinical Privileges, or status as a participating provider denied, revoked, suspended or terminated by any health care facility, including this Hospital, or health plan for reasons related to clinical competence or professional conduct;

(g) Have never resigned Medical Staff appointment or relinquished Privileges during an investigation or in exchange for not conducting such an investigation at any

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1 An applicant bears the burden of demonstrating exceptional circumstances, and that his or her qualifications are equivalent to, or exceed, the criterion in question.

2 Applications from applicants awaiting a Georgia license may be processed.

health care facility, including this Hospital or have never had Privileges automatically resigned due to an omission;

(h) Have not been arrested, charged, indicted convicted of, or entered a plea of guilty or no contest to any felony; or to any misdemeanor related to: (a) Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse; (b) controlled substances; (c) illegal drugs; (d) violent act; (e) sexual misconduct; (f) moral turpitude; (g) child or elder abuse, or (h) the practitioner-patient relationship, or have been required to pay a civil monetary penalty for governmental fraud or program abuse;

(i) Agree to fulfill all Medical Staff responsibilities including, as applicable, emergency call for their specialty;

(j) Have an appropriate coverage arrangement with other Members of the Medical Staff for those times when the individual will be unavailable;

(k) Document compliance with all applicable training and educational protocols that may be adopted by the Medical Executive Committee and required by the Board, including, but not limited to, those involving electronic medical records or patient safety;

(l) Meet any current or future eligibility requirements that are applicable to the Clinical Privileges being sought or granted;

(m) If applying for Privileges in an area that is covered by an exclusive contract or arrangement, meet the specific requirements set forth in that contract or arrangement;

(n) Demonstrate recent clinical activity in their primary area of practice during the last two (2) years;

(o) Have successfully completed[3]*:

(1) A residency and/or, if applicable, a fellowship training program approved by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, the Royal College of Physicians and Surgeons of Canada, College of Family Physicians of Canada, or such successor organizations as applicable, in the specialty in which the applicant seeks Clinical Privileges;

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3 These requirements will be applicable only to those individuals who apply for initial Medical Staff appointment after the date of adoption of this Policy. Existing Members will be governed by the residency training and Board Certification requirements in effect at the time of their most recent reappointment.

(2) A dental or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association; or

(3) A podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association;

(p) Be Board Certified in their primary area of practice at the Hospital by the appropriate specialty/subspecialty board of the American Board of Medical Specialties ("ABMS"), the American Osteopathic Association ("AOA"), the American Board of Oral and Maxillofacial Surgery (ABOMS), the American Dental Association ("ADA"), the American Board of Podiatric Medicine ("ABPM"), the American Board of Foot and Ankle Surgery ("ABFAS"), the College of Family Physicians of Canada ("CFPC"), be a Fellow of the Royal College of Physicians of Canada ("FRCPC") or a Fellow of the Royal College of Surgeons of Canada ("FRCSC"), as applicable, or such other certifying boards as the Board may approve from time to time to be equivalent boards upon the review and recommendation of the Chief Medical Officer. Applicants who are not Board Certified at the time of application will be eligible for Medical Staff appointment if they are within the Board Certification eligibility time period defined by their respective specialty board, or within five (5) years from completion of accredited training in instances in which the specialty board has not defined a Board Certification eligibility period. Practitioners that fail to achieve initial Board Certification in their primary area of practice prior to the end of their Board Certification eligibility period will be ineligible to apply for initial appointment, reappointment or Clinical Privileges until they regain their board eligibility status by fulfilling the requirements set forth by their respective specialty board;

(q) Maintain Board Certification in their primary area of practice at the Hospital and, to the extent required by the applicable specialty/subspecialty board, continue to be recognized as Board Certified. Certification will be assessed at reappointment*[4;]

(r) For Medical Staff Membership at Emory University Hospital, be an Emory University employee and have a regular faculty appointment – continuous or limited – to the Emory University School of Medicine;

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4 The applicable time frame for existing Medical Staff Members with lapsed certifications to obtain recertification may be extended for up to one (1) additional appointment term. This extension shall not exceed two (2) years from the date the certification lapsed. In order to be eligible to request an extension in these situations, an individual must, at a minimum, satisfy the following criteria:

(a) Provide documentation from the appropriate certifying board confirming that the individual remains eligible to take the certification examination; and

(b) The appropriate service or section chief at the Hospital provides a favorable report concerning the individual's qualifications.

Exception(s): Under the following limited circumstances, the Emory University Hospital Medical Executive Committee may recommend waiving these requirements to the Board: (1) emergencies, (2) temporary Medical Staff shortages, or (3) contractual arrangements that authorize the performance of services in Emory University Hospital without requiring Emory employment or a faculty appointment as identified above. Exceptions based solely on contractual arrangements are not available for Emory University Hospital's Clifton campus unless pre-approved by the Executive Vice President for Health Affairs of Emory University.

(s) If seeking to practice as an APP or AHP, must have a Delegating or Sponsoring Physician and any required job description or protocol agreement that meets all applicable requirements of Georgia law and Hospital policy, as applicable; and

(t) Moreover, any Member who is summarily suspended from any hospital where he or she holds medical staff membership or has the right to exercise Clinical Privileges or any Member who is excluded or debarred from participation in any government health care program, must notify the Hospital within twenty-four (24) hours of such summary suspension, exclusion, or debarment.

2.A.2. Waiver of Threshold Eligibility Criteria:

(a) Any individual who does not satisfy a criterion may request that it be waived. The individual requesting the waiver bears the burden of demonstrating that his or her qualifications are equivalent to, or exceed, the criterion in question.

(b) The Board may grant waivers in exceptional cases after considering the findings of the Credentials Committee, Medical Executive Committee, or other committee designated by the Board; the specific qualifications of the individual in question; and the best interests of the Hospital and the community it serves. The granting of a waiver in a particular case is not intended to set a precedent for any other individual or group of individuals.

(c) No individual is entitled to a waiver or to a hearing if the Board determines not to grant a waiver.

(d) A determination that an individual is not entitled to a waiver is not a "denial" of Medical Staff appointment or Clinical Privileges. Rather, that individual is ineligible to request Medical Staff appointment or Clinical Privileges. A determination of ineligibility is not a matter that is reportable to either the state licensure board or the National Practitioner Data Bank.

(e) An application for Medical Staff appointment that does not satisfy an eligibility criterion will not be processed until the Board has determined that a waiver should be granted.

(f) If a waiver is granted that does not specifically include a time limitation, the waiver is considered to be permanent and the individual does not have to request a waiver at subsequent recredentialing cycles.

2.A.3. Factors for Evaluation:

The following factors will be evaluated as part of the Medical Staff appointment and reappointment processes:

(a) relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment and an understanding of the contexts and systems within which care is provided;

(b) adherence to the ethics of the profession, continuous professional development, an understanding of and sensitivity to diversity, equity, and inclusion and a responsible attitude toward patients and the profession;

(c) good reputation and character;

(d) ability to safely and competently perform the Clinical Privileges requested;

(e) ability to work harmoniously with others, including, but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families, and other members of health care teams; and

(f) recognition of the importance of, and willingness to support, a commitment to quality care and recognition that interpersonal skills and collegiality are essential to the provision of quality patient care.

2.A.4. No Entitlement to Appointment:

No one is entitled to receive an application, be appointed or reappointed to the Medical Staff or be granted permission to exercise particular Clinical Privileges merely because he or she:

(a) is employed by this Hospital or its subsidiaries or has a contract with this Hospital;

(b) is or is not a member or employee of any particular Physician group;

(c) is licensed to practice a profession in this or any other state;

(d) is a member of any particular professional organization;

(e) has had in the past, or currently has, Medical Staff appointment or Privileges at any hospital or health care facility;

(f) resides in the geographic service area of the Hospital; or

(g) is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity.

2.A.5. Nondiscrimination:

The Hospital will not discriminate in granting Medical Staff Membership and/or Privileges on the basis of gender, race, religion, age, national origin, disability unrelated to the provision of patient care or required Medical Staff responsibilities, or any other basis prohibited by applicable law, to the extent the applicant is otherwise qualified.

2.B. GENERAL CONDITIONS OF APPOINTMENT, REAPPOINTMENT, AND CLINICAL PRIVILEGES

2.B.1. Basic Responsibilities and Requirements:

As a condition of being granted Medical Staff appointment or reappointment or Clinical Privileges, and as a condition of ongoing appointment and maintenance of Clinical Privileges, every individual specifically agrees to the following:

(a) to provide continuous and timely care to all patients for whom the individual has responsibility, including cross-coverage twenty four hours, seven Days a week (24/7) by a Member of the Medical Staff with the same set of Core Privileges to manage emergent situations in the field;

(b) to abide by the bylaws, policies, and rules and regulations of the Hospital, Medical Staff and Emory Healthcare;

(c) to participate in Medical Staff affairs through committee service and participation in Performance Improvement and peer review activities, and to perform such other reasonable duties and responsibilities as may be assigned;

(d) to provide emergency call coverage, consultations, and care for Unassigned Patients;

(e) to comply with clinical practice or evidence-based protocols pertinent to his or her medical specialty, as may be adopted by the Medical Executive Committee or document the clinical reasons for variance;

(f) to obtain, when requested, an appropriate fitness for practice evaluation, which may include diagnostic testing (such as blood and/or urine test) or a complete physical, mental, and/or behavioral evaluation, as set forth in this Policy;

(g) to participate in personal or phone interviews in regard to an application for initial appointment or reappointment, if requested;

(h) to use the Hospital sufficiently, as determined by the chief of service, to allow for continuing assessment of current competence;

(i) to seek consultation whenever necessary;

(j) to complete in a timely manner all medical and other required records;

(k) to perform all services and to act in a cooperative and professional manner;

(1) to promptly pay any applicable dues, assessments, or fines;

(m) to comply with Emory Healthcare and the Hospital's policies around the use of electronic medical record system;

(n) to satisfy Continuing Medical Education requirements as may be established by MEC and Board;

(o) to complete any applicable orientation programs at the Hospital before participating in direct patient care;

(p) to comply with all applicable training and educational protocols that may be adopted by the Medical Executive Committee, including, but not limited to, those involving electronic medical records, patient safety, and infection control;

(q) to maintain with the Emory Healthcare Medical Staff Services Department, and access on an ongoing basis, an active personal current e-mail address that goes directly to the Medical Staff Member which will be the primary mechanism used to communicate all Medical Staff information to the Member;

(r) to disclose conflicts of interest regarding relationships with pharmaceutical companies, device manufacturers, other vendors or other persons or entities as may be required by EHC, Hospital or Medical Staff policies, 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 to purchase;

(s) to participate in an OHCA with the Hospital and abide by the terms of the Hospital's notice of privacy practices with respect to health care delivered in the Hospital;

(t) that, if the individual is a Member of the Medical Staff who serves or plans to serve as a Delegating or Supervising Physician to an APP or AHP, the Member of the

Medical Staff will abide by the supervision requirements and conditions of practice set forth by the APP and AHP Policy; and

(u) that, if the individual is a Member of the Medical Staff at Emory Saint Joseph's Hospital, the individual shall abide by the terms of the Ethical and Religious Directives for Catholic Health Care Services promulgated by the National Conference of Catholic Bishops with respect to their practice at the Hospital. No activity prohibited by said directives shall be engaged in at the Hospital by any Member.

2.B.2. Burden of Providing Information:

(a) All applicants and Members have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, character, ethics, and other qualifications and for resolving any doubts.

(b) Applicants have the burden of providing evidence that all the statements made and all information provided by the applicant in support of the application, are accurate and complete.

(c) An application will be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application will become incomplete if the need arises for new, additional, or clarifying information. Any application that continues to be incomplete thirty (30) Days after the applicant has been notified of new, additional or clarifying information required and the applicant has been unresponsive may be deemed to be withdrawn.

(d) Applicants are responsible for providing a complete application, including adequate responses from references. An incomplete application will not be processed.

(e) Applications will not be processed from individuals who resigned from the Medical Staff within three hundred sixty-five (365) Days preceding the application, or whose previous application was deemed to be withdrawn or ineligible for continued processing due to failure of the applicant to respond timely to a request for information, or who had Membership or Privileges automatically relinquished, at this or any affiliated Hospital due to a finding of material omission or misrepresentation, unless the applicant provides good cause, and only in the sole discretion of the Credentials Committee, MEC, and Board.

