

February 5, 2009

MEMORANDUM

TO: The Medical Center Operating Board:

E. Darracott Vaughan, Jr., M.D., Chair	
W. Heywood Fralin, Rector	The Hon. Lewis F. Payne
Sam D. Graham, Jr., M.D.	Randl L. Shure
William P. Kanto, Jr., M.D.	Edward J. Stemmler, M.D.
Randy J. Koporc	John O. Wynne
Vincent J. Mastracco, Jr.	

Ex Officio Advisory Members:

Steven T. DeKosky, M.D.	R. Edward Howell
John B. Hanks, M.D.	Leonard W. Sandridge

and

The Remaining Members of the Board of Visitors:

Daniel R. Abramson	Robert D. Hardie
A. Macdonald Caputo	Glynn D. Key
The Honorable Alan A. Diamonstein	Austin Ligon
Susan Y. Dorsey	Don R. Pippin
Helen E. Dragas	Warren M. Thompson
Thomas F. Farrell, II	Adom Getachew

FROM: Alexander G. Gilliam, Jr.

RE: Cover Note for Minutes of the Meeting of the Medical Center Operating Board on February 5, 2009

Although my name appears as the Minute taker on these Minutes, they were written by Susan Harris in her capacity as Secretary to the Board-elect. She very kindly offered to do this as an exercise in preparation for taking office on May 1<sup>st</sup>.

AGG:lah

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FROM: Alexander G. Gilliam, Jr.

RE: Minutes of the Meeting of the Medical Center Operating Board  
on February 5, 2009

The Medical Center Operating Board of the Board of Visitors of the University of Virginia met, in Open Session, at 8:30 a.m., Thursday, February 5, 2009, in the Board Room at the Medical Center; E. Darracott Vaughan, Jr., M.D., Chair, presided.

W. Heywood Fralin, William P. Kanto, Jr., M.D., Randy J. Koporc, Vincent J. Mastracco, Jr., The Hon. Lewis F. Payne, Edward J. Stemmler, M.D., and John O. Wynne were present. Randl L. Shure participated by telephone.

Steven T. DeKosky, M.D., John B. Hanks, M.D., R. Edward Howell, and Leonard W. Sandridge, all *ex officio* Members, also were present.

Other Board of Visitors members attending the meeting were Daniel R. Abramson, A. Macdonald Caputo, Ms. Helen E. Dragas, and Robert D. Hardie.

Present as well were Arthur Garson Jr., M.D., Susan E. Kirk, M.D., Ms. Barbara Baldwin, Ms. Priscilla Shuler, Robert Gibson, M.D., Ms. Lynn Fleming, Larry Fitzgerald, Ms. Pamela Cipriano, Ms. Karen Rendleman, Marshall Ruffin, M.D., Ms. Patricia L. Cluff, Barry Marshall, John Boswell, Alexander G. Gilliam, Jr., and Ms. Jeanne Flippo Bailes.

The Chair opened the meeting by introducing William P. Kanto, M.D., a new member of the Board, and providing a brief background on Dr. Kanto. Dr. Kanto, an alumnus of both the College and the School of Medicine, is a member of the faculty and Chairman of the Department of Pediatrics at the Medical College of Georgia.

The Chair asked Dr. Stemmler to introduce members of the Quality Subcommittee present for the meeting.

ACTION ITEM: Amended and Restated Bylaws of the Clinical Staff of the Medical Center

The Chair called on Dr. Hanks to review amendments to the Clinical Staff Bylaws and seek approval of the revised Bylaws.

On motion, the Medical Center Operating Board adopted the following resolution:

RESOLVED, the Medical Center Operating Board approves the Amended and Restated Bylaws of the Clinical Staff of the Medical Center. These amendments, which are appended to this Resolution as an Attachment, shall be effective as of February 5, 2009.

VICE PRESIDENT'S REMARKS

Mr. Howell introduced Courtney Terry, who is in a joint Medical School and Darden School of Business program and is a Fellow in the office of the Vice President and Chief Executive Officer.

Mr. Howell reported that the first six months of performance have fallen short of expectations due to a reduction in overall patient volumes. This appears to be related to the economic situation in that patient volumes are down throughout Virginia and

across academic medicine. The Medical Center is tracking what others are doing. Actions include modifying the patient transfer process, communicating with referring physicians, enhancing accessibility through the web site, monitoring length of stay, and monitoring and managing operating expenses. Mr. Howell stated that he assumed this mode of operation will continue for some time.

Mr. Howell stated the bad debt and indigent care costs have remained fairly constant. This is unlikely to continue; it is likely they will increase because of the current economic climate. The Virginia Hospital Association developed a report on the community benefit and economic impact of Virginia's hospitals which was provided to all Board members. Virginia has two Tier 1 Hospitals, UVA and MCV, which provide nearly 42 percent of the indigent care provided to Virginians.

The Medical Center has exceeded its patient satisfaction goal for calendar year 2008, and the original goal for 2009. The administrative staff has questioned if the performance goals are set high enough. Mr. Howell proposed that the calendar year 2009 measure be revised upward to reflect a higher level of performance for patient satisfaction as well as employee engagement because that has improved as well. This does not require Board action.

Two weeks ago, the Medical Center broke ground for the new Long-Term Acute Care Hospital (LTACH) at the Northridge grounds. The facility should be completed by the fourth quarter of calendar year 2010. The LTACH will expand inpatient capacity by 40 beds as well as permit the Medical Center to focus care on this patient population.

The first inpatient unit refurbishment was completed last week. The "new" hospital is now 20 years old and the units are in need of attention. All inpatient units will be refurbished over the next 20 months.

Mr. Howell discussed three new Buchanan awards: Helical Tomotherapy, Stroke Telemedicine, and Fetal Cardiology. An overview of the program will be presented at the June MCOB meeting.

Mr. Howell provided copies of *The Journal of Diagnostic Imaging* article on the 21<sup>st</sup> Century Reading Room. The design of the facility is drawing national attention. Mr. Howell offered to arrange tours of the facility.

REMARKS BY THE VICE PRESIDENT AND DEAN OF THE SCHOOL OF MEDICINE

In follow-up to Mr. Howell's comments, the Chair commented that the case mix index for the Medical Center was now 1.8, which is very high. The Chair then asked Dr. DeKosky to give the customary report by

the Vice President and Dean of the Medical School, including commenting on the high volume of applications to the Medical School.

Dr. DeKosky mentioned the open Chair searches. He said they had developed a short list for the Chair of Obstetrics and Gynecology.

Students admitted to the School of Medicine this year are of outstanding quality.

The Cyclotron research and technical center will be operational at Fontaine Research Park within 18 months.

NIH research is holding steady, but funding nationally is up in the air.

#### FINANCIAL REPORT

Mr. Howell asked Mr. Fitzgerald, Chief Financial Officer of the Medical Center, to present the Financial Report.

Mr. Fitzgerald said that as of the end of December, admissions are 6.2% below budget and the length of stay is 7.6% above budget. Cardiology revenue is down and this has been a profitable service. Orthopedics is also down, but surgery is up.

The operating revenue is 2.9% below budget; the longer length of stay creates more revenue, but also generates more expense. Length of stay appears to be affected by the economy because patients cannot be transferred.

The operating margin through December is 3.7%, which was budgeted at 4.1%. Total expenses are below budget by 2.5% but total operating revenue is also below budget by 2.9%. The net income loss on investments is \$83 million for fiscal year 2009 year to date. Discharge by noon percentage is now 44%.

Indigent care charges of \$73.9 million for the period July 1, 2008 through November 30, 2008 have been written off. Recoveries over the same period totaled \$19.6 million.

Bad debt charges of \$18 million for the first five months of fiscal year 2009 have been written off. \$7.1 million was recovered through suits, collection agencies, and Virginia refund set-off.

OPERATIONS REPORT

The Chair asked Ms. Cipriano, Chief Clinical Officer, to give the customary Operations Report.

Ms. Cipriano described a variety of matters of interest to the Board, including the Care Partners Program. Care Partners enables a patient to designate an individual, a family member or a friend, as a Care Partner to help the patient through the hospital stay and recovery. The Care Partners Program was developed by the Professional Nursing Staff Organization, piloted in the Children's Hospital inpatient units, and approved for implementation hospital-wide in 2008 by the Patient Care Committee.

GRADUATE MEDICAL EDUCATION

At the Chair's request, Susan Kirk, M.D., the Designated Institutional Official and Associate Dean for Medical Education, made the report. Dr. Kirk said the University filled all programs in the National Residency Match Program. The University offered 148 positions to applicants from across the country.

ACGME, the national accrediting body for residency programs, has given full accreditation to all of the University's residency programs. More than half are on 5-year cycles, which is the best outcome.

The University has made changes to improve the house staff work environment and benefits. The changes include increasing salaries by 3.8% in order to remain competitive nationally, as well as covering the increase in parking fees, increasing the employer payment for medical insurance, and installing a new duty hour and evaluation system.

Dr. Kirk reviewed some innovations in Graduate Medical Education in 2008, including the Master Educator Awards and the GME Retreat for Program Directors and Coordinators, which was made possible through a generous contribution from Mr. Fralin.

Dr. Kirk mentioned a new Medical Center Conflict of Interest policy for interactions with industry. It is no longer acceptable to receive even nominal gifts from vendors.

The ACGME has set limitations on duty hours that the University has been following. Now, the Institute of Medicine has issued recommendations for more stringent restrictions. Dr. Kirk stated that nationally the Institute of Medicine duty hours restrictions would require 5,700 more residents or 6,000 additional mid-level providers and 5,000 more faculty, and will cost an additional \$1.6 billion. The

ACGME is analyzing the Institute of Medicine recommendations and they will conduct a symposium in March on international duty hours.

REPORT BY THE PRESIDENT OF THE CLINICAL STAFF

The Chair asked Dr. Hanks, President of the Clinical Staff, to give his customary report.

Dr. Hanks' comments were centered around the importance of the electronic medical record to the Clinical Staff. He emphasized that this will not be an easy transition in large part because of the differences among Clinical Staff in computer data entry and acquisition skills. Questions about implementation, including order entry, medicine reconciliation, and rapid flow of information to multiple sites and scheduling areas, must be resolved and it is unclear who will make these decisions. Ongoing education will be crucial. Physician input will be key and this needs to be done in collaboration with nursing and administrative colleagues.

The fourth Clinical Staff Retreat on March 20 and 21, 2009, will focus on the implementation of the electronic medical record. All MCOB members are invited as well as nursing and administration colleagues. The agenda is currently being developed.

EXECUTIVE SESSION

After adopting the following motions enabling it to meet in closed session, the Medical Center Operating Board went into Executive Session at 9:45 a.m.:

That the Medical Center Operating Board go into Closed Session to discuss proprietary business-related information pertaining to operations of the Medical Center in connection with strategic personnel, financial, market, and resource considerations and efforts regarding the Medical Center. These matters include potential investment of public funds for an electronic medical record, capacity planning and potential strategic joint ventures or other competitive efforts where public disclosure would adversely affect the Medical Center's bargaining position.

The Medical Center Operating Board also is to consider confidential information and data related to the adequacy and quality of professional services, patient safety in clinical care, and patient grievances, all for the purpose of improving patient care.

And further, in consultation with legal counsel, to discuss the Medical Center's compliance with relevant federal reimbursement regulations, licensure and accreditation standards, including Medicaid Disproportionate Share, as well as negotiations concerning performance of

a contract and related litigation, which will also involve proprietary business information of the Medical Center; also evaluation of the performance of specific Medical Center personnel.

Disclosure of all these matters at this time would adversely affect the competitive position of the Medical Center.

The foregoing motion is authorized by Sections 2.2-3711 (A) (1), (6), (7), (8) and (22) of the Code of Virginia. The Closed Session of the Medical Center Operating Board is further privileged under Section 8.01-581.17 of the Code of Virginia.

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That the Medical Center Operating Board go into Closed Session to consider proposed personnel actions regarding the appointment, reappointment, resignation, assignment, performance and credentialing of specific clinical staff members and allied health care professionals. The foregoing motion is authorized by Section 2.2-3711 (A) (1), of the Code of Virginia. The Closed Session of the Medical Center Operating Board is further privileged under Section 8.01-581.17 of the Code of Virginia.

The Medical Center Operating Board resumed its meeting in Open Session at 11:40 a.m., and adopted the following resolution certifying that its discussions in Executive Session had been conducted in accord with the exemptions permitted by the Virginia Freedom of Information Act:

That we vote on and record our certification that, to the best of each Board member's knowledge, only public business matters lawfully exempted from open meeting requirements and which were identified in the motion(s) authorizing the closed session, were heard, discussed or considered in closed session.

ACTION ITEM: Approval of Credentialing and Recredentialing Actions

The Medical Center Operating Board approved the following Credentialing and Recredentialing resolutions, which were discussed in Executive Session:

CREDENTIALING AND RE-CREDENTIALING ACTIONS

NEW APPOINTMENTS TO THE CLINICAL STAFF

RESOLVED that the recommendations of the Clinical Staff Executive Committee for appointment to the Clinical Staff of the University of Virginia Medical Center and the granting of specific privileges to the following practitioners are approved:

Anschel, David J., M.D., Neurologist in the Department of Neurology; Attending Staff Status; Period of Appointment: December 12, 2008, through December 11, 2009; Privileged in Neurology.

Bleeker, Jonathan S., M.D., Physician in the Department of Medicine; Instructor Staff Status; Period of Appointment: January 19, 2009, through May 10, 2009; Privileged in Medicine.

Cauthen, Clay A., M.D., Physician in the Department of Medicine; Instructor Staff Status; Period of Appointment: December 12, 2008, through December 11, 2009; Privileged in Medicine.

Davidson, Kelly M., M.D., Physician in the Department of Medicine; Attending Staff Status; Period of Appointment: January 2, 2009, through January 1, 2010; Privileged in Medicine.

Hall, Courtney N., M.D., Psychiatrist in the Department of Physical Medicine and Rehabilitation; Instructor Staff Status; Period of Appointment: November 15, 2008, through December 14, 2008; Privileged in Psychiatry.

Helms, Adam S., M.D., Physician in the Department of Medicine; Instructor Staff Status; Period of Appointment: February 4, 2009, through February 3, 2010; Privileged in Medicine.

Janardhanan, Rajesh, M.D., Physician in the Department of Medicine; Consulting Staff Status; Period of Appointment: January 15, 2009, through January 14, 2010; Privileged in Medicine.

Mikolaenko, Ivan, M.D., Neurologist in the Department of Neurology; Instructor Staff Status; Period of Appointment: January 9, 2009, through November 24, 2009; Privileged in Neurology.

Mills, Angela M., M.D., Physician in the Department of Medicine; Consulting Staff Status; Period of Appointment: December 19, 2008, through December 18, 2009; Privileged in Medicine.

Montero, Robert J., M.D., Pediatrician in the Department of Pediatrics; Attending Staff Status; Period of Appointment: November 18, 2008, through November 2, 2009; Privileged in Pediatrics.

Prichard, Jefferson M., M.D., Physician in the Department of Medicine; Consulting Staff Status; Period of Appointment: December 19, 2008, through December 18, 2009; Privileged in Medicine.

Saad, Wael, M.D., Radiologist in the Department of Radiology; Attending Staff Status; Period of Appointment: April 1, 2009, through March 31, 2010; Privileged in Radiology.

Schafer, Katherine R., M.D., Physician in the Department of Medicine; Instructor Staff Status; Period of Appointment: January 19, 2009, through August 31, 2009; Privileged in Medicine.

Vega-Bermude, Francisco, M.D., Physician in the Department of Medicine; Consulting Staff Status; Period of Appointment: December 18, 2008, through December 17, 2009; Privileged in Medicine.

#### STATUS CHANGES TO CLINICAL STAFF

RESOLVED that the recommendations of the Clinical Staff Executive Committee for the status changes in clinical privileges to the following practitioners are approved:

Fletcher, Page M., M.D., Psychiatrist in the Department of Psychiatry and Neurobehavioral Sciences; Attending Staff Status; Date of Reappointment changed to April 1, 2009 - March 31, 2010.

Gregg, Vanessa H., M.D., Obstetrician and Gynecologist in the Department of Obstetrics and Gynecology; Attending Staff Status; Date of Reappointment Changed to August 1, 2008 through September 24, 2009; Privileged in Obstetrics and Gynecology.

Gunderson, Erik W., M.D., Physician in the Department of Medicine; Attending Staff Status; Date of Secondary Reappointment Changed to January 6, 2009 through January 5, 2011; Privileged in Medicine.

Maughan, Karen L., M.D., Physician in the Department of Family Medicine; Attending Staff Status; Date of Reappointment Changed to November 25, 2008 through November 24, 2009; Privileged in Family Medicine.

Warren, Cirle A., M.D., Physician in the Department of Medicine; Attending Staff Status; Date of Reappointment Changed to November 25, 2008 through November 24, 2009; Privileged in Medicine.

RESIGNATIONS FROM THE CLINICAL STAFF

RESOLVED that the recommendations of the Clinical Staff Executive Committee for the resignation and expiration of clinical privileges to the following practitioners are approved:

Bickston, Stephen J., M.D., Physician in the Department of Medicine; Attending Staff Status; Effective date of Resignation: January 1, 2009.

