



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

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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 an acute care 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.

**MISSION, VISION AND VALUES OF THE UNIVERSITY OF VIRGINIA MEDICAL
CENTER**

Mission

To provide excellence, innovation and superlative quality in the care of patients, the training of health professionals, and the creation and sharing of health knowledge.

Vision

In all that we do, we work to benefit human health and improve the quality of life. We will be:

- Our local community's provider of choice for its healthcare needs
- A national leader in quality, patient safety, service and compassionate care
- The leading provider of technologically-advanced, ground-breaking care throughout Virginia
- Recognized for translating research discoveries into improvements in clinical care and patient outcomes
- Fostering innovative care delivery and teaching/training models that respond to the evolving health environment

Values

This institution exists to serve others, and does so through the expression of our core values:

Respect: To recognize the dignity of every person

Integrity: To be honest, fair and trustworthy

Stewardship: To manage resources responsibly

Excellence: To work at the highest level of performance, with a commitment to continuous improvement

UVA Health System Goals

- Become the safest place to receive care.
- Be the healthiest work environment.
- Provide exceptional clinical care.
- Generate biomedical discovery that better the human condition.
- Train healthcare providers of the future to work in multi-disciplinary teams.
- Ensure value-driven and efficient stewardship of resources.

ARTICLE I DEFINITIONS

“Active Clinical Staff” mean those Members of the Clinical Staff who meet the criteria set forth in Section 4.4.1 of these Bylaws.

“Active Clinical Staff – Provisional” means those Members of the Clinical Staff who are in their first year of appointment as an Active Member of the Clinical Staff as described in Section 4.4.1 of the Bylaws.

“Administrative Clinical Staff” mean those Members of the Clinical Staff who meet the criteria set forth in Section 4.4.3 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 9.2 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” means 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. The Allied Health Professionals Manual is incorporated by reference into these Bylaws.

“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.

“Associate Chief Medical Officers (ACMO)” means Active Members in good standing who are appointed by the CMO, in consultation with the Chief Executive Officer and who are responsible for assisting the Clinical Staff in performing their assigned functions, in coordinating such functions with the responsibilities and programs of the Medical Center including compliance with all relevant policies concerning the operations of the Medical Center, and the performance of other duties as outlined in these Bylaws may be necessary from time to time. Each ACMO is accountable to the CMO.

“Be Safe” means to advance the University of Virginia Medical Center’s status as the safest place to work and to receive care. The core belief is that patient and team member safety are preconditions to excellence in health care, and that collective system-wide focus on these areas will jointly improve outcomes and develop broad capacity to engage in organizational problem solving and continuous improvement. Based in Lean management principles, the Be Safe program emphasizes real-time root cause problem solving, the use of standard work as a basis for

improvement, and rapid escalation of safety issues within a tiered chain of leadership support.

“Board Certified” means that a Practitioner, if a Physician, is certified as a specialist by a specialty board organization, recognized as such by the American Board of Medical Specialties, or the American Osteopathic Association’s Council for Graduate Medical Education; if an Oral Surgeon, is specialty certified as such by the Virginia Board of Dentistry and the American Board of Maxillo-Facial Surgery; if a Podiatrist, is certified by the American Board of Podiatric Surgery; and if a Dentist, is certified by the American Board of Dentistry; and if a clinical pathologist, is certified by a CLIA-approved certifying agency such as the American Board of Clinical Chemistry.

“Board Qualified” means a Practitioner has met the educational, post-graduate training and skill qualifications, and is currently eligible to sit, within a specified amount of time for a board certification examination of a specialty board recognized by the American Board of Medical Specialties, the American Osteopathic Association, American Dental Association or the American Podiatric Medical Association or a CLIA-approved certifying agency such as the American Board of Clinical Chemistry.

“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.

“Chief Medical Officer” means an Active Member in good standing, appointed by the CEO who is responsible for assisting the Clinical Staff in performing its assigned functions, in coordinating such functions with the responsibilities and programs of the Medical Center including compliance with all relevant policies concerning the operations of the Medical Center, and the performance of other duties as may be necessary from time to time.

“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 the formal organizations of all licensed Physicians, Dentists,

PhD Clinical Psychologists, PhD Clinical Pathologists and Podiatrists who may practice independently and who are granted recognition as Members under the terms of 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 XI 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” mean those representatives selected by the Clinical Staff to serve on the Clinical Staff Executive Committee as provided in Article XI.

“Clinical Staff Year” means 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 that is described in [Medical Center Policy No. 0291 \(“Clinical Staff Code of Conduct”\)](#).

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

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

“Complete Application” means an application for either initial appointment or reappointment to the Clinical Staff, or an application for clinical privileges that has been determined by the applicable Chair (or the Chair’s Deputy), the Credentials Committee, the Clinical Staff Executive Committee (CSEC), and the MCOB to meet the requirements of these Bylaws and related policies and procedures. Specifically, to be complete, the application must be submitted on a form approved by CSEC, MCOB and include all required supporting documentation and verifications of information, and any additional information needed to perform the required review of qualifications and competence of the applicant.

“Compliance Code of Conduct” means the Medical Center Compliance Code of Conduct that is described in [Medical Center Policy No. 0235 \(“Compliance Code of Conduct”\)](#).

“Credentialing” means the process of verifying the authenticity and adequacy of a Practitioner’s educational, training, and work history in order to determine whether the individual meets predefined criteria for membership and/or privileges.

“Credentials Manual” means the Clinical Staff and Resource Manual as such may be in effect from time to time. The [Credentials Manual](#) is an associate manual to these Bylaws.

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

“Dean” means the 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, the Chief Medical Officer with respect to Community Medicine, and the UPG Medical Director of Outreach programs for Outreach Physicians.

“Deputy” means the one active member of the Clinical Staff appointed by the Department Chair for one year for the sole purpose of attending meetings of CSEC when the Department Chair is unable to attend those meetings. Only one Deputy shall be appointed each year. The Deputy may attend CSEC meetings and vote in place of the Chair and will count in establishing the quorum.

“Disaster Privileges” means those Clinical Privileges granted during a declared disaster as more specifically provided in Section 6.10 of these Bylaws.

“Division” means a subdivision of a Department.

“Emergency Privileges” means those Clinical Privileges granted already existing Practitioners to provide emergency treatment outside the scope of their existing privileges in order to save the life, limb, or organ of a patient as provided in Section 6.9 of these Bylaws.

“Executive Vice President for Health Affairs (“EVPHA”) means an individual appointed by the Board of Visitors with operational, financial and strategic oversight of the Medical Center, School of Medicine, and Health Sciences Library.

“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 a structured and time-limited evaluation of the competence of a practitioner to safely exercise a clinical privilege or set of privileges. FPPE is performed at the time of initial appointment to the clinical staff; upon the request of a new privilege, if the practitioner cannot provide prior documentation of competence to perform the requested procedure; or when a question arises regarding the ability of a currently privileged practitioner to competently and safely exercise the privileges he or she is currently granted. [See Medical Center Policy No. 0279](#) (“Professional Practice Evaluations for Members of the Clinical Staff”), Medical Center Policy No. 0280 (“Allied Health Professionals Practice Evaluations”) and [the Credentials Manual](#).

“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.

“Graduate Medical Trainee Staff” or “GME Trainee” means 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 IX herein.

“Honorary Clinical Staff” mean those Members of the Clinical Staff who meet the criteria set forth in Section 4.4.4 of these Bylaws.

“Hospital-Based Specialty” means the clinical services of anesthesia, emergency medicine, pathology, radiology, and radiation oncology.

“In Good Standing” means a Member is currently serving without any limitation of prerogatives imposed by operation of the Bylaws or policies of the Medical Center.

“Investigation” means the process specifically authorized by these Bylaws in order to perform a final assessment of whether a recommended corrective action is warranted.

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

“Licensed Independent Practitioners or LIPs” means licensed independent practitioners who provide medical care to patients, in accordance with state licensing laws.

“Medical Center” or “UVAMC” means the University of Virginia academic medical center comprised of the acute care 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 Operating Board Quality Subcommittee” or “MCOB Quality Subcommittee” means a Committee of the MCOB with oversight of the quality and safety of care in the Medical Center and as designated by the MCOB from time to time.

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

“Medical Director” means a clinical staff member in good standing who provides medical direction and leadership for a specific function at UVAMC. Responsibilities include

administrative and clinical duties. Medical Directors are appointed by the CMO, and report to the CMO through the appropriate ACMO.

“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, Ph.D. Clinical Pathologist or AHP 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 X of these Bylaws.

“Ongoing Professional Practice Evaluation (“OPPE”)” means a process that allows identification of professional practice trends of practitioners who have been granted clinical privileges 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 \(“Professional Practice Evaluations for Members of the Clinical Staff”\)](#), [Medical Center Policy No. 0280 \(“Allied Health Professionals Practice Evaluations”\)](#) and the [Credentials Manual](#).

“Peer” means a Practitioner or clinician whose interest and expertise as documented by clinical practice is reasonably determined to be comparable 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 doctoral degree (e.g., Ph.D., or D.Sc.) in a scientific discipline and completed additional clinical training in an area of clinical 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.

“Practitioner” means a care provider privileged through the processes in these Bylaws.

“Prerogative” means the participatory rights granted, by virtue of staff category or otherwise, to a Clinical Staff Member, which is exercisable subject to, in accordance with, the conditions imposed by these Bylaws.

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

“Privileging” means the process of granting the right to examine and treat patients after verification of the authenticity and adequacy of a Practitioner’s educational, training, and work history.

“Proctor” means an LIP in good standing at the University of Virginia Medical Center, who holds the privilege being monitored.

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

“Resident” means an individual who has been awarded an M.D., a D.D.S., or a Ph.D. in clinical psychology who is participating in a program of post-doctoral education in anticipation of fulfilling the requirements for first board certification.

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

“Standing Committee of the Clinical Staff Executive Committee” means a duly-authorized Committee of the Clinical Staff reporting to the Clinical Staff Executive Committee.

“Temporary Privileges” means those Clinical Privileges granted for a period not to exceed 120 days as more specifically described in Section 6.8 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.

“University Physicians Group (UPG)” means the physician group practice of the University of Virginia, representing doctors and other allied health professionals who provide care within the Medical Center.

“Vice President” means the Vice President of the Clinical Staff as described in Article X of these Bylaws.

**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 XI hereof.

**ARTICLE III
NAME AND PURPOSE**

3.1 NAME

The name of the clinical staff organization shall be the “Clinical Staff” of the University of Virginia Medical Center (UVAMC). The organized Clinical Staff is accountable to the Medical Center Operating Board. For the purposes of these Bylaws, the words “Clinical Staff” shall be interpreted to include all Physicians, Dentists, Podiatrists, PhD Clinical Psychologists and PhD Clinical Pathologists who are authorized to provide care to patients of the UVAMC, including its outpatient facilities, and in any other medical care activity administered by UVAMC.

3.2 STATEMENT OF PURPOSE

The purposes of the Clinical Staff Bylaws are to:

1. Facilitate the provision of quality care to patients of the University of Virginia Medical Center and in any other medical care activity administered by the UVAMC without any form of discrimination.
2. Clarify roles and responsibilities of Clinical Staff Members and Officers of the UVAMC.
3. Promote professional standards among members of the Clinical Staff.
4. Provide a means whereby problems may be resolved by the Clinical Staff with the collaboration of the MCOB.