(f) Applicants and Practitioners credentialed through the Medical Staff process are responsible for notifying the Chief Medical Officer as soon as possible but no later than thirty (30) Days of any change in status or any change in the information provided on the application form. This information is required to be provided with or without request, at the time the change occurs, and includes, but not be limited to:

(1) any change in information on the application form including, but not limited to changes in practice, address, or contact information;

(2) any threshold eligibility criteria for Medical Staff appointment or Clinical Privileges except that applicants and Members must report immediately those changes set forth in (d) of this Section;

(4) changes in professional liability insurance coverage; and

(5) the filing of a professional liability lawsuit against the Practitioner;

(g) Applicants and Practitioners credentialed through the Medical Staff process are responsible for notifying the Chief Medical Officer or his or her designee immediately, but not later than forty-eight (48) hours, of any change in status of the following:

(1) any and all complaints, including Georgia Composite Medical Board or other state licensing board/agency complaints, documents or other information known to the Practitioner regarding, or changes in, licensure status or DEA controlled substance authorization;

(2) arrest, charge, indictment, conviction, or a plea of guilty or no contest in any criminal matter;

(3) exclusion or preclusion from participation in Medicare, Medicaid or any other federal or state healthcare program or any sanctions imposed with respect to the same;

(4) any involuntary Restriction, probation, requirement for consultation or supervision, reduction, revocation, or suspension of Clinical Privileges at another facility within or outside the System; and

(5) any changes in the Practitioner's ability to safely and competently exercise Clinical Privileges or perform the duties and responsibilities of Medical Staff appointment because of health status issues, including, but not limited to, impairment due to addiction (all of which will be referred for review under the policy on Practitioner health).

2.B.3. Ethical and Religious Directives

All Medical Staff Members of Emory Saint Joseph's Hospital shall abide by the terms of the Ethical and Religious Directives for Catholic Health Care Services promulgated by the National Conference of Catholic Bishops with respect to their practice at Emory Saint Joseph's Hospital. No activity prohibited by said directives shall be engaged in at Emory Saint Joseph's Hospital by any Member.

2.C. APPLICATION

2.C.1. Information:

(a) Changes to the application forms for Medical Staff appointment or reappointment and Clinical Privileges, which are beyond administrative changes, will be approved by the Board, upon recommendation by the Credentials Committee and the Medical Executive Committee.

(b) The applications for initial Medical Staff appointment or reappointment and Clinical Privileges existing now and as may be revised, are incorporated by reference and made a part of this Policy.

(c) The application will contain a request for specific Clinical Privileges and will require detailed information concerning the applicant's professional qualifications, competency, and training. The applicant will sign the application and certify that he or she is able to perform the Privileges requested and the responsibilities of appointment. The applicant will be required to provide a copy of a government-issued photo identification

2.C.2. Misstatements and Omissions:

(a) Any misstatement in, or omission from, the application is grounds to stop processing the application. The applicant will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The Chief Medical Officer will review the response and determine whether the application should be processed further.

(b) If appointment has been granted prior to the discovery of a misstatement or omission, appointment and Privileges may be deemed to be automatically relinquished pursuant to this Policy.

(c) No action taken pursuant to this Section will entitle the applicant or Member to a hearing or appeal.

2.C.3. Grant of Immunity and Authorization to Obtain/Release Information:

(a) Conditions Prerequisite to Application and Consideration:

As a condition of having a request for application considered or applying for Medical Staff appointment or reappointment or Clinical Privileges, every individual accepts the terms set forth in this Section 2.C.

(b) Use and Disclosure of Information about Individuals:

(1) Information Defined:

For purposes of this Section 2.C, "information" means information about the individual, regardless of the form (which will include verbal, electronic, and paper), which pertains to the individual's Medical Staff appointment or reappointment or Clinical Privileges, or the individual's qualifications for the same, including, but not limited to:

(i) information pertaining to the individual's clinical competence, professional conduct, reputation, ethics, and ability to practice safely with or without accommodation;

(ii) any matter addressed on the application form or in the Medical Staff Bylaws, Credentials Policy, and other policies and rules and regulations of the Hospital, Medical Staff and Emory Healthcare;

(iii) any reports about the individual which are made by the Hospital, its Medical Staff Leaders, or their representatives to the National Practitioner Data Bank or relevant state licensing boards/agencies; and;

(iv) any references received or given about the individual.

(2) Authorization for Criminal Background Check:

The individual agrees to sign consent forms to permit a consumer reporting agency to conduct a criminal background check and report the results to the Hospital.

(3) Authorization to Share Information within the System:

The individual specifically authorizes the Hospital and all of Emory Healthcare to share information with one another, as provided in applicable System policies. This information may be shared at initial appointment, reappointment, and/or any other time during the individual's appointment.

(4) Authorization to Obtain Information from Third Parties:

The individual specifically authorizes the Hospital, Medical Staff Leaders, 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.

(5) Authorization to Disclose Information to Third Parties:

The individual also authorizes Hospital representatives and Medical Staff Leaders 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 or her professional qualifications for appointment, Privileges, and/or participation at the requesting organization/facility, and any licensure or regulatory matter.

(6) Access to Information by Individuals:

(i) Upon request, applicants will be informed of the status of their applications for Medical Staff appointment or reappointment or Clinical Privileges.

(ii) Except during the hearing and appeal processes, which are governed by Articles 7 and 8 of this Policy, an individual may review information obtained or maintained by the Hospital only upon request and only if the identity of the individual who provided the information will not be revealed.

(iii) If an individual disputes any information obtained or maintained by the Hospital, the individual may submit, in writing, a correction or clarification of the relevant information which will be maintained in the individual's file.

(c) Hearing and Appeal Procedures:

The individual agrees that the hearing and appeal procedures set forth in this Policy will be the sole and exclusive remedy with respect to any professional review action taken by the Hospital.

(d) 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 or the Board, any Member of the Medical Staff or the Board, their authorized

representatives, and third parties who provide information for any matter relating to Medical Staff appointment or reappointment or Clinical Privileges, or the individual's qualifications for the same.

This immunity covers any actions, recommendations, reports, statements, communications, or disclosures that are made, taken, or received by the Hospital, its representatives, or third parties in the course of credentialing and peer review activities or when using or disclosing information as described in this Section 2.C.. Nothing herein will be deemed to waive any other immunity or privilege provided by federal or Georgia law.

(e) Legal Actions:

If, despite this Section 2.C., an individual institutes legal action challenging any credentialing, privileging, peer review, or other professional review action or activity and does not prevail, he or she will reimburse the Hospital, the Board, and the Medical Staff, their authorized representatives, any Members of the Medical Staff, or Board, and any third party who provides information involved in the action for all costs incurred in defending such legal action, including costs and attorneys' fees and expert witness fees.

ARTICLE 3

PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES

3.A. PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES

3.A.1. Application:

(a) Prospective applicants will be sent the application and information that outlines the threshold eligibility criteria for Medical Staff appointment and the applicable criteria for Clinical Privileges.

(b) A completed application form with copies of all required documents should be returned to the Emory Healthcare Medical Staff Services Department within thirty (30) Days after receipt. The application must be accompanied by the application fee, if applicable.

(c) Applications may be provided to residents or fellows who are in the final six (6) months of their training. Final action will not be taken until all applicable threshold eligibility criteria are satisfied.

3.A.2. Initial Review of Application:

(a) As a preliminary step, the application will be reviewed by the Emory Healthcare Medical Staff Services Department to determine that all questions have been answered and that the applicant satisfies all threshold eligibility criteria. Applicants who fail to return completed applications or fail to meet the threshold eligibility criteria will be notified that their applications will not be processed. A determination of ineligibility does not entitle the individual to a hearing and appeal.

(b) The Emory Healthcare Medical Staff Services Department will oversee the process of gathering and verifying relevant information and confirming that all references and other information deemed pertinent have been received.

(c) Evidence of the applicant's character, professional competence, qualifications, behavior, and ethical standing will be examined. This information may be contained in the application and/or obtained from references and other available sources, including the applicant's past or current department chair at other health care entities, training director, and others including, but not limited to, hospital and medical staff leaders who may have knowledge about the applicant's education, training, experience, and ability to work with others. The National Practitioner Data Bank and the Office of Inspector General, and Medicare/Medicaid Exclusions will be queried, as required, and a criminal background check will be obtained.

(d) An interview(s) with the applicant may be conducted. The purpose of the interview is to discuss and review any aspect of the applicant's application, qualifications,

and requested Clinical Privileges. This interview will be conducted by one (1) or any combination of any of the following: chief of service, section chief, the Credentials Committee, a Credentials Committee representative, the Medical Executive Committee, the Chief of Staff, Chief Medical Officer, or the Chief Executive Officer.

3.A.3. Chief of Service, Section Chief and Chief Nursing Officer Procedure:

(a) The Medical Staff Office will transmit the complete application and all supporting materials to the chief of service and/or section chief of each clinical service in which the applicant seeks Clinical Privileges. The chief of service or section chief will prepare a recommendation regarding whether the applicant has satisfied all of the qualifications for appointment and the Clinical Privileges requested. The recommendation will be in the format required by the Medical Staff Office. The chief nursing officer, or their designee, will also review and make a recommendation on the applications for all advanced practice registered nurses.

(b) The chief of service, section chief, or chief nursing officer shall be available to the Credentials Committee, the MEC, and the Board to answer any questions that may be raised with respect to the recommendation.

3.A.4. Credentials Committee Procedure:

(a) The Credentials Committee will consider the completed report and will make a recommendation.

(b) The Credentials Committee may use the expertise of the chief of service, section chief, any Practitioner within the clinical service, or an outside consultant if additional information is required regarding the applicant's qualifications.

(c) After determining that an applicant is otherwise qualified for appointment and Privileges, if there is any question about the applicant's ability to perform the Privileges requested and the responsibilities of appointment, the Credentials Committee may require a fitness for practice evaluation pursuant to Section 6.E of this Policy by a Physician(s) satisfactory to the Credentials Committee. The results of this evaluation will be made available to the Committee.

(d) The Credentials Committee may recommend the imposition of specific conditions related to behavior, health or clinical issues. The Credentials Committee may also recommend that appointment be granted for a period of less than two (2) years in order to permit closer monitoring of the applicant's compliance with any conditions.

(e) If the recommendation of the Credentials Committee is delayed longer than sixty (60) Days, the chair of the Credentials Committee will send a letter to the applicant, with a copy to the Chief Executive Officer, explaining the reasons for the delay.

3.A.5. Medical Executive Committee Recommendation:

(a) At its next regular meeting after receipt of the written report and recommendation of the Credentials Committee, the Medical Executive Committee will:

(1) adopt the report and recommendation of the Credentials Committee as its own; or

(2) refer the matter back to the Credentials Committee for further consideration of specific questions; or

(3) state its reasons for disagreement with the report and recommendation of the Credentials Committee.

(b) If the recommendation of the Medical Executive Committee is to appoint, the recommendation will be forwarded to the Board.

(c) If the recommendation of the Medical Executive Committee would entitle the applicant to request a hearing, the Medical Executive Committee will forward its recommendation to the Chief Executive Officer, who will promptly send special notice to the applicant. The Chief Executive Officer will then hold the application until after the applicant has completed or waived a hearing and appeal.

3.A.6. Board Action:

(a) The Board may delegate to another expedited credentialing body, whose membership includes at least two (2) Board members, final action on appointment, reappointment, and Clinical Privileges if there has been a favorable recommendation from the Credentials Committee and the Medical Executive Committee for those applicants who meet the minimum criteria approved by the Board and set forth in the Emory Healthcare Expedited Credentialing Policy.

Any decision reached by the Expedited Credentialing Body to appoint applicants who qualify for expedited action will be forwarded to the Board for information at a subsequent meeting. At the reasonable discretion of the Expedited Credentialing Body, credentialing decisions on any applicant eligible for expedited action may be referred to the full Board for further review and/or action. Credentialing decisions referred to the full Board, either because they do not meet the criteria for expedited action directly from the MEC or because the Expedited Credentialing Body has decided to refer the decision to the Board, will require a signed letter to the Board from the chief of service, section chief or Chief Medical Officer describing in detail the recommendation for status and Privileges requested by the applicant. The Board may, at its discretion, require the chief of service, section chief, or Chief Medical Officer to appear personally before the Board to discuss the recommendation for status and Privileges requested by the applicant.

(b) When there has been no delegation to the Expedited Credentialing Committee, upon receipt of a recommendation that the applicant be granted appointment and Clinical Privileges, the Board may:

(1) grant appointment and Clinical Privileges as recommended; or

(2) refer the matter back to the Credentials Committee or Medical Executive Committee or to another source for additional research or information; or

(3) reject or modify the recommendation.

(c) If the Board or delegated Expedited Credentialing Body rejects the recommendation of the Credentials Committee and MEC to appoint or reappoint, it should first discuss the matter with the chair of the Credentials Committee and the chair of the Medical Executive Committee. If the Board's determination remains unfavorable, the Chief Executive Officer will promptly send special notice that the applicant is entitled to request a hearing.

(d) Any final decision by the Board to grant, deny, modify, or revoke appointment or Clinical Privileges will be disseminated to appropriate individuals and, as required, reported to appropriate entities.

