

SHANDS AT AGH/UF

**MEDICAL STAFF
POLICY ON APPOINTMENT AND REAPPOINTMENT**

**Adopted by Shands Teaching Hospital and Clinics, Inc.
Board of Directors Quality Committee, September 23, 1998**

**Revised: June 5, 2001
July 2, 2001
December 3, 2001
August 19, 2002
September 16, 2002
November 6, 2002
March 26, 2003
August 27, 2003
February 25, 2004
April 28, 2004
October 27, 2004
March 23, 2005
October 26, 2005
January 24, 2007
October 24, 2007
February 27, 2008
June 25, 2008
July 23, 2008
December 12, 2008
January 28, 2009
February 25, 2009
March 25, 2009
May 27, 2009**

TABLE OF CONTENTS

DEFINITIONS.....	1
ARTICLE I. INITIAL APPOINTMENT.....	3
SECTION 1. TERM OF APPOINTMENT	3
SECTION 2. APPLICATION FOR INITIAL APPOINTMENT AND CLINICAL PRIVILEGES.....	3
A. Pre-application.....	3
B. Application	3
C. Application Fee	5
D. Undertakings	5
E. Burden of Providing Information	6
F. Authorization to Obtain Information	6
SECTION 3. PROCESSING APPLICATIONS.....	7
A. Department/Operations Committee.....	7
B. Credentials Committee.....	8
C. Executive Committee.....	8
D. Deferral	8
E. Board Approval.....	9
F. Time for Final Action	9
SECTION 4. APPOINTMENT PRIOR TO RESIDENCY COMPLETION	9
ARTICLE II. CLINICAL PRIVILEGES	10
SECTION 1. GENERAL	10
SECTION 2. APPLICATION FOR INCREASED CLINICAL PRIVILEGES	10
SECTION 3. TEMPORARY PRIVILEGES	10
SECTION 4. TERMINATION OF TEMPORARY CLINICAL PRIVILEGES.....	11
SECTION 5. EMERGENCY PRIVILEGES	12
SECTION 6. TELEMEDICINE PRIVILEGES	13
ARTICLE III. REAPPOINTMENT.....	13
SECTION 1. APPLICATION	13
SECTION 2. FACTORS TO BE CONSIDERED.....	13
SECTION 3. REAPPOINTMENT PROCEDURE	14
ARTICLE IV. STATUS CHANGES	14
SECTION 1. LEAVE OF ABSENCE	14
SECTION 2. CHANGE OF PRIMARY CAMPUS.....	14
SECTION 3. CHANGE IN CATEGORY	15
ARTICLE V. MEDICAL STAFF HEALTH ASSISTANCE	15
SECTION 1. GENERAL	15
SECTION 2. EDUCATION OF STAFF	15

SECTION 3. REFERRAL.....	15
SECTION 4. CONFIDENTIALITY	16
SECTION 5. EVALUATION OF COMPLAINTS OR CONCERNS	16
SECTION 6. MONITORING	16
SECTION 7. REPORTING TO MEDICAL STAFF LEADERSHIP	17
ARTICLE VI. PROFESSIONAL CONDUCT	17
SECTION 1. GENERAL	17
SECTION 2. DESIRABLE BEHAVIOR.....	18
SECTION 3. DISRUPTIVE BEHAVIOR.....	18
SECTION 4. REPORTING EPISODES OF DISRUPTIVE BEHAVIOR.....	19
SECTION 5. PROCESSING REPORTED EPISODES OF DISRUPTIVE BEHAVIOR.....	20
ARTICLE VII. FOCUSED PROFESSIONAL PRACTICE EVALUATION.....	21
SECTION 1. PURPOSE	21
SECTION 2. PERFORMANCE OF THE FPPE.....	21
SECTION 3. REQUIREMENTS.....	21
SECTION 4. TIMEFRAME FOR COMPLETION	22
SECTION 5. REVIEW OF RESULTS	22
ARTICLE VIII. ONGOING PROFESSIONAL PRACTICE EVALUATION.....	22
SECTION 1. PURPOSE.....	22
SECTION 2. SCOPE.....	22
SECTION 3. FREQUENCY	23
SECTION 4. REQUIREMENTS.....	23
SECTION 5. REVIEW	23
ARTICLE IX. CORRECTIVE ACTIONS.....	23
SECTION 1. SUMMARY SUSPENSION OF PRIVILEGES PRIOR TO INVESTIGATION	24
SECTION 2. GROUNDS FOR INITIATING AN INVESTIGATION.....	25
SECTION 3. SELF REFERRAL.....	25
SECTION 4. SUSPENSION OF PRIVILEGES DURING INVESTIGATION.....	25
SECTION 5. INVESTIGATIVE PROCEDURE	26
SECTION 6. RECOMMENDATIONS FOR CORRECTIVE ACTIONS.....	27
SECTION 7. AUTOMATIC SUSPENSION OF PRIVILEGES OR TERMINATION OF MEMBERSHIP	28
SECTION 8. CONFIDENTIALITY AND REPORTING	29
ARTICLE X. FAIR HEARING AND APPEALS PROCEDURES.....	30
SECTION 1. INITIATION AND SCHEDULING OF A HEARING.....	30
A. Right to Hearing	30
B. Actions Not Giving Rise to Hearing Right.....	30
C. Notice of Adverse Recommendation or Action and Request for Hearing.....	31
D. Scheduling and Notice of Hearing.....	32
E. Exchange of Witness Lists.....	32

SECTION 2. HEARING PROCEDURE	33
A. Appointment of Hearing Panel or Hearing Officer	33
B. Appointment of Presiding Officer	33
C. Rights of Affected Practitioner.....	34
D. Rights of the Hospital	34
E. Requests for Documents	35
F. Postponement of Hearing	35
G. Failure to Appear.....	35
H. Attendance by Panel Members	35
I. Hearing Record.....	35
J. Presentation of Evidence	35
K. Standard of Proof.....	36
L. Adjournment and Conclusion	36
M. Deliberations and Recommendation of the Hearing Panel	36
SECTION 3. APPELLATE REVIEW	37
A. Request for Appellate Review	37
B. Grounds for Appeal.....	37
C. Scheduling and Notice of Appellate Review.....	37
D. Appointment of Appellate Review Panel	38
E. Attendance by Appellate Review Panel Members	38
F. Purpose and Standard of Appellate Review	38
G. Additional Evidence.....	39
H. Recommendation of the Appellate Review Panel	39
SECTION 4. FINAL DECISION OF THE BOARD	39
A. Final Board Action	39
B. Further Review	40
SECTION 5. REAPPLICATION TO THE STAFF AFTER ADVERSE FINAL ACTION...40	
ARTICLE XI. AMENDMENTS	40
SECTION 1. INITIATION	40
SECTION 2. EXECUTIVE COMMITTEE RECOMMENDATION	40
SECTION 3. ADOPTION AND DISTRIBUTION	40

SHANDS AT AGH/UF MEDICAL STAFF

POLICY ON APPOINTMENT AND CLINICAL PRIVILEGES

DEFINITIONS

The following definitions shall apply to terms in this Policy:

- (1) “Administrator”: for purposes of actions involving a Medical Staff member with her/his primary site of practice at the Shands at UF campus, the Chief Operating Officer, and for the purposes of a member with primary site of practice at the Shands at AGH campus, the Administrator of that campus.
- (2) “Board”: the Board of Directors of Shands HealthCare.
- (3) “Chief Operating Officer”: the Chief Operating Officer of Shands HealthCare.
- (4) “Executive Committee”: the Executive Committee of the Medical Staff.
- (5) “Medical Staff”: medical and osteopathic physicians, dentists, and podiatrists who have met the requirements of the Medical Staff bylaws and who have received an appointment by the Board.
- (6) “Notice” shall mean and be deemed given when a written communication is (a) hand delivered to the addressee’s business office, as indicated by signature of addressee or addressee’s office staff member, or (b) deposited with any type of delivery service then offered by USPS, FED EX or other commercial express delivery service to be delivered to the addressee’s last known business or home address, or (c) transmitted by facsimile or e-mail to the addressee’s last known business fax or email address.
- (6) “Physicians”: doctors of both medicine and osteopathy.
- (7) “Primary site of practice”: the campus at which a practitioner provides most of her/his patient care services.
- (8) “Practitioner”: unless otherwise indicated by context, a physician, dentist or podiatrist who is applying to be or is a member of the Medical Staff.
- (9) “Professional Review Body”: the Board, the Credentials Committee or the Executive Committee, or any other person/committee, as appropriate, which has the authority to make an adverse recommendation or take an adverse action against a practitioner when assisting the Board in a professional review activity.
- (10) “Operations Committee”: a committee of the Medical Staff established at each campus to support the Executive Committee.

- (11) “Telemedicine”: the use of medical information exchanged from one site to another via electronic communications for the health and education of the patient or healthcare provider and for the purpose of improving patient care, treatment and services. The originating site is the site at which the patient is receiving care. The distant site is the site from which the prescribing or treating services are provided.

ARTICLE I. INITIAL APPOINTMENT

SECTION 1. TERM OF APPOINTMENT

Appointments to the Medical Staff shall be made by the Board, for a period not to exceed two years. The initial two-year appointment is considered the Provisional Period, but review may occur sooner.

SECTION 2. APPLICATION FOR INITIAL APPOINTMENT AND CLINICAL PRIVILEGES

A. Pre-application

A pre-application screening process shall be implemented to ascertain whether a practitioner meets the minimum objective criteria for appointment as set forth in the Medical Staff Bylaws and this Policy. Only those individuals shall be provided applications. The purpose for the pre-application screening process shall be to avoid the costly and time-consuming application process in those circumstances where an applicant fails to meet threshold qualifications.