Bonds, Denise E., M.D., Physician in the Department of Medicine; Attending Staff Status; Effective date of Resignation: January 3, 2009.

Wheby, Munsey S., M.D., Physician in the Department of Medicine; Attending Staff Status; Effective date of Resignation: September 30, 2008.

PRIVILEGES FOR NEW ALLIED HEALTH PROFESSIONALS

RESOLVED that the recommendations of the Clinical Staff Executive Committee for the granting of privileges to the following Allied Health Professionals are approved:

Cantore, Lisa M., R.N., N.P., Pediatric Nurse Practitioner at KCRC; Period of Privileging: December 2, 2008, through December 1, 2009; Privileged as a Pediatric Nurse Practitioner.

Wood, Susan P., R.N., N.P., Family Nurse Practitioner in EP/Cath Lab; Period of Privileging: November 18, 2008 through November 17, 2009; Privileged as a Family Nurse Practitioner.

STATUS CHANGES FOR ALLIED HEALTH PROFESSIONALS

RESOLVED that the recommendations of the Clinical Staff Executive Committee for the status change in privileges to the following Allied Health Professional are approved:

Childress, Reba, R.N., N.P., Family Nurse Practitioner in the Nephrology Clinic; Date of Privileges Changed to November 4, 2008 through November 3, 2009; Privileged as Family Nurse Practitioner.

Fitzhugh, Cawood B., R.N., N.P., Family Nurse Practitioner in the Cancer Center; Date of Privileges Changed to January 24, 2009 through January 4, 2010; Privileged as a Family Nurse Practitioner.

Sams, Robert M., R.N., N.P., Certified Nurse Anesthetist in the Operating Room; Date of Privileges Changed to February 1, 2009 through January 31, 2011; Privileged as a Certified Nurse Anesthetist.

RESIGNATIONS OF ALLIED HEALTH PROFESSIONALS

RESOLVED that the recommendations of the Clinical Staff Executive Committee for the resignation and expiration of privileges to the following Allied Health Professionals are approved:

Enterline, Leslie, P.A., Physician Assistant in the Hematology Oncology Clinic; Effective Date of Resignation: November 5, 2008.

Tribble, Sidenia S., R.N., N.P., Acute Care Nurse Practitioner in the MSICU; Effective Date of Resignation: November 1, 2008.

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The Medical Center Operating Board approved the following resolution on the procurement of a Health Care Information Management System (Electronic Medical Record):

APPROVAL OF SIGNATORY AUTHORITY FOR MEDICAL CENTER PROCUREMENT OF HEALTH CARE INFORMATION MANAGEMENT SYSTEM (Electronic Medical Record)

WHEREAS, the Medical Center Operating Board finds it to be in the best interest of the University of Virginia and its Medical Center for the Medical Center to acquire a health care information management system that will include an electronic medical record for all inpatient and outpatient clinical care provided by the Medical Center; and

RESOLVED, the Medical Center Operating Board authorizes and recommends to the Finance Committee and to the Board of Visitors approval for the Executive Vice President and Chief Operating Officer of the University, with the concurrence of the Chairs of the Medical Center Operating Board and the Finance Committee, to execute one or more contracts for the procurement of a health care information management system for the University of Virginia Medical Center. The system will include an electronic medical record, along with the associated implementation and integration services. This action is based on the recommendation of the Vice President and Chief Executive Officer of the Medical Center and in accordance with Medical Center procurement policy.

On motion, the meeting was adjourned at 11:42 a.m.

AGG:lah

These minutes have been posted to the University of Virginia's Board of Visitors website.

<http://www.virginia.edu/bov/mcobminutes.html>

**ATTACHMENT**

**AMENDED AND RESTATED  
BYLAWS  
OF THE CLINICAL STAFF  
OF THE  
UNIVERSITY OF VIRGINIA MEDICAL CENTER**

**September 19, 2002  
REVISED September 1, 2005  
REVISED October 2, 2008  
REVISED February 5, 2009**

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**AMENDED AND RESTATED  
BYLAWS  
OF THE CLINICAL STAFF  
OF THE UNIVERSITY OF VIRGINIA MEDICAL CENTER**

**PREAMBLE**

WHEREAS, the University of Virginia Medical Center is an integral part of the University of Virginia, which is a public corporation organized under the laws of the Commonwealth of Virginia and an agency of the Commonwealth; and

WHEREAS, the Medical Center is an academic medical center comprised of a teaching hospital, a Children's Hospital within that hospital, outpatient clinics, clinical outreach programs, and related health care facilities, as designated by the Operating Board of the University of Virginia Medical Center from time to time, which provide inpatient and outpatient medical and dental services, and health sciences education and related clinical research in conjunction with the University of Virginia School of Medicine and the University of Virginia School of Nursing; and

WHEREAS, the Operating Board of the University of Virginia Medical Center is the governing body for the Medical Center and has delegated to the Clinical Staff the responsibility for the provision of quality clinical care it provides throughout the Medical Center; and

WHEREAS, these Bylaws set forth the requirements for membership on the Clinical Staff, including a mechanism for reviewing the qualifications of Applicants for Clinical Privileges and a process for their continuing review and evaluation, and provide for the internal governance of the Clinical Staff;

NOW, THEREFORE, these Bylaws are adopted by the Clinical Staff and approved by the Operating Board to accomplish the aims, goals, and purposes set forth in these Bylaws.

## **ARTICLE I DEFINITIONS**

“Active Clinical Staff” mean those Members of the Clinical Staff who meet the criteria set forth in Section 3.5 of these Bylaws.

“Administrative Clinical Staff” mean those Members of the Clinical Staff who meet the criteria set forth in Section 3.6 of these Bylaws.

“Adverse Action” means the reduction, restriction (including the requirement of prospective or concurrent consultation), suspension, revocation, or denial of Clinical Privileges of a Member that constitute grounds for a hearing as provided in Section 8.2 of these Bylaws. Adverse Action shall not include warnings, letters of admonition, letters of reprimand or recommendations or actions taken as a result of an individual’s failure to satisfy specified objective credentialing criteria that are applicable to all similarly situated individuals.

“Allied Health Professionals” may include, but are not limited to, Optometrists, Audiologists, Certified Substance Abuse Counselors, Licensed Professional Counselors, Licensed Clinical Social Workers, Nurse Practitioners, Physician Assistants, and Certified Registered Nurse Anesthetists.

“Allied Health Professionals Manual” means the Medical Center Allied Health Professionals Staff Credentialing Manual, as such may be in effect from time to time.

“Applicant” means a person who is applying for appointment or reappointment of Clinical Staff membership and may also mean a person who is applying for Clinical Privileges to practice within the University of Virginia Medical Center, as the context requires.

“Board of Visitors” means the governing body of the University of Virginia as appointed by the Governor of Virginia.

“Bylaws” means these Amended and Restated Bylaws of the Clinical Staff of the University of Virginia Medical Center, as amended from time to time.

“Case Review” means a full review and analysis of an event related to a single patient’s experience in the Medical Center and may also mean a review of multiple patient cases involving a single procedure, as the context requires.

“Chief Executive Officer” or “CEO” means the individual appointed by the Board of Visitors or the Medical Center Operating Board, as applicable, to serve as its representative in the overall administration of the Medical Center.

“Children’s Hospital” means a hospital within the Medical Center that is comprised of all inpatient and outpatient services, diagnostic services, clinical outreach programs and related healthcare services and staff that are specifically dedicated to providing healthcare to children in a patient and family centered care environment.

“Clinical Privileges” means the permission granted to a Member or Non-Member to render specific diagnostic, therapeutic, medical, dental, or surgical services for patients of the Medical Center.

“Clinical Staff” or “Staff” means those Physicians, Dentists, Podiatrists, Ph.D. Clinical Psychologists and Ph.D. Clinical Pathologists who hold a faculty appointment in the School of Medicine and have obtained membership status as provided in these Bylaws.

“Clinical Staff Executive Committee” or “Executive Committee” or “CSEC” means the executive committee of the Clinical Staff as more particularly described in Article X of these Bylaws.

“Clinical Staff Office” means the administrative office of the Medical Center responsible for the administration of the Clinical Staff, including the process for membership and the granting of Clinical Privileges.

“Clinical Staff Representatives” means those representatives selected by the Clinical Staff to serve on the Clinical Staff Executive Committee as provided in Article X.

“Clinical Staff Year” shall coincide with the fiscal year of the Medical Center, currently July 1 to June 30, as such fiscal year may be changed from time to time.

“CMS” means the Center for Medicare and Medicaid Services.

“Code of Conduct” means the Code of Conduct for the Clinical Staff as it may exist from time to time.

“Code of Ethics” means the Medical Center Code of Ethics that is described and contained in Medical Center Policy No. 0263 and found online at <http://www.healthsystem.virginia.edu/OPR/manuals/mc/0263-Medical-Center-Code-of-Ethics-and-Ethics-Committee.pdf>.

“Committees” means those standing Committees of the Clinical Staff as described in Article XII of these Bylaws.

“Community Medicine” means Community Medicine University of Virginia, LLC, a Virginia limited liability company.

“Compliance Code of Conduct” means the Medical Center Compliance Code of Conduct that is described in Medical Center Policy No. 0235 and found online at: <http://www.healthsystem.virginia.edu/OPR/manuals/mc/0235---Compliance-Code-of-Conduct.pdf>.

“Credentials Manual” means the Procedures for Appointment and Reappointment to the Clinical Staff and Delineation of Appropriate Clinical Privileges as such may be in effect from time to time. [/internet/clinical-staff-office/doc/Clinical-Staff-Manua\\_rev011108.doc](/internet/clinical-staff-office/doc/Clinical-Staff-Manua_rev011108.doc).

“DEA” means the Federal Drug Enforcement Agency, or any successor agency.

“Dean” means the Vice President and Dean of the School of Medicine of the University of Virginia.

“Dentist” means any individual who has received a degree in and is currently licensed to practice dentistry in the Commonwealth of Virginia.

“Department” means a clinical department within the Medical Center.

“Department Chair” or “Chair” means the Active Member appointed by the Dean of the School of Medicine who has the responsibility for overseeing his or her Department and who is the liaison between the Members in his or her Department and the Clinical Staff Executive Committee.

“Department Chair” also shall mean the Medical Director of Regional Primary Care with respect to Regional Primary Care and the Senior Associate Dean for Clinical Affairs with respect to Community Medicine.

“Division” means a subdivision of a Department.

“Emergency Privileges” means those Clinical Privileges granted during an emergency as more specifically provided in Section 5.8 of these Bylaws.

“Fellow” means a Physician, Dentist or Ph.D. Clinical Psychologist in a program of graduate medical education that is beyond the requirements for eligibility for first board certification in the discipline.

“Focused Professional Practice Evaluation (“FPPE”)” means an evaluation of the privilege-specific competence of a member of the Clinical Staff who does not have documented evidence of competently performing the requested privilege, or when a question arises regarding the ability of a currently privileged member of the Clinical Staff to provide safe, effective high quality care. See [Medical Center Policy No. 0279](#) and Credentials Manual [/internet/clinical-staff-office/doc/Clinical-Staff-Manua\\_rev011108.doc](/internet/clinical-staff-office/doc/Clinical-Staff-Manua_rev011108.doc).

“GME Manual” means the University of Virginia Medical Center Graduate Medical Education Manual, as such may be in effect from time to time and that is found online at [http://www.healthsystem.virginia.edu/alive/gme/doc/Manual\\_GradMedTrainee\\_Nov2007.pdf](http://www.healthsystem.virginia.edu/alive/gme/doc/Manual_GradMedTrainee_Nov2007.pdf).

“Graduate Medical Trainees” mean Residents and Fellows.

“HCQIA” means the Health Care Quality Improvement Act of 1986, 42 U.S.C. Sections 11101 - 11152, as such law may be amended from time to time.

“Hearing Entity” means the entity appointed by the Clinical Staff Executive Committee to conduct an evidentiary hearing upon the request of a Member who has been the subject of an Adverse Action that is grounds for a hearing in accordance with Article VIII herein.

“Honorary Clinical Staff” means those Members of the Clinical Staff who meet the criteria set forth in Section 3.7 of these Bylaws.

“Joint Commission” means the hospital accrediting body whose standards are referred to in these Bylaws.

“Medical Center” means the University of Virginia academic medical center comprised of the hospital, inpatient and outpatient clinics, clinical outreach programs, and related health care facilities as designated by the Medical Center Operating Board from time to time.

“Medical Center Operating Board” or “Operating Board” or “MCOB” means the governing body of the Medical Center as designated by the Board of Visitors.

“Medical Center Policy Manual” means the manual containing the administrative and various patient care policies of the Medical Center.

“Member” means any Physician, Dentist, Podiatrist, Ph.D. Clinical Psychologist or Ph.D. Clinical Pathologist who is a member of the Clinical Staff of the University of Virginia Medical Center.

“National Practitioner Data Bank” or “NPDB” means the national clearinghouse established pursuant to HCQIA, as amended from time to time, for obtaining and reporting information with respect to adverse actions or malpractice claims against physicians or other practitioners.

“Non-Member” means any Physician, Dentist, Podiatrist, Ph.D. Clinical Psychologist or Ph.D. Clinical Pathologist who does not qualify as a Member of the Clinical Staff but who is required to have Clinical Privileges in order to provide patient care in the Medical Center.

“Officer” means an elected official of the Clinical Staff as more particularly described in Article IX of these Bylaws.

“Ongoing Professional Practice Evaluation (“OPPE”)” means a process that allows identification of professional practice trends of members of the Clinical Staff that impact on quality of care and patient safety on an ongoing basis and focuses on the individual member’s performance and competence related to his or her Clinical Staff privileges. See [Medical Center Policy No. 0279](#) and [Credentials Manual /internet/clinical-staff-office/doc/Clinical-Staff-Manua\\_rev011108.doc](#).

“Peer” means a practitioner or clinician whose interest and expertise as documented by clinical practice or academic rank and/or post graduate degree(s) is reasonably determined to be equivalent in scope and emphasis to that of another practitioner or clinician.

“Peer Review” means a systematic review of a practitioner’s or clinician’s clinical practice or professionalism, or a review of a portion of the clinical practice or professionalism, by a Peer or Peers of the individual practitioner or clinician.

“Ph.D. Clinical Pathologist” means an individual who has been awarded a Ph.D. degree in the field of pathology.

“Ph.D. Clinical Psychologist” means an individual who has been awarded a Ph.D. degree or equivalent terminal degree in Clinical Psychology and who holds a current license to practice clinical psychology issued by the Virginia Board of Psychology.

“Physician” means any individual who has received a Doctor of Medicine or Doctor of Osteopathy degree and holds a current license to practice medicine in the Commonwealth of Virginia.

“Podiatrist” means an individual who has received a Doctor of Podiatric Medicine degree and who holds a current license to practice podiatry issued by the Virginia Board of Medicine.

“President” means the most senior elected Officer of the Clinical Staff as described in Article IX of these Bylaws.

“President-elect” means the president-elect of the Clinical Staff as described in Article IX of these Bylaws.

“Regional Primary Care” means the primary care satellite offices as designated by the Medical Center from time to time.

“Resident” means a Physician, Dentist or Ph.D. Clinical Psychologist in a program of graduate medical education in anticipation of fulfilling the requirements for first board certification.

“School of Medicine” means the medical school at the University of Virginia.

“Senior Associate Dean for Clinical Affairs” means that Member appointed by the Dean to serve as the Senior Associate Dean for Clinical Affairs.

“Temporary Privileges” means those Clinical Privileges granted for a period not to exceed 120 days as more specifically described in Section 5.7 of these Bylaws.

“University” or “University of Virginia” means the corporation known as The Rector and Visitors of the University of Virginia, which is an agency of the Commonwealth of Virginia.

**ARTICLE II  
GOVERNANCE OF THE MEDICAL CENTER**

**2.1 Medical Center Operating Board**

The Medical Center Operating Board is the governing body of the Medical Center. Each Member of the Clinical Staff assumes his or her responsibilities subject to the authority of the MCOB. The MCOB shall be constituted as directed by the Board of Visitors of the University from time to time.

**2.2 Clinical Staff Executive Committee**

The Clinical Staff Executive Committee serves as the executive committee of the Clinical Staff and reports to the MCOB. In this role, the Clinical Staff Executive Committee oversees the quality of the clinical care delivered within the Medical Center and delineates and adopts clinical policy within the Medical Center. It is responsible for communications to Members of the Clinical Staff and other Non-Members regarding clinical practice issues and it represents the interests of the Clinical Staff to the MCOB. The Clinical Staff Executive Committee is empowered to act for the Clinical Staff in the intervals between Clinical Staff meetings and independently with respect to those matters over which it is given authority in these Bylaws. The Clinical Staff Executive Committee shall be constituted and have the other duties as described in Article X hereof.