5. Create a system of self-governance, and to initiate and maintain, policies and procedures governing the conduct of Clinical Staff, subject to the ultimate authority of the MCOB.

3.3 THE PURPOSES OF THE ORGANIZED CLINICAL STAFF

The purposes of the organized Clinical Staff of the UVAMC are:

1. To provide quality medical care to all patients admitted or treated in any of the UVAMC facilities
2. To establish and maintain high professional and ethical standards
3. To establish and maintain collaborative, collegial relationships within the Clinical Staff and between all team members
4. To oversee the quality of professional services by all practitioners with clinical privileges
5. To provide a formalized organizational structure to facilitate the credentialing and review of the professional activities of practitioners and to make recommendations to the MCOB on appointment and/or clinical privileges granted to such individuals
6. To appropriately delineate, in conjunction with the MCOB, the clinical privileges each practitioner may exercise through the continued review and evaluation
7. To stimulate, promote and conduct research in human health, disease and delivery of medical care
8. To cooperate with the various academic units of the University, affiliated hospitals and other health facilities and maintain standards at predoctoral and postdoctoral levels
9. To initiate and maintain rules for governance of the Clinical staff and provide a means whereby issues and problems concerning the Clinical staff can be discussed and resolved
10. To initiate, develop, review, approve, implement and enforce these Bylaws and associated Clinical Staff polices
11. To provide a means for effective communication among the Clinical staff, administration and the MCOB on matters of mutual concern
12. To collaborate with Health System leadership to continuously enhance the quality, safety and efficiency of patient care, treatment and services as delegated to CSEC by the MCOB

ARTICLE IV CLINICAL STAFF MEMBERSHIP AND CLASSIFICATION

4.1 MEMBERSHIP

Membership on the Clinical Staff shall be extended to Physicians, Dentists, Podiatrists, and PhD Clinical Psychologists and PhD Clinical Pathologists who continuously meet the requirements, qualifications, and responsibilities set forth in these Bylaws and who are appointed by the MCOB. Membership on the Clinical Staff or clinical privileges shall not be granted or denied on the basis of race, religion, color, age, gender, national origin, ancestry, economic status, marital status, veteran status, disability or sexual orientation, provided the individual is competent to render care of the generally-recognized professional level of quality established by the Clinical Staff Executive Committee and the MCOB, and provided the UVAMC services occur in the appropriate environment of care setting.

No Physician, Dentist, Podiatrist, PhD Clinical Psychologist, or PhD Clinical Pathologist shall admit or provide services to patients in UVAMC facilities unless he/she is a Member of the Clinical Staff or has been granted Temporary, Disaster, or Emergency privileges in accordance with the procedures set forth in these Bylaws.

GME Trainees who are in a UVAMC approved residency program shall not be eligible for membership on the Active Clinical Staff and shall be under the supervision of the GME Program Director and/or an attending Physician. A Department Chair may request privileges for GME Trainees to perform clinical work in a medical discipline for which they have had previous training. Such Applicants must meet the requirements, qualifications and responsibilities for such privileges and are subject to such policies and procedures as may be established by the Credentials Committee and the Clinical Staff Executive Committee. Graduate Medical Trainee appointments and job descriptions including job qualifications and current competencies are maintained by the Graduate Medical Education Office and by the Clinical Competency Committees of their respective academic departments.

4.2 EFFECT OF OTHER AFFILIATIONS

No Physician, Dentist, Podiatrist, PhD Clinical Psychologist or PhD Clinical Pathologist shall be automatically entitled to Clinical Staff membership, a particular Clinical Staff category or to exercise any particular clinical privilege merely because he/she hold a certain degree; is licensed to practice in Virginia or any other state; is a member of any professional organization; is certified by any clinical board; previously had membership or privileges at UVAMC; or had, or presently has, staff membership or privileges at another health care facility. Clinical Staff membership or clinical privileges shall not be conditioned or determined on the basis of an individual's participation or non-participation in a particular medical group, IPA, PPO, PHO, or Medical Center sponsored foundation.

4.3 REQUIREMENTS FOR CLINICAL STAFF MEMBERSHIP

4.3.1 NATURE OF CLINICAL STAFF MEMBERSHIP

Membership on the Clinical Staff is a an honor that shall be limited to professionally competent Practitioners who continuously meet the qualifications, requirements and responsibilities set forth in these Bylaws, in applicable Medical Center policies, including but not limited to Medical Center Policy No. 0291 ("Clinical Staff Code of Conduct") and Medical Center Policy No. 0305 ("General Requirements for Clinicians Holding Clinical Privileges"), 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.

4.3.2 BASIC QUALIFICATIONS OF CLINICAL STAFF MEMBERSHIP

In order to obtain or maintain membership on the Clinical Staff and in order to be granted privileges as a Member of the Clinical Staff, Applicants must have and document:

1. A faculty appointment in the School of Medicine or an employment contract with UPG;
2. A current, unrestricted license, if such license is required by Virginia law, to practice medicine and surgery, dentistry, clinical psychology PhD or clinical pathology PhD in the Commonwealth of Virginia;
3. Except for specific exemptions permitted under UVAMC Policy No. 0221 (“Board Certification Requirements for Medical Center Physicians”), a Practitioner who seeks to be or is a Member must be Board Certified for the specialty in which he or she expects to exercise clinical privileges within six (6) years of completion of training. A Member who seeks or holds clinical privileges must be Board Certified in accordance with the specific requirements of the specialty, and in compliance with specific Departmental criteria for Delineation of Privileges. If an Applicant does not meet the board certification requirements and the Applicant may qualify for an exemption specified in [Medical Center Policy No. 0221 \(“Board Certification Requirements for Medical Center Physicians”\)](#), the Department Chair must send a written request to the Credentials Committee requesting an exemption. Reappointment is contingent upon Board Certification or recertification as outlined in [Medical Center Policy No. 0221 \(“Board Certification Requirements for Medical Center Physicians”\)](#), which is incorporated herein by reference;
4. Eligibility to participate in Medicare, Medicaid and other federally sponsored health programs; and
5. Members shall have in force professional liability insurance satisfactory to the Medical Center which covers all privileges requested.

A Practitioner who does not meet these basic requirements is ineligible to apply for Clinical Staff membership, and the application shall not be accepted for review, except that Members of the Administrative and Honorary Staff do not need to comply with these basic qualifications. If it is determined during the processing that the Applicant does not meet all of the basic qualifications, the review of the application shall be discontinued. An Applicant who does not meet the basic qualifications is not entitled to the procedural rights set forth in Article IX.

4.3.3 GENERAL REQUIREMENTS OF CLINICAL STAFF MEMBERSHIP

In order to obtain or maintain membership on the Clinical Staff and in order to be granted clinical privileges as a member of the clinical staff, applicants must demonstrate:

- A. Current competency. Applicants for staff privileges shall have the background, relevant training, experience and competency that are sufficient to demonstrate to the satisfaction of the Credentials Committee and the MCOB that he or she can capably and safely exercise clinical privileges within the Medical Center. Current competency shall be demonstrated as described in Medical Center Policy No. 0291 (“Clinical Staff Code of Conduct”) and Medical Center Policy No. 0305 (“General Requirements for Clinicians Holding Clinical Privileges”).
- B. Compliance with Bylaws and Policies. Compliance with the Bylaws, Clinical Staff policies, Departmental and Service rules and regulations, as well as all enunciated policies of UVAMC.

- C. Appropriate Management of Medical Records. Preparing in legible and accurate form, completing within prescribed timelines and maintaining the confidentiality of medical records for all patients to whom the Member provides care in UVAMC facilities in accordance with applicable policies of UVAMC and the University Physicians Group. This shall include, but is not limited to, performing histories and physicals and completing all necessary documentation as required by Medical Center Policy 0094 (“Documentation of Patient Care (Electronic Medical Record)”) which is incorporated herein by reference.

A medical history and physical examination (H&P) shall be completed no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. An updated examination of the patient, including any changes in the patient’s condition, be completed and documented within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination is completed within thirty (30) days before admission or registration. The updated examination of the patient, including any changes in the patient’s condition, must be completed and documented by a physician, an oral and maxillofacial surgeon, dentist, podiatrist, or other qualified licensed individual in accordance with State law and Medical Center policy. (see Medical Center Policy No. 0094, “Documentation of Patient Care (Electronic Medical Record)”).

4.3.4 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. The Clinical Staff member shall meet the requirements as contained in the GME Policy and Procedure 012, and applicable Medical Center and Departmental policies and as required by the ACGME and noted on the [ACGME website](#).

4.3.5 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 mission of the Medical Center; see Medical Center Policy 0291 (“Clinical Staff Code of Conduct”) and Medical Center Policy Medical Center Policy No. 0305 (“General Requirements for Clinicians Holding Clinical Privileges”).
- C. Attending meetings of the Clinical Staff, Department, Division, as appropriate, and committees to which a Member has been appointed, as required; and
- D. 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.

4.4 CATEGORIES OF THE CLINICAL STAFF

The categories of Clinical Staff membership shall be divided into the Active Staff, Associate Staff, Administrative Staff, and Honorary Staff. Non-members include Contract Physicians, Consulting and Visiting Clinical Staff, Telemedicine providers, Graduate Medical Trainees, Allied Health Professionals, and Visiting/Re-Entry Physicians. Each time Clinical Staff membership is granted or renewed, or at other times deemed appropriate, the Clinical Staff Executive Committee, and subsequently the MCOB, will approve the member's staff category.

Each Clinical Staff Member shall be assigned to a Clinical Staff category based upon qualifications defined in these Bylaws. For the purposes of the below qualifications, patient contact includes admissions, treatments, consults, outpatient clinic visits, and outpatient surgery and procedures.

The Members of each Clinical Staff category shall have the prerogatives and shall carry out the duties defined in these Bylaws. Action may be initiated to change the Clinical Staff category or to terminate the membership of any Member who fails to meet the qualifications or fulfill the duties described in these Bylaws. Changes in Clinical Staff category shall not be grounds for a hearing unless they adversely affect the Member's privileges.

4.4.1 ACTIVE CLINICAL STAFF

A. Qualifications

The Active Clinical Staff are voting members and shall consist of Physicians, Dentists, Podiatrists, PhD Clinical Pathologists, and PhD Clinical Psychologists who hold a School of Medicine faculty appointment and:

1. Meet the criteria for Clinical Staff membership set forth in these Bylaws and specifically in Section 4.3; and
2. Regularly admit patients to the Medical Center or regularly practice in a hospital-
3. based or a Medical Center recognized practice, or are regularly involved in the direct care of patients at a facility under the provider number of UVAMC and regularly participate in Clinical Staff functions as determined by Clinical Staff governance. See also Medical Center Policy 0304 ("Responsibilities of Attending Physicians on Inpatient Services")
4. Have satisfactorily completed their designated term in the Provisional status.

B. Prerogatives and Responsibilities

1. Exercise an option to vote on all matters presented at general and special meetings of the Clinical Staff;
2. Exercise an option to practice the clinical privileges as granted in accordance with these Bylaws and the Credentials Manual; and
3. Exercise an option to be considered for office in the Clinical Staff organization.

