

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

The Honorable KISTY Lea Harrington, Circuit Court Judge

RECEIVED

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Case No 2010-CP-10-3410

SC Court of Appeals

Dr Cynthia Holmes, M D

Appellant,

v

East Cooper Community Hospital, Inc ,
Tenet HealthSystem Medical, Inc ,

Respondents

RECORD ON APPEAL

Vol 3 of 3

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day after the expiration of the prescribed time period and shall continue until the medical records in issue are satisfactorily completed. The suspension may be terminated by the joint action of the Administrator and the Chief of Staff if they or their designees determine that failure to timely complete the records was justified (e.g., illness or other circumstances beyond the control of the affected Practitioner) or upon the request of the suspended Practitioner the Chief of Staff may temporarily lift the suspension only if the Chief of Staff as the designee of the MEC determines that an emergency exists in which the health and safety of any patient will be jeopardized by failure to allow the Practitioner to treat that patient. With the exception of emergency care for which only the Practitioner is qualified and available and the care of patients already hospitalized at the time of the suspension, such temporary suspension shall include all admitting and clinical privileges, as well as the scheduling of elective operations, assisting at elective operations and deliveries. Unverified emergency admissions shall not be used to bypass such suspension. Failure to complete the medical records within sixty (60) days of suspension shall be deemed a voluntary resignation from the Medical Staff and the voluntary relinquishment of all clinical privileges. Practitioners whose clinical privileges are automatically suspended or who have been deemed to have voluntarily resigned from the staff pursuant to this Section shall not be entitled to the hearing and appeal rights under these Bylaws.

B Licensure Whenever a Practitioner's license to practice in this state is revoked, not renewed, restricted, suspended, voluntarily or involuntarily relinquished or made subject to any probationary provisions by the licensing agency, the Practitioner's staff membership and clinical privileges shall automatically terminate upon receipt by the hospital of notice thereof. If a Practitioner's license to practice is made subject to probationary terms by the licensing agency, the Practitioner's privileges and membership shall automatically become subject to the terms of probation, subject to review by the MEC and approval by the Governing Body. Action automatically imposed under this Section does not entitle the practitioner to the hearing and appeal rights provided under Article VIII of these Bylaws.

C Drugs/Medication A temporary automatic suspension of a Practitioner's privileges to prescribe or obtain controlled substances or other medications at or through the hospital or any of its facilities shall be immediately imposed by the Administrator upon the receipt by the hospital of notice that such Practitioner's right or license to prescribe or obtain controlled substances or medications has been suspended, revoked or otherwise restricted by the applicable governmental agency. Such automatic suspension shall include only those controlled substances or medications suspended or revoked by the governmental agency and shall be effective until the governmental agency reinstates the Practitioner's right or license in question, unless the MEC determines otherwise and so notifies the affected Practitioner. If a Practitioner's right or license to prescribe or obtain controlled substances or medications is subject to an order of probation, the Practitioner's privileges to prescribe or obtain controlled substances or other medications at or through the hospital or any of its facilities shall automatically become subject to the terms of the probation effective upon and for at least the term of the probation. An affected Practitioner shall not be permitted to prescribe medications under the hospital's

DEA number. Action imposed under this Section does not entitle the Practitioner to the hearing and appeal rights under these Bylaws.

D Loss of Malpractice Insurance If a Practitioner fails to maintain professional liability insurance as required by the Governing Body or fails to provide evidence of such coverage, the Practitioner's membership and clinical privileges, after written warning of delinquency, shall be automatically suspended and shall remain so suspended until the Practitioner provides evidence to the MEC that he has secured the required professional liability coverage. Failure to provide such evidence within sixty (60) days after the date the automatic suspension became effective shall be deemed a voluntary resignation from the Medical Staff. A Practitioner whose clinical privileges are automatically suspended or who has been deemed to have voluntarily resigned from the Medical Staff pursuant to this Section may request a meeting to discuss the matter informally with the MEC or its designee, but the practitioner shall not be entitled to the hearing and appeal rights under these Bylaws.

E Felony Conviction A Practitioner who has been convicted or pled "guilty" or "no contest" or its equivalent to a felony in any jurisdiction shall be automatically suspended. Such suspension shall become effective immediately upon such conviction or plea regardless of whether an appeal is filed. Such suspension shall remain in effect unless and until the matter is resolved by subsequent recommendation by the MEC and action by the Governing Body or through corrective action, if necessary.

F Quality/Performance Improvement and Peer Review Inquiries Practitioners have an obligation to timely and satisfactorily respond to inquiries from Medical Staff committees and their designees on issues relating to the Practitioner's qualifications, character, behavior, ethics, health status in terms of the practitioner's ability to practice in the area in which privileges are sought or have been granted, case management, and the Practitioner's compliance with the Bylaws, rules and regulations, and policies of the Medical Staff and Hospital. Unless provided otherwise in these Bylaws, the Department or committee Chairman shall send a certified letter to the practitioner requesting a response within thirty (30) days. If the Practitioner fails to timely respond, the Chief of Staff shall send a notice advising that failure to comply within seven (7) days shall result in an automatic suspension of membership and all privileges. Such suspension shall continue until the inquiring person or body confirms that a satisfactory response has been received. With the exception of emergency care which only the Practitioner is qualified and available to render, and the care of patients already hospitalized at the time of the suspension, such suspension shall include all admitting and clinical privileges, as well as scheduling of elective operations, assisting in elective operations and deliveries. Unverified emergency admissions shall not be used to bypass such restriction. Failure to satisfactorily comply within sixty (60) days of the date of the suspension shall be deemed a voluntary resignation and relinquishment of all privileges. Action taken pursuant to this Section shall not entitle the affected Practitioner to the hearing and appeal rights of these Bylaws.

G Notice Unless otherwise specified in this Section, the Administrator shall

immediately notify the affected Practitioner and the Chief of Staff in writing either by personal delivery or certified mail of any suspension or termination under this Section. Such notice shall set forth the effective date and the reason for the suspension or termination. By state law the State Board of Medical Examiners shall be notified in writing by the Administrator of the Hospital of any revocation, suspension or limitation of a practitioner's clinical privileges.

H Application to Medical Staff after Termination Unless reinstated by the MEC and the Governing Body, any Practitioner who is terminated from membership or who has clinical privileges terminated and who desires to be admitted to the Medical Staff or granted clinical privileges shall be required to apply for membership and privileges and such application shall be processed as for an initial applicant.

SECTION 5 - OTHER INVESTIGATIONS

Notwithstanding anything in these Bylaws to the contrary, the MEC in its sole discretion may investigate any matter or any Practitioner brought to its attention by anyone and may take any action it deems appropriate, subject to review by the Governing Body. Such investigation shall not be deemed a hearing and may be substantiated as described in Section 2B. The MEC shall act with reasonable promptness and shall be given notice of any action thus taken or recommended within seven (7) days therefrom, to any affected Practitioner and the Administrator. The Practitioner shall only have a right to request a hearing if the action or recommendation falls into one or more of the grounds for a hearing specifically set forth in Article VIII; in such cases, the notice to the affected practitioner shall comply with the notice requirements of Article VIII.

ARTICLE VIII

HEARING AND APPELLATE REVIEW PROCEDURES

SECTION I - GENERAL PROVISIONS, DEFINITIONS, SETTLEMENT

A Duty to Exhaust Remedies The purpose of this Article is to permit the Medical Staff and Hospital to resolve issues related to professional practice and qualifications for Medical Staff membership and clinical privileges fairly, expeditiously and with due regard for both the need to protect patients and the interest of Practitioners. Each applicant and member agrees to follow and complete the procedures set forth in this Article, including appellate procedures, before attempting to obtain judicial relief related to any issue or decision which may be subject to a hearing and appeal under this Article. The absence of an interlocutory appeal process (temporary provisional process) for reviewing any alleged violation of the Bylaws or the affected Practitioner's fair procedure.

rights does not warrant judicial intervention

B For the purposes of this Article, the following definitions shall apply

- 1 **Affected Practitioner** means the Medical Staff member or applicant for membership with respect to whom any of the actions specified in Section 2B below have been taken or recommended and whose membership or privileges may be affected thereby
- 3 **Body Whose Decision Prompted the Hearing** means the person, committee or body (which will generally be the MEC that pursuant to these Bylaws, took the action or made the recommendation that resulted in a hearing being requested
- 3 **Parties or Party** means, unless clearly indicated otherwise by particular context collectively or individually, as the case may be the affected Practitioner the MEC and/or the body whose decision prompted the hearing (if other than the MEC)
- 4 **Notice** means a written communication delivered personally to the required addressee or sent by United States Postal Service first-class postage prepaid certified or registered mail, return receipt requested addressed to the required addressee at his address as it appears in the records of the Hospital Copies shall be as effective as the original for the purpose of giving notice Any such notice shall be deemed effective on the date it was first received or five (5) working days after it was mailed first class postage prepaid, whichever occurs first

C Settlements At any time following receipt of notice of a recommendation or action which would entitle a Practitioner to request a hearing under this Article, the Practitioner may ask the body whose decision prompted the hearing to discuss voluntary settlement or resolution of the matter Upon such request and subject to the Practitioner's waiver of time requirements to allow such discussions to proceed, the MEC may authorize one or more of its members to conduct confidential discussions with the Practitioner provided, the MEC shall not be obligated to conduct such discussions if it concludes the request is interposed primarily for delay or a settlement is not feasible If the Practitioner and the body whose decision prompted the hearing reach a written agreement which could settle the matter the body whose decision prompted the hearing shall promptly notify the Administrator and the Governing Body (Any such written settlement agreement should include an acknowledgment by the Practitioner that he voluntarily waives his hearing and appeal rights under these Bylaws that the settlement is entered into voluntarily and that he will waive all claims relating in any way to the matter against all Medical Staff and Hospital personnel)

SECTION 2 - THE HEARING PROCESS

A Notice of Adverse Action or Recommended Action/Request for Hearing

Whenever any of the actions constituting grounds for a hearing as set forth in Section 2B below has been taken or recommended the person, committee or body causing same to occur shall give notice to the affected Practitioner

The notice shall

- 1 describe what action has been taken or recommended
- 2 state the reasons for the action (a statement of charges will be provided in the event a hearing is properly requested)
- 3 advise the Practitioner of the right to request a hearing and, such request must be in writing and received by the Administrator within thirty(30) days after the affected practitioner's receipt of the Notice of Adverse Action or Recommendation,
- 4 contain a summary of the Practitioner's rights in the hearing,
- 5 state the action if finally adopted, will be reported to the appropriate licensing entity and to the National Practitioner Data Bank (NPDB) as required by law

Whenever the MEC has given notice of action that constitutes grounds for a hearing as described in Section 2B below the affected Practitioner shall have thirty (30) days following the date such notice was given within which to request a hearing. A request for a hearing must be in writing and delivered to the Administrator within the applicable time period set forth above. Failure of the affected Practitioner to request a hearing within the time and in the manner set forth in this subsection shall be deemed an acceptance by the Practitioner of such action or recommendation and a waiver by such party of all hearing and appeal rights under these Bylaws. The matter shall thereupon be forwarded to the Governing Body for its final decision in accordance with Article VIII Section 6F. The Administrator shall give notice to all parties of any such waiver and acceptance.

B Grounds for Hearing Except as otherwise provided in these Bylaws, the taking or recommending of any one or more of the following actions when based on the member's professional conduct or competence unless taken in compliance with a policy decision of the hospital (e.g., closing a department or service or physical plant changes) shall constitute grounds for a hearing pursuant to this Article

1 B Grounds for Hearing Except as otherwise provided in these Bylaws the taking or recommending of any one or more of the following actions when based on the member's professional conduct or competence unless taken in compliance

with a policy decision of the hospital (e.g. closing a department or service or physical plant changes) shall constitute grounds for a hearing pursuant to this Article.

- 1 denial of initial appointment to the Medical Staff
- 2 denial of staff reappointment
- 3 reduction or suspension of staff membership or clinical privileges for more than thirty (30) days
- 4 termination, revocation or reduction of staff, category
- 5 denial or termination of clinical privileges,
- 6 summary suspension of clinical privileges for more than thirty (30) days
- 7 significant consultation or co-admitting requirements other than in compliance with the Medical Staff Bylaws, Rules and Regulations or departmental rules and regulations
- 8 denial of requested advancement in staff category, and
- 9 denial of requested service affiliation, and

C Notice of Hearing

- 1 Upon receipt of a proper request for hearing, the Administrator shall deliver the request to the MEC, stating the date the Administrator received it, then
- 2 the MEC shall, within thirty (30) days after receipt by the Administrator of the request, schedule a date for a hearing, then
- 3 the MEC shall, not less than thirty (30) days prior to the date of the hearing, give notice to the parties of the time, place and date thereof, and shall deliver a copy of these Bylaws and a Statement of Charges as provided in the following paragraph, to the affected Practitioner. The date of commencement of the hearing shall not be less than thirty (30) days from the date of the notice of hearing nor more than sixty (60) days from the date of receipt of the request for a hearing by the Administrator, except when the request is received from a member who is under suspension, the hearing shall commence as soon as reasonably practicable but not later than forty (40) days from the date of receipt by the Administrator of the request for hearing. In such instances the notice of hearing shall be provided within a reasonable time prior to the date of commencement. The parties and the MEC shall cooperate with each other in scheduling additional hearing sessions as necessary to complete the process as soon as practicable.

D Statement of Charges As a part of or together with the Notice of Hearing referred to in the previous paragraph of these Bylaws the MEC shall state the acts or omissions with which the affected Practitioner is charged including if applicable a list of chart numbers under question if any and the reasons for the action or recommendation. The Medical Staff representative at the hearing may make amendments to the statement of charges from time to time, but not later than the close of the case. Such amendments may delete, modify or add to the acts, omissions, charts, or reasons specified in the original notice. Notice of each amendment shall be given to the affected Practitioner, the Hearing Officer and each party. If the affected Practitioner promptly gives written request to the medical review hearing committee he shall be entitled to a reasonable postponement of the hearing to prepare a response or defense to any such amendment that adds acts, omissions, charts or reasons to the original notice. The medical review hearing committee shall give prompt notice to the parties of each such postponement.

E Medical Review Committee (MRC) or Arbitrator, Appointment, Removal, and Qualifications Promptly after a hearing has been properly requested, the Chief of Staff as a designee of the MEC or alternatively the MEC shall determine if the hearing shall be held before (1) an arbitrator or arbitrators selected by a process mutually acceptable to the Practitioner and the MEC or (2) before a panel referred to as a MRC. Should the Chief of Staff as a designee of the MEC or alternatively the MEC determine that a medical review committee shall be used he shall promptly appoint such a MRC and its Chairman to act as the peer review group in the hearing. The MRC shall consist of not less than three (3) nor more than seven (7) members, at least the majority of whom shall be physicians who shall be licensed to practice medicine but need not be members of the Medical Staff. When feasible, the MRC shall include at least one (1) individual practicing in the same specialty as the affected Practitioner. They may have knowledge of the matters to be heard but each shall be willing to hear the matters objectively and without prejudgment. They shall not have acted as accusers, investigators, fact finders or initial decision makers in connection with the same matter, shall gain no direct financial benefit from the outcome, and shall not be in direct economic competition with the affected Practitioner.

F Hearing Officer/Chairman of MRC The Administrator may appoint a Hearing Officer to conduct the hearing. The hearing officer may be a member of the South Carolina Bar and should be familiar with the law applicable to Hospital administrative proceedings.

The Hearing Officer shall conduct the hearing impartially such that the proceeding will be to the extent reasonably possible fair, efficient, and protective of the rights of all parties and witnesses. The Hearing Officer shall gain no direct financial benefit from the outcome of the hearing and shall not act as a prosecuting officer or advocate. The Hearing Officer shall act as advisor to the MRC as to procedural matters including the drafting of its decision and report but he shall not be entitled to vote. In the alternative the Administrator after consulting the MEC may appoint a Medical Hearing Officer to conduct the hearing. The Medical Hearing Officer must be a member of the Medical

Staff but may not be in direct economic competition with the affected Practitioner. He should be familiar with the applicable medical issues and with medical staff administrative proceedings. He shall conduct the hearing impartially such that the proceeding will be to the extent reasonably possible fair, efficient and protective of the rights of all parties and witnesses. He shall decide all procedural matters. All references to the "Hearing Officer" shall refer to the Medical Hearing Officer if one is appointed. If a Hearing Officer is not appointed, the Chairman of the MRC shall conduct the hearing and rule on procedural matters and all references to the "Hearing Officer" shall be deemed to refer to the Chairman of the MRC or the arbitrator, as appropriate.

G Postponements and Extensions After the appointment of the MRC and before the commencement of the hearing, postponements beyond the times required by these Bylaws may be requested by any of the parties, and shall be granted upon agreement of the parties or by the arbitrator or presiding officer on a showing of good cause. The MRC shall promptly give notice to the parties of each such postponement.

H Medical Staff Representative After a hearing has been properly requested, the Chief of Staff or alternatively the MEC shall promptly appoint a Medical Staff member ("Medical Staff Representative") to present the case on behalf of and otherwise represent, the body whose decision prompted the hearing. The Chief of Staff or alternatively the MEC may, in its sole discretion, remove or replace the Medical Staff Representative at any time.

SECTION 3 - HEARING PROCEDURE

A General It shall be the duty of the Practitioner and the body whose decision prompted the hearing to exercise reasonable diligence in notifying the Hearing Officer of any pending or anticipated procedural irregularity or any objection to the hearing panel or to the Hearing Officer, as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may expeditiously be made. Objection to any such pre-hearing decisions shall be raised on the record at the hearing and when so raised shall be preserved for consideration at any appellate review hearing which thereafter might be requested.

B Witness List At the request of either party, the parties must exchange at least ten (10) days before the hearing: (1) lists of witnesses expected to testify at the hearing and (2) copies of all documents expected to be introduced at the hearing. Failure of a party to produce these materials or to update them at least ten (10) days before the commencement of the hearing, shall constitute good cause for the Hearing Officer to grant a continuance or to bar or otherwise limit the introduction of any documents not provided to the other party or testimony from witnesses not identified pursuant to this provision.

C Failure to Appear Failure of the affected Practitioner to appear at the hearing shall be deemed to constitute the affected Practitioner's voluntary acceptance of the

recommendation or action and waiver of all hearing and appeal rights under these Bylaws unless the MRC finds good cause for such failure based upon written request by the affected Practitioner or his representative

D Representation The hearings provided for in these Bylaws are for the purpose intra professional resolution of matters bearing on conduct or professional competency. The physician involved has the right to representation by an attorney or other person of the physician's choice. Any request for legal representation shall be made at the time the hearing request is made. In no event shall legal counsel represent the body whose decision prompted the hearing if the affected Practitioner is not so represented. Any request for legal representation shall be made at the time the hearing request is made. In no event shall legal counsel represent the body whose decision prompted the hearing if the affected Practitioner is not so represented. Any party may obtain legal counsel at their expense for the purpose of preparing for the hearing.

E Record of the Hearing The MRC proceedings shall be taken and transcribed by a court reporter and a copy of the transcript of each session shall be available for purchase by either party. Each party shall be responsible for payment of all costs and charges associated with any transcript that it requests.

F Oath of Witness The MRC may in its discretion, order all testimony at the hearing to be under oath administered by a person authorized to administer oaths.

G Organization and Conduct of Hearing Process Unless otherwise expressly provided in these Bylaws the hearing shall be conducted as follows:

- 1 The parties shall have a reasonable opportunity to voir dire (examine) the MRC members and the Hearing Officer, and the right to challenge the appointment of any MRC member or the Hearing Officer. The Hearing Officer shall establish the procedure by which this right may be exercised, which may include requirements that voir dire (examine) questions be proposed in writing in advance of the hearing and that the questions be presented by the Hearing Officer. The Hearing Officer shall rule on any challenges in accordance with applicable legal principles defining standards of impartiality for hearing panels and Hearing Officers in proceedings of this type.
- 2 The Medical Staff representative shall present an opening statement summarizing the background of the matter, the notices given, any administrative decisions rendered to date, and, if he chooses, the salient general conclusions the representative expects to prove.
- 3 The medical staff representative shall then present the facts upon which he is relying by calling the witnesses and presenting the written evidence to support the case. He may call any person or opposing party who is present in support of the case.

- 4 At the close of the Medical Staff representative's case unless the MRC believes the action or recommendation being reviewed was clearly not supported by the medical staff representative's presentation (in which case the hearing may terminate by such a ruling at this point) the affected Practitioner or his representative shall make an opening statement and shall make a case representation of evidence and testimony. He may call any person or opposing party who is present in support of the case.
- 5 Upon the close of the initial presentations of the opposing parties each party shall be entitled to present evidence to rebut the presentation of the other subject to reasonable limitations by the Hearing Officer as to order, time, relevance and repetition.
- 6 In the close of all presentations and evidentiary rebuttals, the parties shall be entitled, subject to reasonable limitation by the Hearing Officer, to submit a written statement and give closing statements and argument.
- 7 Upon the close of all presentations, rebuttals, statements and argument the hearing Officer shall declare the hearing finally adjourned, and all persons other than the MRC and Hearing Officer shall thereupon leave the hearing. The MRC shall thereafter, at the convenience of its members but subject to the provisions of Section 4 below deliberate in order to reach its decision.
- 8 Liberality may be exercised in accommodating the schedules of witnesses, MRC members, parties and representatives, in allowing modification of required notices, in allowing recesses or extensions of time upon a reasonable showing of need, and in allowing changes in the order of the proceedings or the presentation of evidence. The decision of the Hearing Officer after consultation with the MRC regarding such matters shall be final, subject to later reconsideration for good cause only.
- 9 No person shall disrupt any hearing. Any person in attendance (whether a party or any other person) who disrupts a hearing after being warned by the Hearing Officer to cease such disruption on penalty of indefinite exclusion shall, at the direction of the Hearing Officer, leave the hearing. Unless directed otherwise for good cause by the Hearing Officer, the hearing shall proceed in the absence of such excluded person. If such excluded person is the affected Practitioner or a witness, he shall have the right to submit to the MRC not later than ten (10) days after such exclusion (unless extended by the Hearing Officer for good cause) a written affidavit of his testimony or other evidence, with copies thereof to the other parties.
- 10 Except as otherwise provided in these Bylaws and subject to reasonable restriction by the Hearing Officer, the following shall be permitted to attend the entire hearing in addition to the MRC: the Hearing Officer.

court reporter and parties the Administrator or his designee one (1) person designated by the Administrator (or designee) the Medical Staff Coordinator or assistant one (1) key consultant for each party and one (1) or more representatives of the entity that owns the hospital

H Burden of Proof The affected Practitioner shall have the burden of proving by clear and convincing evidence, that the action or recommendation of the body whose decision prompted the hearing which is the subject matter of the hearing is arbitrary, capricious or unreasonable

I Admissible Evidence and General Procedure Except as otherwise provided in these Bylaws The following rules shall apply in the hearing

- 1 The general rule of evidence shall be that any relevant matter Whether written or oral, upon which responsible individuals would be expected to rely in the conduct of serious affairs, shall be admitted, regardless of its admissibility in a court of law The MRC shall have the discretion to recognize any matters either technical or scientific including statistical data, relating to the issues under consideration, which is common knowledge in the general medical community and/or any medical specialty
- 2 Parties or their representatives shall have the right to
 - (a) a reasonable opportunity to voir dire the MRC members and the hearing officer, and the right to challenge the impartiality of any MRC member or the Hearing Officer The Hearing Officer shall rule upon such challenges
 - (b) be provided with all information made available to the MRC,
 - (c) call and examine witnesses on relevant evidence and to cross-examine witnesses
 - (d) introduce relevant documentary evidence
 - (e) present evidence that tends to impeach any witness on relevant matters provided that, to prevent abuse of this right, the Hearing Officer may, in his discretion, require a prior offer of proof summarizing such evidence and may in his discretion reject such evidence if the party fails to submit such offer of proof or if the offer of proof reasonably justifies such rejection and
 - (f) submit a written statement at the close of the presentation of evidence

3 Evidence of relevant activities or practices at any location or facility shall be admissible unless the Hearing Officer upon a showing of good cause imposes limitations

4 The MRC may receive and consider any brief or memorandum presented by any party

5 Any relevant material contained in Medical Staff files regarding the affected practitioner is admissible including but not limited to applications, references, and accompanying documents

SECTION 4 - DECISION AND REPORT OF MRC NOTICE

After adjournment of the final session of the hearing the MRC shall begin its deliberations Within thirty (30) days after closure of the deliberations of the MRC the MRC shall render and deliver to the Administrator a written report and decision The MRC may recommend that the Governing Body affirm, terminate or modify the action or recommendation that prompted the hearing If the recommendation is to modify the MRC must identify the modifications recommended The decision and report shall be based on evidence produced at the hearing, including any recognized matters and reasonable inferences that may be drawn The decision and report shall include findings of fact and conclusions articulating the connection between the evidence produced at the hearing and the decision reached It shall include sufficient detail to enable the parties and the Governing Body to determine the basis for the MRC's decision on each issue contained in the statement of charges It shall also contain a description of the appellate rights provided under these Bylaws The Administrator within five (5) working days after receiving the decision and report shall send a copy of them to the parties

SECTION 5 - GOVERNING BODY ACTION AFTER MRC DECISION

The Governing Body shall take no action regarding the underlying matter or the decision and report of the MRC, until after the expiration of the time for requesting appellate review under Section 6, provided that if an appellate review is properly requested under Section 6, the Governing Body shall take no action except in compliance with the procedures and provisions of this Article If an appellate review is not timely requested the Governing Body shall make its final decision in accordance with Section 6

SECTION 6 - APPEAL TO GOVERNING BODY

A **Time for Requesting Appeal** Within thirty (30) days after receipt of notice of the decision of the MRC either the affected Practitioner or the body whose decision prompted the hearing may request an appellate review by the Governing Body The

request shall be in writing and must be received by the Administrator within the applicable time period set forth above. The Administrator shall immediately deliver copies of the request to the Governing Body and to the other parties. The request shall set forth the ground(s) for appeal as noted under Section 6C. If an appellate review is not requested as set forth in this paragraph, all parties shall be deemed to have waived all rights to appeal.

B Nature and Effect of Appellate Review The appellate review shall be by the Governing Body or a committee thereof and all references to the "Governing Body" shall include such committees. Appellate review shall consist of a review of the prior proceedings and decision in the matter being reviewed, an appellate review meeting, deliberations, review of any further recommendations, and a final decision. In its final decision, the Governing Body may affirm, modify or reverse the decision of the MRC. No person or entity that participated in bringing the charges or in officially reviewing the matter shall participate in the appellate review process, even if such removal leaves the Governing Body with less than a quorum.

C Grounds for Appeal The grounds for appeal are limited to: substantial and prejudicial failure of the MRC or the MEC to comply with these Bylaws or to afford due process or a fair hearing; the action or recommendation that prompted the hearing, or any substantial part, was arbitrary or capricious; or the MRC's decision or any substantial part was clearly contrary to the weight of the evidence. The MRC's decision or any substantial part was clearly contrary to the weight of the evidence.

D Notice of Time, Date, Place of Appellate Review Meeting The Governing Body shall, within thirty (30) days after receipt by the Administrator of a timely request for appeal, schedule a date for an appellate review meeting. The Governing Body shall not less than ten (10) days prior to the date of the appellate review meeting give the parties written notice of the time, place, and date. The date thereof shall be not less than ten (10) days nor more than sixty (60) days from the date of receipt by the Administrator of the request for appellate review, except that when a request for appellate review is from a member who is then under suspension, the appellate review meeting shall be held as soon as reasonably practicable but not later than forty (40) days from the date of receipt of the request. The chairman of the governing body for good cause may extend the date for the appellate review meeting.

F Appellate Review Proceedings The appellate review shall be conducted as follows:

1. The Governing Body shall limit its review to the record of the hearing before the MRC, the MRC decision and report, and any written briefs submitted by the parties. The Governing Body may, however, in its sole discretion, accept additional issues or oral or written evidence subject to the same rights of cross-examination and rebuttal provided for MRC hearings. Such acceptance of additional issues or evidence may be based on the Governing Body's own motion or upon the request of a party if not less than seven (7) days prior to the appellate

review meeting date the party desiring to present such additional issues or evidence makes written request to the Governing Body to do so specifying the nature and relevance of the issues or evidence and gives notice of such request to all other parties. The Governing Body shall give notice of its decision in such matters to all parties as soon as reasonably possible.

2 The Governing Body may in its sole discretion appoint a Hearing Officer to conduct the appellate review meeting rule on procedural matters act as advisor to the governing body as to procedural matters and without voting rights participate in its deliberations and assist in the preparation of its decision.

3 Each party shall have the right to submit a written brief in support of his position on appeal, provided that copies of such brief shall be given to all other parties at such time as may be directed by the Governing Body.

4 The Governing Body in its sole discretion, has the option to allow each party or party's representative to appear personally and make oral argument at the appellate review hearing provided that such party shall make written application therefor to the Governing Body not less than seven (7) days prior to the date of the appellate review meeting. The Governing Body shall give notice of its response to such applications to all parties as soon as reasonably possible. If personal appearance is allowed the affected Practitioner, if present and all other parties and representatives present, shall answer any questions posed by any member of the Governing Body.

5 The Governing Body may, from time to time, adjourn and continue the appellate review meeting to another date or dates if it decides in its sole discretion, that such action is necessary or desirable in order to conduct a fair and thorough appellate review in the matter. The Governing Body shall give notice to the parties of any such date and time, unless the parties were present when the Governing Body announced such date and time.

6 At the conclusion of the appellate review meeting including oral argument if held the Governing Body shall at a time convenient to itself conduct deliberations outside the presence of the parties and their representatives, in order to determine whether to affirm modify, or reverse the decision of the MRC.

7 The Governing Body shall in its sole discretion decide the order of procedures to be followed in the appellate review as well as answers to questions not otherwise addressed in these Bylaws to the end that the appellate review including the appellate review meeting shall be thorough, orderly efficient and fair.

8 No person shall disrupt any appellate review proceeding. Any person in

attendance (whether a party or any other person) who disrupts an appellate review meeting after being warned by the Chairman of the Governing Body (or his designee or the hearing officer) to cease such disruption on penalty of indefinite exclusion shall at the direction of such chairman (or designee or the Hearing Officer) leave the meeting. Unless directed otherwise for good cause by the Chairman (or designee or the Hearing Officer) the appellate review meeting shall proceed in the absence of such excluded person.

F Final Decision/Effective Date The appellate review process shall conclude with the Governing Body's final decision in the matter which shall be made in accordance with the following rules:

1 Within thirty (30) days after either the waiver of appellate rights or the conclusion of the appellate review meeting the Governing Body shall render its final decision unless it refers the matter to the MRC for further review and recommendation. The governing body however may exercise its independent judgment in determining whether the hearing procedures in these Bylaws were followed.

2 If the Governing Body refers the matter to the MRC for further review and recommendation such referral may include instructions such as that the MRC arrange for further hearings on specific issues. The Governing Body shall give notice of such referral to the parties. The MRC shall conduct such review in accordance with any such instructions, and shall deliver its written recommendation to the Governing Body within forty-five (45) days after the receipt of the referral from the Governing Body. Within forty five (45) days after receipt of such recommendation the Governing Body shall render its final decision.

The Governing Body's final decision shall be in writing and shall include a statement of the Governing Body's basis for its decision. The decision shall be effective immediately and not subject to further hearing or appeal. As soon as the final decision is effective, a copy of it shall be delivered to the affected Practitioner, the Administrator, and each party, in person or by certified mail.

SECTION 7 - RIGHT TO ONLY ONE MRC HEARING AND APPELLATE REVIEW

No party shall be entitled to more than one (1) evidentiary hearing and one appellate review on any matter that may be the subject of a MRC hearing or appeal.

SECTION 8 - INFORMAL INTERVIEWS

Nothing in these Bylaws shall be deemed to prevent any committee or person

contemplating any action or recommendation set forth in Section 2B from at its sole discretion inviting the affected Practitioner to participate in an informal discussion of the contemplated action or recommendation. Such discussion shall not be deemed to constitute a hearing under this Article.

SECTION 9 - RESIGNATION OR WITHDRAWAL OF APPLICATION

Notwithstanding any other provision of these Bylaws, whenever the affected Practitioner unconditionally (a) resigns from the Medical Staff, (b) resigns and relinquishes the privileges that are the subject matter of a hearing, (c) withdraws the application that is the subject matter of hearing, (d) amends an application or request with regard to the items that are the subject matter of the hearing, or (e) consents in writing to the action or recommendation that prompted the hearing, and there are no other issues before the hearing, all hearing and appellate review proceedings with respect to the Practitioner, his privileges or application, as the case may be, shall terminate as of the first day after such resignation, withdrawal, amendment, or consent. Once so terminated, the proceedings shall not be reopened except when ordered by the Governing Body after receiving a written request from or giving notice to the affected Practitioner and determining that good cause exists for such reopening.

SECTION 10-CONFIDENTIALITY

In addition to the provisions provided in Article XIII (Confidentiality/Immunity from Liability) of these Bylaws, all Medical Staff applicants and members, committee members and committee guests, peer review consultants, persons involved in any peer review activity at this hospital, as well as parties, participants, and attendees at a Medical Staff peer review hearing, shall keep all peer review investigations as well as all hearing and appellate review proceedings and the contents thereof confidential. No one shall disclose or release any information from or about the proceedings to any person or the public.

SECTION 11 EXCEPTIONS TO HEARING AND APPEAL RIGHTS

In addition to other exceptions set forth in these Bylaws, the hearing and appeal rights under these Bylaws are not applicable under the following circumstances:

A. Closed Department/Exclusive Contracts The hearing and appeal rights under these Bylaws do not apply to a Practitioner whose application for Medical Staff membership and privileges was denied on the basis that the privileges he seeks are granted only pursuant to a closed staff or exclusive use policy.

B. Medico-Administrative Practitioner The hearing and appeal rights under these Bylaws do not apply to those persons serving the hospital in a medico-administrative

capacity. Termination of such persons' rights to practice in the hospital shall instead be governed by the terms of their individual contract with the hospital. However, the hearing and appeal rights of these Bylaws shall only apply to the extent that membership status or clinical privileges which are independent of the Practitioner's contract are also removed or suspended unless the contract includes a specific provision establishing alternative procedural rights applicable to such decisions.

C Automatic Suspension or Termination of Privileges The hearing and appeal rights under these Bylaws are not granted if a member's Medical Staff membership or clinical privileges are automatically suspended or terminated in accordance with these Bylaws.

D Specified Professional Personnel Specified Professional Personnel are not entitled to the hearing and appeal rights under these Bylaws.

E Removal from Emergency Room Call Schedule Emergency Room call schedule participation is not a benefit or privilege or staff membership but rather is an obligation. No hearing or appeal rights under these Bylaws are available for any action or recommendation affecting a Practitioner's emergency room call schedule obligation(s).

F Hospital Policy Decision The hearing and appeal rights of these Bylaws are not available if the hospital makes a policy decision (e.g. closing a department or service or physical plant changes) that adversely affects the staff membership or clinical privileges of any member or applicant.

G Termination of Hospital Employed Practitioner The privileges and staff membership of any Practitioner employed to the hospital shall be subject to termination in accordance with the terms of the Practitioner's contract. Such Practitioner shall not be entitled to the hearing and appeal rights under these Bylaws except to the extent that the Practitioner's staff membership or privileges which would otherwise exist independent of the contract are to be limited or terminated or unless otherwise provided in the Practitioner's contract.

ARTICLE IX

OFFICERS OF THE MEDICAL STAFF

SECTION I – OFFICERS Officers of the medical staff shall be the

- A Chief of Staff
- B Vice Chief of Staff
- C Immediate Past Chief of Staff
- D Secretary Treasurer

SECTION 2 - QUALIFICATIONS

Officers must be members of the active staff at the time of their nomination and election. They must maintain their active status and remain in good professional and ethical standing during their term of office. Because of the peer responsibilities of their offices, the Chief of Staff and Vice Chief of Staff shall be physicians with demonstrated competence in their fields of practice and ability to direct the medico administrative aspects of medical staff activities. Officers must have demonstrated good interpersonal relationships with Medical Staff members and Hospital staff and have indicated a willingness to accept the responsibilities of the office.

SECTION 3 - NOMINATION AND ELECTION OF OFFICERS

A Officers shall be elected for a two (2) year term by the active staff members at the final meeting of the designated medical staff term. Election shall be by oral vote or showing of hands unless written two (2) or more eligible voters request ballot. The candidate must be elected by a majority vote of the active staff members present at the meeting. When three (3) or more candidates are running and a majority is not obtained, the candidate with the least votes will be eliminated each time until a candidate receives a majority vote. Voting by proxy shall not be permitted.

B Nominations may be made in the following ways, provided that written consent to serve is obtained from the proposed nominee prior to placing the nominee's name into nomination:

- 1 By a nominating committee. The nominating committee shall consist of five (5) members of the active medical staff appointed by the Chief of Staff subject to approval of the MEC. The nominating committee shall convene at least thirty (30) days prior to the final meeting of the medical staff term and shall submit to the medical staff coordinator one (1) or more qualified nominees for each office at least thirty (30) days prior to the meeting. The nominees shall be for the offices of Chief of Staff, Vice Chief of Staff and Secretary Treasurer.
- 2 By petition. Nominating by petition requires the signature of at least ten (10%) percent of the active staff members and must be filed with the medical staff coordinator at least ten (10) days prior to the final medical staff meeting. The Medical Staff shall be notified of these additional nominees at the time of this meeting.

- 3 From the floor Nominating may be done from the floor at the time of the final meeting of the medical staff term

SECTION 4 - TERM OF OFFICE/VACANCIES

A **Term of Office** Each officer shall serve a two year term beginning the first day of the Medical Staff term following their election. Each officer shall serve until the end of his term or until a successor is elected unless he shall sooner resign or be removed from office.

B **Vacancies in Office** The Medical Staff MEC shall fill Vacancies in office during the Medical Staff term except for the Chief of Staff. If there is a vacancy in the office of Chief of Staff, the Vice Chief of Staff shall serve out the remaining term. A vacancy in the office of immediate past Chief of Staff will not be filled.

SECTION 5 - REMOVAL OF ELECTED OFFICERS FROM OFFICE

A **Removal** Removal of a medical staff officer may be initiated by a two thirds (2/3) majority vote of the active Medical Staff. The Governing Body may remove any officer for cause as described in Section 5B, below.