B. Application

The application for medical staff appointment shall be submitted in writing on the prescribed form and signed by the applicant. The application shall include a request for specific clinical privileges desired by the applicant and shall require detailed information concerning the applicant's professional qualifications, including, at a minimum:

- (1) the names and complete addresses of at least four professionals who are familiar with the applicant's current clinical competency. Not more than one may be associated or about to be associated with the applicant in a professional practice. At least one reference shall be from the same professional and specialty area as the applicant; and none of the references may be related to the applicant;
- (2) the names and complete addresses of any and all hospitals or other healthcare institutions at which the applicant has worked or trained;
- (3) information as to whether there have been any previously successful or currently pending challenges which have or may result in any of the following being denied or voluntarily or involuntarily suspended, reduced, revoked, relinquished or withdrawn, or not renewed for any reason: membership status and/or clinical privileges at any hospital or healthcare institution; membership in local, state, or national professional organization; specialty Board Certification; license(s) to practice any profession in any jurisdiction; or Drug Enforcement Agency (DEA) Registration;
- (4) information as to whether the applicant has ever been subjected to any other disciplinary action by any of the institutions or agencies above, including, but not limited to, mandatory

chart review, requirements for CME credits, probation (subsequent to initial probation period upon first application);

(5) information regarding the applicant's current and past professional liability insurance coverage, the names of the insurance companies, and the amounts and classifications of such coverage;

(6) information about whether any malpractice actions (including notice of intent), arbitrations, or other proceedings have ever been instituted against the applicant;

(7) information about whether any professional liability carriers have ever denied, cancelled, limited, or not renewed the applicant's liability coverage;

(8) information about whether the applicant has any physical or mental condition which would prevent her/him, with or without reasonable accommodation, from performing professional or medical practice duties required for the privileges requested;

(9) information about whether the applicant has ever been reprimanded, censured, excluded, suspended, or disqualified by any private or federal health insurance program;

(10) information about whether the applicant's privileges have ever been limited, suspended, revoked, or cancelled, either temporarily or permanently by any healthcare organization;

(11) information about whether the applicant has ever been convicted of a felony, or is presently under indictment for a felony;

(12) information about whether the applicant has, within the last year, engaged in the use of illegal drugs or any other substance that could impair the applicant's ability to perform his/her professional or medical practice duties;

(13) information about whether the applicant has ever been the subject of any investigation by a state license board, Medicare, Medicaid, or any other federal program, hospital or managed care organization;

(14) a copy of the applicant's current license to practice in Florida;

(15) a copy of the applicant's DEA registration, if applicable;

(16) a copy of the applicant's current, dated Curriculum Vitae which reflects, at a minimum, all professional activity since degree awarded and all educational activities;

(17) a copy of the Educational Council for Foreign Medical Graduates (ECFMG) Certificate, if applicable;

(18) a copy of Board Certification or Board Admissibility letter;

(19) a copy of Basic Life Support, or equivalent, certification, if applicable;

- (20) a copy of the current certificate of liability coverage which indicates the effective dates, amount and coverage exclusions and identifies the applicant by name;
- (21) the applicant's dated signature on the prescribed authorization and release form, as described in Article II, Section 4, "Undertakings";
- (22) documentation of participation for Florida Medicare, or Medicare application, with subsequent receipt of provider numbers within six months of appointment and/or granting of clinical privileges; and
- (23) a current picture hospital ID card or valid picture ID issued by a state or federal agency shall be presented for verification that the individual requesting approval is the same individual identified in the credentialing documents; and
- (24) such other information as the Board may require.

C. Application Fee

An application fee may be required to help defray the costs of processing the application. Such fee shall be established by the Executive Committee upon approval by the Board.

D. Undertakings

The following undertakings shall be applicable to every medical staff applicant and/or appointee as a condition of consideration of such application for appointment/reappointment and as a condition of continued medical staff appointment:

- (1) an agreement to be bound by all policies, procedures, bylaws and/or rules and regulations of the Hospital, relevant campuses, and/or Shands HealthCare;
- (2) an acknowledgement that the applicant has the burden of producing adequate information for a proper evaluation of the applicant's competence, character, ethics, health status and other qualifications and for resolving any questions about such qualifications;
- (3) an agreement to appear for an interview, if requested an acknowledgement that failure to produce requested information or appear for a requested interview will prevent the application from being evaluated and acted upon;
- (4) an agreement to undergo a physical and/or mental health examination at any time, at the request of the Credentials or Executive Committee or the Board. Such request shall be supported by a statement of reasons;
- (5) an attestation that the information in the application is true, complete and correct, and an agreement to notify Shands HealthCare, in writing and within thirty days, of any changes or additions to the information provided by the applicant;

(6) an acknowledgement that as a condition of making an application, any misrepresentation, misstatement, or omission, may constitute cause for automatic and immediate rejection of the application, including acknowledgement that, in the event that approval has been granted prior to the discovery of such misrepresentation, misstatement, or omission, such discovery may result in immediate termination from the Medical Staff;

(7) an agreement to provide or arrange for the provision of continuous quality patient care for her/his patients if granted appointment and/or clinical privileges, which shall include an agreement to self report any physical, psychiatric, or emotional impairment which may result in an inability to perform her/his professional responsibilities;

Each applicant for medical staff appointment and reappointment shall specifically agree to these undertakings as part of the application.

E. Burden of Providing Information

The applicant shall have the burden of providing adequate information for a proper evaluation of her/his competence, character, ethics, and other qualifications, and of resolving any questions about such qualifications. The applicant shall have the burden of providing evidence that all the statements made and information given on the application are true and correct. An application is not considered complete until all information requested by the hospital has been received, including: an application form with all required responses provided; verification of all necessary information; adequate responses from references; and any other additional information deemed necessary and appropriate. It is the responsibility of the applicant to ensure that the application is complete. An application shall be deemed incomplete if at any time during the evaluation the need arises for new, additional, or clarifying information. An incomplete application will not be processed. Applications which are not complete within five months because of a failure of an applicant to provide requested information, shall be deemed expired.

Should information provided in the application for appointment or reappointment change during the course of an appointment, the practitioner must provide notice of such change and sufficient information about such change for the Credentials Committee's review and assessment.

F. Authorization to Obtain Information

The following statements, which shall be included on the application form and which form a part of this policy, are express conditions applicable to any medical staff applicant, any appointee to the medical staff, and to all others having or seeking clinical privileges in the hospital. By applying for appointment, reappointment, or clinical privileges, the applicant expressly accepts these conditions during the processing and consideration of his/her application, whether or not he/she is granted appointment or clinical privileges. This acceptance also applies during the time of any appointment or reappointment.

(1) Authorization to Obtain Information: The applicant shall specifically authorize Shands HealthCare to inspect all records and documents that may be material to evaluating the

applicant's professional qualifications and competence and to carry out the clinical privileges requested, as well as the applicant's moral and ethical qualifications. The applicant shall specifically authorize Shands HealthCare and its authorized representatives to consult with any individual(s) and/or entities who may have information, including, but not limited to, otherwise privileged or confidential information, bearing on the professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior or any other matter bearing on the satisfaction of the criteria for appointment and/or granting of clinical privileges. The applicant shall specifically authorize said individual(s) and/or entities, which shall include but not be limited to: (a) insurance companies; (b) The National Practitioner Data Bank; (c) The Federation of State Medical Boards; (d) personal references; (e) specialty boards; (f) health care plans; (g) schools; (h) employers; (i) hospitals or facilities with which the applicant has been in association; (j) state licensing boards; (k) claims adjusters, attorneys or others who may have information regarding professional liability claims or lawsuits; and (l) residency training programs, to release said information to the facilities and/or programs of Shands HealthCare, upon request and receipt of a copy of the applicant's consent and release form.

(2) Immunity: The applicant shall specifically agree to release from any and all liability, to the fullest extent permitted by law, all individuals and organizations who provide information to Shands HealthCare in good faith and without malice concerning the applicant's competence, ethics, character and other qualifications for staff appointment/reappointment and/or clinical privileges, including otherwise privileged and confidential information, as regards the application and/or continued appointment.

(3) Authorization to Release Information: The applicant shall specifically authorize Shands HealthCare to release information to managed care organizations with which Shands HealthCare may become affiliated, and release Shands HealthCare from any and all liability for providing information concerning the applicant's competence, ethics, character, and other qualifications for staff appointment/reappointment and/or clinical privileges, including otherwise privileged and confidential information, so long as such release of information is given without malice and in good faith.

The applicant shall authorize Shands HealthCare to disclose and make available to any Shands HealthCare hospital/facility/program to which the applicant has made or makes application, any and all information contained in her/his application and/or obtained as a result thereof.

SECTION 3. PROCESSING APPLICATIONS

A. Department/Operations Committee

After receiving references, verifications and all other information or materials deemed pertinent, the Administrator or her/his designee shall transmit the application and all supporting materials to the appropriate Department Chair, or if none, to the Operations Committee at the applicant's anticipated or designated primary site of practice for evaluation. Within thirty (30) days of receipt of a complete application, the Department Chair/Operations Committee shall provide the Credentials Committee with a recommendation regarding the experience, training and competence of the applicant, relative to the clinical privileges requested. If the recommendation

is from a Department Chair, a copy shall be simultaneously forwarded to the Operations Committee of both campuses for their information and comment, if appropriate.

B. Credentials Committee

The Credentials Committee shall review the application, the supporting documentation, recommendations, evidence of adherence to accepted professional ethical standards and behavior, and such other information available that may be relevant to consideration of the applicant's qualifications for the staff category and clinical privileges requested. The Credentials Committee shall then forward a report of its recommendations to the Executive Committee for action and to the Operations Committees of both campuses for their information.

C. Executive Committee

(1) After considering the report from the Credentials Committee, the Executive Committee shall recommend action upon each application and/or request for privileges. If a recommendation is favorable to the applicant, the recommendation shall be forwarded to the Board for final action. All recommendations to approve appointment and/or grant privileges must also recommend the specific clinical privileges to be granted.

(2) If an adverse recommendation is made, either with respect to appointment or the scope of privileges, the reason for such recommendation shall be stated and supported by reference to the completed application and all other documentation considered by the Executive Committee, all of which shall be forwarded to the Chief Operating Officer (“COO”) or his/her designee. The COO or her/his designee shall promptly notify the applicant, by hand delivery or certified mail, return receipt requested, of the proposed adverse recommendation and of the applicant’s right to a hearing, if any, in accordance with the Fair Hearing procedure set forth in Article IX.

(3) If the applicant waives her/his right to a hearing, or does not have such right pursuant to Article IX, the COO or her/his designee shall forward the Executive Committee’s recommendation with supporting documentation to the Board for final action. If the applicant exercises her/his right to a hearing, the Executive Committee may reconsider its adverse recommendation after receiving the Hearing Panel report and recommendation. The Executive Committee shall forward its final recommendation to the Board for final action, with a copy provided to both Operations Committees for their information.

D. Deferral

When the recommendation of the Credentials Committee or the Executive Committee is to defer the application for further consideration, the applicant shall be notified of the reason for deferral by hand delivery or certified mail, return receipt requested. The committee must make a subsequent recommendation within 60 days.