C. Transfer of Active Staff Members

After two (2) consecutive years in which a Member of the Active Clinical Staff does not regularly care for patients at UVAMC and/or be regularly involved in Clinical Staff functions as determined by the Clinical Staff, that Member may be transferred to the appropriate category, if any, for which the member is qualified.

4.4.2 ASSOCIATE CLINICAL STAFF

A. Qualifications

The Associate Staff, a non-voting member, shall consist of Physicians, Dentists, Podiatrists, Ph.D. Clinical Psychologists, and Ph.D. Clinical Pathologists, who hold an employment contract with UPG but who do not hold a School of Medicine faculty appointment. Associate Staff Members:

1. Meet the criteria for Staff membership set forth in these Bylaws and specifically in Section 4.3
2. Are regularly involved in the care of patients at a facility that is under the provider number of UVAMC and who need to be privileged and re-privileged through UVAMC; and
3. Do not admit or treat patients at the Acute Care Hospital facilities of the Medical Center, including the outpatient surgery center. and
4. Have satisfactorily completed their designated term in the Provisional status.

B. Prerogative and Responsibilities

1. Exercise an option to practice the clinical privileges as granted in accordance with these Bylaws and the Credentials Manual pursuant to Article VI at a facility that is under the provider number of UVAMC; and
2. Actively participate in performance improvement and quality assurance activities, supervising provisional appointees, evaluating and monitoring Clinical Staff Members, and in discharging such other Staff functions as may from time to time be required.

C. Limitations

1. Shall not have the right to vote at general and special meetings of the Clinical Staff, except to the extent the right to vote is specified at the time of appointment; and
2. Cannot hold office in the Clinical Staff organization.

D. Transfer of Associate Clinical Staff Members

After two (2) consecutive years in which a Member of the Associate Clinical Staff does not regularly care for patients at UVAMC and/or be regularly involved in Clinical Staff functions as determined by the Clinical Staff, that Member may be transferred to the appropriate category, if any, for which the member is qualified.

4.4.3 ADMINISTRATIVE STAFF

A. Qualifications

The Administrative Staff category shall be held by any Physician, Dentist, Podiatrist, PhD Clinical Psychologist or PhD Clinical Pathologist who is not otherwise eligible for another staff category and who is to perform ongoing medical administrative activities.

1. Are charged with assisting the Clinical Staff in carrying out medical-administrative functions, including but not limited to quality assessments of clinical programs and utilization reviews;
2. Are able to document their good judgment, current physical and mental health status so as to demonstrate to the satisfaction of the Clinical Staff that they are professionally and ethically competent to exercise their duties, and is able to work cooperatively with the Clinical Staff office; and
3. Are willing to participate and properly discharge those responsibilities as determined by the VP and CEO and the Dean.

B. Responsibilities

1. Defined by the VP and CEO and the Dean; and
2. Exercise an option to attend and vote at general and special meetings of the Clinical Staff.

C. Limitations

1. Cannot hold office in the Clinical Staff organization; and
2. Cannot admit patients or exercise clinical privileges.

4.4.4 HONORARY CLINICAL STAFF

A. Qualifications

The Honorary Clinical Staff shall consist of Physicians, Dentists, Podiatrists, PhD Clinical Psychologists and PhD Clinical Pathologists, each of whom is a former Member of the Clinical Staff who has retired or withdrawn from practice and who are honored by an emeritus title in the School of Medicine, and/or have been nominated by the current Department Chair in which the person practiced or by Dean in recognition of his or her noteworthy contributions to the UVAMC.

- ##### **B.**
- Was a member in good standing of the Clinical Staff at the time of his or her retirement or withdrawal from clinical practice

C. Responsibilities

1. Exercise an option to attend general and special meetings of the Clinical Staff;
2. Exercise an option to vote on Clinical Staff Committees that he/she has been requested to serve on.

D. Limitations

1. Shall not be granted or exercise clinical privileges;
2. Shall not vote at general or special meetings of the Clinical staff;
3. Shall not hold office in the Clinical Staff organization.

4.5 NON-MEMBERS WITH PRIVILEGES

Other healthcare professionals not described above may not be Members of the Clinical Staff. 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 VI and the Credentials Manual. Allied Health Professionals are also Non-members who are granted privileges. Non-members, who are not Physicians or Dentists, shall have none of the rights conferred on Members in these Bylaws, including but not limited to those provided in Articles IX hereof, but shall be required to follow policies and procedures of the Medical Center and the Clinical Departments.

4.5.1 CONSULTING AND VISITING STAFF

Consulting and Visiting Staff do not hold faculty appointments, nor are contracted with UVAMC or UPG, but are granted privileges to provide services that are not otherwise available at UVAMC or to assist in difficult cases.

A. Qualifications

The Consulting and Visiting Staff shall consist of Physicians, Dentists, Podiatrists, and PhD Clinical Psychologists who:

1. Meet the criteria for Staff membership set forth in these Bylaws excluding the faculty appointment or UPG contract and Meet the criteria for Staff membership set forth in Section 4.3;
2. Hold appropriate clinical privileges at another accredited health care facility; and
3. Have a maximum of ten (10) patient contacts per year at the Medical Center.

B. Responsibilities

1. Exercise an option to provide clinical care at UVAMC within the privileges as are granted to him/her pursuant to Article VI;
2. Provide patient activity and quality review information from primary facility as requested at time of reappointment; and
3. Satisfy the requirements of the Clinical Department of which he/she is associated.
4. Actively participate in performance improvement and quality assurance activities, supervising provisional appointees, evaluating and monitoring as may from time to time be required.

C. Limitations

1. Shall not vote at general or special meetings of the Clinical staff; and
2. Shall not hold office in the Clinical Staff organization.
3. Shall not attend meetings of the Clinical Staff

D. Transfer of Consulting and Visiting Staff

Consulting and Visiting Staff members who regularly care for more than ten (10) patients per year at the Medical Center will be reviewed by the Credentials Committee to consider appointment to another staff category.

4.5.2 CONTRACT PHYSICIAN STAFF

The Contract Physician Staff shall consist of GME Trainees at UVAMC who are engaged by the Medical Center to provide explicit medical services outside their training program at a UVAMC facility. A contract physician must obtain prior approval for the outside activities in accordance with the GME Internal and External Moonlighting Activity Policy and provide a copy of the contract under which he or she will be working at the time the credentialing process begins. Members of the Contract Physician Staff must be board certified or board qualified in the specialty related to the privilege request, and has attestations of qualifications from both the Program Director and the Department Chair. Contract Physician Staff are not eligible to vote on Clinical Staff matters or to hold Clinical Staff Office.

In addition, Contract Physician Staff:

1. May not serve as the attending physician of record or admit patients to the Medical Center unless an exemption is granted. Exemptions are considered at the request of the Designated Institutional Officer with explicit conditions regarding concurrent proctoring and agreed to by the Credentials Committee;
2. Can treat patients if authorized to do so in accordance with the Practitioner's delineated clinical privileges and Article VI of these Bylaws;
3. Appointment procedures for Contract Physician Staff will be the same as the procedures for the Clinical Staff in accordance with Article VII of these Bylaws;
4. Shall actively participate in performance improvement and quality assurance activities of the Clinical Staff;
5. Shall meet the basic responsibilities of Staff membership as set forth in these Bylaws; and
6. The Contract Physician Staff Practitioner's privileges will automatically terminate upon the termination or expiration of his/her contract or agreement with the UVAMC or UPG, and the Practitioner shall have none of the rights conferred on Members in these Bylaws, including but not limited to those provided in Article IX.

4.5.3 TELEMEDICINE

Telemedicine providers are privileged as set forth in Article VI. Telemedicine providers access patients remotely and do not practice within the UVAMC facilities. Telemedicine providers are not eligible to vote on Clinical Staff matters or hold Clinical Staff Office.

4.5.4 GRADUATE MEDICAL TRAINEES

Except as provided in Section 4.5.2 above, members of the Graduate Medical Trainee staff as defined in these Bylaws do not have independent privileges to admit or treat patients at the UVAMC. They are employees of the University of Virginia Medical Center and their scope of practice is defined by the Graduate Medical Education Program. They are not governed by these Bylaws. Graduate Medical Trainees shall be required to follow GME policies and procedures and will act only under the supervision of a Clinical Staff Member in accordance with all relevant Clinical Staff, UVAMC, and GME policies.

GME Trainees, who are working in an independent practice capacity as Contract physicians in the organization, must be granted privileges as set forth in Article VI of these Bylaws.

4.5.5 ALLIED HEALTH PROFESSIONALS

AHPs are individuals that hold a license, certificate, or other legal credential to practice as required by Virginia law that authorizes the provision of complex and clinical services to patients. AHPs treat and/or perform services on patients at a facility that is under the provider number of UVAMC. AHPs adhere to Clinical Staff Bylaws which are applicable to the AHP, Department policies, Medical Center policies and professional guidelines. (See, e.g., Medical Center Policy No. 280 “Allied Health Professionals Practice Evaluations”) AHPs are not Members of the Clinical Staff but are granted clinical privileges. AHPs may vote for the AHP representative to CSEC, and serve as voting members on Clinical Staff Committees. Only AHP’s are eligible to serve as the AHP representative to CSEC.

4.5.6 VISITING/RE-ENTRY PHYSICIAN STATUS

A Non-member of the Clinical Staff may apply for re-entry status to learn a specific defined patient care technique under the direction of one of the Departments at UVAMC. Individuals applying for visiting postgraduate trainee status shall be licensed to practice medicine, dentistry or clinical psychology in any one of the United States and shall have been accepted by the course director to participate in a specific clinical training program at UVAMC. These Bylaws and other applicable UVAMC policies and procedures shall govern the activities and conduct of Visiting Postgraduate Trainees.

A. Limitations

1. Shall not perform any independent patient care or evaluation at UVAMC facilities;
2. Shall not take call; and
3. Shall not use the UVAMC Visiting/Re-Entry Trainee status as the basis for independent practice at any other site.

4.6 MODIFICATION OF MEMBERSHIP

On its own, upon recommendation of the Credentials Committee, or pursuant to a request from a Member, the Clinical Staff Executive Committee may recommend a change in the Clinical Staff category of a Member, consistent with the requirements of these Bylaws, to the MCOB.

4.7 MEMBER RIGHTS

Clinical Staff Member Rights

1. Each Member in the Active category has the right to initiate a recall election of a Clinical Staff Officer by following the procedure outlined in Article X of these Bylaws, regarding removal and resignation from office.
2. Each Member in the Active category may initiate a call for a general staff meeting to discuss a matter relevant to the Clinical Staff by presenting a petition signed by ten percent (10%) of the Members of the Active category. Upon presentation of such a petition, CSEC shall schedule a general staff meeting for the specific purposes addressed by the petitioners. No business other than that detailed in the petition may be transacted.
3. Each Member in the Active category may challenge any rule, regulation or policy established by the CSEC. In the event that a rule, regulation or policy is thought to be inappropriate, any Clinical Staff Member may submit a petition signed by ten percent (10%) of the Members of the Active category. Upon presentation of such a petition, the adoption procedure noted in section Article XVI will be followed.
4. The above sections 1 to 3 do not pertain to issues involving individual peer review, formal investigations of professional performance or conduct, denial of requests for appointment or clinical privileges, or any other matter relating to individual membership or privileges. The Bylaws provide recourse in these matters.
5. Any Practitioner eligible for Clinical Staff membership has a right to a hearing/appeal pursuant to the conditions and procedures described in the Clinical Staff's hearing and appeal plan.
6. These member rights serve as a conflict resolution mechanism between the Clinical Staff and the Clinical Staff Executive Committee.