B **Grounds for Removal** Each of the following conditions in itself constitutes cause for removal of a staff officer from office:

- 1 Revocation of professional license by the authorizing state agency
- 2 Suspension from the Medical Staff
- 3 Failure to perform the required duties of the office
- 4 Failure to adhere to professional ethics
- 5 Failure to comply with or support enforcement of the Hospital and
- 6 Medical Staff Bylaws, Rules and Regulations and policies
- 7 Failure to maintain adequate professional liability insurance and
- 8 Failure to maintain active staff membership

SECTION 6 - RESPONSIBILITIES, DUTIES, AND AUTHORITY OFFICERS

A **Chief of Staff** The responsibilities, duties, and authority of the Chief of Staff are to:

- 1 call preside at and determine the agenda of all general and special meetings of the Medical Staff
- 2 serve as chairman of the MEC with tie breaking vote prerogative only
- 3 enforce medical staff Bylaws rules and regulations and appropriate hospital rules and policies, implement sanctions when they are indicated and enforce the medical staff's compliance with procedural safeguards in all instances in which corrective action has been requested or initiated against a Practitioner
- 4 appoint the chairman and all Medical Staff members of Medical Staff standing and ad hoc committees, except the MEC appoint the Medical Staff members of Hospital and Governing Body committees when these are not designated by position or by specific direction of the Governing Body
- 5 represent the views policies concerns needs and grievances of the Medical Staff to the Governing Body and Administration serve ex officio as a voting member of the Governing Body
- 6 advise the Governing Body on the effectiveness of the quality/performance improvement program and the overall quality of patient care in the Hospital,
- 7 advise the Governing Body, Administration and the MEC on that impact on patient care and clinical services including the need for new or modified programs/ services for recruitment and training of professional and support staff personnel, and for staffing patterns, and
- 8 serve as spokesman for the Medical Staff in its external professional and relations

B Vice Chief of Staff The responsibilities duties and authority of the Vice Chief of Staff are to

- 1 assume the responsibilities duties and authority of the Chief of Staff during the latter's absence whether the absence is temporary or permanent
- 2 serve as an ex officio voting member of the MEC, and
- 3 serve as chairman of the Performance Improvement Committee

C Immediate Past Chief of Staff The responsibilities duties and authority of the Immediate Past Chief of Staff are to

- 1 serve as an ex-officio voting member of the MEC
- 2 advise the Chief of Staff and MEC on matters concerning the Medical Staff
- 3 perform other functions at the request of the Chief of Staff and
- 4 assume the responsibilities, duties, and authority of the Chief of Staff when both the latter and the Vice Chief of Staff are temporarily absent

D Secretary-Treasurer The responsibilities, duties, and authority of the Secretary Treasurer are to

- 1 serve as an ex-officio voting member of the MEC, assure the preparation and maintenance of accurate and complete minutes for all medical staff meetings on order of the Chief of Staff,
- 2 supervise any staff funds if any, and perform other such duties as ordinarily pertain to the Office of Secretary Treasurer

In the temporary absence of the Chief of Staff, Vice Chief of Staff and the immediate past Chief of Staff, the Secretary Treasurer shall assume all the duties and have the authority of the Chief of Staff. In the event that all four officers are absent, the Executive Committee shall appoint an acting Chief of Staff who shall assume all the duties and have the authority of the Chief of Staff.

ARTICLE X

CLINICAL DEPARTMENTS

SECTION I - ORGANIZATION

A Structure Each department shall be organized as a separate part of the Medical Staff and shall have a chairman who shall be responsible for the overall supervision of the clinical work within his department and is selected and has the authority, duties, and specific responsibilities as specified in this Article. Each department shall have at least five (5) members including the chairman and the vice chairman.

B Departments There shall be departments of Medicine, Surgery, Family Practice and OB GYN Pediatrics.

- 1 The Medical Department shall include any staff members in the following practice specialties: internal medicine, cardiology, pulmonology, critical care, dermatology, oncology, hematology, nephrology, neurology, emergency.

medicine diagnostic internal medicine radiology gastroenterology
hematology oncology nuclear medicine psychiatry rheumatology and infectious
disease

2 The Department of Surgery shall include any staff member in the
following practice specialties vascular surgery neurosurgery orthopedic surgery
plastic surgery urologic surgery ophthalmology otorhinolaryngology
maxillofacial surgery general dentistry and all dental specialties podiatry
pathology physiatry, and anesthesiology pediatric surgery colon rectal surgery
cardio thoracic

3 The Family Practice Department shall consist of Family Practitioners only

4 The OB/GYN/Pediatrics Department shall include the following
obstetricians and gynecologists and all pediatricians and sub specialties of the
above

C Changes in Departments When deemed appropriate for better organizational
efficiency and improved patient care the MEC with the approval of the Governing
Body may create new eliminate subdivide or combine clinical departments

D Clinical Services When clinical services are established, they shall be organized
as a specialty subdivision within a department, shall be directly responsible to the
department within which they function, and have a Chief of Service who is selected and
has the authority, duties and responsibilities as specified in this Article Each service
shall ordinarily have at least five (5) members

E Formation of Clinical Services A group of Practitioners of the same specialty
that desire to become a clinical service must have a recommendation for such from the
parent department to the MEC Denial of such a request by the department must be
accompanied by the reason for the denial The MEC and Governing Body will then act
on the request as follows

- 1 If the MEC approves a positive recommendation from the department
the committee recommendation is forwarded to the Governing Body
- 2 If MEC disagrees with a positive recommendation from the department
the issue can then be referred to the next general Medical Staff meeting
The recommendation of the Medical Staff will then be forwarded to the
Governing Body
- 3 If a negative recommendation from the department is supported by the
MEC the issue is considered closed
- 4 If the MEC reverses a negative decision from the department the
department may request that the issue be referred to the next general
Medical Staff meeting The recommendation of the Medical Staff will

then be forwarded to the Governing Body

4 All final approval rests with the Governing Body

SECTION 2 - PERFORMANCE ASSESSMENT AND IMPROVEMENT

A Responsibility It shall be the responsibility of the chairmen of the clinical departments and specialty services, working through departmental committees and with the assistance as appropriate of the standing committees to design and implement effective programs

(1) to monitor and assess the quality of professional performance in each department and service and

(2) to promote quality practice in each department and service by (a) providing education and counseling by the medical staff both to families of patients as well as to members of the hospital staff for general medical education and update (b) issuing letters of instruction admonition warning or censure as necessary (c) requiring routine monitoring when deemed appropriate by the department or service and (d) to participate as required in multi-disciplinary studies/systems

B Procedure

(1) Each department or service committee shall conduct regular patient care reviews and studies of performance and patient care outcomes within the department or service in conformity with a written quality management plan approved by the MEC and Governing Body

(2) In order to assist department or service members to conform their conduct or professional practice to the standards of the Medical Staff and Hospital department or service chairmen may make informal comments or suggestions either orally or in writing. A summary of such statements will be kept in the member's credentials file. Such comments or suggestions shall be subject to the confidentiality requirements of all Medical Staff peer review information and may be issued with or without prior consultation with either the affected member or the department or service committee. Such comments or suggestions shall not constitute a restriction of privileges and shall not give rise to the hearing and appeal rights under these Bylaws. Such comments are eligible for peer review protection under state laws and statutes.

(3) Following discussion of identified concerns with a member any department or service committee may authorize the chairman to issue a letter of instruction admonition or warning to the member or to require the member to be subject to routine monitoring for such time as shall appear reasonable to the department or service. The term routine monitoring as used in this section shall mean review of a member's performance for which the member's only obligation is to provide

reasonable notice of patient admissions procedures or other patient care activity. All members of the Medical Staff regardless of status shall be subject to potential routine monitoring. The discussions of such actions with individual members shall be informal. Such actions shall not constitute a restriction of privileges shall not be considered to constitute corrective action and shall not give rise to the hearing and appeal rights under these Bylaws.

(4) Written letters of instruction, admonition or warning or routine monitoring required pursuant to subparagraph three (3) above shall be reported to the MEC promptly after such actions are taken.

SECTION 3 - ASSIGNMENT TO CLINICAL DEPARTMENTS

A Assignment Each member of the medical staff shall be assigned membership in one (1) clinical department based on the bulk of the clinical services he provides. Members may in addition be granted clinical privileges in one (1) or more other departments.

B Meetings Each member will be allowed to vote in only one (1) department and to represent only one (1) department on committees (including the MEC) and shall be responsible for attending the required number of meetings only in the department to which he is primarily assigned. However, each Practitioner is encouraged to attend meetings in all departments in which he exercises privileges and should keep himself informed of departmental activities particularly as they relate to findings of patient care and performance evaluation activities.

C Rules and Regulations The exercise of clinical privileges granted by the Governing Body or the performance of specified services within any department shall be subject to the rules and regulations of that department and the defined authority of the department chairman.

SECTION 4 - FUNCTIONS OF CLINICAL DEPARTMENTS

The primary responsibility delegated to each department is to implement and conduct ongoing specific review and evaluation activities that contribute to the preservation and improvement of the quality, performance, effectiveness and efficiency of patient care provided through the department. To carry out this responsibility, each department either alone or in concert with other organizational components of the Medical Staff and of the Hospital shall:

A Objectively reviews, analyze and evaluate the quality of care and performance provided through the department. In the interest of achieving quality patient care and performance, each department through an established system shall evaluate all clinical work performed under its jurisdiction, whether or not any particular Practitioner or other individual with clinical privileges whose work is subject to such evaluation is a member of the department. This must be done at least quarterly and must be based on objective

measurable standards of care performance. All or part of such review may be carried out through clinical services or designated specialty groups with periodic (at least quarterly) reporting of the interpreted findings to the appropriate medical staff department(s). Alternatively, a department as a whole may perform the required review and evaluation functions. The department may also elect to send the review to the Medical Staff Peer Review Committee.

B Establish criteria for the granting of clinical privileges and, as appropriate, for the holding of office within the department.

C Recommend to the Credentials Committee the specific clinical privileges that each staff member or Medical Staff applicant may exercise in the department and the specific services that each designated professional personnel may provide.

D Establish such committees or other mechanisms as are necessary and desirable to maintain quality clinical performance.

E Monitor its members' performance on a concurrent basis for

- 1 adherence to Medical Staff, Hospital, and departmental rules and regulations and policies/procedures,
- 2 meeting requirements for alternate coverage and for obtaining consultation; adherence to sound principles of clinical practice;
- 3 appropriate invasive procedures and other patient care interventions,
- 4 unexpected clinical occurrences including compliance with the Hospital Occurrence/Incident Screening Program (HOR) and
- 5 all relevant aspects of patient safety.

F fulfill the responsibilities designated to the department as set forth in the quality/performance improvement plan.

G receive and evaluate the compliance with medical necessity (admission and intervention) and clinical management criteria; the findings from use of occurrence screening criteria; reports of Medical Staff and other departmental committees; and compliance with the established patient care requirements (rules, regulations, policies, protocols) of the department and Medical Staff.

H coordinate with nursing and ancillary clinical patient care services and with other administrative support services the patient care provided by the department's members.

I conduct or participate in and make recommendations regarding the need for continuing education programs pertinent to state of the art changes and in particular to

the findings of performance assessment and improvement activities

J maintain a permanent record of all department meetings activities to include the discussion content as well as conclusions reached or actions taken or recommended. Copies of minutes should be transmitted to the Medical Executive Committee.

SECTION 5 DEPARTMENT CHAIRMAN AND VICE CHAIRMAN

A **Qualifications** Each chairman and vice chairman shall be a member of the active staff qualified by training, experience, and demonstrated ability for the position. Each shall have demonstrated professional ability in at least one (1) of the clinical areas covered by the department, shall meet all state regulatory requirements, and shall be willing, able, and eligible to discharge faithfully the functions of his office. The Department Director shall be certified by an appropriate specialty board or affirmatively establish comparable competence through the credentialing process.

B **Selection of Chairman and Vice Chairman** Each chairman and vice chairman shall be elected by the department membership from nominees submitted in writing by department members or verbal nomination subject to approval of the MEC. Each chairman and vice chairman shall be appointed by the Chief of Staff after consultation with the MEC. If the MEC fails to approve the election of the chairman and vice chairman, the department shall hold another election.

C **Terms of Office** Department chairman and vice chairman shall serve a two (2) year term beginning on the first day of the Medical Staff term following his selection. The department chairman or elected department vice chairman may succeed himself. The department chairman or elected department vice chairman shall serve until his successor is chosen, unless he shall resign sooner or be removed from office. In the temporary or permanent absence of the department chairman, the vice chairman shall assume all duties, responsibilities, and authority of the chairman and will become a member of the MEC. The vice chairman may be elected by the department membership or appointed by the Chief of Staff.

D **Removal of Department Chairman or Vice Chairman** Removal of a department chairman or vice chairman may be initiated by a two thirds (2/3) majority vote of department members eligible to vote and subject to approval of the MEC. The MEC or Governing Board may remove for cause as listed under Section 5B of Article IX of these Bylaws relating to removal of Medical Staff officers.

E **Responsibilities, Duties, and Authority of Department Chairman** Each chairman shall

1 account to the MEC for all professional and administrative activities within his department.

- 2 develop and implement in cooperation with the Chief of Staff and consistent with these Bylaws departmental mechanisms for performing the credentials review delineating clinical privileges and assigning staff classification concurrent monitoring of practice performance that is objective and measurable include an occurrence screening program and the use of medical necessity and clinical management criteria quality management activities continuing medical education and utilization review
- 3 transmit to the Credentials Committee the department's recommendation concerning appointment and reappointment delineation of clinical privileges and corrective action with respect to practitioners in the department
- 4 maintain ongoing review of the professional performance of all Practitioners and any Specified Professional Personnel within the department contribute data to individual Practitioner's performance profiles and report regularly to the Credentials Committee and MEC upon request and at the time of reappointment The report will include evidence of consideration of each Practitioner's health status in terms of the Practitioners ability to practice in the area in which privileges are sought
- 5 develop implement, and enforce in cooperation with the Chief of Staff and/or Vice Chief of Staff programs to perform the quality assessment and improvement and maintenance functions delegated to his service
- 6 serve as a member of the MEC, giving guidance on the overall medical policies of the Hospital and making specific recommendations and suggestions regarding his own department in order to promote quality patient care Within the department chairman shall implement actions taken by the MEC
- 7 enforce the Hospital and Medical Staff Bylaws Rules and Regulations, and policies, and the departmental rules and regulations including when appropriate the initiation of corrective action and investigative services and participate as consultants on an as- needed basis when his area is involved
- 8 actively encourage all department members to complete adequately and in a timely manner the medical records of their discharged patients (within the period required by these Bylaws rules and regulations and by any regulatory agency)
- 9 assign proctors to individuals who have been granted temporary privileges prior to staff membership approval or who are in provisional status as new appointed staff members or as otherwise requested by the MEC
- 10 cause departmental rules and regulations relating to standards of patient care

to be developed approved implemented and reviewed at least annually for any needed revision

- 11 cause all standing orders of Practitioners to be reviewed initially on change and periodically (e.g. annually) if the responsibility is not assigned to a standing committee of the Medical Staff (e.g. Pharmacy and Therapeutics Committee)
- 12 assist in the preparation of such annual reports including budgetary planning pertaining to the department as may be required by the MEC the Administrator or the Governing Body
- 13 assess and recommend to the Administrator off site sources for needed patient care services not provided by the department service or the Hospital
- 14 determine whom, outside of the department members the Chief of Staff Administrator or his designee quality management coordinator and recording secretary may attend department meetings
- 15 perform such other duties commensurate with his office as may from time to time be reasonably requested of him by the Chief of Staff the MEC or Governing Body
- 16 coordinate and integrate interdepartmental and intradepartmental services
- 17 exercise general supervision over all clinical work performed through the service, and
- 18 act as presiding officer at all service meetings and cause a permanent meeting report to be maintained and distributed as required

ARTICLE XI

COMMITTEES & FUNCTIONS

SECTION I - GENERAL CONSIDERATIONS

A **Standing and Special Committees** There shall be standing and special (ad hoc) committees of the Medical Staff. Unless stated otherwise in these Bylaws, the committees of this Article shall be standing committees of the Medical Staff. Special or ad hoc committees may be created by the MEC to perform specified tasks.

B **Appointment and Removal** Unless otherwise specified, the Chairman and members (except the MEC and its Chairman) of all committees shall be appointed for a two (2) year term and may be removed by the Chief of Staff after consultation with and approval of the MEC.

C **Minutes** Unless stated otherwise in these Bylaws, each committee shall submit a copy of its minutes to the MEC and shall maintain a permanent record of its proceedings including pertinent discussion and any conclusions, recommendations, and actions.

D **Participation of Non-Medical Staff Members** Persons who participate or attend committees or functions who are not Medical Staff members shall be selected by the Administrator with the concurrence of the committee Chairman or Chief of Staff. Non-medical staff members shall not be entitled to vote but may participate if invited in discussion.

E **Ex officio members** Ex officio committee members shall serve without vote.

F **Performance of Functions** Whenever these Bylaws require that a function be performed by

- 1 A Medical Staff committee but no committee has been specified, the MEC shall perform the function or designate a subcommittee to perform it.
- 2 The MEC, but a standing or special committee has been formed to perform the function, the committee so formed shall act in accordance with the authority delegated to it.

G **Vacancies** Unless stated otherwise in these Bylaws, vacancies on any committee shall be filled in the manner of original appointment to the committee. If an individual obtains membership by virtue of these Bylaws and is removed for cause, a successor may be selected by the MEC.

H **Medical Staff Committee Chairman** The chairman of each medical staff committee will change every two- (2) years. A physician may succeed himself or herself as chairman of any medical staff committee.

SECTION 2 - MEDICAL EXECUTIVE COMMITTEE (MEC)

A **Composition** The Medical Executive Committee shall be a standing committee of the Medical Staff. It shall consist of the officers of the staff: Chief of Staff, Vice Chief of Staff, and Secretary-treasurer, Chairman of all Medical Staff

Departments the most recent ex chief of staff the Chairman of Credentials Committee the Chairman of the Med Surg PCU Committee one member selected at large from the Medical Staff by the Chief of Staff the Chief Medical Officer of the hospital who shall be an ex officio member without vote and the Administrator of the hospital who shall be an ex officio member without vote. The Chief of Staff shall be Chairman of the committee. Each voting member regardless of staff department or other committee position held shall have only one (1) vote.

B Responsibilities, Duties, and Authority The MEC shall

- 1 represent and act on behalf of the Medical Staff subject to such limitation as may be imposed by these Bylaws
- 2 make recommendations to the Governing Body on all matters relating to appointments, reappointments clinical privileges staff category and clinical department/service assignments, and corrective action. When Specified Professional Personnel provide or are recommended to provide services in the Hospital the committee shall make recommendations to the Governing Body regarding their qualifications to provide those services and on the degree of supervision required
- 3 receive and act upon reports and recommendations from Medical Staff committees all clinical departments and staff officers concerning performance improvement activities and the discharge of their delegated administrative responsibilities,
- 4 ensure through evaluation by this committee or the Environment of Care Committee that each Medical Staff peer evaluation and performance assessment and improvement activity is performed effectively
- 5 coordinate the activities of and policies adopted by, the staff departments/services and committees,
- 6 fulfill the medical staffs' accountability to the Governing Body for the medical care rendered to patients in the Hospital
- 7 initiate and pursue corrective action when warranted in accordance with these Bylaws
- 8 take all reasonable steps to help provide for professional ethical conduct competence and clinical performance on the part of all staff members
- 9 make recommendations to the Governing Body on medico administrative and Hospital management matters as requested particularly as they relate to patient care through the Administrator and Chief of Staff

- 10 submit recommendations to the Governing Body for changes in the Medical Staff Bylaws, Rules and Regulations and other organizational documents pertaining to the Medical Staff
- 11 serve as a liaison to provide and promote effective relationships among the Medical Staff, Administration, and the Governing Body
- 12 participate in identifying community health needs, setting Hospital goals and implementing programs to meet those needs
- 13 actively maintain effective Medical Staff participation in the hospital's occurrence screening program and
- 14 promote in house Medical Staff continuing education activities that are relevant to the care and services provided in the hospital and in particular to the findings of Medical Staff peer evaluation and performance improvement activities

C **Meetings** The MEC shall meet as often as necessary to accomplish its functions but at least ten (10) times per year

SECTION 3 - CREDENTIALS COMMITTEE

A **Composition** The Credentials Committee shall be a standing committee of the Medical Staff and shall consist of five (5) or more members of the active staff with ex officio representation from administration who shall not vote. The physician members shall be representative of the major clinical departments. Whenever possible, when a physician is being reviewed, a peer representative who is not a member of the committee, will participate for that part of the meeting. The Chairman of the committee shall be an active member of the Medical Staff appointed by the Chief of Staff.

B **Responsibilities, Duties and Authority** The committee shall

- 1 review and evaluate the qualifications of each applicant for initial appointment, reappointment or modification of appointment and for clinical privileges
- 2 review each application prior to processing to determine if it is complete for processing and shall not process any application for membership or privileges that is incomplete
- 3 review and evaluate the qualifications of specified professional personnel to provide specific patient care services in the Hospital and to obtain and consider

the recommendations of the appropriate department

4 obtain and consider the recommendations of the appropriate departments regarding initial appointment, reappointment or modification of appointment and for clinical privileges

5 submit a report in accordance with these Bylaws to the MEC on the qualifications of each applicant for staff membership or clinical privileges and of each specified professional personnel to provide specific patient care services. Such report shall include recommendations for Medical Staff applicants as to appointment, staff category assignment, department service affiliation and clinical privileges and for specified professional personnel the specific services to be performed. In either case any special conditions will be recommended at the same time,

6 submit reports to the MEC on the status of pending applications, including the specific reasons for any unusual delay in processing an application or request

7 monitor the number of patient contacts and the number of department and quarterly medical staff meetings of Practitioners in provisional status pending their final Medical Staff appointment,

8 provide that a separate credentials file is maintained for each staff member, each practitioner with clinical privileges and each specified professional personnel including reports from quality/performance assessment and improvement activities and of corrective actions of any degree

C Meetings The Credentials Committee shall meet as often as necessary to accomplish its functions

SECTION 4 - ENVIRONMENT OF CARE COMMITTEE

A Composition The Environment of Care Committee shall be a standing committee and shall consist of at least one active physician member from the medical staff, the Administrator or designee, the Chief Nursing Officer, the Quality Improvement Coordinator and the Risk Manager and other hospital staff as appointed by the administrator. Other individuals from either the Medical or Hospital staffs may participate as consultants on an as needed basis.

B Responsibilities, Duties, and Authority The committee shall

1 review quality control reports from the various hospital departments to identify any trends and/or opportunities for improvement

- 2 receive analyze and recommend action regarding any significant findings from quality control safety or infection control reviews
- 3 review and approve the hospital plans for performance improvement safety and infection control
- 4 receive and review safety reports including those related to emergency preparedness provide input to effect positive change review and approve safety policies
- 5 receive review and approve hospital infection control policies, issues and reports and provide input to effect improvement and positive changes
- 6 perform at least an annual evaluation of the Environment of Care program to assure its comprehensiveness and effectiveness
- 7 assure that an updated report is presented to the Governing Body annually
- 8 analyze the incidence and major causes of hospital acquired infections and make recommendations for improvement,
- 9 receive reports and monitor a preventive and corrective program designed to minimize infection hazards including an employee health program
- 10 institute appropriate control measures or studies if there is suspicion of a danger to patients or personnel When the situation is considered to be urgent, the committee chairman or a physician member of the committee or the infection control practitioner may institute the control measure immediately and will be assisted by hospital personnel in doing so The Chief of Staff and the Administrator shall be notified as soon as any urgent control measure is instituted and shall be consulted prior to the institution of any non urgent measure The attending practitioner shall be notified as soon as possible however, when the patient's attending practitioner does not consider the measure necessary (e.g. the need to isolate a patient) the decision of the committee chairman or infection control practitioner in following established infection control policy shall prevail
- 11 review and approve cleaning agents to be used in the hospital and
- 12 determine when environmental cultures are required

C Meetings The Environment of Care Committee shall meet as often as necessary to accomplish its functions but at least (6) six times per year The overall findings will be sent to MEC

SECTION 5 PHARMACY AND THERAPEUTICS COMMITTEE

- A Composition The Pharmacy and Therapeutics Committee is a standing committee of the medical staff and shall consist of at least one physician from the active Medical Staff a pharmacist from the hospital's pharmacy service a representative from the laboratory infection control administration and from nursing services and when indicated a clinical dietitian The physicians shall represent each Medical Staff department The chairman shall be selected by the Chief of Staff
- B Responsibilities, Duties & and Authority The committee shall
- 1 evaluate the clinical usage of drugs (particularly high risk problem prone and investigative drugs) in the hospital establishing priorities for specific drug or drug category reviews, and using measurable criteria in the review process After any required peer review the findings will be entered into the appropriate practitioner performance profiles
 - 2 establish and implement a well controlled or closed formulary to help control the use of drugs in the hospital The committee will make recommendations to the MEC regarding any changes to the formulary Requests for formulary changes from individual medical staff members must be submitted to the committee in writing and include the rationale for the change The committee chairman will transmit the committee's action to the requesting Practitioner;
 - 3 define and evaluate all significant untoward reactions to drugs In addition the committee shall strive for adequate reporting of actual or suspected untoward drug reactions including the recommendation of periodic inservice training for nursing personnel and other appropriate hospital personnel
 - 4 define and evaluate all significant medication errors
 - 5 evaluate initially, when changes are made and at least annually standing and routine orders containing medication orders
 - 6 assist in the formulation of and approval of all professional policies regarding the evaluation, appraisal selection, procurement storage distribution use safety procedures and other matters relating to drug usage in the hospital
 - 7 ensure the adequacy and centralization of intravenous mixtures total parenteral nutrition and the mixture of chemotherapeutic agents
 - 8 make recommendations to the MEC on protocols proposed for the use of investigational or experimental and high risk drugs and specific drug categories

for use in the hospital

9 review statistics and reports related to blood and blood product ordering handling dispensing administering and monitoring the effects on patients and make recommendations as needed

10 maintain in conjunction with the P & T Committee an objective ongoing evaluation of the clinical use of all antibiotics used in the hospital whether the drugs are prescribed prophylactically empirically or therapeutically The committee shall recommend action for any required practice change to the MEC and shall follow-up through the Performance Improvement Committee to be sure the approved change has occurred The committee shall recommend objective and measurable criteria for use in all facets of antibiotic use evaluation

11 evaluate clinical practice objectively for compliance with measurable criteria for the use of whole blood and each of its components administered in the hospital,

12 evaluate untoward transfusion reactions In addition the committee shall strive for adequate reporting of actual or suspected transfusion reactions including the recommendation of periodic in-service training for nursing personnel to identify such reactions,

13 maintain and evaluate blood use statistics in order to determine blood waste and recommend or take appropriate action

14 encourage strongly the increased use of the type and screen vs type-and crossmatch procedure based on periodic (e.g. annual) actual use statistics by practitioner departments/clinical specialties and specific therapeutic interventions (e.g. specific surgical procedures etc),

15 the physician representatives will review blood and blood product usage Any isolated instances or patterns of inappropriate blood usage felt to be significant in the view of the Committee will be referred to the appropriate department for further review

16 set priorities for any aspect of blood therapy evaluation and

17 Review and support activities to infection control including policy development, surveillance prevention and control measures Data and trends related to infection control will be reviewed and processes for improvement of outcomes will be identified

© Meetings The Pharmacy and Therapeutics Committee shall meet as often as necessary to accomplish its function but at least four (4) times per year

SECTION 6 - OPERATING ROOM COMMITTEE

- A Composition The Operating Room Committee shall be a standing committee and shall consist of active members of the Medical Staff from departments such as Anesthesia and Surgery specialties. In addition, the committee shall have representation from the Administration, Director of Surgical Services, and other support departments as needed. The OR Committee shall have several subcommittees including but not limited to the following:

1 LASER COMMITTEE

a Composition The Laser Committee shall be a subcommittee of the OR Committee consisting of active Medical Staff from the surgery specialty, the Bio-Medical technician, the Director of Surgical Services, and a representative from Hospital Administration.

b Responsibilities, Duties, and Authority The responsibilities, duties, and authority of the Laser Committee shall be to:

- 1 monitor and trend laser usage and safety through the monitoring of quality indicators
- 2 make recommendations to the OR Committee policy and procedure development, continuing education, privilege/credential guidelines, and other quality of care issues, and
- 3 report any concerns and/or laser needs to the OR Committee

c Meetings The Laser Committee shall meet as often as needed. The chairman of the Laser Committee shall be a member of the OR Committee appointed by the Chief of Staff and serve as a liaison from the Medical Staff to Hospital Administration and report any issues to the OR Committee.

2 ENDOSCOPY COMMITTEE

a Composition The Endoscopy Committee shall be a subcommittee of the OR Committee consisting of active medical staff from both the Surgery and Medicine specialties, the Endoscopy nurse(s), and a representative from the Hospital Administration.

b Responsibilities, Duties, and Authority The responsibilities, duties, and authority of the Endoscopy Committee shall be to:

- 1 monitor and trend endoscopy usage and safety
- 2 make recommendations to the OR Committee for policy and procedure development continuing education privilege credential guidelines and other quality of care issues and
- 3 report any concerns and or needs to the OR Committee

c Meetings The Endoscopy Committee shall meet as often as needed. The chairman of the Endoscopy Committee shall be a member of the OR Committee appointed by the Chief of Staff and serve as a liaison from the Medical Staff to Hospital Administration and report any issues to the OR Committee

3 PAIN MANAGEMENT COMMITTEE

a Composition The Pain Management Committee shall be a subcommittee of the OR Committee consisting of the active Medical Staff nursing representation from the Block Suite the Director of Spine Services and a representative from Hospital Administration

b Responsibilities, Duties, and Authority The responsibilities duties and authority of the Pain Management Committee shall be to

- 1 monitor and trend block suite patient care and safety through monitoring of designated quality indicators,
- 2 make recommendations to the OR Committee for policy and procedure development continuing education privilege delineation credentials guidelines and other quality care issues
- 3 report any concerns and / or Pain Management needs to the OR Committee

c Meetings The Pain Management Committee shall meet as often as needed. The chairman of the Pain Management Committee shall be a member of the OR Committee appointed by the Chief of Staff and shall serve as a liaison from the Medical Staff to Hospital Administration and report any issues to the OR Committee

B Responsibilities, Duties, and Authority The responsibilities of the Operating Room (OR) Committee shall be to

- 1 review and monitor utilization of the operating room time including starting times operative times and efficient daily running of the operating room

schedule

2 develop policies concerning hours of the operating room operation including times that elective cases may be scheduled as well as hours which during the week that will be designated as emergency operative time

3 develop policies concerning the posting and scheduling of patients and efficient utilization of all available time and space in the operating room. Develop policies and procedures as deemed necessary from time to time to assure the most cooperative and efficient use of the operating room,

4 review Performance Improvement procedures,

5 make recommendations to ECRMC for obtaining new OR equipment and review of OR design change

6 assume other duties and responsibilities as would naturally fall under the direction of an OR Committee

C Meetings The OR Committee shall meet quarterly or as often as necessary to accomplish its functions

SECTION 7 - PERFORMANCE IMPROVEMENT COMMITTEE

A Composition The Performance Improvement Committee shall consist of at least one active member of the medical staff appointed by the Chief of Staff and shall serve as the Committee Chairperson. The other members of the PI Committee shall include the VPPCS COO Quality Management Coordinator, and four department directors selected annually by the CEO

B Responsibilities, Duties, Authority The committee shall be responsible for performance improvement through

1 providing oversight to the implementation of the Hospital's plan for performance improvement

2 reviewing and approving department performance improvement indicators, data to be collected and interventions

3 recommending and/or approving performance improvement teams for the purpose of process improvement

4 review and evaluation of and approving performance improvement data analysis and intervention

5 providing for the Medical Executive Committee and the Board of Directors an annual evaluation of the effectiveness of all aspects and components of the performance improvement process and recommendation for improvement and a projected plan for the following year

C Meetings The Performance Improvement Committee shall meet as often as needed to accomplish its functions but at least six (6) times a year

SECTION 8 - BYLAWS, RULES AND REGULATIONS COMMITTEE

A Composition The Bylaws Rules and Regulations Committee is a standing committee of the medical staff and shall consist of three (3) or more physician members of the active staff including the Chief of Staff and the immediate past Chief of Staff The Medical Staff Coordinator shall participate as an ex officio member without vote

B Responsibilities, Duties, and Authority The responsibilities duties and authority of the Bylaws Rules and Regulations Committee shall be to

1 review at least annually the Medical Staff Bylaws, Rules and Regulations and recommend to the MEC and the Governing Body any changes deemed necessary for compliance with applicable laws and accreditation requirements and

2 ensure through ongoing review, that the Bylaws, Rules and Regulations reflect current practice and an efficient organization of the Medical Staff in performing its functions

3 ask each clinical department to develop and implement rules and regulations to establish standards of patient care and ascertain that these rules and regulations are consistent with Medical Staff Bylaws Rules and Regulations and with Hospital and Governing Body policies

C Meetings The Bylaws Rules and Regulations Committee shall meet as often as necessary to accomplish its functions

SECTION 9 - MEDICAL RECORD/UTILIZATION REVIEW COMMITTEE

A Composition The Medical Record Utilization Review Committee is a standing committee of the Medical Staff and shall consist of physicians from the active staff representing the major departments a representative from administration and from

nursing services utilization review coordinator and discharge planner and the Health Information Services Director

B Responsibilities, Duties, and Authority The committee shall

- 1 review and evaluate medical records objectively using prescribed work sheets to assist in providing records that are adequate with regard to (a) continuity of care (b) use in quality assessment and improvement activities (c) assisting in protecting the legal interest of the patient the hospital and the responsible practitioner (d) clinical pertinence (particularly all significant changes in patient status) to be done by physicians (e) required documentation (f) patient/family involvement in the plan of care (g) receipt and acknowledgment of patient/family instructions (h) age specific information (particularly for infants and children) (i) pertinent psychosocial information and (j) evidence of informed consent
- 2 establish the format of the medical record in concert with the director of the Health Information Management department and review and advise the Administrator and MEC regarding all forms to be used in the medical record
- 3 review and recommend approval or not of all policies rules and regulations relating to medical records
- 4 recommend any need for and the interval for microfilming medical records and participate in decisions for computerization of medical record data
- 5 develop, or cause to be developed and implement a record review system that, over a reasonable period of time causes a representative sampling of the records of all practitioners to be evaluated for quality and clinical pertinence
- 6 furnish to medical staff and administration on a regular basis timely statistical data, the nature of which is to be determined through the information needs of the Hospital and Medical Staff
- 7 comply with applicable requirements of the utilization review plan approved by the Medical Staff and Governing Body
- 8 require documentation that utilization review is applied regardless of payment source
- 9 require that focused reviews be emphasized and
- 10 determine whether under utilization and/or over utilization of practices has an adverse impact upon the quality of patient care and recommend appropriate corrective actions to be taken

B Meetings The Medical Record UR Committee shall meet as often as necessary

to accomplish its functions and clinical pertinence review

SECTION 10 - MEDICAL ETHICS COMMITTEE

A Composition The Medical Ethics Committee which may also be referred to as the Medical Ethics shall be a standing Medical Staff committee which shall have active Medical Staff members. It may include lay representatives, nurses, social workers, clergy, ethicists, and an attorney, the Administrator (or designee). Its membership shall represent a diversity of professions and shall include both men and women. A Medical Ethics member may not participate in the initial or continuing review of any project in which the member has a conflicting interest except to provide information as requested by the Medical Ethics Committee. The Medical Ethics Committee may, at its discretion, invite nonvoting individuals with competence in special areas to assist in the review of issues which require expertise beyond or in addition to that available on the Medical Ethics Committee. The chairman shall be an experienced Medical Staff member and shall assist in the appointment along with the Chief of Staff of the remaining committee members.

B Meetings The Medical Ethics Committee shall meet as often as necessary to accomplish its functions at the call of the chairman. Except when an expedited review procedure is used, the Ethics Committee shall review proposed research at convened meetings at which a majority of the members of the Ethics Committee are present, including at least one member whose primary concerns are in nonscientific areas. The Ethics Committee shall prepare and maintain adequate documentation of Ethics Committee activities and shall report to the MEC.

SECTION 11 - MEDICAL/SURGICAL/PCU (MED/SURG/PCU) COMMITTEE

A Composition The Med/Surg Committee shall be a standing committee of the Medical Staff and shall consist of at least one medical staff member of the active medical staff, the Director of Med/Surg and a Head Charge nurse. The Chairman of the Committee shall be a standing member of the Medical Executive Committee. The nursing staff will be ex-officio members and shall not vote. Other appropriate personnel can be appointed as deemed necessary by the Chairman of the Med/Surg Committee.

B Responsibilities, Duties, and Authority The committee shall be responsible for

- 1 enhancing the quality of care on the general Med/Surg floors
- 2 assisting administration in planning programs of care for the continued growth of the Med/Surg unit
- 3 making recommendations for patient flow and interacting with the other clinical departments in matters that affect the operations of the Med/Surg unit
- 4 identifying the patient care needs and promoting the attainment of patient

care goals

- 5 serving as a liaison between the nursing staff, medical staff, and administration, and
- 6 making recommendations to the Medical Executive Committee on any area of quality control issues or recommendations for the improvement in hospital services.

B Meetings The Med Surg Committee shall meet as often as necessary to accomplish its function.

SECTION 12 – PATIENT SAFETY COMMITTEE

A Composition The Patient Safety Committee shall be a standing committee of the Medical Staff and shall consist of the Chief of Staff and an appointed active medical staff member as designated by the COS, the Patient Safety Officer. One of the physician members shall serve as Chairperson of the committee. The Committee shall call upon other physicians and staff members to participate in Committee meetings that relate to their department.

B Responsibilities, Duties, and Authority The committee shall be responsible for

- 1 Providing a systematic, coordinated and continuous approach to maintenance and improvement of patient safety.
- 2 developing a confidential system to track near misses, adverse events, sentinel events, patients, physician and staff,
- 3 assemble relevant patient safety data from internal and external sources.
- 4 The assembled information will be relayed to the MEC and Board of Directors,
- 5 conduct proactive risk assessment of a high risk process identified in the JCAHO Sentinel Event Alert or as identified by the Committee,
- 6 monitor and track Occurrence reports.
- 7 survey patients, family members, medical staff and other staff regarding their opinions, needs and perceptions of the risks to patients.
- 8 notify patient and family when appropriate about outcomes of care including unanticipated outcomes and shall assure them that appropriate clinical measures are taken to respond to the unanticipated outcome.

C Meetings The Patient Safety shall meet quarterly or as often as necessary to accomplish its function.