**ARTICLE III  
CLINICAL STAFF PURPOSE AND MEMBERSHIP**

**3.1 Purposes of Organization**

The purposes of the Clinical Staff of the University of Virginia Medical Center shall be:

- (a) to provide a system of Clinical Staff governance and patient care whereby patients treated in any Medical Center facility shall receive quality health care;
- (b) to provide a mechanism for reviewing the qualifications of Applicants for Clinical Staff membership and a process regarding recommendations to the MCOB for the admission and termination of membership to the Clinical Staff as provided in these Bylaws;
- (c) to provide a mechanism for reviewing the qualifications of Applicants for Clinical Privileges and a process regarding recommendation to the MCOB for the granting of Clinical Privileges as provided in these Bylaws and in the Credentials Manual;
- (d) to provide a mechanism for ongoing review and evaluation of the performance of each Member and Non-Member providing professional services to patients to ensure a high level of professional and ethical performance, and to recommend corrective action when any Member's or Non-Member's performance falls below the standards established for such professionals;
- (e) to provide an appropriate educational setting that will maintain scientific standards and promote continuous advancement in professional knowledge and skill; and
- (f) to fulfill such other missions as the MCOB may adopt for the Medical Center from time to time.

**3.1.1 Nature of Clinical Staff Membership**

Membership on the Clinical Staff is a privilege that is extended to professionally competent practitioners who continuously meet the qualifications, obligations, responsibilities, standards and requirements stated in these Bylaws and the Credentials Manual. Membership implies active participation in Clinical Staff activities to an extent commensurate with the exercise of the Clinical Staff Member's privileges and as may be required by the Clinical Staff Member's Department and Division.

**3.2 Eligibility for Clinical Staff Membership**

Membership on the Clinical Staff may be extended only to Physicians, Dentists, Podiatrists, Ph.D. Clinical Psychologists and Ph.D. Clinical Pathologists who maintain a faculty appointment in the School of Medicine (excluding Honorary Members who shall be former faculty in the

School of Medicine) and meet the other requirements for Clinical Staff membership as provided in these Bylaws. No person shall be entitled automatically to membership solely on the basis of licensure to practice in the Commonwealth of Virginia or any other state; membership in any professional organization; certification by any clinical board; or staff membership at any health care facility or practice setting. No Applicant for membership on the Clinical Staff shall be granted or denied membership on the basis of sex, race, age, creed, color, national origin, sexual orientation, religion, veteran status or disability.

### **3.3 Categories and Assignment of Clinical Staff**

The categories of Clinical Staff membership shall be:

Active Clinical Staff  
Administrative Clinical Staff  
Honorary Clinical Staff  
Ph.D. Clinical Pathologist Staff

Each Member shall be categorized as Active, Administrative, Honorary or Ph.D. Clinical Pathologist as proposed and approved as provided in these Bylaws. All Active and Ph.D. Clinical Pathologist Members shall be assigned to a specific clinical Department or other clinical enterprise within the University of Virginia, such as Community Medicine or Regional Primary Care. Joint appointments between clinical Departments and/or other clinical enterprises within the University shall be considered on an individual basis.

### **3.4 Basic Responsibilities of Clinical Staff Membership**

#### **3.4.1 Delivery of Health Care**

Active and Ph.D. Clinical Pathologist Members are responsible for the quality of health care delivered within the Medical Center facilities and accept this responsibility subject to the ultimate authority of and accountability to the MCOB. Ongoing responsibilities for the delivery of health care by Members in accordance with the privileges granted them, shall include but are not limited to the following:

- (a) providing patients with the quality of care that meets the professional standards and volume standard consistent with reasonably active clinical practice of the Clinical Staff of the Medical Center;
- (b) abiding by these Bylaws, the Code of Conduct, the Compliance Code of Conduct, the Medical Center's Code of Ethics and Medical Center policies, procedures, rules and regulations;
- (c) complying with Procedures for Appointment and Reappointment to the Clinical Staff as set forth in the Credentials Manual [/internet/clinical-staff-office/doc/Clinical-Staff-Manua\\_rev011108.doc](#);

- (d) preparing in legible form, completing within prescribed timelines and maintaining the confidentiality of medical records for all the patients to whom the Member provides care in the Medical Center as required by Medical Center policies;
- (d) working collaboratively and collegially with Members, non-Members, nurses, Allied Health Professionals, Graduate Medical Trainees, Medical Center administration and employees, and others so as not to adversely affect patient care;
- (e) retaining responsibility for the continuous care and supervision of the Member's patients, including securing appropriate coverage when he or she is unavailable, or arranging a suitable alternative;
- (f) refusing to engage in improper inducements for patient referrals;
- (g) participating in such emergency service coverage or consultation panels as may be determined by the Clinical Staff Executive Committee;
- (h) complying with federal and state laws regarding the treatment of patients with emergency medical conditions in all Medical Center inpatient and outpatient facilities.
- (i) avoiding actual, potential or perceived conflicts of interest in the delivery of patient care in accordance with federal and state laws and Medical Center policies;
- (j) conducting histories and physicals as required by [Medical Center Policy No. 0094](#); and
- (k) performing all patient care related tasks required by the CMS Medicare and Medicaid Conditions of Participation or the Joint Commission that are applicable to the Member's patients or required for the Medical Center to remain a participant in the Medicare and Medicaid programs and to be accredited by the Joint Commission.

### **3.4.2 Professional Ethics and Conduct**

Each Member of the Clinical Staff shall demonstrate moral character and adherence to generally recognized standards of medical and professional ethics. Specifically, but without limitation, this requirement includes refraining from: paying or accepting commissions or referral fees for professional services; delegating the responsibility for diagnosis and care of patients to a practitioner not qualified to undertake that responsibility; failing to seek appropriate consultation when medically indicated; failing to provide or arrange for appropriate and timely medical coverage and care for patients for whom he/she is responsible; failing to obtain required informed consent; failing to adhere to standards of appropriate professional behavior; and failing to follow

appropriate requirements for billing and reimbursement for professional services. All members of the Clinical Staff are expected to fully comply with state and federal laws and accreditation requirements and to adhere to all University of Virginia and University of Virginia Medical Center policies, procedures, rules and regulations.

### **3.4.3 Supervision of Graduate Medical Trainees**

The Clinical Staff shall supervise participants in the Graduate Medical Education program in the performance of clinical activities within the Medical Center. Such supervision requirements are contained in the [GME Manual](#) and applicable Medical Center and Departmental policies and as required by the ACGME and noted on the ACGME website <http://www.acgme.org/acWebsite/home/home.asp>.

### **3.4.4 Other Member Responsibilities**

Additional responsibilities of Members may include, as appropriate:

- (a) abiding by the Standards of Professional Conduct of the Virginia Boards of Medicine, Psychology and Dentistry, as appropriate, and ethical requirements of the Medical Society of Virginia, the American Board of Medical Specialties (as applicable), or the other professional associations of dentists, podiatrists, and psychologists, as appropriate;
- (b) engaging in conduct that is professional, cooperative, respectful and courteous of others and is consistent with and reinforcing of the missions of the Medical Center;
- (c) participating in any Clinical Staff approved educational programs for medical students, Graduate Medical Trainees, Members, non-Members, nurses, Allied Health Professionals, and other Medical Center personnel;
- (d) attending meetings of the Clinical Staff, Department, Division, as applicable, and committees to which a Member has been appointed, as required; and
- (e) participating in recognized functions of Clinical Staff appointment, including quality improvement activities, FPPE as necessary, OPPE, Case Review and Peer Review and discharging other Clinical Staff functions as may be required from time to time by the Department Chair, the Division Chief, the Clinical Staff, the Clinical Staff Executive Committee or the MCOB.

## **3.5 Active Clinical Staff Members**

### **3.5.1 Qualifications**

The Active Clinical Staff shall consist of Physicians, Dentists, Podiatrists, and Ph.D. Clinical Psychologists, each of whom:

- (a) is appointed a member of the full-time or part-time faculty of the School of Medicine and is appointed to an appropriate clinical Department;
- (b) is licensed by the appropriate Commonwealth of Virginia licensing board for his or her profession, and has obtained a controlled substances registration from the DEA unless not required for the scope of professional practice of the Active Member;
- (c) documents relevant training or experience, current licensure, current competence and ability, as documented by FPPE or OPPE, to perform the privileges requested and demonstrates clinical ability and physical and mental health, all so as to demonstrate to the satisfaction of the Clinical Staff Executive Committee and the MCOB that each is professionally and ethically competent and that patients treated by him or her can reasonably expect to receive quality medical care;
- (d) has been granted Clinical Privileges in accordance with Articles V and VI of these Bylaws and the Credentials Manual;
- (e) has and maintains professional liability insurance coverage or self-insurance plan in an amount satisfactory to the MCOB, as established by resolution from time to time;
- (f) if a Physician, is board certified as required by [Medical Center Policy No. 0221](#);
- (g) adheres strictly to the ethics of his or her profession; and
- (h) is willing to participate and share equitably in the discharge of Clinical Staff responsibilities, including but not limited to Department, Division and committee assignments and on-call patient care responsibilities.

### **3.5.2 Prerogatives**

The prerogatives of an Active Clinical Staff Member shall be to:

- (a) participate fully in the care of patients, educational activities and research, within the scope of his or her delineated Clinical Privileges;
- (b) if privileged to do so, admit patients to the Medical Center inpatient facilities;
- (c) exercise Clinical Privileges as granted in accordance with these Bylaws and the Credentials Manual, except as otherwise provided in these Bylaws, the Credentials Manual or by specific privilege restriction;

- (d) vote on all matters presented at general and special meetings of the Clinical Staff, and of the Department and/or Division and committees to which the Member is appointed;
- (e) be considered for election to Clinical Staff office; and
- (f) attend Clinical Staff, Department, and as applicable, Division meetings and serve on Clinical Staff Committees.

### **3.6 Administrative Clinical Staff**

#### **3.6.1 Qualifications**

The Administrative Clinical Staff shall consist of Physicians, Dentists, Podiatrists, Ph.D. Clinical Psychologists, and Ph.D. Clinical Pathologists, each of whom is appointed by the Dean and the Chief Executive Officer to participate in the management of the Medical Center but has no direct patient care responsibilities.

#### **3.6.2 Prerogatives**

The prerogatives of an Administrative Clinical Staff Member shall be to:

- (a) vote on all matters presented at general and special meetings of the Clinical Staff, and of the Department and/or Division and Committees to which the Member is appointed, if any; and
- (b) attend Clinical Staff, Department, and as applicable, Division meetings and serve on Clinical Staff Committees.

#### **3.6.3 Limitations**

Administrative Clinical Staff Members shall not (i) be granted or exercise Clinical Privileges, (ii) attend or admit patients to Medical Center facilities, or (iii) hold office in the Clinical Staff.

### **3.7 Honorary Clinical Staff**

#### **3.7.1 Qualifications**

The Honorary Clinical Staff shall consist of Physicians, Dentists, Podiatrists, Ph.D. Clinical Psychologists and Ph.D. Clinical Pathologists, each of whom is a former Member of the Clinical Staff who has retired or withdrawn from practice and has been nominated to be an Honorary Member by the current Chair of the Department in which the person practiced or by the Dean in recognition of his or her noteworthy contributions to the Medical Center; and

- (a) was a member in good standing of the Clinical Staff at the time of his or her retirement or withdrawal from practice; and
- (b) continues to adhere strictly to the ethics of his or her profession.

### **3.7.2 Prerogatives**

Honorary Clinical Staff may:

- (a) attend Clinical Staff, Department and as applicable, Division meetings but they are not required to do so; and
- (b) serve on Clinical Staff Committees.

### **3.7.3 Limitations**

Honorary Clinical Staff Members shall not (i) be granted or exercise Clinical Privileges, (ii) attend or admit patients to Medical Center facilities, (iii) vote or (iv) hold office in the Clinical Staff.

## **3.8 Ph.D. Clinical Pathologist Staff**

### **3.8.1 Qualifications**

The Ph.D. Clinical Pathologist Staff shall consist of Pathologists who hold a faculty appointment in the School of Medicine and who may, because of scientific skills, contribute to patient care, education or research and each of whom:

- (a) is appointed a member of the full-time or part-time faculty of the School of Medicine and is appointed to the Department of Pathology;
- (b) documents relevant training or experience, current competence, as documented by FPPE or OPPE, to perform the privileges requested and demonstrates clinical ability and physical and mental health, all so as to demonstrate to the satisfaction of the Clinical Staff and the MCOB that each is professionally and ethically competent;
- (c) has been granted Clinical Privileges in accordance with Articles V and VI of these Bylaws and the Credentials Manual;
- (d) has and maintains professional liability insurance coverage or self-insurance plan in an amount satisfactory to the MCOB, as established by resolution from time to time;
- (e) adheres strictly to the ethics of his or her profession; and

- (f) is willing to participate and share equitably in the discharge of Clinical Staff responsibilities, including but not limited to Department, Division and committee assignments and on-call patient care responsibilities.

### **3.8.2 Prerogatives**

The prerogatives of the Ph.D. Clinical Pathologist Staff Members shall be to:

- (a) advise Active Members regarding patient care;
- (b) exercise Clinical Privileges as granted in accordance with these Bylaws and the Credentials Manual, except as otherwise provided in these Bylaws, the Credentials Manual or by specific privilege restriction;
- (c) participate in educational activities and research;
- (d) vote on all matters presented at general and special meetings of the Clinical Staff, and of the Department and/or Division and Committees to which the Member is appointed; and
- (e) attend Clinical Staff, Department and, as applicable, Division meetings and serve on Clinical Staff Committees.

### **3.8.3. Limitations**

Ph.D. Clinical Pathologist Staff Members shall not (i) attend or admit patients to Medical Center facilities, or (ii) hold office in the Clinical Staff.

## **3.9 Children's Hospital Clinical Staff**

The Children's Hospital Clinical Staff shall consist of Physicians, Dentists, Podiatrists, Ph.D. Clinical Psychologists and Ph.D. Clinical Pathologists who are Members of the Clinical Staff, each of whom is self-identified as being willing to:

- (a) provide a system of coordination and patient care whereby all patients admitted to or treated in any Children's Hospital facility shall receive the highest quality health care in a safe and patient and family-centered care environment, and
- (b) provide the forum and mechanisms that enable communications and sharing of information and to assess and formulate recommendations on matters of common interest regarding the provision of care and services to children.

Meetings of the Children's Hospital Clinical Staff may be called from time to time by the Chair of the Children's Hospital Clinical Practice Committee.

### **3.10 Other Healthcare Professionals**

Other healthcare professionals not described above may not be Members of the Clinical Staff.

#### **3.10.1 Non-Members**

Non-Members are Physicians, Dentists, Podiatrists, Ph.D. Clinical Psychologists or Ph.D. Clinical Pathologists who are not Members of Clinical Staff but who are granted privileges to provide care to patients of the Medical Center from time to time as provided in these Bylaws and in the Credentials Manual. Non-Members shall have Clinical Privileges as provided in Article V and the Credentials Manual. Non-Members shall have none of the rights conferred on Members in these Bylaws, including but not limited to those provided in Article VIII hereof, but shall be required to follow policies and procedures of the Medical Center and the Clinical Departments for patient care.

#### **3.10.2 Graduate Medical Trainees**

Graduate Medical Trainees as defined in Article I of these Bylaws, are privileged by the Medical Center under a separate process specified in the GME Manual and are not governed by these Bylaws. Graduate Medical Trainees shall be required to follow policies and procedures of the Medical Center and the clinical Departments both for medical training and patient care. Department Chairs must delineate the specific procedures and activities for which the Graduate Medical Trainee is qualified and provide documentation of Departmental review and assessment that supports the delineation of specific procedures and activities.

#### **3.10.3 Allied Health Professionals**

Allied Health Professionals, as defined in Article I of these Bylaws, are privileged under a separate process that is specified in the Allied Health Professionals Manual. Allied Health Professionals are not governed by these Bylaws. All Allied Health Professionals working for or in the Medical Center shall be required to follow policies and procedures of the Medical Center.

## **ARTICLE IV PROCEDURES FOR MEMBERSHIP**

### **4.1 Procedure for Active Clinical Staff Membership**

In order to become an Active Member of the Clinical Staff, the individual Physician, Dentist, Podiatrist, or Ph.D. Clinical Psychologist shall follow the applicable procedure in effect from time to time for obtaining an appointment as a Clinical Faculty Member in the School of Medicine, satisfy the criteria set forth in Article III of these Bylaws for an Active Member and follow the procedure for obtaining Clinical Privileges as provided in these Bylaws and the Credentials Manual, all as verified by the Clinical Staff Office. The Dean and the applicable Department Chair shall jointly make the request in writing to the Clinical Staff Office for an individual to be appointed or reappointed as an Active Member in accordance with Article VI of these Bylaws.

The Credentials Manual establishes requirements for application for Clinical Staff Clinical Privileges. [/internet/clinical-staff-office/doc/Clinical-Staff-Manua\\_rev011108.doc](/internet/clinical-staff-office/doc/Clinical-Staff-Manua_rev011108.doc). The Credentials Manual may be amended from time to time by the Chair of the Credentials Committee in consultation with the President of the Clinical Staff and the Chief Executive Officer of the Medical Center.

### **4.2 Procedure for Administrative Clinical Staff Membership**

The Clinical Staff Executive Committee shall approve the appointment of any person selected by the Chief Executive Officer or the Dean to be an Administrative Member.