3.A.7. Time Periods for Processing:

Once an application is deemed complete, it is expected to be processed within one hundred twenty (120) Days, unless it becomes incomplete. This time period is intended to be a guideline only and will not create any right for the applicant to have the application processed within this precise time period.

3.A.8. Reapplication

An applicant who has received a final adverse action concerning appointment or Clinical Privileges, shall not be eligible to reapply for appointment to the Medical Staff for a period of five (5) years unless the Board expressly provides otherwise. Upon the reapplication, the applicant shall submit additional specific information showing the condition or basis for the earlier adverse determination no longer exists.

ARTICLE 4

CLINICAL PRIVILEGES

4.A. CLINICAL PRIVILEGES

4.A.1. General:

(a) Appointment or reappointment will not confer any Clinical Privileges or right to practice at the Hospital. Only those Clinical Privileges granted by the Board may be exercised, subject to the terms of this Policy.

(b) A request for Privileges will be processed only when an applicant satisfies threshold eligibility criteria for the delineated Privileges. An individual who does not satisfy the eligibility criteria for Clinical Privileges may request, in writing, that the criteria be waived.

(c) Requests for Clinical Privileges that are subject to an exclusive contract or arrangement must be consistent with the applicable contract or arrangement.

(d) Recommendations for Clinical Privileges may be based on consideration of the following:

(1) education, relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, judgment, interpersonal and communication skills, and professionalism with patients, families, and other members of the health care team and peer evaluations relating to these criteria;

(2) appropriateness of utilization patterns to the extent such information is available and relevant;

(3) ability to perform the Privileges requested competently and safely;

(4) information resulting from Ongoing Professional Practice Evaluation, Focused Professional Practice Evaluation and other Performance Improvement activities, as applicable;

(5) availability of coverage in case of the applicant's illness or unavailability;

(6) adequate professional liability insurance coverage for the Clinical Privileges requested in the amounts of $1 million/$3 million or as determined by the Board and prior acts or tail coverage required per the applicable Georgia statute of limitations, with a company licensed or authorized to do business in the State of Georgia, or participation in the Professional Liability Program of Emory Healthcare, Inc.;

(7) the Hospital's available resources and personnel;

(8) any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration;

(9) any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or Clinical Privileges at another hospital;

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

(11) morbidity and mortality data, when available; and

(12) professional liability actions, especially any such actions that reflect an unusual pattern or number of actions.

e) Requests for additional Clinical Privileges must state the additional Clinical Privileges requested and provide information sufficient to establish eligibility.

4.A.2. Privilege Waivers:

a) In specialized circumstances, the Hospital may waive the requirement that Core Privileges, in whole or part, be granted. If an individual wants to request, or a chief of service or section chief wants to recommend, a partial or complete waiver of Core Privileges, the request or recommendation must be submitted in writing to the Hospital's Medical Staff Office. The request must indicate the specific Clinical Privileges that the individual does not wish to provide, state a good cause basis for the request, and include evidence that he or she does not provide the relevant patient care services in any health care facility.

(b) The Medical Staff Member seeking a waiver bears the burden of demonstrating exceptional circumstances, and that his or her qualifications are equivalent to, or exceed, the criterion in question. The chief of service must review the waiver request and recommend the waiver to the MEC, who will review and make a recommendation to the Board.

(c) It is the sole discretion of the Hospital to grant a waiver in exceptional circumstances. The following factors, among others, may be considered in deciding whether to grant a waiver:

(1) the Hospital's mission and ability to serve the health care needs of the community by providing timely, appropriate care;

(2) the effect of the request on the Hospital's ability to comply with applicable regulatory requirements;

(3) the expectations of Members who rely on the specialty;

(4) fairness to the individual requesting the waiver;

(5) fairness to other Medical Staff Members who serve on the call roster in the relevant specialty, including the effect that the modification would have on them; and

(6) the potential for gaps in call coverage that might result from an individual's removal from the call roster and the feasibility of safely transferring patients to other facilities.

(d) If the Board grants a waiver related to Privileges, it will specify the effective date.

(e) If the Medical Staff Member is granted a waiver, the Medical Staff Member shall be responsible for ensuring specialty coverage and transferring care in the event the Medical Staff Member lacks a Privilege to perform a certain procedure while serving on the call roster.

(f) No one is entitled to a waiver or to a hearing or appeal if a waiver is not granted.

4.A.3. Relinquishment of Individual Clinical Privileges:

In between reappointment cycles, a request to relinquish any individual clinical privilege, whether or not part of the core, must provide a good cause basis for the modification of Clinical Privileges. All such requests will be processed in the same manner as a request for waiver, as described above.

4.A.4. Resignation of Appointment and Clinical Privileges:

A request to resign all Clinical Privileges must (a) specify the desired date of resignation, which must be at least thirty (30) Days from the date of the request, and (b) provide evidence that the individual has completed all medical records and will be able to appropriately discharge or transfer responsibility for the care of any hospitalized patient. If appropriate arrangements have been made regarding the transfer of patient care, the CMO may reduce the resignation period. After consulting with the Chief Medical Officer, the CEO will act on the request. If an individual fails to complete the requirements listed above prior to the effective date of the resignation, he or she will not be considered to have resigned "in good standing" for purposes of future reference responses.

4.A.5. Clinical Privileges for New Procedures:

(a) Requests for Clinical Privileges to perform either a procedure not currently being performed at the Hospital or a new technique to perform an existing procedure ("new procedure") will not be processed until a determination has been made that the procedure will be offered by the Hospital and criteria for the Clinical Privilege(s) have been adopted.

(b) As an initial step in the process, the individual seeking to perform the new procedure will prepare and submit a report to the chief of service and the Credentials Committee addressing the following:

(1) minimum education, training, and experience necessary to perform the new procedure safely and competently;

(2) clinical indications for when the new procedure is appropriate;

(3) whether there is empirical evidence of improved patient outcomes with the new procedure or other clinical benefits to patients;

(4) whether proficiency for the new procedure is volume-sensitive and if the requisite volume would be available;

(5) whether the new procedure is being performed at other similar hospitals and the experiences of those institutions; and

(6) whether the Hospital currently has the resources, including space, equipment, personnel, and other support services, to safely and effectively perform the new procedure.

The chief of service and the Credentials Committee will review this report, conduct additional research as necessary, and make a preliminary recommendation as to whether the new procedure should be offered at the Hospital.

(c) If the preliminary recommendation is favorable, the Credentials Committee will then develop threshold credentialing criteria to determine those individuals who are eligible to request the Clinical Privileges. In developing the criteria, the Credentials Committee may conduct additional research and consult with experts, as necessary, and develop recommendations regarding:

(1) the minimum education, training, and experience necessary to perform the procedure or service;

(2) the clinical indications for when the procedure or service is appropriate;

(3) the extent (time frame and mechanism) of focused monitoring and supervision that should occur if the Privileges are granted; and

(4) the manner in which the procedure would be reviewed as part of the Hospital's Ongoing and Focused Professional Practice Evaluation activities.

(d) The Credentials Committee will forward its recommendations to the Medical Executive Committee, which will review the matter and forward its recommendations to the Board for final action.

4.A.6. Clinical Privileges That Cross Specialty Lines:

(a) As an initial step in the process, the individual seeking to add a non-core Clinical Privilege will 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 Clinical Privilege at other similar hospitals, and the experiences of those other hospitals in terms of patient care outcomes and quality of care.

(b) The Credentials Committee will then conduct additional research and consult with experts, as necessary, including those on the Medical Staff (e.g., chief of service, section chief, 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).

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

(1) the minimum education, training, and experience necessary to perform the Clinical Privileges in question;

(2) the clinical indications for when the procedure is appropriate;

(3) 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;

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

(5) 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

(6) the impact, if any, on emergency call responsibilities.

(d) The Credentials Committee will forward its recommendations to the Medical Executive Committee, which will 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 sixty (60) Days of receipt of the MEC's recommendation.

(e) Once the foregoing steps are completed, specific requests from eligible Medical Staff Members who wish to exercise the Privileges in question may be processed.

4.A.7. Practitioners in Training:

(a) Practitioners in accredited training programs will not be granted Clinical Privileges in the specific area where they are receiving training when they are functioning in a training program. The program director, clinical faculty, or attending Medical Staff Member will be responsible for the direction and supervision of the on-site or day-to-day patient care activities of each trainee, who will be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements, or training protocols approved by the Medical Executive Committee or its designee, and the Graduate Medical Education Committee of the Hospital. The applicable program director will be responsible for verifying and evaluating the qualifications of each Physician in training.

(b) Practitioners in non-accredited training programs will not be granted Clinical Privileges in the specific area where they are receiving additional training when they are functioning in the training program, unless the Practitioner satisfies the threshold eligibility criteria for the delineated Privileges in accordance with 4.A.1

(c) Termination in either training program will result in the automatic relinquishment of Clinical Privileges, without a right to the hearing and appeal procedures.

4.A.8. Telemedicine Privileges:

(a) Telemedicine is the provision of clinical services to patients by Practitioners from a distance via electronic communications.

(b) A qualified individual may be granted telemedicine Privileges, but need not be appointed to the Medical Staff.

(d) Requests for initial or renewed telemedicine Privileges will be processed through the same process for Medical Staff applications as set forth in this Policy unless a credentialing by proxy agreement is in place. In such case, the individual must satisfy all qualifications and requirements set forth in this Policy, except for those relating to geographic location, coverage arrangements, immunization, TB test, influenza vaccination and emergency call responsibilities. Notwithstanding the process set forth in this Subsection, the Hospital may determine that an applicant

for telemedicine Privileges is ineligible for appointment or Clinical Privileges if the applicant fails to satisfy the threshold eligibility criteria set forth in this Policy.

(d) Telemedicine Privileges, if granted, will be for a period of not more than two (2) years.

(e) Individuals granted telemedicine Privileges will be subject to the Hospital's peer review activities, including Focused Professional Practice Evaluation and Ongoing Professional Practice Evaluation. The results of the peer review activities, including any adverse events and complaints filed about the Practitioner providing telemedicine services from patients, other practitioners or staff, will be shared with the hospital or entity providing telemedicine services.

(f) Telemedicine Privileges granted in conjunction with a contractual agreement will be incident to and coterminous with the agreement.

4.A.9. Focused Professional Practice Evaluation for Initial Privileges:

(a) All initial grants of Clinical Privileges, whether at the time of appointment, reappointment, or during the term of an appointment, will be subject to Focused Professional Practice Evaluation by the chief of service, or by a Physician(s) designated by the chief of service. This Focused Professional Practice Evaluation will be conducted in accordance with the Hospital's FPPE policy.

(b) When, based upon information obtained through the Focused Professional Practice Evaluation process, a recommendation is made to terminate, revoke, or restrict Clinical Privileges for reasons related to clinical competence or professional conduct, the Member will be entitled to a hearing and appeal.

4.B. TEMPORARY CLINICAL PRIVILEGES

4.B.1. Temporary Clinical Privileges:

(a) Applicants. Temporary Privileges for an applicant for initial appointment may be granted by the Chief Executive Officer, upon recommendation of the Chief Medical Officer, under the following conditions:

i. The applicant has submitted a complete application, along with the application fee, if applicable;

ii. The verification process is complete, including verification of current licensure, relevant training or experience, current competence, ability to exercise the Privileges requested, and current professional liability coverage; compliance with Privileges criteria; consideration of information

from the National Practitioner Data Bank, a criminal background check, and from Office of Inspector General inquiries;

iii. The applicant meets the Hospital's criteria for expedited credentialing and raises no concerns;

iv. The application is pending review by the Credentials Committee, the MEC, and the Board, following a favorable report by the chief of service or section chief;

v. Temporary Privileges for a Medical Staff applicant will be granted for a maximum period of one hundred twenty (120) Days;

vi. Prior to any temporary Privileges being granted, the individual must agree in writing to be bound by the bylaws, policies, and rules and regulations of the Hospital, Medical Staff and Emory Healthcare;

vii. Individuals who are granted temporary Privileges will be subject to the Hospital policy regarding Focused Professional Practice Evaluation;

viii. The granting of temporary Clinical Privileges is a courtesy that may be withdrawn by the Chief Executive Officer at any time, after consulting with the Chief Medical Officer, the chair of the Credentials Committee or the chief of service; and

ix. Upon expiration of temporary Privileges, the chief of service, section chief, or Chief Medical Officer will assign to another member of the Medical Staff responsibility for the care of patients until such patients are discharged. Whenever possible, consideration will be given to the wishes of the patient in the selection of a substitute Physician.

(b) Visiting. Temporary Privileges may also be granted in other limited and exceptional situations by the CEO, upon recommendation of the Chief Medical Officer and the applicable chief of service or section chief, when there is an important patient care, treatment, or service need. Specifically, temporary Privileges may be granted for situations such as the following:

i. the care of a specific patient or a critical care need;

ii. when a proctoring or consulting Physician is needed, but is otherwise unavailable; or

iii. when necessary to prevent a lack or lapse of services in a needed specialty area.