E. Board Approval

1. The Board of Directors has final responsibility for approval or disapproval of all applications for membership, continued membership, and/or privileges.
2. The Board of Directors has delegated to the Shands HealthCare Quality Committee of the Board the responsibility of acting upon applications for membership, continued membership, and/or privileges for all applications except that:
 - a. Any application in which the MEC has made a final recommendation that is adverse or has limitations shall be forwarded to the full Board with Board Quality Committee recommendation.
 - b. The following applications usually result in ineligibility for the expedited review, and shall be evaluated on a case-by-case basis:
 - (1) There is current challenge or a previously successful challenge to licensure or registration;
 - (2) The applicant has received an involuntary termination of medical staff membership at another organization;
 - (3) The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges; or,
 - (4) The hospital determines that there has been either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

Notice of the Board's decision shall be sent to the applicant within 30 days of the meeting during which it was considered unless the process has been delayed by a hearing or unless otherwise waived by the Board for good cause. Adverse decisions shall be sent by certified mail, return receipt requested.

F. Time for Final Action

Once received from the Department Chair/ Operations Committee, an application must be acted upon by the Credentials Committee and the Executive Committee and presented to the Board within 60 days, unless the process has been delayed by a hearing or unless otherwise waived by the Board for good cause.

SECTION 4. APPOINTMENT PRIOR TO RESIDENCY COMPLETION

In order to avoid undue hardship on the applicant, processing of an application prior to the completion of residency training may be warranted. In such cases, Medical Staff appointment and all admitting and clinical privileges shall be contingent upon final documentation of residency completion.

ARTICLE II. CLINICAL PRIVILEGES

SECTION 1. GENERAL

Medical Staff appointment or reappointment shall not confer any clinical privileges or right to practice in the hospital. Only individual who has been given an appointment to the Medical Staff, except as provided in Sections 3 and 5 of this Article, shall be entitled to exercise clinical privileges specifically granted by the Board. The clinical privileges recommended to the Board shall be based upon the applicant's education, training, experience, demonstrated current competence and ability to perform those privileges requested, the ability to assure qualified medical coverage in the practitioner's absence, the availability of hospital resources and personnel to support the privileges requested, and other relevant information. The applicant shall have the burden of establishing her/his qualifications for and competence to exercise the clinical privileges requested.

Only those individuals who have requested and been granted admitting privileges may admit patients to inpatient services.

SECTION 2. APPLICATION FOR INCREASED CLINICAL PRIVILEGES

Whenever, during the term of an appointment to the medical staff, an individual desires additional clinical privileges, s/he shall make the request in writing, stating in detail the specific additional clinical privileges desired and the appointee's relevant recent training and experience which justify such additional privileges. The request will be processed in the same manner as an application for initial clinical privileges.

SECTION 3. TEMPORARY PRIVILEGES

(a) Upon the recommendation of a Department Chair or Operations Committee Chair, and the concurrence of the Chief of Staff, the Chief Executive Officer of Shands HealthCare ("CEO") or her/his designee may, at her/his sole discretion, grant temporary privileges to a practitioner for a specified period of time. For the purposes of any rights and responsibilities set forth in the Medical Staff Bylaws or this Policy for Medical Staff members, such practitioner is not a member of the Medical Staff.

(b) Upon a written request and appropriate documentation as provided below, a physician, podiatrist or dentist may be granted temporary privileges in the following circumstances: (1) to fulfill an important patient care, treatment, and service need (the primary examples being: a) to prevent a significant decrease in ability to provide services; b) to proctor a member of the Medical Staff; c) to assist on a specific case; or d) to serve as locum tenens for a member of the Medical Staff); or, (2) when a new applicant for appointment, with a complete, clean, application that raises no concerns is awaiting review and approval of the Credentials Committee, Medical Staff Executive Committee and the Governing Body.

(c) A clean application is one where the applicant has no current or previously successful challenge to licensure or registration; nor has s/he been subject to involuntary termination of

medical staff membership at another organization; nor has s/he been subject to any involuntary limitation, reduction, denial, or loss of clinical privileges at another organization; nor has the applicant been excluded from participation in Medicare and/or Medicaid.

(d) The term of temporary privileges to fulfill important patient care, treatment, and service needs shall be set as appropriate for the circumstances, but shall not exceed 90 contiguous days. A practitioner may be granted multiple terms of temporary privileges, as appropriate to the circumstances, provided however, that the combined terms for such temporary privilege episodes shall not exceed 90 days in a 365 day period. Each term requires a separate written request. Extensions beyond the 90 day maximum period may be granted by the CEO under extraordinary circumstances only. Temporary privileges for new applicants shall not exceed 120 days.

(e) Prior to granting such privilege, under the first circumstance of (b) above, the following documentation shall have been acquired within the previous 90 days: (1) a query of the National Practitioner Data Bank; (2) proof of valid licensure; (3) evidence of professional liability coverage of a type and in an amount established by the Board; and (4) current competence for the privileges requested, and (5) a review of the AMA, AOA or other appropriate Profile when education and training have not been verified previously with the primary source. In circumstance 2 of (b) above, all verifications must have been completed as with any application for full membership and clinical privileges. In addition, any practitioner requesting temporary privileges must sign a statement subscribing to the following: (1) an agreement to be bound by all policies, procedures, bylaws and/or Rules and Regulations of the Hospital, relevant campus and/or Shands HealthCare; (2) an acknowledgement that the applicant has the burden of producing adequate information for proper evaluation of his/her competence; (3) an authorization for Shands HealthCare and its authorized representatives to request and inspect all records and documents that may be material to evaluating the applicant's professional qualifications, competence, and ability to carry out the clinical privileges requested; (4) an agreement to release from any and all liability, to the fullest extent permitted by law, all individuals and organizations who provide information to Shands HealthCare in good faith and without malice concerning the applicant's competence, ethics, character and other qualifications for the privileges requested, including otherwise privileged and confidential information; and, (5) an attestation that the information provided in the request for temporary privileges is true, complete and correct.

SECTION 4. TERMINATION OF TEMPORARY CLINICAL PRIVILEGES

(a) Temporary admitting and/or clinical privileges may be terminated by the Chair of the Board or her/his designee, the CEO or her/his designee, the Administrator, or the Chief of Staff at any time with or without cause. Neither the granting, denial, or termination of such privileges shall entitle the practitioner concerned to any of the procedural rights provided in this policy with respect to hearings or appeals.

(b) Temporary privileges shall be automatically terminated at such time as the Credentials Committee makes an adverse recommendation with respect to an applicant's appointment to the staff.

(c) The responsibility for the care of any patients under the care of a practitioner whose temporary privileges are terminated, shall be transferred by the appropriate Chair of the Operations Committee to a member of the Medical Staff. In making such a transfer, the wishes of the patient shall be considered whenever possible.

SECTION 5. EMERGENCY PRIVILEGES

- (a) **Emergency Privileges for Life-Saving Measures:** In the case of an emergency, any member of the Medical Staff who has clinical privileges shall be permitted to provide any type of patient care necessary as a life-saving measure or to prevent serious harm, regardless of his or her Medical Staff status or clinical privileges, provided that the care rendered is within the scope of the individual's license. For the purpose of this section, an "emergency" is defined as a condition which would result in serious or permanent harm to a patient, or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.
- (b) **Emergency Privileges in Time of Disaster:** In circumstances of disaster(s), in which the emergency management plan has been activated and the Hospital is unable to meet immediate patient needs, the Chief Executive Officer or his/her designee may grant emergency privileges to individuals who are not members of the Medical Staff to provide services during the emergency. An individual requesting temporary privileges in these circumstances shall produce his/her pocket license to practice medicine (or a copy of the license), a valid government-issued photo ID, issued by a state or federal agency, the name of her/his malpractice insurance carrier, and the name and telephone number of a hospital where she/he currently has privileges or has recently practiced. In granting emergency privileges in this circumstance, the hospital shall make every effort to verify current licensure directly with the appropriate state-licensing agency, within 72 hours from the time the volunteer practitioner presents to the Hospital. In addition, the hospital shall attempt to contact the facility at which the applicant has recently practiced to verify that she/he is in good standing. Once the emergency situation is under control, the hospital shall verify all information in accordance with Article II, Section 3 of this policy. Privileges granted in such situations shall be whatever is granted as core privileges in the volunteer's specialty. All individuals granted emergency privileges under these circumstances shall follow the hospital's Disaster Plan procedures. The practitioner granted emergency privileges shall be paired with a credentialed practitioner currently on staff who has a similar specialty, and who shall oversee the professional performance of the volunteer. At all times, the volunteer shall wear identification, which identifies her/him as a volunteer. Within 72 hours of initial granting of privileges, a decision shall be made regarding continuation of privileges, based on information acquired regarding the professional practice of the volunteer. A practitioner's privileges, granted under this emergency situation, may be terminated at any time without any reason or cause. Termination of these privileges shall not give rise to a hearing or appellate review.

SECTION 6. TELEMEDICINE PRIVILEGES

Practitioners providing Shands at AGH/UF patients with telemedicine services must be credentialed by this hospital if these services include prescribing care or otherwise treating patients. When practitioners provide telemedicine services to Shands at AGH/UF patients limited to interpretation and second opinions, and the prescription of care or other treatment is provided by a Shands at AGH/UF practitioner, the hospital may rely on the credentialing performed at the distant site only if that site is a Shands Healthcare facility. When relying on the credentialing performed at the distant site, the practitioner must be privileged at the distant site hospital for those services to be provided at this hospital. In addition, information regarding the telemedicine practitioner's quality of care, including, at least, any information related to adverse outcomes resulting from sentinel events occurring at this hospital as a result of the telemedicine services, shall be provided to the distant site for consideration in the credentialing and recredentialing process. When the distant site is not a Shands Healthcare facility, the practitioner providing telemedicine services, regardless of level of service, must be fully credentialed in accordance with this Policy.

ARTICLE III. REAPPOINTMENT

SECTION 1. APPLICATION

Each practitioner who wishes to be reappointed to the Medical Staff shall be responsible for returning a completed reappointment application, accompanied by all required supporting documents, by a specified deadline. Applications received after the requested deadline are subject to a late fee as established by the Shands HealthCare Central Credentialing Office and may result in automatic expiration of the appointment and clinical privileges, if insufficient time is remaining in which to process the application before the current appointment expires. In applying for reappointment, the practitioner shall have the burden of producing adequate information to assure that s/he continues to meet those criteria outlined in the Medical Staff Bylaws and in Article I of this Policy. If granted by the Board, reappointment shall be for a period not to exceed two years.

SECTION 2. FACTORS TO BE CONSIDERED

Each recommendation concerning reappointment of a practitioner, or concerning change in staff category, shall be based, in part, upon the member's:

- (a) ethical behavior, current clinical competence, clinical judgment and quality of care in the treatment of patients;
- (b) compliance with the Hospital bylaws, policies and procedures and with the Medical Staff bylaws and rules and regulations;
- (c) behavior in the Hospital, cooperation with Medical Staff and Hospital personnel as it relates to patient care or the orderly operation of this Hospital, and general attitude toward patients, the Hospital and its personnel;

- (d) ability to perform the clinical privileges requested;
- (e) completion of the appropriate State of Florida licensing board's mandated continuing education requirements for the individual's most recent license renewal period, with a majority of the required hours related to the individual's clinical privileges (as determined by the Department Chair), specialty and/or subspecialty; and,
- (f) any other findings relevant to the practitioner's competence and ability to perform her/his professional duties and responsibilities and work harmoniously with others in the Hospital to ensure delivery of quality patient care.