ARTICLE V PROCEDURES FOR MEMBERSHIP

The process for evaluation of credentials for membership and/or privileges is the same for all Members and Non-members. The Credentials Committee shall follow the credentialing procedures set forth in the Credentials Manual including the procedure 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, upon review by the Department Chair, 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.

If there is a recommendation for the denial of membership and/or privileges by the CSEC or MCOB, the applicant is entitled to the fair hearing and appeal plan appropriate to their clinical status.

5.1 PROCEDURE FOR ACTIVE AND ASSOCIATE CLINICAL STAFF MEMBERSHIP

In order to become an Active or Associate Member of the Clinical Staff, the individual Physician, Dentist, Podiatrist, Ph.D. Clinical Psychologist or 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 School of Medicine, an employment contract with UPG, satisfy the criteria set forth in Article IV of these Bylaws for an Active or Associate Member and if applicable, 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 a Member in accordance with Article VII of these Bylaws. In the case of individuals who do not hold School of Medicine faculty appointments, the Chief Executive Officer of UPG will fill the role of the Dean for the procedures described above.

The [Credentials Manual](#) establishes requirements for application for Clinical Staff Clinical Privileges. 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.

5.2 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.

5.3 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 IV of these Bylaws shall be nominated by his or her former Chair or the Dean and approved by the Clinical Staff Executive Committee.

5.4 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 or UPG, 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 and the Dean of the School of Medicine or Chief Executive Officer of UPG (for Associate Members) 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 IX 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.

If membership and/or privileges expire during the leave of absence, then the Practitioner must reapply for membership and/or privileges.

5.5 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 or resignation, retirement or termination from the School of Medicine or UPG.

ARTICLE VI CATEGORIES OF CLINICAL PRIVILEGES

6.1 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 and the Clinical Staff Executive Committee and approved by the MCOB, except as provided in Sections 6.6, 6.7, and 6.8 of this Article. Every Non-member shall be entitled to exercise only those delineated Clinical Privileges specifically reviewed by the Department Chair, recommended by the Credentials Committee, recommended by the Clinical Staff Executive Committee and approved by the MCOB, except as provided in Sections 6.6, 6.7, and 6.8 of this Article. 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.

6.2 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 Service 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.

6.3 PRIVILEGES FOR NON-MEMBERS (EXCEPT AHP)

Physicians, Dentists, Podiatrists, PhD Clinical Pathologists and PhD Clinical Psychologists who are 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, Visiting Privileges, Telemedicine or Contract Physicians.

6.4 PRIVILEGES FOR ALLIED HEALTH PROFESSIONALS

Allied Health Professionals, as defined in these Bylaws are privileged under a separate process that is specified in the Allied Health Professionals Manual. They are subject to the applicable sections of these Bylaws. Allied Health Professionals shall be required to follow policies and procedures as set forth in the AHP Manual and Medical Center policies and will act under the supervision of a Clinical Staff Member in accordance with all relevant Clinical Staff and UVAMC policies. An official list of current AHPs will be kept in the Clinical Staff Office.

6.5 CONSULTING PRIVILEGES

6.5.1 Description

Non-members who may be granted Consulting Privileges shall consist of Physicians, Dentists, Podiatrists, Ph.D. Clinical Pathologists and Ph.D. Clinical Psychologists who will participate in patient care activities for Medical Center patients at the request of a Member of the Clinical Staff, each of whom shall provide information and documentation required by the Credentials Manual and Medical Center policies.

6.5.2 Prerogatives

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

6.5.3 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.

6.6 VISITING PRIVILEGES

6.6.1 Description

Non-members who may be granted Visiting Privileges shall consist of Physicians, Dentists, Podiatrists, PhD. Clinical Pathologists and Ph.D. Clinical Psychologists who will participate in patient care activities for Medical Center patients for a period of time at the request of a Member of the Clinical Staff, with the support of his or her Department 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.

6.6.2 Prerogatives

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

- A. Participate as applicable in the care of patients within the scope of his or her delineated Clinical Privileges;
- B. Exercise Clinical Privileges as specifically delineated; and
- C. Attend Clinical Staff, Department and as applicable, Division meetings as invited.

6.6.3 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.

6.7 TEMPORARY PRIVILEGES

6.7.1 Circumstances Under Which Temporary Privileges May Be Granted

Temporary Privileges shall be granted in only two 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; or
- B. When an Applicant with a complete verified 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, the Credentials Committee, after review by the Department Chair, may recommend that the CEO or designee, upon recommendation of the President of the Clinical Staff or designee, grant temporary privileges pending review and approval by the Clinical Staff Executive Committee and approval of the MCOB.

6.7.2 Application and Review

- A. Where an important patient care need mandates an immediate authorization to practice as contemplated by 6.7.1 (a), the CEO or designee, with the written concurrence of the Department Chair and the President of the Clinical Staff or designee, may grant Temporary Privileges. Such temporary grant of privileges shall not be made unless the following verifications are present:
1. 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) and their recommendation for approval;
 2. Primary source verification of current license;
 3. Listing of delineated privileges requested with appropriate documentation of competence to perform each of the specified tasks;
 4. Proof of current liability coverage, showing coverage limits and dates of coverage; and
 5. 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 Section 6.7., the CEO or designee, upon recommendation of the President of the Clinical Staff or designee, 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:
1. Complete application is received and all verifications are received;
 2. Evidence of a completed query to the National Practitioner Data Bank and an analysis of the evaluation of the results of such query; and
 3. The Applicant satisfies the requirements of Section 6.7.1 b. and has not been subject to involuntary termination of Clinical 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.

6.7.3 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 Department 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 Department Chair or the Chair's designee when Temporary Privileges have been granted to an Applicant in the Clinical 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 of the Clinical Staff or the CEO, or unless affirmatively renewed, up to a maximum of 120 days, following the procedure set forth in Section 6.7.2
- B. Requirements for proctoring and monitoring, including FPPE, shall 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 IX because a request for Temporary Privileges is refused or because all or any portion of Temporary Privileges are terminated or suspended for reasons not related to competence or conduct. Termination or suspension of Temporary Privileges which lasts longer than 14 days and for reasons of competence or conduct shall afford fair hearing and appeal rights.
- E. All persons requesting or receiving Temporary Privileges shall be bound by the Bylaws, the Credentials Manual, and the policies, procedures, of the Medical Center.

6.8 EMERGENCY PRIVILEGES

In the case of a medical emergency, any currently privileged Practitioner is authorized to do everything possible to save the patient's life or to save the patient from serious harm, to the degree permitted by the Practitioner's license, regardless of Clinical Service affiliation, staff category, or level of privileges. A Practitioner exercising emergency privileges is obligated to summon all consultative assistance deemed necessary and to arrange appropriate follow-up.

6.9 DISASTER 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 VP and CEO, 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. Before a volunteer clinician is considered eligible to function as a licensed independent Practitioner, the Medical Center will obtain his or her valid government issued photo identification (for example, a driver's license or passport). When the emergency situation no longer exists, any such clinician must apply for the staff privileges necessary to continue to treat patients. Primary source verification of licensure occurs as soon as the disaster is under control or within 72 hours from the time the volunteer licensed independent Practitioner presents himself or herself to the Medical Center whichever comes first. In the event such privileges are denied or are not requested, the patients shall be assigned to another Member.

- A. If the Medical Center Emergency Management Plan has been activated and the organization is unable to meet immediate patient needs, the CEO or other individuals as identified in the Medical Center Emergency Management Plan with similar authority may, on a case by case basis consistent with medical licensing and other relevant state statutes, grant disaster privileges to selected LIPs. These Practitioners must present a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:
 1. A current picture Medical Center ID card that clearly identifies professional designation;
 2. A current license to practice;
 3. Primary source verification of the license;
 4. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or groups;
 5. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity); or
 6. Identification by a current Medical Center or Clinical Staff member (s) who possesses personal knowledge regarding the volunteer's ability to act as a licensed independent Practitioner during a disaster.
- B. The Clinical Staff has a mechanism (i.e., badging) to readily identify volunteer Practitioners who have been granted disaster privileges.
- C. The Clinical Staff oversees the professional performance of volunteer Practitioners who have been granted disaster privileges by direct observation, mentoring, or clinical record review. The organization makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours whether disaster recovery privileges should be continued.

- D. Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer Practitioner presents to the organization. If primary source verification cannot be completed in 72 hours, there is documentation of the following: 1) why primary source verification could not be performed in 72 hours; 2) evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and 3) an attempt to rectify the situation as soon as possible.
- E. Once the immediate situation has passed and such determination has been made consistent with the Medical Center Emergency Management Plan, the Practitioner's disaster privileges will terminate immediately.
- F. Any individual identified in the Medical Center Emergency Management Plan with the authority to grant disaster privileges shall also have the authority to terminate disaster privileges. Such authority may be exercised in the sole discretion of the Medical Center and will not give rise to a right to a fair hearing or an appeal.

6.10 TELEMEDICINE CREDENTIALING AND PRIVILEGING

6.10.1 Receipt of Telemedicine Services From Other Sites

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.

Telemedicine is the provision of clinical services to patients by Practitioners from a distance via electronic communications. The originating site is the site where the patient is located; the distant site is the site where the Practitioner is physically viewing the telemedicine images. Practitioners providing only telemedicine services to the Medical Center from a distant site will not be appointed to the Clinical Staff but must be granted privileges at the Medical Center. The Clinical Staff may recommend privileges to the MCOB through one of the following mechanisms:

- A. The Medical Center uses the credentialing and privileging decision made by the distant-site to make a final privileging decision. For the Clinical Staff to rely upon the credentialing and privileging decisions made by the distant-site hospital when making recommendation on privileges for the individual distant-site physicians and Practitioners providing such services, the MCOB ensures, through the Medical Center's written agreement with the distant-site hospital, that all of the following provisions are met:
 - 1. The distant site providing the telemedicine services is a Medicare-participating and Joint Commission-accredited hospital or ambulatory care organization;
 - 2. The individual distant-site physician or Practitioner is privileged at the distant-site providing the telemedicine services for those services to be provided at the originating site, and the distant site provides a current list of the distant site physician's or Practitioner's privileges at the distant-site hospital or ambulatory care organization;
 - 3. The individual distant-site physician or Practitioner holds a license issued or recognized by the State in which the hospital whose patients are receiving the telemedicine services is located; and

4. With respect to a distant-site physician or Practitioner who holds current privileges at the Medical Center, the Medical Center has evidence of an internal review of the distant-site physician's or Practitioner's performance of these privileges and sends the distant-site hospital such performance information for use in the periodic appraisal of the distant-site physician or Practitioner. At a minimum, this information must include all adverse outcomes related to sentinel events considered reviewable by The Joint Commission that result from the telemedicine services provided by the distant-site physician or Practitioner to the Medical Center's patients; and all complaints the Medical Center has received about the distant-site physician or Practitioner.
- B. The Clinical Staff privileges Practitioners using credentialing information from the distant site if the distant site is a Joint Commission accredited organization. Once the Clinical Staff makes its recommendation regarding the privileging of the telemedicine provider, it then must go through the remainder of the credentialing process for a decision regarding approval by the MCOB as set forth in Article VII of these Bylaws.