At a minimum, the following factors will be considered and verified prior to the granting of temporary Privileges in these situations: current licensure and current competence (verification of good standing in all hospitals where the individual practiced for at least the previous two (2) years), current professional liability coverage

acceptable to the Hospital, and results of a query to the National Practitioner Data Bank and from Officer of Inspector General queries and a determination that the provider meets the Hospital's expedited credentialing criteria. The grant of Clinical Privileges in these situations will not exceed sixty (60) Days. In exceptional situations, this period of time may be extended in the discretion of the CEO and the Chief Medical Officer.

Any individual seeking visiting temporary Privileges who is currently appointed in good standing to another Emory Healthcare hospital with a grant of Clinical Privileges relevant to the request for visiting Privileges shall be immediately authorized to exercise visiting Privileges upon verification of good standing by the Emory Healthcare Medical Staff Services Department and the completion of a query to the National Practitioner Data Bank; verification of the additional factors referenced above is not required. For all other individuals, the verifications for such grants of Privileges shall generally be accomplished in advance; however, in an emergency situation, where life-threatening circumstances exist, the verifications listed above may be completed immediately after the grant of Privileges.

(c.) Locum Tenens. Requests for initial or renewed Privileges as a locum tenens provider will be processed through the same process for Medical Staff applications, as set forth in this Policy. In such case, the individual must satisfy all qualifications and requirements set forth in this Policy.

4.C. EMERGENCY SITUATIONS

(1) For the purpose of this Section, an "emergency" is defined as a condition which could result in serious or permanent harm to patient(s) and in which any delay in administering treatment would add to that harm.

(2) In an emergency situation, a Practitioner may administer treatment to the extent permitted by his or her license if no Practitioner having necessary Privileges is available, regardless of section status or specific grant of Clinical Privileges.

(3) When the emergency situation no longer exists, the patient will be assigned by the chief of service or the Chief Medical Officer to a Medical Staff Member with appropriate Clinical Privileges, considering the wishes of the patient.

4.D. DISASTER PRIVILEGES

(1) The Hospital may allow for the temporary privileging of Practitioners s to handle immediate patient care needs in the event of an Emergency Disaster. An "Emergency Disaster" is defined to mean that the Chief Medical Officer (or designee) has activated the emergency preparedness plan (internal/external) or has declared a disaster exists. The Chief Medical Officer is authorized to grant disaster Privileges.

(a) Before a volunteer licensed independent Practitioner is allowed to function, the Hospital will obtain his or her valid government issued

identification (for example, a driver's license or passport) and at least one of the following:

(i) A current picture identification card from a healthcare organization that clearly identifies professional designation;

(ii) Agency current license to practice;

(iii) Primary source verification of licensure;

(iv) 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-VHAP), or other recognized state or federal response hospital or group;

(v) Identification that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances; or

(vi) Confirmation by a licensed independent Practitioner currently privileged by the Hospital or by a Medical Staff Member with personal knowledge of the volunteer Practitioner's ability to act as a licensed independent Practitioner during a disaster.

(b) All volunteers shall complete a "Disaster Emergency Privilege Form." Volunteers will be issued a generic badge "MD Volunteer." or "Medical Volunteer" that clearly distinguishes the volunteer practitioners from Medical Staff Members or Hospital employees.

(c) The scope of Privileges granted will be Core Privileges consistent with the training, knowledge, and experience to practice in the specialty identified and supervised by a Physician in same specialty.

(d) Oversight of the care, treatment and services provided by volunteer licensed independent Practitioner will be conducted through direct observation or medical record review by the CMO or other Hospital designee or through other appropriate mechanisms developed by the Medical Staff or Hospital. Based on the oversight of each volunteer licensed independent Practitioner, the Hospital will determine within seventy-two (72) hours of the Practitioner's arrival whether the individual's status as a volunteer should continue.

(e) Unless sooner terminated, temporary Privileges granted will automatically terminate upon the termination of the disaster as determined by the EHC Command Center. The termination, denial, modification, or limitation of temporary Privileges shall not give rise to appeal rights under the Medical Staff Bylaws or any other authority.

(f) Primary source verification of licensure begins as soon as the immediate situation is under control and should be completed within seventy-two (72) hours from the time the volunteer Practitioner presents to the Hospital.

(g) All temporary Privileges granted to the volunteer Practitioner during the disaster will be presented to the Credentials Committee at the next meeting after the disaster is declared to be over.

(h) In the extraordinary circumstance that primary source verification cannot be completed in seventy-two (72) hours (e.g., no means of communication or a lack of resources), it is expected that it be done as soon as possible. In this extraordinary circumstance, there must be documentation of the following: (1) the reasons why primary source verification could not be performed in the required time frame; (2) evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and (3) an attempt to rectify the situation as soon as possible. Primary source verification of licensure would not be required if the volunteer Practitioner has not provided care, treatment, and services under the disaster Privileges.

4.E. CONTRACTS FOR SERVICES

(1) From time to time, the Hospital may enter into contracts with Physicians, Dentists, Oral/Maxillofacial Surgeons, or Podiatrists and/or groups of Physicians, Dentists, Oral/Maxillofacial Surgeons, or Podiatrists for the performance of clinical and/or administrative services at the Hospital. All individuals functioning pursuant to such contracts shall obtain and maintain Medical Staff appointment and/or Clinical Privileges, as applicable, at the Hospital, in accordance with the terms of this Policy.

(2) To the extent that any such contract confers the exclusive right to perform specified services at the Hospital on the other party to the contract, no other person may exercise Clinical Privileges to perform the specified services while the contract is in effect, unless the contract explicitly states otherwise.

(3) If any such exclusive contract would have the effect of preventing an existing Medical Staff Member from exercising Clinical Privileges that had previously been granted, the affected Member shall be given notice of the exclusive contract and

have the right to meet with the Board or a committee designated by the Board to discuss the matter prior to the effective date of the contract in question. At the meeting, the affected Member shall be entitled to present any information relevant to the decision to enter into the exclusive contract. That individual shall not be entitled to any other procedural rights with respect to the decision or the effect of the contract on his/her Clinical Privileges, notwithstanding any other provision of this Policy. The inability of a Physician to exercise Clinical Privileges due to an exclusive contract is not a matter that requires a report to the state licensure board or to the National Practitioner Data Bank.

(4) In the event of any conflict between this Policy and the Medical Staff Bylaws and the terms of any contract, the terms of the contract shall control, unless the contract explicitly states otherwise.

ARTICLE 5

PROCEDURE FOR REAPPOINTMENT

5.A. PROCEDURE FOR REAPPOINTMENT

All terms, conditions, requirements, and procedures relating to initial appointment will apply to continued appointment, reappointment, and grants of Clinical Privileges.

5.B. REAPPOINTMENT CRITERIA

5.B.1. Eligibility for Reappointment:

To be eligible to apply for reappointment and renewal of Clinical Privileges, an individual must have, during the previous appointment term:

(a) completed all Continuing Medical Education requirements;

(b) satisfied all Medical Staff responsibilities, including payment of any dues, fines, and assessments when applicable;

(c) continued to meet all qualifications and criteria for appointment and the Clinical Privileges requested as deemed sufficient by the chief of service or section chief;

(d) paid any applicable reappointment processing fee;

(e) had sufficient Patient Contacts to enable the assessment of current clinical judgment and competence for the Privileges requested. Any Member seeking reappointment who has minimal activity at the Hospital or within the System must submit such information as may be requested (such as a copy of his or her confidential quality profile from his or her primary hospital, clinical information from his or her private office practice, or a quality profile from a managed care organization or insurer), before the application will be considered complete and processed further;[5] and

(f) at Emory University Hospital, continued to have a regular faculty appointment – continuous or limited – to the Emory University School of Medicine.

5.B.2. Factors for Evaluation:

In considering an application for reappointment, the factors listed in Section 2.A.3 of this Policy will be considered. Additionally, the following factors will be evaluated as part of the reappointment process:

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5 The Hospital may determine whether Medical Staff Member has had sufficient Patient Contacts by reviewing information from other Emory Healthcare Hospitals.

(a) compliance with the bylaws, policies, and rules and regulations of the Hospital, Medical Staff, and Emory Healthcare;

(b) participation in Medical Staff duties, including committee assignments and emergency call, consultation requests, participation in quality improvement, utilization activities, and professional practice evaluation activities, and such other reasonable duties and responsibilities as assigned;

(c) the results of Performance Improvement activities, taking into consideration Practitioner-specific information compared to aggregate information or data from individuals in the same or similar specialty (provided that, other Practitioners will not be identified);

(d) results of any Focused and Ongoing Professional Practice Evaluations;

(e) review and appropriate resolution of verified complaints received from patients or staff;

(f) other reasonable indicators of continuing qualifications including, but not limited to, timely completion of medical records;

(g) behavior at the Hospital, including cooperation with Medical Staff and Hospital personnel as it relates to patient care, the orderly operation of the Hospital, and ability to work with others;

(h) whether the applicant's medical staff appointment or clinical privileges have been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, subjected to probationary or other conditions, or otherwise limited at any other hospital or health care facility, or are currently being investigated or challenged;

(i) whether the applicant's license to practice in any state, DEA registration, or any state controlled substances registration has been voluntarily or involuntarily suspended, modified, terminated, restricted, or relinquished, or is currently being investigated or challenged;

(j) whether the applicant's professional liability coverage and/or professional liability litigation experience has changed, including specifically information concerning past and pending claims, final judgments, or settlements; the substance of the allegations as well as the findings and the ultimate disposition; and any additional information concerning such proceedings or actions as the Credentials Committee, the Medical Executive Committee, or the Board may request;

(k) current ability to safely and competently exercise the Clinical Privileges requested and perform the responsibilities of Medical Staff appointment;

(l) capacity to satisfactorily treat patients as indicated by the results of the Hospital's Performance Improvement and professional and peer review activities;

(m) demonstration of current competence in patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and system-based practice;

(n) unusual pattern or excessive number of suits resulting in verdicts against the applicant; and

(o) documentation of the applicant's health status.

5.C. REAPPOINTMENT PROCESS

5.C.1. Reappointment Application Form:

(a) Appointment terms will not extend beyond two (2) years.

(b) An application for reappointment will be furnished to Members at least six (6) months prior to the expiration of their current appointment term. A completed reappointment application should be returned to the Emory Healthcare Medical Staff Services Department within thirty (30) Days of receipt by the Member.

(c) Failure to return a complete application within sixty (60) Days of receipt may result in the expiration of appointment and Clinical Privileges at the end of the then current term of appointment.

(d) The application will be reviewed by the Emory Healthcare Medical Staff Services Department to determine that all questions have been answered and that the Member satisfies all threshold eligibility criteria for reappointment and for the Clinical Privileges requested.

The Emory Healthcare Medical Staff Services Department will oversee the process of gathering and verifying relevant information. The Emory Healthcare Medical Staff Services Department will also be responsible for confirming that all relevant information has been received.

5.C.2. Conditional Reappointments:

(a) Recommendations for reappointment may be subject to an applicant's compliance with specific conditions. These conditions may relate to behavior (e.g., professional code of conduct) or to clinical issues. Reappointments may be recommended for periods of less than two (2) years.

(b) A recommendation of a conditional reappointment or for reappointment for a period of less than two (2) years does not, in and of itself, entitle a Member to request a hearing or appeal.

(c) In the event the applicant for reappointment is the subject of an investigation or a hearing at the time reappointment is being considered, a conditional reappointment for a period of less than two (2) years may be granted pending the completion of that process.

5.C.3. Potential Adverse Recommendation:

(a) If the Credentials Committee or the Medical Executive Committee is considering a recommendation to deny reappointment or to reduce Clinical Privileges, the chair of the Credentials Committee or MEC, as applicable, will notify the Member of the possible recommendation and invite the Member to meet with the Credentials Committee or MEC, as applicable, or designee(s) prior to any final recommendation being made.

(b) Prior to this meeting, the Member will be notified of the general nature of the information supporting the recommendation contemplated.

(c) At the meeting, the Member will be invited to discuss, explain, or refute this information. A summary of the interview will be made and included with the recommendation of the Credentials Committee or MEC, as applicable.

(d) This meeting is not a hearing, and none of the procedural rules for hearings set forth in Article 7 will apply. The Member will not have the right to be represented by legal counsel at this meeting.

(e) An applicant who has received a final adverse action concerning reappointment or Clinical Privileges shall not be eligible to reapply for appointment to the Medical Staff or apply for that particular privilege for a period of five (5) years unless the Board expressly provides otherwise. Upon the reapplication, the applicant shall submit additional specific information showing the condition or basis for the earlier adverse determination no longer exists.