SECTION 3. REAPPOINTMENT PROCEDURE

The completed application and supporting documents shall be forwarded to the Department Chair/Operations Committee Chair of the practitioner's primary site of practice for evaluation of her/his demonstrated competence, professional performance, judgment, and clinical/technical skills, as indicated by quality monitoring and evaluation activities and other reasonable indicators of continuing qualifications, and by observation of the individual's ability to perform the clinical privileges granted. Peer recommendations may also be solicited and considered in recommending Medical Staff reappointment and/or continuation of specific clinical privileges. Upon completion of the Department Chair/Operations Committee Chair evaluations, the procedure provided in Article I, Section 3 (Processing Applications) shall be followed.

ARTICLE IV. STATUS CHANGES

SECTION 1. LEAVE OF ABSENCE

Persons appointed to the Medical Staff may be granted leaves of absences by the Board for up to one year. At the end of one year, members who do not return to active practice will be automatically terminated unless a request for an extension is made and approved by the Board for extenuating circumstances. At the conclusion of the approved leave of absence, the practitioner may be reinstated upon written request, accompanied by a written statement summarizing her/his professional activities during the leave of absence. If the practitioner is not clinically active during the leave of absence, evidence of her/his current clinical competence related to the privileges requested, shall be required. In acting upon the request for reinstatement, the Board may approve reinstatement either to the same or a different staff category, and may recommend limitation or modification of the clinical privileges to be extended the practitioner upon reinstatement.

SECTION 2. CHANGE OF PRIMARY CAMPUS

Whenever, during the term of an appointment to the medical staff, an individual desires to change her/his primary campus, s/he shall make the request in writing, stating in detail the reasons for the change. The request will be processed in the same manner as an application for initial appointment.

SECTION 3. CHANGE IN CATEGORY

Whenever, during the term of an appointment to the medical staff, an individual desires to change her/his category, s/he shall make the request in writing, stating in detail the reasons for the change. The request will be processed in the same manner as an application for initial appointment.

ARTICLE V. MEDICAL STAFF HEALTH ASSISTANCE

SECTION 1. GENERAL

1. The Medical Staff, Hospital Administration, and the Board have an obligation to protect patients from harm. Toward this goal, the Medical Staff adopts the following process to identify and manage individual medical staff health matters that have the potential of adversely affecting patient care.
2. The impaired practitioner is one who is unable to practice with reasonable skill, and safety to patients, because of mental/emotional illness or deficiency, physical illness or condition, or use/abuse of drugs or alcohol.
3. This process is designed to focus on assisting the impaired practitioner by facilitating confidential diagnosis, treatment, and rehabilitation of physicians who suffer from a potentially impairing condition, in order to permit him/her to retain or regain optimal professional functioning, consistent with the protection of patients, and without recourse to the Medical Staff disciplinary process. The process also aims to provide education about physician health and address prevention of physical, psychiatric, or emotional illness.

SECTION 2. EDUCATION OF STAFF

Upon appointment to the Medical Staff, practitioners shall receive information regarding illness and impairment recognition issues.

SECTION 3. REFERRAL

1. As part of her/his commitment to provide or arrange for the provision of continuous quality patient care for her/his patients if granted appointment and/or clinical privileges, in making application for Medical Staff membership and clinical privileges, the practitioner shall agree, in writing, to self-report any physical, psychiatric or emotional impairment which may compromise her/his ability to perform her/his professional responsibilities.
2. Whenever a Medical Staff member has cause to question her/his own ability to perform her/his professional responsibilities due to physical, psychiatric or emotional illness or impairment, s/he shall report confidentially to the Chair of the Operations Committee, or designee (“Chair”) of her/his primary campus. The Chair, in consultation with the Hospital Administrator, or designee, shall facilitate a referral to the appropriate internal or external resource(s) for diagnosis, treatment and/or rehabilitation. The affected practitioner shall cooperate fully with the Chair

and Hospital Administrator to assure that patient care is not compromised, including, but not limited to, the voluntary relinquishment of privileges if necessary. The Chair or Administrator shall communicate, as appropriate to assure patient safety, with the Chair or designee of the Operations Committee of the non-primary campus and with the non-primary campus Administrator or designee as necessary.

3. If the Chair of the Operations Committee or the Hospital Administrator receives information from a practitioner or hospital staff indicating the possibility of impairment of a Medical Staff member, the Chair/Administrator shall request a written report from the concerned practitioner/hospital staff member describing the specific incident(s)/circumstance(s) (including witnesses) which has/have lead her/him to believe that the affected practitioner is impaired.
4. The Chair/Administrator shall discuss the information with the affected practitioner and, if appropriate, facilitate a referral to the appropriate internal or external resource(s) for evaluation and/or treatment. The affected practitioner shall cooperate fully with the Chair and Hospital Administrator to assure that patient care is not compromised, including, but not limited to, the voluntarily relinquishing privileges if necessary.

SECTION 4. CONFIDENTIALITY

The referral of any Medical Staff member for assistance pursuant to paragraph 3 or 4 shall be kept confidential, except as limited by law, ethical obligation, or as necessary to ensure patient safety.

SECTION 5. EVALUATION OF COMPLAINTS OR CONCERNS

1. In the event that a Medical Staff member does not self-refer, and/or is not fully cooperative with the Chair's referral for evaluation under paragraphs 3 or 4, the Medical Staff shall investigate complaints or concerns regarding the Medical Staff member's physical, psychiatric or emotional illness or impairment to determine its credibility and impact on patient care and the orderly functioning of the hospital. Such investigation shall be made in accordance with Article IX of the Shands at AGH/UF Medical Staff Policy on Appointment and Reappointment.
2. If the investigation indicates that the practitioner may be affected by an illness or impairment, which may compromise her/his ability to perform her/his professional responsibilities, a referral to the appropriate professional internal or external resource(s) for physical, psychiatric or emotional diagnostic and/or rehabilitative program shall be facilitated.
3. If the affected practitioner does not cooperate with the Chair and Hospital Administrator regarding the referral, appropriate corrective action pursuant to Article IX of the Policy on Appointment shall be taken in order to protect patients and maintain the orderly operation of the hospital.

SECTION 6. MONITORING

1. Any recommendation for action (either through this Policy or Article IX of the Policy on Appointment) shall provide for hospital monitoring of the affected practitioner to the extent

necessary to assure patient safety. Such monitoring may include, but is not limited to, the following: chart review; mandatory consultation; interviews with staff working with the affected practitioner; and reports from a treatment/rehabilitation program or other physician recovery program.

2. In order to facilitate appropriate monitoring, the affected practitioner shall agree to provide the Chair and Hospital Administrator with the contract and/or status reports from any treatment, rehabilitation or other monitoring/physician recovery program in which s/he is participating.
3. Monitoring conditions agreed to as part of this Policy are not subject to hearing and appeals. Monitoring conditions imposed pursuant to Article IX of the Policy on Appointment are subject to hearing and appeals as provided in Article IX.
4. If the affected practitioner's privileges have at any time during the process been limited, either voluntarily or involuntarily, or a leave of absence effected, reinstatement of privileges shall be made only at such time as the affected practitioner can demonstrate that s/he can practice safely. A finding from the practitioner's treatment/rehabilitative/physician recovery program that s/he is able to practice without compromising patient safety shall be required. All other factors usually considered when a practitioner requests reinstatement of privileges (such as proof of current competency) are also relevant.
5. If the affected practitioner disagrees with a decision regarding the reinstatement of her/his voluntarily restricted/relinquished privileges, s/he may request a fair hearing regarding that issue in accordance with Article IX of the Policy on Appointment.

SECTION 7. REPORTING TO MEDICAL STAFF LEADERSHIP

If at any time during the diagnosis, treatment, or rehabilitation phase of the process under paragraphs 3, 5, or 6 above, it is determined that a physician is unable to safely perform the privileges s/he has been granted, the affected practitioner shall first be granted the opportunity to voluntarily relinquish her/his privileges or take a leave of absence. If s/he does not voluntarily limit his/her practice or take a leave of absence to ensure patient safety, the matter shall be referred to the medical staff leadership for appropriate corrective action in accordance with Article IX of the Policy on Appointment.

ARTICLE VI. PROFESSIONAL CONDUCT

SECTION 1. GENERAL

1. It is the policy of the Medical Staff that all individuals granted privileges in the hospital must conduct themselves in a professional manner, treating all persons with courtesy, respect and dignity. Failure to do so may result in corrective action, up to and including suspension or termination of privileges in accordance with this Policy. To that end, the Medical Staff requires that all individuals granted clinical privileges in the hospital conduct themselves in a professional and cooperative manner.

Intimidating and disruptive behaviors can foster medical errors, contribute to poor patient satisfaction and result in adverse outcomes. In addition, such behavior may increase the cost of care, and may cause qualified clinicians, administrators and managers to seek new positions in more professional environments. Safety and quality of patient care are dependent on teamwork, communication, and a collaborative work environment. To assure quality and to promote a culture of safety, the Medical Staff is committed to addressing the problem of behaviors that threaten the performance of the health care team.

2. The Medical Staff shall work to ensure optimum patient care by promoting a safe, cooperative and professional healthcare environment, by fostering desirable behavior . Episodes of unprofessional behavior shall be addressed and appropriate action taken to eliminate disruptive behavior.

SECTION 2. DESIRABLE BEHAVIOR

Desirable behaviors shall include:

1. communication which takes place in a timely fashion, involving the appropriate person(s), in an appropriate setting;
2. communications, including spoken remarks, body language, written documents, and emails which are honest and direct and conducted in a professional, constructive, respectful and efficient manner;
3. telephone communications that are respectful and professional. Initiators should prepare for their calls by gathering all necessary information, organizing their questions or comments, and coordinating with others who need to reach the same individual about other issues. Receivers should respond in a courteous and professional manner;
4. cooperation and availability when on call. When individuals are paged, they must respond promptly and appropriately to the issue(s) at hand.
5. an understanding that a variety of experience levels exists, and that tolerance for those who are learning is expected.