6.10.2 Provision of Telemedicine Services to Other Sites

Practitioners providing telemedicine services to other hospitals from the Medical Center must be granted privileges at the Medical Center for any services that are rendered via telemedicine to other site(s). If this service is rendered by Residents or Fellows, then any telemedicine interpretation must be overseen by a Practitioner with appropriate clinical privileges before the reading can be furnished to the other site(s).

6.11 EXPEDITED CREDENTIALING

6.11.1 Eligibility:

An expedited review and approval process may be used for initial appointment and for reappointment. All initial applications for membership and/or privileges will be designated as eligible for expedited credentialing or not. A completed application that does not raise concerns, as identified by the lack of any of the criteria noted below, is eligible for expedited credentialing:

- A. The application is deemed to be incomplete;
- B. The final recommendation of the CSEC is adverse or with limitation;
- C. The Applicant is found to have experienced an involuntary termination of clinical staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges at another organization or has a current challenge or a previously successful challenge to licensure or registration;
- D. The Applicant is, or has been, under investigation by a state medical board or has prior disciplinary actions or legal sanctions;
- E. The Applicant has had two (2) or more or an unusual pattern of malpractice cases filed within the past five (5) years or one final adverse judgment in a professional liability action in excess of \$250,000;
- F. The Applicant has one or more reference responses that raise concerns or questions;
- G. A discrepancy is found between information received from the Applicant and references or verified information;

- H. The Applicant has an adverse National Practitioner Data Bank report;
- I. The request for privileges is not reasonable based upon applicant's experience, training, and demonstrated current competence, and/or is not in compliance with applicable criteria;
- J. The Applicant has been removed from a managed care panel for reasons of professional conduct or quality;
- K. The Applicant has potentially relevant physical, mental and/or emotional health problems;
- L. Other reasons as determined by a clinical staff leader or other representative of the Medical Center which raise questions about the qualifications, competency, professionalism or appropriateness of the Applicant for membership or privileges.

6.11.2 Approval Process:

Applicants for expedited credentialing will be granted Clinical Staff membership and/or privileges after review and action by the following: the Department Chair, the Credentials Committee, and CSEC with a quorum as defined for expedited credentialing and a committee of the MCOB consisting of at least two individuals.

ARTICLE VII APPOINTMENT AND REAPPOINTMENT

7.1 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.

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, upon recommendation of the Department Chair, 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.

In the case of an application for Associate Membership, the procedures outlined in the Credentials Manual shall be considered until all required information and documentation is completed within the timeframes specified in the Credentials Manual.

7.2 PROVISIONAL APPOINTMENT STATUS

Initial appointments and all initially granted Clinical Privileges for all Practitioners 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 Department Chair, Division Chair, or Peer designee of the applicable Clinical Department. If at the end of the year the Practitioner satisfies the requirements to become a Clinical Staff Member or have a privileging status as provided in the Credentials Manual, the provisional status ceases. If at the end of the year the Practitioner does not satisfy the requirements as specified in the Credentials Manual, then membership in the Clinical Staff and Clinical Privileges for that individual shall cease. Failure to achieve the appropriate status from provisional status, when due to a lack of clinical volume, shall not give rise to the procedural rights, afforded by Article IX of these Bylaws. Failure to achieve the appropriate status from provisional status, due to issues of competency or conduct, shall give rise to the procedural rights afforded by Article IX of these Bylaws.

All initial Clinical Staff appointees to the Active or Associate Categories and all Non-member appointees to the Consulting/Visiting, Contract Physician, Telemedicine, Visiting/Re-entry Postgraduate Trainee, or AHP categories, and all re-appointees to these categories after termination of a prior appointment, shall serve a provisional status period of no less than one (1) year. During this time proctoring must be satisfactorily completed unless a specific exception is applied for by the Department Chair and approved by the Credentials Committee as specified in section B below. Each Member in provisional status shall be assigned to a Department in which their performance shall be evaluated through proctoring to determine their eligibility for advancement to non-provisional status in the appropriate Clinical Staff category.

A. Responsibilities

A Practitioner in provisional status shall have all of the responsibilities of the membership category.

B. Proctoring

Each provisional appointee shall complete such proctoring (Focused Professional Practice Evaluation) as required by the Clinical Service and approved by the Credentials Committee in accordance with [Medical Center Policy No. 0279](#) ("[Professional Practice Evaluations for Members of the Clinical Staff](#)") and [Medical Center Policy No. 0280](#) ("[Allied Health Professionals Practice Evaluations](#)").

7.3 PROCEDURE FOR REAPPOINTMENT

Periodic redetermination of Clinical Privileges for Active 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 Article IX shall not apply.

7.4 END OF PROVISIONAL STATUS

A Member in provisional status may become an Active or Associate Member 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.

7.5 CHANGES 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 8.6 or Article IX will apply.

7.6 NEW OR ADDITIONAL CLINICAL PRIVILEGES

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. Licensure and the National Practitioner Data Bank will be queried at any request for new privileges. 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 MCOB 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 IX of these Bylaws. The Applicant's performance and clinical competence shall be observed and evaluated through FPPE by the Department Chair, Division Chief, and Peer designee of the applicable Clinical Department and documentation is completed within the timeframes specified in the Credentials Manual.

7.7 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 or the Dean of the School of Medicine. 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 Clinicians 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 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.

ARTICLE VIII CORRECTIVE ACTION FOR MEMBERS AND NON-MEMBERS WITH CLINICAL PRIVILEGES

8.1 CRITERIA FOR INITIATION

A Member's or Non-member's Clinical Privileges may be reduced, suspended or revoked 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 Service. Any person may provide information to a Department Chair, the Clinical Staff Executive Committee, the Chief Executive Officer, the Dean, the Chief Medical Officer, the President, the Vice President, 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 worker safety, 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. In order to safeguard the privileged peer review status of a peer review investigation, the individual requesting an investigation may not be entitled to receive information about the course or findings of the investigation. The Chair of the Credentials Committee may inform the individual requesting an investigation about the status of the investigation (ongoing or concluded) and the expected date of completion.

8.2 ROUTINE 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 formal corrective action, shall not afford the individual subject to such collegial efforts to the right to a fair hearing, and shall not require reporting to the National Practitioner Data Bank, except as otherwise provided in these Bylaws or required by law. Alternatives to formal 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, , 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.

8.3 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 Clinicians' 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; see also Medical Center Policy No. 0242 ("Clinicians Wellness Program"). If the Member or Non-member refuses to undergo the examination, his/her Clinical Privileges shall be automatically inactivated 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 Clinicians' Wellness Program Any time limit

for action by the Credentials Committee, as specified in Section 8.4 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 and staff members 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 arrange for the evaluation by the Clinical Wellness Program 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 Clinicians' Wellness Program and/or the Faculty and Employee Assistance Program or any successor program thereto.

The Credentials Committee may also require periodic monitoring after completion of any evaluation treatment/ or 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 8.4 or 8.5 automatic relinquishment 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 others working with the affected practitioner and to aid the Member or Non-member in retaining or regaining optimal professional functioning. Non-member

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 8.4 or 8.5, as appropriate, below. Additionally, the Credentials Committee shall adhere to any state or federal statutes or regulations containing mandatory reporting requirements.

8.4 INITIATING EVALUATION AND RECOMMENDATION FOR FORMAL CORRECTIVE ACTION

8.4.1 Investigation

Upon receipt of the request for initiation of formal 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 IX, 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 forty (40) days of the receipt of the request for initiation of investigation, the Credentials Committee shall report to the Clinical Staff Executive Committee on the progress of the investigation and the estimated time required to complete the investigation. In most instances, the investigation shall not last longer than ninety (90) days. However, for good cause, the Chair of the Credentials Committee may ask the Clinical Staff Executive Committee to extend the time for completion of the investigation. At the completion of the investigation, the Chair of the Credentials Committee shall submit to the Clinical Staff Executive Committee the Credentials Committee's findings and recommendations resulting from the investigation.

The Clinical Staff Executive Committee may accept, reject or modify the findings and recommendations of the Credentials Committee and recommend to the MCOB approval of a final action. The Member and the Department Chair to which the Member is assigned shall be notified in writing of the recommendation of the Clinical Staff Executive Committee.

8.4.2 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;
- E. Recommending suspension or revocation of Clinical Staff membership;
- F. Recommending concurrent monitoring or retrospective auditing;
- G. Requiring additional training;
- H. Requiring evaluation by a clinician assessment organization or individual; or
- I. 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 IX of these Bylaws.

8.4.3 Cooperation with Investigation

All Members and Non-members shall cooperate as necessary for the conduct of any investigation.

8.5 PRECAUTIONARY SUMMARY SUSPENSION

Whenever the conduct of a Member or a Non-member who has been granted Clinical Privileges reasonably appears to pose a threat that requires that action be taken to protect the health, life or safety of patients or prospective patients, or any other person in or associated with the Medical Center, or whenever the conduct of a Member or a Non-member who has been granted Clinical Privileges reasonably appears to pose a substantial harm to the life, health and safety of any patient, prospective patient, or staff member then in any such event the President, the Chair of the Credentials Committee, the Department Chair, 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 and to the, the Department Chair and the Division Head, if applicable, to which the Member is assigned. The Chief Executive Officer, the Clinical Staff Executive Committee, and President of the Clinical Staff shall also be promptly notified. 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 IX with respect to Members and Non-members who are Physicians and Dentists only. An alternative fair hearing and appeal plan is available for Non-members who are not Physicians or Dentists and for AHPs as noted in Section 9.5.1. Unless otherwise indicated by the terms of the summary restriction or suspension, the Clinical Department Chair or his/her designee shall assign the patients of the Member or Non-member in question to another Member. Should the member or Non-member who is subject to a precautionary summary suspension, upon being notified of the suspension, decide to voluntarily request inactivation of his/her privileges during the duration of the investigation required by 8.4.1, the precautionary summary suspension may be voided and withdrawn at the direction of the President of the Clinical Staff. A request for voluntary inactivation of privileges must be submitted in writing to the President within three business days of notification regarding precautionary summary restriction or suspension.

8.5.1 PROCEDURE FOR MEMBERS

No later than 30 days after the date of the precautionary summary suspension and if the precautionary summary suspension still remains in effect, the Chair of the Clinical Staff Executive Committee shall designate a panel of its members to convene for review and consideration of the action; provided, however, that the Clinical Staff Executive Committee may extend the 30 day period for review for good cause if so requested by either the Member or the Chair of the Credentials Committee. Upon request and on such terms and conditions as the panel of the Clinical Staff Executive Committee may impose, the Member may attend and make a statement concerning the issues that led to the precautionary summary suspension, although in no event shall any meeting of the panel of the Clinical Staff Executive Committee, with or without the Member, constitute a "hearing" within the meaning of Article IX, nor shall any procedural rules apply except those adopted by the panel of the Clinical Staff Executive Committee. The panel of the Clinical Staff Executive Committee may recommend to the Clinical Staff Executive Committee that the summary restriction or suspension be modified, continued or terminated. The Clinical Staff Executive Committee shall consider this recommendation at its next scheduled meeting and shall furnish the Member with written notice of its decision.