### **4.3 Procedure for Honorary Clinical Staff Membership**

In order to become an Honorary Member of the Clinical Staff, the individual who satisfies the criteria set forth in Article III of these Bylaws shall be nominated by his or her former Chair or the Dean and approved by the Clinical Staff Executive Committee.

### **4.4 Procedure for the Ph.D. Clinical Pathologist Staff Membership**

In order to become a Ph.D. Clinical Pathologist Staff Member of the Clinical Staff, the Ph.D. Clinical Pathologist shall follow the applicable procedure in effect from time to time for obtaining an appointment as a Clinical Faculty Member in the Department of Pathology in the School of Medicine and satisfy the criteria set forth in Article III of these Bylaws for a Ph.D. Clinical Pathologist Staff Member, as verified by the Clinical Staff Office. The Dean and the Chair of the Department of Pathology shall jointly make the request in writing to the Clinical Staff Office for an individual to be appointed or reappointed as a Ph.D. Clinical Pathologist Staff Member in accordance with Article VI of these Bylaws.

#### **4.5 Leave of Absence**

A Member of the Clinical Staff who has obtained a leave of absence from the School of Medicine, consistent with applicable faculty policies, may also obtain a leave of absence from clinical practice. Contemporaneously with a request for leave of absence from the School of Medicine, the Member shall provide notice to the Credentials Committee of the leave, including the reasons for the leave and the approximate period of leave desired. In addition the Chair of the Member's Department and the Dean of the School of Medicine shall provide notice to the Credentials Committee of any leave of absence granted to a Member. Such leave of absence is further subject to conditions and limitations that the President of the Clinical Staff, the Chair of the Credentials Committee or the CEO of the Medical Center determines to be appropriate. During the leave of absence, the Member shall not exercise his/her her Clinical Privileges and his/her Clinical Staff responsibilities and prerogatives shall be inactive. The Department Chair of the Member on leave shall be responsible for arranging for alternative care for the Member's patients while the Member is on leave.

Prior to returning from a leave of absence, a Member shall notify the Credentials Committee in writing in accordance with the procedures and the timelines set forth in the Credentials Manual and shall provide all necessary information needed for the Credentials Committee to evaluate whether the Member is qualified to resume Clinical Staff membership, including the exercise of Clinical Privileges. A Member who has been on leave of absence may not have his or her Clinical Privileges reactivated until a determination is made by the Credentials Committee that the Member may return to clinical practice and the conditions of the return. If the Clinical Privileges of a Member who has been on leave are not reactivated, the Member shall have access to the procedures outlined in Article VIII of these Bylaws.

Failure, without good cause, to request reinstatement prior to the end of an approved leave of absence shall be deemed a voluntary resignation from the Clinical Staff and voluntary relinquishment of Clinical Privileges. A request for Clinical Staff membership or Clinical Privileges subsequently received from an Applicant deemed to have voluntarily resigned shall be submitted and processed in the manner specified for applications for initial appointment.

#### **4.6 Cessation of Membership**

Membership in the Clinical Staff shall cease automatically when the individual no longer meets the criteria set forth in these Bylaws, including failure to be reappointed to the faculty of the School of Medicine (excluding Honorary Members) or resignation, retirement or termination from the School of Medicine (excluding Honorary Members).

**ARTICLE V  
CATEGORIES OF CLINICAL PRIVILEGES**

**5.1 Exercise of Clinical Privileges**

Every Member, in connection with such membership, shall be entitled to exercise only those delineated Clinical Privileges specifically recommended by the Credentials Committee, recommended by the Clinical Staff Executive Committee and approved by the MCOB, except as provided in Sections 5.7 and 5.8 of this Article V. Every Non-Member shall be entitled to exercise only those delineated Clinical Privileges specifically recommended by the Credentials Committee, recommended by the Clinical Staff Executive Committee and approved by the MCOB, except as provided in Sections 5.7 and 5.8 of this Article V. The Medical Center has the prerogative to audit from time to time Members' clinical practice to verify that Members are practicing within the scope of the specific Clinical Privileges that have been granted.

**5.2 Delineation of Privileges**

Every application for Clinical Staff appointment or reappointment (excluding Administrative and Honorary Members) and every request for Clinical Privileges must contain a request for the specific Clinical Privileges desired by the Applicant. The evaluation of such request shall be based upon the Applicant's education, training, experience, demonstrated competence as documented by evaluations from Peers, supervision or monitoring during a first or provisional year, FPPE and OPPE, references and other relevant information, including an appraisal by the clinical Department in which such privileges are sought. The specific procedures set forth in these Bylaws and the Credentials Manual shall be followed throughout the appointment and reappointment process.

**5.3 Privileges for Active Staff and Ph.D. Clinical Pathologist Staff**

Active Staff and Ph.D. Clinical Pathologist Staff must have Clinical Privileges as more specifically provided in the Credentials Manual.

**5.4 Privileges for Non-Members**

Non-Members who desire to practice in the Medical Center may be granted limited privileges only as specifically permitted by the Credentials Manual or required by the Credentials Committee. Non-Members may be issued Clinical Privileges in one of the following categories: Consulting Privileges or Visiting Privileges.

**5.5 Consulting Privileges**

**5.5.1 Description**

Non-Members who may be granted Consulting Privileges shall consist of Physicians, Dentists, Podiatrists, and Ph.D. Clinical Psychologists who will participate in patient care activities for Medical Center patients at the request of an Active Member of the Clinical

Staff, each of whom shall provide information and documentation required by the Credentials Manual and Medical Center policies. Non-Members who are granted Consulting Privileges may include individuals providing care and treatment to Medical Center patients through telemedicine or individuals providing care and treatment to patients who are receiving services in Medical Center hospital units located within other healthcare entities.

### **5.5.2 Prerogatives**

The prerogatives of the Non-Member with Consulting Privileges shall be to consult regarding care to patients at the request of an Active Member and only as specifically delineated in his or her Clinical Privileges.

### **5.5.3 Limitations**

The Non-Member with Consulting Privileges shall not admit patients to an inpatient facility of the Medical Center nor serve as the primary attending of record in Medical Center facilities.

## **5.6 Visiting Privileges**

### **5.6.1 Description**

Non-Members who may be granted Visiting Privileges shall consist of Physicians, Dentists, Podiatrists, and Ph.D. Clinical Psychologists who will participate in patient care activities for Medical Center patients for a time-limited period at the request of an Active Member of the Clinical Staff, with the support of his or her Chair, each of whom shall provide information and documentation relevant to his or her privilege specific expertise as may be required by the Credentials Committee.

### **5.6.2 Prerogatives**

The prerogatives of the Non-Member with Visiting Privileges shall be to:

- (a) participate as applicable in the care of patients, educational activities and research facilities, within the scope of his or her delineated Clinical Privileges;
- (b) exercise Clinical Privileges as granted in accordance with these Bylaws and the Credentials Manual, except as otherwise provided in these Bylaws, the Credentials Manual or by specific privilege restriction; and
- (c) attend Clinical Staff, Department and as applicable, Division meetings as invited.

### **5.6.3 Limitations**

The Non-Member with Visiting Privileges shall not admit patients to an inpatient facility of the Medical Center nor serve as the primary attending of record in Medical Center facilities.

## **5.7 Temporary Privileges**

### **5.7.1 Circumstances Under Which Temporary Privileges May Be Granted**

Temporary Privileges shall be granted in only two (2) circumstances:

- (a) When an important patient care need mandates an immediate authorization to practice, an application for temporary privileges will be considered on a case-by-case basis. (This circumstance includes situations in which a Member with specific skills and expertise becomes ill or takes a leave of absence and an individual knowledgeable about the area of practice is needed to provide certain services to a patient or when a patient's needs require specific, specialized expertise that no other Member possesses); or
- (b) When the Chair of the Credentials Committee has recommended that an Applicant with a complete application with no indication of adverse information about state licensing actions, DEA registrations, current medical, psychiatric or substance abuse impairments that could affect practice, criminal convictions or verdicts/settlements of concern to the Credentials Committee may be granted specific privileges and that recommendation is awaiting review by the full Credentials Committee and the Clinical Staff Executive Committee and approval of the MCOB.

### **5.7.2 Application and Review**

- (a) Where an important patient care need mandates an immediate authorization to practice as contemplated by 5.7.1 (a), the Chair of the Credentials Committee, with the written concurrence of the Department Chair and the President of the Clinical Staff, may grant Temporary Privileges. Such temporary grant of privileges shall not be made unless the following verifications are present:
  - (i) Letter from the appropriate Department Chair explaining the important nature of the situation and the benefit to a patient or patients as a result of immediate authorization of the specified task(s);
  - (ii) Copy of current Virginia license;
  - (iii) Listing of delineated privileges requested with appropriate documentation of competence to perform each of the specified tasks;

- (iv) Proof of current liability coverage, showing coverage limits and dates of coverage; and
- (v) There exist no state licensing actions, DEA registrations, current medical, psychiatric or substance abuse impairments that could affect practice, criminal convictions or verdicts/settlements of concern to the Credentials Committee.

If the above requirements are not satisfied, Temporary Privileges may not be granted. In addition the Credentials Manual may specify additional verifications required before such Temporary Privileges may be granted.

- (b) For all situations arising under 5.7.1 (b), the Chair of the Credentials Committee may grant Temporary Privileges for not more than one hundred twenty (120) days or until such time as the request is officially approved, whichever time is shorter. No such Temporary Privileges may be granted unless there is:
  - (i) Verification of current licensure, relevant training or experience, documentation of current competence, ability to perform the privileges requested as verified by a evaluations from peers, supervision or monitoring during first or provisional year, FPPE, and a certificate of insurance for current liability coverage showing coverage limits and dates of coverage;
  - (ii) Evidence of a completed query to the National Practitioner Data Bank and an analysis of the evaluation of the results of such query; and
  - (iii) The Applicant has not been subject to involuntary termination of medical staff membership at another organization, has not been subject to involuntary limitation, reduction, denial or loss of Clinical Privileges and has not relinquished Clinical Privileges at another organization while under investigation by that organization.

The Credentials Manual may specify additional documentation required before such Temporary Privileges may be granted.

### **5.7.3 General Conditions**

If granted Temporary Privileges, the Applicant shall act under the supervision of the Department Chair, or his or her designee, to which the Applicant has been assigned, and shall ensure that the Chair, or the Chair's designee, is kept closely informed as to his or her activities within the Medical Center. The Credentials Manual specifies supervisory requirements for the Chair or the Chair's designee when Temporary Privileges have been granted to an Applicant in the Department.

- (a) Temporary Privileges shall automatically terminate at the end of the designated period, unless earlier terminated by the Credentials Committee upon recommendation of the Department Chair, the President or the Chief Executive Officer, or unless affirmatively renewed following the procedure set forth in Section 6.2.
- (b) Requirements for proctoring and monitoring, including FPPE or OPPE, may be imposed on such terms as may be appropriate under the circumstances upon any Member granted Temporary Privileges by the Chair of the Credentials Committee after consultation with the Department Chair or his or her designee.
- (c) At any time, Temporary Privileges may be terminated by the Clinical Staff Executive Committee. In such cases, the appropriate Department Chair shall assign a Member to assume responsibility for the care of such practitioner's patient(s). The preferences of the patient shall be considered in the choice of a replacement Member.
- (d) A person shall not be entitled to the procedural rights afforded by Article VIII because a request for Temporary Privileges is refused or because all or any portion of Temporary Privileges are terminated or suspended.
- (e) All persons requesting or receiving Temporary Privileges shall be bound by the Bylaws, the Credentials Manual, and the policies, procedures, rules and regulations of the Medical Center.

## **5.8 Emergency Privileges**

In the case of unpredictable emergencies, including but not limited to those caused by natural disasters and bioterrorism, which result in the activation of the Medical Center Emergency Management Plan, any clinician, to the degree permitted by his or her license and regardless of service or staff status or the lack thereof, shall perform services to save the life of a patient, using every facility of the Medical Center necessary, including the calling of any consultation appropriate or desirable. The Chief Executive Officer, the President of the Clinical Staff or the Chair of the Credentials Committee may grant Emergency Privileges for the period required to supplement normal patient care services during the emergency as more specifically provided in the Credentials Manual. When the emergency situation no longer exists, any such clinician must apply for the staff privileges necessary to continue to treat the patient(s). In the event such privileges are denied or are not requested, the patient(s) shall be assigned to another Member.

## **5.9 Telemedicine Credentialing and Privileging**

All Members who diagnose or treat patients via telemedicine link are subject to the credentialing and privileging processes of the organization that receives the telemedicine service, or by the Medical Center in accordance with a written agreement with the organization receiving the telemedicine service.

## **ARTICLE VI APPOINTMENT AND REAPPOINTMENT**

### **6.1 Procedure for Initial Appointment**

When the Dean and a Department Chair have mutually agreed upon a candidate (hereinafter referred to as “Applicant”) for his or her Department, the Dean and the Chair jointly shall forward a copy of the offer letter and a request for appointment and privileges to the Credentials Committee for an initial period not to exceed one (1) year. All required information and documentation shall be submitted in accordance with the Credentials Manual, including the deadlines set forth therein using the application form or other forms required thereby. No application shall be considered until all required information and documentation is completed within the timeframes specified in the Credentials Manual. [/internet/clinical-staff-office/doc/Clinical-Staff-Manua\\_rev011108.doc](#)

The Credentials Committee shall then follow the credentialing procedures set forth in the Credentials Manual including the process related to the information required in an application for initial appointment and the processing of the application. Upon receipt and review of all necessary credentialing documentation, the Credentials Committee shall recommend to the Clinical Staff Executive Committee that such Applicant should either be granted or denied initial privileges in the Medical Center. The Clinical Staff Executive Committee shall then review the Credentials Committee’s recommendation and all applicable documentation. If the Credentials Committee and the Clinical Staff Executive Committee are both in favor of granting privileges to the Applicant, the favorable recommendation shall be forwarded to the MCOB for final action.

### **6.2 Provisional Appointment Status**

Initial appointments and all initially granted Clinical Privileges for Active and Ph.D. Clinical Pathologist Staff shall be provisional for a period of one year. During this provisional period, the individual’s performance and clinical competence shall be observed and evaluated through FPPE and OPPE by the Chair, Division Chief, or Peer designee of the applicable Department. If at the end of the year the Active or Ph.D. Clinical Pathologist Staff satisfies the requirements to become an active Member as more specifically provided in these Bylaws and the Credentials Manual, the provisional status ceases. If at the end of the year the Active or Ph.D. Clinical Pathologist Staff does not satisfy the requirements to become an active Member as required by these Bylaws and the Credentials Manual, then membership in the Clinical Staff and Clinical Privileges for that individual shall cease. Failure to achieve active status from provisional status shall not give rise to the procedural rights, afforded by Article VIII of these Bylaws.

### **6.3 Procedure for Reappointment**

Periodic redetermination of Clinical Privileges for Active and Ph.D. Clinical Staff Members, and the increase or curtailment of same, shall be based upon the reappointment procedures set forth in the Credentials Manual, including deadlines for submission of information and documentation and the forms required thereby. Criteria to be considered at the time of reappointment may

include specific information derived from the Department's direct observation of care provided, information gathered through FPPE and OPPE, review of records of patients treated in this or other medical centers, review of the records of the Departmental Clinical Staff as compared to the records of the particular Member and an appropriate comparison of the performance of the Member with his or her professional colleagues in the Department. If a Member chooses not to seek reappointment or renew privileges, the procedures set forth in Articles VII and VIII shall not apply.

#### **6.4 Active Status**

An Active or Ph.D. Clinical Pathologist Staff Member may become an active Member with Clinical Privileges upon the satisfactory conclusion of provisional status as provided in these Bylaws and the Credentials Manual, which appointment shall be for no more than two (2) years at a time and as more specifically provided in the Credentials Manual.

#### **6.5 Change in Qualification**

If during the course of any period of appointment, the qualifications of the Member change, or the Department learns of Adverse Action taken by an official licensing or certification body or Medicare or Medicaid, then those changes in qualification or Adverse Action must be reported immediately to the Member's Department Chair and the Credentials Committee who will review the information and determine whether the Member's privileges should be revoked, revised, or suspended. The provisions of Section 7.6 or Article VIII may apply.

#### **6.6 New or Additional Clinical Privileges**

Requests for new or additional Clinical Privileges, including those related to the use of new technology or a new procedure, technique or treatment modality, shall be processed only when the Applicant meets the Medical Center approved criteria. In the event there are no approved criteria, the Medical Center shall first determine whether it will allow the new or additional Clinical Privilege, and if so the procedure described in the Credentials Manual or Medical Center policy for new or additional Clinical Privileges shall be followed. Applications for new or additional Clinical Privileges must be in writing and submitted by the Applicant as well as by the appropriate Department Chair. All applications for new or additional Clinical Privileges shall be submitted on a form prescribed by the Credentials Committee upon which the type of Clinical Privileges desired and, among other things, the Member's relevant recent training and/or experience are set out, together with any other information required by the Credentials Manual or the Credentials Committee. Such applications shall be processed as provided in the Credentials Manual, including the timeline for processing. The Credentials Committee shall determine the conditions and requirements upon which any new or additional Clinical Privileges shall be granted, including but not limited to, how current competence will be demonstrated and any proctoring or other monitoring requirements, and will recommend the requirements to the Clinical Staff Executive Committee for consideration. In turn CSEC shall make appropriate recommendations regarding new or additional Clinical Privileges to the Medical Center Operating Board for final determination. A decision not to approve a new or additional Clinical Privilege to be performed within the Medical Center and/or to be added to the Medical Center

privilege list shall not be deemed an Adverse Action or a denial of privileges nor entitle any individual to the hearing rights set forth in Article VIII of these Bylaws.