SECTION 3. DISRUPTIVE BEHAVIOR

1. Disruptive behavior is defined as: conduct, whether verbal or physical, that negatively affects or that potentially may negatively affect patient care, including, but not limited to behavior which:
 - disrupts the operation of the hospital;
 - affects the ability of others to perform their jobs;
 - has the effect of being personally degrading to others in the workplace;

- creates a hostile work environment;
- interferes with an individual's ability to practice competently; or,

Appropriate criticism that is offered in an appropriate place and manner, with the aim of improving patient care should not be construed as disruptive behavior.

2. Unacceptable, disruptive behaviors may include, but are not limited to the following:
 - a) Attacks or outbursts – verbal or physical – leveled at other Medical Staff members, other individuals with clinical privileges, residents or students, other hospital personnel, patients, patients' families, or visitors;
 - b) Comments (or illustrations) made in patient medical records or other official documents that are unnecessary for patient care or impugn the quality of care in the hospital or attack particular physicians, nurses or hospital policies;
 - c) Criticism leveled at the recipient in such a way that it intimidates, undermines confidence, belittles, or implies stupidity or incompetence;
 - d) Refusal to accept medical staff assignments or refusal to participate in committee or departmental affairs in a professional and appropriate manner;
 - e) Verbal or physical outbursts, including: shouting or yelling; use of profanity; slamming or throwing of objects in anger or disgust, whether or not directed at a specific individual;
 - f) Hostile, condemning, or demeaning communications;
 - g) Criticism of performance and/or competency which is delivered in an inappropriate location and not aimed at performance improvement;
 - h) Other behavior demonstrating disrespect, intimidation, or disruption to the delivery of quality patient care (e.g., reluctance or refusal to answer questions, return phone calls or pages; condescending language or voice intonation; and impatience with questions);
 - i) Retaliation against any person who addresses or reports unacceptable behavior.

SECTION 4. REPORTING EPISODES OF DISRUPTIVE BEHAVIOR

Any Medical Staff member, Allied Health Professional, employee, patient, or visitor, may report perceived disruptive conduct to a hospital manager and/or Chair of Operations, as appropriate, by providing the following information:

1. Factual and objective description of the situation and the questionable behavior (including date and time);

2. A statement of whether the behavior affected or involved a patient in any way; and, if so, information identifying the patient;
3. Persons present during the incident; and,
4. Any immediate response to the situation.

SECTION 5. PROCESSING REPORTED EPISODES OF DISRUPTIVE BEHAVIOR

1. Upon receipt of a report of disruptive behavior, the hospital manager and/or Chair of Operations shall conduct an inquiry to confirm details of the incident with interviews as appropriate with other witnesses to the purported behavior unless otherwise directed by the Chair of Operations.
2. Upon completion of the inquiry, the report and documentation of any additional information shall be forwarded to the Chair of Operations for her/his review.
3. If it is determined that a violation of the policy has not occurred, the individual bringing the complaint shall be notified.
4. If it is determined that there appears to have been an episode of disruptive behavior, the Chair of Operations may:
 - request that the practitioner provide him/her with a written response to the allegation; and/or,
 - meet with the practitioner for discussion and collegial counseling (including identification of methods and resources for structuring professional and working relationships and resolving problems without disruptive behavior) with documentation of the discussion and any specific actions the individual has agreed to take, with a copy forwarded to the Medical Staff Office; or,
 - if the practitioner has had previous occurrences, forward to the MEC for consideration of further action either under Article V or Article VII of this Policy; or,
 - all instances of egregious disruptive behavior shall automatically go to the MEC for consideration under Article V or VII of this Policy.
5. Whenever an episode of disruptive behavior has been confirmed and action taken in 4 above:
 - a) A copy of this policy shall be provided to the offending individual, who shall also be informed that the Medical Staff and Board of Directors require compliance with this policy. The approach during such an initial intervention should be collegial and helpful to the individual and the hospital.

- b) Attempts to confront, intimidate, or otherwise retaliate against the individual(s) who reported the behavior in question, by the involved practitioner will be considered a violation of this policy and grounds for further disciplinary action.
6. A single egregious incident, such as sexual harassment (physical or verbal), assault, a felony conviction, a fraudulent act, stealing, or damaging hospital property, or inappropriate physical behavior, may result in corrective action up to and including suspension and/or termination of privileges or Medical Staff appointment in accordance with Article VII of this Policy or the Allied Health Professional Policy on Clinical Privileges.
7. All documented episodes of disruptive behavior shall be filed in the individual's credentialing file.

ARTICLE VII. FOCUSED PROFESSIONAL PRACTICE EVALUATION

SECTION 1. PURPOSE

The purpose of the Focused Professional Practice Evaluation (FPPE) is to establish:

1. a systematic review and evaluation process for assuring that individuals who have been granted initial or expanded privileges are performing those new privileges competently and;
2. a deliberate and focused professional practice evaluation when indicated by Ongoing Professional Practice Evaluation (OPPE) mechanisms or by other quality monitoring mechanisms identified in the Medical Staff Bylaws and/or Allied Health Professional policies.

SECTION 2. PERFORMANCE OF THE FPPE

The FPPE will be performed:

1. Upon the grant of initial privileges to a practitioner;
2. Upon the grant of any new privilege(s) to a practitioner currently practicing in the facility; or,
3. When indicated by OPPE thresholds, or other quality indicators or sources of information that raise questions regarding a practitioner's ability to exercise his/her privilege(s).

SECTION 3. REQUIREMENTS

1. Each clinical department chair will develop well-defined monitoring specifications to evaluate the privilege-specific competence of any practitioner granted new privileges in his/her

department. Such monitoring may include chart review, monitoring clinical practice patterns, simulation, proctoring, or discussions with other practitioners involved in the care of each patient.

- a. Monitoring specifications shall include a recommended minimum period of time and/or number of procedures for review.
 - b. Circumstances under which monitoring by an external source is required will be identified.
 - c. At the conclusion of the monitoring period, the chair shall review the data and report to the Credentials Committee either that the practitioner has demonstrated his/her competence, or make appropriate recommendations for further evaluation/action.
2. Each department shall develop specific thresholds for OPPE indicators that will trigger an FPPE on the indicator and/or a recommendation to the Chair of the Operations Committee for a more comprehensive review of the practitioner's competency, as appropriate. FPPE initiated through other quality monitoring mechanisms identified in the Medical Staff Bylaws and/or Allied Health Professional policies will follow the process set forth in the applicable document(s).
 3. The FPPE indicators and thresholds must be consistently implemented and applied.

SECTION 4. TIMEFRAME FOR COMPLETION

The timeframe for completion of the FPPE shall be no greater than six months unless an extension is granted by the Credentials Committee and/or Medical Executive Committee.

SECTION 5. REVIEW OF RESULTS

The results of each FPPE will be reviewed by the department chair, and/or the MEC if required or otherwise appropriate under the Medical Staff Bylaws. If indicated, a specific performance improvement and/or corrective action plan shall be implemented to assure patient safety and high quality care.

ARTICLE VIII. ONGOING PROFESSIONAL PRACTICE EVALUATION

SECTION 1. PURPOSE

The purpose of the OPPE is to establish a process for ongoing evaluation of each privileged practitioner's professional practice to facilitate the ability to determine whether privileges are continuously being performed competently.

SECTION 2. SCOPE

An OPPE will be conducted on all individuals privileged through the Medical Staff process.

SECTION 3. FREQUENCY

An OPPE report will be generated for each privileged practitioner at 8 month intervals.

SECTION 4. REQUIREMENTS

1. As part of the OPPE report each department chair shall identify:
 - a. at least two specific data elements to be collected for each privileged practitioner that are reliable indicators of the practitioner's competency to maintain his/her privilege.
 - b. when applicable, at least one CMS/TJC "Core" measure to be collected for each privileged practitioner that is a reliable indicator of the practitioner's competency to maintain his/her privilege in his/her department.
 - c. the threshold for each of the above elements that will result in a FPPE to determine the necessity for performance improvement intervention, or modification of privileges, as appropriate to ensure patient safety and high quality care.
2. Results from Routine Peer Review, conducted in accordance with hospital policy, will also be incorporated into the OPPE report of each privileged practitioner. The department chair will establish a threshold for each Routine Peer Review indicator that will trigger an FPPE.
3. Indicators and thresholds recommended by the department chairs shall become effective upon approval of the MEC. Every two years, each chair shall review the indicators for his/her department and make recommendations for revisions to the MEC as indicated to assure that they continue to be reliable measures of competency.

SECTION 5. REVIEW

1. Each department chair shall timely review each 8-month OPPE report for his/her department and determine whether there is cause to refer the report to the Chair of the Operations Committee for FPPE in accordance with the procedures detailed in the Medical Staff bylaws or policies.
2. At the time of reappointment, the department chair shall consider the practitioner's OPPEs for the previous appointment cycle in making his/her recommendation for continuation of specific privileges to the Credentials Committee.

ARTICLE IX. CORRECTIVE ACTIONS

The Medical Staff, Hospital Administration, and the Board have the obligation to protect patients from harm. The procedures set forth below provide guidelines for the Medical Staff to evaluate complaints or concerns regarding patient care and orderly functioning of the hospital, to formulate

corrective action, and to monitor performance through resolution of all safety concerns.

SECTION 1. SUMMARY SUSPENSION OF PRIVILEGES PRIOR TO INVESTIGATION

(a) The Chief of Staff, the chair of a department, the chair of an Operations Committee, the Administrator, or in her/his absence, her/his designee, or the Chair of the Board shall each have the authority to summarily suspend or restrict all or any portion of the clinical privileges of a Medical Staff member upon a reasonable belief that failure to take such action may result in imminent danger to the health and/or safety of any individual. Prior to implementing such summary suspension or restriction, the Administrator, her/his designee or the Chair of the Board shall, whenever practicable, consult with either the Chief of Staff or the chair of the affected member's department. Such suspension shall be deemed an interim precautionary step in the professional review activity and shall not imply a final finding of responsibility for the situation that prompted the suspension.

(b) The Medical Director of the Trauma Service shall have the authority to summarily suspend or restrict all or any portion of the clinical privileges of a Medical Staff member upon a reasonable belief that failure to take such action may compromise the health, safety or welfare of trauma patients. Prior to implementing such summary suspension or restriction, the Medical Director shall, whenever practicable, consult with either the Chief of Staff or the chair of the affected member's department. Such suspension shall be deemed an interim precautionary step in the professional review activity and shall not imply a final finding of responsibility for the situation that prompted the suspension.

(c) Any individual who exercises authority under subsection (a) or (b) to summarily suspend clinical privileges must immediately report this action in writing to the Administrator, the Chief of Staff, and the Chairs of both Medical Staff Operations Committees. Such summary suspension shall become effective immediately upon imposition and remain in effect unless or until modified by the Administrator or the Board.