ARTICLE 6

MATTERS INVOLVING PROFFESIONAL PERFORMANCE OF MEDICAL STAFF MEMBERS

6.A. OVERVIEW AND GENERAL PRINCIPLES

6.A.1. Options Available to Medical Staff Leaders:

(a) The various options available to Medical Staff Leaders, the Chief Executive Officer and Chief Medical Officer or his or her designee, and the mechanisms they may use when questions pertaining to competence, health or behavior are raised are outlined below and include, but are not limited to, the following:

(1) collegial intervention and progressive steps;

(2) Ongoing and Focused Professional Practice Evaluations;

(3) mandatory meeting;

(4) fitness for practice evaluation (including blood and/or urine test);

(5) automatic relinquishment of appointment and Clinical Privileges;

(6) leaves of absence;

(7) precautionary suspension;

(8) formal investigation; or

(9) to determine whether a matter should be handled in accordance with another policy (e.g., code of conduct policy, practitioner health policy, peer review policy) or should be referred to the Medical Executive Committee for further action.

6.A.2. Documentation:

(a) Except as otherwise expressly provided, the Chief Executive Officer, Chief Medical Officer, and Medical Staff Leaders may use their discretion to decide whether to document any meeting with an individual that may take place pursuant to the processes and procedures outlined in this Article.

(b) Any documentation that is prepared may be shared with the individual. The individual may have an opportunity to review the documentation and respond to it. The initial documentation, along with any response, will be maintained in the individual's confidential file.

6.A.3. No Recordings of Meetings:

It is the policy of the Hospital to maintain the confidentiality of Medical Staff meetings such as the Medical Executive Committee Meetings, Credentials Committee meeting and peer review meetings. The discussions that take place at such meetings are private conversations that occur in a private place. In addition to existing Bylaws and policies governing confidentiality, individuals in attendance at such meetings are prohibited from making audio, video, or phone recordings at such meetings unless authorized to do so in writing by the individual chairing the meeting or by the Chief Executive Officer.

6.A.4. No Right to Counsel:

a) The processes and procedures outlined in this Article are designed to be carried out in an informal manner. Therefore, outside counsel will not be present for any meeting that takes place pursuant to this Article. By agreement of the Chief Medical Officer and Chief Executive Officer, an exception may be made to this general rule.

(b) If the individual refuses to meet without his or her lawyer present, the meeting will be canceled and it will be reported to the Medical Executive Committee that the individual failed to attend the meeting.

6.A.5. No Right to the Presence of Others:

Peer review activities are confidential and privileged to the fullest extent permitted by law. Accordingly, the individual may not be accompanied by friends, relatives or colleagues, either in-person or by electronic means, when attending a meeting that takes place pursuant to this Article.

6.B. COLLEGIAL INTERVENTION AND PROGRESSIVE STEPS

(1) The use of collegial intervention efforts and progressive steps by the Chief Executive Officer, Chief Medical Officer, and Medical Staff Leaders are encouraged.

(2) The goal of those efforts is to arrive at voluntary, responsive actions by the individual to resolve an issue that has been raised. Collegial efforts and progressive steps may be carried out, within the discretion of the Chief Executive Officer, Chief Medical Officer, and Medical Staff Leaders, but are not mandatory.

(3) Collegial intervention efforts and progressive steps are part of the Hospital's peer review and Ongoing and Focused Professional Practice Evaluation activities and may include, but are not limited to, the following:

(a) sharing and discussing applicable policies, such as policies regarding appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;

(b) counseling, mentoring, monitoring, proctoring, consultation, and education;

(c) sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist an individual to conform his or her practice to appropriate norms;

(d) communicating expectations for professionalism and behaviors that promote a culture of safety;

(e) informational letters of guidance, education, or counseling; and

(f) Performance Improvement plans.

6.C. ONGOING AND FOCUSED PROFESSIONAL PRACTICE EVALUATION

(1) Individuals who are initially granted Clinical Privileges, whether at the time of initial appointment, reappointment, or during the term of appointment, will be subject to Focused Professional Practice Evaluation to confirm their competence.

(2) All individuals who provide patient care services at the Hospital will have their care evaluated on an ongoing basis. This Ongoing Professional Practice Evaluation process may include an analysis of data to provide feedback and to identify issues in an individual's professional performance, if any.

(3) When concerns are raised about an individual's practice through the Ongoing Practice Evaluation Process or through a specialty-specific trigger, a reported concern, or other triggers (i.e., clinical trend or specific case that requires further review, patient complaint, corporate compliance issue, or sentinel event), a Focused Professional Practice Evaluation may be undertaken to evaluate the concern.

(4) Ongoing Professional Practice Evaluation and Focused Professional Practice Evaluation will be conducted in accordance with applicable policies, including those relating to information sharing within the System.

6.D. MANDATORY MEETING

(1) Whenever there is a serious concern regarding an individual's clinical practice or professional conduct, the Chief Executive Officer, Chief Medical Officer, and Medical Staff Leaders may require the individual to attend a mandatory meeting.

(2) Special notice will be given at least three (3) Days prior to the meeting and will inform the individual that attendance at the meeting is mandatory.

(3) Failure of an individual to attend a mandatory meeting may result in an automatic relinquishment of appointment and Privileges as set forth below.

6.E. FITNESS FOR PRACTICE EVALUATION

(1) An individual may be requested to submit to an appropriate evaluation (such as blood and/or urine test), or a complete fitness for practice evaluation to determine his or her ability to safely practice.

(2) A request for an evaluation may be made of an applicant during the initial appointment or reappointment processes or of a Member during an investigation. A request for an evaluation may also be made when at least two (2) Medical Staff Leaders (or one Medical Staff Leader and the Chief Executive Officer or Chief Medical Officer) are concerned with the individual's ability to safely and competently care for patients.

(3) The Chief Executive Officer, Chief Medical Officer, or Medical Staff Leaders or committee that requests the evaluation will: (i) identify the health care professional(s) to perform the evaluation; (ii) inform the individual of the time period within which the evaluation must occur; and (iii) provide the individual with all appropriate releases and/or authorizations to allow the Medical Staff Leaders, or relevant committee, to discuss with the health care professional(s) the reasons for the evaluation and to allow the health care professional to discuss and report the results to the Medical Staff Leaders or relevant committee.

(4) Failure to obtain the requested evaluation may result in an application being withdrawn or an automatic relinquishment of appointment and Privileges as set forth below.

6.F. AUTOMATIC RELINQUISHMENT

Any of the occurrences described in this Section will constitute grounds for the automatic relinquishment or suspension of an individual's appointment and Clinical Privileges. An automatic relinquishment is considered an administrative step and, as such, it does not trigger an obligation on the part of the Hospital to file a report with the National Practitioner Data Bank.

Except as otherwise provided below, an automatic relinquishment of appointment and Privileges will be effective immediately upon actual or special notice to the individual and shall continue, unless a waiver of the threshold eligibility criteria is granted pursuant to Section 2.A.2, or until the matter is resolved and the individual is reinstated, as may be applicable.

6.F.1. Failure to Complete Medical Records:

Failure of an individual to complete medical records, after notification by the medical records department of delinquency in accordance with applicable policies and rules and regulations, will result in automatic relinquishment of all Clinical Privileges.

6.F.2. Failure to Satisfy Threshold Eligibility Criteria:

Failure of an individual to satisfy any of the threshold eligibility criteria set forth in this Policy in Section 2.A.1. will result in automatic relinquishment of appointment and Clinical Privileges.

6.F.3. Criminal or Civil Activity:

The occurrence of specific criminal or civil actions will result in the automatic relinquishment of appointment and Clinical Privileges. Specifically, an arrest, charge, indictment, conviction, plea of guilty or plea of no contest pertaining to any felony; or to any misdemeanor involving the following, will result in an automatic relinquishment: (a) Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse; (b) controlled substances; (c) illegal drugs; (d) violent act; (e) sexual misconduct; (f) moral turpitude; (g) child or elder abuse, (h) the Practitioner-patient relationship, or (i) requirement to pay or have paid a civil monetary penalty for governmental fraud or program abuse.

6.F.4. Failure to Provide Information:

(a) Failure of an individual to notify the Chief Medical Officer or Chief Executive Officer of any change in any information provided on an application for initial appointment or reappointment will, as determined by the Medical Executive Committee, result in the automatic relinquishment of appointment and Clinical Privileges.

(b) Failure of an individual to provide information pertaining to an individual's professional qualifications, clinical care, or professionalism in response to a written request from the Credentials Committee, the Medical Executive Committee, or any other authorized committee will, as determined by the Medical Executive Committee, result in the automatic relinquishment of appointment and Clinical Privileges until the information is provided to the satisfaction of the requesting party.

6.F.5. Failure to Attend a Mandatory Meeting:

Failure to attend a mandatory meeting requested by the Chief Executive Officer, Chief Medical Officer, or Medical Staff Leaders after appropriate notice has been given will result in the automatic relinquishment of appointment and Clinical Privileges. The

relinquishment will remain in effect until the individual attends the mandatory meeting and reinstatement is granted as set forth below.

6.F.6. Failure to Complete or Comply with Training or Educational Requirements:

Failure of an individual to complete or comply with training and educational requirements that are adopted by the Medical Executive Committee and/or required by the Board, including, but not limited to, those pertinent to electronic medical records or patient safety, will result in the automatic relinquishment of Clinical Privileges.

6.F.7. Failure to Comply with Request for Fitness for Practice Evaluation:

(a) Failure of an applicant to undergo a requested fitness for practice evaluation or to execute any of the required releases (i.e., to allow the Medical Staff Leaders, or the relevant committee, to discuss with the health care professional(s) the reasons for the evaluation and to allow the health care professional to report the results to the Medical Staff Leaders or relevant committee) will be considered a voluntary withdrawal of the application.

(b) Failure of a Member to undergo a requested fitness for practice evaluation or to execute any of the required releases (i.e., to allow the Medical Staff Leaders, or the relevant committee, to discuss with the health care professional(s) the reasons for the evaluation and to allow the health care professional to report the results to the Medical Staff Leaders or relevant committee) will result in the automatic relinquishment of appointment and Privileges.

6.F.8. Action at One Emory Healthcare Hospital

Any professional review action, involuntary change in appointment and/or Clinical Privileges status, or the development of a Performance Improvement plan (collectively "action") that occurs at one hospital within Emory Healthcare (except those relating to medical record completion infractions) shall automatically and immediately be effective at all hospitals within the System, without the individual's recourse to any additional review, investigation, hearing or appeal (as may be applicable). This automatic action may be waived by the MEC and the Board in exceptional circumstances, after a full review of the specific circumstances and any relevant peer review documents (e.g., professional practice evaluation, investigation, and hearing documents) from the Emory Healthcare hospital where the action first occurred. The Chief Medical Officer at the hospital where the professional review action occurs should immediately notify the other Chief Medical Officers at the other hospitals within Emory Healthcare when a professional review action has occurred.

6.F.9. Reinstatement from Automatic Relinquishment and Automatic Resignation:

(a) If an individual believes that the matter leading to the automatic relinquishment of appointment and Privileges has been fully resolved within forty-five (45) Days of

the relinquishment (i.e., the individual can establish that he or she continues to meet all threshold eligibility criteria), the individual may request to be reinstated. If an arrest, charge or indictment as defined above has not been fully resolved within the 45-day time period or if the 45-day time period has not yet occurred, an individual may request reinstatement but bears the burden of demonstrating, in the full discretion of the relevant chief of service, the Chair of the Credentials Committee, Chief Medical Officer, and the Chief Executive Officer that the underlying matter does not raise concerns about the individual's professional qualifications and/or ability to completely and safely exercise Clinical Privileges.

(b) A request for reinstatement from an automatic relinquishment following completion of all delinquent records will be processed in accordance with Section 6.F.10 of this Policy. Failure to complete the medical records that caused relinquishment within the time required will result in automatic resignation from the Medical Staff.

(c) Requests for reinstatement from an automatic relinquishment following the expiration or lapse of a license, controlled substance authorization, or insurance coverage will be processed by the Medical Staff Office. If any questions or concerns are noted, the Emory Healthcare Medical Staff Services Department will refer the matter for further review in accordance with (d) below.

(d) All other requests for reinstatement from an automatic relinquishment will be reviewed by the relevant chief of service, the chair of the Credentials Committee, the Chief Medical Officer, and the Chief Executive Officer. If all these individuals make a favorable recommendation on reinstatement, the individual may immediately resume clinical practice at the Hospital. This determination will then be forwarded to the Credentials Committee, the Medical Executive Committee, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, Medical Executive Committee and Board for review and recommendation.

(e) Failure to resolve a matter leading to an automatic relinquishment within 45 day of the relinquishment, and to be reinstated as set forth above, will result in an automatic resignation from the Medical Staff.