### **6.7 Burden of Producing Information**

In connection with all applications for appointment of membership and for Clinical Privileges, the Applicant shall have the burden of producing information for an adequate evaluation of the Applicant's qualifications and suitability for the Clinical Privileges requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information. This burden may include submission to a medical or psychological examination, at the Applicant's expense, if deemed appropriate by the Department Chair, the President of the Clinical Staff, the Chair of the Credentials Committee, the Chief Executive Officer of the Medical Center, the Dean of the School of Medicine, or the Director of the Physician Wellness Program. The President of the Clinical Staff, the Chair of the Credentials Committee, the Chief Executive Officer of the Medical Center, or the Director of the Physician Wellness Program shall select the examining physician, program, and/or site of the examination.

The Applicant or Member has a duty to advise the Credentials Committee, within fifteen (15) days, of any change in information previously submitted by him or her related to his or her credentials. The Applicant's failure to sustain these duties shall be grounds for denial of the application or termination of a Member's Clinical Staff membership and a Member or Non-Member's Clinical Privileges.

### **6.8 Acknowledgment of Applicant**

Each Applicant shall sign and specifically acknowledge his or her agreement:

- (a) to provide for appropriate continuous care and supervision of his or her patients;
- (b) to abide by the Clinical Staff Bylaws, the Medical Center Policy Manual, the Code of Conduct, the Compliance Code of Conduct, the Code of Ethics and all other Medical Center policies, procedure, rules, or regulations applicable to the Clinical Staff or to Non-Members;
- (c) to comply with procedures for appointment and reappointment to the Clinical Staff as set forth in the Credentials Manual or otherwise deemed appropriate by the Credentials Committee;
- (d) to participate in quality improvement and Peer Review activities of the Medical Center and to accept committee assignments, as applicable;
- (e) to release from liability, to the fullest extent permitted by law, all persons for their acts performed in connection with investigating and evaluating the Applicant;
- (f) to submit to a mental or physical health examination as requested by the Department Chair, the President of the Clinical Staff, the Chair of the Credentials Committee, the

Chief Executive Officer of the Medical Center, the Dean of the School of Medicine, or the Director of the Physician Wellness Program; and

- (g) to abide by all requirements contained in the Appointment Acceptance Form and all other requirements contained in the Credentials Manual.

## **ARTICLE VII CORRECTIVE ACTION FOR MEMBERS AND NON-MEMBERS WITH CLINICAL PRIVILEGES**

### **7.1 Criteria for Initiation**

A Member's and Non-Member's Clinical Privileges may be reduced, suspended or terminated for activities or professional conduct considered to be lower than the standards of the Medical Center and the Clinical Staff, or to be disruptive to operations of the Medical Center, or for violation of these Bylaws, directives of the Clinical Staff Executive Committee or the MCOB, the Code of Conduct, or policies, procedures, rules or regulations of the Medical Center or the applicable Clinical Department. Any person may provide information to a Department Chair, the Clinical Staff Executive Committee, the Chief Executive Officer, the Dean, the Senior Associate Dean for Clinical Affairs, the President, the President-elect, the MCOB or any member of the administration of the Medical Center about the conduct, performance, or competence of any Member or Non-Member who has been granted Clinical Privileges.

A request for initiation of investigation or action against such Member or Non-Member shall be made by written request from any other Member, including the President, or from the Chief Executive Officer. Upon receipt of a written request for investigation or action, the individual or entity that received such request shall immediately forward the matter to the Credentials Committee for investigation when the information provided indicates that such Member or Non-Member may have exhibited acts, demeanor, or conduct reasonably likely to be: (a) detrimental to patient safety or to the delivery of quality patient care; (b) unethical; (c) contrary to the Medical Center's policies and procedures, these Bylaws, or the Code of Conduct; (d) disruptive to the operation of the Medical Center; (e) below applicable professional standards; or (f) the result of impairment of the Member or Non-Member by reason of illness, use of drugs, narcotics, alcohol, chemicals or other substances or as a result of any physical or mental condition that impairs the Member's or Non-Member's clinical practice. To the extent possible, the identity of the individual requesting initiation of investigation shall not be disclosed.

### **7.2 Alternatives to Corrective Action**

Initial collegial efforts may be made prior to resorting to formal corrective action, when appropriate. Such collegial interventions on the part of Clinical Staff leaders in addressing the conduct or performance of an individual shall not constitute corrective action, shall not afford the individual subject to such efforts to the right to a fair hearing, and shall not require reporting to the NPDB, except as otherwise provided in these Bylaws or required by law. Alternatives to corrective action may include:

- (a) Informal discussions or formal meetings regarding the concerns raised about conduct or performance, including the actions outlined in these Bylaws or Medical Center policies that may be taken to address disruptive conduct;
- (b) Written letters of guidance, reprimand, or warning regarding the concerns about conduct or performance;
- (c) Notification that future conduct or performance shall be closely monitored and notification of expectations for improvement;
- (d) Suggestions or requirements that the individual seek continuing education, consultations, or other assistance in improving performance;
- (e) Warnings regarding the potential consequences of failure to improve conduct or performance; and/or
- (f) Requirements to seek assistance for impairment, as provided in these Bylaws.

### **7.3 Initiating Evaluation and/or Investigation of Possible Impairing Conditions**

At any time, a Department Chair, the President, the Chief Executive Officer, the Dean, the Chair of the Credentials Committee, or the Director of the Physicians' Wellness Program may require that a Member or Non-Member who has been granted Clinical Privileges undergo a physical and/or mental examination(s) by one or more qualified practitioners or programs specified by the individual requiring the evaluation. If the Member or Non-Member refuses to undergo the examination, his/her Clinical Privileges shall be automatically suspended and there shall be no further consideration of continued privileges until the examination is performed. The Member or Non-Member shall authorize the qualified practitioner(s), to submit reports of the evaluation(s), as appropriate, to the Chair of the Credentials Committee, the Department Chair, the President, the Chief Executive Officer, the Dean, the Director of the Physician's Wellness Program and the person or entity requesting the examination(s). Any time limit for action by the Credentials Committee, as specified in Section 7.4 below, shall be extended for the number of days from the request for the examination(s) to the receipt of the examination report(s).

The MCOB and the Clinical Staff Executive Committee recognize the need to assist Members or Non-Members who have been granted Clinical Privileges regarding their physical and mental health issues as well as to protect patients from harm. Accordingly, upon the recommendation of the Department Chair, the President, the Dean or the Chief Executive Officer, or on its own initiative, the Credentials Committee shall investigate any Member or Non-Member who appears to suffer from a potentially impairing condition. Any such Member or Non-Member is encouraged to seek assistance from the Physicians' Wellness Program and/or the Employee Assistance Program or any successor program thereto.

The Credentials Committee may also require periodic monitoring after completion of the initial treatment/rehabilitation. If the Member or Non-Member does not complete the initial

treatment/rehabilitation program or does not comply with the required monitoring, the provisions of Article 7.4 or 7.5 shall be applicable. In addition, the Credentials Committee shall strictly adhere to any state or federal statutes or regulations containing mandatory reporting requirements.

The purpose of the evaluation and investigation process concerning potential impairing conditions is to protect patients and to aid the Member or Non-Member in retaining or regaining optimal professional functioning. If the Member or Non-Member in question seeks such assistance, the Credentials Committee shall report to the Clinical Staff Executive Committee that he/she is voluntarily seeking treatment and has agreed to appropriate monitoring.

If at any time during the diagnosis, treatment, or rehabilitation phase of the process it is determined that a Member or Non-Member is unable to safely perform the Clinical Privileges he or she has been granted, the Credentials Committee shall proceed in accordance with Sections 7.4 or 7.5, as appropriate, below. Additionally, the Credentials Committee shall strictly adhere to any state or federal statutes or regulations containing mandatory reporting requirements.

## **7.4 Initiating Evaluation and Recommendation for Corrective Action**

### **7.4.1 Investigation**

Upon receipt of the request for initiation of corrective action, the Credentials Committee shall conduct a thorough investigation of the Member or Non-Member who has been granted Clinical Privileges in question. The Member or Non-Member shall be notified in writing that an investigation is being conducted. In addition the applicable Department Chair, the Dean, and the Chief Executive Officer shall be notified of the investigation. The Member or Non-Member shall provide to the Credentials Committee all available information that it requests. Failure to provide such requested information will itself be considered grounds for corrective action. The Credentials Committee may, but is not obligated to, review medical files or other documents and conduct interviews with witnesses; however, such investigation shall not constitute a “hearing” as that term is used in Article VIII, nor shall the procedural rules with respect to hearings or appeals apply. The Credentials Committee may, in its sole discretion, request an interview with the Member or Non-Member under investigation and, during such interview, question the Member or Non-Member about matters under investigation. A record of such interview shall be made by the Credentials Committee. Within thirty (30) days of the receipt of the request for initiation of investigation, the Credentials Committee shall submit the recorded interview along with the report of the Committee’s recommendations to the Clinical Staff Executive Committee and the Chair of the Department in which the Member being investigated practices.

#### **7.4.2 Recommendation**

The Credentials Committee's written recommendation to the Clinical Staff Executive Committee of action to be taken on the matter may include, without limitation:

- (a) determining that no further action is necessary on the matter;
- (b) issuing a warning, a letter of admonition, or a letter of reprimand;
- (c) recommending terms of probation or requirements of consultation;
- (d) recommending reduction, suspension or revocation of Clinical Privileges in accordance with Sections 7.5 and 7.6 herein;
- (e) recommending reduction of Clinical Staff category or limitation of any Staff prerogatives directly related to patient care;
- (f) recommending suspension or revocation of Clinical Staff membership;
- (g) recommending concurrent monitoring or retrospective auditing;
- (h) requiring additional training;
- (i) requiring evaluation by a physician assessment organization or individual; or
- (j) requiring a proctor for all procedures.

Any corrective action in accordance with subsections (c) through (f) of this Section shall entitle the Member to the procedural rights provided in Article VIII of these Bylaws.

#### **7.5 Precautionary Summary Suspension**

(i) Whenever the conduct of a Member or a non-Member who has been granted Clinical Privileges reasonably appears to pose an imminent threat that requires that immediate action be taken to protect the health, life or well-being of patients or prospective patients, or any other person in or associated with the Medical Center, or (ii) whenever the conduct of a Member or a Non-Member who has been granted Clinical Privileges reasonably appears to pose a substantial likelihood of harm to the life, health and safety of any patient or prospective patient, or (iii) whenever the Member or Non-Member who has been granted Clinical Privileges refuses to follow these Bylaws, the Credentials Manual, the policies, procedures, rules and regulations of the Clinical Staff and/or the Medical Center, or (iv) whenever a Member or Non-Member has made a material misrepresentation on the application for Clinical Staff membership or Clinical Privileges, then in any such event the President, the Chair of the Credentials Committee, or the Chief Executive Officer may summarily restrict or suspend the Clinical Staff membership or Clinical Privileges of such Member or non-Member. Unless otherwise stated, such summary suspension shall become effective immediately upon imposition, and the person responsible shall

promptly give written notice of the suspension or restriction to the Member or non-Member in question, the MCOB and the Clinical Staff Executive Committee. The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if not so limited, shall remain in effect until resolved by the procedures specified in Article VIII with respect to Members only. Unless otherwise indicated by the terms of the summary restriction or suspension, the President or his/her designee shall assign the patients of the Member or Non-Member in question to another Member.

### **7.5.1 Procedure for Members**

Within ten (10) working days of such suspension of a Member, a meeting of the Clinical Staff Executive Committee shall be convened to review and consider the action; provided, however, that the Clinical Staff Executive Committee may extend the period of review for good cause. Upon request, the Member may attend and make a statement concerning the issues under investigation, on such terms and conditions as the Clinical Staff Executive Committee may impose, although in no event shall any meeting of the Clinical Staff Executive Committee, with or without the Member, constitute a “hearing” within the meaning of Article VIII, nor shall any procedural rules apply except those adopted by the Clinical Staff Executive Committee. The Member’s failure without good cause to attend any Clinical Staff Executive Committee meeting upon request shall constitute a waiver of his or her rights under Article VIII. The Clinical Staff Executive Committee may modify, continue, or terminate the summary restriction or suspension, but in any event it shall furnish the Member with notice of its decision.

Unless the Clinical Staff Executive Committee terminates the summary restriction or suspension within ten (10) working days of such restriction or suspension, the Member shall be entitled to the procedural rights afforded by Article VIII of these Bylaws.

### **7.5.2 Procedure for Non-Members**

A Non-Member whose Clinical Privileges are summarily suspended pursuant to Section 7.5 shall be notified in writing of the suspension and the grounds for the suspension. Within ten (10) working days of such suspension, the Non-Member may request a meeting with the Chair of the Credentials Committee in order to discuss the suspension. In any event, the Chair of the Credentials Committee shall refer the matter to the Credentials Committee at its next scheduled meeting. The Non-Member shall not be entitled to the procedural rights afforded by Article VIII of the Bylaws.

## **7.6 Automatic Suspension**

In the following instances, the Member’s or Non-Member’s Clinical Privileges may be automatically suspended or limited, as specifically described by the President, the Chair of the Credentials Committee or the Chief Executive Officer. In addition, in each of the instances listed below, the Member’s Clinical Staff Membership shall be suspended or limited, as specifically described by the President, the Chair of the Credentials Committee or the Chief Executive Officer:

## **7.6.1 Change in Licensure**

### **7.6.1.1 Revocation or Suspension**

Whenever a Member's or Non-Member's license authorizing practice in the Commonwealth of Virginia is revoked or suspended by the applicable health regulatory board, Clinical Privileges shall be automatically revoked or suspended as of the date such action becomes effective.

### **7.6.1.2 Probation and Other Restriction**

If a Member's or Non-Member's license authorizing practice in the Commonwealth of Virginia is placed on probation by the applicable health regulatory board, his or her Clinical Privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its duration.

Whenever a Member's or Non-Member's license authorizing practice in the Commonwealth of Virginia is limited or restricted by the applicable health regulatory board, any Clinical Privileges that the Member or Non-Member has been granted by the Medical Center that are within the scope of such limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such licensing or certifying authority's action becomes effective and throughout its duration.

## **7.6.2 Change in DEA Certificate Status**

### **7.6.2.1 Revocation or Suspension**

If a Member's or Non-Member's DEA certificate is revoked, limited, or suspended, the Member or Non-Member shall automatically be divested of the right to prescribe medications covered by the certificate as of the date such action becomes effective and throughout its term.

### **7.6.2.2 Probation**

If a Member's or a Non-Member's DEA certificate is subject to probation, the Member's or Non-Member's right to prescribe such medications automatically shall become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

## **7.6.3 Lack of Required Professional Liability Insurance**

Failure to maintain professional liability insurance in amounts and of a type required by the MCOB, as such amounts shall be defined from time to time, shall be a basis for automatic suspension of a Member's or a Non-Member's Clinical Privileges. If within

30 days after written warnings of such delinquency, the Member or Non-Member does not provide evidence of the required professional liability insurance, such individual's Clinical Privileges shall be automatically terminated.

#### **7.6.4 Federal Program Exclusion**

If a Member of a Non-Member is convicted of a crime pursuant to the Medicare and Medicaid Protection Act of 1987, Pub. L. 100-93, or a crime related to the provision of health care items or services for which one may be excluded under 42 U.S.C. Section 1320a7(a), or is suspended, excluded, debarred or otherwise declared ineligible to participate in Medicare or Medicaid or other federal or state health care or other programs, such Member's or Non-Member's Clinical Privileges shall be automatically suspended as of the date such conviction or action with respect to the Medicare or Medicaid federal program becomes effective.

#### **7.6.5 Loss of Faculty Appointment**

If a Member's faculty appointment in the School of Medicine is terminated for any reason or for any length of time, his/her membership and Clinical Privileges within the Medical Center shall be automatically revoked or suspended as of the date such loss of faculty appointment becomes effective. Loss of faculty appointment shall not give rise to a hearing under Article VIII as such appointment is a prerequisite to membership. Due process procedures applicable to contesting the loss of a faculty appointment are set forth in the University of Virginia Faculty Handbook.

#### **7.6.6 Failure to Undergo Physical and/or Mental Examination**

If a Member or Non-Member fails or refuses to undergo a physical and/or mental examination as required by Section 7.3 of these Bylaws, such failure or refusal shall result in automatic suspension of the Clinical Privileges of the Member or Non-Member.

#### **7.6.7 Article VIII Inapplicable**

When a Member's or Non-Member's privileges are restricted pursuant to any of the circumstances set out in this Section 7.6, the hearing and appeal rights of Article VIII shall not apply and the action shall be effective for the time specified. If the Member believes that any such automatic restriction of privileges is the result of an error, the Member may request a meeting with the Clinical Staff Executive Committee. A Non-Member shall have no right to a meeting with the Clinical Staff Executive Committee.