(d) The Chair of the Operations Committee of the member's primary site of practice shall initiate an investigation of the matter prompting the summary suspension in accordance with Section 4 of this Article. Such investigation must be completed within 14 days of the suspension or reasons for the delay shall be transmitted to the Board so that it may consider, as soon as practicable, whether the suspension should be lifted prior to its completion.

(e) Immediately upon the imposition of a summary suspension, the appropriate department chair or, in her/his absence, the Chair of the appropriate Operations Committee shall transfer the care of the suspended member's patients to another Medical Staff member. In making such a transfer, the wishes of the patient shall be considered whenever possible.

(f) It shall be the duty of the Chair of the Operations Committee and the department chair to cooperate with the Administrator in enforcing all suspensions.

SECTION 2. GROUNDS FOR INITIATING AN INVESTIGATION

Whenever, on the basis of information and belief, the Chief of Staff, the chairperson of a clinical department, the chair or a majority of any Medical Staff committee, a Medical Staff member, the Chairperson of the Board, or the Administrator has cause to question:

- (a) the clinical competence of any Medical Staff member;
- (b) the care or treatment of a patient or patients or management of a case by any Medical Staff member;
- (c) the conduct of any Medical Staff member with regards to applicable ethical standards or a violation of the bylaws, policies, procedures, rules or regulations of the Hospital, Board or Medical Staff, including, but not limited to the Hospital's quality improvement, risk management, and utilization review programs; or
- (d) the conduct of any Medical Staff member that may be considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff, including the inability of the member to work harmoniously with others,

a written request for an investigation of the matter shall be addressed to the Chief of Staff, making specific reference to the incident(s), activity(ies) or conduct that constitutes the basis for the request. The Chief of Staff shall promptly notify the Administrator of all such requests and refer the request to the Chair of the Operations Committee of the member's primary site of practice for further action in accordance with the investigation procedures outlined in this Article. Nothing in this Article is meant to restrict the ability of any medical review or peer review committee to conduct a review or informal investigation of a member's practice in connection with such committee's quality improvement and/or assurance responsibilities.

SECTION 3. SELF REFERRAL

Whenever a practitioner has cause to question his/her own ability to perform his/her professional responsibilities due to physical, psychiatric or emotional illness, the Chair, Operations Committee for the primary campus, shall assist in facilitating a referral to the appropriate agency. The physician shall cooperate with the Chair, Operations Committee, to assure that patient care is not compromised.

SECTION 4. SUSPENSION OF PRIVILEGES DURING INVESTIGATION

(a) At any time during an investigation, the Executive Committee, with the approval of the Administrator, may suspend all or any part of the clinical privileges of the member being investigated whenever failure to take such actions may result in an imminent danger to the health and/or safety of any individual. This suspension shall be deemed to be administrative in nature and does not indicate the validity of the charges.

(b) The suspension shall become effective immediately upon imposition and remain in

effect unless or until modified by the Administrator or the Board. If such a suspension is placed into effect, the investigation must be completed within 14 days of the suspension, or reasons for the delay shall be transmitted to the Board so that it may consider whether the suspension should be lifted prior to completion of the investigation.

(c) Immediately upon the imposition of a suspension, the appropriate department chair or, in her/his absence, the Chair of the appropriate Operations Committee shall transfer the care of the suspended member's patients to another Medical Staff member. In making such a transfer, the wishes of the patient shall be considered whenever possible.

(d) It shall be the duty of the Chair of the Operations Committee and the department chair to cooperate with the Administrator in enforcing all suspensions.

SECTION 5. INVESTIGATIVE PROCEDURE

If, after receiving the request for investigation, the Chair of the Operations Committee determines:

(a) the request for investigation contains sufficient information to support a recommendation, s/he shall make a recommendation for action to the Executive Committee, with or without a personal interview with the member; or

(b) the request for investigation does not contain sufficient information to support a recommendation, the Chair of the Operations Committee shall immediately appoint a subcommittee of the Operations Committee to do so, or, appoint an Ad Hoc Investigating Committee.

(1) An Ad Hoc Investigating Committee shall consist of up to three practitioners, any of whom may or may not hold an appointment to the Medical Staff. If possible, this committee shall not include partners, associates, or relatives of the subject of the investigation, nor practitioners in direct economic competition with the subject of the investigation.

(2) The investigating committee, whether it be a subcommittee of the Operations Committee or an Ad Hoc Investigating Committee, shall have available to it the full resources of the Medical Staff and the Hospital to aid in its work, as well as the authority to use outside consultants as required.

(3) The investigating committee may require a physical and/or mental examination of the member by a physician(s) satisfactory to the committee and that the results of such examination be made available for the committee's consideration.

(4) The subject of the investigation shall have an opportunity to meet with the investigating committee before it makes its report. At this meeting (but not, as a matter of right, in advance of it) the member shall be informed of the general nature of the evidence supporting the investigation and shall be invited to discuss, explain or refute it. The proceedings of an investigating committee are considered an administrative matter and not an adversarial proceeding. This interview does not constitute a hearing, and none of the procedural rules provided in this Policy with respect to hearings, including

the right to have legal counsel present, apply. A summary of such interview shall be made by the investigating committee and included with its report to the Chair of the Operations Committee.

(5) The investigating committee shall make a report to the Chair of the Operations Committee which includes, the evidence, its findings and, if appropriate, a proposal for corrective action. This report shall also be promptly forwarded to the Executive Committee for review and recommendation to the Board.

SECTION 6. RECOMMENDATIONS FOR CORRECTIVE ACTIONS

(a) In acting after the investigation, the Executive Committee may recommend:

- (1) that no action is justified;
- (2) issuance of a written warning;
- (3) issuance of a letter of reprimand;
- (4) probation;
- (5) a requirement for consultation;
- (6) reduction of clinical privileges;
- (7) suspension of clinical privileges for a term;
- (8) revocation of staff appointment;
- (9) referral to the appropriate professional internal or external resource, including physical, psychiatric or emotional diagnostic and/or rehabilitative programs;
- (10) such other recommendations as it deems necessary or appropriate.

(b) Any recommendation for action will provide for monitoring of the affected practitioner to the extent necessary to assure patient safety.

(c) If the recommendation of the Executive Committee would entitle the affected member to a hearing in accordance with Article IX, the recommendation shall be forwarded to the Administrator, who shall promptly notify the affected member by hand-delivery or certified mail, return receipt requested, of her/his right to a hearing. The Administrator shall then hold the recommendation until after the member has exercised or waived her/his right to a hearing and appeal as provided in Article IX. At that time, the Administrator shall forward the recommendation of the Executive Committee, together with all supporting documentation, to the Board. The Chief of Staff or her/his designee shall be available to the Board to answer any questions that may be raised with respect to the recommendation.

(d) If the recommendation of the Executive Committee would not entitle the individual to a hearing, in accordance with Article IX, Section 2, the action shall take effect immediately. A report of the action taken and reasons therefore shall be made to the Board through the Administrator and the action shall stand unless modified by the Board.

(e) In the event the Board considers modification of an action of the Executive Committee taken pursuant to subsection (c), and such modification would entitle the individual to a hearing, the affected appointee, shall be notified by the Administrator, and no final action thereon shall be taken by the Board until the individual has exercised or waived her/his right to a hearing and appeal.

SECTION 7. AUTOMATIC SUSPENSION OF PRIVILEGES OR TERMINATION OF MEMBERSHIP

Suspension of all clinical privileges, or termination of membership as well as all clinical privileges, shall occur automatically as indicated upon the occurrence of any of the following events:

(a) Termination of appointment to or resignation from a UF faculty or clinical position shall result in automatic termination of membership, unless the member would otherwise meet qualifications for appointment pursuant to the Medical Staff Bylaws and this Policy.

(b) Revocation of license to practice shall result in automatic termination of membership. Suspension of license to practice shall result in automatic suspension of all clinical privileges for a concomitant period of time and prompt initiation of an investigation in accordance with this Article.

(c) Failure to take appropriate steps to cause license renewal, thereby rendering the license inactive, shall result in automatic suspension of all clinical privileges. The suspension shall remain in effect until proof of current licensure has been submitted.

(d) Failure to report to the Hospital any restriction or condition imposed on or probation with respect to the appointee's license within thirty (30) days of the imposition of such restriction, condition or probation shall result in automatic termination of membership.

(e) Revocation of license to prescribe or administer any controlled substances, if required for the exercise of the appointee's clinical privileges, shall result in automatic termination of membership.

(f) Failure to appear at a Medical Staff or Hospital committee meeting to which the appointee has been invited, and at which a discussion of the appointee's suspected deviation from standard clinical or professional practice is scheduled, unless excused by the Executive Committee upon a showing of good cause, shall result in automatic termination of membership. Such termination will be automatically rescinded upon the appointee's participation in a rescheduled conference; provided that the practitioner requests rescheduling within 14 days of the original conference date

(g) Failure to complete medical records in a timely fashion pursuant to the Rules and

Regulations of the Medical Staff, after warning, shall result in automatic suspension of all clinical privileges until such time as completion has occurred.

(h) Failure to maintain the minimum profession liability insurance coverage established by the Board shall result in automatic termination of membership, unless the appointee has requested waiver of such requirement from the Board and is awaiting final action on such request.

(i) Failure of the appointee to maintain a location in sufficient proximity to the hospital to be able to provide continuity of quality care to her/his patients as defined by Medical Staff Rules and Regulations shall result in automatic termination of membership, unless the appointee has requested waiver of such requirement from the Board and is awaiting final action on such request.

(j) Exclusion from participation in any federal program shall result in automatic termination of membership.

(k) Failure to return the reappointment application following notice by certified mail, that such failure will result in automatic termination of membership.

(l) Lack of patient care activity during the last reappointment cycle shall result in automatic termination of membership.

(m) Failure to acquire Board Certification within the timeframe established in the Medical Staff Bylaws shall result in automatic termination of membership.

(n) Failure to continuously meet the objective qualifications for membership established in the Medical Staff Bylaws shall result in automatic termination of membership.

Upon the occurrence of any of the foregoing events, the Administrator, or her/his designee, shall promptly give notice, by hand-delivery or certified mail, return receipt requested, of the automatic termination or suspension to the affected Medical Staff appointee, and the specific grounds for the termination/suspension. Within ten (10) days of receipt of such notice, the affected appointee may present written evidence to the Administrator that negates the grounds for the automatic suspension or termination. If the Administrator determines, in his/her sole discretion, that the written evidence is sufficient to negate the grounds for the automatic suspension or termination, s/he shall so notify the affected appointee and the automatic suspension or termination shall be considered void from the beginning. Any automatic suspension that is not corrected within thirty days shall result in automatic termination, without further notice.