SECTION 13-PEER-REVIEW COMMITTEE

A Composition The Peer Review Committee is a standing committee of the Medical Staff and shall consist of the Chief of Staff or Designee to Chair the Committee, Chairman, Department of Medicine or Designee, Chairman, Department of Surgery or

Designee Chairman Department of OB GYN or Designee Chairman Department of Pediatrics or Designee Chairman Department of Family Medicine or Designee Member At Large appointed by Chief of Staff and the Chief Medical Officer who is an ex officio adviser and nonvoting member

B Responsibilities, Duties, and Authority The committee shall

- 1 Conduct fair meaningful and comprehensive peer review by assessing data measuring physician performance with respect to the following (a) medical assessment and treatment of patients (b) medication use and management (c) operative and other invasive procedures (d) resuscitation and its outcomes and (e) the appropriateness of clinical practice patterns
- 2 Assess aspects of physician behavior as it relates to appropriate medical management of patients and staff relationships
- 3 Assess departures from the usual utilization practices

C Processes

- 1 Conduct individual case reviews where performance is questioned as a result of measurement and assessment activities. An initial screening review will be done by either the clinical department or the Chief Medical Officer. The body doing the initial screening review will be determined by the individual clinical department. Charts reviewed by the Chief Medical Officer which need further review will be referred to the appropriate clinical department. Charts deemed by the clinical department to need still further review will be referred to the Peer Review Committee. The Chief Medical Officer may do an independent screening review on any charts initially screened by a clinical department.
- 2 The clinical department may consult a specialty reviewer which is either inside or outside the hospital's Medical Staff if needed to conduct individual case reviews.
- 3 Provide for participation in the review process by the individual whose performances are being reviewed.
- 4 Collect and maintain individual practitioner data for tracking trends to enhance education, patient safety and quality improvement.
- 5 Report composite data to MEC, Governing Board of the Hospital and clinical departments as indicated.
- 6 Provide individual practitioner data to the Credentials Committee for use in the reappointment process.

7 Refer Appropriate Cases to the Clinical Department MEC Governing Board or other entities to consider disciplinary action

D Meetings

1 To be held monthly or as indicated by the need for prompt case review

2 Contingency meetings can be called at any time by the Chairman of the Peer Review Committee with sufficient notice to deal with individual problems that are time sensitive

ARTICLE XII
MEETINGS

SECTION 1 - QUARTERLY MEDICAL STAFF MEETINGS

A Regular Meeting Medical Staff meetings shall be held on a quarterly basis. The agenda shall include cumulative reports by staff officers and by committee and department chairman for the review and evaluation of the work done. Elections for staff office will be held at this meeting. The Chief of Staff shall preside at all general meetings of the Medical Staff.

B Order of Business and Agenda The order of business and agenda of the Quarterly Medical Staff meeting will be determined by the Chief of Staff.

C Special Meeting Special meeting of the Medical Staff may be called at any time by the Chief of Staff or at the written request of the Administrator Governing Body the MEC or at least one-fourth (1/4) of the active staff members. The Chief of Staff shall call a special meeting within seven (7) days of his written request.

- 1 Written or printed notice stating the place, day and hour of any special meeting of the medical staff shall be delivered. Either personally or by mail to each member of the active staff not less than five (5) nor more than ten (10) days before the date of such meeting by or at the direction of the Chief of Staff. If mailed, the notice of the meeting shall be deemed delivered when deposited postage prepaid in the United States mail addressed to each staff member at his address as it appears in the records of the Hospital. Notice may also be sent to members of other Medical Staff groups who have so requested. If a Medical Staff member is present at the time a special meeting is called, this shall constitute a waiver of notice of such meeting and
- 2 No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

SECTION 2 - COMMITTEE AND DEPARTMENT MEETINGS

A Medical staff committees department and clinical services may by resolution provide the time for holding regular meetings and no notice other than in such resolution shall then be required. Departments shall meet at least quarterly. Committees shall meet as required by these Bylaws.

B A special meeting of any committee or department may be called by or at the request of the chairman or chief thereof by the Chief of Staff or by one third (1/3) of the group's current members. No business shall be transacted at any special meeting except that stated in the meeting notice.

C Notice of Meetings (Committee or Department)

- 1 Notice of regular meetings may be given orally or written.
- 2 For any special meeting or any regular meeting not held pursuant to resolution, written or oral notice stating the place, day and hour of the meeting shall be given to each member not less than five (5) days before the time such meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited in the United States mail addressed to the member at his address as it appears on the records of the hospital with postage prepaid.
- 3 The attendance of the Medical Staff member at the time a specific meeting is called shall constitute a waiver of notice to such meeting.

SECTION 3 - QUORUM

A General Staff Meeting (Regular or Special, Committee Meetings or Departmental Meetings)

1 The presence of ten percent (10%) of the voting members of the Medical Staff at any regular or special meeting shall constitute a quorum for the purpose of transaction of any business including amendment to the Bylaws, Rules and Regulations and the election of staff officers. A simple majority of those voting members who cast votes will be required to make decisions for the medical staff.

2 In the event that a quorum is not present at any regular or special meeting, those members present may meet as a sub-committee of the whole. Any action taken by those present acting as a sub-committee of the whole shall be referred for ratification purposes to the next regular or special meeting called for that purpose at which a quorum is present.

B Committee or Department Meeting

1 One half (1/2) of the voting members of a committee or department but not less than two (2) members shall constitute a quorum at any meeting

SECTION 4 - MANNER OF ACTION

A Except as otherwise specified in these Bylaws the action of majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group

B Action may be taken without a meeting of a committee or department by writing setting forth the action so taken and signed and dated by a majority of the members entitled to vote

SECTION 5 - MEETING MINUTES

Minutes of all meetings shall be prepared by the coordinator of the meeting and shall include a record of attendance and the vote taken on each matter. The minutes shall record a brief discussion of all problems discussed indicating any recommendation made and forwarded conclusions reached, and actions taken. The minutes shall be signed by the presiding officer, approved by the attendees, and forwarded to the MEC. A permanent file of the minutes of each meeting (and actions taken without an actual meeting) shall be maintained.

SECTION 6 - ATTENDANCE REQUIREMENT

A Regular Attendance Each member of the active staff shall be required to attend the following

- 1 At least fifty percent (50%) of the Quarterly Medical Staff meetings
- 2 Attendance at departmental meetings is determined by each department
Attendance at departmental meetings is required for a member of the medical staff when one of the member's cases is being reviewed or when the member is assigned to review cases of his peers

B Absence from Meeting

- 1 A member who is compelled to be absent from the required number of Quarterly Medical Staff meetings or attendance at required departmental meetings shall provide promptly in writing or verbally to the Medical Staff Coordinator the reason for such absence

- 2 Failure of an active member to attend the required number of Quarterly Medical Staff meetings or peer review assignments unless excused as described above for just cause shall automatically place the member on the provisional active staff for a period of one year
- 3 The meeting attendance record of each practitioner shall be maintained and made a part of the performance profile section of his credentials file

C Special Attendance Requirement

1 A practitioner whose patient's clinical course of treatment is scheduled for discussion at a meeting shall be so notified in writing by the Chairman or the Medical Staff Coordinator at least ten (10) days prior to the meeting. The notification shall indicate the time and place of the meeting, a statement of the issue(s) involved, and whenever apparent or suspect deviation from standard clinical practice is involved, and the fact that the Practitioner's appearance is mandatory.

2 Failure of a practitioner to attend any meeting with respect to which he was given notice that his attendance was mandatory shall, unless excused by the MEC upon a showing of good cause, result in an automatic suspension of all or such portion of the practitioner's clinical privileges as the MEC may direct pursuant to Article VII of these Bylaws. Such suspension shall remain in effect until the matter is resolved by subsequent action of the MEC or of the Governing Body, if necessary, pursuant to Article VII. In all other cases if the practitioner shall make a timely request for postponement supported by an adequate excuse that his absence will be unavoidable, such presentation may be postponed by the Chief of Staff or by the MEC if the Chief of Staff is involved until not later than the next committee or department meeting. Otherwise the pertinent clinical information available shall be presented and discussed as scheduled.

SECTION 7 - NONVOTING EX - OFFICIO MEMBERS

Individuals serving under these Bylaws as nonvoting ex officio members of a committee shall, unless otherwise specified, have all other right and privileges of regular members except they shall not be counted in determining the existence of a quorum.

SECTION 8 - MEETING AS A COMMITTEE -OF-THE-WHOLE

Notwithstanding any other provision of these Bylaws, whenever the Medical staff or a department or committee meets, it shall be considered to be meeting as a committee of the whole medical staff or department, respectively.

SECTION 9 - CONDUCT OF MEETING

All meetings shall follow an acceptable form of parliamentary procedure such as Robert's Rules of Order in the conduct of meeting business

ARTICLE VIII

CONFIDENTIALITY/IMMUNITY FROM LIABILITY

SECTION 1 - CONFIDENTIALITY OF INFORMATION

A General Records and proceedings of all medical staff committees having the responsibility of the evaluation and improvement of quality of care and performance in this hospital and including information regarding any member or applicant to the medical staff or for clinical privileges or practice prerogatives shall be confidential subject to release only in accordance with policies of the Medical Staff and privileged to the fullest extent permitted by law

B Agreement to maintain confidentiality All individuals participating in or attending such committees or otherwise entitled to access such information shall keep all of the proceedings, minutes discussions and documents related to any peer review clinical performance or quality management matter confidential and subject to disclosure only in accordance with policies of the Medical Staff

C Breach of confidentiality Inasmuch as effective peer review credentialing and quality/performance management activities must be based on free and candid discussions, any breach of confidentiality of the discussions deliberations or records of any medical staff meeting department or committee is outside appropriate standards of conduct for this medical staff and will be deemed disruptive to the operation of the hospital and as having an adverse impact on the quality of patient care Such breach or threatened breach shall subject the individual to disciplinary action under the Medical Staff Bylaws Rules and Regulations and applicable hospital policies

D In all matters relating to patients care and communications standards set forth by HIPAA shall be adhered to and enforced

SECTION 2 - PRIVILEGES/IMMUNITY

A Privileges Any act communication report recommendation or disclosure with respect to any applicant or member of the Medical Staff committee member or practice prerogatives performed or made for the purpose of assessing patient care or achieving and maintaining quality patient care in this or any other health care facility shall be privileged to the fullest extent permitted by law

B Application Such privileges shall extend to all individuals participating in the process of assessing patient care or achieving and maintaining quality patient care and practitioner performance including but not limited to members of the Medical Staff or Governing Body, Specified Professional Personnel the Administrator and designees and to third parties who supply information to any of the individuals or committees authorized to receive release or act upon such information For the purpose of this Article the term, "third parties" mean both individuals and organizations from which information has been requested and/or received by an authorized representative of a health care facility its Governing Body, the Medical Staff or any committee or component thereof

C Immunity Immunity from civil liability for any act communication report recommendation or disclosure shall be upheld to the fullest extent permitted by law

SECTION 3 - RELEASES

All applicants and members of the medical staff shall execute a release of liability and of confidential information pursuant to these Bylaws

ARTICLE XIV

AMENDMENT AND ADOPTION OF BYLAWS

SECTION 1- MEDICAL STAFF RESPONSIBILITY

The Medical Staff (through its Bylaws Committee and the MEC) shall have the initial responsibility to formulate, adopt and recommend to the Governing Body Medical Staff Bylaws and amendments thereto which shall be effective when approved by the Governing Body Such responsibility shall be exercised in good faith and in a reasonable timely and responsible manner reflecting the interests of providing patient care of the generally recognized professional level of quality and efficiency and of maintaining a harmony of purpose and effort with the Governing Body and with the community Neither Body may unilaterally amend the Medical Staff Bylaws Written notification of Bylaw changes shall be made available to the Medical Staff and other Licensed

Independent Practitioner

SECTION 2- METHODOLOGY

Medical Staff Bylaws must be adopted, amended, or repealed by the following process:

- A the affirmative vote of the majority of the Bylaws, Rules and Regulations Committee
- B the affirmative vote of the MEC
- C the affirmative vote of the Medical Staff members eligible to vote on this matter by written ballot or by action at a meeting at which a quorum is present, requiring a two-third vote, and
- D the approval of the Governing Body, which shall not be unreasonably withheld

ARTICLE XV

RULES AND REGULATIONS

SECTION 1- MEDICAL STAFF RULES AND REGULATIONS

The Medical Staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found within these Bylaws. The rules and regulations shall relate to the proper conduct of the Medical Staff organizational activities and will embody the specific standards and level of practice that are required of each medical staff member and other designated individuals who exercise clinical privileges or provide designated patient care services in the hospital. Such rules and regulations may be amended or repealed at any regular meeting of the Medical Executive Committee at which a quorum is present, by two-thirds (2/3) vote of the voting members present. Any such changes in the rules and regulations shall not become effective until approved by the Governing Body. Neither Body may unilaterally amend the Rules and Regulations. Written notification of Rules and Regulations changes shall be made available to the Medical Staff and other Licensed Independent Practitioners.

SECTION 2 - DEPARTMENTAL RULES AND REGULATIONS

Each department may establish through these Bylaws a set of rules and regulations which will become effective upon approval of the MEC and the Governing Body. Departmental rules and regulations shall be consistent with these Bylaws, with the

Medical Staff Rules and Regulations and with established Hospital policies and will include standards of performance for department members

SECTION 3 - RELATIONSHIP TO BYLAWS

In the event there is a discrepancy between the Bylaws and any Rules and Regulations the Bylaws shall supersede the Rules and Regulations

ARTICLE XVI

HIPAA PRIVACY RULE COMPLIANCE

SECTION 1 - COMMITMENT TO PRIVACY RULE COMPLIANCE

The use and disclosure of health information is governed, in part by the Standards for Privacy of Individually Identifiable Health Information adopted by the U.S. Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 as it may be amended from time to time (the Privacy Rule). Medical Staff members and Specified Professional Personnel authorized to provide services at the Hospital shall protect the privacy of patients' health information as required by the Privacy Rule, other applicable law and the Hospital's privacy policies and procedures. Further, the Medical Staff and Specified Professional Personnel are committed to protecting the privacy of patient health information in a manner that reasonably minimizes disruption to quality patient care.

SECTION 2 - ORGANIZED HEALTH CARE ARRANGEMENT

The Privacy Rule permits multiple health care providers that are Covered Entities (as defined in the Privacy Rule) and provide health care in a clinically integrated care setting such as the hospital setting to declare themselves an organized health care arrangement (OHCA). Organized health care arrangement status generally permits its health care provider's participants to use and disclose health information for purposes of treatment, payment and health care operations activities of the arrangement. As such, it protects patient privacy while minimizing disruption to quality patient care. Accordingly, the Hospital has organized an organized health care arrangement to facilitate the appropriate sharing of health information in the Hospital between and among the Hospital, its workforce members and business associates, Medical Staff members and Specified Professional Personnel authorized to provide services at the Hospital (the Hospital OHCA).

SECTION 3- AGREEMENT TO PARTICIPATE IN OHCA

By applying for an exercising clinical privileges at the Hospital each Medical Staff member and Specified Professional Personnel with service authorization agrees to participate in the Hospital OHCA

SECTION 4 - JOINT NOTICE OF PRIVACY PRACTICES

A The Privacy Rule requires a direct treatment provider who is a Covered Entity to deliver a notice of privacy practices to a patient no later than the provider's first date of service of the patient. Health care providers who participate in an organized health care arrangement may comply with this requirement by a joint notice. The implementation of a joint notice streamlines compliance with the Privacy Rule. Accordingly, with respect to Protected Health Information (as defined in the Privacy Rule) created or received by a Medical Staff member or an Specified Professional Personnel in connection with his or her provision of services in the Hospital, the Medical Staff member or Specified Professional Personnel provider agrees to abide by the terms of the joint Notice of Privacy Practices of the Hospital OHCA then in effect unless the Medical Staff member or Specified Professional Personnel provider has delivered a written notice to the Hospital specifying that he/she has opted out of the joint Notice of Privacy Practices. If a Medical Staff member or Specified Professional Personnel provider opts out, he/she shall reference the Hospital OHCA in their individual Notice of Privacy Practices.

B The Hospital may revise the Hospital OHCA's joint Notice of Privacy Practices in its reasonable discretion upon thirty days notice of a revision (with a copy of the revised joint notice) to the Medical Executive Committee (unless the compliance date of a law necessitates a shorter notice period). If the Medical Executive Committee does not object to the revised joint Notice of Privacy Practices before the expiration of the notice period, it shall become effective and binding upon Medical Staff members and Specified Professional Personnel providers with serve authorization upon expiration of the notice period.

SECTION 5 - CORRECTIVE ACTION

Whenever a Medical Staff member or Specified Professional Personnel provider with service authorization uses or discloses health information in a manner inconsistent with the Privacy Rule, other applicable law, the Hospital's privacy policies and procedures or the Hospital OHCA's joint Notice of Privacy Practices, such use or disclosure will be deemed disruptive to the operations of the Hospital and contrary to these Medical Staff

Bylaws Rules and Regulations and Hospital policies. If the Medical Executive Committee determines that such an inconsistent use or disclosure has occurred it may undertake such corrective action as it deems appropriate in accordance with these Medical Staff Bylaws Rule and Regulations

These Medical Staff Bylaws were updated for printing on

CHIEF OF STAFF

DATE

PRESIDENT/CEO

DATE

CHAIRMAN OF THE BOARD

DATE

 East Cooper
Regional Medical Center

MEDICAL STAFF BYLAWS

Revised December 2007



EAST COOPER REGIONAL MEDICAL CENTER
MEDICAL STAFF BYLAWS

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EAST COOPER REGIONAL MEDICAL CENTER
A Tenet Health System Facility
MEDICAL STAFF BYLAWS

PREAMBLE

East Cooper Regional Medical Center, a Tenet Health System Facility, is a corporation organized under the laws of the state of South Carolina and its purpose is to serve as a general acute care hospital providing patient care, education and research

Recognizing that the Medical Staff is responsible for the quality of medical care in the Hospital and must accept and assume this responsibility, subject to the ultimate authority of the Hospital's Governing Body, and that the best interests of the patient are better protected by concerted effort, the Practitioners of this Hospital are organized in conformity with these Bylaws and the Medical Staff Rules and Regulations. These Medical Staff Bylaws, Rules and Regulations create a framework within which medical staff members can act with a reasonable degree of freedom and confidence.

These Bylaws were prepared for compliance, and are to be construed in conformity with applicable hospital licensing laws, applicable accreditation guidelines and regulatory requirements, they do not constitute an express or implied contract between or among any individual, committee or entity, unless otherwise expressly determined by state law.

DEFINITIONS

The use of the male pronoun (he/his/him) throughout these Bylaws is applicable to either male or female.

- 1 **Administrator/Hospital President** the individual appointed by the Hospital to act on its behalf in the overall management of the Hospital
- 2 **Administrative Officer** a practitioner employed by the Hospital in a purely administrative capacity with no clinical duties or privileges and is subject to the regular personnel policies of the Hospital and to the terms of his contract or other conditions of employment, and need not be a member of the Medical Staff
- 3 **Asynchronous, Store and Forward Technologies** transmission of the patient's medical information from an originating site to the Physician at a distant site. Images must be specific to the patient's medical condition and of a quality appropriate for rendering or confirming a diagnosis or treatment plan. Asynchronous technology does not include telephone calls, images transmitted via facsimile machines and text messages. Photographs must be specific to the patient's medical condition and adequate for rendering or confirming a diagnosis.

or treatment plan

- 4 **Chief of Staff** a member of the active Medical Staff who is elected in accordance with these Bylaws to serve as chief officer of the Medical Staff of this Hospital
- 5 **Clinical Privilege/Privileges** specified diagnostic and therapeutic services that may be exercised by authorized individuals on approval of the Governing Body
- 6 **Completed Application** an application, either for initial appointment or reappointment to the Medical Staff or for clinical privileges, that has been determined by the applicable Medical Staff department (s), Credentials Committee, Medical Executive Committee (MEC) and the Governing Body to meet the requirements of the Medical Staff Bylaws Rules and Regulations
- 7 **Core Privileges** the Clinical Privileges the Medical Executive Committee determines reasonably necessary to pursue a practice specialty at the Hospital
- 8 **Patient Contact** a patient contact is defined as any (1) inpatient admission, (2) outpatient admission requiring direct physician contact, (3) consultation or (4) direct emergency room contact
- 9 **Days** calendar days, unless otherwise noted
- 10 **Dentist** an individual, who has received a Doctor of Dental Surgery or a Doctor of Dental Medicine degree and has a current, unrestricted license to practice dentistry in this South Carolina Categorized as Allied Health Professionals
- 11 **Department** a clinical division of the Medical Staff, grouping members in accordance with their specialty or major practice interest, as specified in these Bylaws
- 12 **Department Chairman** the member of the active Medical Staff who is duly selected in accordance with these Bylaws to serve as the head or director of a clinic department or service
- 13 **Ex Officio** service as a member of a body by virtue of an office or position held, and unless otherwise expressly provided and doesn't have voting rights
- 14 **Good Standing** the term "good standing" means a staff member whom, at the time the issue is raised, has met the attendance and committee participation and has the appropriate patient contacts requirements during the previous Medical Staff year, and has not received a suspension or restriction of membership or privileges in the previous twelve- (12) months

- 15 **Governing Body/Local Board** the local Governing Body of the Hospital, is the Board of Directors of East Cooper Regional Medical Center
- 16 **Hospital** East Cooper Regional Medical Center, A Tenet Healthcare System Facility
- 17 **Interactive Telecommunication System** multimedia communications equipment including at a minimum, audio and video equipment permitting two way, real-time interactive communications between patient and Physician at the sending site and Physician at the remote site The term does not include telephone, facsimile machines and electronic mail systems
- 18 **Medical Executive Committee/(MEC)** the Medical Executive Committee of the Medical Staff, unless otherwise specified
- 19 **Medical Review Committee (MRC)** the committee appointed pursuant to these Bylaws for the purpose of evaluating the evidence and making findings in a Medical Staff hearing
- 20 **Medical Staff** the formal organization of all physicians, oral surgeons and podiatrists, who hold an unrestricted license in the state of South Carolina and who are privileged to provide patient care services at East Cooper Regional Medical Center within the scope of their licensure and approved clinical privileges
- 21 **Medical Staff Term/Year** two years
- 22 **Medico Administrative Practitioner** The Medico-Administrative Staff category shall consist of Practitioners who serve the hospital in an administrative capacity without consistent clinical responsibilities Medico Administrative Staff shall attain staff membership through the same procedure required for other Medical Staff categories Their clinical privileges will be determined by the Credentials Committee and approved by the Medical Executive Committee on an individual basis when and if the need arises for clinical duties They will not hold Medical Staff office nor have a vote on departmental or hospital-wide matters They will not be responsible for Emergency Room call unless performing approved consistent clinical duties with appropriate on-call coverage with other physicians on the Medical Staff The right to Fair Hearing and Appeal process shall apply under these Bylaws only to clinical duties which are independent of the Practitioner's contract with the hospital
- 23 **Member** a practitioner who has been granted and maintains Medical Staff membership and (except for honorary staff) clinical privileges and who is in good standing pursuant to these Bylaws
- 24 **Physician** an individual who holds a current, unrestricted license as a M D

or D O in this state

- 25 **Podiatrist** an individual who has a doctor of podiatric medicine degree and a current, unrestricted license to practice podiatry in this state
- 26 **Practitioner** a physician as defined in these Bylaws with a current, unrestricted license issued by the state of South Carolina
- 27 **Service** a subdivision of either the Medical Staff or a clinical department, grouping members in accordance with their specialty or major practice interest, as specified in these Bylaws
- 28 **Allied Health Professionals (AHP)** individuals, other than those defined under "Practitioner," who provide direct patient care services in the Hospital under a defined degree of supervision, exercising judgment within the areas of documented professional competence and consistent with applicable law. These are individuals who are designated as AHP's by the Governing Body to be credentialed through the Medical Staff system. AHP's are not eligible for Medical Staff membership.
- 29 **Telemedicine** Telemedicine involves the use of electronic communication or other communication technologies to provide or support clinical care at a distance. Diagnosis and treatment of a patient may be performed via telemedicine link.
- 30 **Telemedicine Practitioner** Telemedicine means the use by a Practitioner of medical information exchanged from one site to another via electronic communications using 1) Interactive Telecommunications Systems, and 11) Asynchronous, Store and Forward technologies. Any practitioner providing Telemedicine services to inpatients and outpatients at the Hospital shall have an unrestricted license to practice medicine in this State.

ARTICLE I

NAME

These are the Bylaws of the Medical Staff of East Cooper Regional Medical Center, a Tenet Healthcare System Facility

ARTICLE II

PURPOSES AND RESPONSIBILITIES

SECTION I - PURPOSES OF THE MEDICAL STAFF

The purposes of the Medical Staff are to

A provide an organized body through which the benefit of Medical Staff membership (mutual education, consultation, and professional support) may be obtained by each Medical Staff member and the obligations of Medical Staff membership may be fulfilled,

B serve as the primary means for accountability to the Governing Body for the quality and appropriateness of the professional performance and ethical conduct of its members as well as of Allied Health Professionals,

C to strive for achievable quality patient care, efficiently delivered and maintained consistent with available resources, to the degree reasonably possible as determined by the state of the healing arts and resources locally available,

D develop a structure, reflected in Medical Staff Bylaws, Rules and Regulations, policies, protocols, and other applicable documents, that adequately defines the responsibility and when appropriate the authority and accountability of each Medical Staff component, and provide a means through which the Medical Staff may provide recommendations to the hospital's policy making and planning process

SECTION 2 - RESPONSIBILITIES OF THE MEDICAL STAFF

The responsibilities of the Medical Staff are to account for the quality and appropriateness of patient care rendered by all Practitioners and Allied Health Professionals authorized to provide patient care services in the Hospital by

A processing credentials in a manner that matches verified qualifications, performance, and competence with clinical privileges for all Medical Staff applicants and members, and practice prerogatives for all Allied Health Professionals,

B making recommendations to the Governing Body with respect to Medical Staff appointments, reappointments, staff category, provisional status, clinical privilege delineation, and as appropriate, department, service and/or unit assignment and corrective actions,

C participating in the Hospital quality/performance improvement program by conducting objectively all required peer evaluation activities through Medical Staff and/or department/service review, specific (committee) monitoring processes, and a comprehensive occurrence screening program,

D providing an effective utilization review program for allocation of medical services based upon patient-specific determinations of individual medical needs,

E providing continuing education that is relevant to patient care provided in the Hospital as determined, to the degree reasonably possible, from the findings of quality/performance related activities,

F initiating and pursuing corrective action when indicated,

G enforcing the Medical Staff Bylaws, Rules and Regulations uniformly and consistently, and

H providing the Medical Staff Office a copy of their current State Medical license or Dental license, current State DEA and Federal DEA registration certificates and appropriate verification of malpractice insurance coverage annually

ARTICLE III

MEDICAL STAFF MEMBERSHIP

SECTION I - MEMBERSHIP AS A PRIVILEGE

A Membership on the Medical Staff of this Hospital and/or assignment of clinical privileges shall only be granted and maintained by those professionally qualified and currently competent practitioners who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and the Rules and Regulations and policies of the Hospital. Appointment to and membership on the Medical Staff shall confer on the member only such clinical privileges which the Governing Body in accordance with these Bylaws has granted rights as

B No individual is automatically entitled to initial or continued membership on the Medical Staff or to exercise any clinical privilege in the Hospital merely because he is licensed to practice in this or any other state, or because he has previously been a member of this Medical Staff, or because he had, or now has membership or privileges at this or

another health care facility or another practice setting, or because he is a member of any professional organization

C Medical Staff membership does not create an employment or agency relationship between the Practitioner and the Hospital

D No physician shall admit or provide services to patients in the Hospital unless he is a member of the staff or has been granted temporary privileges in accordance with the procedures set forth in these Bylaws

SECTION 2 - GENERAL CRITERIA FOR MEMBERSHIP

Subject to exceptions provided by law or stated herein, Medical Staff membership and/or clinical privileges shall not be denied on the basis of sex, age, race, religion, creed, color, disability, or national origin, but shall be related to professional ability and judgment, relevant training and experience health status (subject to any necessary reasonable accommodation to the extent required by law), current competence, and to the Hospital's purposes, needs, and non-exclusive capabilities. When the determination is based on the Hospital's needs or its non-exclusive ability to provide the facilities, beds, and support staffing/services, consideration will be given, or as otherwise provided by law, to utilization patterns, and actual and planned allocations of physical, financial, and human resources, to general and specialized clinical and support services, and to the Hospital's specific goals and objectives as reflected in the Hospital's short and long range plans. It is recognized that some patient care services at the Hospital may be provided exclusively by a limited number of Practitioners selected by the Hospital, and who have been properly processed and granted Medical Staff membership and/or clinical privileges

SECTION 3 - QUALIFICATIONS AND OBLIGATIONS OF MEMBERSHIP OR PRIVILEGES

A **Qualification** In addition to the general criteria for membership, only physicians with a current, unrestricted license to practice in this state who can document their background, professional experience, worthy character, education, relevant training, judgment, and demonstrated current competence, adherence to the ethics of their profession, good reputation, health status (subject to any necessary reasonable accommodation to the extent required by law), the ability to work with others (staff members, members of other health care disciplines, Hospital management and employees, visitors, patients, and the community in general), and refrain from disruptive behavior which has or could interfere with patient care or the orderly operation of the Hospital, so as to demonstrate to the Medical Staff and Governing Body that any patient treated by them in the Hospital or in any of its facilities will be given care of the professional level of quality and efficiency as established by the Medical Staff and Hospital, shall be qualified for membership on the Medical Staff

B **Obligations** In addition to the other obligations listed in these Bylaws, each

applicant, by applying for or being granted membership or clinical privileges (temporary or otherwise), thereby agrees to

- 1 adhere to the generally recognized standards of professional ethics of his profession
- 2 not participate in fee splitting or "ghost" surgical or medical care
- 3 participate as required in peer evaluation activities
- 4 provide continuous care for his patients and delegate the responsibility for diagnosis or care of patients only to a member in good standing who has unrestricted clinical privileges to undertake that responsibility
- 5 obtain and document in the patient's medical record appropriate informed consent
- 6 abide by the Medical Staff Bylaws, Rules and Regulations, and applicable Hospital policies
- 7 complete adequately, and in a timely fashion, the medical and any other required records for all patients he admits or in any way provides care for in the Hospital. This will include timely completion of medical history and physical examinations for each patient admitted to the hospital
- 8 seek consultation whenever necessary
- 9 maintain the required amount of professional liability insurance in an amount and with a carrier approved by Tenet and the Governing Body and provide the hospital with a current certificate of insurance. The required coverage is \$1 million/\$3 million. The insurance must cover the types of privileges requested
- 10 reasonably assist the Hospital in fulfilling its uncompensated or partially compensated patient care obligations in the areas of professional competence and privileges
- 11 reasonably cooperate with the Hospital in its efforts to comply with accreditation, reimbursement, and legal or other regulatory requirements
- 12 supply requested information and appear for interviews with regard to membership or privileges
- 13 immediately notify the Administrator of the revocation or suspension of the applicant's professional license or the imposition of terms of probation or limitation of practice by any state licensing agency or the DEA, or of

any actions pending with regard to such adverse licensure activity, of the voluntary or involuntary loss of staff membership or clinical privileges at any health care institution, of the cancellation or restriction of professional liability coverage, of any adverse determination by a peer review organization or a third party payer reimbursement program concerning quality of care, of the commencement of a formal investigation or the filing of charges by the Department of Health and Human Services or any law enforcement agency or health regulatory agency of the United States or of any state, of the notice of intent to file or the filing of a claim alleging professional liability, or the filing of any criminal charges

- 14 maintain the confidentiality of all Medical Staff peer review matters, pursuant to these Bylaws
- 15 provide patients with care at the professional level of quality and efficiency as defined by the Medical Staff and Governing Body
- 16 discharge staff, department, committee and hospital functions for which he is responsible by staff category assignment, appointment, and election or otherwise
- 17 authorize the Hospital to consult with members of the Medical Staffs of other Hospitals with which the applicant has been associated and with others who may have information bearing on his competence, skill, character, ethical and other qualifications
- 18 consent to the Hospital's inspection of all records and documents that may be material to an evaluation of his professional qualifications for the clinical privileges he requests as well as his moral and ethical qualifications for staff membership
- 19 release from any liability, to the fullest extent permitted by law, all persons for their acts performed in connection with the investigation and evaluation of the applicant and his credentials
- 20 release from any liability, to the fullest extent permitted by law, all individuals and organizations who provide information regarding the applicant, including otherwise confidential information
- 21 consent to the disclosure to other health care entities, medical associations, licensing boards and other organizations any information regarding his professional or ethical standing that the hospital or medical staff may have, and release the medical staff and hospital from liability to the fullest extent permitted by law
- 22 comply with Medical Staff policies, rules and regulations

SECTION 4 - PARTICULAR QUALIFICATIONS

A Physicians An applicant for physician membership in the Medical Staff must hold an MD or DO degree issued by a medical or osteopathic school approved, at the time of issuance of such degree, by the State Board of Medical Examiners of the State of South Carolina and must also hold a valid, unrevoked and unsuspended certificate to practice medicine issued to him by the Board of Medical Examiners of the State of South Carolina. The clinical departments will establish specific qualifications for the granting of clinical privileges. Applicant must possess Board Certification recognized by the American Board of Medical Specialties (ABMS) within the specified time frame as determined by the applicant's respective board. If a specialty board does not specify a time frame for certification, the physician will have five (5) years from the time of completion of residency training to obtain specialty board certification. Physicians not only must obtain board certification by the ABMS, but they must maintain board certification in order to maintain medical staff membership. The requirement to maintain board certification will only apply to physicians appointed to the medical staff after February 1, 2004.

B Oral and Maxillofacial Surgeons An applicant for oral and maxillofacial surgeon membership in the Medical Staff must hold a doctor of dental medicine (DMD) degree or doctor of dental surgery (DDS) degree issued by a dental school approved, at the time of issuance of such degree, by the Board of Dental Examiners of South Carolina and must hold a valid, unrevoked and unsuspended certificate to practice dental medicine, as well as, a specialty certificate in oral and maxillofacial surgery, issued to him by the Board of Dental Examiners of South Carolina and must have successfully completed a post graduate program in oral and maxillofacial surgery accredited by a nationally recognized accredited body approved by the United States Department of Education. Applicant must possess Certification by the American Board of Oral and Maxillofacial Surgery (ABOMS) within the specified time frame as determined by the Board, or obtain Certification within (5) years from the time of completion of residency training. Oral and Maxillofacial Surgeons not only must obtain board certification by the ABOMS, but they must maintain board certification in order to maintain medical staff membership. The requirement to obtain and maintain ABOMS Board Certification will only apply to physicians appointed to the medical staff after February 1, 2007.

C Podiatrists An applicant for podiatric privileges in the medical staff must hold podiatric medicine degree (DPM) or equivalent degree issued by an approved podiatric school at the time of issuance. They must be approved by the State Board of Podiatry, hold a valid, unrevoked, unsuspended, certificate to practice podiatric medicine in the State of South Carolina. Applicant must possess Certification by the American Board of Podiatric Surgery (ABPS) within the specified time frame as determined by the Board, or obtain Certification within (5) years from the time of completion of residency training. Podiatrists not only must obtain board certification by the ABPS, but they must maintain board certification in order to maintain medical staff membership. The requirement to

obtain and maintain ABPS Board Certification will only apply to physicians appointed to the medical staff after February 1, 2007. The podiatrist would be responsible for the podiatric care of the patient, including the podiatric history and the physical examination as well as all appropriate elements of the patient's record. The podiatrist may write orders within the scope of his/her license, be consistent with the medical staff rules and regulations and in compliance with the hospital and medical staff bylaws.

D Allied Health Professionals Allied Health Professionals are not eligible for membership in the Medical Staff but may be granted appropriate practice privileges in the Hospital because they are duly licensed to practice in this or any state, or because they had, or presently have, staff membership or privileges at another health care facility or in another practice setting.

SECTION 5 - REQUEST FOR MODIFICATION OF MEMBERSHIP STATUS OR PRIVILEGES

A staff member may, either in connection with reappointment or at any other time, request modification of his staff category, department assignment, or clinical privileges by submitting a written request/application to the Hospital President. Such request/application shall be processed as noted in Article VI, Section 5.

ARTICLE IV

CATEGORIES OF THE MEDICAL STAFF

SECTION 1 - MEDICAL STAFF

The Medical Staff shall be divided into the following categories: active, associate, courtesy, consultative and honorary.

SECTION 2 - ACTIVE STAFF

A Qualifications The active staff category shall consist of physicians, oral Surgeons and podiatrists who regularly admit, or personally provide services other than written consultation, to patients in the Hospital and who are located (primary or satellite office and temporary or permanent residence) within a reasonable distance and/or travel time to the Hospital in order to provide continuous care to their patients.

At the time of initial appointment and at all times subsequent thereto, a member of the active staff shall meet all of the threshold criteria for exercising Core Privileges in his respective Department. The threshold criteria, which shall be identified by the Department and approved by the Medical Executive Committee, shall relate to minimum formal training, current board certification within five years of completing residency or

fellowship training, professional experience within the preceding twelve months, and clinical references

For clinical Departments which require a minimum number of admissions, procedures or patient contacts per year as a condition of Core Privileges, at least 24 of such procedures, admissions or patient contacts shall be performed at the Hospital per 12-month period. In the event that Core Privileges for a Department do not require a minimum number of admissions or procedures, the active staff member must demonstrate a minimum of 24 patient contacts per 12-month period at the Hospital. Failure to demonstrate the minimum number of procedures, admissions, or patient contacts during the relevant 12-month period shall be deemed a request for modification of membership status at the time of reappointment.

Upon reappointment, active staff members in Departments which require a specified number of procedures or admissions to qualify for and maintain Core Privileges must be able to demonstrate that a minimum of 48 procedures, admissions or patient contacts were performed at the Hospital during the preceding 24-month period. In the event a Department does not require a minimum number of procedures, admissions or patient contacts to qualify for Core Privileges, a practitioner seeking reappointment to the active staff must demonstrate a minimum of 48 patient contacts during the preceding 24-month period at the Hospital.

Hospital-based Practitioners who do not admit patients may be members of the active Medical Staff if otherwise qualified. Active staff members assume the functions and responsibilities of membership including, when appropriate, emergency service care, disaster plan assignment, and consultation assignments. Members of the active staff shall be eligible to vote, hold staff and departmental office, and serve on Medical Staff, departmental and Governing Body committees. Departmental meeting attendance will be determined by each department. Attendance at departmental meetings is required for a member of the medical staff when one of that member's cases is being reviewed or when the member is assigned to review cases of his peers. Active staff members shall participate in the performance improvement activities required of the Medical Staff and shall serve, when qualified and required to do so, as proctors for other practitioners during any period of temporary privileges pending membership processing or during initial membership provisional status period. Active staff will be required to participate in the Emergency Room call schedule if their specialty has one. Active staff applicants will be on a provisional status for one year following Board approval. At that one-year anniversary date they will be re-evaluated to determine their status.