Unless the Clinical Staff Executive Committee terminates the summary restriction or suspension within fourteen (14) working days of such restriction or suspension, the Member shall be entitled to the procedural rights afforded by Article IX of these Bylaws.

8.5.2 PROCEDURE FOR NON-MEMBERS

When a Non-member's Clinical Privileges are summarily suspended pursuant to Section 8.5 the Non-member shall be notified in writing of the restriction or suspension and the grounds for the suspension. The Chair of the Credentials Committee shall refer the matter to the Credentials Committee at its next scheduled meeting. The Non-member, who is not a Physician or a Dentist, shall not be entitled to the procedural rights afforded by Article IX of the Bylaws. An alternative fair hearing and appeal plan is available for Non-members who are not Physicians or Dentists and for AHPs, as noted in Section 9.5.1

8.6 AUTOMATIC ACTIONS

The Member's or Non Member's clinical privileges or Clinical Staff membership may be subject to automatic actions as follows:

8.6.1 CHANGE IN LICENSURE

8.6.1.1 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.

8.6.1.2 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.

8.6.2 Change in DEA Certificate Status

8.6.2.1 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.

8.6.2.2 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.

8.6.3 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, and prior acts coverage for the uninsured period, such individual's Clinical Privileges shall be automatically terminated.

8.6.4 FEDERAL PROGRAM EXCLUSION

If a Member or 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.

8.6.5 LOSS OF FACULTY APPOINTMENT OR TERMINATION OF EMPLOYMENT

If a Member's or Non-member's faculty appointment in the School of Medicine or contract with UPG is terminated for any reason or for any length of time, his/her membership and Clinical Privileges shall be automatically revoked or suspended as of the date such loss of faculty appointment or termination of UPG contract becomes effective. Loss of faculty appointment or termination of UPG contract shall not give rise to a hearing under Article IX as such appointment is a prerequisite being granted clinical privileges. Due process procedures applicable to contesting the loss of a faculty appointment are set forth in the University of Virginia Faculty Handbook. In the case of AHP's, if Medical Center employment or UPG employment is terminated for any reason or any length of time, his/her Clinical Privileges within the Medical Center shall automatically be revoked or suspended as of the date of such termination. Loss of privileges due to such termination shall not give rise to a hearing appeal under Article 9.5. Due process procedures applicable under these circumstances are specified by applicable Medical Center HR Policy or UPG contract.

8.6.6 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 or fails to complete the evaluation, treatment, rehabilitation program or does not comply with

the required monitoring as required by Section 8.3 of these Bylaws, such failure or refusal shall result in automatic suspension of the Clinical Privileges of the Member or Non-member. Refusal to comply with health screening and/or infection control policies shall also result in automatic inactivation of Clinical Privileges.

8.6.7 MATERIAL MISREPRESENTATION ON APPLICATION/REAPPLICATION

Whenever a Member or Non-member has made a material misrepresentation on the application/reapplication for Clinical Privileges, the application/reapplication processing will stop (if still in progress) or membership and/or privileges will be automatically inactivated if they have already been granted prior to discovery of the material misrepresentation.

8.6.8 FAILURE TO COMPLY WITH MEDICAL RECORDS COMPLETION REQUIREMENTS

Whenever a Practitioner has failed to comply with the medical records completion requirements per [Medical Center Policy No. 0094 \(“Documentation of Patient Care \(Electronic Medical Record\)”\)](#), the Practitioner may have his/her membership and/or Clinical Privileges inactivated until he/she is compliant with those requirements.

8.6.9 FAILURE TO BECOME BOARD CERTIFIED OR FAILURE TO MAINTAIN BOARD CERTIFICATION

The Clinical Privileges of a Practitioner who fails to become board certified or to maintain board certification shall be inactivated, unless the Practitioner has been granted an exception to these requirements by the Credentials Committee under the process outlined in Medical Center Policy No. 0221 (“Board Certification Requirements for Medical Center Physicians”).

8.6.10 CONVICTION OF A FELONY OR OTHER SERIOUS CRIME

Conviction of a crime as set out in Va. Code Section 37.2-314 shall result in automatic suspension of Clinical Privileges and inactivation of Clinical Staff membership.

8.6.11 ARTICLE IX INAPPLICABLE

When a Member’s or Non-member’s privileges are restricted pursuant to any of the circumstances set out in this Section 8.6 , the hearing and appeal rights of Article IX 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.

8.6.12 CLINICAL PRIVILEGES AND CLINICAL STAFF MEMBERSHIP LINKAGE

Except when explicitly stated otherwise in these Bylaws, the automatic inactivation of clinical privileges also results in automatic inactivation of Clinical Staff Membership.

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

9.1 GENERAL PROVISIONS

The provisions of Article IX do not apply to those actions specified in Section 8.6 or to the informal actions specified in Section 8.2 of Article VIII.

Non-members who are not Physicians, Clinical Psychologists or Dentists shall be governed by the procedures set out in Section 9.5 below.

9.1.1 Right to Hearing and Appellate Review

- A. When any Member, or a Non-member who is a Physician or Dentist, receives notice of a recommendation of the Clinical Staff Executive Committee that, if approved by 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 Chair or Vice Chair of 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 IX to assure that the affected Member is accorded all rights to which he or she is entitled.

9.1.2 Exhaustion of Remedies

If Adverse Action described in Section 9.2 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 IX, the term "Member" may include "Applicant", as appropriate under the circumstances.

9.2 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 or Revocation of Clinical Staff Membership;

- D. Denial of requested Clinical Privileges (excluding Temporary Privileges) for a Member;
- E. Involuntary reduction of current Clinical Privileges for a Member;
- F. Suspension of Clinical Staff Membership or Clinical Privileges for a Member if the duration of the suspension is for greater than 14 days and the reason for the suspension is one of competence or conduct; or
- G. Suspension or Revocation of Clinical Privileges (excluding loss of faculty appointment) for a Member.

Actions described above in this Section that are the result of automatic relinquishment imposed pursuant to Section 8.6 of these Bylaws, shall not be considered an Adverse Action for purposes of Article IX.

9.3 REQUESTS FOR HEARING; WAIVER

9.3.1 Notice of Proposed Action

In all cases in which a recommendation has been made as set forth in Section 9.2, the Chair or Vice Chair of the Clinical Staff Executive 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 Member's notice, (b) reasons for the Adverse Action recommended, including the acts or omissions that form the basis of recommendation and a list of the patients in question if applicable, and (c) his or her rights at such a hearing, including the hearing procedures described in Section 9.4. Such notice shall be sent by hand delivery or certified mail, return receipt requested.

9.3.2 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 Clinical Staff Executive Committee. 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 9.4 through 9.4.8 of Article IX 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 reappoints the Practitioner until the hearing is concluded, or (ii) the Member is reappointed according to final action by the MCOB.

The Credentials Committee and the affected Practitioner shall be parties to the hearing.

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

9.3.4 Notice of Time, Place and Procedures for Hearing

Upon receipt of a request for hearing, the Chair or Vice 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 9.3.5 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.

9.3.5 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 the Chief Executive Officer 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, nor have been involved in the request for corrective action, any subsequent investigative process, or the decision to proceed with corrective action, 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 Chief Executive Officer or designee shall be responsible for performing the duties described in this paragraph.

9.3.6 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.

9.3.7 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 be granted only for good cause.

9.4 HEARING PROCEDURE

9.4.1 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 9.4.2, 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.

9.4.2 The Hearing Officer

The President of the Clinical Staff 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.

9.4.3 The Presiding Officer

The Hearing Entity shall have a presiding officer. If the President of the Clinical Staff appoints a hearing officer pursuant to Section 9.4.2, 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.

9.4.4 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, the cost of the transcript, if any, shall be borne by the party requesting it.

9.4.5 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 9.2 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. 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.

9.4.6 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 IX 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.

9.4.7 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.

9.4.8 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.

9.4.9 Decision of Clinical Staff Executive Committee and MCOB

At its next 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 written 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.

9.4.10 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 provide a copy of the Member's statement to the MCOB and the Chair of the Clinical Staff Executive Committee. 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.

9.4.11 Decision by the Operating Board

- A. At a meeting following receipt of the Member's written appeal statement (or after 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 reach a final decision, 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. The MCOB may also refer the decision back to the Clinical Staff Executive Committee for reconsideration, or remand the matter to the hearing entity for further review. If the matter is remanded to the Hearing Entity for further review and recommendation, such Hearing Entity shall conduct its review within sixty 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. 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, or appellate review.

9.4.12 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.

9.5 HEARING AND APPEAL PLAN FOR NON-MEMBERS

9.5.1 Hearing Procedure

Allied Health Professionals and other Non-members who are not Physicians, Clinical Psychologists or Dentists are not entitled to the hearing and appeals procedures set forth in the Clinical Staff Bylaws. In the event one of these Practitioners receives notice of a recommendation by the Clinical Staff Executive Committee that will adversely affect his/her exercise of Clinical Privileges, the Practitioner and his/her supervising physician, as applicable, shall have the right to meet personally with two Physicians and a Peer assigned by the President of the Clinical Staff to discuss the recommendation. The Practitioner and the supervising physician, as applicable, must request such a meeting in writing to the Clinical Staff Office within 10 working days from the date of receipt of such notice. At the meeting, the Practitioner and the supervising physician, as applicable, must be present to discuss, explain, or refute the recommendation, but such meeting shall not constitute a hearing and none of the procedural rules set forth in the Clinical Staff Bylaws with respect to hearings shall apply. Findings from this review body will be forwarded to the affected Practitioner, CSEC, and the MCOB.

9.5.2 Appeal

The Practitioner and the supervising physician, as applicable, may request an appeal in writing to the CEO within 10 days of receipt of the findings of the review body. Two members of the Clinical Staff assigned by the chair of the CSEC shall hear the appeal from the Practitioner and the supervising physician as applicable. A representative from the Clinical Staff leadership and from Medical Center leadership may be present. The decision of the appeal body will be forwarded to the MCOB for final decision. The Practitioner and the supervising physician will be notified within 10 days of the final decision of the MCOB.

ARTICLE X OFFICERS OF THE CLINICAL STAFF

10.1 IDENTIFICATION OF OFFICERS

The Officers of the Clinical staff shall be:

- A. President
- B. Vice President

10.2 QUALIFICATIONS OF OFFICERS

Officers must be Physician or Dentist 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.

10.3 NOMINATIONS

All nominations for Officers shall be made by the Nominating Committee (which is described in Article XIII 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.

10.4 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.

10.5 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.

10.6 VACANCIES IN OFFICE

If there is a vacancy in the office of the President, the Vice President shall serve during the vacancy. If there is a vacancy in the office of the Vice President, the Clinical Staff Executive Committee shall appoint an Active Member of the Clinical Staff to serve as Vice President 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.

10.7 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, 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 (see, for example, Medical Center Policy No. 0013 "Interactions with Vendors, Sales and Service Representatives").