It is the responsibility of the Chief of Staff and Chairs of the Operations Committees, with the cooperation of the Administrator, to enforce all automatic suspensions and terminations.

SECTION 8. CONFIDENTIALITY AND REPORTING

All minutes, reports, recommendations, communications, and actions made or taken pursuant to this Policy are deemed confidential pursuant to the provisions of federal or state statute providing protection to peer review or related activities and to the provision of such policies regarding

confidentiality as may be adopted by the Board. Furthermore, the committees and/or panels charged with making reports, findings, recommendations or investigations pursuant to this Policy shall be considered to be acting on behalf of the Hospital and its Board when engaged in such professional review activities and thus shall be deemed the "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986.

Reports of actions taken pursuant to this Policy shall be made by the Administrator to such governmental agencies as may be required by law.

ARTICLE X. FAIR HEARING AND APPEALS PROCEDURES

SECTION 1. INITIATION AND SCHEDULING OF A HEARING

A. Right to Hearing

Except as provided in Section 2, a practitioner is only entitled to a hearing whenever any of the following adverse recommendations, or adverse actions without a recommendation, has been made or taken by the Executive Committee, or by the Board, in the event the Board intends to take such adverse action without a similar recommendation from the Executive Committee:

- (1) denial of initial medical staff appointment or reappointment;
- (2) revocation of medical staff membership;
- (3) denial of requested initial clinical privileges;
- (4) denial of requested increased clinical privileges;
- (5) decrease of clinical privileges when not requested by the practitioner;
- (6) suspension of clinical privileges;
- (7) imposition of mandatory concurring consultation requirement.

No practitioner shall be entitled to more than one hearing with respect to the subject matter of any proposed adverse recommendation or action giving rise to a hearing right. A hearing right provided as to an initial or proposed adverse recommendation or action satisfies the requirements for a hearing right as to the final recommendation or action which is based on the same subject matter.

B. Actions Not Giving Rise to Hearing Right

Recommendations for, or imposition of, any of the following actions by the Executive Committee or Board do not constitute grounds for a hearing:

- (1) denial of medical staff application, appointment or reappointment, or revocation of medical staff appointment based on an inability to meet any one of the minimum objective criteria for appointment set forth in Article I, Section 3 of the Medical Staff Bylaws;
- (2) automatic suspension of privileges or termination of membership pursuant to Article IX, Section 7 of this Policy;
- (3) summary suspension pursuant to Article IX, Sections 1 and 3, unless such suspension remains effective for more than 14 days;
- (4) denial or termination of temporary privileges under Article III, Sections 3 and 4, or emergency privileges under Section 5, of this Policy;
- (5) requirement for supervision or observation of a practitioner which does not restrict the clinical privileges of the practitioner;
- (6) a general consultation or corrective counseling requirement;
- (7) issuance of a letter of warning, admonition or reprimand;
- (8) denial of a request for waiver from the Board of any appointment criteria set forth in Article I, Section 3 of the Medical Staff Bylaws;
- (9) denial of reappointment due to lack of patient care activity during the last reappointment cycle.

C. Notice of Adverse Recommendation or Action and Request for Hearing

- (1) When a recommendation is made or action is taken that entitles an individual to a hearing prior to final action of the Board, the affected practitioner shall promptly be given written notice by the Administrator, by hand-delivery or certified mail, return receipt requested. This notice shall contain:
 - (a) a statement of the recommendation/action made/taken and the general reasons for it;
 - (b) a statement that the individual has a right to a hearing on the recommendation and thirty (30) days from receipt of the notice to request such hearing;
 - (c) a statement that failure to request a hearing in the time and manner specified will result in a waiver of the practitioner's right to a hearing and acceptance of the adverse recommendation; and
 - (d) a summary of the practitioner's rights during the hearing as provided for in Part B of this Article.

(2) The affected practitioner shall have thirty (30) days from the date of receipt of such notice, as indicated by the return receipt, to submit a written request for a hearing to the Administrator.

(3) If the affected practitioner does not submit a written request for a hearing within thirty (30) days of receipt of the notice, s/he shall be deemed to have waived her/his right to such hearing and to have accepted the recommendation and/or action, and any action taken by the Board shall be deemed final.

D. Scheduling and Notice of Hearing

Within fifteen (15) days of receipt of the affected practitioner's written request for a hearing, the Administrator shall schedule the hearing and give written notice of its time, place and date, by hand-delivery or certified mail, return receipt requested, to the practitioner. The hearing shall begin as soon as practicable, but no sooner than thirty (30) days from the date of notice of the hearing, unless an earlier hearing date has been specifically agreed to in writing by the affected practitioner.

(1) The notice shall also:

(a) include a concise statement of the specific reasons for the recommendation giving rise to the hearing;

(b) list the patient records and other information supporting the recommendation;

(c) in accordance with Section 5 of this Part, list the witnesses who are expected to testify or present evidence at the hearing in support of the recommendation, and inform the practitioner of her/his obligation to provide the Administrator within fifteen (15) days of receipt of the notice with a list of witnesses s/he expects to testify or present evidence on her/his behalf; and

(d) inform the practitioner of her/his right to be represented at the hearing by an attorney or other person of her/his choice and her/his obligation to advise the Administrator within fifteen (15) days of receipt of the notice of the name and address of such attorney or other person.

(2) The statement of reasons and list of supporting documents may be amended or supplemented at any time, even during the hearing, provided that the new material is relevant to the appointment or clinical privileges of the affected practitioner, and that the practitioner and her/his counsel have sufficient time to study the new information and rebut it.

E. Exchange of Witness Lists

A written list of the names, addresses and phone numbers of the individuals expected to give testimony or present evidence in support of the recommendation giving rise to the hearing shall

be provided to the affected practitioner with the notice of hearing. Within fifteen (15) days of receiving the notice of the hearing, the affected practitioner shall provide a written list of names, addresses and phone numbers of the individuals expected to give testimony or present evidence at the hearing on her/his behalf. The witness list of either party may be supplemented or amended at any time prior to the hearing, provided that notice of the change is given to the other party.

SECTION 2. HEARING PROCEDURE

The purpose of the hearing shall be to recommend a course of action to the Board, and the duties of the Hearing Panel shall be so defined and so carried out. The hearing shall be conducted in as informal a manner as possible, subject to the rules and procedures set forth in this policy.

A. Appointment of Hearing Panel or Hearing Officer

When a hearing is requested, the Administrator, after considering the recommendations of the Chairs of the Operations Committees (and that of the Chair of the Board, if the hearing is occasioned by a Board determination), shall appoint a Hearing Panel or Hearing Officer.

(1) A Hearing Panel shall be composed of not less than three practitioners. Medical Staff appointees to the Hearing Panel shall not have actively participated in the consideration of the matter involved at any previous level. Nor shall the Hearing Panel include any individual who is in direct economic competition with the affected practitioner, nor any individual who is professionally associated with or related to the practitioner. Knowledge of the matter involved, however, shall not preclude any individual from serving as a member of the Hearing Panel. The Administrator shall designate a Chair of the Hearing Panel.

(2) As an alternative to a Hearing Panel, the Administrator may appoint a Hearing Officer to perform the functions that would otherwise be carried out by the Hearing Panel. The Hearing Officer shall preferably be an attorney (who may also be legal counsel to the hospital) or some other individual capable of conducting the hearing. The Hearing Officer may not be an individual who is in direct economic competition with the affected practitioner, and shall not act as a prosecuting officer or as an advocate to either side at the hearing. In the event a Hearing Officer is appointed instead of a Hearing Panel, all references in this Article to the "Hearing Panel" or "Presiding Officer" shall be deemed to refer to the Hearing Officer, unless the context would clearly otherwise require.

B. Appointment of Presiding Officer

The Administrator shall select a person to act as the Presiding Officer during the hearing.

(1) The Presiding Officer may either be the Chair of the Hearing Panel, or an individual who is not a member of the hearing panel, including an attorney, who meets the criteria set forth in Section 1(a).

(2) The Presiding Officer shall:

(a) act to insure that all participants in the hearing have a reasonable opportunity to be

heard and to present relevant oral testimony and/or documentary evidence and that decorum is maintained throughout the hearing;

(b) determine the order of proceeding throughout the hearing;

(c) have the authority and discretion to make rulings, consistent with this Policy, on all questions of procedure and admissibility of evidence; and

(d) have the authority to remove any person who is disruptive to the orderly and professional process of the hearing.

The Presiding Officer may be advised on these matters by legal counsel to the Hospital.

(3) The Presiding Officer must not act as a prosecuting officer, or as an advocate for either side at the hearing. S/he may participate in the private deliberations of the Hearing Panel and be a legal advisor to it, but shall not be entitled to vote on its recommendations, unless s/he is the Chair of the Hearing Panel.

C. Rights of Affected Practitioner

During the hearing, the affected practitioner has the right to:

(1) representation by an attorney or any other person of her/his choice;

(2) call, examine and cross-examine witnesses;

(3) present evidence determined to be relevant by the Presiding Officer; and

(4) submit a written statement at the close of the hearing, in accordance with Section 10(e) of this Part.

D. Rights of the Hospital

During the hearing, the Professional Review Body whose recommendation prompted the hearing has the right to:

(1) representation at the hearing by a Medical Staff member, or by an attorney, if the affected practitioner is represented by an attorney;

(2) call, examine and cross-examine witnesses, including the affected practitioner;

(3) present evidence determined to be relevant by the Presiding Officer; and

(4) submit a written statement at the close of the hearing, in accordance with Section 10(e) of this Part.

E. Requests for Documents

Upon the request of either party prior to the hearing, the Presiding Officer may require the other party to provide documents in its possession that are not subject to any privilege or confidentiality as provided by law or policy, and which the other party plans to rely on as evidence at the hearing.

F. Postponement of Hearing

Postponement of the hearing beyond the time originally noticed may be requested by either party, but permitted only by the Hearing Panel Chair upon a showing of good cause.

G. Failure to Appear

The personal presence of the affected practitioner at the hearing is required. Failure of the affected practitioner to appear or proceed with the hearing, without good cause as determined by the Presiding Officer, shall be deemed to constitute acceptance of the recommendation(s) or action(s) pending. Such recommendation(s) or pending action(s) shall become final and effective upon Board action.

H. Attendance by Panel Members

Recognizing that it may not be possible for all members of the Hearing Panel to be continually present during the hearing, and the importance of concluding a hearing within a reasonable timeframe, the hearing shall continue even though all members of the Hearing Panel are not present at all times. The fact that not all panel members were physically present at all times during the hearing shall not invalidate it.