B Request for Provisional Status Change A physician can request in writing to the Medical Staff Office to be placed on a one-year probation when his Active status is in question. The Medical Staff Office will issue a letter stating the probationary period and the requirements. The requesting physician will read and sign the letter and return it back to the Medical Staff Office. The request will be forwarded to the Credentials Committee, Medical Executive Committee and the Board of Directors for final approval. If after one year the physician fails to meet the requirements set forth in the Bylaws for Active staff,

he will be placed on Courtesy or Consulting staff until his next reappointment

SECTION 3 - ASSOCIATE

A Qualifications The Associate staff category shall consist of practitioners who 1) do not have privileges at any other hospital, but who 11) meet all the criteria for active staff membership except the minimum required number of admissions, procedures or patient contacts per year or preceding 12-month period. No surgical privileges will be granted in this category. Physicians awarded surgical clinical privileges prior to November 7, 2007 shall be permitted to maintain these privileges in accordance with the criteria set forth below

At the time of initial appointment and at all time subsequent thereto, a member of the associate staff shall meet all of the threshold criteria for exercising Core Privileges in his respective Department. The threshold criteria, which shall be identified by the Department and approved by the Medical Executive Committee, shall relate to minimum formal training, current board certification within five years of completing residency or fellowship training, professional experience within the preceding twelve months and clinical references

In order to facilitate ongoing professional practice evaluation, all patient admissions, procedures and patient contacts by members of the associate staff will be reviewed by the Department to which the Practitioner is assigned. Members of the associate staff must fulfill all requirements of the Active staff including, when appropriate, emergency service care, disaster plan assignment, and consultation assignments. They may serve on medical staff departmental and Governing Body committees. Departmental meeting attendance will be determined by each department. Attendance at departmental meetings shall be required for a member of the associate medical staff when one of that member's cases is being reviewed or when the member is assigned to review cases of his peers. Members of the Associate staff shall be eligible to vote at departmental and assigned committee meetings only. They may not vote at Quarterly Medical Staff meetings. Associate staff will be required to participate in the Emergency Room call schedule if their specialty has one. Associate staff members shall participate in the performance improvement activities of the medical staff.

If the number of admissions, procedures or patient contacts exceeds 24 or more in any 12-month period, the Associate staff practitioner will be advanced to Active staff membership. If the practitioner should attain Active staff privileges at any other hospital, he will be placed on Courtesy staff.

SECTION 4 - COURTESY STAFF

A Qualifications The Courtesy staff category shall consist of Practitioners who 1) are located (primary or satellite office) within a reasonable distance and/or travel time to the Hospital to provide continuous care for their patients, and 11) are members of the active or associate active staff of another hospital in which their regular participation in

performance improvement activities is documented and their performance evaluated. At the time of initial appointment and at all time subsequent thereto, a member of the courtesy staff shall meet all of the threshold criteria for exercising Core Privileges in his respective department. The threshold criteria, which shall be identified by the Department and approved by the Medical Executive Committee, shall relate to minimum formal training, current board certification within five years of completing residency or fellowship training, professional experience within the preceding twelve months, and clinical references.

Except for written consultations which may be unlimited, a member of the courtesy staff shall have not more than 24 admissions, procedures or patient contacts at the Hospital during a 12-month period. In the event a Practitioner exceeds the maximum number of admissions, procedures or patient contacts for courtesy staff status, he will be appointed automatically to the active staff category for the next reappointment date.

Upon reappointment, courtesy staff members in Departments which require a specified number of procedures, admissions or patient contacts to qualify for and maintain Core Privileges must be able to demonstrate that no more than 48 procedures or admissions were performed at the Hospital during the preceding 24-month period. In the event a Department does not require a minimum number of procedures, admissions or patient contacts to qualify for Core Privileges, a Practitioner seeking reappointment to the courtesy staff must demonstrate that he had no more than 48 patient contacts during the preceding 24-month period at the Hospital.

Courtesy staff membership shall provide satisfactory evidence to the Credentials Committee of such membership, participation, and evaluation. Courtesy staff members are not eligible to vote on Medical Staff or departmental matters, or hold Medical Staff office. They may serve as non-voting members of designated departmental and Hospital committees in which they participate, except for the Credentials Committee and the Medical Executive Committee. They shall not be required to serve on the emergency roster.

SECTION 5 - CONSULTING STAFF

Qualifications The Consulting Medical Staff consists of physicians who do not admit patients to the hospital but who desire privileges in order to provide only consultative services to patients at the request of active, associate or courtesy staff physicians. There is no numeric limit to the number of written consultations that can be provided. Consulting staff generally provides expertise in a specialty or subspecialty that is not otherwise available through active or courtesy membership. Consulting staff members are not eligible to admit patients, perform surgery, vote, or hold office. They are not required to serve on committees or to take part in the emergency room call schedule. Consulting staff members may render assistance in the operating room at the specific request of a surgeon who has admitting and operative privileges at East Cooper Regional Medical Center. They are required to abide by the Bylaws, Rules and Regulations of the

Medical Staff and Governing Body and applicable hospital policies

SECTION 6 - HONORARY STAFF

Qualifications The Honorary staff category shall consist of Practitioners who are not active in the Hospital or who are honored for emeritus positions. These Practitioners may have retired from active practice and may no longer reside in the immediate community. They are not eligible to vote on Medical Staff matters, hold Medical Staff or departmental office, serve on committees, or admit or care for patients. They must discharge the basic responsibilities of all Medical Staff members, abide by all policies, Bylaws, Rules and Regulations and uphold the ethical principles of their profession. They are not required to have professional liability insurance or to attend Medical Staff or departmental meetings, but may do so if they wish.

SECTION 7 - LIMITATIONS

The prerogatives set forth under each staff category are general in nature and may be subject to limitations by special conditions attached to a Practitioner's staff membership, by other Sections of these Bylaws, and by other policies of the Hospital. The Board of Directors will have the prerogatives to waive and/or amend particular qualification only after due consideration and documentation of an individual's physical limitations.

SECTION 8 - WAIVER OF QUALIFICATIONS

Any qualifications may be waived at the discretion of the Board upon determination that such waiver will serve the best interests of the patients.

ARTICLE V

PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

SECTION 1 - CONDITIONS AND DURATION OF APPOINTMENT AND REAPPOINTMENT

Initial appointment and reappointments to the Medical Staff shall be made by the Governing Body upon a recommendation from the MEC, and shall be for a period up to, but not to exceed two (2) years. However, in the event of unusual delay or inappropriate recommendation on the part of the MEC, the Governing Body may act without or contrary to such recommendation on the basis of documented evidence of the applicant's or member's professional and ethical conduct. Prior to taking such action, however, the Governing Body shall notify the MEC of its intent and shall designate an action date prior to which the MEC may still fulfill its responsibility. Peer input shall be obtained.

and considered for all applicants for appointment and reappointment

SECTION 2 - PROCEDURE FOR APPOINTMENT

A Application for Initial Appointment Each application for appointment to the Medical Staff shall be in writing, submitted on the prescribed form, and signed by the applicant. When an applicant is provided an application, he shall also be given access to a copy of these Bylaws, the Medical Staff and departmental Rules and Regulations, and applicable Hospital policies.

B Applicant's Responsibility The applicant shall have the burden of producing adequate information for a proper evaluation of his competence, character, skill, ethics, health status (subject to necessary reasonable accommodation to the extent required by law), ability to work with others, and other qualifications. Neither the Governing Body nor any Medical Staff committee shall have any obligation to review any application until the applicant completes it in all respects and submits all required information and supporting material. The applicant shall provide accurate, up to date information on the application. The applicant shall be responsible for resolving any doubts regarding the application and qualifications for membership and privileges requested. The application process must be completed within one (1) year from the time application was received by the Medical Staff Office. The applicant agrees to report immediately to the Administrator any change in the information that occurs after an application has been submitted. Any committee or its designee may request the applicant to appear for an interview with regard to the application. Failure to comply with any of these provisions, including failure to appear for any requested interview, may result in the application being deemed incomplete, or in the denial of membership or privileges, or may subject the practitioner to disciplinary action.

The information shall include, but not be limited to

- 1 identifying information
- 2 undergraduate education
- 3 postgraduate education and professional degrees (need source verification)
- 4 internship (need source verification)
- 5 residency/fellowship (need source verification)
- 6 all past and present Hospital and other health care entity affiliations (need source verification)
- 7 memberships in professional associations, societies, academies, colleges, and faculty/training appointments (need source verification)

- 8 specialty board certification status (need source verification)
- 9 state licensure with expiration date(s) (need source verification)
- 10 Drug Enforcement Administration (DEA) registration with expiration date (Both state and Federal DEA's)
- 11 professional references consisting of three (3) references two must be physicians, one in the same medical specialty as the applicant, and preferably one from an active ECRMC physician For applicants recently completing medical training the third reference will be the head of the clinical department where the applicant trained For applicants recently employed by a teaching or training hospital, the third reference must be from the head of that clinical department For applicants who have not recently been associated with a teaching center the third reference must be a physician familiar with the applicant's medical expertise All references must have recently worked with the applicant and directly observed his professional performance over a reasonable period of time They must be willing to provide reliable information regarding the applicant's current clinical ability, ethical character, and ability to work with others
- 12 previous practice data
- 13 continuing medical education for the past two years
- 14 bibliography of publications speeches, and meetings attended, with dates
- 15 professional liability insurance, including carrier, amount and dates of coverage (need source verification) and past and present professional liability history
- 16 Responses to the following questions can and may be asked
 - (a) Has any professional license of yours, in any jurisdiction, or your DEA registration ever been denied, limited (either voluntarily or involuntarily), suspended, revoked, voluntarily or involuntarily surrendered or otherwise acted against or is any such action pending?
 - (b) Have your clinical privileges (including, but not limited to temporary, locum tenens, admitting, consulting, and assisting) or membership at any health care facility ever been limited, suspended, reduced, denied, modified, revoked, not renewed, voluntarily or involuntarily relinquished or limited, or otherwise adversely acted upon, or is any such action pending?

(c) Have your clinical privileges or membership in any managed care organization, or medical or professional group (e.g., HMO, PPO, IPA, etc.) ever been (either voluntarily or involuntarily) limited, suspended, reduced, denied, modified, revoked, not renewed, voluntarily relinquished or otherwise adversely acted upon, or is any such action pending?

(d) Have you ever been denied or voluntarily or involuntarily relinquished membership, or renewal thereof, or had your membership or affiliation revoked or otherwise acted against, or been subject to disciplinary action at any health care facility, medical group, in any medical or professional group or organization, or is any such action pending?

(e) Have you ever been notified of an investigation or to appear before any licensing agency (State Board of Examiners, DEA, etc.) for a hearing or complaint with regard to your professional license or DEA registration?

(f) Have you ever been convicted of a felony or misdemeanor (other than minor traffic offenses) or is any such action pending?

(g) Has any judgment or settlement been made against you in a professional liability case? If so, on a separate sheet, list the complete case name, the court in which the case was filed, the date of loss, the date you first received notice of the claim, the date of resolution, your insurance carrier and the amount of judgment or settlement paid on your behalf for each judgment or settlement

(h) Has any professional liability insurance claim been filed against you or have you reported any malpractice claim to your insurance carrier or have you received any letter of intent to sue?

(i) Are there any professional liability cases pending against you? If so, on a separate sheet, list the complete case name, court in which it was filed, date of loss, date you received notice of the claim, its current status, the name of your insurance carrier, and an explanation of the nature of the case

(j) Has any professional liability insurance carrier canceled, refused coverage, excluded specific procedures from your coverage, or has your insurance been rated up or has a surcharge been imposed by your insurance carrier, or is any such action pending?

(k) Have you ever discontinued practice for any reason (other than for routine vacation or formal education/training) for one month or more?

(l) Have you ever been sanctioned, suspended, or otherwise restricted

from participation in Medicare, Medicaid, or any government or private insurance plan?

The Medical Staff and Governing Body shall inquire, to the extent and in a manner permitted by law, into the physical and mental health status of the applicant so as to determine the practitioner's qualifications to render the privileges requested

- 17 a request for staff membership category and, if such exists, the department or clinical service assignment desired
- 18 clinical privileges desired
- 19 a specific signed consent for immunity and release from liability for all individuals involved in and performing the credentialing function
- 20 a small photo for identification purposes only
- 21 a list of medical staff physicians who have agreed to provide patient coverage in the absence of the applicant

C Submission of the Application The application shall be submitted through the Administrator to the Medical Staff Office for the purpose of assisting the Credentials Committee chairman, or designee, to have all information verified. The Hospital shall query the National Practitioner Data Bank (NPDB) and applicable state licensing board, if required, in compliance with existing laws and hospital policy, for all practitioners who are applying for privileges or membership. The applicant must immediately report to the Medical Staff Office any change in the information in the application that occurs after the application has been submitted.

D Significant Misrepresentation If an applicant supplies information in the application process that contains significant misrepresentations or omissions, this may be grounds for denial of the application, or if membership or privileges have been granted, for corrective action under these Bylaws.

E Incomplete Application - Further Information - Application Withdrawn From Processing Any committee or individual charged under these Bylaws with the responsibility of reviewing an application for appointment, reappointment, or new clinical privileges, may, upon review of the application, deem any such application incomplete. The fact that an application is deemed complete by the Medical Staff Office or a department or committee does not preclude the medical staff office or a committee or department which subsequently reviews the application from deeming it incomplete. If an application is deemed incomplete, it will not be processed. The individual or committee that deems an application incomplete shall request further documentation or clarification from the applicant. Such committee or individual requesting further documentation or clarification shall notify the applicant in writing and shall afford the applicant a set period of time to provide the requested information and clarification.

Such Period of time shall be as deemed appropriate by the individual or committee requesting the information, but shall not exceed sixty (60) calendar days from receipt of the request to provide the requested information. Failure of an applicant to timely produce all of the requested information, documentation and clarification shall result in the application being deemed incomplete and voluntarily withdrawn. Such action will not result in the filing of a report with the applicable state-licensing agency nor with the National Practitioner Data Bank. Any subsequent application submitted by this Practitioner shall be processed as an initial application under these Bylaws. Notwithstanding any other provision of these Bylaws, any Practitioner whose application is discontinued from processing pursuant to this section will not be entitled to the hearing and appeal rights under these Bylaws.

F Departmental Review Within sixty (60) days of receipt of the completed application, the Chairman of each department in which the applicant seeks privileges shall provide the Credentials Committee with a specific written or oral recommendation relating to staff category, clinical privileges, department affiliation, and any conditions or recommend that the application be deferred for further consideration.

G Credential Committee Review Within sixty (60) days of receipt of the completed application and recommendation of the department(s), the Credentials Committee shall make a written recommendation to the MEC as to membership, and, if membership is recommended, as to staff category, privilege delineation, department/service assignment, and any conditions attached to the appointment.

H MEC Review and Recommendation At its next regular meeting after receipt of the recommendations of the Credentials Committee, the MEC shall submit its recommendation to the Governing Body relating to membership, and if appointment is recommended, to staff category, clinical privileges, and department affiliation and any special requirements or conditions. The recommendation shall be based on the review of all available information. The MEC may take action by recommending that the Governing Body either

- (a) defer making a recommendation,
- (b) appoint the applicant to a medical staff category in provisional status, clinical privileges, and department affiliation, or
- (c) reject the applicant's request for membership and/or privileges

- 1 The MEC may defer action on a complete application for a period not to exceed thirty (30) days except for good cause
- 2 When the recommendation of the MEC is favorable to the applicant, the Administrator will forward it, together with all supporting documentation, to the Governing Body for consideration at its next scheduled meeting
- 3 When the recommendation of the MEC is adverse to the applicant, the Administrator shall so inform the applicant within seven (7) working days

advising him of his hearing and appeal rights under these Bylaws

- 4 Notice of an adverse recommendation shall be forwarded to the Governing Body for its information, but shall not be acted upon until after the affected individual has exercised or waived the right to a hearing and appeal under these Bylaws

II Action by the Governing Body

- 1 Unless subject to the provisions of Hearing and Appellate Review Procedures of these Bylaws, the Governing Body or its duly authorized committee shall act on the matter at its next regular meeting following receipt of the recommendation of the MEC
 - (a) If the Governing Body adopts the recommendation of the MEC, it shall become the final action of the Hospital
 - (b) If the Governing Body does not adopt the recommendation of the MEC, the Governing Body may refer the matter to the MEC with instructions for further review and recommendation and a time frame for responding to the Governing Body. The MEC shall review the matter and shall forward its recommendation to the Governing Body. If the Governing Body adopts the recommendation of the MEC, it shall become the final action of the Hospital
 - (c) If the action of the Governing Body is adverse to the applicant, the Administrator shall send written notice to the applicant within seven (7) working days advising the applicant if he is entitled to the hearing and appeal rights under these Bylaws
 - (d) An adverse decision of the Governing Body shall not become final until the applicant has exercised or waived his hearing and appeal rights under these Bylaws. Except for corrective action taken pursuant to Article VII, Section 3, adverse action recommended by the MEC shall not take effect until the Governing Body has made its final decision. The fact that such adverse decision is not yet final shall not be deemed to confer membership or privileges when none existed before
- 2 At its next regular meeting, after all of the affected individual's hearing and appeal rights under these Bylaws have been exhausted or waived, the Governing Body shall take final action. All decisions to appoint shall include a delineation of clinical privileges, staff category, department affiliation and any applicable conditions and the applicant shall be so notified

Subject to any applicable provisions of the Fair Hearing and Appellate Review Procedures, notice of the Governing Body's final decision shall be given in writing through the Administrator to the applicant within seven (7) working days of the final decision. The Chief of Staff shall give notice to the

MEC, the Credentials Committee, and the department chairman. In the event a hearing and/or appeal was held, Fair Hearing and Appellate Review Procedures, Appeal to Governing Body, shall govern notice of the Governing Body's final decision.

J Provisional Status All initial appointments to any category of the Medical Staff shall be provisional for twelve (12) months. The care observed shall be relevant to the privileges granted. The purpose of observation is to determine the individual's eligibility for advancement from provisional status and for exercising the clinical privileges provisionally granted. The Chairman shall complete a provisional form with comments on the appointee's performance. Each provisional report will be evaluated when the provisional year is completed in order to track the physician's compliance with the requirements of the Medical Staff. A Practitioner may request an additional year on provision to meet the Active staff requirements. If after that one (1) year, the practitioner fails to meet the necessary requirements, he'll be assigned to the Courtesy or Consulting staff category and will not be able to apply to the Active staff for one (1) year. No member may be on provisional status for a total period longer than twenty-four (24) months. Unless excused for good cause by the MEC and Governing Body, a Practitioner's failure to complete the required number of Patient Contacts, Quarterly Medical Staff meetings or required peer review assignments shall be deemed voluntary relinquishment of Active staff privileges and membership, such affected practitioner shall not be entitled to the hearing and appeal rights under these Bylaws.

K Previously Denied or Terminated Applicants Notwithstanding any other provision of these Bylaws, if an application is tendered by an applicant who has been previously denied membership and/or privileges, or who has had membership and/or privileges terminated, or whose prior application was deemed incomplete and withdrawn, and it appears that the application is based on substantially the same information as when previously denied, terminated, or deemed withdrawn, then the application shall be deemed insufficient by the Credentials Committee and returned to the applicant as unacceptable for processing. No such application shall be processed, and no right of hearing or appeal shall be available in connection with the return of such application. Applicant must then wait one 12 month period before reapplying.

L Telemedicine Practitioner Any Practitioner wishing to provide Telemedicine services for the diagnosis and treatment of patients at the Hospital, shall have an unrestricted license to practice medicine in the State. In determining whether to grant Privileges in Telemedicine, the Hospital may utilize credentialing information from the distant site (the site where the practitioner providing the professional practice is located).

SECTION 3 - THE REAPPOINTMENT PROCESS

A Application At least ninety (90) days prior to a Practitioner's privileges expiring (based on a two year reappointment) the Medical Staff Office shall provide each member

with an approved "Application for Reappointment" form which must be completed and returned within thirty (30) days to the Medical Staff Office for review. A late fee will be charged for the continued processing of the application past the 30 day deadline. Information to be available for review shall include at least objective evidence of the individual's clinical competence based on peer review activities,

- 1 evidence of the individual's support of the Medical Staff and Hospital (e g , medical record deficiency/delinquency status, meeting attendance, committee service, satisfaction of minimum patient care requirements to maintain staff category, compliance with the Bylaws, Rules and Regulations, and applicable hospital policies),
- 2 any request or recommendation for changes in staff category, clinical privileges, or department assignment, citing the reasons and supporting information,
- 3 evidence of consideration of the staff member's health status (subject to necessary reasonable accommodation to the extent required by law),
- 4 information regarding any sanctions imposed by another health care facility, professional organization, or licensing authority,
- 5 malpractice claims experience since the last reappraisal, including at a minimum, final judgments and settlements against the applicant, identifying the case name, court, date of loss, date of disposition, amount paid in judgment or settlement and a description of the case,
- 6 evidence of current licensure and DEA registration,
- 7 evidence of professional liability coverage (carrier, type, policy number, amount, and expiration date) and any limitations,
- 8 information regarding previously successful or currently pending, challenges to any licensure or registration (DEA) or the voluntary or involuntarily relinquishment of such licensure or registration,
- 9 information regarding voluntary or involuntary termination of membership, or the voluntary or involuntary limitation, reduction, or loss of clinical privileges at another health care facility,
- 10 evidence of a query sent to the National Practitioner Data Bank, information regarding any pending criminal charges or criminal convictions,
- 11 As of January 1, 2000, All staff members are required to complete forty (40) CME credit hours every two-(2) years in Category I AMA approved

credit within the staff member's medical specialty Any staff member who fails to meet this requirement shall be given six (6) months to complete the required CME hours He will be on Provisional staff until the hours are accomplished Failure to complete the required hours in six (6) months will result in loss of staff privileges, and

12 List of staff member's physician to cover patients in his absence

B Failure to Complete Application/Incomplete Application A Practitioner who fails to return the form or to supply all of the required information within thirty (30) days prior to the expiration of the current appointment period or respond in a timely manner to a request for information shall be deemed to have resigned his Medical Staff membership, effective as of the date of the expiration of his current appointment A Practitioner who is deemed to have resigned under this section shall not be entitled to the hearing and appeal rights under these Bylaws

C Applicant's Responsibility The applicant shall have the burden of producing adequate information for a proper evaluation of his current competence, character, skill, ethics, health status in terms of his ability to practice in the area in which privileges are sought (subject to necessary reasonable accommodation to the extent required by law), ability to work with others, and other qualifications By applying for appointment or reappointment to the Medical Staff, or for clinical privileges, the Practitioner agrees to comply with the Medical Staff Bylaws, the Medical Staff and departmental Rules and Regulations, and applicable Hospital policies

D Processing Delays The time periods specified are to guide the parties in accomplishing their tasks If reappointment processing has not been completed by an appointment expiration date through no fault of the member, the member shall maintain his current membership status and privileges until such processing is completed, except to the extent that corrective action is taken If the processing delay is attributable to the member's failure to provide required information, his membership shall terminate pursuant to Section 6 in this Article Any extension of an appointment pursuant to this Section does not create a vested right in the member for continued appointment through the entire next cycle but only until such time as processing of the application is concluded

E Department Review The Medical Staff Office shall forward to the department Chairman the reappointment application and all relevant information The department Chairman shall render to the Credentials Committee within thirty (30) days of receipt, an individual specific written statement regarding the department member's reappointment and clinical privileges based on the above information and any other pertinent information available The reason for any change shall be documented

F Credentials Committee Review The Credentials Committee shall review all pertinent information and within thirty (30) days make its written recommendation to the MEC concerning the member's reappointment and clinical privilege delineation The

reason for any change of such recommendation shall be stated and documented. Action by the Governing Body shall be governed by Section 2 I of Article V of these Bylaws.

SECTION 4 - CLOSED -STAFF, EXCLUSIVE CONTRACTS

A Exclusive Contracts The Governing Body may determine as a matter of policy that certain Hospital clinical facilities may be used only on an exclusive basis in accordance with written contracts between the Hospital and qualified professionals. These may include, but are not limited to, emergency care services, anesthesiology services, radiology services, pathology and clinical laboratory services. Applications for initial appointment or for privileges related to those Hospital facilities and services specified in such contract(s) will not be accepted for processing unless submitted with confirmation from the Administrator that they are from applicants that have an existing or proposed contract with the Hospital.

B Contract Practitioners A Practitioner who is providing contract services pursuant to Section 4 A, must meet the same membership qualifications, must be processed for appointment, reappointment, and clinical privilege delineation in the same manner, and must fulfill all of the obligations for membership category and clinical privileges as any other applicant or member.

C Termination/Reduction of Privileges Practice at the Hospital is always contingent upon continued staff membership, and is also dependent on the clinical privileges granted. The right of a Practitioner who is providing contract services to practice at the Hospital is automatically terminated when his staff membership expires or is terminated. Similarly, his right to render services under the contract is automatically limited to the extent that his clinical privileges are reduced, restricted or terminated.

D Expiration/Termination of Contract The effect of expiration or other termination of a contract upon a Practitioner's staff membership and clinical privileges will be governed solely by the terms of the Practitioner's contract. If the contract is silent on the matter, then contract expiration or termination will not affect the Practitioner's staff membership or clinical privileges, except that the Practitioner may not thereafter exercise any clinical privileges for which the Hospital has made exclusive contractual arrangements with another Practitioner.

SECTION 5 - MEDICO-ADMINISTRATIVE PRACTITIONERS

Practitioners who have a contract with the Hospital, either full time or part-time, in a Medico Administrative position that includes staff clinical responsibilities or functions, must be members of the Medical Staff. In addition to any applicable terms of the contract, such Practitioners shall achieve staff membership and clinical privilege delineation through the same procedure as is required for other Medical Staff members. The right to the hearing and appeal procedures under these Bylaws shall apply if the

Practitioner's clinical privileges, which are independent of the Practitioner's contract, are also terminated, removed or suspended

SECTION 6 - LEAVE OF ABSENCE FOR EDUCATIONAL, MEDICAL OR PERSONAL REASONS

A Request for Leave of Absence A member may request a voluntary leave of absence from the Medical Staff by submitting a written request to the Administrator whom will transmit this request to the Credentials Committee and the MEC. The request shall state the reason for the request and the specific time period that may not exceed the member's current term of appointment. The MEC and the Governing Body must approve all leaves. By requesting a leave of absence the member understands and agrees that he will be treated as an initial applicant for the purpose of evaluating his qualifications for reinstatement and he shall bear the burden of proof to demonstrate to the satisfaction of the MEC and the Governing Body that he is qualified for reinstatement. During the period of leave, the member's clinical privileges shall be inactive.

B Request for Reinstatement At least thirty (30) days prior to termination of leave, or at any earlier time, the member may request reinstatement of privileges by submitting a written notice to that effect to the Administrator, who will transmit this notice to the Credentials Committee and the MEC. The member must also submit a written summary, detailing his professional and patient care activities during the leave. The Credentials Committee shall evaluate the request and may deem it incomplete if any necessary information is not provided. The MEC on receipt of the recommendation of the Credentials Committee, may deem the request incomplete, may request further information from the member, may defer action on the request, or may make a recommendation to the Governing Body concerning the reinstatement of the member's privileges and any conditions that should be attached. Thereafter the procedure provided in Article V, Section 2 shall apply.

C Failure to Request Reinstatement Failure without good cause to request reinstatement to supply sufficient information for the request to be deemed complete, or failure to provide a summary of professional and other activities as above required shall constitute a voluntary resignation from the staff effective immediately. The MEC shall in its sole discretion, and after giving the Practitioner an opportunity to address the MEC, determine whether good cause exists. Such voluntary resignation shall not entitle the Practitioner to the hearing and appeal rights under these Bylaws. A request for staff membership subsequently received from this Practitioner shall be treated and processed as an application for initial appointment.

D Routine Observation Requirement In the discretion of the MEC, reinstatement may be made subject to an observation requirement for a period of time during which the Practitioner's clinical performance is observed by one (1) or more designated Medical Staff members. Such routine observation shall not be considered disciplinary action and shall not entitle the practitioner to the hearing and appeal rights under these Bylaws.

E Request for Leave of Absence for Medical Reasons If a member of the medical staff is absent from his usual practice of medicine for greater than 30 days for medical reasons, a request for medical leave of absence must be submitted to the Chief of Staff who will refer the request to the Credentials Committee and the MEC. The request must state the reason for the medical leave and the anticipated length of leave. The request must be approved by the MEC and the Governing Body. Upon return to active medical practice, the member must submit a letter from his physician to the Chief of Staff stating the member's physical and mental competence to return to hospital medical practice. The MEC and the Governing Board will approve the member's return to the medical staff. If a significant period of time elapses between the time the competency letter is received and the next meeting of the MEC, the administrator in collaboration with the Chief of Staff can grant reinstatement pending approval at the next scheduled meeting of the MEC and Governing Board.

SECTION 7 – IMPAIRED PHYSICIAN POLICY

For the purpose of these Bylaws the term impaired is hereby defined as any physical, mental or pharmacologically induced disability that interferes with a practitioner's ability to perform his medical or administrative duties. This policy is separate from any disciplinary action towards the practitioner for any reason other than impairment. If any individual working in the medical center has a reasonable suspicion that a practitioner appointed to the medical staff exhibits signs of physical and/or mental impairment the following steps should be taken:

The individual who suspects the Practitioner of being impaired must give a written report to the Chief Executive Officer (CEO) and Chief of Staff (COS). The individual making the reports does not need to have definitive proof of the impairment, but a factual report must be submitted to include a description of the actions or incident(s) that led to the belief that a Practitioner might be impaired. The CEO will forward any reports received to the COS, and the COS will forward any reports received to the CEO for information. Initial informal resolution may be attempted with the involvement of the COS and CEO, the individual making the report and the Practitioner. The Practitioner and the individual making the report may each meet separately with the COS and CEO in an attempt to resolve the issue. The name(s) of the individual(s) who filed the report will be kept confidential until such time as formal action is undertaken to address the incident or documented pattern of impairment. If after discussion of the incident(s) with the parties involved, the COS believes there is enough information to warrant an investigation, an investigation shall be conducted and a report of the findings rendered by an investigating committee consisting of one of the following:

- 1 The COS and appropriate Department Chairman
- 2 A sub-committee of the medical staff as appointed by the COS

The Practitioner will be notified in writing by the COS that an investigation will occur in

connection with obtaining the facts of the investigation, the Practitioner shall have the opportunity for an interview with the investigating committee. At this meeting, the Practitioner will be informed of the nature of the matter(s) being investigated and shall be invited to discuss, explain, or refute the allegations.

The interview is considered part of the investigation of the facts and does not constitute a hearing. This interview is preliminary to the taking of any professional review action and the hearing procedural rules of the Fair Hearing and Appellate Review shall not apply to the interview. A written and/or audio tape recording of this interview shall be made. No video records will be made.

After the facts have been gathered and interview(s) conducted, the committee will meet to take action on the results of the investigation. The committee's investigation report and recommendations will then be prepared.

If the investigation produces sufficient evidence that the Practitioner is impaired, the COS shall meet personally with that Practitioner or designate another appropriate individual to do so. The Practitioner shall be informed that the results of the investigation identified that the Practitioner suffers from an impairment that affects his clinical judgment and/or competence to provide quality patient care.

The Practitioner has the right to be informed of the substantive details of the specific incident(s) in question. The name(s) of the individual(s) who filed the report will be kept confidential until such time as formal action is undertaken to address the incident or documented pattern of impairment.

A copy of the investigating committee's report and recommendations will be provided to the Practitioner, who will then be permitted to submit a response. If the Practitioner does not feel the report is a fair representation of the investigation, they may submit an addendum to be attached to the report.

The investigating committee will then submit its report and the Practitioner's response to the Medical Executive Committee (MEC). A copy of both documents will also be provided to the CEO.

Depending upon the severity of the problem and the nature of the impairment, the MEC may recommend one or more of the following actions:

1. Require the Practitioner to undertake a rehabilitation program as a condition of continued appointment and clinical privileges.
2. Impose appropriate restrictions on the Practitioner's clinical practice.
3. Immediately suspend the Practitioner's clinical privileges to the medical center until rehabilitation has been successfully accomplished.
4. Accept the Practitioner's voluntary relinquishment of clinical privileges.
5. Any other action which the MEC and/or the Board in consultation with the CEO, determines will best serve the interests of the Practitioner, medical staff, and/or

medical center, and/or patients

A report shall be made to all administrative bodies as required by law. The MEC shall seek the advice of the medical center's legal counsel to determine whether any conduct

must be reported to the law enforcement authorities or other government agencies, and what further steps must be taken

If an "adverse action" is recommended by the MEC with respect to the Practitioner's privileges, the physician is entitled to procedural rights defined in the Fair Hearing and Appellate Review section of the Medical Staff Bylaws

The original report and a description of the actions will be included in the Practitioner's peer review file. If the investigation reveals that there is no merit to the report, all copies of the report and all pertinent documents shall be removed from the practitioner's file and destroyed. If the investigation reveals that there may be some merit to the report, but not enough to warrant immediate action, the report shall be included in the peer review file. The Practitioner's activities and clinical privileges shall be monitored until it can be established whether there is an impairment problem.

The COS shall notify the individual in writing that filed the report and any action taken. The COS shall inform the CEO when the notification has taken place.

Throughout this process, all parties shall avoid speculation, conclusions, gossip, and any discussions of this matter to anyone not involved in the investigation and review process described in this policy. All reports and information gathered during the course of the investigation and review process will be treated by all parties as strictly confidential.

Rehabilitation

If a program of rehabilitation is necessary, the COS or designee shall assist the Practitioner in locating a suitable rehabilitation program. The MEC shall not reinstate a Practitioner until it is established to the Board's satisfaction, that the Practitioner has successfully completed a rehabilitation program approved in writing by the MEC.

The MEC must be provided with a letter from the Medical Director of the rehabilitation program where the Practitioner was treated. This letter must be submitted monthly and must state

- 1 whether the Practitioner is participating in the program,
- 2 whether the Practitioner is in compliance with all the terms of the program,
- 3 whether the Practitioner attends program meetings regularly (if appropriate),
- 4 to what extent the Practitioner's behavior and conduct are monitored,
- 5 whether, in the opinion of the Medical Director of the rehabilitation program, the Practitioner is rehabilitated,
- 6 whether an after-care program has been recommended to the Practitioner and, if so, a

- description of the after-care program
- 7 whether, in the Medical Director's opinion, the Practitioner is capable of resuming medical practice and providing continuous, competent care to patients

The Practitioner must inform the MEC of the name, address and phone number of his primary care physician, and must authorize the physician to provide the MEC with information regarding the Practitioner's condition and treatment. The MEC has the right to require an opinion from other physician consultants of their choice. The MEC shall request the primary care physician to provide information regarding the precise nature of the Practitioner's condition and treatment as it related to the impairment.

Failure to comply with all of the above conditions may result in suspension or revocation of the Practitioner's medical staff privileges.

Reinstatement

If the MEC is satisfied that the Practitioner has successfully completed a rehabilitation program, the MEC may recommend to the Board consideration of the reinstatement of that Practitioner to the medical staff.

When considering an impaired Practitioner for reinstatement, the MEC and the Board must consider interests concerning the quality of patient care to be paramount. If all information received by the MEC indicates that a Practitioner is rehabilitated and capable of resuming patient care, the Board must take the following additional precautions when considering restoration of the clinical privileges:

The Practitioner must identify two physicians who are willing to certify, in writing, their willingness to assume responsibility for the care of the Practitioner's patients in the event the Practitioner is unable or unavailable to care for them. The MEC shall require the Practitioner to provide periodic reports from the Practitioner's primary care physician, for a period of time specified by the CEO and the COS, stating that the Practitioner is continuing treatment or therapy, as appropriate, and his ability to treat and care for patients in the medical center is not impaired.

The Department Chairman or a medical staff member appointed by the department chairman should monitor the Practitioner's exercise of clinical privileges in the medical center. The MEC shall determine the nature of the monitoring after reviewing all of the circumstances.

The Practitioner must agree to submit to an alcohol, blood, or other substance screening test appropriate to the impairment at the request of the COS, or designee, if there is reasonable suspicion that the Practitioner may be under the influence of drugs, alcohol or other substance.

Failure to comply with all the above conditions may result in suspension or revocation of the Practitioner's medical staff privileges.

All requests for information concerning the impaired Practitioner shall be forwarded to the COS for response

SECTION 8 - RESIGNATION FROM THE MEDICAL STAFF

Any Practitioner who desires to resign from the Medical Staff must submit a letter of resignation, through the assigned department chairman, to the MEC and the Administrator. Such a Practitioner's subsequent application for Medical Staff membership or clinical privileges will not be processed if he has any unfulfilled obligations under these Bylaws or the Rules and Regulations, including, but not limited to, the need to complete delinquent medical records. Subsequent application for staff membership or clinical privileges will not be processed while outstanding obligations remain, and this status will be reported in response to any requests for references.

SECTION 9 - HOSPITAL EMPLOYEES

The Hospital may determine as a matter of policy that certain Practitioners may be employed in accordance with a written contract between the Hospital and the Practitioner. An employed Practitioner must meet the same membership qualifications, must be processed for appointment, reappointment, and clinical privilege delineation in the same manner, and must fulfill all of the obligations for membership category as any other member of the medical staff. Corrective action of an employed Practitioner shall be handled in accordance with the provisions of the Fair Hearing and Appellate Review Procedures, Exception to Hearing and Appeal Rights, Article VIII, Section 11g, termination of Hospital employed Practitioners.

ARTICLE VI

CLINICAL PRIVILEGES

SECTION 1 - EXERCISE OF PRIVILEGES

Every Practitioner providing direct clinical services at this Hospital, by virtue of membership or otherwise, shall, in connection with such practice and except as provided in Sections 3 and 4 below, be entitled to exercise only those privileges specifically granted to him by the Governing Body. The privileges must be within the scope of the license authorizing the Practitioner to practice in this state. Regardless of the privileges granted, each Practitioner must obtain consultation when necessary for the safety of his patients or when required by these Bylaws, the Medical Staff and departmental Rules and Regulations and other policies of the Medical Staff and the Hospital.

SECTION 2 - DELINEATION OF CLINICAL PRIVILEGES

A Application Clinical privileges may be granted only upon formal request on forms provided by the hospital with subsequent processing and approval. Telemedicine practitioners must submit an application for telemedicine privileges. Every application for staff appointment and reappointment must contain a request for the specific clinical privileges desired by the applicant. A request by a Practitioner for a modification of privileges must be supported by documentation of additional training and/or experience supportive of the request.