**ARTICLE VIII  
HEARING AND APPELLATE REVIEW FOR MEMBERS**

**8.1 General Provisions**

**8.1.1 Right to Hearing and Appellate Review**

- (a) When any Member receives notice of a recommendation of the Credentials Committee that, if approved by the Clinical Staff Executive Committee and the MCOB, will adversely affect his or her appointment to or status as a Member or his or her exercise of Clinical Privileges, he or she shall be entitled to a hearing before a hearing committee appointed by the Clinical Staff Executive Committee. If the recommendation of the Clinical Staff Executive Committee following such hearing is still adverse to the affected Member, he or she shall then be entitled to an appellate review by the MCOB or a committee appointed by the Chair of the MCOB, before the MCOB makes a final decision on the matter. Such review shall be made based on the evidentiary record, unless the MCOB or the committee appointed by the MCOB to hear the appeal requests additional information.
- (b) All hearings and appellate reviews shall be in accordance with the procedural safeguards set forth in Article VIII to assure that the affected Member is accorded all rights to which he or she is entitled.

**8.1.2 Exhaustion of Remedies**

If Adverse Action described in Section 8.2 is taken or recommended, the Applicant or Member must exhaust the remedies afforded by these Bylaws before resorting to legal action. For purposes of Article VIII, the term “Member” may include “Applicant”, as appropriate under the circumstances.

**8.2 Grounds For Hearing**

Except as otherwise specified in these Bylaws, the following recommended actions or actions shall be deemed Adverse Actions and constitute grounds for a hearing, if such action is based on professional conduct, professional competence, or character:

- (a) denial of Clinical Staff Membership;
- (b) denial of Clinical Staff reappointment (excluding failure to obtain active status following provisional status);
- (c) suspension of Clinical Staff Membership;
- (d) revocation of Clinical Staff Membership;
- (e) denial of requested Clinical Privileges (excluding Temporary Privileges) for a Member;

- (f) involuntary reduction of current Clinical Privileges (excluding Temporary Privileges) for a Member;
- (g) suspension of Clinical Privileges (excluding Temporary Privileges) for a Member; or
- (h) termination of all Clinical Privileges (excluding Temporary Privileges and excluding loss of faculty appointment) for a Member.

However, actions described above in this Section that are the result of automatic suspension imposed pursuant to Section 7.6 of these Bylaws, shall not be considered an Adverse Action for purposes of Article VIII.

### **8.3 Requests For Hearing; Waiver**

#### **8.3.1 Notice of Proposed Action**

In all cases in which a recommendation has been made as set forth in Section 8.2, the Chair or Vice Chair of the Credentials Committee shall send a Member affected by an Adverse Action written notice of (a) his or her right to a hearing if requested by him or her within thirty (30) days of the notice, (b) clear and concise reasons for the Adverse Action recommended, including the acts or omissions with which the Member is charged and a list of the medical charts in question, if applicable, and (c) his or her rights at such a hearing, including the hearing procedures described in Section 8.4. Such notice shall be sent by personal delivery or certified mail, return receipt requested.

#### **8.3.2 Request for Hearing**

The Member shall have thirty (30) days following receipt of notice of such action to request a hearing. The request shall be in writing addressed to the Chair of the Credentials Committee who shall transmit a copy to the Clinical Staff Executive Committee and to the MCOB. The request shall contain a statement signed by the Member that the Member shall maintain confidentiality of all documents provided to the Member during the hearing process and shall not disclose or use the documents for any purpose outside the hearing process. Unless the Member is under summary suspension, he or she shall retain existing rights and privileges until all steps provided for in Sections 8.4 through 8.4.8 of Article VIII of these Bylaws below have concluded. If, however, the Member's reappointment term is scheduled to expire during the hearing process, the Member's membership and privileges shall expire unless (i) the Clinical Staff Executive Committee extends the reappointment until the hearing is concluded, or (ii) the Member is reappointed according to final action by the MCOB.

#### **8.3.3 Waiver of Hearing**

In the event the Member does not request a hearing within the time and manner described, the Member shall be deemed to have waived any right to a hearing and

accepted the recommendation involved. The recommendation of the Credentials Committee shall then become final and effective as to the Member when it is approved by the Clinical Staff Executive Committee and the MCOB.

#### **8.3.4 Notice of Time, Place and Procedures for Hearing**

Upon receipt of a request for hearing, the Chair of the Clinical Staff Executive Committee shall schedule a hearing and give notice to the Member of the time, place and date of the hearing, which shall not be less than thirty (30) days after the date of the notice. Each party shall provide the other with a list of witnesses within fifteen (15) days of the hearing date, unless both parties agree otherwise. Witness lists shall be finalized no later than five (5) working days before the hearing. Notwithstanding the foregoing, the Hearing Entity shall have the right to call such witnesses as it deems appropriate and necessary. Unless extended by the Chair of the Hearing Entity, described in Section 8.3.5 below, the date of the commencement of the hearing shall be not less than thirty (30) days, nor more than ninety (90) days from the date of receipt of the request for a hearing; provided, however, that when the request is received from a Member who is under summary suspension, the hearing shall be held as soon as the arrangements may reasonably be made and provided further that the parties may agree to a mutually convenient date beyond the ninety (90) day period.

#### **8.3.5 Hearing Entity**

The Chair of the Clinical Staff Executive Committee may, in his or her discretion and in consultation with the Chair of the Credentials Committee, the Chief Executive Officer and other members of CSEC as he or she deems appropriate, direct that the hearing be held: (1) before a panel of no fewer than three (3) Members who are appointed by the Chair of the Clinical Staff Executive Committee and if possible are Peers of the Member in clinical practice or academic rank and are not in direct economic competition with the Member involved, or (2) by an independent Peer Review panel from outside the Medical Center whose members are not in direct economic competition with the Member involved, or (3) a panel consisting of a combination of (1) and (2). Each type of panel described in the preceding sentence shall be referred to hereinafter as the "Hearing Entity." Knowledge of the matter involved shall not preclude a Clinical Staff Member from serving as a member of the Hearing Entity; however each member must certify at the time of appointment and also on the record at the hearing that any prior knowledge he or she may have does not preclude rendering a fair and impartial decision. The Chair of the Clinical Staff Executive Committee shall designate the chair of the Hearing Entity. At least three-quarters of the members of the Hearing Entity shall be present when the hearing takes place and no member may vote by proxy. In the event of any conflict involving the Chair of the Clinical Staff Executive Committee, the Vice Chair of CSEC shall be responsible for performing the duties described in this paragraph.

### **8.3.6 Failure to Attend and Proceed**

Failure without good cause of the affected Member to personally attend and proceed at such a hearing shall be deemed to constitute voluntary acceptance of the recommendations involved and his or her request for a hearing shall be deemed to have been withdrawn.

### **8.3.7 Postponements and Extensions**

Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted in these Bylaws may be permitted by the Hearing Entity, or its chairperson, acting upon its behalf. Such decisions are solely within the discretion of the Hearing Entity or its presiding officer and may only be granted for good cause.

## **8.4 Hearing Procedure**

### **8.4.1 Representation**

The hearings provided for in these Bylaws are for the purpose of intra-professional resolution of matters bearing on professional conduct, professional competency or character. If requested by either the affected Member or the Credentials Committee in accordance with Section 8.4.2, however, both sides may be represented by legal counsel. In lieu of legal counsel, the Member may be represented by another person of the Member's choice.

### **8.4.2 The Hearing Officer**

The President may appoint a hearing officer to preside at the hearing. In the sole discretion of the President, the hearing officer may be an attorney qualified to preside over a quasi-judicial hearing. If requested by the Hearing Entity, the hearing officer may participate in the deliberations of the Hearing Entity and be an advisor to it, but the hearing officer shall not be entitled to vote.

### **8.4.3 The Presiding Officer**

The Hearing Entity shall have a presiding officer. If the President appoints a hearing officer pursuant to Section 8.4.2, then the hearing officer shall serve as the presiding officer. If no hearing officer is appointed, then the Chair of the Hearing Entity shall serve as the presiding officer. The presiding officer shall strive to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The presiding officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions that pertain to matters of law, procedure, or the admissibility of evidence. If the presiding officer determines that either side in a

hearing is not proceeding in an efficient and expeditious manner, the presiding officer may take such discretionary action as seems warranted by the circumstances.

#### **8.4.4 Record of the Hearing**

An official reporter shall be present to make a record of the hearing proceedings. The cost of attendance of the reporter shall be borne by the Medical Center, but the cost of the transcript, if any, shall be borne by the party requesting it.

#### **8.4.5 Rights of the Parties**

Within reasonable limitations imposed by the presiding officer, the Credentials Committee, the Hearing Entity and the affected Member may call and examine witnesses for relevant testimony, introduce relevant exhibits or other documents, cross-examine or impeach witnesses who have testified orally on any matter relevant to the issues and otherwise rebut evidence. The Member may be called by the Credentials Committee or the Hearing Entity, as appropriate, and be examined as if under cross-examination.

- (a) Burden of Proof. The Credentials Committee shall appoint one of its members to represent it at the hearing, to present facts in support of its adverse recommendation and to examine witnesses. Where the issue concerns the denial of initial Clinical Staff membership, it shall be the obligation of the affected practitioner to present appropriate evidence in support of his or her application, but the Credentials Committee representative shall then be responsible for showing that evidence exists to support the decision and that the Credentials Committee appropriately exercised its authority under these Bylaws and other applicable rules or regulations of the Medical Center. In all other situations outlined in Section 8.2 above, it shall be the obligation of the Credentials Committee representative to present appropriate evidence in support of the adverse recommendation, but the affected Member shall then be responsible for supporting his or her challenge to the adverse recommendation by providing appropriate evidence showing that the grounds for the decision lacked support in fact or that such grounds or action based upon such grounds is either arbitrary or capricious.
- (b) Written Statement. Each party shall have the right to submit a written statement at the close of the hearing.
- (c) Written Decision. Upon completion of the hearing, the affected Member shall be informed in writing by the Clinical Staff Executive Committee of the recommendation of the Hearing Entity, including a statement of the basis for the recommendation, and shall be informed in writing of the decisions of the Clinical Staff Executive Committee and the MCOB, including a statement of the basis for the decision.

#### **8.4.6 Evidence**

Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under Article VIII of these Bylaws. Any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The Hearing Entity may question the witnesses or call additional witnesses if it deems such action appropriate. At its discretion, the Hearing Entity may request both parties to file written arguments.

#### **8.4.7 Recess and Conclusion**

After consultation with the Hearing Entity, the presiding officer may recess the hearing and reconvene the same at such times and intervals as may be reasonable, with due consideration for reaching an expeditious conclusion to the hearing. Upon conclusion of the presentation of oral and documentary evidence and the receipt of any closing written arguments, the hearing shall be closed. The Hearing Entity shall, at a time convenient to itself, conduct its deliberations outside the presence of the parties. The Hearing Entity may seek legal counsel during its deliberations and the preparation of its report. Upon conclusion of its deliberations, the hearing shall be declared finally adjourned.

#### **8.4.8 Decision of the Hearing Entity**

Within fifteen (15) days after final adjournment of the hearing, the Hearing Entity shall render a decision, which shall be accompanied by a report in writing and shall be delivered to the Clinical Staff Executive Committee. If the affected Member is currently under summary suspension, the Hearing Entity shall render a decision and report to the Clinical Staff Executive Committee within five (5) working days after final adjournment. A copy of the decision shall also be forwarded to the MCOB and the affected Member. The report shall contain a concise statement of the reasons supporting the decision.

#### **8.4.9 Decision of Clinical Staff Executive Committee and MCOB**

At its next regularly scheduled meeting, the Clinical Staff Executive Committee shall review the report and decision of the Hearing Entity and shall, within thirty (30) days of such meeting, give notice of its recommendation to the MCOB and the Member. The Clinical Staff Executive Committee may affirm, modify or reverse the decision of the Hearing Entity.

#### **8.4.10 Appeal**

The Member may submit to the Chief Executive Officer a written appeal statement detailing the findings of fact, conclusions, and procedural matters with which he/she disagrees, and his/her reasons for such disagreement. This written appeal statement may cover any matters raised at any step in the hearing process, and legal counsel may assist

in its preparation. The statement shall be delivered by hand or by certified or registered mail to the Chief Executive Officer and received no later than fourteen (14) days after the Member's receipt of the recommendation of the Clinical Staff Executive Committee. The Chief Executive Officer shall promptly provide a copy of the Member's statement to the MCOB. In response to the statement submitted by the affected Member, the Clinical Staff Executive Committee may also submit a written statement to the MCOB and shall provide a copy of any such written statement to the Member.

#### **8.4.11 Decision by the Operating Board**

- (a) At a regularly scheduled meeting following receipt of the Member's written appeal statement (or the expiration of the time in which the Member had the opportunity to submit a written statement) and the Clinical Staff Executive Committee's written statement, the MCOB shall render a decision in writing and shall forward copies thereof to each party involved in the hearing. The decision of the MCOB shall include a statement of the basis for its decision.
- (b) The MCOB may affirm, modify, or reverse the decision of the Clinical Staff Executive Committee, or remand the matter to the Hearing Entity or the Clinical Staff Executive Committee for reconsideration. If the matter is remanded to the Hearing Entity for further review and recommendation, such Hearing Entity shall conduct its review within fifteen (15) working days and make its recommendations to the MCOB. This further review and the time required to report back shall not exceed sixty (60) days except as the parties may otherwise agree, for good cause, as jointly determined by the Chair of the MCOB and the Hearing Entity or Clinical Staff Executive Committee. The MCOB shall thereafter make its final decision.
- (c) The decision of the MCOB as reflected in paragraphs (a) or (b) above shall constitute final action. This decision shall be immediately effective and shall not be subject to further hearing, appellate or judicial review.

#### **8.4.12 Right to One Hearing and One Appeal**

No Member shall be entitled to more than one evidentiary hearing and one appeal on any matter that shall have been the subject of Adverse Action or recommendation.

**ARTICLE IX  
OFFICERS OF THE CLINICAL STAFF**

**9.1 Identification of Officers**

The Officers of the Clinical staff shall be:

- (a) President
- (b) President-elect

**9.2 Qualifications of Officers**

Officers must be Members of the Active Clinical Staff in good standing at the time of their election and must remain Members of the Active Clinical Staff in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

**9.3 Nominations**

All nominations for Officers shall be made by the Nominating Committee (which is described in Article XII of these Bylaws) with the concurrence of the Chief Executive Officer and the Dean. Any Active Clinical Staff or Ph.D. Clinical Pathologist Staff may submit the name or names of any Member(s) of the Active Clinical Staff to the Nominating Committee for consideration as an Officer candidate. The Nominating Committee shall nominate one or more candidates for each office at least thirty (30) days prior to the election.

The Nominating Committee shall report its nominations for Officers to the Clinical Staff Executive Committee, with the approval of the Chief Executive Officer and the Dean, prior to the election and shall mail or deliver the nominations to the Clinical Staff at least ten (10) days prior to the election. Nominations for Officers shall not be accepted from the floor at the time of the election if voting occurs at a meeting.

**9.4 Elections**

The Officers shall be elected by electronic ballot. Only members of the Active Clinical Staff and Ph.D. Clinical Pathologist Staff shall be eligible to vote. The nominee receiving the most votes shall be elected. In the case of a tie, a majority vote of the Clinical Staff Executive Committee shall decide the election by secret written ballot at its next meeting or a special meeting called for that purpose.

**9.5 Terms of Office**

The Officers shall take office on the first day of July following election to office. The Officers shall serve for terms of three (3) years, unless any one of them shall resign sooner or be removed

from office. The Officers each shall be eligible for re-election for one additional three (3) year term.

## **9.6 Vacancies in Office**

If there is a vacancy in the office of the President, the President-elect shall serve during the vacancy. If there is a vacancy in the office of the President-elect, the Clinical Staff Executive Committee shall appoint an Active Member of the Clinical Staff to serve as President-elect until a special election to fill the position shall occur at a special meeting of the Clinical Staff, called for such purpose, or at a regular Clinical Staff meeting. The replacement Officer shall serve out the term of the original Officer.

## **9.7 Removing Elected Officers**

Elected Officers may be removed by a two-thirds (2/3) vote of the Members of the Active and Ph.D. Clinical Pathologist Staff, or by a majority vote of the MCOB.

Permissible bases for removal of an elected Officer of the Clinical Staff include, but are not limited to:

- (a) failure to perform the duties of the position in a timely and appropriate manner;
- (b) failure to satisfy continuously the qualifications for the position;
- (c) having an automatic or summary suspension, or corrective action imposed that adversely affects the Officer's membership or privileges;
- (d) failure to follow the Clinical Staff Bylaws, Credentials Manual, the Code of Conduct, the Compliance Code of Conduct, the Code of Ethics or Medical Center policies, procedures, rules, or regulations; or
- (e) conduct or statements inimical or damaging to the best interests of the Clinical Staff or the Medical Center, including but not limited to violations of state or federal law or Medical Center policy related to conflict of interest or relationships with vendors.