I. Hearing Record

- (1) The Hearing Panel shall maintain a record of the hearing by securing the presence of a court reporter or by an electronic recording of the proceedings. The cost of such reporter shall be borne by the Hospital, but copies of the transcripts shall be provided to the affected practitioner at her/his expense.
- (2) The Hearing Panel may, but shall not be required to, order that oral evidence be taken only on oath or affirmation administered by a person entitled to notarize documents in this State.

J. Presentation of Evidence

- (1) The Professional Review Body whose recommendation prompted the hearing shall present its evidence first. Upon completion of its presentation, the affected practitioner shall present her/his evidence. The Professional Review Body shall then have an opportunity to rebut any evidence presented by the affected practitioner.
- (2) Both parties to the hearing shall be permitted to present evidence determined to be

relevant by the Presiding Officer, regardless of the admissibility of such evidence in a court of law. The Presiding Officer shall admit any evidence which is commonly relied upon by reasonably prudent persons in the conduct of serious affairs.

(3) The Hearing Panel may interrogate the witnesses, call additional witnesses, or request documentary evidence, if it deems it appropriate.

(4) The Hearing Panel shall have the discretion to take official notice of any relevant matters as to which the Panel believes there can be no reasonable dispute. Official notice may also be taken of generally recognized technical or scientific facts within the Hearing Panel's members' specialized knowledge. Participants in the hearing shall be informed of the matters to be officially noticed and such matters shall be noted in the record of the hearing. Either party shall have the opportunity to request that a matter be officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority. Reasonable additional time shall be granted, if requested, to present written rebuttal of any evidence admitted on official notice.

(5) At the close of the hearing, each party shall have the right to submit a written statement concerning any issue, procedure, or alleged fact. Such written statement may take the form of a memorandum of points and authorities. The Hearing Panel may request that such a statement or memorandum be filed by either party.

K. Standard of Proof

The affected practitioner has the burden of proving that the recommendation that prompted the hearing was unreasonable, not sustained by the evidence, or otherwise unfounded. Unless s/he so proves, the Hearing Panel shall recommend in favor of the Professional Review Body making the recommendation.

L. Adjournment and Conclusion

The Presiding Officer may, without special notice, adjourn and reconvene the hearing at the convenience of the participants. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed.

M. Deliberations and Recommendation of the Hearing Panel

(1) Within twenty (20) days after conclusion of the hearing, the Hearing Panel shall:

(a) conduct its deliberations outside the presence of any other person, except the Presiding Officer, and upon the request of the Hearing Panel, appropriate Hospital support personnel (including the Hospital's attorney);

(b) render a recommendation in accordance with subsection (b), accompanied by a report containing a concise summary of the reasons justifying the Hearing Panel's recommendation; and

(c) deliver its recommendation and report to the Administrator.

(2) The recommendation shall be based on the evidence produced at the hearing, which may include: oral testimony of witnesses; documentary evidence admitted during the hearing; all officially noticed matters; any other evidence that has been admitted. In addition, the Hearing Panel may consider any written statement or memorandum of points and authorities submitted by the parties. The recommendation shall comport with the burden of proof requirement set forth in Section 11 of this Part. Agreement by a majority of all the members of the Hearing Panel shall be required for the issuance by the Hearing Panel of any recommendation or report.

(3) Upon its receipt, the Administrator shall forward the Hearing Panel's recommendation and report, along with all supporting documentation, to the Board for further action. The Administrator shall also send a copy of the recommendation and report to the Professional Review Body whose adverse recommendation prompted the hearing, the Executive Committee, and the appropriate Operations Committee, for informational purposes, and by hand-delivery or certified mail, return receipt requested, to the affected practitioner.

SECTION 3. APPELLATE REVIEW

A. Request for Appellate Review

Within 10 days of notification of an adverse recommendation from the Hearing Panel, the affected practitioner may request appellate review. The request shall be in writing, and shall be delivered to the Administrator by hand-delivery or by certified mail, return receipt requested, and shall include a brief statement of the grounds for the appeal. The Administrator shall promptly forward the request to the Chair of the Board. If such appellate review is not requested in a timely fashion and the manner required, the affected practitioner shall be deemed to have waived her/his right to an appeal and to have accepted the adverse recommendation of the Hearing Panel.

B. Grounds for Appeal

The grounds for an appeal are that:

- (1) there was substantial failure on the part of the Hearing Panel to comply with this Policy and/or the Hospital or Medical Staff bylaws, so as to deny a fair hearing; or
- (2) the recommendations of the Hearing Panel were made arbitrarily, capriciously, or with prejudice; or
- (3) the recommendations of the Hearing Panel were not supported by the evidence.

C. Scheduling and Notice of Appellate Review

Within 10 days of receipt of a request for an appeal, the Chair of the Board shall schedule and arrange for an appellate review. The date of appellate review shall be not less than 20 days, nor more than 30 days, from the date of receipt of the request; provided, however, that when a

request for appellate review is from an appointee who is under a suspension then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made and not more than 14 days from the date of receipt of the request. The Administrator shall give the affected practitioner notice of the time, place, and date of the appellate review by hand-delivery or by certified mail, return receipt requested. The time for appellate review may be extended by the Chair of the Board for good cause. The Chair of the Appellate Review Panel may, without special notice, adjourn and reconvene the review meeting at the convenience of the participants.

D. Appointment of Appellate Review Panel

(1) The Chair of the Board shall appoint a Review Panel composed of not less than five persons, who may be members of the Board or others, including but not limited to reputable persons outside the hospital, to consider the record upon which the Hearing Panel recommendation was made.

(2) Appointees to the Appellate Review Panel shall not have actively participated in the consideration of the matter involved at any previous level. Nor shall it include any individual who is in direct economic competition with the affected practitioner, nor any individual who is professionally associated with or related to the practitioner. Knowledge of the matter involved, however, shall not preclude any individual from serving as a member of the Appellate Review Panel. The Chair of the Board shall designate a Chair of the Appellate Review Panel.

E. Attendance by Appellate Review Panel Members

A majority of the members of the Appellate Review Panel must be present at each meeting of the Panel.

F. Purpose and Standard of Appellate Review

(1) The purpose of the Appellate Review is to ascertain the fairness of the hearing procedure and to determine whether the recommendation of the Hearing Panel is supported by the evidence and other testimony and documents submitted at the hearing. The Appellate Review Panel shall review the hearing record, including all documentary evidence and any written statements submitted by the parties before making its determinations and recommendations to the Board.

(2) The Appellate Review Panel shall uphold the recommendation of the Hearing Panel unless it finds that:

(a) the Hearing Panel's recommendation was not supported by substantial evidence in the record, or was arbitrary, capricious, or made with prejudice;

(b) the procedures followed in reaching the recommendation were not fair or not in substantial compliance with the Hospital or Medical Staff Bylaws or this Policy.

G. Additional Evidence

- (1) The Appellate Review Panel may not accept additional oral or written evidence, unless so directed by the Board upon a good faith belief that the affected practitioner was unfairly denied the opportunity to present such evidence at the hearing.
- (2) Nevertheless, the Appellate Review Panel may, in its sole discretion, invite the affected practitioner to appear and make a statement.

H. Recommendation of the Appellate Review Panel

- (1) Within fourteen (14) days of the date noticed for the Appellate Review, the Appellate Review Panel shall forward its recommendation and report of the reasons for the recommendation to the Board and the Administrator. The recommendation shall comport with the standard of review set forth in Section 6 of this Part. If the Appellate Review Panel's recommendation does not uphold the Hearing Panel's recommendation, it may recommend referral back to the Hearing Panel or the Executive Committee, as appropriate, with instructions for remedial action. Agreement by a majority of all the members of the Appellate Review Panel shall be required for the issuance by the Panel of any recommendation or report.
- (2) Upon its receipt, the Administrator shall forward the Appellate Review Panel's recommendation and report to the Hearing Panel, the Executive Committee, and the appropriate Operations Committee, and by hand-delivery or certified mail, return receipt requested, to the affected practitioner.

SECTION 4. FINAL DECISION OF THE BOARD

A. Final Board Action

- (1) The Board may affirm, modify or reverse the recommendation presented to it for final action, after exhaustion or waiver of hearing and appeal rights, or, in its sole discretion, refer the matter for further review and recommendations, to be completed within 30 days or less, as per the Board's direction.
- (2) If the Board proposes an adverse final action inconsistent with that of the final recommendation before it, the Chair of the Board shall consult with a majority of the Executive Committee before taking such final action.
- (3) Final Board action shall be rendered in writing to the Administrator within 30 days of receipt of the final recommendation. The Administrator shall promptly deliver copies thereof by hand or by certified mail, return receipt requested, to the affected practitioner, the panel providing the recommendation, and the Chief of Staff, who shall distribute to other Medical Staff committees as appropriate.

B. Further Review

Except where the matter is referred for further action and recommendation in accordance with Section 1 of this Part, the final decision of the Board following the hearing and appeal process, or if waived, following the recommendation of the Executive Committee, shall be effective immediately and shall not be subject to further review. No practitioner shall be entitled as a matter of right to more than one hearing or appellate review on any single matter.

SECTION 5. REAPPLICATION TO THE STAFF AFTER ADVERSE FINAL ACTION

In the event that the Board denies initial appointment or reappointment to the practitioner, or revokes or terminates the practitioner's Medical Staff appointment and/or clinical privileges, that practitioner may not again apply for Medical Staff appointment or clinical privileges at this Hospital for a period of five years, unless the Board provides otherwise in its written final decision.

ARTICLE XI. AMENDMENTS

SECTION 1. INITIATION

Amendments to this policy may be initiated by the Board, the Executive Committee, the Credentials Committee, or an Operations Committee through the Credentials Committee. If initiated by the Board or Executive Committee, proposed amendments must be provided to the Credentials Committee and both Operations Committees for their comments prior to the Executive Committee's vote on the proposed amendment. Except that, the following types of amendments may be initiated by the Board or Executive Committee and adopted without prior notice to or comment from the Credentials Committee or Operations Committees:

- (a) amendments that are technical or legal clarifications;
- (b) amendments that are required in order to comply with any federal, state, or local law or regulation, or with JCAHO or other accrediting agency standards, as appropriate; or
- (c) amendments that are merely for the purpose of reorganization or renumbering, or to correct punctuation, spelling or other errors of grammar or expression.

SECTION 2. EXECUTIVE COMMITTEE RECOMMENDATION

Amendments may be recommended to the Board upon a majority vote of the members of the Executive Committee present and voting at any meeting of that committee where a quorum exists.

SECTION 3. ADOPTION AND DISTRIBUTION

An amendment shall be effective upon adoption by the Board, and distributed thereupon to all Medical Staff members.