B Basis for Privilege Determination Requests for clinical privileges shall be evaluated on the basis of the Practitioner's training, experience, education, demonstrated current competence, any required references, other relevant information, and to include an appraisal by the chairman of the department or by the chief of staff, and health status (subject to necessary reasonable accommodation to the extent required by law). In granting privileges, consideration must be given to objective information received from sources outside the Hospital, to the need for an adequate ongoing successful experience to maintain proficiency, to the Hospital's ability to support such patient care services, and to the objective findings of patient care evaluation and peer review activities. Peer input shall be obtained and considered in determining clinical privileges.

C Procedure All requests for clinical privileges shall be processed pursuant to the procedures outlined in Article III for Medical Staff membership.

D Special Conditions for Clinical Privileges Requests for practice privileges for Licensed Independent Practitioners shall be processed in the manner specified in the Allied Health Professionals section of the Rules and Regulations, and shall be based on their training, experience, education, health status in terms of the applicant's ability to practice in the area in which privileges are sought, demonstrated current competence, and the need for their services in the hospital. Surgical procedures that each dentist and podiatrist may perform shall be under the overall supervision of the Chairman of Surgery. An adequate history and physical examination on all dental and podiatric patient admissions shall be performed and recorded in the medical record by a physician member of the Medical Staff, or, in some cases by a physician approved by the Medical Staff. The dentist or podiatrist shall be responsible for completing the part of the history and physical examination related to any dental or podiatric problem justifying the reason for admission. A physician member of the Medical Staff must be assigned the responsibility for the care of any medical problem present at the time of admission or that arises during hospitalization.

E Unavailable Clinical Privileges Notwithstanding any other provisions of these Bylaws, to the extent that any requested clinical privilege is not available at the Hospital (whether because of exclusive contract, lack of facilities, policy decision of the governing body, or otherwise), the request shall be rejected without the necessity of processing pursuant to Section 2C above. Because such a rejection is unrelated to the applicant's qualifications, an applicant whose request is so rejected shall not be entitled to the

hearing and appeal rights under these bylaws

SECTION 3 - TEMPORARY PRIVILEGES

A Qualifications for Temporary Privileges Prior to temporary privileges being granted, the Medical Staff Office must receive all application requirements and primary verification. The application must have been approved by the Credentials Committee and be awaiting approval by the Medical Executive Committee and the Governing Board. By applying for temporary privileges all Practitioners agree to be bound by the Medical Staff Bylaws, Rules and Regulations, departmental rules and regulations and applicable Hospital policies.

B Authority to Grant Temporary Privileges/Condition

1 The Administrator or his designee, with the written concurrence of the Chairman of the applicable department or in his absence, the Chief of Staff, may grant temporary privileges under the circumstances noted below. In all cases, temporary privileges shall be granted for a specific period of time, not to exceed ninety (90) days. The practitioner will automatically lose his temporary privileges unless an extension is granted through a written request by the Practitioner to the Credentials Committee for a specific reason. Temporary privileges shall terminate automatically at the end of the ninety-(90) days or the specific period for which they were granted, without the hearing and appeal rights set forth in these bylaws. Special requirements of supervision and consultation may be imposed upon the granting of temporary privileges.

2 In all cases, if temporary privileges are granted prior to the Medical Staff and Governing Board's receipt and review of a report from the National Practitioner Data Bank (NPDB), the Practitioner agrees, as a condition of applying for or being granted temporary privileges, that such privileges are strictly conditional upon the receipt and review of a response from the NPDB deemed favorable by both the MEC and the Governing Body. In the event that a response is received which the MEC or the Governing Body believes warrants further investigation, and then the practitioner's conditional temporary privileges shall automatically expire and his application for temporary privileges shall be deemed incomplete. Irrespective of any other provision under these Bylaws, any Practitioner whose temporary privileges automatically expire under this provision shall not be entitled to the hearing and appeal rights under these Bylaws.

3 Temporary privileges may be granted for

(a) Care of a Specific Patient Temporary privileges may be granted to a Practitioner who is not an applicant for staff membership but whose services are required for the care of a specific patient who is not transportable and his required expertise is not available through the Medical Staff membership.

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B **Basis for Privilege Determination** Requests for clinical privileges shall be evaluated on the basis of the Practitioner's training, experience, education, demonstrated current competence, any required references, other relevant information, and to include an appraisal by the chairman of the department or by the chief of staff, and health status (subject to necessary reasonable accommodation to the extent required by law). In granting privileges, consideration must be given to objective information received from sources outside the Hospital, to the need for an adequate ongoing successful experience to maintain proficiency, to the Hospital's ability to support such patient care services, and to the objective findings of patient care evaluation and peer review activities. Peer input shall be obtained and considered in determining clinical privileges.

C **Procedure** All requests for clinical privileges shall be processed pursuant to the procedures outlined in Article III for Medical Staff membership.

D **Special Conditions for Clinical Privileges** Requests for practice privileges for Licensed Independent Practitioners shall be processed in the manner specified in the Allied Health Professionals section of the Rules and Regulations, and shall be based on their training, experience, education, health status in terms of the applicant's ability to practice in the area in which privileges are sought, demonstrated current competence, and the need for their services in the hospital. Surgical procedures that each dentist and podiatrist may perform shall be under the overall supervision of the Chairman of Surgery. An adequate history and physical examination on all dental and podiatric patient admissions shall be performed and recorded in the medical record by a physician member of the Medical Staff, or, in some cases by a physician approved by the Medical Staff. The dentist or podiatrist shall be responsible for completing the part of the history and physical examination related to any dental or podiatric problem justifying the reason for admission. A physician member of the Medical Staff must be assigned the responsibility for the care of any medical problem present at the time of admission or that arises during hospitalization.

E **Unavailable Clinical Privileges** Notwithstanding any other provisions of these Bylaws, to the extent that any requested clinical privilege is not available at the Hospital (whether because of exclusive contract, lack of facilities, policy decision of the governing body, or otherwise), the request shall be rejected without the necessity of processing pursuant to Section 2C above. Because such a rejection is unrelated to the applicant's qualifications, an applicant whose request is so rejected shall not be entitled to the

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B Authority to Grant Temporary Privileges/Condition

1 The Administrator or his designee, with the written concurrence of the Chairman of the applicable department or in his absence, the Chief of Staff, may grant temporary privileges under the circumstances noted below. In all cases, temporary privileges shall be granted for a specific period of time, not to exceed ninety (90) days. The practitioner will automatically lose his temporary privileges unless an extension is granted through a written request by the Practitioner to the Credentials Committee for a specific reason. Temporary privileges shall terminate automatically at the end of the ninety-(90) days or the specific period for which they were granted, without the hearing and appeal rights set forth in these bylaws. Special requirements of supervision and consultation may be imposed upon the granting of temporary privileges.

2 In all cases, if temporary privileges are granted prior to the Medical Staff and Governing Board's receipt and review of a report from the National Practitioner Data Bank (NPDB), the Practitioner agrees, as a condition of applying for or being granted temporary privileges, that such privileges are strictly conditional upon the receipt and review of a response from the NPDB deemed favorable by both the MEC and the Governing Body. In the event that a response is received which the MEC or the Governing Body believes warrants further investigation, and then the practitioner's conditional temporary privileges shall automatically expire and his application for temporary privileges shall be deemed incomplete. Irrespective of any other provision under these Bylaws, any Practitioner whose temporary privileges automatically expire under this provision shall not be entitled to the hearing and appeal rights under these Bylaws.

3 Temporary privileges may be granted for

(a) Care of a Specific Patient Temporary privileges may be granted to a Practitioner who is not an applicant for staff membership but whose services are required for the care of a specific patient who is not transportable and his required expertise is not available through the Medical Staff membership.

(b) **Locum Tenens** Temporary privileges may be granted to a qualified Practitioner serving as locum tenens for a member of the Medical Staff. Such privileges shall be limited based on the locum tenens Practitioner's individual training, experience, and qualifications. The locum tenens Practitioner will not be granted privileges in excess of those granted to the Practitioner being temporarily replaced, unless the Medical Staff and the Governing Body grant an exception.

(c) **Pending Appointment to the Medical Staff** In addition to the requirements noted in Section 3 A above, the applicant's professional degree must be verified (e.g., M.D., D.O.) as well as his current license, current DEA registration, any specialty training claimed, at least two (2) references relating positively to professional and ethical status, and documentation of the required professional liability insurance coverage. Temporary privileges may be granted for no more than three (3) separate and successive thirty (30) day periods (a maximum period of ninety (90) days) at which time they automatically expire. The Practitioner will automatically lose temporary privileges unless an extension has been granted by a written request from the Practitioner to the Credentials Committee for a specific reason. The applicant shall be under the supervision of the Chairman of the department to which he will be assigned. All of the care provided by the Practitioner shall be reviewed during this period. The supervising Practitioner may impose special consultation requirements and reporting.

(d) **Organ/Tissue Harvesting Team** Temporary privileges may be granted to Practitioners who need to attend the patient as part of their duties as a member of an Organ/Tissue Harvesting Team. If a physician is registered by any certified organ procurement agency, they may have temporary privileges without submitting the usual required information as set forth in Article VI, Section 3A.

(e) **Participant in a Medical Review Committee** In the rare situation where there are no qualified members of the Medical Staff to act as a member of a Medical Review Committee, temporary privileges may be granted to a qualified individual for the limited purpose of participating as a member of a Medical Review Committee as defined under the fair hearing and appellate review article of these Bylaws.

(f) **Participate as a Consultant on Peer Review Matters** In those cases where a peer review committee or department deems it necessary to obtain a review of a practitioner's practice by an outside consultant who is not a member of the Medical Staff, the outside consultant may be granted temporary privileges for the limited purpose of conducting the review, reporting to the peer review committee or department, and for testifying at a hearing or appeal with regard to that review.

C Denial, Termination or Restriction of Temporary Privileges Temporary privileges, unless acted upon pursuant to other provisions of these bylaws, shall terminate automatically at the end of ninety (90) days or the specific period for which they were

granted, without the hearing and appeal rights under these bylaws. The Administrator, Chief of Staff or department Chairman or their designees may terminate or restrict temporary privileges in the event of the discovery of questionable qualifications/ability or false information provided by the Practitioner, or when the life or health of a patient could be endangered by the treatment by that Practitioner or for similar reasons. No Practitioner is entitled to the hearing and appeal rights set forth in these Bylaws for the denial, nonrenewal, restriction or termination of temporary privileges based on the Practitioner's professional conduct or competence. In the event a Practitioner's temporary privileges are terminated or restricted, the Practitioner's patients then in the Hospital shall be assigned to another Practitioner by the department Chairman responsible for supervision or by the Chief of Staff. The wishes of the patient shall be considered, when feasible, in choosing a substitute practitioner.

SECTION 4 - EMERGENCY PRIVILEGES

A Privileges In an emergency, any Practitioner to the degree permitted by his license shall be permitted to do everything he deems reasonably necessary and appropriate to save the life or limb of a patient. The Administrator shall be notified promptly in such cases.

B Conclusion of Emergency When the emergency no longer exists, the practitioner must request the privileges necessary to continue to treat the patient if he so desires. In the event such privileges are denied or he does not desire to request privileges, the patient shall be assigned to an appropriate member of the Medical Staff.

C Definition of Emergency For the purpose of this Section, an "emergency" is defined as a condition in which serious harm would result to a patient or in which the life or limb of a patient is in immediate danger and any delay in administering treatment would add to that danger.

SECTION 5 - CHANGE IN MEMBERSHIP, PRIVILEGES OR STAFF CATEGORY

A staff member may, at any time, request a change of staff category or department affiliation by submitting a written notification to the Medical Staff Office. The Medical Staff Office will issue a letter requiring the physician to read and sign the letter stating the requirements of the provisional change in status. The request will be forwarded to the department Chairman, then to the Credentials Committee. The Credentials Committee will recommend to the MEC the request, and the MEC will forward their recommendation to the Board of Directors for final approval. After final approval, the medical staff office will notify the physician of the final decision. The Medical Staff Office will track the provisional change for one (1) year and the Credentials Committee will evaluate the physician at that time to determine if he meets the necessary requirements set forth by the requested status change. If a physician requests privileges addition/change/deletion, such application shall be processed in substantially the same

manner as an initial appointment application. The physician must give supporting documentation of his additional training/experience. The physician's request will be forwarded to the department Chairman, Credentials Committee, MEC and the Board of Directors for approval.

ARTICLE VII

CORRECTIVE ACTIONS

SECTION I - ALTERNATIVES TO CORRECTIVE ACTION

Under certain circumstances, routine monitoring and education of a Practitioner in accordance with Departmental procedures as described in Article X, Section 2, may be an appropriate alternative to corrective action.

SECTION 2 - CORRECTIVE ACTION

A Grounds/Initiation Whenever the conduct of any Medical Staff member ("affected Practitioner") is considered to be lower than the standards of the Medical Staff, or to be disruptive to the operations of the Hospital, or to constitute fraud or abuse, or to be detrimental to the quality of patient care at the Hospital, or to be detrimental to the Hospital's licensure or accreditation, or to be detrimental to Hospital or Medical Staff efforts to comply with any professional review organization, third-party payer (private or governmental), or utilization review requirements, or to be in violation of the Medical Staff Bylaws, rules and regulations, or policies of the Hospital, Medical Staff or any Department or committee thereof, or to be in violation of the ethics of their profession, or if any affected Practitioner is believed to have engaged in criminal conduct, corrective action may be requested against such Practitioner by the requesting party who may be any member of the Medical Staff or the Governing Body, or the Administrator. All requests for corrective action shall be in writing, shall be submitted to the MEC through its Chairman, and shall set forth the specific conduct constituting the basis for the request.

B Investigation The MEC, before taking action on the request, shall conduct such investigation as it deems necessary, which may, in its discretion, include informal interviews with the requesting party and the affected Practitioner (each out of the presence of the other), informal interviews with or reports from other persons, any required or requested departmental review, and chart reviews, if applicable. Neither the investigation nor any other activities of the MEC in acting upon a request for corrective action shall constitute a hearing, they shall be informal, and none of the hearing and appeal rights under these Bylaws shall apply.

C Time for Taking Action/Notice/Right to Hearing Within sixty (60) days after receipt by the MEC of a request for corrective action, or within such reasonable additional time as the MEC deems necessary, the MEC shall take action upon the request.

Within five (5) days after taking action, the MEC shall give written notice to the affected Practitioner and the Governing Body stating which of the actions set forth in this Section the MEC has taken or recommended. If the action is of a type requiring notice as described Article VIII, Section 2, the notice shall comply with the applicable Sections of Article VIII. In no event shall the Practitioner be entitled to the rights under Article VIII when the only action of the MEC was to issue a letter of admonition or reprimand.

D Possible Action The action of the MEC on a request for corrective action may be to (1) reject the request, (2) issue a letter of admonition or reprimand, (3) impose terms of probation or require proctoring, co-admitting, or consultation, (4) recommend reduction, suspension, proctoring, co-admitting, consultation, or revocation of clinical privileges, (5) recommend that an already imposed summary suspension of membership or clinical privileges be terminated, modified, or sustained, (6) recommend that the Practitioner's membership be suspended or revoked, or (7) take or recommend other actions deemed appropriate by the MEC.

E Notice to Administrator The chairman of the MEC shall promptly notify the Administrator in writing of each request for corrective action received by the MEC and the date of its receipt, and shall keep the Administrator fully informed of all communications, meetings, and actions in connection with each request.

F Governing Body Action At any time that it believes corrective action to be warranted, the Governing Body, or its designee, may initiate it. Before initiating such corrective action, the Governing Body, or its designee, shall consult with the Chief of Staff. Thereafter the Governing Body, or its designee, may direct the MEC to conduct an investigation or otherwise initiate corrective action. In the event the MEC fails to take action in response to a direction from the Governing Body, or its designee, the Governing Body, or its designee, may conduct an investigation or otherwise initiate corrective action proceedings. If applicable, such proceedings shall afford the affected Practitioner the hearing and appeal rights described in these Bylaws.

G Use of Membership/Privileges The affected Practitioner shall retain the use of his membership and privileges pending final action by the Governing Body unless such membership and/or privileges are otherwise suspended as provided in this Article.

SECTION 3 - SUMMARY SUSPENSION OR SUMMARY RESTRICTION

A Grounds/Authority All or any portion of a Practitioner's clinical privileges may be summarily suspended or restricted where the failure to take summary action may result in imminent danger to the health of any individual. The following persons are authorized by the Medical Staff to take summary action: the Chief of Staff, the Chairman of a clinical department, the MEC or the Administrator. Suspension or restriction pursuant to this paragraph shall be temporary and effective only until further action is taken by the MEC pursuant to Section 3. When no person or committee referenced above is available to impose a summary suspension or restrict clinical privileges, the Governing Body, or its designee, may take such action if a failure to do so would be likely to result

in an imminent danger to the health of any individual

B Effective Date/Notice A summary suspension or restriction shall become effective immediately upon imposition and the person or body imposing same shall promptly give written or verbal notice of the suspension or restriction to the suspended Practitioner, stating by whom it was imposed and the reasons for same. The notice shall be deemed to have been given on the date on which it is either personally delivered or sent by certified mail to the suspended or restricted Practitioner, whichever occurs first. The notice or a written confirmation of it, shall inform the suspended or restricted Practitioner (1) of his right to an informal interview upon his written request under Section 3C, and (2) if the summary suspension or restriction could be reportable to the National Practitioner Data Bank and to any state licensing agency, and (3) that unless the suspension or restriction is terminated when the MEC takes further action under Section 3 D, the Practitioner will be entitled to the hearing and appeal rights under these Bylaws. In the event that the suspension or restriction is terminated when the MEC takes further action the practitioner shall be entitled to a hearing and appeal under these Bylaws, however, the sole issue shall be whether there was probable cause for the summary suspension or restriction. A copy of the notice shall promptly be delivered to the Administrator, the MEC, and the Governing Body.

C Investigation The MEC, before taking further action, shall conduct such investigation as it deems necessary, which shall include at least one (1) meeting of the MEC, and may include an informal interview with the suspending party. An informal interview with the affected Practitioner (out of the presence of the suspending party, if other than the MEC) may be held if the affected practitioner delivers a request for an informal interview in writing within seven (7) days after notice of the suspension was given to him or if requested in writing by the MEC. The MEC's investigation may include chart reviews, if applicable, and informal interviews with or reports from other persons or relevant departments or committees. Neither the investigation nor any other activities of the MEC in taking its further action shall constitute a hearing. They shall be informal, and none of the hearing and appeal rights under these Bylaws shall apply.

D Further Action/Time Within fourteen (14) days after the date of the suspension or restriction, the MEC shall take further action with respect to the suspension, and may modify, continue for a definite or indefinite period or terminate the summary suspension or restriction. Such further action shall remain in effect unless and until altered or terminated pursuant to other provisions of these Bylaws. If the MEC upholds a summary suspension or restriction, it shall also decide if the affected Practitioner's medical staff membership and clinical privileges should be terminated. The MEC shall promptly give written notice of its further action to the suspended Practitioner, the Administrator and the person or body who imposed the suspension or restriction (if other than the MEC).

E Rights to Hearing Following the decision of the MEC regarding further action, the provisions of Article VIII shall govern the hearing and appeal rights under these Bylaws.

F Alternate Patient Coverage Immediately upon the imposition of a summary suspension or restriction, the Chief of Staff or responsible departmental Chairman shall provide for alternate medical coverage by a member of the Medical Staff for the patients of the suspended Practitioner remaining in the Hospital at the time of such suspension, if the privileges to provide such coverage were suspended. The wishes of the patients shall be considered in the selection of such alternate coverage.

SECTION 4 - AUTOMATIC SUSPENSION, TERMINATION

The following shall result in the automatic suspension and possible termination of medical staff membership and/or clinical privileges and shall not entitle the affected Practitioner to the hearing and appeal rights specified in these Bylaws, unless otherwise expressly provided.

A Medical Records/Suspension Practitioners must complete their patients' medical records within 30 days of each patient's discharge or within such time, as the Governing Body requires. Medical records that the Practitioner fails to complete within the required period will be considered delinquent. The Director of Health Information Services shall send a written notice to a Practitioner who has incomplete medical records near delinquent status. This notice may be sent by either personal delivery or by certified mail, return receipt requested, and a phone call to remind the Practitioner that his clinical privileges will be automatically suspended if such records are not completed. If the Practitioner completes the records within the time allotted, the Director of Health Information Services shall notify the Chief of Staff who shall immediately reinstate the Practitioner's clinical privileges. If the Practitioner does not complete the medical records within the time provided, then the Administrator shall automatically impose a temporary suspension of all privileges. Such suspension shall be effective as of the first day after the expiration of the prescribed time period and shall continue until the medical records in issue are satisfactorily completed. The suspension may be terminated by the joint action of the Administrator and the Chief of Staff if they, or their designees, determine that failure to timely complete the records was justified (e.g., illness or other circumstances beyond the control of the affected Practitioner) or, upon the request of the suspended Practitioner, the Chief of Staff may temporarily lift the suspension only if the Chief of Staff, as the designee of the MEC, determines that an emergency exists in which the health and safety of any patient will be jeopardized by failure to allow the Practitioner to treat that patient. With the exception of emergency care for which only the Practitioner is qualified and available and the care of patients already hospitalized at the time of the suspension, such temporary suspension shall include all admitting and clinical privileges, as well as the scheduling of elective operations, assisting at elective operations, and deliveries. Unverified emergency admissions shall not be used to bypass such suspension. Failure to complete the medical records within sixty (60) days of suspension shall be deemed a voluntary resignation from the Medical Staff and the voluntary relinquishment of all clinical privileges. Practitioners whose clinical privileges are automatically suspended or who have been deemed to have voluntarily resigned from the staff pursuant to this Section shall not be entitled to the hearing and appeal rights under these Bylaws.

B Licensure Whenever a Practitioner's license to practice in this state is revoked, not renewed, restricted, suspended, voluntarily or involuntarily relinquished or made subject to any probationary provisions by the licensing agency, the Practitioner's staff membership and clinical privileges shall automatically terminate upon receipt by the hospital of notice thereof. If a Practitioner's license to practice is made subject to probationary terms by the licensing agency, the Practitioner's privileges and membership shall automatically become subject to the terms of probation, subject to review by the MEC and approval by the Governing Body. Action automatically imposed under this Section does not entitle the practitioner to the hearing and appeal rights provided under Article VIII of these Bylaws.

C Drugs/Medication A temporary automatic suspension of a Practitioner's privileges to prescribe or obtain controlled substances or other medications at or through the hospital or any of its facilities shall be immediately imposed by the Administrator upon the receipt by the hospital of notice that such Practitioner's right or license to prescribe or obtain controlled substances or medications has been suspended, revoked or otherwise restricted by the applicable governmental agency. Such automatic suspension shall include only those controlled substances or medications suspended or revoked by the governmental agency and shall be effective until the governmental agency reinstates the Practitioner's right or license in question, unless the MEC determines otherwise and so notifies the affected Practitioner. If a Practitioner's right or license to prescribe or obtain controlled substances or medications is subject to an order of probation, the Practitioner's privileges to prescribe or obtain controlled substances or other medications at or through the hospital or any of its facilities shall automatically become subject to the terms of the probation effective upon and for at least the term of the probation. An affected Practitioner shall not be permitted to prescribe medications under the hospital's DEA number. Action imposed under this Section does not entitle the Practitioner to the hearing and appeal rights under these Bylaws.

D Loss of Malpractice Insurance If a Practitioner fails to maintain professional liability insurance as required by the Governing Body, or fails to provide evidence of such coverage, the Practitioner's membership and clinical privileges, after written warning of delinquency, shall be automatically suspended and shall remain so suspended until the Practitioner provides evidence to the MEC that he has secured the required professional liability coverage. Failure to provide such evidence within sixty (60) days after the date the automatic suspension became effective shall be deemed a voluntary resignation from the Medical Staff. A Practitioner whose clinical privileges are automatically suspended or who has been deemed to have voluntarily resigned from the Medical Staff pursuant to this Section may request a meeting to discuss the matter informally with the MEC or its designee, but the practitioner shall not be entitled to the hearing and appeal rights under these Bylaws.

E Felony Conviction A Practitioner who has been convicted or pled "guilty" or "no contest" or its equivalent to a felony in any jurisdiction shall be automatically suspended. Such suspension shall become effective immediately upon such conviction or

plea regardless of whether an appeal is filed. Such suspension shall remain in effect unless and until the matter is resolved by subsequent recommendation by the MEC and action by the Governing Body or through corrective action, if necessary.

F Quality/Performance Improvement and Peer Review Inquiries Practitioners have an obligation to timely and satisfactorily respond to inquiries from Medical Staff committees and their designees on issues relating to the Practitioner's qualifications, character, behavior, ethics, health status in terms of the practitioner's ability to practice in the area in which privileges are sought or have been granted, case management, and the Practitioner's compliance with the Bylaws, rules and regulations, and policies of the Medical Staff and Hospital. Unless provided otherwise in these Bylaws, the Department or committee Chairman shall send a certified letter to the practitioner requesting a response within thirty (30) days. If the Practitioner fails to timely respond, the Chief of Staff shall send a notice advising that failure to comply within seven (7) days shall result in an automatic suspension of membership and all privileges. Such suspension shall continue until the inquiring person or body confirms that a satisfactory response has been received. With the exception of emergency care which only the Practitioner is qualified and available to render, and the care of patients already hospitalized at the time of the suspension, such suspension shall include all admitting and clinical privileges, as well as scheduling of elective operations, assisting in elective operations, and deliveries. Unverified emergency admissions shall not be used to bypass such restriction. Failure to satisfactorily comply within sixty (60) days of the date of the suspension shall be deemed a voluntary resignation and relinquishment of all privileges. Action taken pursuant to this Section shall not entitle the affected Practitioner to the hearing and appeal rights of these Bylaws.

G Notice Unless otherwise specified in this Section, the Administrator shall immediately notify the affected Practitioner and the Chief of Staff in writing, either by personal delivery or certified mail, of any suspension or termination under this Section. Such notice shall set forth the effective date and the reason for the suspension or termination. By state law the State Board of Medical Examiners shall be notified in writing by the Administrator of the Hospital of any revocation, suspension, or limitation of a practitioner's clinical privileges.

H Application to Medical Staff after Termination Unless reinstated by the MEC and the Governing Body, any Practitioner who is terminated from membership or who has clinical privileges terminated and who desires to be admitted to the Medical Staff or granted clinical privileges shall be required to apply for membership and privileges and such application shall be processed as for an initial applicant.

SECTION 5 - OTHER INVESTIGATIONS

Notwithstanding anything in these Bylaws to the contrary, the MEC in its sole discretion may investigate any matter or any Practitioner brought to its attention by anyone and may take any action it deems appropriate, subject to review by the Governing Body. Such

investigation shall not be deemed a hearing and may be substantiated as described in Section 2B. The MEC shall act with reasonable promptness and shall be given notice of any action thus taken or recommended within seven (7) days therefrom, to any affected Practitioner and the Administrator. The Practitioner shall only have a right to request a hearing if the action or recommendation falls into one or more of the grounds for a hearing specifically set forth in Article VIII, in such cases, the notice to the affected practitioner shall comply with the notice requirements of Article VIII.

ARTICLE VIII

HEARING AND APPELLATE REVIEW PROCEDURES

SECTION I - GENERAL PROVISIONS, DEFINITIONS, SETTLEMENT

A Duty to Exhaust Remedies The purpose of this Article is to permit the Medical Staff and Hospital to resolve issues related to professional practice and qualifications for Medical Staff membership and clinical privileges fairly, expeditiously and with due regard for both the need to protect patients and the interest of Practitioners. Each applicant and member agrees to follow and complete the procedures set forth in this Article, including appellate procedures, before attempting to obtain judicial relief related to any issue or decision which may be subject to a hearing and appeal under this Article. The absence of an interlocutory appeal process (temporary/provisional process) for reviewing any alleged violation of the Bylaws or the affected Practitioner's fair procedure rights does not warrant judicial intervention.

B For the purposes of this Article, the following definitions shall apply

- 1 Affected Practitioner means the Medical Staff member or applicant for membership with respect to whom any of the actions specified in Section 2B below have been taken or recommended, and whose membership or privileges may be affected thereby.
- 3 Body Whose Decision Prompted the Hearing means the person, committee, or body (which will generally be the MEC, that pursuant to these Bylaws, took the action or made the recommendation that resulted in a hearing being requested).
- 3 Parties or Party means, unless clearly indicated otherwise by particular context, collectively or individually, as the case may be the affected Practitioner, the MEC, and/or the body whose decision prompted the hearing (if other than the MEC).
- 4 Notice means a written communication delivered personally to the required addressee or sent by United States Postal Service, first-class postage prepaid, certified or registered mail, return receipt requested, addressed to the required

addressee at his address as it appears in the records of the Hospital. Copies shall be as effective as the original for the purpose of giving notice. Any such notice shall be deemed effective on the date it was first received or five (5) working days after it was mailed first-class postage prepaid, whichever occurs first.

C **Settlements** At any time following receipt of notice of a recommendation or action which would entitle a Practitioner to request a hearing under this Article, the Practitioner may ask the body whose decision prompted the hearing to discuss voluntary settlement or resolution of the matter. Upon such request and subject to the Practitioner's waiver of time requirements to allow such discussions to proceed, the MEC may authorize one or more of its members to conduct confidential discussions with the Practitioner, provided, the MEC shall not be obligated to conduct such discussions if it concludes the request is interposed primarily for delay or a settlement is not feasible. If the Practitioner and the body whose decision prompted the hearing reach a written agreement, which could settle the matter, the body whose decision prompted the hearing shall promptly notify the Administrator and the Governing Body. (Any such written settlement agreement should include an acknowledgment by the Practitioner that he voluntarily waives his hearing and appeal rights under these Bylaws, that the settlement is entered into voluntarily and that he will waive all claims relating in any way to the matter against all Medical Staff and Hospital personnel.)

SECTION 2 - THE HEARING PROCESS

A **Notice of Adverse Action or Recommended Action/Request for Hearing**
Whenever any of the actions constituting grounds for a hearing as set forth in Section 2B below has been taken or recommended, the person, committee, or body causing same to occur shall give notice to the affected Practitioner.

The notice shall

- 1 describe what action has been taken or recommended,
- 2 state the reasons for the action (a statement of charges will be provided in the event a hearing is properly requested),
- 3 advise the Affected Practitioner of the right to request a hearing and that such request must be in writing and received by the Administrator within thirty (30) days after the Affected Practitioner's receipt of the Notice of Adverse Action or Recommendation,
- 4 summarize the Practitioner's rights in the hearing,
- 5 state whether the action or recommendation, if finally adopted, will be reported to the appropriate licensing entity and to the National Practitioner Data Bank (NPDB) as required by law.

Whenever the MEC has given notice of action that constitutes grounds for a hearing as described in Section 2B below, the affected Practitioner shall have thirty (30) days following the date such notice was given within which to request a hearing. A request for a hearing must be in writing and delivered to the Administrator within the applicable time period set forth above. Failure of the affected Practitioner to request a hearing within the time and in the manner set forth in this subsection shall be deemed an acceptance by the Practitioner of such action or recommendation and a waiver by such party of all hearing and appeal rights under these Bylaws. The matter shall thereupon be forwarded to the Governing Body for its final decision in accordance with Article VIII, Section 6F. The Administrator shall give notice to all parties of any such waiver and acceptance.

B Grounds for Hearing Except as otherwise provided in these Bylaws, the taking or recommending of any one or more of the following actions when based on the member's professional conduct or competence, unless taken in compliance with a policy decision of the hospital (e.g., closing a department or service or physical plant changes), shall constitute grounds for a hearing pursuant to this Article:

- 1 denial of initial appointment to the Medical Staff,
- 2 denial of staff reappointment,
- 3 reduction or suspension of staff membership or clinical privileges for more than thirty (30) days
- 4 termination, revocation or reduction of staff, category
- 5 denial or termination of clinical privileges,
- 6 summary suspension of clinical privileges for more than thirty (30) days,
- 7 significant consultation or co-admitting requirements other than in compliance with the Medical Staff Bylaws, Rules and Regulations or departmental rules and regulations,
- 8 denial of requested advancement in staff category, and
- 9 denial of requested service affiliation

C Notice of Hearing

- 1 Upon receipt of a proper request for hearing, the Administrator shall deliver the request to the MEC, stating the date the Administrator received it, then
- 2 the MEC shall, within thirty (30) days after receipt by the Administrator of the request, schedule a date for a hearing, then

- 3 the MEC shall, not less than thirty (30) days prior to the date of the hearing, give notice to the parties of the time, place, and date thereof, and shall deliver a copy of these Bylaws and a Statement of Charges as provided in the following paragraph, to the affected Practitioner. The date of commencement of the hearing shall not be less than thirty (30) days from the date of the notice of hearing nor more than sixty (60) days from the date of receipt of the request for a hearing by the Administrator, except when the request is received from a member who is under suspension, the hearing shall commence as soon as reasonably practicable, but not later than forty (40) days from the date of receipt by the Administrator of the request for hearing. In such instances, the notice of hearing shall be provided within a reasonable time prior to the date of commencement. The parties and the MRC shall cooperate with each other in scheduling additional hearing sessions, as necessary, to complete the process as soon as practicable.

D Statement of Charges As a part of, or together with, the Notice of Hearing referred to in the previous paragraph of these Bylaws, the MEC shall state the acts or omissions with which the affected Practitioner is charged including, if applicable, a list of chart numbers under question, if any, and the reasons for the action or recommendation. The Medical Staff representative at the hearing may make amendments to the statement of charges from time to time, but not later than the close of the case. Such amendments may delete, modify, or add to the acts, omissions, charts, or reasons specified in the original notice. Notice of each amendment shall be given to the affected Practitioner, the Hearing Officer, and each party. If the affected Practitioner promptly gives written request to the medical review hearing committee, he shall be entitled to a reasonable postponement of the hearing to prepare a response or defense to any such amendment that adds acts, omissions, charts, or reasons to the original notice. The medical review hearing committee shall give prompt notice to the parties of each such postponement.

E Medical Review Committee (MRC) or Arbitrator, Appointment, Removal, and Qualifications Promptly after a hearing has been properly requested, the Chief of Staff as a designee of the MEC or alternatively the MEC shall determine if the hearing shall be held before (1) an arbitrator or arbitrators selected by a process mutually acceptable to the Practitioner and the MEC, or (2) before a panel referred to as a MRC. Should the Chief of Staff as a designee of the MEC or alternatively the MEC determine that a medical review committee shall be used, he shall promptly appoint such a MRC and its Chairman to act as the peer review group in the hearing. The MRC shall consist of not less than three (3) nor more than seven (7) members, at least the majority of whom shall be physicians who shall be licensed to practice medicine but need not be members of the Medical Staff. When feasible, the MRC shall include at least one (1) individual practicing in the same specialty as the affected Practitioner. They may have knowledge of the matters to be heard, but each shall be willing to hear the matters objectively and without prejudgment. They shall not have acted as accusers, investigators, fact finders or initial decision makers in connection with the same matter, shall gain no direct financial benefit from the outcome, and shall not be in direct economic competition with the

affected Practitioner

F Hearing Officer/Chairman of MRC The Administrator may appoint a Hearing Officer to conduct the hearing. The hearing officer may be a member of the South Carolina Bar and should be familiar with the law applicable to Hospital administrative proceedings.

The Hearing Officer shall conduct the hearing impartially such that the proceeding will be, to the extent reasonably possible, fair, efficient, and protective of the rights of all parties and witnesses. The Hearing Officer shall gain no direct financial benefit from the outcome of the hearing and shall not act as a prosecuting officer or advocate. The Hearing Officer shall act as advisor to the MRC as to procedural matters, including the drafting of its decision and report, but he shall not be entitled to vote. In the alternative, the Administrator, after consulting the MEC, may appoint a Medical Hearing Officer to conduct the hearing. The Medical Hearing Officer must be a member of the Medical Staff but may not be in direct economic competition with the affected Practitioner. He should be familiar with the applicable medical issues and with medical staff administrative proceedings. He shall conduct the hearing impartially such that the proceeding will be, to the extent reasonably possible, fair, efficient, and protective of the rights of all parties and witnesses. He shall decide all procedural matters. All references to the "Hearing Officer" shall refer to the Medical Hearing Officer if one is appointed. If a Hearing Officer is not appointed, the Chairman of the MRC shall conduct the hearing and rule on procedural matters, and all references to the "Hearing Officer" shall be deemed to refer to the Chairman of the MRC or the arbitrator, as appropriate.

G Postponements and Extensions After the appointment of the MRC and before the commencement of the hearing, postponements beyond the times required by these Bylaws may be requested by any of the parties, and shall be granted upon agreement of the parties or by the arbitrator or presiding officer on a showing of good cause. The MRC shall promptly give notice to the parties of each such postponement.

H Medical Staff Representative After a hearing has been properly requested, the Chief of Staff or alternatively the MEC shall promptly appoint a Medical Staff member ("Medical Staff Representative") to present the case on behalf of, and otherwise represent, the body whose decision prompted the hearing. The Chief of Staff or alternatively the MEC may, in its sole discretion, remove or replace the Medical Staff Representative at any time.

SECTION 3 - HEARING PROCEDURE

A General It shall be the duty of the Practitioner and the body whose decision prompted the hearing to exercise reasonable diligence in notifying the Hearing Officer of any pending or anticipated procedural irregularity or any objection to the hearing panel or to the Hearing Officer, as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may expeditiously be made. Objection to any such pre-hearing decisions shall be raised on the record at the hearing and when so raised

shall be preserved for consideration at any appellate review hearing which thereafter might be requested

B Witness List At the request of either party, the parties must exchange at least ten (10) days before the hearing (1) lists of witnesses expected to testify at the hearing, and (2) copies of all documents expected to be introduced at the hearing. Failure of a party to produce these materials, or to update them, at least ten (10) days before the commencement of the hearing, shall constitute good cause for the Hearing Officer to grant a continuance, or to bar or otherwise limit the introduction of any documents not provided to the other party or testimony from witnesses not identified pursuant to this provision.

C Failure to Appear Failure of the affected Practitioner to appear at the hearing shall be deemed to constitute the affected Practitioner's voluntary acceptance of the recommendation or action and waiver of all hearing and appeal rights under these Bylaws, unless the MRC finds good cause for such failure, based upon written request by the affected Practitioner or his representative.

D Representation The hearings provided for in these Bylaws are for the purpose of intra-professional resolution of matters bearing on conduct or professional competency. The physician involved has the right to representation by an attorney or other person of the physician's choice. The Body Whose Decision Prompted the Hearing shall be similarly entitled to representation by counsel.

E Record of the Hearing The MRC proceedings shall be taken and transcribed by a court reporter and a copy of the transcript of each session shall be available for purchase by either party. Each party shall be responsible for payment of all costs and charges associated with any transcript that it requests.

F Oath of Witness The MRC may, in its discretion, order all testimony at the hearing to be under oath administered by a person authorized to administer oaths.