6.F.10. Delinquent Medical Records

(a) It is the responsibility of any Physician caring for a hospitalized patient to prepare and complete medical records in a timely fashion in accordance with the specific provisions of the Rules and Regulations and other relevant policies of the Hospital.

If a Physician fails to complete his or her medical records within thirty (30) Days after a patient's discharge, the Physician will be notified in writing of the specific medical records that are delinquent in accordance with the relevant Hospital policy.

6.G. LEAVES OF ABSENCE

6.G.1. Initiation:

(a) An individual appointed to the Medical Staff may request a leave of absence by submitting a written request to the Medical Staff Office. Except in extraordinary circumstances or unexpected illness, injury, or event, this request must be submitted at least thirty (30) Days prior to the anticipated start of the leave in order to permit adjustment of the call roster and assure adequate coverage of clinical and/or administrative activities. The request must state the beginning and ending dates of the leave, which shall not exceed one (1) year, and the reasons for the leave.

(b) The Chief Executive Officer will determine whether a request for a leave of absence will be granted, after consulting with the Chief Medical Officer and the relevant chief of service or section chief. The granting of a leave of absence or reinstatement may be conditioned upon the individual's completion of all medical records.

(c) Members of the Medical Staff must report to the Chief Executive Officer any time they are away from the Medical Staff, or patient care responsibilities for longer than thirty (30) Days and must report whether the reason for such absence is either related to (i) their physical or mental health or (ii) their ability to otherwise care for patients safely and competently. Upon becoming aware of such circumstances, the Chief Executive Officer, in consultation with the Chief Medical Officer, may trigger an automatic medical leave of absence at any point after becoming aware of the Medical Staff Member's absence from patient care.

(d) Leaves of absence are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination will be final, with no recourse to a hearing and appeal.

6.G.2. Duties of Member on Leave:

During a leave of absence, the individual will not exercise any Clinical Privileges and will be excused from Medical Staff responsibilities (e.g., meeting attendance, committee service, emergency service call obligations). The obligation to pay any applicable dues will continue during a leave of absence except that a Member granted a leave of absence for U.S. military service will be exempt from this obligation.

6.G.3. Reinstatement:

a) Individuals requesting reinstatement will submit a written summary of their professional activities during the leave and any other information that may be requested by the Hospital. Requests for reinstatement will then be reviewed by the relevant chief of service or section chief, the chair of the Credentials Committee, the Chief Medical Officer, and the Chief Executive Officer.

(b) If a favorable recommendation on reinstatement is made, the individual may immediately resume clinical practice. However, if any of the individuals reviewing the request have any questions, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, Medical Executive Committee, and Board.

(c) If the leave of absence was for health reasons (except for parental leave), the request for reinstatement must be accompanied by a report from the individual's Physician indicating that the individual is capable of resuming a hospital practice and safely exercising the Clinical Privileges requested.

(d) Absence for longer than one (1) year will result in resignation of Medical Staff appointment and Clinical Privileges unless an extension is granted by the Chief Executive Officer. Extensions will be considered only in extraordinary cases where the extension of a leave is in the best interest of the Hospital.

(e) If an individual's current appointment is due to expire during the leave, the individual must submit a reappointment application and meet all of the factors listed in Sections 2.A.3 and 5.B.2 of this Policy prior to the expiration of their appointment, or the individual's appointment and Clinical Privileges will expire at the end of the appointment period and the individual will be required to apply for appointment as an initial applicant upon their return.

6.H. PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

6.H.I. Grounds for Precautionary Suspension or Restriction:

(a) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the Chief Executive Officer, the Chief Medical Officer or his or her designee, the Medical Executive Committee, or the Board chair is authorized to suspend or restrict all or any portion of an individual's Clinical Privileges as a precaution.

(b) A precautionary suspension or Restriction can be imposed at any time, including after a specific event, a pattern of events, or a recommendation by the Medical Executive Committee that would entitle the individual to request a hearing. When possible, prior to the imposition of a precautionary suspension, the person(s) considering the suspension will meet with the individual and review the concerns that support the suspension and afford the individual an opportunity to respond.

(c) Precautionary suspension or Restriction is an interim step in the professional review activity and does not imply any final finding regarding the concerns supporting the suspension.

(d) A precautionary suspension or Restriction is effective immediately and will be promptly reported to the chief of service, Chief of Staff, Chief Executive Officer

and the Chief Medical Officer. A precautionary suspension will remain in effect unless it is modified by the Chief Executive Officer or Medical Executive Committee.

(e) Within three (3) Days of the imposition of a suspension, the individual will be provided with a brief written description of the reason(s) for the action, including the names and medical record numbers of the patient(s) involved (if any). The notice will advise the individual that suspensions lasting longer than thirty (30) Days must be reported to the National Practitioner Data Bank.

(f) The relevant Supervising Physician and, in instances in which the individual is an employee of the Hospital or Emory Healthcare, the Director of Advanced Practice Providers will be notified when the affected individual is a member of the APP/AHP staff.

6.H.2. Medical Executive Committee Procedure:

(a) Within a reasonable time, not to exceed fourteen (14) Days of the imposition of the suspension, the Medical Executive Committee will review the reasons for the precautionary suspension or Restriction.

(b) As part of this review, the individual will be invited to meet with the Medical Executive Committee. In advance of the meeting, the individual may submit a written statement and other information to the Medical Executive Committee.

(c) At the meeting, the individual may provide information to the Medical Executive Committee and should respond to questions that may be raised by MEC members. The individual may also propose ways, other than precautionary suspension or Restriction, to protect patients, employees or others while the matter is being reviewed. The individual is not entitled to representation by counsel at this meeting.

(d) After considering the reasons for the suspension or Restriction and the individual's response, if any, the Medical Executive Committee will determine whether the precautionary suspension should be continued, modified, or lifted. Within thirty (30) Days of the precautionary suspension or Restriction, the Medical Executive Committee may also determine whether to begin an investigation.

(e) If the Medical Executive Committee decides to continue the suspension, it will send the individual written notice of its decision, including the basis for it.

(f) There is no right to a hearing based on the imposition or continuation of a precautionary suspension. The procedures outlined above are deemed to be fair under the circumstances.

(g) Upon the imposition of a precautionary suspension, the Chief Medical Officer, or his or her designee, will assign responsibility for the care of any hospitalized patients

to another individual with appropriate Clinical Privileges. Whenever possible, consideration will be given to the wishes of the patient in the selection of a covering Physician.

6.I. INVESTIGATIONS

6.I.1. Initial Review:

a) Whenever a serious question has been raised, or where collegial efforts including a review by the Professional Practice Evaluation Committee have not resolved an issue regarding the following, the matter may be referred to the Chief of Staff, the Chief Medical Officer, the Chief Executive Officer, the MEC, or the chair of the Board:

(1) clinical competence or clinical practice, including patient care, treatment or management;

(2) the safety or proper care being provided to patients;

(3) the known or suspected violation of applicable ethical standards or the bylaws, policies, rules and regulations of the Hospital, the Medical Staff or Emory Healthcare; or

(4) conduct that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital, its Medical Staff, including the inability of the Member to work harmoniously with others.

(b) In addition, if the Board becomes aware of information that raises concerns about the qualifications of any Medical Staff Member, the matter will be referred the Chief Medical Officer or the Chief Executive Officer.

(c) The person to whom the question is referred will make a sufficient inquiry to determine whether the question is credible and, if so, may forward it to the Medical Executive Committee. If the question pertains to a member of the APP/AHP staff, the Supervising Physician, and in cases in which the APP/AHP is employed by the Hospital, Emory University or Emory Healthcare, the Director of Advanced Practice Providers will also be notified.

(d) To preserve impartiality, the person to whom the matter is directed will not be a member of the same practice as, or a relative of, the person that is being reviewed, unless such restriction is deemed not practicable, appropriate, or relevant by the Chief Medical Officer.

(e) No action taken pursuant to this initial review will constitute an investigation.

6.I.2. Initiation of Investigation:

(a) The Medical Executive Committee will review the matter in question, may discuss the matter with the individual, and will determine whether to conduct an investigation or direct that the matter be handled pursuant to another policy. An investigation will commence only after a determination by the Medical Executive Committee to commence an investigation.

(b) The Medical Executive Committee will inform the individual that an investigation has begun. The notification shall include:

(1) the date on which the investigation was commenced;

(2) the committee that will be conducting the investigation, if already identified;

(3) a statement that the Physician will be given the opportunity to meet with the committee conducting the investigation before the investigation concludes; and

(4) a copy of Section 6.I.3 of this Policy, which outlines the process for investigations.

Notification may be delayed if, in the judgment of the Medical Executive Committee, informing the individual immediately might compromise the investigation or disrupt the operation of the Hospital Medical Staff.

(c) The Board may also determine to commence an investigation and may delegate the investigation to the Medical Executive Committee, a subcommittee of the Board, or an ad hoc committee.

6.I.3. Investigative Procedure:

(a) Once a determination has been made by the Medical Executive Committee to begin an investigation, the Medical Executive Committee will investigate the issue itself or appoint an individual or committee ("Investigating Committee") to do so. The Investigating Committee may include individuals not on the Medical Staff. The Investigating Committee will not include any individual who:

(1) is in direct economic competition with the individual being investigated;

(2) is professionally associated with, a relative of, or involved in a referral relationship with, the individual being investigated; or

(3) has an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the issue;

(b) Whenever the issues raised concern the clinical competence of the individual under review, the ad hoc committee will include a peer of the individual (e.g., Physician, Dentist, Oral/Maxillofacial Surgeon, APP/AHP or Podiatrist).

(c) The individual will be notified of the composition of the Investigating Committee. Within five (5) Days of receipt of this notice, the individual must submit any reasonable objections to the service of any Investigating Committee member to the Chief Executive Officer or the Chief Medical Officer. The objections must be in writing. The Chief Executive Officer or the Chief Medical Officer will review the objection and determine whether another member should be selected to serve on the Investigating Committee.

(d) The Investigating Committee may:

(1) review relevant documents, which may include patient records, incident reports and relevant literature or guidelines;

(2) conduct interviews;

(3) use outside consultants, as needed, for timeliness, expertise, thoroughness and objectivity; or

(4) require an examination or assessment by a health care professional(s) acceptable to it. The individual being investigated will execute a release allowing the Investigating Committee to discuss with the health care professional(s) the reasons for the examination or assessment and allowing the health care professional to discuss and report the results to the Investigating Committee.

(e) If a decision is made to obtain an external review, the individual under investigation shall be notified of that decision and the nature of the external review. However, the individual under investigation may not demand an external review or dictate who performs the external review. Upon completion of the external review, the individual shall be provided a copy of the reviewer's report and provided an opportunity to respond to it in writing.

(f) As part of the investigation, the individual will have an opportunity to meet with the Investigating Committee. Prior to this meeting, the individual will be informed of the issues being investigated and will be invited to discuss, explain, or refute the issues. The Investigating Committee may also ask the individual to provide written responses to specific questions related to the investigation and/or a written explanation of his or her perspective on the events that led to the investigation for review by the Investigating Committee prior to the meeting. This meeting is not a hearing, and none of the procedural rules for hearings will apply. No recording (audio or video) or transcript of the meeting shall be permitted or made. Lawyers

will not be present at this meeting. A summary of the interview will be made and included with the Investigating Committee's report.

(g) The Investigating Committee will make a reasonable effort to complete the investigation and issue its report within thirty (30) Days, provided that an outside review is not necessary. When an outside review is used, the Investigating Committee will make a reasonable effort to complete the investigation and issue its report within thirty (30) Days of receiving the results of the outside review. These time frames are intended to serve as guidelines and, as such, will not be deemed to create any right for an individual to have an investigation completed within such time periods.

(h) At the conclusion of the investigation, the Investigating Committee will prepare a written report to the Medical Executive Committee. The report should include a summary of the review process (e.g., a list of documents that were reviewed, any individuals who were interviewed, etc.), specific findings and conclusions regarding each concern that was under review, and the Investigating Committee's recommendations.

6.I.4. Recommendation:

(a) The Medical Executive Committee may accept, modify, or reject any recommendation it receives from an Investigating Committee. Specifically, the Medical Executive Committee may:

(1) determine that no action is justified;

(2) issue a letter of guidance, counsel, warning, or reprimand;

(3) impose conditions for continued appointment;

(4) require monitoring, proctoring or consultation;

(5) require additional training or education;

(6) recommend reduction or Restriction of Clinical Privileges;

(7) recommend suspension of Clinical Privileges for a term;

(8) recommend revocation of appointment or Clinical Privileges; or

(9) make any other recommendation that it deems necessary or appropriate.

(b) A recommendation by the Medical Executive Committee that does not entitle the individual to request a hearing, will take effect immediately and will remain in effect unless modified by the Board.

(c) A recommendation by the Medical Executive Committee that would entitle the individual to request a hearing will be forwarded to the Chief Executive Officer, who will promptly inform the individual by special notice. The recommendation will not be forwarded to the Board until after the individual has completed or waived a hearing and appeal.