## **9.8 Duties of Officers**

### **9.8.1 Duties of the President**

The President shall be the spokesperson for the Clinical Staff and shall:

- (a) act in coordination and cooperation with the Chief Executive Officer and Medical Center senior leadership in all matters of mutual concern within the Medical Center;

- (b) call, preside at, and be responsible for the agenda of all general meetings of the Clinical Staff;
- (c) subject to the desire by the MCOB, serve on the MCOB as a nonvoting advisory member;
- (d) serve as the Chair of the Clinical Staff Executive Committee and as ex-officio member of all other Clinical Staff committees;
- (e) represent the views, policies, needs and grievances of the Clinical Staff to the MCOB, the Clinical Staff Executive Committee, and senior administration of the Medical Center, including the presentation to the MCOB of a report of the Clinical Staff at every meeting of the MCOB or as otherwise requested by the MCOB;
- (f) provide oversight of Clinical Staff affairs, including the Clinical Staff application process, committee performance, compliance with Joint Commission on Accreditation of Healthcare Organizations and licensure requirements as they pertain to clinical practice and physician and patient concerns regarding clinical services;
- (g) jointly with the Chief Executive Officer, appoint individuals to committees of the Clinical Staff, unless otherwise provided in these Bylaws; and
- (h) perform such other functions as may be assigned to him or her by these Bylaws, the Clinical Staff Executive Committee or the MCOB.

### **9.8.2 Duties of the President-elect**

The President-elect shall serve as the Chair of the Credentials Committee and the Vice-Chair of the Clinical Staff Executive Committee. In the absence of the President, the President-elect shall assume all the duties and have the authority of the President. The President-elect shall perform such other duties as the President may assign or as may be delegated by these Bylaws, the Clinical Staff Executive Committee or the MCOB.

**ARTICLE X**  
**CLINICAL STAFF EXECUTIVE COMMITTEE**

**10.1 Duties of the Clinical Staff Executive Committee**

Subject to the overall authority of the MCOB, the Clinical Staff Executive Committee shall be the executive committee of the Clinical Staff with the following duties:

- (a) monitor, oversee and, where appropriate, manage the quality of clinical care delivered within the Medical Center;
- (b) communicate to Members and Non-Members of the Clinical Staff regarding clinical practice issues and present the interests of the Clinical Staff to the MCOB;
- (c) act for and on behalf of the Clinical Staff in the intervals between Clinical Staff meetings and independently with respect to those matters over which CSEC is given authority in these Bylaws;
- (d) establish, review, and enforce the policies applicable to the Clinical Staff, including the Bylaws, the Code of Conduct, the Code of Ethics and all other Medical Center clinical policies regarding patient care;
- (e) control and monitor the membership of the Clinical Staff through oversight of the appointment, credentialing, and privileging process;
- (f) coordinate the activities and general clinical policies of the Medical Center to support an institutional and integrated approach to patient care within the Medical Center;
- (g) oversee the functions of performance improvement of the professional services provided by the Clinical Staff within the Medical Center;
- (h) advise the Medical Center management regarding the allocation and distribution of clinical resources, including assignments of beds, clinics, operating rooms, and other elements that are important to efficient and effective medical care within the Medical Center;
- (i) provide Clinical Staff representation and participation in any Medical Center deliberation affecting the discharge of Clinical Staff responsibilities;
- (j) report to the MCOB, as required, on the activities of the Clinical Staff Executive Committee and the Clinical Staff and makes specific recommendations to the MCOB relating to the clinical efforts of the Medical Center;
- (k) approve the creation of and oversee committees of the Clinical Staff as necessary for compliance with accreditation standards, regulatory requirements and governance of the Clinical Staff;

- (l) receive and act on reports and recommendations from the Clinical Staff committees and Departments; and
- (m) perform such other duties as may be assigned to it by the MCOB.

## **10.2 Membership of the Clinical Staff Executive Committee**

The membership of the Clinical Staff Executive Committee shall consist of the following individuals, all of whom shall be voting members:

- President of the Clinical Staff
- President-elect of the Clinical Staff
- Chief Executive Officer of the Medical Center
- Chief Clinical Officer of the Medical Center
- Dean of the School of Medicine
- Senior Associate Dean for Clinical Affairs
- Designated Institutional Officer for Graduate Medical Education
- Chairs of the clinical Departments of the Medical Center
- Chair, Children's Hospital Clinical Practice Committee
- Four (4) Clinical Staff Representatives selected by the entire Clinical Staff as provided in Section 10.3.
- President of the Nursing Staff.

In addition, the President(s) of the Graduate Medical Trainees' Executive Council shall serve on the Clinical Staff Executive Committee as a non-voting, ex-officio member(s).

In the event that any of the positions listed above are renamed, then the newly named position shall be substituted automatically in lieu of the old position without the necessity for an amendment of these Bylaws.

## **10.3 Selection of the Clinical Staff Representatives**

There shall be one Member representative on the Clinical Staff Executive Committee from each of the four following areas (the "Clinical Staff Representatives"):

- Primary Care (drawn from General Internal Medicine, General Pediatrics, General Obstetrics, Family Medicine, Regional Primary Care, and Community Medicine)
- Medical Specialties (drawn from Internal Medicine, Pediatrics, Neurology, Psychiatry, and PM&R)
- Surgical Specialties (drawn from Surgery, Orthopaedic Surgery, Neurological Surgery, Urology, Ophthalmology, Otolaryngology, Plastic Surgery, Dentistry, Dermatology, and Obstetrics and Gynecology)
- Hospital-Based Specialties (drawn from Anesthesiology, Pathology, Radiology, Radiation Oncology, and Emergency Medicine)

All Clinical Staff Representatives shall be Active Members of the Clinical Staff in good standing, but may not be Chairs of the clinical Departments of the Medical Center. The Nominating Committee may specify requirements necessary to complete nominations for Clinical Staff Representatives. The Nominating Committee shall solicit nominations for the Clinical Staff Representatives from the Clinical Staff as necessary from time to time. The Nominating Committee shall nominate one or more candidates for each Clinical Staff Representative for which the term is ending, and the Clinical Staff Office shall mail or deliver the nominations to the Clinical Staff at least ten (10) days prior to the election. At a meeting called for such purpose or by electronic means, each Member shall vote for one nominee from each of the areas enumerated above, for a total of four (4) votes. The nominee receiving the most votes in each of the four (4) enumerated areas shall become the Clinical Staff Representative of the Clinical Staff Executive Committee.

Each Clinical Staff Representative shall serve for a term of three (3) years and shall serve until the earlier to occur of (a) the end of such period and until his or her successor is appointed, or (b) the resignation or removal of such Clinical Staff Representative. A Clinical Staff Representative may be removed upon a two-thirds ( $\frac{2}{3}$ ) vote of the Clinical Staff or upon a majority vote of the MCOB. No Clinical Staff Representative shall serve on the Clinical Staff Executive Committee in the capacity of Clinical Staff Representative for more than two (2) consecutive terms.

#### **10.4 Meetings of the Clinical Staff Executive Committee**

The Clinical Staff Executive Committee shall meet monthly at a time and place as designated by the Chair of the Clinical Staff Executive Committee, and the expectation is the each member of the Clinical Staff Executive Committee will attend these monthly meetings. Fifty-one percent (51%) of the membership of the Clinical Staff Executive Committee shall constitute a quorum. Attendance at the Clinical Staff Executive Committee meetings is not assignable for voting purposes. A substitute may attend a meeting for purposes of information sharing but may not vote by proxy and will not count in the quorum.

#### **10.5 Duties of the Chair of the Clinical Staff Executive Committee**

- (a) The President shall serve as the Chair of the Clinical Staff Executive Committee. The duties of the Chair are to:
- (b) set the agenda for meetings of the Clinical Staff Executive Committee;
- (c) preside at the meetings of the Clinical Staff Executive Committee;
- (d) jointly with the Chief Executive Officer, coordinate and appoint committee members to all standing, special and multi-disciplinary committees of the Clinical Staff Executive Committee;
- (e) report as appropriate to the Clinical Staff on the activities of the Clinical Staff Executive Committee;

- (f) in conjunction with the Chief Executive Officer, appoint individuals to serve on the Clinical Staff Committees described in Article XII or otherwise created by the Clinical Staff Executive Committee; and
- (g) report to the MCOB, as required, on the activities of the Clinical Staff Executive Committee and the Clinical Staff.

#### **10.6 Duties of the Vice Chair of the Clinical Staff Executive Committee**

The President-elect shall serve as the Vice Chair of the Clinical Staff Executive Committee. The duties of the Vice Chair are to:

- (a) preside at the meetings of the Clinical Staff Executive Committee in the absence of the Chair;
- (b) present a monthly Credentials Committee report to the Clinical Staff Executive Committee;
- (c) assume all the duties and have the authority of the Chair in the event of the Chair's temporary inability to perform his/her duties due to illness, absence from the community or unavailability for any other reason;
- (d) assume all the duties and have the authority of the Chair in the event of his/her resignation as until such time as a successor is designated; and
- (e) perform such other duties as may be assigned by the Chair.

#### **10.7 Duties of the Secretary of the Clinical Staff Executive Committee**

The Chair of the Clinical Staff Executive Committee shall appoint a Secretary of the Clinical Staff Executive Committee. The Secretary is not required to be a Member. The duties of the Secretary are to:

- (a) keep accurate and complete minutes of the meetings of the Clinical Staff Executive Committee;
- (b) maintain a roster of the members of the Clinical Staff Executive Committee;
- (c) send notices of meetings to the members of the Clinical Staff Executive Committee;
- (d) attend to all correspondence of the Clinical Staff Executive Committee; and
- (e) perform such other duties as ordinarily pertain to the office of secretary.

## **ARTICLE XI CLINICAL DEPARTMENTS**

### **11.1 Organization of Clinical Departments**

- (a) The Medical Center and the School of Medicine are components of an academic Medical Center at the University of Virginia. The Members of the Clinical Staff of the Medical Center have faculty appointments in the School of Medicine, and all Clinical Staff are required to have faculty appointments in the School of Medicine as a condition of appointment to the Clinical Staff. Exceptions to this requirement will be considered only when practitioners are requesting Temporary Privileges under emergency circumstances to meet patient care needs as provided in the Bylaws, for Honorary Members, or such other exceptional circumstances as may be approved by the Chief Executive Officer, the President or the Chair of the Credentials Committee.
- (b) The Clinical Staff is divided into clinical Departments, and some Departments are further subdivided into clinical Divisions. Each Department is organized as a separate component of the Clinical Staff and shall have a Chair selected and entrusted by the Dean, with the authority, duties and responsibilities specified in Section 11.6. A Division of a Department is directly responsible to the Department within which it functions, and each Division has a Division Chief selected and entrusted with the authority, duties and responsibilities specified in Section 11.10.
- (c) Departmental status, including the creation, elimination, modification or combination thereof, shall be designated by the Dean. Division status shall be designated upon recommendation of the Chair or Chairs of the applicable Department(s) and approved by the Dean.

### **11.2 Current Departments**

#### **11.2.1 Departments**

The current clinical Departments are:

- (a) Anesthesiology
- (b) Dentistry
- (c) Dermatology
- (d) Emergency Medicine
- (e) Family Medicine
- (f) Medicine
- (g) Neurological Surgery
- (h) Neurology
- (i) Obstetrics and Gynecology
- (j) Ophthalmology
- (k) Orthopaedic Surgery
- (l) Otolaryngology – Head and Neck Surgery

- (m) Pathology
- (n) Pediatrics
- (o) Physical Medicine and Rehabilitation
- (p) Plastic and Maxillofacial Surgery
- (q) Psychiatric Medicine
- (r) Radiation Oncology
- (s) Radiology
- (t) Surgery
- (u) Urology

### **11.2.2 Other Clinical Enterprises**

For purposes of these Bylaws, Community Medicine and Regional Primary Care shall be treated as “Departments.” The Senior Associate Dean for Clinical Affairs shall be considered the “Chair” of Community Medicine, and the Medical Director of Regional Primary Care shall be considered the “Chair” of Regional Primary Care. The MCOB may designate other clinical enterprises within the Medical Center from time to time that shall be considered Departments for purposes of these Bylaws. In such event, the MCOB shall designate the person to serve as “Chair.”

### **11.3 Assignments**

Each Member shall be assigned to at least one Department, and if applicable, to a Division within such Department. Members may be granted membership and/or Clinical Privileges in more than one Department or Division consistent with practice privileges granted. For Members with joint appointments, the Chairs from each Department shall sign off on the faculty appointment and recommendation of Clinical Privileges.

### **11.4 Functions of Departments and Divisions**

The general functions of each Department and Division, as applicable, include:

- (a) conducting patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the Department and Division. The number of such reviews to be conducted during the year shall be as determined by the Clinical Staff Executive Committee in consultation with other appropriate committees. The Department, and as applicable, the Division, shall routinely collect information about important aspects of patient care provided in the Department or Division, periodically assess this information, and develop objective criteria for use in evaluating patient care. Patient care reviews shall include all clinical work performed under the jurisdiction of the Department or Division, regardless of whether the Member whose work is subject to such review is a member of that Department or Division;
- (b) recommending to the Credentials Committee criteria for the granting of Clinical Privileges (both core privileges and privileges outside the core as well as new or

additional Clinical Privileges) and the performance of specified services within the Department or Division;

- (c) evaluating and making appropriate recommendations regarding the qualifications of Applicants seeking appointment or reappointment to the Clinical Staff and Clinical Privileges within that Department or Division;
- (d) reviewing and evaluating departmental adherence to Clinical Staff and Medical Center policies and procedures and sound principles of clinical practice;
- (e) coordinating and integrating patient care provided by the Department's or Division's members with patient care provided in other Departments or Divisions and with nursing and ancillary patient care services;
- (f) submitting written reports to the Clinical Staff Executive Committee concerning: (i) the Department's and/or Division's review and evaluation of activities, actions taken thereon, and the results of such actions; and (ii) recommendations for maintaining and improving the quality of care provided in the Department and/or Division and the Medical Center;
- (g) having at least quarterly meetings for the purpose of considering patient care review findings and the results of the Department's other review and evaluation activities, as well as reports on other Department and Clinical Staff functions;
- (h) taking appropriate action when important problems in patient care and clinical performance or opportunities to improve care are identified;
- (i) accounting to the Clinical Staff Executive Committee for all professional activities within the Department;
- (j) appointing such committees or other mechanisms as may be necessary or appropriate to conduct Department functions;
- (k) formulating recommendations for Departmental or Division rules and regulations reasonably necessary for the proper discharge of its responsibilities, subject to compliance with Medical Center policies; and
- (l) encouraging the continuing education of Members of the Clinical Staff in the Department.

### **11.5 Department Chairs**

- (a) Each Department other than Community Medicine and Regional Primary Care shall have a Chair who is a Member of the Active Clinical Staff and is appointed by the Dean of the School of Medicine. Department Chairs shall be certified as diplomats of their specialty board or be equivalently qualified. Each Chair shall report to the Dean and shall be

accountable to the Clinical Staff Executive Committee for all clinical matters in his or her Department.

- (b) For purposes of these Bylaws, the Chair for Community Medicine shall be the Senior Associate Dean for Clinical Affairs, and the Chair for Regional Primary Care shall be its Medical Director. The Senior Associate Dean for Clinical Affairs and the Regional Primary Care Medical Director shall have the same responsibilities as to Department Chairs set forth in these Bylaws, the Rules and Regulations or the Credentials Manual with respect to Community Medicine and Regional Primary Care.