G Organization and Conduct of Hearing Process Unless otherwise expressly provided in these Bylaws, the hearing shall be conducted as follows:

- 1 The parties shall have a reasonable opportunity to voir dire (examine) the MRC members and the Hearing Officer, and the right to challenge the appointment of any MRC member or the Hearing Officer. The Hearing Officer shall establish the procedure by which this right may be exercised, which may include requirements that voir dire (examine) questions be proposed in writing in advance of the hearing and that the questions be presented by the Hearing Officer. The Hearing Officer shall rule on any challenges in accordance with applicable legal principles defining standards of impartiality for hearing panels and Hearing Officers in proceedings of this type.

- 2 The Medical Staff representative shall present an opening statement summarizing the background of the matter, the notices given, any administrative decisions rendered to date, and, if he chooses, the salient general conclusions the representative expects to prove
- 3 The medical staff representative shall then present the facts upon which he is relying, by calling the witnesses and presenting the written evidence to support the case. He may call any person or opposing party, who is present, in support of the case
- 4 At the close of the Medical Staff representative's case, unless the MRC believes the action or recommendation being reviewed was clearly not supported by the medical staff representative's presentation (in which case the hearing may terminate by such a ruling at this point), the affected Practitioner or his representative shall make an opening statement and shall make a case representation of evidence and testimony. He may call any person or opposing party, who is present, in support of the case
- 5 Upon the close of the initial presentations of the opposing parties, each party shall be entitled to present evidence to rebut the presentation of the other, subject to reasonable limitations by the Hearing Officer as to order, time, relevance, and repetition
- 6 In the close of all presentations and evidentiary rebuttals, the parties shall be entitled, subject to reasonable limitation by the Hearing Officer, to submit a written statement and give closing statements and argument
- 7 Upon the close of all presentations, rebuttals, statements, and argument, the hearing Officer shall declare the hearing finally adjourned, and all persons other than the MRC and Hearing Officer shall thereupon leave the hearing. The MRC shall thereafter, at the convenience of its members but subject to the provisions of Section 4 below deliberate in order to reach its decision
- 8 Liberality may be exercised in accommodating the schedules of witnesses, MRC members, parties, and representatives, in allowing modification of required notices, in allowing recesses or extensions of time upon a reasonable showing of need, and in allowing changes in the order of the proceedings or the presentation of evidence. The decision of the Hearing Officer after consultation with the MRC regarding such matters shall be final, subject to later reconsideration for good cause only
- 9 No person shall disrupt any hearing. Any person in attendance (whether a party or any other person) who disrupts a hearing after being warned by the Hearing Officer to cease such disruption on penalty of indefinite exclusion, shall, at the direction of the Hearing Officer, leave the hearing. Unless directed otherwise for good cause by the Hearing Officer, the hearing shall

proceed in the absence of such excluded person. If such excluded person is the affected Practitioner or a witness, he shall have the right to submit to the MRC, not later than ten (10) days after such exclusion (unless extended by the Hearing Officer for good cause), a written affidavit of his testimony or other evidence, with copies thereof to the other parties.

- 10 Except as otherwise provided in these Bylaws and subject to reasonable restriction by the Hearing Officer, the following shall be permitted to attend the entire hearing in addition to the MRC, the Hearing Officer, court reporter, and parties, the Administrator or his designee, one (1) person designated by the Administrator (or designee), the Medical Staff Coordinator or assistant, one (1) key consultant for each party, and one (1) or more representatives of the entity that owns the hospital.

H Burden of Proof The affected Practitioner shall have the burden of proving, by clear and convincing evidence, that the action or recommendation of the body whose decision prompted the hearing, which is the subject matter of the hearing, is arbitrary, capricious or unreasonable.

I Admissible Evidence and General Procedure Except as otherwise provided in these Bylaws, the following rules shall apply in the hearing:

- 1 The general rule of evidence shall be that any relevant matter, whether written or oral, upon which responsible individuals would be expected to rely in the conduct of serious affairs, shall be admitted, regardless of its admissibility in a court of law. The MRC shall have the discretion to recognize any matters, either technical or scientific, including statistical data, relating to the issues under consideration, which is common knowledge in the general medical community and/or any medical specialty.
- 2 Parties or their representatives shall have the right to
 - (a) a reasonable opportunity to voir dire the MRC members and the hearing officer, and the right to challenge the impartiality of any MRC member or the Hearing Officer. The Hearing Officer shall rule upon such challenges,
 - (b) be provided with all information made available to the MRC,
 - (c) call and examine witnesses on relevant evidence and to cross-examine witnesses,
 - (d) introduce relevant documentary evidence,
 - (e) present evidence that tends to impeach any witness on relevant

matters, provided that, to prevent abuse of this right, the Hearing Officer may, in his discretion, require a prior offer of proof summarizing such evidence and may in his discretion reject such evidence if the party fails to submit such offer of proof or if the offer of proof reasonably justifies such rejection, and

(f) submit a written statement at the close of the presentation of evidence

3 Evidence of relevant activities or practices at any location or facility shall be admissible unless the Hearing Officer upon a showing of good cause imposes limitations

4 The MRC may receive and consider any brief or memorandum presented by any party

5 Any relevant material contained in Medical Staff files regarding the affected practitioner is admissible, including but not limited to applications, references, and accompanying documents

SECTION 4 - DECISION AND REPORT OF MRC NOTICE

After adjournment of the final session of the hearing, the MRC shall begin its deliberations. Within thirty (30) days after closure of the deliberations of the MRC, the MRC shall render and deliver to the Administrator a written report and decision. The MRC may recommend that the Governing Body affirm, terminate or modify the action or recommendation that prompted the hearing. If the recommendation is to modify, the MRC must identify the modifications recommended. The decision and report shall be based on evidence produced at the hearing, including any recognized matters and reasonable inferences that may be drawn. The decision and report shall include findings of fact and conclusions articulating the connection between the evidence produced at the hearing and the decision reached. It shall include sufficient detail to enable the parties and the Governing Body to determine the basis for the MRC's decision on each issue contained in the statement of charges. It shall also contain a description of the appellate rights provided under these Bylaws. The Administrator, within five (5) working days after receiving the decision and report shall send a copy of them to the parties.

SECTION 5 - GOVERNING BODY ACTION AFTER MRC DECISION

The Governing Body shall take no action regarding the underlying matter or the decision and report of the MRC, until after the expiration of the time for requesting appellate review under Section 6, provided that if an appellate review is properly requested under Section 6, the Governing Body shall take no action except in compliance with the procedures and provisions of this Article. If an appellate review is not timely requested, the Governing Body shall make its final decision in accordance with Section 6.

SECTION 6 - APPEAL TO GOVERNING BODY

A Time for Requesting Appeal Within thirty (30) days after receipt of notice of the decision of the MRC, either the affected Practitioner or the body whose decision prompted the hearing, may request an appellate review by the Governing Body. The request shall be in writing and must be received by the Administrator within the applicable time period set forth above. The Administrator shall immediately deliver copies of the request to the Governing Body and to the other parties. The request shall set forth the ground (s) for appeal as noted under Section 6C. If an appellate review is not requested as set forth in this paragraph, all parties shall be deemed to have waived all rights to appeal.

B Nature and Effect of Appellate Review The appellate review shall be by the Governing Body or a committee thereof and all references to the "Governing Body" shall include such committees. Appellate review shall consist of a review of the prior proceedings and decision in the matter being reviewed, an appellate review meeting, deliberations, review of any further recommendations, and a final decision. In its final decision the Governing Body may affirm, modify or reverse the decision of the MRC. No person or entity shall sit as a member of the Governing Body or a committee thereof and participate in the appellate review process if such person or entity participated in bringing the charges or in officially reviewing the matter even if such removal leaves the Governing Body with less than a quorum.

C Grounds for Appeal The grounds for appeal are limited to substantial and prejudicial failure of the MRC or the MEC to comply with these Bylaws or to afford due process or a fair hearing, the action or recommendation that prompted the hearing, or any substantial part was arbitrary or capricious or the MRC's decision or any substantial part was clearly contrary to the weight of the evidence.

D Notice of Time, Date, Place of Appellate Review Meeting The Governing Body shall, within thirty (30) days after receipt by the Administrator of a timely request for appeal, schedule a date for an appellate review meeting. The Governing Body shall, not less than ten (10) days prior to the date of the appellate review meeting, give the parties written notice of the time, place, and date. The date thereof shall be not less than ten (10) days, nor more than sixty (60) days from the date of receipt by the Administrator of the request for appellate review, except that when a request for appellate review is from a member who is then under suspension, the appellate review meeting shall be held as soon as reasonably practicable but not later than forty (40) days from the date of receipt of the request. The chairman of the governing body for good cause may extend the date for the appellate review meeting.

E Appellate Review Proceedings The appellate review shall be conducted as follows:

- 1 The Governing Body shall limit its review to the record of the hearing before the MRC, the MRC decision and report, and any written briefs submitted

by the parties. The Governing Body may, however, in its sole discretion, accept additional issues or oral or written evidence subject to the same rights of cross-examination and rebuttal provided for MRC hearings. Such acceptance of additional issues or evidence may be based on the Governing Body's own motion, or upon the request of a party if, not less than seven (7) days prior to the appellate review meeting date, the party desiring to present such additional issues or evidence makes written request to the Governing Body to do so, specifying the nature and relevance of the issues or evidence, and gives notice of such request to all other parties. The Governing Body shall give notice of its decision in such matters to all parties as soon as reasonably possible.

2 The Governing Body may, in its sole discretion, appoint a Hearing Officer to conduct the appellate review meeting, rule on procedural matters, act as advisor to the governing body as to procedural matters, and without voting rights, participate in its deliberations and assist in the preparation of its decision.

3 Each party shall have the right to submit a written brief in support of his position on appeal, provided that copies of such brief shall be given to all other parties at such time as may be directed by the Governing Body.

4 The Governing Body, in its sole discretion, has the option to allow each party or party's representative to appear personally and make oral argument at the appellate review hearing, provided that such party shall make written application therefore to the Governing Body not less than seven (7) days prior to the date of the appellate review meeting. The Governing Body shall give notice of its response to such applications to all parties as soon as reasonably possible. If personal appearance is allowed, the affected Practitioner, if present, and all other parties and representatives present, shall answer any questions posed by any member of the Governing Body.

5 The Governing Body may, from time to time, adjourn and continue the appellate review meeting to another date or dates if it decides, in its sole discretion, that such action is necessary or desirable in order to conduct a fair and thorough appellate review in the matter. The Governing Body shall give notice to the parties of any such date and time, unless the parties were present when the Governing Body announced such date and time.

6 At the conclusion of the appellate review meeting, including oral argument, if held, the Governing Body shall, at a time convenient to itself, conduct deliberations outside the presence of the parties and their representatives, in order to determine whether to affirm, modify, or reverse the decision of the MRC.

7 The Governing Body shall, in its sole discretion, decide the order of procedures to be followed in the appellate review, as well as answers to questions.

not otherwise addressed in these Bylaws, to the end that the appellate review, including the appellate review meeting, shall be thorough, orderly, efficient, and fair

8 No person shall disrupt any appellate review proceeding Any person in attendance (whether a party or any other person) who disrupts an appellate review meeting after being warned by the Chairman of the Governing Body (or his designee or the hearing officer) to cease such disruption on penalty of indefinite exclusion, shall, at the direction of such chairman (or designee or the Hearing Officer), leave the meeting Unless directed otherwise for good cause by the Chairman (or designee or the Hearing Officer), the appellate review meeting shall proceed in the absence of such excluded person

F Final Decision/Effective Date The appellate review process shall conclude with the Governing Body's final decision in the matter, which shall be made in accordance with the following rules

1 Within thirty (30) days after either the waiver of appellate rights or the conclusion of the appellate review meeting, the Governing Body shall render its final decision, unless it refers the matter to the MRC for further review and recommendation The governing body, however, may exercise its independent judgment in determining whether the hearing procedures in these Bylaws were followed

2 If the Governing Body refers the matter to the MRC for further review and recommendation, such referral may include instructions such as that the MRC arrange for further hearings on specific issues The Governing Body shall give notice of such referral to the parties The MRC shall conduct such review in accordance with any such instructions, and shall deliver its written recommendation to the Governing Body within forty-five (45) days after the receipt of the referral from the Governing Body Within forty-five (45) days after receipt of such recommendation, the Governing Body shall render its final decision

The Governing Body's final decision shall be in writing and shall include a statement of the Governing Body's basis for its decision The decision shall be effective immediately and not subject to further hearing or appeal As soon as the final decision is effective, a copy of it shall be delivered to the affected Practitioner, the Administrator, and each party, in person or by certified mail

SECTION 7 - RIGHT TO ONLY ONE MRC HEARING AND APPELLATE REVIEW

No party shall be entitled to more than one (1) evidentiary hearing and one appellate review on any matter that may be the subject of a MRC hearing or appeal

SECTION 8 - INFORMAL INTERVIEWS

Nothing in these Bylaws shall be deemed to prevent any committee, or person contemplating any action or recommendation set forth in Section 2B, from, at its sole discretion, inviting the affected Practitioner to participate in an informal discussion of the contemplated action or recommendation. Such discussion shall not be deemed to constitute a hearing under this Article.

SECTION 9 - RESIGNATION OR WITHDRAWAL OF APPLICATION

Notwithstanding any other provision of these Bylaws, whenever the affected Practitioner unconditionally (a) resigns from the Medical Staff, (b) resigns and relinquishes the privileges that are the subject matter of a hearing, (c) withdraws the application that is the subject matter of hearing, (d) amends an application or request with regard to the items that are the subject matter of the hearing, or (e) consents in writing to the action or recommendation that prompted the hearing, and there are no other issues before the hearing, all hearing and appellate review proceedings with respect to the Practitioner, his privileges or application, as the case may be, shall terminate as of the first day after such resignation, withdrawal, amendment, or consent. Once so terminated, the proceedings shall not be reopened except when ordered by the Governing Body, after receiving a written request from, or giving notice to, the affected Practitioner, and determining that good cause exists for such reopening.

SECTION 10-CONFIDENTIALITY

In addition to the provisions provided in Article XIII (Confidentiality/Immunity from Liability) of these Bylaws, all Medical Staff applicants and members, committee members and committee guests, peer review consultants, persons involved in any peer review activity at this hospital, as well as parties, participants, and attendees at a Medical Staff peer review hearing, shall keep all peer review investigations as well as all hearing and appellate review proceedings and the contents thereof confidential. No one shall disclose or release any information from or about the proceedings to any person or the public.

SECTION 11-EXCEPTIONS TO HEARING AND APPEAL RIGHTS

In addition to other exceptions set forth in these Bylaws, the hearing and appeal rights under these Bylaws are not applicable under the following circumstances:

A Closed Department/Exclusive Contracts The hearing and appeal rights under these Bylaws do not apply to a Practitioner whose application for Medical Staff membership and privileges was denied on the basis that the privileges he seeks are granted only pursuant to a closed staff or exclusive use policy.

B Medico-Administrative Practitioner The hearing and appeal rights under these Bylaws do not apply to those persons serving the hospital in a medico-administrative

capacity Termination of such persons' rights to practice in the hospital shall instead be governed by the terms of their individual contract with the hospital However, the hearing and appeal rights of these Bylaws shall only apply to the extent that membership status or clinical privileges, which are independent of the Practitioner's contract, are also removed or suspended, unless the contract includes a specific provision establishing alternative procedural rights applicable to such decisions

C Automatic Suspension or Termination of Privileges The hearing and appeal rights under these Bylaws are not granted if a member's Medical Staff membership or clinical privileges are automatically suspended or terminated in accordance with these Bylaws

D Allied Health Professionals Allied Health Professionals are not entitled to the hearing and appeal rights under these Bylaws

E Removal from Emergency Room Call Schedule Emergency Room call schedule participation is not a benefit or privilege or staff membership, but rather is an obligation No hearing or appeal rights under these Bylaws are available for any action or recommendation affecting a Practitioner's emergency room call schedule obligation(s)

F Hospital Policy Decision The hearing and appeal rights of these Bylaws are not available if the hospital makes a policy decision (e g closing a department or service or physical plant changes) that adversely affects the staff membership or clinical privileges of any member or applicant

G Termination of Hospital Employed Practitioner The privileges and staff membership of any Practitioner employed to the hospital shall be subject to termination in accordance with the terms of the Practitioner's contract Such Practitioner shall not be entitled to the hearing and appeal rights under these Bylaws, except to the extent that the Practitioners staff membership or privileges, which would otherwise exist independent of the contract are to be limited or terminated, or unless otherwise provided in the Practitioner's contract

ARTICLE IX

OFFICERS OF THE MEDICAL STAFF

SECTION I – OFFICERS Officers of the medical staff shall be the

- A Chief of Staff**
- B Vice Chief of Staff**
- C Immediate Past Chief of Staff**
- D Secretary-Treasurer**

SECTION 2 - QUALIFICATIONS

Officers must be members of the active staff at the time of their nomination and election. They must maintain their active status and remain in good professional and ethical standing during their term of office. Because of the peer responsibilities of their offices, the Chief of Staff and Vice Chief of Staff shall be physicians, with demonstrated competence in their fields of practice and ability to direct the medico-administrative aspects of medical staff activities. Officers must have demonstrated good interpersonal relationships with Medical Staff members and Hospital staff, and have indicated a willingness to accept the responsibilities of the office.

SECTION 3 - NOMINATION AND ELECTION OF OFFICERS

A Officers shall be elected for a two (2) year term by the active staff members at the final meeting of the designated medical staff term. Election shall be by oral vote or showing of hands unless written two (2) or more eligible voters request ballot. The candidate must be elected by a majority vote of the active staff members present at the meeting. When three (3) or more candidates are running and a majority is not obtained, the candidate with the least votes will be eliminated each time until a candidate receives a majority vote. Voting by proxy shall not be permitted.

B Nominations may be made in the following ways, provided that written consent to serve is obtained from the proposed nominee prior to placing the nominee's name into nomination.

- 1 By a nominating committee. The nominating committee shall consist of five (5) members of the active medical staff appointed by the Chief of Staff subject to approval of the MEC. The nominating committee shall convene at least thirty (30) days prior to the final meeting of the medical staff term and shall submit to the Medical Staff Services Director one (1) or more qualified nominees for each office at least thirty (30) days prior to the meeting. The nominees shall be for the offices of Chief of Staff, Vice Chief of Staff and Secretary-Treasurer.
- 2 By petition. Nominating by petition requires the signature of at least ten (10%) percent of the active staff members and must be filed with the Medical Staff Services Director at least ten (10) days prior to the final medical staff meeting. The Medical Staff shall be notified of these additional nominees at the time of this meeting.
- 3 From the floor. Nominating may be done from the floor at the time of the final meeting of the medical staff term.

SECTION 4 - TERM OF OFFICE/VACANCIES

A Term of Office Each officer shall serve a two year term, beginning the first day

of the Medical Staff term following their election. Each officer shall serve until the end of his term or until a successor is elected, unless he shall sooner resign or be removed from office.

B Vacancies in Office The Medical Staff MEC shall fill Vacancies in office during the Medical Staff term, except for the Chief of Staff. If there is a vacancy in the office of Chief of Staff, the Vice Chief of Staff shall serve out the remaining term. A vacancy in the office of immediate past Chief of Staff will not be filled.

SECTION 5 - REMOVAL OF ELECTED OFFICERS FROM OFFICE

A Removal Removal of a medical staff officer may be initiated by a two-thirds (2/3) majority vote of the active Medical Staff. The Governing Body may remove any officer for cause as described in Section 5B, below.

B Grounds for Removal Each of the following conditions in itself constitutes cause for removal of a staff officer from office:

- 1 Revocation of professional license by the authorizing state agency,
- 2 Suspension from the Medical Staff,
- 3 Failure to perform the required duties of the office,
- 4 Failure to adhere to professional ethics,
- 5 Failure to comply with or support enforcement of the Hospital and
- 6 Medical Staff Bylaws, Rules and Regulations, and policies,
- 7 Failure to maintain adequate professional liability insurance, and
- 8 Failure to maintain active staff membership.

SECTION 6 - RESPONSIBILITIES, DUTIES, AND AUTHORITY OFFICERS

A Chief of Staff The responsibilities, duties, and authority of the Chief of Staff are to:

- 1 call, preside at, and determine the agenda of all general and special meetings of the Medical Staff,
- 2 serve as chairman of the MEC with tie-breaking vote prerogative only,
- 3 enforce medical staff Bylaws, rules and regulations and appropriate hospital rules and policies, implement sanctions when they are

indicated, and enforce the medical staff's compliance with procedural safeguards in all instances in which corrective action has been requested or initiated against a Practitioner,

- 4 appoint the chairman and all Medical Staff members of Medical Staff standing and ad hoc committees except the MEC appoint the Medical Staff members of Hospital and Governing Body committees when these are not designated by position or by specific direction of the Governing Body,
- 5 represent the views, policies, concerns, needs, and grievances of the Medical Staff to the Governing Body and Administration, serve ex officio as a voting member of the Governing Body,
- 6 advise the Governing Body on the effectiveness of the quality/performance improvement program and the overall quality of patient care in the Hospital
- 7 advise the Governing Body, Administration, and the MEC on that impact on patient care and clinical services, including the need for new or modified programs/ services, for recruitment and training of professional and support staff personnel, and for staffing patterns, and
- 8 serve as spokesman for the Medical Staff in its external professional and relations

B Vice Chief of Staff The responsibilities, duties, and authority of the Vice Chief of Staff are to

- 1 assume the responsibilities, duties, and authority of the Chief of Staff during the latter's absence whether the absence is temporary or permanent,
- 2 serve as an ex-officio voting member of the MEC, and
- 3 serve as chairman of the Performance Improvement Committee

C Immediate Past Chief of Staff The responsibilities, duties, and authority of the Immediate Past Chief of Staff are to

- 1 serve as an ex officio voting member of the MEC,
- 2 advise the Chief of Staff and MEC on matters concerning the Medical Staff
- 3 perform other functions at the request of the Chief of Staff and

- 4 assume the responsibilities, duties, and authority of the Chief of Staff when both the latter and the Vice Chief of Staff are temporarily absent

D Secretary-Treasurer The responsibilities, duties, and authority of the Secretary-Treasurer are to

- 1 serve as an ex officio voting member of the MEC, assure the preparation and maintenance of accurate and complete minutes for all medical staff meetings on order of the Chief of Staff,
- 2 supervise any staff funds if any, and perform other such duties as ordinarily pertain to the Office of Secretary- Treasurer

In the temporary absence of the Chief of Staff, Vice Chief of Staff, and the immediate past Chief of Staff, the Secretary-Treasurer shall assume all the duties and have the authority of the Chief of Staff. In the event that all four officers are absent, the Executive Committee shall appoint an acting Chief of Staff who shall assume all the duties and have the authority of the Chief of Staff.

ARTICLE X

CLINICAL DEPARTMENTS

SECTION I – ORGANIZATION

A Structure Each department shall be organized as a separate part of the Medical Staff and shall have a chairman who shall be responsible for the overall supervision of the clinical work within his department and is selected and has the authority, duties, and specific responsibilities as specified in this Article. Each department shall have at least five (5) members including the chairman and the vice-chairman.

B Departments There shall be departments of Medicine, Surgery, Family Practice and OB/GYN/Pediatrics.

1 The Medical Department shall include any staff members in the following practice specialties: internal medicine, cardiology, pulmonology/critical care, dermatology, oncology, hematology, nephrology, neurology, emergency medicine, diagnostic internal medicine, radiology, gastroenterology, hematology/oncology, nuclear medicine, psychiatry, rheumatology, and infectious disease.

2 The Department of Surgery shall include any staff member in the following practice specialties: vascular surgery, neurosurgery, orthopedic surgery, plastic surgery, urologic surgery, ophthalmology, otorhinolaryngology, maxillofacial surgery, general dentistry and all dental specialties, podiatry,

pathology, physiatry, and anesthesiology, pediatric surgery, colon/rectal surgery, cardio-thoracic

3 The Family Practice Department shall consist of Family Practitioners only

4 The OB/GYN/Pediatrics Department shall include the following obstetricians and gynecologists and all pediatricians and sub-specialties of the above

C Changes in Departments When deemed appropriate for better organizational efficiency and improved patient care, the MEC, with the approval of the Governing Body, may create new, eliminate, subdivide, or combine clinical departments

D Clinical Services When clinical services are established, they shall be organized as a specialty subdivision within a department, shall be directly responsible to the department within which they function, and have a Chief of Service who is selected and has the authority, duties, and responsibilities as specified in this Article Each service shall ordinarily have at least five (5) members

E Formation of Clinical Services A group of Practitioners of the same specialty that desire to become a clinical service must have a recommendation for such from the parent department to the MEC Denial of such a request by the department must be accompanied by the reason for the denial The MEC and Governing Body will then act on the request as follows

- 1 If the MEC approves a positive recommendation from the department, the committee recommendation is forwarded to the Governing Body
- 2 If MEC disagrees with a positive recommendation from the department, the issue can then be referred to the next general Medical Staff meeting The recommendation of the Medical Staff will then be forwarded to the Governing Body
- 3 If a negative recommendation from the department is supported by the MEC, the issue is considered closed
- 4 If the MEC reverses a negative decision from the department, the department may request that the issue be referred to the next general Medical Staff meeting The recommendation of the Medical Staff will then be forwarded to the Governing Body
- 4 All final approval rests with the Governing Body

SECTION 2 - PERFORMANCE ASSESSMENT AND IMPROVEMENT

A Responsibility It shall be the responsibility of the chairmen of the clinical

departments and specialty services, working through departmental committees and with the assistance as appropriate of the standing committees, to design and implement effective programs

(1) to monitor and assess the quality of professional performance in each department and service, and

(2) to promote quality practice in each department and service by (a) providing education and counseling by the medical staff both to families of patients as well as to members of the hospital staff for general medical education and update, (b) issuing letters of instruction admonition, warning or censure, as necessary, (c) requiring routine monitoring when deemed appropriate by the department or service, and (d) to participate as required in multi-disciplinary studies/systems

B Procedure

(1) Each department or service committee shall conduct regular patient care reviews and studies of performance and patient care outcomes within the department or service in conformity with a written quality management plan approved by the MEC and Governing Body

(2) In order to assist department or service members to conform their conduct or professional practice to the standards of the Medical Staff and Hospital, department or service chairmen may make informal comments or suggestions either orally or in writing. A summary of such statements will be kept in the member's credentials file. Such comments or suggestions shall be subject to the confidentiality requirements of all Medical Staff peer review information and may be issued with or without prior consultation with either the affected member or the department or service committee. Such comments or suggestions shall not constitute a restriction of privileges and shall not give rise to the hearing and appeal rights under these Bylaws. Such comments are eligible for peer review protection under state laws and statutes

(3) Following discussion of identified concerns with a member, any department or service committee may authorize the chairman to issue a letter of instruction, admonition or warning to the member or to require the member to be subject to routine monitoring for such time as shall appear reasonable to the department or service. The term "routine monitoring" as used in this section shall mean review of a member's performance for which the member's only obligation is to provide reasonable notice of patient admissions, procedures or other patient care activity. All members of the Medical Staff, regardless of status, shall be subject to potential routine monitoring. The discussions of such actions with individual members shall be informal. Such actions shall not constitute a restriction of privileges, shall not be considered to constitute corrective action and shall not give rise to the hearing and appeal rights under these Bylaws

(4) Written letters of instruction, admonition or warning or routine monitoring required pursuant to subparagraph three (3) above shall be reported to the MEC promptly after such actions are taken

SECTION 3 - ASSIGNMENT TO CLINICAL DEPARTMENTS

A **Assignment** Each member of the medical staff shall be assigned membership in one (1) clinical department, based on the bulk of the clinical services he provides. Members may, in addition, be granted clinical privileges in one (1) or more other departments

B **Meetings** Each member will be allowed to vote in only one (1) department and to represent only one (1) department on committees (including the MEC), and shall be responsible for attending the required number of meetings only in the department to which he is primarily assigned. However, each Practitioner is encouraged to attend meetings in all departments in which he exercises privileges and should keep himself informed of departmental activities, particularly as they relate to findings of patient care and performance evaluation activities

C **Rules and Regulations** The exercise of clinical privileges granted by the Governing Body or the performance of specified services within any department shall be subject to the rules and regulations of that department and the defined authority of the department chairman

SECTION 4 - FUNCTIONS OF CLINICAL DEPARTMENTS

The primary responsibility delegated to each department is to implement and conduct ongoing specific review and evaluation activities that contribute to the preservation and improvement of the quality, performance, effectiveness and efficiency of patient care provided through the department. To carry out this responsibility, each department either alone or in concert with other organizational components of the Medical Staff and of the Hospital, shall

A Objectively reviews, analyze, and evaluate the quality of care and performance provided through the department. In the interest of achieving quality patient care and performance, each department, through an established system, shall evaluate all clinical work performed under its jurisdiction, whether or not any particular Practitioner or other individual with clinical privileges whose work is subject to such evaluation is a member of the department. This must be done at least quarterly and must be based on objective, measurable standards of care/performance. All or part of such review may be carried out through clinical services or designated specialty groups, with periodic (at least quarterly) reporting of the interpreted findings to the appropriate medical staff department(s). Alternatively, a department as a whole may perform the required review and evaluation functions. The department may also elect to send the review to the Medical Staff Peer Review Committee

B Establish criteria for the granting of clinical privileges and, as appropriate, for the holding of office within the department

C Recommend to the Credentials Committee the specific clinical privileges that each staff member or Medical Staff applicant may exercise in the department and the specific services that each designated professional personnel may provide

D Establish such committees or other mechanisms as are necessary and desirable to maintain quality clinical performance

E Monitor its members' performance on a concurrent basis for

- 1 adherence to Medical Staff, Hospital, and departmental rules and regulations, and policies/procedures,
- 2 meeting requirements for alternate coverage and for obtaining consultation, adherence to sound principles of clinical practice,
- 3 appropriate invasive procedures and other patient care interventions,
- 4 unexpected clinical occurrences, including compliance with the Hospital Occurrence/Incident Screening Program (HOR), and
- 5 all relevant aspects of patient safety

F fulfill the responsibilities designated to the department as set forth in the quality/performance improvement plan

G receive and evaluate the compliance with medical necessity (admission and intervention) and clinical management criteria, the findings from use of occurrence screening criteria, reports of Medical Staff and other departmental committees, and compliance with the established patient care requirements (rules, regulations, policies, protocols) of the department and Medical Staff

H coordinate with nursing and ancillary clinical patient care services, and with other administrative support services, the patient care provided by the department's members

I conduct or participate in, and make recommendations regarding the need for continuing education programs, pertinent to state-of-the-art changes, and, in particular, to the findings of performance assessment and improvement activities

J maintain a permanent record of all department meetings/activities to include the discussion content as well as conclusions reached or actions taken or recommended. Copies of minutes should be transmitted to the Medical Executive Committee

SECTION 5 - DEPARTMENT CHAIRMAN AND VICE CHAIRMAN

A Qualifications Each chairman and vice chairman shall be a member of the active staff, qualified by training, experience, and demonstrated ability for the position. Each shall have demonstrated professional ability in at least one (1) of the clinical areas covered by the department, shall meet all state regulatory requirements, and shall be willing, able, and eligible to discharge faithfully the functions of his office. The Department Director shall be certified by an appropriate specialty board or affirmatively establish comparable competence through the credentialing process.

B Selection of Chairman and Vice Chairman Each chairman and vice chairman shall be elected by the department membership from nominees submitted in writing by department members or verbal nomination subject to approval of the MEC or each chairman and vice chairman shall be appointed by the Chief of Staff after consultation with the MEC. If the MEC fails to approve the election of the chairman and vice chairman, the department shall hold another election.

C Terms of Office Department chairman and vice chairman shall serve a two (2) year term beginning on the first day of the Medical Staff term following his selection. The department chairman or elected department vice chairman may succeed himself. The department chairman or elected department vice chairman shall serve until his successor is chosen, unless he shall resign sooner or be removed from office. In the temporary or permanent absence of the department chairman, the vice chairman shall assume all duties, responsibilities, and authority of the chairman, and will become a member of the MEC. The vice chairman may be elected by the department membership or appointed by the Chief of Staff.

D Removal of Department Chairman or Vice Chairman Removal of a department chairman or vice chairman may be initiated by a two-thirds (2/3) majority vote of department members eligible to vote, and subject to approval of the MEC. The MEC or Governing Board may remove for cause as listed under Section 5B of Article IX of these Bylaws, relating to removal of Medical Staff officers.

E Responsibilities, Duties, and Authority of Department Chairman Each chairman shall

- 1 account to the MEC for all professional and administrative activities within his department,
- 2 develop and implement in cooperation with the Chief of Staff and consistent with these Bylaws, departmental mechanisms for performing the credentials review, delineating clinical privileges, and assigning staff classification, concurrent monitoring of practice/performance that is objective and measurable, include an occurrence screening program and the use of medical necessity and clinical management criteria, quality management activities,

- continuing medical education, and utilization review,
- 3 transmit to the Credentials Committee the department's recommendation concerning appointment and reappointment, delineation of clinical privileges, and corrective action with respect to practitioners in the department,
 - 4 maintain ongoing review of the professional performance of all Practitioners and any Allied Health Professionals within the department, contribute data to individual Practitioner's performance profiles, and report regularly to the Credentials Committee and MEC upon request and at the time of reappointment. The report will include evidence of consideration of each Practitioner's health status in terms of the Practitioner's ability to practice in the area in which privileges are sought,
 - 5 develop, implement, and enforce, in cooperation with the Chief of Staff and/or Vice Chief of Staff, programs to perform the quality assessment and improvement and maintenance functions delegated to his service,
 - 6 serve as a member of the MEC, giving guidance on the overall medical policies of the Hospital and making specific recommendations and suggestions regarding his own department in order to promote quality patient care. Within the department chairman shall implement actions taken by the MEC,
 - 7 enforce the Hospital and Medical Staff Bylaws, Rules and Regulations, and policies, and the departmental rules and regulations, including, when appropriate, the initiation of corrective action and investigative services and participate as consultants on an as-needed basis when his area is involved,
 - 8 actively encourage all department members to complete adequately and in a timely manner the medical records of their discharged patients (within the period required by these Bylaws, rules and regulations and by any regulatory agency),
 - 9 assign proctors to individuals who have been granted temporary privileges prior to staff membership approval or who are in provisional status as new appointed staff members or as otherwise requested by the MEC,
 - 10 cause departmental rules and regulations relating to standards of patient care to be developed, approved, implemented, and reviewed at least annually for any needed revision,
 - 11 cause all standing orders of Practitioners to be reviewed initially, on change, and periodically (e.g., annually), if the responsibility is not assigned to a standing committee of the Medical Staff (e.g., Pharmacy and Therapeutics Committee),

- 12 assist in the preparation of such annual reports, including budgetary planning, pertaining to the department as may be required by the MEC, the Administrator, or the Governing Body,
- 13 assess and recommend to the Administrator off-site sources for needed patient care services not provided by the department/service or the Hospital,
- 14 determine whom, outside of the department members, the Chief of Staff, Administrator or his designee, quality management coordinator, and recording secretary, may attend department meetings,
- 15 perform such other duties commensurate with his office as may from time to time be reasonably requested of him by the Chief of Staff, the MEC, or Governing Body,
- 16 coordinate and integrate interdepartmental and intradepartmental services,
- 17 exercise general supervision over all clinical work performed through the service, and
- 18 act as presiding officer at all service meetings and cause a permanent meeting report to be maintained and distributed as required

ARTICLE XI

COMMITTEES & FUNCTIONS

SECTION I - GENERAL CONSIDERATIONS

A Standing and Special Committees There shall be standing and special (ad hoc) committees of the Medical Staff Unless stated otherwise in these Bylaws, the committees of this Article shall be standing committees of the Medical Staff Special or ad hoc committees may be created by the MEC to perform specified tasks

B Appointment and Removal Unless otherwise specified, the Chairman and members (except the MEC and its Chairman) of all committees shall be appointed for a two (2) year term and may be removed by the Chief of Staff after consultation with and approval of the MEC

C Minutes Unless stated otherwise in these Bylaws, each committee shall submit a copy of its minutes to the MEC and shall maintain a permanent record of its proceedings, including pertinent discussion and any conclusions, recommendations, and actions

D Participation of Non-Medical Staff Members Persons who participate or

attend committees or functions who are not Medical Staff members shall be selected by the Administrator with the concurrence of the committee Chairman or Chief of Staff. Non-medical staff members shall not be entitled to vote, but may participate if invited in discussion.

E Ex officio members Ex officio committee members shall serve without vote.

F Performance of Functions Whenever these Bylaws require that a function be performed by

- 1 A Medical Staff committee but no committee has been specified, the MEC shall perform the function or designate a subcommittee to perform it.
- 2 The MEC, but a standing or special committee has been formed to perform the function, the committee so formed shall act in accordance with the authority delegated to it.

G Vacancies Unless stated otherwise in these Bylaws, vacancies on any committee shall be filled in the manner of original appointment to the committee. If an individual obtains membership by virtue of these Bylaws and is removed for cause, a successor may be selected by the MEC.

H Medical Staff Committee Chairman The chairman of each medical staff committee will change every two- (2) years. A physician may succeed himself/herself as chairman of any medical staff committee.

SECTION 2 - MEDICAL EXECUTIVE COMMITTEE (MEC)

A Composition The Medical Executive Committee shall be a standing committee of the Medical Staff. It shall consist of the officers of the staff: Chief of Staff, Vice-Chief of Staff, and Secretary-treasurer, Chairman of all Medical Staff Departments, the most recent ex-chief of staff, the Chairman of Credentials Committee, the Chairman of the Med/Surg/PCU Committee, one member selected at large from the Medical Staff by the Chief of Staff, the Chief Medical Officer of the hospital who shall be an ex-officio member without vote, and the Administrator of the hospital who shall be an ex-officio member without vote. The Chief of Staff shall be Chairman of the committee. Each voting member, regardless of staff, department, or other committee position held shall have only one (1) vote.