10.8 DUTIES OF OFFICERS

10.8.1 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 The Joint Commission 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.

10.8.2 Duties of the Vice President

The Vice President 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 Vice President shall assume all the duties and have the authority of the President. The Vice President 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 XI CLINICAL STAFF EXECUTIVE COMMITTEE

11.1 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 to:

- 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, 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;
- M. Develop a procedure for managing such conflict as may arise between the Clinical Staff and the Clinical Staff Executive Committee on issues related to the adoption of or amendment to Clinical Policies of the Medical Center;
- N. Notify Members of the Clinical Staff of its adoption of or amendment to Clinical Staff Policies of the Medical Center, and
- O. Perform such other duties as may be assigned to it by the MCOB.

11.2 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
- Vice President of the Clinical Staff
- Chief Executive Officer of the Medical Center
- Chief Medical Officer of the Medical Center
- Chief Nursing Officer of the Medical Center
- Chief of Quality and Performance Improvement
- Dean of the School of Medicine
- Designated Institutional Officer for Graduate Medical Education

- Chairs of the Departments of the Medical Center
- Chair, Children’s Hospital Clinical Practice Committee
- Five (5) Clinical Staff Representatives selected by the Clinical Staff and AHPs as provided in Section 11.3
- President of the Nursing Staff

In addition, the President(s) of the GME Executive Council, the Associate VP for Hospital and Clinic Operations, and the Chief Medical Officer of University of Virginia Transitional Care Hospital Post-Acute Division shall serve on the Clinical Staff Executive Committee as a non-voting, ex-officio member(s). When the Department Chair is unable to attend a CSEC meeting, the Deputy may attend and vote in place of the Department Chair. The Deputy will count in establishing a quorum.

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.

11.3 SELECTION OF THE CLINICAL STAFF REPRESENTATIVES

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

- Primary Care (drawn from General Internal Medicine, General Pediatrics, 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, Orthopedic 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)
- AHP Representative (drawn from AHP’s with UVAMC privileges)

All Clinical Staff Representatives, excluding the AHP representative, shall be Active Members of the Clinical Staff in Good Standing, but may not be Department 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 Representatives 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 or AHP shall vote for one nominee from the area applicable to their specialty. The nominees receiving the most votes in each of the five (5) enumerated areas shall become the Clinical Staff Representatives 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-third (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.

11.4 MEETINGS OF THE CLINICAL STAFF EXECUTIVE COMMITTEE

The Clinical Staff Executive Committee shall meet at least (10) times per year 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 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 who is not a deputy may attend a meeting for purposes of information sharing but may not vote by proxy and will not count in the quorum.

11.5 DUTIES OF THE CHAIR OF THE CLINICAL STAFF EXECUTIVE COMMITTEE

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

- A. Set the agenda for meetings of the Clinical Staff Executive Committee;
- B. Preside at the meetings of the Clinical Staff Executive Committee;
- C. 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;
- D. Report as appropriate to the Clinical Staff on the activities of the Clinical Staff Executive Committee;
- E. In conjunction with the Chief Executive Officer, appoint individuals to serve on the Clinical Staff Committees described in Article XIII or otherwise created by the Clinical Staff Executive Committee; and
- F. Report to the MCOB, as required, on the activities of the Clinical Staff Executive Committee and the Clinical Staff.

11.6 DUTIES OF THE VICE CHAIR OF THE CLINICAL STAFF EXECUTIVE COMMITTEE

The Vice President 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 each 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.

11.7 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.

11.8 DELEGATING AND REMOVING AUTHORITY OF THE CLINICAL STAFF EXECUTIVE COMMITTEE

The Clinical Staff may from time to time propose the delegation of additional duties to the Clinical Staff Executive Committee and/or the removal of any of the duties specified in Article XI for which the Clinical Staff Executive Committee is responsible whenever the Active Clinical Staff votes at a special meeting of the Clinical Staff called for such purpose to approve such proposals as provided in this Section.

- A. Any Member of the Active Clinical Staff may propose the delegation of additional duties to the Clinical Staff Executive Committee and/or the removal of any of the duties specified in Article XI for which the Clinical Staff Executive Committee is responsible by notifying the President of the Clinical Staff, in writing, of the proposal.
- B. Upon receipt of the proposal the President will seek legal review of the proposal to ensure legal sufficiency and compliance. Any changes necessitated by law or regulation shall be made to the proposal.

- C. Once the legal review is complete, the Clinical Staff Office shall circulate the proposal to all members of the Active Clinical Staff for review.
- D. In accordance with the provisions of Article XIV of these Bylaws, if not less than fifteen percent (15%) of the Active Clinical Staff request a special meeting to consider any proposal to delegate additional duties to the Clinical Staff Executive Committee and/or to remove any of the duties specified in Article XI for which the Clinical Staff Executive Committee is responsible, the President shall call a special meeting of the Clinical Staff. If not, any such proposal shall not proceed
- E. A quorum for any such special meeting of the Clinical Staff shall be as provided in Section 14.3 of these Bylaws. If a quorum is present at the special meeting, any decision to add or remove any duties of the Clinical Staff Executive Committee shall require a majority vote in favor of the proposal by those Active Clinical Staff present at the special meeting.
- F. Any such proposal to add or remove any of the duties of the Clinical Staff Executive Committee shall also require the approval of the Medical Center Operating Board.

ARTICLE XII CLINICAL DEPARTMENTS

12.1. 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 or an employment contract with UPG 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 12.6. 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 12.9.
- 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.

12.2 Current Departments

12.2.1 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) Orthopedic 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

12.2.2 Other Clinical Enterprises

For purposes of these Bylaws, Community Medicine and Regional Primary Care shall be treated as “Departments.” The Chief Medical Officer 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 EVPHA on behalf of 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 EVPHA on behalf of the MCOB shall designate the person to serve as “Chair.”

12.3 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 in two Departments, the Chairs from each Department shall sign off on the faculty appointment and recommendation of Clinical Privileges.

12.4 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 the clinical functions of the Department;

- K. Formulating recommendations for Departmental or Division rules and regulations reasonably necessary for the proper discharge of its clinical responsibilities, subject to compliance with Medical Center policies; and
- L. Encouraging the continuing education of Members of the Clinical Staff in the Department.

12.5 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 and be accountable to the Dean and shall also be accountable to the Clinical Staff Executive Committee and the MCOB for all clinical matters in his or her Department.
- B. For purposes of these Bylaws, the Chair for Community Medicine shall be the Chief Medical Officer, and the Chair for Regional Primary Care shall be its Medical Director. The Chief Medical Officer and the Regional Primary Care Medical Director shall have the same responsibilities as to Department Chairs set forth in these Bylaws or the Credentials Manual with respect to Community Medicine and Regional Primary Care.

12.6 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 and the MCOB regarding all professional, clinical and appropriate 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, and procedures, 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, 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, the MCOB, or the MCOB Quality Subcommittee;
- I. Monitor the quality of patient care and outcomes of 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, the MCOB, or the MCOB Quality Subcommittee;
- N. 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 use of informatics to support practice;

- 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;
- R. Assess and recommend to the Medical Center resources such as space, number of clinical staff Members, and contract services needed to provide for patient care or treatment;
- S. Integrate the Department into the primary functions of the Medical Center to include coordination and integration of interdepartmental and intradepartmental services; and
- T. 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, the MCOB, or the MCOB Quality Subcommittee.

12.7 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.

12.8 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 diplomats of their specialty Board or be equivalently qualified.

12.9 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 outcomes for quality and performance improvement, all as part of the Peer Review process;
- C. Evaluate the quality of clinical work performed and outcomes for 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, the MCOB, the MCOB Quality Subcommittee, 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.

12.10 Medical Directors

The Medical Director coordinates, directs and evaluates all aspects of patient care rendered by the Licensed Independent Providers (faculty, nurse practitioners, and physician assistants) and GME trainees in the assigned Service area. In collaboration with other clinical departments and operational manager, the Medical Director oversees the care of patients being treated in assigned service area.

The Medical Director partners with the Medical Center manager to serve as co-leader of the Unit Based Clinical Leadership (UBL) team for their service area.

12.11 Duties of the Medical Directors

Medical director responsibilities include: regularly attending and leading weekly UBL team and leadership meetings, participating in unit-based patient reviews to identify opportunities for improvement, and have peer to peer dialogues with colleagues as required by Medical Center Policy 0262, "Standards for Professional Behavior", including the investigation and analysis of adverse events, clinical errors, and incidents, utilizing the institution's Be Safe program and methods.

Departments and Medical Directors are expected to work together to accomplish the goals of the UVAMC and the Health System.

**ARTICLE XIII
CLINICAL STAFF STANDING COMMITTEES**

13.1 STRUCTURE

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

13.1.1 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 maintain minutes of each meeting and shall report its activities to the Clinical Staff Executive Committee by submitting a written report on an annual basis 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.

13.1.2 Membership

The membership of the Clinical Staff Committees may consist of Members, Allied Health Professionals, Medical Center 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.

13.1.3 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.

13.1.4 Quorum, Voting and Meetings

A quorum for each Clinical Staff Executive Committee shall be thirty percent (30%) of the members currently serving, unless the decision involves privileging, and/or corrective action of an individual Practitioner or governance in which the quorum shall be fifty-one percent (51%). All voting and decisions ordinarily shall occur in meetings of the Clinical Staff Committees, 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 four (4) times per year, or as otherwise defined in these Bylaws, and as otherwise called by the chair of the Clinical Staff Committee.

13.1.5 Subcommittees

Each Standing Committee may, with the approval of the Clinical Staff Executive Committee, form Subcommittees or Task Forces as appropriate to carry out the charge of the Standing Committee. All such groups shall be considered Committees of the Clinical Staff.

The chair of each Subcommittee shall report its activities to the appropriate Clinical Staff Committee by submitting a written report on an annual basis and maintaining minutes with attendance for each meeting. Subcommittees shall meet at least four (4) times per year and as otherwise called by the chair of the Subcommittee.

13.2 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 a biannual 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 annually. The President of the Clinical Staff shall serve as Chair of the Bylaws Committee. Only Members of the Clinical Staff serving on the Bylaws Committee shall be eligible to vote on Bylaws Committee matters.

The Bylaws Committee has the power to adopt revisions that are, in its judgement, non-substantial modifications for the purpose of clarifying, reorganizing or updating references, or to correct titles, punctuation, spelling or errors of grammar or expression.

13.3 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. When appropriate, the Credentials Committee shall interview a Member or Applicant and/or the Chair of the involved Department in order to resolve questions about appointment, reappointment, or change in 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 authority to amend the Credentials Manual. The Credentials Committee shall also serve as the investigatory body for all matters set forth in Article VIII of these Bylaws. The Credentials Committee shall also independently assess the departmental Peer Review process for Members of the Clinical Staff and for Allied Health Professionals in order to ensure that data related to qualifications and performance of individual Practitioners is collected,

regularly assessed, compared to Peers, and acted upon by the Department in a timely manner. When appropriate, the Credentials Committee shall also refer Practitioners to the Physician Wellness Program or Employee Assistance Program, and shall work with these programs to determine appropriate privileges for each Practitioner's individual circumstances. The Vice President 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.

13.4 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.