(d) If the Board makes a modification to the recommendation of the Medical Executive Committee that would entitle the individual to request a hearing, the Chief Executive Officer will inform the individual by special notice. No final action will occur until the individual has completed or waived a hearing and appeal.

ARTICLE 7

HEARING AND APPEAL PROCEDURES

7.A. INITIATION OF HEARING

7.A.1. Grounds for Hearing:

(a) An individual is entitled to request a hearing whenever the Medical Executive Committee makes one of the following recommendations:

(1) denial of initial appointment, reappointment or requested Clinical Privileges when all threshold eligibility criteria is met;

(2) revocation of appointment or Clinical Privileges;

(3) suspension of Clinical Privileges for more than thirty (30) Days (other than precautionary suspension) which entitles an individual to the procedures outlined in Section 6.H.2 of this Policy, which are deemed fair under the circumstances);

(4) a Restriction of Clinical Privileges for more than thirty (30) Days; or

(5) denial of reinstatement from a leave of absence if the reasons relate to professional competence or conduct.

(b) No other recommendation or action will entitle the individual to a hearing.

(c) If the Board determines to take any of these actions without an adverse recommendation by the Medical Executive Committee, an individual is entitled to request a hearing. For ease of use, this Article refers to adverse recommendations of the Medical Executive Committee. When a hearing is triggered by an adverse proposed action of the Board, any reference in this Article to the "Medical Executive Committee" will be interpreted as a reference to the "Board."

7.A.2. Actions Not Grounds for Hearing:

None of the following actions constitute grounds for a hearing. These actions take effect without hearing or appeal. The individual is entitled to submit a written statement regarding these actions for inclusion in his or her file:

(a) a letter of guidance, counsel, warning, or reprimand;

(b) conditions, monitoring, proctoring, or a general consultation requirement;

(c) a lapse, withdrawal of or decision not to grant or not to renew temporary Privileges;

(d) automatic relinquishment of appointment or Privileges;

(e) a requirement for additional training or Continuing Medical Education;

(f) precautionary suspension;

(g) denial of a request for leave of absence or for an extension of a leave;

(h) removal from the on-call roster or any reading or rotational panel;

(i) the voluntary acceptance of a Performance Improvement Plan option;

(j) determination that an application is incomplete;

(k) determination that an application will not be processed due to a misstatement or omission;

(l) determination of ineligibility based on a failure to meet threshold eligibility criteria, a lack of need or resources, or because of an exclusive contract; or

(m) at Emory University Hospital, the termination of regular faculty appointment–continuous or limited, at the Emory University School of Medicine simultaneously terminates an appointment to the Medical Staff of the Emory University Hospital without any hearing or appeal rights set forth in this Article.

7.A.3. Notice of Recommendation:

The Chief Executive Officer will promptly give special notice of a recommendation which entitles an individual to request a hearing. This notice will contain:

(a) a statement of the recommendation and the general reasons for it;

(b) a statement that the individual has the right to request a hearing on the recommendation within thirty (30) Days of receipt of this notice; and

(c) a copy of this Article.

7.A.4. Request for Hearing:

An individual has thirty (30) Days following receipt of the notice to request a hearing, in writing, to the Chief Executive Officer, including the name, address, and telephone number of the individual's counsel, if any. Failure to request a hearing will constitute waiver of the right to a hearing, and the recommendation will be transmitted to the Board for final action.

7.A.5. Notice of Hearing and Statement of Reasons:

(a) The Chief Executive Officer will schedule the hearing and provide to the individual requesting the hearing, by special notice, the following:

(1) the time, place, and date of the hearing;

(2) a proposed list of witnesses who will give testimony at the hearing and a brief summary of the anticipated testimony;

(3) the names of the Hearing Panel members and Presiding Officer (or Hearing Officer) if known; and

(4) a statement of the specific reasons for the recommendation, including a list of patient records (if applicable), and information supporting the recommendation. This statement may be revised or amended at any time, even during the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications and the individual has had a sufficient opportunity, up to thirty (30) Days, to review and respond with additional information.

(b) The hearing will begin as soon as practicable, but no sooner than thirty (30) Days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to in writing by the parties.

7.A.6. Hearing Panel, Presiding Officer, and Hearing Officer:

(a) Hearing Panel:

The Chief Executive Officer, after consulting with the Chief Medical Officer and Chief of Staff, if applicable, will appoint a Hearing Panel in accordance with the following guidelines:

(1) The Hearing Panel will consist of at least three (3) members, one of whom will be designated as chair.

(2) The Hearing Panel may include any combination of:

(i) any Member of the Medical Staff, or

(ii) Physicians or laypersons not connected with the Hospital (i.e., Physicians not on the Medical Staff or laypersons not affiliated with the Hospital).

(3) Knowledge of the underlying peer review matter, in and of itself, will not preclude the individual from serving on the Hearing Panel.

(4) Employment by, or other contractual arrangement with, the Hospital or an affiliate will not preclude an individual from serving on the Panel.

(5) The Hearing Panel will not include any individual who:

(i) is in direct economic competition with the individual requesting the hearing;

(ii) is professionally associated with, a relative of, or involved in a referral relationship with, the individual requesting the hearing;

(iii) has an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter; or

(iv) actively participated in the matter at any previous level.

(b) Presiding Officer:

(1) The Chief Executive Officer, after consultation with the Chief Medical Officer and Chief of Staff, if applicable, will appoint an attorney to serve as Presiding Officer. The Presiding Officer will not act as an advocate for either side at the hearing.

(2) The Presiding Officer will:

(i) schedule and conduct a pre-hearing conference;

(ii) allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination;

(iii) prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant or abusive or that causes undue delay;

(iv) maintain decorum throughout the hearing;

(v) determine the order of procedure;

(vi) rule on matters of procedure and the admissibility of evidence; and

(vii) conduct argument by counsel on procedural points outside the presence of the Hearing Panel unless the Panel wishes to be present.

(3) The Presiding Officer may be advised by legal counsel to the Hospital with regard to the hearing procedure.

(4) The Presiding Officer may participate in the private deliberations of the Hearing Panel, may be a legal advisor to it, and may draft the report of the Hearing Panel's decision based upon the findings and discussions of the Panel, but will not vote on its recommendations.

(c) Hearing Officer:

(1) As an alternative to a Hearing Panel, in matters in which the underlying recommendation is based upon concerns involving behavior, sexual harassment, or failure to comply with rules, regulations or policies and not issues of clinical competence, knowledge, or technical skill, the Chief Executive Officer, after consulting with and obtaining the agreement of the Chief Medical Officer and Chief of Staff, if applicable, may appoint a Hearing Officer. The Hearing Officer, who should preferably be an attorney, will perform the functions of a Hearing Panel. The Hearing Officer may not be, or represent clients, in direct economic competition with the individual requesting the hearing.

(2) If a Hearing Officer is appointed instead of a Hearing Panel, all references in this Article to the "Hearing Panel" or "Presiding Officer" will be deemed to refer to the Hearing Officer.

(d) Compensation:

Members of the Hearing Panel, the Presiding Officer, or the Hearing Officer may be compensated for their service. The individual requesting the hearing and the Hospital shall share equally costs associated with the hearing panel, except for the costs related to the stenographer's creation of a transcript and the Hearing Officer, which will be borne by the Hospital. Compensation will not constitute grounds for challenging the impartiality of the Hearing Panel members.

(e) Objections:

Any objection to any member of the Hearing Panel, to the Hearing Officer, or to the Presiding Officer, will be made in writing, within ten (10) Days of receipt of notice, to the Chief Executive Officer. The objection must include reasons to support it. A copy of the objection will be provided to the Chief Medical Officer and Chief of Staff, if applicable. The Chief Medical Officer and Chief of Staff, if applicable, will be given a reasonable opportunity to comment. The Chief Executive Officer will rule on the objection and give notice to the parties. The Chief Executive Officer may request that the Presiding Officer make a recommendation as to the validity of the objection.

7.A.7. Counsel:

The Presiding Officer, Hearing Officer, and counsel for either party may be attorneys at law licensed to practice, in good standing, in any state.

7.B. PRE-HEARING PROCEDURES

7.B.1. General Procedures:

(a) The pre-hearing and hearing processes will be conducted in an informal manner. Formal rules of evidence or procedure will not apply.

(b) Neither party has the right to issue subpoenas or interrogatories or to depose witnesses or other individuals prior to the hearing or to otherwise compel any individual to participate in the hearing or pre-hearing process.

(c) Neither the individual who has requested the hearing, nor any other person acting on behalf of the individual, may contact Hospital employees or Medical Staff Members whose names appear on the MEC's witness list or in documents provided pursuant to this Article concerning the subject matter of the hearing, until the Hospital has been notified and has contacted the individuals about their willingness to be interviewed. The Hospital will advise the individual who has requested the hearing once it has contacted such employees or Medical Staff Members and confirmed their willingness to meet. Any employee or Medical Staff Member may agree or decline to be interviewed by or on behalf of the individual who requested a hearing. If an employee or Medical Staff Member who is on the MEC's witness list agrees to be interviewed pursuant to this provision, counsel for the MEC may be present during the interview.

7.B.2. Time Frames:

The following time frames, unless modified by mutual written agreement of the parties, will govern the timing of pre-hearing procedures:

(a) the pre-hearing conference will be scheduled at least fourteen (14) Days prior to the hearing;

(b) the parties will exchange witness lists and proposed exhibits at least ten (10) days prior to the pre-hearing conference; and

(c) any objections to witnesses and/or proposed exhibits must be provided at least five (5) Days prior to the pre-hearing conference.

7.B.3. Witness List:

(a) At least ten (10) Days before the pre-hearing conference, the individual requesting the hearing will provide a written list of the names of witnesses expected to offer testimony on his or her behalf.

(b) The witness list will include a brief summary of the anticipated testimony.

(c) The witness list of either party may, in the discretion of the Presiding Officer, be amended at any time during the course of the hearing, provided that notice of the change is given to the other party.

7.B.4. Provision of Relevant Information:

(a) Prior to receiving any confidential documents, the individual requesting the hearing must agree that all documents and information will be maintained as confidential and will not be disclosed or used for any purpose outside of the hearing. The individual must also provide a written representation that his or her counsel and any expert(s) have executed business associate agreements in connection with any patient protected health information contained in any documents provided.

(b) Upon receipt of the above agreement and representation, the individual requesting the hearing will be provided with a copy of the following:

(1) copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the individual's expense;

(2) reports of experts relied upon by the Medical Executive Committee;

(3) copies of relevant minutes (with portions regarding other Physicians and unrelated matters deleted); and

(4) copies of any other documents relied upon by the Medical Executive Committee.

The provision of this information does not waive any privilege under the state peer review protection statutes.

(c) The individual will have no right to discovery beyond the above information. No information will be provided regarding other Practitioners on the Medical Staff.

(d) Ten (10) Days prior to the pre-hearing conference, or on dates set by the Presiding Officer or agreed upon by both sides, each party will provide the other party with its proposed exhibits.

7.B.5. Pre-Hearing Conference:

(a) The Presiding Officer will require the individual and the Medical Executive Committee (or a representative of each, who may be counsel) to participate in a pre-hearing conference.

(b) All objections to exhibits or witnesses will be submitted, in writing, five (5) Days in advance of the pre-hearing conference. The Presiding Officer will not entertain subsequent objections unless the party offering the objection demonstrates good cause.

(c) At the pre-hearing conference, the Presiding Officer will resolve all procedural questions, including any objections to exhibits or witnesses.

(d) Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant Clinical Privileges will be excluded.

(e) The Presiding Officer will establish the time to be allotted to each witness's testimony and cross-examination.

7.B.6. Stipulations:

The parties will use their best efforts to develop and agree upon stipulations to provide for a more efficient hearing.

7.B.7. Provision of Information to the Hearing Panel:

The following documents will be provided to the Hearing Panel in advance of the hearing:

(a) a pre-hearing statement that each party may choose to submit;

(b) exhibits offered by the parties following the pre-hearing conference (without the need for authentication); and

(c) stipulations agreed to by the parties.

7.C. THE HEARING

7.C.1. Time Allotted for Hearing:

It is expected that the hearing will last no more than ten (10) hours, with each side being afforded approximately five (5) hours to present its case, in terms of both direct and cross-examination of witnesses. Both parties are required to prepare their case so that a hearing will be concluded after a maximum of ten (10) hours, on consecutive Days. The Presiding Officer may, after considering any objections, grant limited extensions upon a demonstration of good cause and to the extent compelled by fundamental fairness.

7.C.2. Record of Hearing:

A stenographic reporter will be present to make a record of the hearing. The cost of the reporter will be borne by the Hospital. Copies of the transcript will be available at the individual's expense. Oral testimony will be taken on oath or affirmation administered by any authorized person.