B Responsibilities, Duties, and Authority The MEC shall

- 1 represent and act on behalf of the Medical Staff, subject to such limitation as may be imposed by these Bylaws,
- 2 make recommendations to the Governing Body on all matters relating to

appointments, reappointments, clinical privileges, staff category and clinical department/service assignments, and corrective action When Allied Health Professionals provide or are recommended to provide services in the Hospital, the committee shall make recommendations to the Governing Body regarding their qualifications to provide those services and on the degree of supervision required,

- 3 receive and act upon reports and recommendations from Medical Staff committees, all clinical departments, and staff officers concerning performance improvement activities and the discharge of their delegated administrative responsibilities,
- 4 ensure, through evaluation by this committee or the Environment of Care Committee, that each Medical Staff peer evaluation and performance assessment and improvement activity is performed effectively,
- 5 coordinate the activities of, and policies adopted by, the staff, departments/services, and committees,
- 6 fulfill the medical staffs' accountability to the Governing Body for the medical care rendered to patients in the Hospital,
- 7 initiate and pursue corrective action, when warranted, in accordance with these Bylaws,
- 8 take all reasonable steps to help provide for professional ethical conduct, competence, and clinical performance on the part of all staff members,
- 9 make recommendations to the Governing Body on medico- administrative and Hospital management matters as requested, particularly as they relate to patient care, through the Administrator and Chief of Staff,
- 10 submit recommendations to the Governing Body for changes in the Medical Staff Bylaws, Rules and Regulations and other organizational documents pertaining to the Medical Staff,
- 11 serve as a liaison to provide and promote effective relationships among the Medical Staff, Administration, and the Governing Body,
- 12 participate in identifying community health needs, setting Hospital goals, and implementing programs to meet those needs,
- 13 actively maintain effective Medical Staff participation in the hospital's occurrence screening program, and
- 14 promote in house Medical Staff continuing education activities that are

relevant to the care and services provided in the hospital and, in particular, to the findings of Medical Staff peer evaluation and performance improvement activities

- C **Meetings** The MEC shall meet as often as necessary to accomplish its functions, but at least ten (10) times per year

SECTION 3 - CREDENTIALS COMMITTEE

- A **Composition** The Credentials Committee shall be a standing committee of the Medical Staff and shall consist of five (5) or more members of the active staff, with ex officio representation from administration who shall not vote. The physician members shall be representative of the major clinical departments. Whenever possible, when a physician is being reviewed, a peer representative, who is not a member of the committee, will participate for that part of the meeting. The Chairman of the committee shall be an active member of the Medical Staff appointed by the Chief of Staff.

- B **Responsibilities, Duties and Authority** The committee shall

- 1 review and evaluate the qualifications of each applicant for initial appointment, reappointment, or modification of appointment, and for clinical privileges,
- 2 review each application prior to processing to determine if it is complete for processing and shall not process any application for membership or privileges that is incomplete,
- 3 review and evaluate the qualifications of Allied Health Professionals to provide specific patient care services in the Hospital and to obtain and consider the recommendations of the appropriate department,
- 4 obtain and consider the recommendations of the appropriate departments regarding initial appointment, reappointment, or modification of appointment and for clinical privileges,
- 5 submit a report, in accordance with these Bylaws, to the MEC on the qualifications of each applicant for staff membership or clinical privileges, and of each Allied Health Professionals, to provide specific patient care services. Such report shall include recommendations for Medical Staff applicants as to appointment, staff category assignment, department/service affiliation, and clinical privileges, and, for Allied Health Professionals the specific services to be performed. In either case, any special conditions will be recommended at the same time,
- 6 submit reports to the MEC on the status of pending applications, including

the specific reasons for any unusual delay in processing an application or request,

7 monitor the number of patient contacts and the number of department and quarterly medial staff meetings of Practitioners in provisional status pending their final Medical Staff appointment,

8 provide that a separate credentials file is maintained for each staff member, each practitioner with clinical privileges, and each Allied Health Professionals, including reports from quality/performance assessment and improvement activities and of corrective actions of any degree

- C Meetings The Credentials Committee shall meet as often as necessary to accomplish its functions

SECTION 4 - ENVIRONMENT OF CARE COMMITTEE

- A Composition The Environment of Care Committee shall be a standing committee and shall consist of at least one active physician member from the medical staff, the Administrator or designee, the Chief Nursing Officer, the Quality Improvement Coordinator, and the Risk Manager, and other hospital staff as appointed by the administrator Other individuals from either the Medical or Hospital staffs may participate as consultants on an as-needed basis

- B Responsibilities, Duties, and Authority The committee shall

- 1 review quality control reports from the various hospital departments to identify any trends and/or opportunities for improvement,
- 2 receive, analyze, and recommend action regarding any significant findings from quality control, safety or infection control reviews,
- 3 review and approve the hospital plans for performance improvement, safety and infection control,
- 4 receive and review safety reports including those related to emergency preparedness, provide input to effect positive change, review and approve safety policies,
- 5 receive, review and approve hospital infection control policies, issues and reports and provide input to effect improvement and positive changes,
- 6 perform at least an annual evaluation of the Environment of Care program to assure its comprehensiveness and effectiveness,
- 7 assure that an updated report is presented to the Governing Body annually,

8 analyze the incidence and major causes of hospital acquired infections and make recommendations for improvement

9 receive reports and monitor a preventive and corrective program designed to minimize infection hazards, including an employee health program,

10 institute appropriate control measures or studies if there is suspicion of a danger to patients or personnel. When the situation is considered to be urgent, the committee chairman or a physician member of the committee or the infection control practitioner may institute the control measure immediately and will be assisted by hospital personnel in doing so. The Chief of Staff and the Administrator shall be notified as soon as any urgent control measure is instituted and shall be consulted prior to the institution of any non-urgent measure. The attending practitioner shall be notified as soon as possible, however, when the patient's attending practitioner does not consider the measure necessary (e.g., the need to isolate a patient), the decision of the committee chairman or infection control practitioner in following established infection control policy, shall prevail,

11 review and approve cleaning agents to be used in the hospital, and

12 determine when environmental cultures are required

C **Meetings** The Environment of Care Committee shall meet as often as necessary to accomplish its functions, but at least (6) six times per year. The overall findings will be sent to MEC.

SECTION 5 - PHARMACY AND THERAPEUTICS COMMITTEE

A **Composition** The Pharmacy and Therapeutics Committee is a standing committee of the medical staff and shall consist of at least one physician from the active Medical Staff, a pharmacist from the hospital's pharmacy service, a representative from the laboratory, infection control, administration and from nursing services and when indicated, a clinical dietitian. The physicians shall represent each Medical Staff department. The chairman shall be selected by the Chief of Staff.

B **Responsibilities, Duties & and Authority** The committee shall

1 evaluate the clinical usage of drugs (particularly high risk, problem-prone and investigative drugs) in the hospital, establishing priorities for specific drug or drug category reviews, and using measurable criteria in the review process. After any required peer review, the findings will be entered into the appropriate practitioner performance profiles,

2 establish and implement a well controlled or closed formulary to help control the use of drugs in the hospital. The committee will make

recommendations to the MEC regarding any changes to the formulary. Requests for formulary changes from individual medical staff members must be submitted to the committee in writing and include the rationale for the change. The committee chairman will transmit the committee's action to the requesting Practitioner,

3 define and evaluate all significant untoward reactions to drugs. In addition, the committee shall strive for adequate reporting of actual or suspected untoward drug reactions, including the recommendation of periodic inservice training for nursing personnel and other appropriate hospital personnel,

4 define and evaluate all significant medication errors,

5 evaluate initially, when changes are made, and at least annually, standing and routine orders containing medication orders,

6 assist in the formulation of and approval of all professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and other matters relating to drug usage in the hospital,

7 ensure the adequacy and centralization of intravenous mixtures, total parenteral nutrition, and the mixture of chemotherapeutic agents,

8 make recommendations to the MEC on protocols proposed for the use of investigational or experimental and, high-risk drugs and specific drug categories for use in the hospital,

9 review statistics and reports related to blood and blood product ordering, handling, dispensing, administering and monitoring the effects on patients and make recommendations as needed,

10 maintain in conjunction with the P & T Committee, an objective ongoing evaluation of the clinical use of all antibiotics used in the hospital, whether the drugs are prescribed prophylactically, empirically, or therapeutically. The committee shall recommend action for any required practice change to the MEC and shall follow-up through the Performance Improvement Committee to be sure the approved change has occurred. The committee shall recommend objective and measurable criteria for use in all facets of antibiotic use evaluation,

11 evaluate clinical practice objectively for compliance with measurable criteria for the use of whole blood and each of its components administered in the hospital,

12 evaluate untoward transfusion reactions. In addition, the committee shall strive for adequate reporting of actual or suspected transfusion reactions, including the recommendation of periodic in-service training for nursing

personnel to identify such reactions,

13 maintain and evaluate blood use statistics in order to determine blood waste and recommend or take appropriate action,

14 encourage strongly the increased use of the type-and-screen vs type-and-crossmatch procedure, based on periodic (e g , annual) actual use statistics by practitioner, departments/clinical specialties, and specific therapeutic interventions (e g , specific surgical procedures, etc),

15 the physician representatives will review blood and blood product usage Any isolated instances or patterns of inappropriate blood usage felt to be significant in the view of the Committee will be referred to the appropriate department for further review,

16 set priorities for any aspect of blood therapy evaluation, and

17 Review and support activities to infection control including policy development, surveillance, prevention and control measures Data and trends related to infection control will be reviewed and processes for improvement of outcomes will be identified

C Meetings The Pharmacy and Therapeutics Committee shall meet as often as necessary to accomplish its function, but at least four (4) times per year

SECTION 6 - OPERATING ROOM COMMITTEE

A Composition The Operating Room Committee shall be a standing committee and shall consist of active members of the Medical Staff from departments such as Anesthesia and Surgery specialties In addition, the committee shall have representation from the Administration, Director of Surgical Services, and other support departments as needed The OR Committee shall have several subcommittees including, but not limited to the following

1 LASER COMMITTEE

a Composition The Laser Committee shall be a subcommittee of the OR Committee consisting of active Medical Staff from the surgery specialty, the Bio-Medical technician, the Director of Surgical Services and a representative from Hospital Administration

b Responsibilities, Duties, and Authority The responsibilities, duties, and authority of the Laser Committee shall be to

1 monitor and trend laser usage and safety through the monitoring of quality indicators,

2 make recommendations to the OR Committee policy and procedure development, continuing education, privilege/credential guidelines, and other quality of care issues, and

3 report any concerns and/or laser needs to the OR Committee

c Meetings The Laser Committee shall meet as often as needed. The chairman of the Laser Committee shall be a member of the OR Committee appointed by the Chief of Staff, and serve as a liaison from the Medical Staff to Hospital Administration and report any issues to the OR Committee

2 ENDOSCOPY COMMITTEE

a Composition The Endoscopy Committee shall be a subcommittee of the OR Committee consisting of active medical staff from both the Surgery and Medicine specialties, the Endoscopy nurse (s) and a representative from the Hospital Administration

b Responsibilities, Duties, and Authority The responsibilities, duties and authority of the Endoscopy Committee shall be to

1 monitor and trend endoscopy usage and safety,

2 make recommendations to the OR Committee for policy and procedure development, continuing education, privilege/credential guidelines, and other quality of care issues, and

3 report any concerns and/or needs to the OR Committee

c Meetings The Endoscopy Committee shall meet as often as needed. The chairman of the Endoscopy Committee shall be a member of the OR Committee appointed by the Chief of Staff, and serve as a liaison from the Medical Staff to Hospital Administration and report any issues to the OR Committee

3 PAIN MANAGEMENT COMMITTEE

a Composition The Pain Management Committee shall be a subcommittee of the OR Committee consisting of the active Medical Staff, nursing representation from the Block Suite, the Director of Spine Services, and a representative from Hospital Administration

b **Responsibilities, Duties, and Authority** The responsibilities, duties, and authority of the Pain Management Committee shall be to

1 monitor and trend block suite patient care and safety through monitoring of designated quality indicators,

2 make recommendations to the OR Committee for policy and procedure development, continuing education, privilege delineation, credentials guidelines, and other quality care issues,

3 report any concerns and / or Pain Management needs to the OR Committee

c **Meetings** The Pain Management Committee shall meet as often as needed The chairman of the Pain Management Committee shall be a member of the OR Committee appointed by the Chief of Staff, and shall serve as a liaison from the Medical Staff to Hospital Administration and report any issues to the OR Committee

B **Responsibilities, Duties, and Authority** The responsibilities of the Operating Room (OR) Committee shall be to

1 review and monitor utilization of the operating room time, including starting times, operative times, and efficient daily running of the operating room schedule,

2 develop policies concerning hours of the operating room' operation including times that elective cases may be scheduled as well as hours which during the week that will be designated as emergency operative time,

3 develop policies concerning the posting and scheduling of patients and efficient utilization of all available time and space in the operating room Develop polices and procedures as deemed necessary from time to time to assure the most cooperative and efficient use of the operating room,

4 review Performance Improvement procedures,

5 make recommendations to ECRMC for obtaining new OR equipment, and review of OR design change,

6 assume other duties and responsibilities as would naturally fall under the direction of an OR Committee

C **Meetings** The OR Committee shall meet quarterly or as often as necessary to accomplish its functions

SECTION 7 – PERFORMANCE IMPROVEMENT COMMITTEE

A Composition The Performance Improvement Committee shall consist of at least one active member of the medical staff appointed by the Chief of Staff and shall serve as the Committee Chairperson. The other members of the PI Committee shall include the VPPCS, COO, Quality Management Coordinator, and four department directors selected annually by the CEO.

B Responsibilities, Duties, Authority The committee shall be responsible for performance improvement through

- 1 providing oversight to the implementation of the Hospital's plan for performance improvement,
- 2 reviewing and approving department performance improvement indicators, data to be collected and interventions,
- 3 recommending and/or approving performance improvement teams for the purpose of process improvement,
- 4 review and evaluation of and approving performance improvement data analysis and intervention,
- 5 providing for the Medical Executive Committee and the Board of Directors an annual evaluation of the effectiveness of all aspects and components of the performance improvement process and recommendation for improvement and a projected plan for the following year.

C Meetings The Performance Improvement Committee shall meet as often as needed to accomplish its functions, but at least six (6) times a year.

SECTION 8 - BYLAWS, RULES AND REGULATIONS COMMITTEE

A Composition The Bylaws, Rules and Regulations Committee is a standing committee of the medical staff and shall consist of three (3) or more physician members of the active staff, including the Chief of Staff and the immediate past Chief of Staff. The Medical Staff Services Director shall participate as an ex officio member without vote.

B Responsibilities, Duties, and Authority The responsibilities, duties, and authority of the Bylaws, Rules and Regulations Committee shall be to

- 1 review at least annually the Medical Staff Bylaws, Rules and Regulations and recommend to the MEC and the Governing Body any changes deemed necessary for compliance with applicable laws and accreditation requirements, and

2 ensure, through ongoing review, that the Bylaws, Rules and Regulations reflect current practice and an efficient organization of the Medical Staff in performing its functions,

3 ask each clinical department to develop and implement rules and regulations to establish standards of patient care and ascertain that these rules and regulations are consistent with Medical Staff Bylaws, Rules and Regulations and with Hospital and Governing Body policies

C Meetings The Bylaws, Rules and Regulations Committee shall meet as often as necessary to accomplish its functions

SECTION 9 - MEDICAL RECORD/UTILIZATION REVIEW COMMITTEE

A Composition The Medical Record/Utilization Review Committee is a standing committee of the Medical Staff and shall consist of physicians from the active staff representing the major departments, a representative from administration and from nursing services, utilization review coordinator and discharge planner, and the Health Information Services Director

B Responsibilities, Duties, and Authority The committee shall

1 review and evaluate medical records objectively, using prescribed work sheets, to assist in providing records that are adequate with regard to (a) continuity of care, (b) use in quality assessment and improvement activities, (c) assisting in protecting the legal interest of the patient, the hospital, and the responsible practitioner, (d) clinical pertinence (particularly all significant changes in patient status) to be done by physicians, (e) required documentation, (f) patient/family involvement in the plan of care, (g) receipt and acknowledgment of patient/family instructions, (h) age specific information (particularly for infants and children), (i) pertinent psychosocial information, and (j) evidence of informed consent,

2 establish the format of the medical record in concert with the director of the Health Information Management department, and review and advise the Administrator and MEC regarding all forms to be used in the medical record,

3 review and recommend approval or not, of all policies, rules, and regulations relating to medical records,

4 recommend any need for and the interval for microfilming medical records, and participate in decisions for computerization of medical record data,

5 develop, or cause to be developed, and implement a record review system that, over a reasonable period of time, causes a representative sampling of the

records of all practitioners to be evaluated for quality and clinical pertinence,

6 furnish to medical staff and administration on a regular basis timely statistical data, the nature of which is to be determined through the information needs of the Hospital and Medical Staff,

7 comply with applicable requirements of the utilization review plan approved by the Medical Staff and Governing Body,

8 require documentation that utilization review is applied regardless of payment source,

9 require that focused reviews be emphasized, and

10 determine whether under utilization and/or over utilization of practices has an adverse impact upon the quality of patient care and recommend appropriate corrective actions to be taken

B Meetings The Medical Record/UR Committee shall meet as often as necessary to accomplish its functions and clinical pertinence review

SECTION 10 - MEDICAL ETHICS COMMITTEE

A Composition The Medical Ethics Committee, which may also be referred to as the Medical Ethics, shall be a standing Medical Staff committee which shall have active Medical Staff members. It may include lay representatives, nurses, social workers, clergy, ethicists, and an attorney, the Administrator (or designee). Its membership shall represent a diversity of professions and shall include both men and women. A Medical Ethics member may not participate in the initial or continuing review of any project in which the member has a conflicting interest except to provide information as requested by the Medical Ethics Committee. The Medical Ethics Committee may, at its discretion, invite nonvoting individuals with competence in special areas to assist in the review of issues which require expertise beyond or in addition to that available on the Medical Ethics Committee. The chairman shall be an experienced, Medical Staff member and shall assist in the appointment along with the Chief of Staff, of the remaining committee members.

B Meetings The Medical Ethics Committee shall meet as often as necessary to accomplish its functions at the call of the chairman. Except when an expedited review procedure is used, the Ethics Committee shall review proposed research at convened meetings at which a majority of the members of the Ethics Committee are present, including at least one member whose primary concerns are in nonscientific areas. The Ethics Committee shall prepare and maintain adequate documentation of Ethics Committee activities and shall report to the MEC.

SECTION 11 – MEDICAL/SURGICAL/PCU (MED/SURG/PCU) COMMITTEE

A Composition The Med/Surg Committee shall be a standing committee of the Medical Staff and shall consist of at least one medical staff member of the active medical staff, the Director of Med/Surg and a Head Charge nurse. The Chairman of the Committee shall be a standing member of the Medical Executive Committee. The nursing staff will be ex-officio members and shall not vote. Other appropriate personnel can be appointed as deemed necessary by the Chairman of the Med/Surg Committee.

B Responsibilities, Duties, and Authority The committee shall be responsible for

- 1 enhancing the quality of care on the general Med/Surg floors,
- 2 assisting administration in planning programs of care for the continued growth of the Med/Surg unit,
- 3 making recommendations for patient flow and interacting with the other clinical departments in matters that affect the operations of the Med/Surg unit,
- 4 identifying the patient care needs and promoting the attainment of patient care goals,
- 5 serving as a liaison between the nursing staff, medical staff, and administration and
- 6 making recommendations to the Medical Executive Committee on any area of quality control issues or recommendations for the improvement in hospital services

B Meetings The Med/Surg Committee shall meet as often as necessary to accomplish its function.

SECTION 12 – PATIENT SAFETY COMMITTEE

A Composition The Patient Safety Committee shall be a standing committee of the Medical Staff and shall consist of the Chief of Staff and an appointed active medical staff member as designated by the COS, the Patient Safety Officer. One of the physician members shall serve as Chairperson of the committee. The Committee shall call upon other physicians and staff members to participate in Committee meetings that relate to their department.

B Responsibilities, Duties, and Authority The committee shall be responsible for

- 1 Providing a systematic, coordinated and continuous approach to maintenance and improvement of patient safety,

- 2 developing a confidential system to track near misses, adverse events, sentinel events, patients, physician and staff,
- 3 assemble relevant patient safety data from internal and external sources,
- 4 The assembled information will be relayed to the MEC and Board of Directors,
- 5 conduct proactive risk assessment of a high-risk process identified in the JCAHO Sentinel Event Alert or as identified by the Committee,
- 6 monitor and track Occurrence reports,
- 7 survey patients, family members , medical staff and other staff regarding their opinions, needs and perceptions of the risks to patients,
- 8 notify patient and family, when appropriate, about outcomes of care, including unanticipated outcomes, and shall assure them that appropriate clinical measures are taken to respond to the unanticipated outcome

C Meetings The Patient Safety shall meet quarterly or as often as necessary to accomplish its function

SECTION 13 -PEER-REVIEW COMMITTEE

A Composition The Peer Review Committee is a standing committee of the Medical Staff and shall consist of the Chief of Staff or Designee to Chair the Committee, Chairman Department of Medicine or Designee, Chairman Department of Surgery or Designee, Chairman Department of OB/GYN or Designee, Chairman Department of Pediatrics or Designee, Chairman Department of Family Medicine or Designee, Member At-Large appointed by Chief of Staff and the Chief Medical Officer who is an ex-officio adviser and nonvoting member

B Responsibilities, Duties, and Authority The committee shall

- 1 Conduct fair, meaningful, and comprehensive peer review by assessing data measuring physician performance with respect to the following (a) medical assessment and treatment of patients, (b) medication use and management, (c) operative and other invasive procedures, (d) resuscitation and its outcomes, and (e) the appropriateness of clinical practice patterns

- 2 Assess aspects of physician behavior as it relates to appropriate medical management of patients and staff relationships

- 3 Assess departures from the usual utilization practices

C Processes

- 1 Conduct individual case reviews where performance is questioned as a result of measurement and assessment activities An initial screening review will be done by either the clinical department or the Chief Medical Officer The body doing the initial screening review will be determined by the individual clinical department Charts reviewed by the Chief Medical Officer which need further review will be

referred to the appropriate clinical department. Charts deemed by the clinical department to need still further review will be referred to the Peer Review Committee. The Chief Medical Officer may do an independent screening review on any charts initially screened by a clinical department.

2 The clinical department may consult a specialty reviewer which is either inside or outside the hospital's Medical Staff if needed to conduct individual case reviews.

3 Provide for participation in the review process by the individual whose performances are being reviewed.

4 Collect and maintain individual practitioner data for tracking trends to enhance education, patient safety, and quality improvement.

5 Report composite data to MEC, Governing Board of the Hospital, and clinical departments as indicated.

6 Provide individual practitioner data to the Credentials Committee for use in the reappointment process.

7 Refer Appropriate Cases to the Clinical Department, MEC, Governing Board or other entities to consider disciplinary action.

D Meetings

1 To be held monthly or as indicated by the need for prompt case review.

2 Contingency meetings can be called at any time by the Chairman of the Peer Review Committee with sufficient notice to deal with individual problems that are time sensitive.

ARTICLE XII
MEETINGS

SECTION 1 – QUARTERLY MEDICAL STAFF MEETINGS

A Regular Meeting Medical Staff meetings shall be held on a quarterly basis. The agenda shall include cumulative reports by staff officers and by committee and department chairman for the review and evaluation of the work done. Elections for staff office will be held at this meeting. The Chief of Staff shall preside at all general meetings of the Medical Staff.

B Order of Business and Agenda The order of business and agenda of the Quarterly Medical Staff meeting will be determined by the Chief of Staff.

C Special Meeting Special meeting of the Medical Staff may be called at any time by the Chief of Staff or at the written request of the Administrator, Governing Body, the MEC, or at least one-fourth (1/4) of the active staff members. The Chief of Staff shall call a special meeting within seven (7) days of his written request.

- 1 Written or printed notice stating the place, day and hour of any special meeting of the medical staff shall be delivered. Either personally or by mail, to each member of the active staff not less than five (5) nor more than ten (10) days before the date of such meeting, by or at the direction of the Chief of Staff. If mailed, the notice of the meeting shall be deemed delivered when deposited, postage prepaid, in the United States mail, addressed to each staff member at his address as it appears in the records of the Hospital. Notice may also be sent to members of other Medical Staff groups who have so requested. If a Medical Staff member is present at the time a specific meeting is called, this shall constitute a waiver of notice of such meeting, and
- 2 No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

SECTION 2 – COMMITTEE AND DEPARTMENT MEETINGS

A Medical staff committees, department, and clinical services may, by resolution, provide the time for holding regular meetings and no notice other than such resolution shall then be required. Departments shall meet at least quarterly. Committees shall meet as required by these Bylaws.

B A special meeting of any committee or department may be called by or at the request of the chairman or chief thereof, by the Chief of Staff, or by one-third (1/3) of the group's current members. No business shall be transacted at any special meeting except that stated in the meeting notice.

C Notice of Meetings (Committee or Department)

- 1 Notice of regular meetings may be given orally or written.
- 2 For any special meeting or any regular meeting not held pursuant to resolution, written or oral notice stating the place, day and hour of the meeting shall be given to each member not less than five (5) days before the time such meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited in the United States mail addressed to the member at his address as it appears on the records of the hospital, with postage prepaid.
- 3 The attendance of the Medical Staff member at the time a specific meeting

is called, shall constitute a waiver of notice to such meeting

SECTION 3 – QUORUM

A General Staff Meeting (Regular or Special)

1 The presence of ten percent (10%) of the voting members of the Medical Staff at any regular or special meeting shall constitute a quorum for the purpose of transaction of any business including amendment to the Bylaws, Rules, and Regulations and the election of staff officers. A simple majority of those voting members who cast votes will be required to make decisions for the medical staff.

2 In the event that a quorum is not present at any regular or special meeting, those members present may meet as a sub-committee of the whole. Any action taken by those present, acting as a sub-committee of the whole, shall be referred for ratification purposes to the next regular or special meeting called for that purpose at which a quorum is present.

B Committee or Department Meeting

One half (1/2) of the voting members of a committee or department, but not less than two (2) members, shall constitute a quorum at any meeting.

SECTION 4 – MANNER OF ACTION

A Except as otherwise specified in these Bylaws, the action of majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group.

B Action may be taken without a meeting of a committee or department by writing setting forth the action so taken and signed and dated by a majority of the members entitled to vote.

SECTION 5 – MEETING MINUTES

Minutes of all meetings shall be prepared by the coordinator of the meeting and shall include a record of attendance and the vote taken on each matter. The minutes shall record a brief discussion of all problems discussed, indicating any recommendation made and forwarded, conclusions reached, and actions taken. The minutes shall be signed by the presiding officer, approved by the attendees, and forwarded to the MEC. A permanent file of the minutes of each meeting (and actions taken without an actual meeting) shall be maintained.

SECTION 6 – ATTENDANCE REQUIREMENT

A Regular Attendance Each member of the active staff shall be required to attend the following

- 1 At least fifty percent (50%) of the Quarterly Medical Staff meetings
- 2 Attendance at departmental meetings is determined by each department
Attendance at departmental meetings is required for a member of the medical staff when one of the member's cases is being reviewed or when the member is assigned to review cases of his peers

B Absence from Meeting

A member who is compelled to be absent from the required number of Quarterly Medical Staff meetings or attendance at required departmental meetings shall provide promptly in writing or verbally to the Medical Staff Services Director the reason for such absence

Failure of an active member to attend the required number of Quarterly Medical Staff meetings or peer review assignments, unless excused as described above for just cause, shall automatically place the member on the provisional active staff for a period of one year

The meeting attendance record of each practitioner shall be maintained and made a part of the performance profile section of his credentials file

C Special Attendance Requirement

1 A practitioner whose patient's clinical course of treatment is scheduled for discussion at a meeting shall be so notified in writing by the Chairman or the Medical Staff Services Director, at least ten (10) days prior to the meeting. The notification shall indicate the time and place of the meeting, a statement of the issue(s) involved, and whenever apparent or suspect deviation from standard clinical practice is involved, and the fact that the Practitioner's appearance is mandatory

2 Failure of a practitioner to attend any meeting with respect to which he was given notice that his attendance was mandatory, shall, unless excused by the MEC upon a showing of good cause, result in an automatic suspension of all or such portion of the practitioner's clinical privileges as the MEC may direct pursuant to Article VII of these Bylaws. Such suspension shall remain in effect until the matter is resolved by subsequent action of the MEC or of the Governing Body, if necessary, pursuant to Article VII. In all other cases if the practitioner shall make a timely request for postponement supported by an adequate excuse that his absence will be unavoidable, such presentation may be postponed by the Chief of Staff, or by the MEC if the Chief of Staff is involved, until not later than

East Cooper
Regional Medical Center

MEDICAL STAFF
RULES AND REGULATIONS

**EAST COOPER REGIONAL MEDICAL CENTER
MEDICAL STAFF RULES AND REGULATIONS**

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I ADMISSION AND DISCHARGE

1 The hospital shall accept patients for care and treatment, except for mentally disturbed patients whose conduct would present a problem regarding their own or other patients' safety, care and comfort and patients for whom appropriate care or treatment is not available at this facility. However, the hospital provides for a multidisciplinary team to evaluate the appropriate psychiatric needs of these patients.

2 Only a member of the medical staff may admit a patient to the hospital with admitting privileges or by a physician who has been granted temporary privileges in accordance to Article VI, section 3 of the Medical Staff Bylaws.

3 Except in an emergency situation, no patient shall be admitted to the hospital without provisional diagnosis or valid reason for admission being stated. In the case of an emergency, this information will be recorded as soon as possible after admission, but in any case, the time to record shall not exceed twenty-four (24) hours.

4 If the patient is considered to be a source of danger to self or others, the admitting practitioner is responsible for providing such information as may be necessary to protect the patient from self-harm and to protect other patients, staff, or visitors.

5 The following patient admission category priorities shall be observed:

A) Emergency admission Following an emergency admission to his service, the attending physician shall be required to complete an admission note to document the need for the admission.

B) Potentially Suicidal/Mentally Disturbed For the protection of the patients, the Medical and nursing staff and the Hospital, certain principles are to be met in the care of the potentially suicidal, alcoholic, mentally disturbed and/or drug overdose patients:

1) Attempted Suicide Patient If any attempted suicide patient must be admitted to the hospital, there must be an around-the-clock companion until such time as the patient is considered non-suicidal by the attending physician or psychiatric consultant and such judgement is appropriately documented in the patient's medical record. Any expense incurred shall be the responsibility of the patient.

2) Suspected Suicide In the event that a patient admitted to the general floors of the hospital is then or later suspected of being suicidal, he/she should be transferred, when medically stable, to an appropriate facility. Prior to transfer, special nursing or companionship must be provided. The companion is to spend the entire time, including all meal times with the patient while the patient is in the Hospital. Any expense incurred shall be the responsibility of the patient.

3) Mentally Disturbed Patients Known mentally disturbed patients needing a closed service should not be admitted to the Hospital routinely. If they are, the attending physician should be contacted immediately and arrangements made for consultation and transfer to a psychiatric facility within a reasonable period of time.

C) Pre-operative admission This includes all patients already scheduled for surgery. If it is not possible to handle all such admissions, the Director of Surgical Services, in consultation with the surgeon (s) and physician (s) of the concerned patients, may decide the urgency of any specific admission. Any disagreement will be referred to the Chairman of the Surgery Department and/or the Hospital President for resolution.

D) Routine admission This includes elective admissions involving all patients. All patients admitted to the hospital shall be seen by the attending physician or his designee within twelve (12) hours of admission. All critically ill patients are to be seen within four (4) hours of admission. All patients in ICU/CCU are considered critically ill.

6 When a bed shortage for elective or routine cases exists, priority shall be given to members of the active medical staff, subject of course to the needs of the patient in each case.

7 A physician member of the medical staff shall be responsible for the medical care and treatment of each patient in the hospital. All patients shall have a complete history and physical performed and recorded in the medical record by a physician who is either a member of the medical staff or who has been approved by the medical staff to do so. When an H&P is recorded in the medical record by a resident, intern, medical student, Advance Practice Nurse, and house physician who has been hired for such duty, or by an authorized Physician's Assistant, the physician responsible for the patient's care will countersign the H&P as soon as possible but not later than 24 hours after admission and before any elective procedure requiring other than local anesthesia. Dentists, Podiatrists and Clinical Psychologists shall be responsible for recording in the medical record a history and physical examination relative to the dental, podiatric or psychological problem. Any medical problem present on admission or arising during the hospitalization of a dental, podiatric, or psychological patient shall become the responsibility of an active Medical Staff member.

8 Each member of the medical staff shall provide continuous care for his hospitalized patients and shall specify a member of the East Cooper Regional Medical Center's Medical Staff with appropriate privileges who will be available to attend his patients in his absence. Failure of a Medical Staff member to meet this requirement shall be reported to the Medical Executive Committee for action deemed appropriate.

9 Except as otherwise provided in hospital policies, no patient will be transferred within the hospital without the approval of the responsible Practitioner, with the exception of a harmful or infectious patient who needs immediate relocation to protect him or others. In the latter case, the responsible Practitioner shall be notified as soon as he can be reached.

10 When a patient is being transferred to another Hospital, a nursing home, or other health care facility, the responsible Practitioner or other individual authorized by Hospital policy shall indicate the reason for the transfer, the name of the receiving facility, the name of the accepting Practitioner, the status of the patient and shall sign the inter-facility transfer documents

11 A patient shall be discharged only on the written order of the responsible Practitioner. The patient may be released after signing the proper forms. However, a patient shall not be detained against his consent. If a patient leaves the hospital against medical advice (AMA), the patient or legally responsible other shall be requested to sign an AMA release statement. Whether or not such a statement is obtained shall be noted in the patient's medical record along with any reason given. Hospital staff witnessing the event shall also be noted. An AMA release form must indicate by the patient's or responsible other's signature that the patient is voluntarily leaving the hospital against the advice of the Practitioner and that in so doing the patient absolves the Practitioner and the Hospital from any and all direct and indirect consequences. A patient leaving the Hospital on his own accord without signing the appropriate documents shall be considered to be discharged.

12 When a patient leaves the Hospital on a "pass", the attending Practitioner must write an order on the Physicians' Order Sheet and specify a given length of time that the patient is to be absent from the Hospital premises, and the reason why the "pass" is being authorized. The patient, or at least one (1) parent, if the patient is a minor, must sign a "Temporary Absence Release" form before leaving the Hospital. The spouse cannot sign the release form for the patient. One (1) copy of the form should be completed and placed in and made a part of the patient's permanent medical record. While the patient is on "pass", the bed will be held and the patient will be charged for the bed. No overnight passes are permitted. If the patient has not returned to the hospital by 12 00 midnight, he will be automatically discharged by the Business Office as an AMA.

13 Admitting Practitioners shall

- a) refer elective cases to the Admitting Office for advance arrangements
- b) complete reports required to secure payment of insurance or compensation claims by the Hospital
- c) record information required for hospital billing
- d) adhere to Hospital admitting policies and procedures

14 Informed Consent forms for any procedure or treatment shall be prepared. All consent forms must be approved and adopted by the MR/UR Committee and the Medical Staff with the aid of legal council. Nursing shall notify the attending Practitioner whenever such consent has not been obtained.

II MEDICAL RECORDS

1 The attending practitioner is responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current. The record shall include identification data, chief complaint, relevant present and past personal history, and family history, history of present illness, psycho-social history and/or needs, a system review.

and physical examination, physical limitations, and special reports such as consultations, clinical laboratory and radiology reports, operative and procedure reports, pathological findings, progress notes, provisional diagnosis on statement of problem, final diagnosis, condition on discharge, discharge summary, final diagnosis, and when performed, an autopsy report. As appropriate, an anesthesia record and any patient/family instructions/education will be documented in the medical record.

2 A comprehensive history and physical examination, performed or reviewed and attested to by a physician member of the Medical Staff, must be recorded in the medical record of all patients within twenty-four (24) hours of admission. Patients who are expected to stay less than twenty-four (24) hours must have at least a short stay history and physical performed. All surgical patients shall have an H & P on the chart prior to the procedure, unless an emergency situation exists. Elective inpatient or outpatient surgery will be canceled or delayed until a history and physical examination is recorded in the medical record.

3 If a history and physical examination has been performed in the physician's office within seven (7) days prior to admission, a durable, legible copy of this report may be used in the patient's hospital medical record, provided (a) there have been no subsequent changes and this is indicated, or (b) any changes that have occurred since performance of the history and physical examination are recorded at the time of admission. When patient is readmitted within 30 days for the same or a related problem, an interval history and physical examination reflecting any subsequent changes may be used in the medical record, provided the original information is readily available.

4 Pertinent progress notes shall be recorded at the time of observation to provide for continuity of care and transferability. They should provide a chronological report of the patient's course in the hospital and should reflect any change in condition and the results of treatment. The patient's clinical problems should be clearly identified and correlated with specific orders as well as any test, procedure, and/or treatment results. Progress notes shall be written at least daily.

5 Operative consents must be signed within thirty (3) days of the operative procedure. It is the responsibility of the surgeon to obtain this operative consent.

6 Operative reports must be written or dictated immediately following a procedure. Failure to have a completed dictated operative report on the patient's chart within 48 hours of completion of the procedure will cause the Practitioner to lose his privilege of posting further operative cases until such time as the operative notes are completed. The operative reports must include a description of the findings, technical procedures and, any specimens removed, the pre-op and post-op diagnoses, type of anesthesia used, estimated blood loss, and the names of the primary and assistant surgeons, and shall be filed in the medical record as soon as possible after surgery. All procedures shall have a brief hand written post-op note. The patient shall be discharged only on the written order of the physician comprehensive enough to permit continuity of care, entered in the medical record immediately after surgery.

7 A pre-anesthesia evaluation of the patient by a physician must be documented in the medical record for all elective surgery cases prior to the patient's transfer to the operating area and before preoperative medication has been administered. This evaluation shall include reference to the choice of anesthesia (general, conscious sedation, spinal, regional, or standby), the patient's allergies and any previous medication, smoking, alcohol use history, other

anesthesia experiences, any potential anesthetic problems and the anticipated time for post anesthesia recovery. The patient's physical status should be categorized using the classification of the American Society of Anesthesiologists.

8 The anesthetist shall record in the medical record evidence of pre-anesthesia check of the anesthesia machine, monitoring equipment, and all anesthesia drugs and agents to be used as well as all pertinent events occurring during the induction of, maintenance of, and emergence from anesthesia. Drugs used, dosage and duration of all anesthetic agents, intravenous fluids, and blood and blood components shall also be documented by the anesthetist in the medical record.

9 There should be evidence in the medical record that patient discharge from the post-anesthesia recovery unit is based on a physician's evaluation and decision.

10 At least one post-anesthesia visit must be made after an inpatient has left the recovery area (Recovery Room, special care unit, designated room in nursing unit), at which time a dated and timed note is to be made in the medical record describing the presence or absence of anesthesia-related complications. When the post-anesthesia visit and record entry by anesthesia personnel is not feasible because of early patient release from the hospital (as may occur in same-day surgery), the practitioner who discharges the patient from the hospital is responsible for the post-anesthesia note.

11 Medical record information from a post-anesthesia recovery area (regardless of type or location) shall include the patient's level of consciousness on entering and leaving the area, vital signs, medications administered, and when such are in use, the status of infusions, surgical dressings, tubes, catheters, and drains.