13.5 CANCER COMMITTEE

The Cancer Committee oversees the cancer care delivered within the Medical Center and reports to the Clinical Staff Executive Committee. The Committee promotes a coordinated multidisciplinary approach to patient care management and ensures that an active, supportive care system is in place for patients, families and staff, and will follow the requirements outlined in the most current American College of Surgeons Commission on Cancer Program Standards.

13.6 ETHICS COMMITTEE

The Ethics Committee is an interdisciplinary committee charged with assisting leadership in ensuring consistency between mission and values, organizational behaviors and clinical practice. It has three primary functions, which include conducting education on ethical issues, recommending policies that are ethically important and conducting case reviews with respect to ethical issues.

13.7 GRADUATE MEDICAL EDUCATION COMMITTEE

The Graduate Medical Education Committee oversees all aspects of GME training and patient care practices within the Medical Center. It ensures that each GME Trainee program provides quality educational experiences and meets the requirements set forth in the ACGME Institutional, Common and individual program requirements. Further, the Committee monitors and coordinates issues applicable or common to all programs, such as those raised by external accreditation agencies (AMA, AAMC, ACGME, and NRMP).

13.8 CHILDREN'S HOSPITAL CLINICAL PRACTICE COMMITTEE

The UVA Children's Hospital Practice Committee is an interdisciplinary committee charged with coordination and implementation of the Plan for Provision of Care for children in both the inpatient and outpatient setting. This Committee addresses clinical practice issues that extend beyond the scope of practice for a single professional discipline (e.g., pediatric medicine and

surgery, nutrition, nursing, pharmacy, therapies, social work, etc.) in all settings across the continuum of care. The Committee is responsible for review, coordination, and submission of policies and practices that directly impact all aspects of the clinical and family-centered care of children. The Committee provides organizational guidance regarding faculty, staff, Graduate Medical Trainee, nursing, and other clinician training and competency for the clinical care of children.

13.9 OPERATING ROOM COMMITTEE

The Operating Room Committee is an interdisciplinary committee charged to coordinate and standardize the care of patients undergoing surgical or other invasive procedures. This Committee oversees clinical practice related to Pre, Peri and Post procedure care. It has the authority to establish clinical procedure and policy within the Medical Center Operating Rooms and recommend policy related to those procedures outside of the Operating Room. It works collaboratively with other Committees to monitor and improve care and ensure patient safety.

13.10 CLINICAL INFORMATION TECHNOLOGY OVERSIGHT COMMITTEE

The Clinical Information Technology Oversight Committee (CITOC) is charged with providing clinical oversight for the continued development of a comprehensive, integrated clinical information system for the University of Virginia Medical Center. CITOC will make recommendations about the use and functionality of all current and future information systems that support clinical care. This will include but not be limited to Epic applications, MedHost, PACS and other clinical information systems. This oversight will assure that system change requests, enhancement requests and deployment across systems promotes integrated work and information flows throughout the clinical areas. The Committee will lead the design of processes and programs which strategically use clinical information systems to transform and continually improve the way clinical care is rendered with the primary purposes of enhancing patient safety, improving the quality of care and outcomes, facilitating clinical education and clinical research. Secondary goals are to improve efficiency and reduce the cost of care.

13.11 PATIENT CARE COMMITTEE

The Patient Care Committee is an interdisciplinary committee charged with coordination and implementation of the Plan for Provision of Care for both the inpatient and outpatient setting. This Committee addresses clinical practice issues that extend beyond the scope of practice for a single professional discipline (e.g., medicine, nutrition, nursing, pharmacy, therapies, social work, etc.) in all settings across the continuum of care.

13.12 QUALITY COMMITTEE

The Quality Committee is responsible for defining, prioritizing, overseeing and monitoring the performance improvement activities, including patient and environmental safety, within the Medical Center. The primary duties of the Quality Committee include analyzing and aggregating institutional performance data, monitoring performance improvement efforts for effectiveness, and making recommendations to the Patient Care Committee and the Clinical Staff Executive Committee for changes in clinical practice and to Medical Center Executives for changes in operations. The Quality Committee coordinates the acquisition of performance

improvement information from Regional and Departmental teams to improve organizational performance.

13.13 PATIENT SAFETY COMMITTEE

The Patient Safety Committee is an interdisciplinary committee charged with the coordination and implementation of programs for ensuring patient safety within the Medical Center, including directing and overseeing proactive risk reduction and patient safety. This Committee conducts a survey of clinical and medical center staff to identify areas for improvement in the understanding of patient safety principles and actions. The Patient Safety Committee evaluates trends from quality reports, adverse event analysis and other sources and recommends appropriate actions to improve patient safety throughout the medical center.

13.14 PATIENT GRIEVANCE COMMITTEE

The Patient Grievance Committee provides oversight to the processes set forth in [Medical Center Policy No. 0070](#) (“Patient Concerns and Grievances”), and assures compliance with all other applicable laws and regulations. The Committee identifies trends and patterns in grievances and recommends corrective action when indicated. The Patient Grievance Committee reports matters of significance to the Quality Subcommittee of the Medical Center Operating Board.

13.15 PHARMACY AND THERAPEUTICS COMMITTEE

The Pharmacy and Therapeutics Subcommittee is an interdisciplinary committee charged with the institutional oversight of the use of pharmaceutical and other therapeutic products. This Committee reports to the Clinical Staff Executive Committee and is authorized to develop and maintain a Medical Center formulary that is financially responsible and clinically effective.

13.16 OTHER COMMITTEES

The Chief Executive Officer and the President of the Clinical Staff may designate such other standing committees of the Clinical Staff Executive Committee 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 13.1. In addition, the Medical Center may create, from time to time, any committees deemed necessary.

ARTICLE XIV MEETINGS OF THE CLINICAL STAFF

14.1 REGULAR MEETINGS

Regular meetings of the Clinical Staff shall be held at a time mutually determined by the President and the Chief Executive Officer. 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.

14.2 SPECIAL MEETINGS

The President or Vice President 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.

14.3 QUORUM

Except as otherwise provided herein where a higher quorum is required, 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 except as otherwise provided herein.

14.4 ATTENDANCE REQUIREMENTS

Each Member of the Active Clinical Staff 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. The Honorary Clinical Staff are encouraged to but are not required to attend.

14.5 ACTION BY ELECTRONIC MEANS

Unless otherwise required by these Bylaws, whenever these Bylaws require the vote of or action by the Clinical Staff or by the Clinical Staff Executive Committee, such vote or action may be taken by electronic means.

ARTICLE XV CONFIDENTIALITY, IMMUNITY, AND RELEASES

15.1 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.

15.2 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.

15.3 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.

15.4 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 facilities or organization's activities concerning, but not limited to:

- A. The 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 revocation or 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 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.

15.5 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 XVI
AMENDMENT OF BYLAWS AND CLINICAL POLICIES**

16.1 AMENDMENT OF BYLAWS

The Allied Health Professional Credentialing Manual is part of the Clinical Staff Bylaws and shall have the same option and amendment process as these Bylaws.

16.1.1 Annual Update

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

16.1.2 Proposals to the MCOB

The Clinical Staff shall have the ability to adopt Bylaws, and amendments thereto, and to propose them directly to the MCOB as provided in these Bylaws.

16.1.3 Process for Amendment

- A. Consideration shall be given to amendment of these Bylaws upon the request of the President, the Vice President, the Chief Executive Officer, the Clinical Staff Executive Committee, the MCOB, upon a written petition signed by at least ten percent (10%) of the Active Clinical Staff 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 review and approve, disapprove, or offer modification, as appropriate.
- C. In the event the Clinical Staff Executive Committee does not approve a request for amendment of the Bylaws that is requested by at least ten percent of the Active Clinical Staff members seeking the amendment may ask the President of the Clinical Staff to present the request for amendment to the MCOB. The President of the Clinical Staff shall present the petition seeking amendment of the Bylaws to the MCOB at the next scheduled meeting of the MCOB. The MCOB shall review the petition and approve, disapprove, or modify the request for amendment of the Bylaws.
- D. Any amendment(s) to the Bylaws adopted by the Clinical Staff Executive Committee shall be submitted to the Active Clinical Staff and the MCOB for review and approval, disapproval or modification, as appropriate.
- E. A minimum of fifty (50) Members of the Active Clinical Staff shall vote in favor or against any proposed amendments to the Bylaws. In order to approve amendments to the Bylaws, a majority of those members of the Active Clinical Staff who vote must vote in favor. Any vote regarding amendments to the Bylaws may be by electronic means.

16.1.4 Review and Action by the MCOB

Proposed Bylaws or amendments shall become effective when approved by the MCOB or on another date as mutually agreed to by the MCOB and Clinical Staff Executive Committee. In the event proposed Bylaws or amendments are not approved or are substantially changed upon MCOB review, such Bylaws or amendments shall be referred to the Bylaws Committee, which shall attempt to resolve the differences among the Clinical Staff or the Clinical Staff Executive Committee and the MCOB. The Clinical Staff, Clinical Staff Executive Committee, or the MCOB may not unilaterally amend these Bylaws.

16.2 Proposing, Adopting and Amending Clinical Policies of the Medical Center

In addition to the policy and procedures set forth in [Medical Center Policy No. 0001](#) (“Medical Center Policy on Policy Development, Review and Approval”) regarding the adoption of or amendment to Medical Center policies, the Clinical Staff may from time to time propose the adoption of or amendment to clinical policies of the Medical Center whenever the Active Clinical Staff votes at a special meeting of the Clinical Staff called for such purpose to approve such proposals as provided in this Section 16.2.

- A. Any Member of the Clinical Staff may propose the adoption of a new Medical Center clinical policy or the amendment of a current Medical Center clinical policy by notifying the President of the Clinical Staff, in writing, of the proposed policy or policy amendment.
- B. Upon receipt of the proposed policy or policy amendment, the President will seek legal review of the proposal to ensure legal sufficiency and compliance. Any changes necessitated by law or regulation shall be made to the proposed policy or policy amendment.
- C. Once the legal review is complete, the Clinical Staff Office shall circulate the proposed policy or policy amendment to all members of the Active Clinical Staff for review.
- D. In accordance with the provisions of Article XIV of these Bylaws, if not less than ten percent (10%) of the Active Clinical Staff request a special meeting to consider the policy or policy amendment, the President shall call a special meeting of the Clinical Staff. If not, the policy or policy amendment shall not proceed.
- E. A quorum for any such special meeting of the Clinical Staff shall be as provided in Section 14.3 of these Bylaws. If a quorum is present at the special meeting, and a majority of the Active Clinical Staff present at the special meeting approves the proposed policy or policy amendment, then the proposal shall be submitted to the Committee of the Clinical Staff (e.g., Credentials Committee, Quality Committee, Patient Care Committee, etc.) that is responsible for the clinical area to which the proposal relates in accordance with Medical Center Policy No. 0001.
- F. If the appropriate Clinical Staff Committee approves the proposed policy or policy amendment, it shall be forwarded to the Clinical Staff Executive Committee for proposed adoption in accordance with the provisions of Medical Center Policy No. 0001.

16.3 Distribution of Bylaws

Each Member shall be provided with on-line access to these Amended and Restated Clinical Staff Bylaws. If at any time amendments are made to the Bylaws, each Member shall be notified and provided with on-line access to such amendments.