### **11.6 Duties of Department Chairs**

Each Chair has the following authority, duties, and responsibilities and shall otherwise perform such duties as may be assigned to him or her:

- (a) act as presiding officer at Departmental meetings, which shall be held at least quarterly for the purpose of quality monitoring and reporting and such other purposes as may be required by the Department;
- (b) attend monthly meetings of the Clinical Staff Executive Committee and other special meetings of the Clinical Staff Executive Committee as may be called from time to time;
- (c) report to the Dean and be accountable to the Clinical Staff Executive Committee regarding all professional and administrative activities within the Department;
- (d) make recommendations regarding the overall clinical policies of the Clinical Staff and the Medical Center;
- (e) make specific recommendations regarding criteria-based privileges and suggestions regarding physician faculty within his or her Department and Divisions therein;
- (f) assure compliance within his or her Department and any Divisions therein with these Bylaws, the Credentials Manual and Medical Center policies, procedure, rules and regulations, including but not limited to, implementing a process for effectively communicating to Members of his or her Department and Divisions therein any amendment or revision of these Bylaws, the Credentials Manual, the Code of Conduct, the Compliance Code of Conduct, the Code of Ethics and any new or revised Medical Center policy, procedure, rule or regulation;
- (g) sign off and transmit to the Credentials Committee the Department's recommendations concerning and required documentation in support of Member appointment and classification, reappointment, criteria for Clinical Privileges, results of any investigation or corrective action with respect to Members with Clinical Privileges in his or her Department. Chairs may delegate this responsibility to a senior level designee within the Department subject to prior written notification to and approval by the Chair of the Credentials Committee. Chairs shall ensure that files on each of their faculty with

Clinical Privileges that include documentation of FPPE and OPPE data and other activities are securely maintained and support the specifically delineated Clinical Privileges requested;

- (h) implement within his or her Department appropriate actions taken by the Clinical Staff Executive Committee or the MCOB;
- (i) generally monitor the quality of patient care and professional performance rendered by Members with Clinical Privileges in the Department through a planned and systematic process, including but not limited to, FPPE and OPPE, and oversee the effective conduct of the patient care, evaluation, and monitoring functions delegated to the Department by the Clinical Staff Executive Committee, the Dean or the President, including evaluating the quality of clinical work performed by each practitioner in the Department at least annually;
- (j) develop, support and implement Departmental programs for retrospective patient care review, ongoing monitoring of clinical and ethical practice, credentials review and privileges delineation, medical education, utilization review, and quality assurance and performance improvement, all as part of the Peer Review process;
- (k) abide by the supervisory requirements when temporary privileges have been granted to a Member in his or her Department or Division;
- (l) participate in every phase of administration of his or her Department, including cooperation with the nursing service and the Medical Center administration in matters such as personnel, supplies, and special regulations, standing orders, and techniques;
- (m) prepare and submit reports pertaining to his or her Department as may be required by the Credentials Committee, the Clinical Staff Executive Committee or the MCOB;
- (n) be responsible for the teaching, education and research programs in his or her Department;
- (o) ensure that Members and Graduate Medical Trainees within his or her Department and the Divisions therein practice within the scope of their Clinical Privileges, are educated to deliver patient-centered and family-centered care as members of interdisciplinary teams, emphasizing professional and ethical conduct, evidence-based practice, quality improvement approaches and informatics;
- (p) facilitate Graduate Medical Trainees' education and training to achieve those competencies identified as necessary by the ACGME or other applicable entity;
- (q) keep appropriate records of all Physicians, Dentists, Podiatrists, Ph.D. Clinical Psychologists and Ph.D. Clinical Pathologist practicing within his or her Department; and

- (f) perform such other duties commensurate with the office as may from time to time be reasonably requested by the Dean, the President, the Clinical Staff Executive Committee or the MCOB.

### **11.7 Committees of the Departments**

The affairs of each Department may be delegated to a designee or to a committee of Department members appointed by the Chair of the Department.

### **11.8 Division Chiefs**

Each Division shall have a Chief who shall be a Member of the Active Clinical Staff in good standing and a member of the Division which he or she is to head, and shall be qualified by training, experience and demonstrated current ability in the clinical area covered by the Division. The Chair of the Department in which the Division functions shall select and remove the Division Chief, and the Division Chief either reports to the Chair of the Department or directly to the Dean in some cases. Division Chiefs shall be certified as diplomates of their specialty Board or be equivalently qualified.

### **11.9 Duties of Division Chiefs**

Each Division Chief shall:

- (a) act as presiding officer at Division meetings, to be held as reasonably necessary;
- (b) assist in the development and implementation, in cooperation with Department Chairs, of programs to carry out the quality review and evaluation and monitoring functions of the Division, including credentials review and criteria-based privilege delineation, medical education, utilization review, and quality assurance and performance improvement, all as part of the Peer Review process;
- (c) evaluate the quality of clinical work performed by each practitioner in the Division at least annually;
- (d) conduct investigations and submit reports and recommendations to the Department Chair regarding complaints from other Members, Non-Members, or others regarding Members of the Division as well as regarding the Clinical Privileges to be exercised within his or her Division by Members or Applicants;
- (e) submit reports of the patient care and quality monitoring activities of his or her Division to the Department Chair as required by the Department Chair;
- (f) perform any of the duties of the Department Chair described in Section 11.6 above if the Chair has delegated such duties to the Division Chief;

- (g) perform such other duties commensurate with the office as may from time to time be reasonably requested by the Department Chair, the Dean, the Clinical Staff Executive Committee or the MCOB or as otherwise contemplated by these Bylaws or the Credentials Manual; and
- (h) sign off and transmit to the Chair the Division's recommendations concerning and required documentation in support of Member appointment and classification, reappointment, criteria for Clinical Privileges, results of any investigation or corrective action with respect to Members with Clinical Privileges in his or her Division. Division Chiefs shall ensure that files on each of their faculty with Clinical Privileges that include documentation of FPPE and OPPE data and other activities are securely maintained and support the specifically delineated Clinical Privileges requested.

## **ARTICLE XII CLINICAL STAFF STANDING COMMITTEES**

### **12.1 Structure**

The standing Committees of the Clinical Staff are as set forth in these Bylaws.

#### **12.1.1 Reporting and Accountability to Clinical Staff Executive Committee**

All Clinical Staff Committees report, and are accountable, to the Clinical Staff Executive Committee. The Chair of each Clinical Staff Committee shall report its activities to the Clinical Staff Executive Committee by submitting a written report on an annual basis, and upon request, submitting a copy of the minutes of each meeting, or as it is otherwise requested by the Chair or Vice Chair of the Clinical Staff Executive Committee, or as otherwise provided by these Bylaws.

#### **12.1.2 Membership**

The membership of the Clinical Staff Committees may consist of Members, Allied Health Professionals, Medical Center administration and administrative staff members, and other professional staff or employees of the Medical Center appointed as provided in these Bylaws. The President and the Chief Executive Officer shall be ex-officio members of all Clinical Staff Committees unless otherwise provided in these Bylaws.

#### **12.1.3 Appointments**

Except as otherwise provided in these Bylaws, all chairpersons and members of Clinical Staff Committees shall be appointed jointly by the President and the Chief Executive Officer. Appointments to Clinical Staff Committees shall be for an indefinite period, subject to the discretion of the President and the Chief Executive Officer, or the resignation of the Clinical Staff Committee member. Each appointment shall be annually reviewed by the President of the Clinical Staff and the Chief Executive Officer.

#### **12.1.4 Quorum, Voting and Meetings**

A quorum for each Clinical Staff Committee shall be thirty percent (30%) of the members currently serving. All voting and decisions ordinarily shall occur in meetings of the Clinical Staff Committee, but decisions may be made by electronic means as may be reasonably necessary from time to time. Except as otherwise provided in these Bylaws, all Clinical Staff Committees shall meet at least quarterly and as otherwise called by the chair of the Clinical Staff Committee.

### **12.2 Bylaws Committee**

The Bylaws Committee shall ensure that the Bylaws of the Clinical Staff are consistent with the Medical Center's operational needs, current Joint Commission Standards, applicable CMS Conditions of Participation and other CMS requirements and the policies, procedures, rules and regulations of the Medical Center. In performing this function, the Bylaws Committee shall: (a) review the Bylaws on at least on an annual basis; (b) review proposed Bylaws amendments that may be proposed by Members of the Clinical Staff; (c) develop draft revisions and recommendations regarding proposed amendments to the Bylaws; (d) present proposed revisions to the Clinical Staff Executive Committee and the MCOB for review and approval; and (e) provide each Member a current copy of the Bylaws.

The Bylaws Committee shall meet as necessary, but not less than once per year.

### **12.3 Credentials Committee**

The Credentials Committee shall review and evaluate the qualifications of each Applicant for initial appointment, reappointment or modification of appointment to the Clinical Staff in accordance with the procedures outlined in the Credentials Manual and these Bylaws. The Credentials Committee shall recommend to the Clinical Staff Executive Committee and the MCOB appointment or denial of all Applicants to the Clinical Staff and the granting of Clinical Privileges.

The Credentials Committee shall review and make recommendations for revisions to the Credentials Manual from time to time; provided however the Chair of the Credentials Committee, in consultation with the President and the Chief Executive Officer, shall have the authority to amend the Credentials Manual. The Credentials Committee shall also serve as the investigatory body for all matters set forth in Article VII of these Bylaws.

The President-elect shall serve as chair of the Credentials Committee. Only Members of the Clinical Staff serving on the Credentials Committee shall be eligible to vote on Credentials Committee matters.

## **12.4 Nominating Committee**

The Nominating Committee shall nominate Members to serve as Officers of the Clinical Staff and shall nominate Members for the Clinical Staff Representatives, as provided in these Bylaws. The Nominating Committee shall consist of (i) the immediate past president of the Clinical Staff, who shall serve as Chair of the Nominating Committee, and (ii) six (6) Members of the Active Clinical Staff chosen by the President, subject to confirmation by the Chief Executive Officer and the Dean.

## **12.5 Children's Hospital Clinical Practice Committee**

The Children's Hospital Clinical Practice Committee is an interdisciplinary committee that shall review, coordinate and recommend policies, protocols and practice guidelines that impact all aspects of the clinical and patient- and family-centered care of children.

The Children's Hospital Clinical Practice Committee may, from time to time, recommend to the Clinical Staff Executive Committee the creation of subcommittees to develop specific recommendations for involving families and children in decision-making, customer service, program development, quality and performance improvement outcomes and practices throughout the Children's Hospital.

Membership on the Children's Hospital Clinical Practice Committee may include Members who have chosen to be part of the Children's Hospital Clinical Staff as well as Allied Health Professionals and Medical Center employees with an interest in children's health care issues. The President and Chief Executive Officer shall select the Chair of the Committee and all Committee members in accordance with Section 12.1.3. of these Bylaws.

## **12.6 Other Committees**

The Clinical Staff Executive Committee may designate such other standing committees of the Clinical Staff as may be necessary from time to time for compliance with accreditation standards, regulatory requirements and governance of the Clinical Staff. In such event, each such committee shall be subject to the provisions of Section 12.1. In addition, the Medical Center may create, from time to time, any committees deemed necessary.

## **ARTICLE XIII MEETINGS OF THE CLINICAL STAFF**

### **13.1 Regular Meetings**

Regular meetings of the Clinical Staff shall be held at a time mutually determined by the President and the Chief Executive Officer but no less than annually. One week prior to the time of the meeting a written or printed notice shall be delivered either personally, by mail or by electronic mail to each Member stating the date, time and place of the meeting. The attendance of a Member at a meeting shall constitute a waiver of notice of such meeting.

### **13.2 Special Meetings**

The President or President-elect of the Clinical Staff, the Chief Executive Officer, the Clinical Staff Executive Committee, or the MCOB may call a special meeting of the Clinical Staff at any time. The President of the Clinical Staff shall call a special meeting within fourteen (14) days after receipt by him or her of a written request for same signed by not less than fifteen percent (15%) of the Active Clinical Staff and stating the purpose for such meeting.

At least twenty-four (24) hours prior to the meeting a written or printed notice stating the date, time and place of the special meeting of the Clinical Staff shall be delivered, either personally, by mail, or by electronic mail to each Member. The attendance of a Member at a meeting shall constitute a waiver of notice of such meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

### **13.3 Quorum**

The presence of fifty (50) Members entitled to vote at any regular or special meeting shall constitute a quorum. No official business may be taken without a quorum.

### **13.4 Attendance Requirements**

Each Member of the Active and Ph.D. Clinical Pathologist Staffs is encouraged to attend all regular Clinical Staff meetings in each year unless unusual circumstances prevent their attendance as well as meetings of all committees to which they have been appointed as members. Attendance at special meetings will be counted toward the attendance requirement. The Honorary Clinical Staff are encouraged to but are not required to attend. A Member of the Active or Ph.D. Clinical Pathologist Staff who is compelled to be absent from any regular Clinical Staff meeting shall promptly submit to the President of the Clinical Staff, in writing, his/her reason for such absence. Unless excused for cause by the President of the Clinical Staff, the failure to meet the foregoing annual attendance requirements shall be grounds for corrective action as outlined in Article VII herein, which may lead to revocation of Clinical Staff membership. Reinstatement of Members whose membership has been revoked because of absence from Clinical Staff meetings shall be made only upon application, and all such applications shall be processed in the same manner as applications for original appointment.

### **13.5 Action by Electronic Means**

Whenever these Bylaws require the vote of or action by the Clinical Staff, such vote or action may be taken by electronic means.

## **ARTICLE XIV CONFIDENTIALITY, IMMUNITY, AND RELEASES**

### **14.1 Authorization and Conditions**

By applying for or exercising Clinical Privileges within this Medical Center, an Applicant:

- (a) authorizes the Medical Center, the Clinical Staff, the Clinical Staff Executive Committee, the MCOB, the MCOB Quality Subcommittee, and the Board of Visitors, and their members and authorized representatives, to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the Applicant's professional ability and qualifications and any other matter within the scope of this Article;
- (b) authorizes all persons and organizations to provide information concerning such Applicant to the Medical Center, the Clinical Staff, the Clinical Staff Executive Committee, the MCOB, the MCOB Quality Subcommittee, and the Board of Visitors, and their members and authorized representatives;
- (c) agrees to be bound by the provisions of this Article and to waive all legal claims against any third party, the Clinical Staff, the Medical Center, the Clinical Staff Executive Committee, the MCOB, the MCOB Quality Subcommittee, and the Board of Visitors, along with their members and authorized representatives, for any matter within the scope of this Article; and
- (d) acknowledges that the provisions of this Article are express conditions to an application for Clinical Staff membership, the continuation of such membership, and to the exercise of Clinical Privileges at the Medical Center.

### **14.2 Confidentiality of Information; Breach of Confidentiality**

- (a) Clinical Staff, Department, Division, Committee, Clinical Staff Executive Committee, MCOB, MCOB Quality Subcommittee, Board of Visitors, or any other applicable minutes, files, and records within the scope of this Article shall, to the fullest extent permitted by law, be confidential. Dissemination of such information and records shall only be made where permitted by law, or pursuant to officially adopted policies of the Medical Center or Clinical Staff, or, where no officially adopted policy exists, only with the express approval of the Clinical Staff Executive Committee or its designee, or to the appropriate University personnel and officers in connection with the discharge of their official duties.

- (b) Because effective Peer Review and consideration of the qualifications of Members and Applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of Clinical Staff Departments, Divisions, or committees, is outside appropriate standards of conduct for this Clinical Staff and will be deemed disruptive to the operations of the Medical Center. If it is determined that such a breach has occurred, the Clinical Staff Executive Committee may undertake such corrective action as it deems appropriate.

### **14.3 Immunity**

The Clinical Staff, the Medical Center, the Clinical Staff Executive Committee, the MCOB, the MCOB Quality Subcommittee, and the Board of Visitors, along with their members and authorized representatives and all third parties, shall be immune, to the fullest extent permitted by law, from liability to an Applicant or Member for damages or other relief for any matter within the scope of this Article.

For the purpose of this Article, “third parties” means both individuals and organizations from whom information has been requested by the Medical Center, the Clinical Staff, the Clinical Staff Executive Committee, the MCOB, the MCOB Quality Subcommittee, or the Board of Visitors, or any of their members or authorized representatives.

### **14.4 Scope of Activities and Information Covered**

The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care facility’s or organization’s activities concerning, but not limited to:

- (a) application for appointment to the Clinical Staff for the granting of Clinical Privileges;
- (b) periodic reappraisals for reappointment to the Clinical Staff or renewals of Clinical Privileges;
- (c) corrective action, including summary or automatic suspension;
- (d) hearings and appeals;
- (e) medical care evaluations;
- (f) utilization reviews;
- (g) other Medical Center, Department, or Division, committee, or Clinical Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct;

- (h) FPPE, OPPE and other Peer Review activities and organizations, the Virginia Board of Medicine, the National Practitioner Data Bank pursuant to HCQIA, and similar reports; and
- (i) to the greatest extent permitted by law, all other actions taken in pursuit of activities provided for under these Bylaws.

The acts, communications, reports, recommendations, and disclosure referred to in this Section may relate to a practitioner's professional qualifications, clinical competency, character, mental and emotional stability, physical condition, ethics, malpractice claims and suits, and any other matter that might directly or indirectly have an effect on patient care.

## **14.5 Releases**

Each Applicant or Member shall, upon request of the Clinical Staff or Medical Center, execute general and specific releases in accordance with the express provisions and general intent of this Article. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

## **ARTICLE XV AMENDMENT OF BYLAWS**

### **15.1 Amendment**

#### **15.1.1 Annual Update**

The Clinical Staff Bylaws shall be reviewed at least annually by the Bylaws Committee and updated as necessary.

#### **15.1.2 Process for Amendment**

- (a) Consideration shall be given to amendment of these Bylaws upon the request of the President, the President-elect, the Chief Executive Officer, the Clinical Staff Executive Committee, the MCOB, or upon a written petition signed by at least ten percent (10%) of the Members entitled to vote, or upon recommendation by the Bylaws Committee.
- (b) All proposed amendments to the Bylaws shall be delivered to the Clinical Staff Executive Committee, which shall, on behalf of the Clinical Staff, review and approve, disapprove, or offer modification, as appropriate.
- (c) Any amendment(s) to the Bylaws adopted by the Clinical Staff Executive Committee shall be submitted to the MCOB for review and approval, disapproval or modification, as appropriate.

- (d) Amendments to these Bylaws shall become effective only upon approval by the Clinical Staff Executive Committee and the MCOB. Neither the Clinical Staff Executive Committee nor the MCOB may unilaterally amend the Bylaws.

## **15.2 Distribution of Bylaws**

Each Member shall be provided with a copy of these Amended and Restated Clinical Staff Bylaws. If at any time amendments are made to the Bylaws, each Member shall be provided with a copy of such amendments.