7.C.3. Rights of Both Sides and the Hearing Panel at the Hearing:

(a) At a hearing, both sides will have the following rights, subject to reasonable limits determined by the Presiding Officer:

(1) to call and examine witnesses, to the extent they are available and willing to testify;

(2) to introduce exhibits;

(3) to cross-examine any witness;

(4) to have representation by counsel who may call, examine, and cross-examine witnesses and present the case;

(5) to submit a written statement at the close of the hearing; and

(6) to submit proposed findings, conclusions and recommendations to the Hearing Panel.

(b) If the individual who requested the hearing does not testify, he or she may be called and questioned.

(c) The Hearing Panel may question witnesses, request the presence of additional witnesses, or request documentary evidence.

7.C.4. Order of Presentation:

The Medical Executive Committee will first present evidence in support of its recommendation. Thereafter, the burden will shift to the individual who requested the hearing to present evidence.

7.C.5. Admissibility of Evidence:

The hearing will not be conducted according to rules of evidence. Evidence will not be excluded merely because it is hearsay. Any relevant evidence will be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs. The guiding principle will be that the record contains information sufficient to allow the Board to decide whether the individual is qualified for appointment and Clinical Privileges.

7.C.6. Persons to Be Present:

The hearing will be restricted to those individuals involved in the proceeding. Administrative personnel may be present as requested by the Chief Executive Officer or the Chief Medical Officer and Chief of Staff, if applicable.

7.C.7. Presence of Hearing Panel Members:

A majority of the Hearing Panel will be present throughout the hearing. In unusual circumstances when a Hearing Panel member must be absent from any part of the hearing, that Hearing Panel member must certify that he or she read the entire transcript of the portion of the hearing from which he or she was absent.

7.C.8. Failure to Appear:

Failure, without good cause, to appear and proceed at the hearing will constitute a waiver of the right to a hearing and the matter will be forwarded to the Board for final action.

7.C.9. Postponements and Extensions:

Postponements and extensions of time may be requested by anyone, but will be permitted only by the Presiding Officer or the Chief Executive Officer on a showing of good cause.

7.D. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

7.D.1. Basis of Hearing Panel Recommendation:

Consistent with the burden on the individual to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial appointment, reappointment and Clinical Privileges, the Hearing Panel will recommend in favor of the Medical Executive Committee unless it finds that the individual who requested the hearing has proved, by a preponderance of the evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

7.D.2. Deliberations and Recommendation of the Hearing Panel:

Within twenty (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 will conduct its deliberations outside the presence of any other person except the Presiding Officer. The Hearing Panel will render a recommendation, accompanied by a report, which will contain a statement of the basis for its recommendation.

7.D.3. Disposition of Hearing Panel Report:

The Hearing Panel will deliver its report to the Chief Executive Officer. The Chief Executive Officer will send by special notice a copy of the report to the individual who requested the hearing. The Chief Executive Officer will also provide a copy of the report to the Chief Medical Officer and Chief of Staff, if applicable, and the Medical Executive Committee.

7.E. APPEAL PROCEDURE

7.E.1. Time for Appeal:

(a) Within ten (10) Days after notice of the Hearing Panel's recommendation, either party may request an appeal. The request will be in writing, delivered to the Chief Executive Officer in person or by certified mail, return receipt requested, and will include a statement of the reasons for appeal and the specific facts or circumstances which justify further review.

(b) If an appeal is not requested within ten (10) Days, an appeal is deemed to be waived and the Hearing Panel's report and recommendation will be forwarded to the Board for final action.

7.E.2. Grounds for Appeal:

The grounds for appeal will be limited to the following:

(a) there was substantial failure by the Hearing Panel to comply with this Policy or the Medical Staff Bylaws during the hearing, so as to deny a fair hearing; or

(b) the recommendations of the Hearing Panel were made arbitrarily or capriciously or were not supported by credible evidence.

7.E.3. Time, Place and Notice:

Whenever an appeal is requested, the chair of the Board will schedule and arrange for an appeal. The individual will be given special notice of the time, place, and date of the appeal. The appeal will be held as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved.

7.E.4. Nature of Appellate Review:

(a) The Board may serve as the Review Panel or the chair of the Board may appoint a Review Panel, composed of members of the Board or others, including but not limited to reputable persons outside the Hospital.

(b) The Review Panel may consider the record upon which the recommendation was made, including the hearing transcripts and exhibits, post-hearing statements, the findings and recommendations of the Medical Executive Committee and Hearing

Panel and any other information that it deems relevant, and recommend final action to the Board.

(c) Each party will have the right to present a written statement in support of its position on appeal. The party requesting the appeal will submit a statement first and the other party will then have ten (10) Days to respond. In its sole discretion, the Review Panel may allow each party or its representative to appear personally and make oral argument not to exceed thirty (30) minutes.

(d) When requested by either party, the Review Panel may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination provided at the Hearing Panel proceedings. Additional evidence will be accepted only if the Review Panel determines that the party seeking to admit it can demonstrate that it is new, relevant evidence or that any opportunity to admit it at the hearing was improperly denied.

7.F. BOARD ACTION

7.F.1. Final Decision of the Board:

(a) The Board will take final action within thirty (30) Days after it (i) considers the appeal as a Review Panel, (ii) receives a recommendation from a separate Review Panel, or (iii) receives the Hearing Panel's report when no appeal has been requested.

(b) The Board may review any information that it deems relevant, including, but not limited to, the findings and recommendations of the Medical Executive Committee, Hearing Panel, and Review Panel (if applicable).

(c) Consistent with its ultimate legal authority for the operation of the Hospital and the quality of care provided, the Board may adopt, modify, or reverse any recommendation that it receives or refer the matter for further review.

(d) The Board will render its final decision in writing, including the basis for its decision, and will send special notice to the individual. A copy will also be provided to the Chief Medical Officer and the Medical Executive Committee.

(e) Except where the matter is referred by the Board for further review, the final decision of the Board will be effective immediately and will not be subject to further review.

7.F.2. Right to One Hearing and One Appeal Only:

No individual will be entitled to more than one hearing and one appeal on any matter.

ARTICLE 8

CONFLICTS OF INTEREST

(A chart summarizing conflict of interest guidelines can be found in Appendix A to this Policy.)

(a) When performing a function outlined in this Policy, the Bylaws, the Organization Manual, or the Medical Staff Rules and Regulations, if any Member has or reasonably could be perceived as having a conflict of interest or a bias, that Member will not participate in the final discussion or voting on the matter, and will be excused from any meeting during that time. However, the member may provide relevant information and may answer any questions concerning the matter before leaving.

(b) Any Member with knowledge of the existence of a potential conflict of interest or bias on the part of any other Member may call the conflict of interest to the attention of the Chief Medical Officer (or the Associate Chief Medical Officer if the Chief Medical Officer is the person with the potential conflict) or the applicable chief of service or committee chair. The Chief Medical Officer or the applicable chief of service or committee chair will make a final determination as to whether the provisions in this Article should be triggered.

(c) The fact that a chair or a Member is in the same specialty as a Member whose performance is being reviewed does not automatically create a conflict. In addition, the assessment of whether a conflict of interest exists will be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. No Member has a right to compel disqualification of another Member based on an allegation of conflict of interest.

(d) The fact that a service or committee Member or Medical Staff Leader chooses to refrain from participation, or is excused from participation, will not be interpreted as a finding of actual conflict.

ARTICLE 9

HOSPITAL EMPLOYEES

(a) Except as provided below, the employment of an individual by the Hospital or one of its affiliates will be governed by applicable employment policies and manuals and the terms of the individual's employment relationship or written contract. To the extent that applicable employment policies or manuals, or the terms of any employment contract, conflict with this Policy, the employment policies, manuals and descriptions and terms of the individual's employment relationship or written contract will apply.

(b) A request for appointment, reappointment or Clinical Privileges, submitted by an applicant or Member who is employed by the Hospital or one of its affiliates, will be processed in accordance with the terms of this Policy. A report regarding each practitioner's qualifications will be made to appropriate management personnel to assist with employment decisions.

(c) If a concern about an employed Member's clinical competence, conduct or behavior arises, then the concern may be reviewed and addressed in accordance with this Policy, in which event a report will be provided to appropriate management personnel. However, nothing herein will require the individual's employer to follow this Policy.

ARTICLE 10

AMENDMENT

Amendments to the Emory Healthcare Credentials Policy should be in accordance with the provisions in the Medical Staff Bylaws.

APPENDIX A

CONFLICT OF INTEREST GUIDELINES

Potential Conflicts	**Levels of Participation**								
	Provide Information	**Individual Reviewer Application/ PPEC Case**	**Committee Member**					**Hearing Panel**	**Board**
			Credentials	**Leadership Council**	**PPEC**	**MEC**	**Investigating Committee**		
Employment/contract relationship with Hospital	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**
Self or family member	**Y**	**N**	**R**	**R**	**R**	**R**	**N**	**N**	**R**
Relevant treatment relationship*	**Y**	**N**	**R**	**R**	**R**	**R**	**N**	**N**	**R**
Significant financial relationship	**Y**	**Y***	**Y***	**Y***	**Y***	**R**	**N**	**N**	**R**
Direct competitor	**Y**	**Y***	**Y***	**Y***	**Y***	**R**	**N**	**N**	**R**
Close friends	**Y**	**Y***	**Y***	**Y***	**Y***	**R**	**N**	**N**	**R**
History of conflict	**Y**	**Y***	**Y***	**Y***	**Y***	**R**	**N**	**N**	**R**
Provided care in case under review (but not subject of review)	**Y**	**Y***	**Y***	**Y***	**Y***	**R**	**N**	**N**	**R**
Involvement in prior VEP or disciplinary action	**Y**	**Y***	**Y***	**Y***	**Y***	**R**	**N**	**N**	**R**
Formally raised the concern	**Y**	**Y***	**Y***	**Y***	**Y***	**R**	**N**	**N**	**R**

Y – means the Interested Member may serve in the indicated role; no extra precautions are necessary.

Y* – means the Interested Member may generally serve in the indicated role. It is legally permissible for Interested Members to serve in these roles because of the check and balance provided by the multiple levels of review and the fact that the Credentials Committee, Leadership Council, and Professional Practice Evaluation Committee have no disciplinary authority.

In addition, the Chair of the Credentials Committee, Leadership Council, and Professional Practice Evaluation Committee always has the authority and discretion to recuse a member in a particular situation if the Chair determines that the Interested Member's presence would (i) inhibit the full and fair discussion of the issue before the committee, (ii) skew the recommendation or determination of the committee, or (iii) otherwise be unfair to the practitioner under review.

N – means the Interested Member should **not** serve in the indicated role.

R – means the Interested Member should be recused, in accordance with the guidelines on the next page.

* Special rules apply both to the provision of information and participation in the review process in this situation. See Article 8 of the Credentials Policy.

<table>
<tr><th colspan="2">RULES FOR RECUSAL</th></tr>
<tr><td>STEP 1

Confirm the conflict of interest</td><td>The Committee Chair or Board Chair should confirm the existence of a conflict of interest relevant to the matter under consideration.</td></tr>
<tr><td>STEP 2

Participation by the Interested Member at the meeting</td><td>The Interested Member may participate in any part of the meeting that does not involve the conflict of interest situation.

When the matter implicating the conflict of interest is ready for consideration, the Committee Chair or Board Chair will note that the Interested Member will be excused from the meeting prior to the group's deliberation and decision-making.

Prior to being excused, the Interested Member may provide information and answer any questions regarding the following:

(i) any factual information for which the Interested Member is the original source;

(ii) clinical expertise that is relevant to the matter under consideration;

(iii) any policies or procedures that are applicable to the committee or Board or are relevant to the matter under consideration;

(iv) the Interested Member's prior involvement in the review of the matter at hand (for example, an Investigating Committee member may describe the Investigating Committee's activities and present the Investigating Committee's written report and recommendations to the MEC prior to being excused from the meeting); and

(v) how the committee or Board has, in the past, managed issues similar or identical to the matter under consideration.</td></tr>
<tr><td>STEP 3

The Interested Member is excused from the meeting</td><td>The Interested Member will then be excused from the meeting (i.e., physically leave the meeting room and/or disconnect from any telephone or other electronic connection) prior to the committee's or Board's deliberation and decision-making.</td></tr>
<tr><td>STEP 4

Record the recusal in the minutes</td><td>The recusal should be documented in the minutes of the committee or Board. The minutes should reflect the fact that the Interested Member was excused from the meeting prior to deliberation and decision-making. As set forth in the Medical Staff Bylaws, once a quorum has been established, the business of the meeting may continue and actions taken will be binding regardless of whether any subsequent recusal of members causes the number of individuals present at the meeting to fall below the number required for a quorum.</td></tr>
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