12 A discharge summary shall be written or dictated on all medical records of patients hospitalized more than 48 hours, with the exception of normal newborn infants, and cases of a "minor" nature (e.g., admission for diagnostic study) or otherwise as may be specified by the Medical Executive Committee. For these excepted categories, a final progress note, including any pertinent instructions to the patient/family, shall suffice. In the event of patient death, a summation statement shall be added to the record either as a final progress note or as a narrative summary, indicating the reason for admission, the findings and course in the hospital, and events leading to death. The content of the medical record shall be sufficient to justify the diagnosis and to warrant the treatment.

13 The discharge summary shall concisely recapitulate the reason for hospitalization, the significant findings, the procedures performed and treatment rendered, the condition of the patient on discharge, and any specific pertinent instructions given to the patient/family or significant other. The condition of the patient on discharge shall be stated in terms that permit a specific measurable comparison with the condition on admission, avoiding the use of vague terminology such as "improved," "satisfactory," "good," etc.

14 In the event of a patient death occurring within the Hospital, the deceased shall be pronounced dead by the attending physician or his designee within a reasonable length of time. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a physician member of the Medical Staff. Exceptions shall be made in those instances of incontrovertible and irreversible terminal disease wherein the patient's course has been adequately documented within a few hours of death. Policies with respect to the release of

dead bodies shall conform to local law. When an autopsy is performed, provisional anatomic diagnoses shall be recorded in the medical record within seventy-two (72) hours, and the complete report shall be made part of the record as soon as possible, but not later than 60 days unless otherwise required by state law. Informed consent from the next of kin or legally authorized agent shall be obtained prior to autopsy. When an autopsy is performed the attending physician will be notified by the Pathologist of the results.

Staff members shall attempt to secure autopsies in deaths that meet the following criteria:

- a) deaths in which autopsy may help to explain unknown or unanticipated medical complications,
- b) all deaths in which the cause of death is not known with certainty on clinical grounds,
- c) deaths in which autopsy may help to allay concerns of the family/public regarding the death, to provide reassurance to them regarding the same,
- d) unexpected or unexplained deaths occurring during or following any dental, medical or surgical diagnostic procedures and/or therapies,
- e) deaths of patients who participate in clinical trials approved by the IRB/Ethics Committee,
- f) deaths at any age in which it is believed that autopsy would disclose a known or suspected illness which may have a bearing on survivors or recipients of transplanted organs,
- g) deaths known or suspected to have resulted from environmental or occupational hazards,
- h) all obstetrical deaths,
- i) all perinatal and pediatrics deaths, and
- j) deaths in which a patient sustained or apparently sustained injury while in the hospital.

15 The patient's medical record shall be completed at the time of discharge and signed in a timely manner, except when the diagnosis is dependent on delayed laboratory, autopsy, etc reports. A Practitioner shall have thirty (30) days in which to complete his portion of the medical record. Failure to complete the records by this time shall result in a suspension of the physician's admitting privileges until the portion of the medical record is completed. If the Practitioner fails to complete his portion of the medical record after three (3) consecutive counts (90) days his name will be forwarded to the Medical Executive Committee. Prior to the third suspension notice, a member of the Medical Executive Committee will contact the Practitioner and notify him of the need to complete his portion of the medical record. If the practitioner fails to complete his medical records and is placed on suspension three consecutive

times, his name will be forwarded to the Medical Executive Committee for action. Practitioners whose clinical privileges have been suspended for failure to complete medical records four times in a calendar year will be fined \$250.00 by the Chief of Staff. Notification will be made by certified letter. Payment of the fine in addition to completion of charts must be accomplished within 10 days of receipt of notification. Each additional suspension within the calendar year will carry a fine of an additional \$250.00. Payment and completion of charts will be accomplished within 10 days of subsequent notifications. Failure to comply will result in the Practitioner's loss of clinical privileges at East Cooper Regional Medical Center. Medical record completion shall otherwise be accomplished in a time period consistent with medical staff, hospital, and regulatory requirements, and not more than thirty (30) days.

16 Final diagnoses and complications shall be recorded in the medical record without use of symbols or abbreviations.

17 All medical record entries shall be dated and authenticated.

18 Rubber-stamp or computer key physician signatures are acceptable to authenticate entries in the patient medical record as long as required procedures are followed.

A When a physician on the Medical Staff requests a rubber-stamp or computer key for authenticating entries, the physician must

- 1) obtain a copy of the signature statement form,
- 2) sign and stamp the statement indicating that he/she shall be the sole user of the rubber-stamp or computer key, and
- 3) file the original signature statement in the medical records department.

B The Physician shall be the only individual to use the respective rubber-stamp or computer key.

C Appropriate use of rubber-stamps and medical records staff during quarterly medical record review shall continuously verify computer keys.

19 The medical record is the property of the hospital and shall be removed from the hospital's jurisdiction and safekeeping only in accordance with court order, subpoena, statute, or other state or federal law. Attending practitioners and the Hospital CEO shall be notified by the Medical Record's Department when his patient's medical record is requested by the patient, patient's family, patient's estate or legal counsel for the above. Unauthorized removal of medical records from the hospital by any practitioner is grounds for suspension of the practitioner for a period to be determined by the Medical Executive Committee or as otherwise provided in the bylaws. A representative of the medical records department of the hospital should be consulted when there is a request for such records. Members of the Medical Staff shall abide by all laws governing the release of certain types of medical records.

20 In case of readmission of a patient, all previous records shall be available for use by the attending practitioner whether the patient is attended by the same practitioner or by another.

21 Subject to applicable laws, access to all medical records of all patients shall be afforded to members of the medical staff for bona fide study and research, consistent with preserving the confidentiality of personal information concerning the individual patients. The Medical Executive Committee shall approve all such projects before records can be studied. Subject to the discretion of the administrator, former members of the medical staff shall be permitted access to information from medical records of their patients covering those periods during which they attended such patients in the hospital.

22 Medical records shall not be permanently filed until completed by the responsible practitioner(s) or as ordered filed by the Medical Executive Committee. An incomplete record will not ordinarily be filed if the responsible practitioner is still a member of the medical staff or holds clinical privileges in the hospital. No medical staff member shall be permitted or requested, for any reason, to complete a medical record on a patient unfamiliar to him, regardless of the status of the practitioner who is responsible for completing the record. Any practitioner who is removed from the medical staff per the bylaws for delinquent records or who resigns from the medical staff without adequately completing all medical records will not be allowed to return or reapply for staff membership until such records are satisfactorily completed.

23 If an error is made on an entry in the medical record, a single line shall be drawn through it, the word "error" written and the correct entry written in along with the date and authentication of the Practitioner. The error is not to be obliterated or erased.

24 Practitioners shall abide by medical record requirements that, because of their relevancy to the subject matter in those sections, have been delineated in other sections of these rules and regulations, the Medical Staff Bylaws or applicable Medical Staff or Hospital policies.

25 Any Practitioner who authenticates another Practitioner's order or who cosigns a history, physical examination, or other medical record entry for another Practitioner or another individual authorized to make such entry has the legal responsibility for the order or the information bearing his authentication.

III ORDERS

1 All patient orders shall be in writing.

2 A verbal order shall be considered to be in writing if dictated to a duly authorized individual and authenticated by the responsible Practitioner as soon as possible. The authorized individual shall write the order, followed by the name of the Practitioner, date and time, and signature of the writer. Verbal orders may be accepted only by RNs or LPNs, registered pharmacists and for limited use in their specialties, by licensed/registered/certified (as appropriate) laboratory technologists, licensed AART personnel, respiratory therapists, cardiopulmonary technologists, dietitians, physical therapists, physical therapy assistants, occupational therapists, certified occupational therapy assistants, speech and language pathologists, when functioning within their sphere of competence.

3 All routine and standing orders shall be signed and dated by the responsible Practitioner, or the designated physician covering the ordering physician's service as soon as possible after the order is given.

4 Practitioner orders must be written clearly, legibly, and completely. Orders that are illegible or improperly written shall not be carried out until rewritten properly or understood by nurse, technologist, therapist, dietitian, etc., as appropriate. Orders must be specific.

5 All orders shall be canceled at the time the patient undergoes surgery unless otherwise directed by the responsible surgeon. Orders shall be rewritten for patients transferred to a lesser or higher level of care, e.g., from a special care unit to a medical-surgical nursing unit or vice versa, or from outpatient to inpatient status.

6 Certain classes of pharmaceuticals have automatic stop orders consistent with the practice of good medicine. See Pharmacy and Therapeutics policies for specific drug stop orders.

IV DRUGS AND MEDICATIONS

1 All drugs and medications administered to patients shall have been approved by the Food and Drug Administration. The only exceptions are those drugs administered under an approved protocol for investigational or experimental drug use that has been approved by the Institutional Review Board/Medical Ethics Committee (IRB/MEC). When certain organic or inorganic substances (such as vitamins, metals, minerals, nutrients, etc.) are used in an unconventional manner, and specifically not defined as a drug or medication, administration of these substances will also be in accordance with an established protocol that has been approved by the medical staff through its designated mechanism.

2 Investigational or experimental drugs shall be used only under the direct supervision of the principal investigator who shall be a physician member of the Medical Staff and who is responsible for securing the necessary consents and for compliance with the requirements of the IRB/Ethics Committee.

3 The protocol for use of an investigational or experimental drug shall be submitted to the Institutional Review Board/Medical Ethics Committee for approval and forwarded to the Medical Executive Committee.

4 When nurses are required to administer an investigational drug, they shall be provided access to basic information concerning the drug, including dosage, strengths available, actions and uses, side effects, symptoms/signs of toxicity, and personal safety, if applicable and known.

5 The pharmacy shall store investigational drugs used in the Hospital unless otherwise specifically notified and shall be responsible for labeling and dispensing in accordance with the physician investigator's written orders.

6 Medications brought from home may be utilized and provided to the patient upon written orders of the physician to include name of drug, dosage, route and schedule for administration. Only those medications authorized in writing by the attending physician to be self-administered may be kept at the patient's bedside. No controlled drugs may be left at the patient's bedside.

7 Under no circumstance will the hospital pharmacy relabel medications obtained from other sources. However, the container may be marked to indicate identification by the pharmacy.

8 For each medication, the administration times or the interval between doses must be clearly stated in the order.

9 The use of "pm" and "on call" in a medication order must be qualified.

10 The Medical Staff department shall initially validate all standing and routine orders (particularly those involving medications) and then the MR/UR Committee and if involve medications, by the Pharmacy & Therapeutics Committee (P&T). Protocols involving more than one department will be reviewed by the MEC.

11 When a medication ordered is not in the pharmacy, the pharmacist shall have the authority to substitute the same drug that has a different brand name or a generic drug in the same dosage, unless specifically otherwise ordered.

12 Drug samples shall not be distributed.

13 When, in the opinion of the nursing staff or the pharmacist, a drug dosage ordered represents a potential hazard (e.g., excessive dose, incompatibility problem, contraindicated for patient's condition) to the patient, and the prescribing Practitioner disagrees, the Chairman of the department/service to which the Practitioner is assigned or the Chief of Staff shall be consulted. If the reviewing physician also agrees that the administration of the drug as ordered is potentially hazardous, the attending Practitioner may be required to administer the drug personally and submit a written prescription to the pharmacy separate from that of the order sheet.

14 When medications are prescribed for a patient at time of discharge, the patient will be informed of potential significant adverse food-drug interactions.

15 The automatic stop order policy for certain categories of drugs is determined by the Pharmacy and Therapeutics Committee of the hospital.

Every Practitioner is expected to review all medications for all patients at daily intervals to insure discontinuation on all orders that are no longer needed. It will be the responsibility of the pharmacy to notify the Practitioner when the next to the last dose of a drug that will be automatically stopped is given. An automatic stop order does not apply when the number of doses or exact period of time is specified by the practitioner.

V CONSULTATIONS

1 The attending Practitioner is responsible for requesting consultation when indicated. The attending Practitioner will write an order in the patient's medical record to consult another Practitioner to attend or examine the patient except when a bona fide emergency precludes this from being done. The attending Practitioner should indicate in writing in the medical record if the consultant is requested to write orders and/or assume care of the patient. The attending Practitioner should also verbally communicate with the consultant if the consultation is that of an emergent or very urgent nature. If the consultation is not emergent or urgent, the

consultation should be completed within 24 hours from the time the consultant is notified or at a later time only if that time is agreed upon by the attending practitioner and the consultant. If the consultant is unable or unwilling to render the consultation, he must communicate that directly to the attending practitioner as soon as possible so that alternate plans can be made.

2 Any qualified Practitioner with clinical privileges in the Hospital may be called by the Practitioner responsible for the patient to provide consultation within the consultant's area of expertise.

3 If the requested consultant has an ongoing relationship with the patient or if he has seen the patient within the past 6 months for a medical reason related to the present consult, the consultant is obligated to render the consultation unless released from that obligation by the attending practitioner.

4 Any consultant refusing to comply with the guidelines may be subject to disciplinary action by the Medical Executive Committee.

5 When the required consultative expertise is not available through the existing Medical Staff membership and the patient cannot be transported elsewhere safely, consultation may be obtained by granting temporary privileges to a qualified Practitioner who is not currently a staff member as provided in the Medical Staff Bylaws.

6 It is the duty of the Medical Staff, through its department chairman and the Medical Executive Committee, to enforce the Bylaws, Rules and Regulations so that Practitioners obtain consultation as needed. Consultation should ordinarily be sought under the following circumstances:

- a) when the patient is a poor risk for surgery or other treatment,
- b) when the patient's response to therapy is not as anticipated,
- c) when there is doubt as to the appropriateness of the therapeutic measures used or proposed or when such measures have failed to help the patient,
- d) in unusually complicated cases, requiring the expertise of other Practitioners,
- e) when the diagnosis remains obscure after the usual diagnostic measures and patient examination has been completed,
- f) when requested by the patient or family,
- h) for use of radiation therapy for conditions (other than pathologically verified malignancy) involving gonads or the thyroid area, or
- i) when there is a question of criminal action.

7 Consultation reports shall show evidence that the consultant has examined both the patient and the medical record, and shall include the consultant's findings and recommendations. A limited statement such as "I concur" generally would not constitute an adequate consultation report. Except in emergency situations, so verified in the medical record, a consultation relative to an operative or potentially hazardous procedure shall be recorded prior to the surgical or other procedure being performed.

8 Forms for requesting radiology and pathology services shall be filled out adequately, indicating the reason for the request and relevant clinical information.

9 When a nurse has any reason to doubt or question the care provided to a patient, or believes that consultation is needed and has not been obtained or requested, he/she may call this to the attention of his supervisor who may call this to the attention of the chief of staff or the chairman of the department to which the Practitioner is assigned. When circumstances justify action, the department/service chairman or the chief of staff may request a consultation.

VI GENERAL REQUIREMENTS

1 Written consent of the patient is required for release of medical information to individuals not otherwise authorized to receive this information.

2 In addition to a general consent obtained by the hospital at the time of the patient's admission, specific consent must be obtained, as required by law, prior to diagnostic or therapeutic interventions. The attending and/or treating Practitioner is responsible for documenting in the medical record the information provided to the patient relative to the intervention anticipated. Exceptions to obtaining the patient's timely consent are limited to emergency and other situations defined in the Hospital's informed consent policy.

3 Qualified members of the Medical Staff present in the Hospital shall respond to an emergency code, such as one requiring cardiopulmonary resuscitation, so that a qualified Physician is on site to participate and give any needed direction or assistance.

4 All practitioners shall participate in patient discharge planning in accordance with the utilization review plan or other written requirements. The attending Practitioner is required to document the need for continued hospitalization after specific periods of stay as identified by the Hospital Medical Record/Utilization Review Committee and approved by the particular clinical department, and the Medical Executive Committee. The statement shall contain an adequate written record of the reason for continued hospitalization and the estimated period of time the patient will need to remain in the Hospital. A simple reconfirmation of the patient's diagnosis is not sufficient. Appropriate post-hospital plans are to be made. Upon the appropriate request, each member of the Medical Staff is required to report to the Medical Record/Utilization Review Committee the necessity for continued hospitalization for any patient hospitalized over the specific number of days of stay and the reasons therefore. This report must be submitted within twenty-four (24) hours of receipt of notice. Failure of compliance with this policy will be brought to the attention of the Medical Executive Committee for review.

5 All Practitioners shall comply with requirements of the hospital's Incident/ Occurrence Trending Program.

6 When medical record entries are authorized to be made by Specified Professional Personnel, the supervising Practitioner shall countersign the entries.

7 All Practitioners shall be informed of their role during a disaster and are responsible for knowing their assignment (station) in the event of a disaster and shall report accordingly. Practitioners shall be informed of the rules regarding patient discharge and other controls to be invoked during a disaster situation and shall participate in disaster drills as required.

8 Continuing education shall be relevant to the patient care services provided and shall be based, to the degree possible, on the findings of Medical Staff quality/performance.

improvement related activities Documentation shall be maintained in the Medical Staff Office

9 Patients may be restrained for the protection of self or others in compliance with applicable laws and hospital policy

10 The ordering of any baseline admission testing (e g , laboratory, X-ray, electrocardiogram, etc) shall be the responsibility of the attending Practitioner on an individual patient basis For surgical cases, this shall be done, as indicated, in conjunction with the anesthesia department/service

11 Clinical laboratory tests shall be done by the Hospital or by an outside (reference) laboratory recommended by the Director of Pathology and Medical Laboratory Services and approved by the medical staff Practitioners who have such tests/examinations performed by laboratory sources other than these may enter the results in the history or progress note section of the medical record, but the report itself shall not be considered the official Hospital medical record report The medical staff shall take reasonable steps to assure itself that any outside laboratory sources, from which test reports are used as the official hospital medical record report, have an acceptable internal quality control and external proficiency testing system in place, are monitored by qualified individuals, and are in compliance with applicable state and federal requirements

12 The Radiology department/service shall provide authenticated reports for all radiological examinations performed in the Hospital and, when requested, for review of examinations performed outside the Hospital In either case, this will provide the official report for the medical record Otherwise, the attending Practitioner may record his own interpretation in the history or progress note section of the medical record When special cardiovascular radiological procedures can be properly interpreted only with the findings and observations of the authorized Practitioner (e g , cardiologist) performing the procedure, this individual shall be responsible, based on approved privileges to do so, for rendering the official report for the medical record

13 Practitioners requesting diagnostic examinations by the pathologist or radiologist should provide in the written request all relevant information available so as to assist in the determination of an accurate diagnosis/impression and proper use of resources

14 Printed instruction sheets or patient care brochures (from clinical departments/specialties, patient care units, or individual Practitioners) provided to patients and/or the Medical Staff shall approve families either in the hospital or at the time of discharge for clinical relevance and patient safety through its designated mechanism Generally such sheets or brochures should not be used by the Practitioner as the sole source of information for purposes of obtaining informed consent

15 Blood that has been cross-matched shall be held for 48 hours at which time it shall be canceled unless reordered Prior to release, the ordering Practitioner shall be notified For cases in which cross-matched blood is frequently ordered but not used, the use of type and screen system should be used instead of cross matching

16 Oxygen and respiratory therapy shall be administered in accordance with the responsible Practitioner's orders or in accordance with established policy approved by the

Medical Staff through its designated mechanism In cases where the duration of treatment is not specified or is stated indefinitely, the treatment shall be discontinued after twenty-four (24) hours unless new orders are written, however, prior to discontinuing the treatment the nurse or therapist shall notify the responsible practitioner and confirm that the treatment should be discontinued

17 The Environment of Care Committee, through its Chairman or Physician members, has the authority to institute any appropriate control measures or studies when it is reasonably believed that a danger to patients, visitors, or personnel exists This includes placing a patient under isolation precautions even though the attending Practitioner may not believe such is necessary

18 All inpatients shall be visited by their attending Practitioner or designee with appropriate privileges at least once daily If an absence of more than a day is contemplated, the attending Practitioner shall arrange for another qualified member of the Medical Staff to attend the patient, and the nursing staff shall be notified of the name of the Practitioner who will be responsible in the interim

VII EMERGENCY SERVICES

1 The Medical Staff shall adopt a method of providing medical coverage in the emergency room area This shall be in accordance with the Hospital's basic plan for delivering such services, including the delineation of clinical privileges for all physicians who render emergency care The duties and responsibilities of all personnel serving patients within the emergency area shall be defined in a procedure manual relating specifically to this facility The Director of Emergency Services shall develop the contents of such a manual, with representation from the emergency service physician, nursing services and the Hospital Administration The manual shall be approved by the Medical Staff

2 An appropriate medical record shall be kept for every patient receiving emergency services In addition to the clinical information related to evaluation, treatment, and disposition of the patient, the emergency medical record shall include the time of the patient's arrival, the means of arrival and by whom transported, any available details of the emergency care rendered to the patient prior to arrival at the Hospital, if known, when and for what the patient visited the emergency room previously, acknowledgment of any ordered test results, the condition on discharge, any instructions given to the patient on discharge, and the patient disposition

3 The Practitioner shall sign each emergency medical record in attendance that is responsible for its accuracy

4 There shall be a review of emergency room medical records utilizing established indicators Reports shall be submitted to the Department of Medicine Committee These medical records shall be reviewed for appropriate documentation and care In addition, the records of all patients dying within twenty-four (24) hours of admission to the emergency room shall be reviewed

5 The determination of the Emergency Department call schedule is based upon the physician level of involvement with the Hospital Physicians achieving and maintaining Active or Provisional Active, Associate or Courtesy status, as specified in the Medical Staff Bylaws,

will be eligible for membership on the Emergency Room call schedule. Courtesy physicians who desire to be on the ER call schedule will request this in writing and be placed on the schedule for a minimum of six months. Requests for removal from the call list from any physician whose circumstance no longer require him to serve on the call schedule, including those changing staff categories, will require a sixty (60) day written notification to the Medical Staff Office. A leave of absence granted for any reason will result in the practitioner's removal from the ER call schedule on the first day of the month following his/her request. If possible, the practitioner should attempt to arrange coverage for the remainder of his call obligation. Call schedules are based on the need of the Hospital to be determined by the Emergency Room Director. Physicians who can demonstrate a thirty-minute (30) response time to the Hospital may serve on the Emergency Room call schedule.

6 A call schedule will be published monthly and distributed to appropriate parties. Physicians on call for the Emergency Department are required to accept patients if asked to do so by Emergency Room personnel. If a change is made in the call schedule, it is the Practitioner's obligation to notify the Medical Staff Office regarding which physician will be providing call coverage. In a non-emergent situation, the Emergency Room Practitioner will wait up to thirty minutes (30) for a telephone response from the Practitioner on call. If the situation is urgent, the Emergency Department Practitioner may proceed down the call list until a Practitioner is located who can respond sooner.

VIII SURGICAL CARE

1 Any questions regarding specific rules and regulations of surgical care, i.e., scheduling, priority time, reservations, and schedule changes, should be referred to the Director of Surgical Services, the Chief Nursing Officer, or the Chairman of Surgery, after checking the OR policy manual.

2 Surgeons must be in the OR and be ready to begin surgery thirty (30) minutes prior to the scheduled operative time. Only for justifiable reasons will the OR be held longer than fifteen (15) minutes after the time scheduled.

3 The primary surgeon is responsible to make the decision to have a first assistant when it would be advantageous for the procedure. A first assistant is defined as a qualified, first assistant with specific hospital privileges granted.

4 An anesthesiologist must see and evaluate all scheduled in-hospital patients the night prior to the scheduled procedure.

5 An anesthesiologist must see and evaluate all other scheduled patients thirty (30) minutes prior to the scheduled time of the procedure.

IX SPECIAL CARE UNITS

1 Admission and discharge criteria must be approved by the Medical Staff and shall be adhered to by all Practitioners using the unit. Any exception must be approved by the Medical Director of the unit.

2 All previous and standing orders must be rewritten by the responsible physician when patients go to or from the unit.

3 Consultation shall be obtained on patients who fall into any of the following categories

- a when a patient is not a good risk for an operation or treatment,
- b when the diagnosis remains obscure after ordinary diagnostic procedures have been completed,
- c when there is doubt as to the choice of therapeutic measures to be taken,
- d when specific skills are needed due to a complicated situation,
- e in the case of an actively suicidal patient,
- f when requested by the patient or family, and/or
- g when a procedure or treatment is beyond the clinical privileges of a physician or he has no documented competency

4 The family of patients transferred into the ICU/CCU unit from another area of the Hospital shall be notified of the transfer by the attending Physician or by the nursing staff

5 When space and staffing permit, elective cardio-versions may be performed in the ICU/CCU unit

6 The unit Physician Medical Director and Surgical Director, or Physician designated to provide medical direction to the unit, has the authority to make a final decision on admissions and discharges when the unit is full and the admission of one or more patients is clinically necessary

7 There shall be a Medical Director and Surgical Director of the Intensive Care and/or Coronary Care Unit who shall be appointed by the Chief of Staff with the approval of the Medical Executive Committee

8 The duties and responsibilities of all personnel serving the patients within this unit shall be defined in a procedure manual relating specifically to their unit. The manual shall be approved by the Medical and Surgical Directors

9 The ICU/CCU Medical Director has advisory responsibility for the administration of this unit. The Medical Director assumes general supervision of medical care within the unit, with authority to request consultation if deemed necessary in the best interest of the patient

10 Patients who shall be considered exclusions for admission to the unit shall be those who are considered terminal, moribund or custodial patients for whom intensive care cannot be reasonably expected to alter outcome

11 Patients must be seen by the attending physician within a reasonable time that is commensurate with the patient's condition, but in no case is this to exceed six (6) hours. If the patient requires immediate care, and the attending physician is not available to see the patient, then the Medical Director of the unit shall be notified

X DISASTER PLAN

There is a plan for the care of casualties at the time of disaster, based on the Hospital's capabilities in conjunction with nearby emergency facilities See Disaster Plan in Hospital Safety manual

XI CLINICAL DEPARTMENTS

1 Each clinical department shall establish its rules and regulations, policies and procedures, as needed, subject to the approval of the Medical Executive Committee and the Board of Directors The clinical departments are

- a) Department of Surgery
- b) Department of Medicine
- c) Department of Family Medicine
- d) Department of OB/GYN/Pediatrics

XII IRB/ETHICS COMMITTEE

1 Responsibilities, Duties and Authority

a) The Institutional Review Board shall adopt and follow written procedures or carrying out the duties imposed by state and federal law (e g , the U S Department of Health and Human Services, the Food and Drug Administration, and state law) The Committee may participate in the development of guidelines for consideration of cases having bioethical implications, development of procedures for review of these cases, and institutional policies regarding this care The IRB/ Medical Ethics Committee may review cases for evaluation of the use of bioethical policies, to determine the need for consultation of concerned parties to facilitate communications and/or to aid in conflict resolution It may provide educational opportunities for the hospital staff and patients/families on bioethical matters Though the committee may discuss various types of cases, the committee's purpose is not to render findings, conclusions or opinions with regard to the care of specific patients The IRB/Medical Ethics Committee is responsible for the initial and ongoing review and approval of research involving human subjects either in a hospital or conducted by an individual affiliated with the hospital if the hospital agrees to assume responsibility for the study It shall make recommendations to the MEC for the approval, modification or disapproval of the proposed research activity The IRB/ Medical Ethics Committee shall conduct continuing reviews of research covered by applicable laws at intervals appropriate to the degree of risk, but not less than once per year, and shall have the authority to observe, or have a third party observe, the informed consent process and the research

b) The IRB/ Medical Ethics Committee shall notify the investigator in writing of its decision to approve or disapprove proposed research activity, or of modifications required to secure IRB/ Medical Ethics Committee approval of the research activity If the IRB/ Medical Ethics Committee decides to disapproval a research activity, it shall include in its written notification a statement of the reasons for its decision and give the investigator an opportunity to respond in person or in writing

c) The IRB/ Medical Ethics Committee shall have the authority to suspend or terminate research that is not being conducted in accordance with applicable laws or the IRB/ Medical Ethics Committee's written procedures or that has been associated with unexpected serious harm to subjects, or that is deemed inadvisable by the IRB/ Medical Ethics Committee for any other reason. Any such suspension or termination shall include a statement of the reasons for the IRB/ Medical Ethics Committee's action and shall be reported promptly to the principal investigator, the Chief of Staff, the Administrator and appropriate regulatory authorities. The IRB/ Medical Ethics Committee shall ensure that all reports required by applicable state and federal laws are promptly filed.

d) Research, which is approved by the IRB/ Medical Ethics Committee, may be subject to further review and approval or disapproval by hospital administration.

XIII CUSTODY OF MEDICAL STAFF FILES AND COMMITTEE MINUTES

1 All written minutes and correspondence relating to activities of an organized Medical Staff committee which are directed towards evaluating the quality of medical care rendered are considered immune from discovery and not admissible into a court of law.

2 Custody of the Medical Staff files is the responsibility of the Hospital President, Chief of Staff and the Director of Medical Staff Services. Only those persons specially authorized by those named shall have access to the Medical Staff files.

3 All credential files, as well as committee files, are considered to be confidential.

4 Access to committee or Practitioner's credential files by individual Medical Staff members not functioning in their capacity as an officer of the Medical Staff or Department Chairman, must be specifically authorized by the Hospital President or the Chief of Staff.

5 Minutes of a Medical Staff committee may be reviewed by the current members of that committee. However, copies of the minutes may not be taken from the meeting room or from the Medical Staff Office.

XIV ALLIED HEALTH PROFESSIONAL

A Allied Health Professional (AHPs) are healthcare providers who

1) hold a current, valid and unrestricted license, certificate, or other legal credential as required by this state which authorizes the AHP to provide patient care services,

2) are in a category of AHPs designated by the Medical Staff to provide practice privileges under a defined degree of supervision and monitoring, and are individually designated by the Medical Staff of this hospital to exercise specific practice privileges in this Hospital, and

3) meet the qualifications in these Rules and Regulations, in the referenced sections of the Medical Staff Bylaws, in departmental rules and regulations, and applicable Medical Staff and Hospital policies.

- B AHPs are not entitled to Medical Staff membership or privileges
- C AHPs are not entitled to the hearing or appeal rights in the Medical Staff Bylaws
- D Nothing in these Rules and Regulations is to be interpreted to construe AHPs as a separate or self-governing entity

1 CATEGORIES OF AHPs ELIGIBLE FOR PRACTICE PRIVILEGES

The Medical Executive Committee shall make recommendations to the Governing Body for the approval of AHPs eligible for practice privileges in the hospital. The MEC shall review and approve the AHPs eligible to apply for practice prerogatives in this Hospital. The degree of supervision required, whether direct or remote, shall be clearly established for each AHP. For each category of AHPs, it shall be determined whether or not they may make entries in the medical record and whether countersignatures are required and by whom.

The Hospital shall make available to the Medical Staff and any interested applicant, a list of the AHP categories that are approved for practice privileges at this Hospital. Any AHP in a category not identified by the Medical Staff as eligible for practice privileges may submit a request in writing to the Chairman of the respective Department asking for consideration to provide patient care services. The Chairman of the Department shall consider such request and submit the decision to the MEC for review and approval, who will then forward their recommendation to the Governing Body for final approval.

2 QUALIFICATIONS

To be eligible for, and to maintain practice privileges, an AHP must at a minimum meet each of the following requirements in addition to any requirement recommended by the Medical Executive Committee:

- A Hold a current, unrestricted license/certificate/appropriate legal credential in a category of AHP's that the MEC has identified as eligible for practice privileges
- B Document his background, relevant training, education, experience, demonstrated current competency, judgment, character, and physical and mental health status (subject to reasonable accommodation if and to the extent required by law), with sufficient adequacy to demonstrate that patient care services will be provided by the AHP at the professional level of quality and efficiency established by the Medical Staff
- C Submit an application for practice privileges on the form prescribed by the Medical Staff, providing requested information and documentation
- C Provide written confirmation of the existence and extent of required supervision by a Physician member of the Medical Staff as required by the MEC

- 1
- E Adhere to the ethics of the Medical Staff and of the AHPs respective profession, his ability and agreement to work cooperatively with others in the hospital setting, and his willingness to commit to and regularly assist the Hospital in fulfilling its obligations related to patient care within the areas of the AHPs professional competence and credentials
 - F Maintain professional liability insurance in the amount of no less than one hundred thousand (\$100,000) dollars per occurrence, three hundred thousand (\$ 300,000) dollars aggregate

3 PROCEDURE FOR GRANTING PRACTICE PRIVILEGES

A Each AHP must apply and qualify for practice privileges by submitting an application on the approved form, providing all necessary information, and agreeing to be bound by the applicable Medical Staff Bylaws, Rules and Regulations, departmental rules and regulations, and Medical Staff and Hospital policies. Temporary privileges may be granted only after the Medical Staff Office receives all application requirements and primary verification. The application must have been approved by the Credentials Committee and be awaiting approval by the MEC and/or the Governing Board. Temporary privileges shall be granted for a specific period of time, not to exceed ninety (90) days. Temporary privileges are not renewable after ninety (90) days.

Applications for initial practice privileges, and at a minimum two (2) year renewal thereof, shall be submitted and processed in accordance with the procedures stated in the Medical Staff Bylaws and the applicable provisions of the Medical Staff and department rules and regulations, however, AHPs shall not be entitled to the hearing or appeal rights in the Medical Staff Bylaws. There must be verification that each AHPs require licensure, certification, registration is current and unrestricted, and documentation that each AHP has the required type and amount of professional liability insurance in full force.

B Each AHP who is granted practice privileges shall be assigned to the clinical department appropriate to the AHPs practice privileges and shall be assigned a supervising Physician on the Medical Staff, for purposes of supervision and reporting. The degree of supervision required, whether direct or remote, shall be clearly established for each AHP.

C For each category of AHP it shall be determined whether or not they may make entries in the medical record and whether countersignatures are required and by whom.

D Unless otherwise specified in the Bylaws or departmental rules and regulations, AHPs shall be subject to terms and conditions paralleling those in the Bylaws as they apply to the more limited practice of AHP's.

E A system for objectively evaluating the performance of each AHP on a periodic basis shall be established. The findings of these evaluations shall be considered in any decision to renew privileges.

F All rules and qualifications shall be applied uniformly to all AHPs in a given category.

G No AHP shall be entitled to exercise any practice privileges at this facility without prior approval of the MEC and the Governing Body, because the individual previously was permitted to exercise that privileges this or any other institution or because the individual is permitted to perform that privileges under state law This Hospital is not required to grant all or any privileges permitted by law or requested by an individual

4 RESPONSIBILITIES

As a condition of applying for, or being granted a practice privileges each AHP agrees to

A Fulfill those responsibilities required by the Medical Staff Bylaws, Rules and Regulations, departmental rules and regulations, and applicable Medical Staff and Hospital policies

B Retains appropriate responsibility within the AHP's area of professional competence and within the scope of practice prerogatives granted, for the care of Hospital patients

C Participate, as appropriate, in performance review, evaluations, and monitoring activities required of AHPs, in supervising initial appointees of the AHPs same profession, and in discharging such other functions as may be required from time to time

D Serve on Medical Staff, departmental and Hospital committees to which the AHP is assigned

E Attend the meetings of the department to which the AHP is assigned, as permitted by departmental rules and regulations

F Attend educational programs in the AHPs field of practice as may be required by the Hospital, by licensure, certification, registration, or the supervising Practitioner All Licensed Independent Practitioners including but not limited to, Dentists, Clinical Psychologists, Licensed Professional Counselors, Advanced Nurse Practitioners, CRNA's, CNM's, RNFA's, PA's, must complete the number of CME hours required by their individual governing body OR the number required by the state board overseeing that specialty, whichever is greater

G Comply with the terms and conditions of the granting of practice privileges and all policies, procedures and protocols that may be implemented from time to time by the department, Medical Staff or Hospital This includes completion of the annual renewal form for Practitioner's Roles and Responsibilities as set forth by the hospital through the Environment of Care Committee Annual documentation of tuberculosis exposure through current PPD administration is required

H Maintain the confidentiality of all peer review related matters and waives any right under state law to voluntarily disclose such matters

5 TERMINATION OF PRACTICE PRIVILEGES

The AHPs practice privileges shall terminate automatically at the sole discretion of the Administrator or Chairman of the Department upon the occurrence of any of the following

- A** Suspension, restriction, termination, voluntary or involuntary relinquishment, or the imposition of terms of probation (whether voluntary or involuntary) on the Medical Staff membership or privileges of any supervising Practitioner
- B** Termination of the supervisory/sponsoring relationship between the AHP and the supervising Practitioner
- C** Suspension, revocation, expiration, voluntary or involuntary relinquishment or restriction, termination, or imposition of terms of probation by the applicable licensing or certifying agency of the AHPs license, certificate or other legal credential which authorizes the AHP to provide health care services
- D** Failure of the AHP to perform properly assigned duties
- E** Conduct by the AHP that interferes with or is detrimental to the provision of quality patient care
- F** Failure of the AHP to maintain professional liability insurance, as required
- G** Failure of the supervising Physician to maintain professional liability insurance, as required
- H** Failure of any supervising Practitioner to maintain staff membership and clinical privileges in good standing
- I** Termination of the supervising practitioner's professional services contract, if any, with the Hospital

6 FAIR HEARING AND APPELLATE REVIEW

Except as required by law, nothing contained in these Rules and Regulations shall be interpreted to entitle an AHP to the Hearing and Appellate rights in the Medical Staff Bylaws, Article VIII. However, an AHP is entitled to a Hearing/Appellate Review as described in these Rules and Regulations section of the Medical Staff Bylaws

An AHP shall be given the opportunity to have any of the following actions reviewed before it becomes final and effective

- 1** Denial of initial application
- 2** Denial of reappointment to AHP status
- 3** Denial of a request for additional clinical practice privileges
- 4** Reduction in existing clinical practices privileges
- 5** Suspension or expulsion from AHP status

An AHP shall have no rights to obtain review in the following instances

- 1 When an application is denied because it is incomplete
- 2 When an application is denied because the AHP is not from a category that the Hospital's Governing Body has accepted for practice privileges
- 3 When an application is denied or AHP status is revoked because of the existence of an employment, contractual, panel, or other relationship between the Hospital and any AHP in the affected category which limits the number of AHP's in that category that may practice at the Hospital

Notice of adverse action must be sent via certified mail to the AHP within (30) thirty days of the Governing Board's decision. An AHP who is subject to an adverse action may challenge the action by filing a written notice, within fifteen (15) days of receipt of notice to the Department Chairman (via the Medical Staff Office) to which they have been assigned. The Department Chairman shall initiate a careful investigation and afford the affected AHP an opportunity for an interview before an ad-hoc committee appointed by the Department Chairman. The interview shall not constitute the same type of hearing as established in the Medical Staff Bylaws, Fair Hearing and Appellate Review, Article VIII. Before the interview the AHP shall be informed of the general nature of the circumstances giving rise to the adverse action. At the interview the AHP may present information relevant thereto. The Ad-Hoc Committee shall forward their findings and recommendations to the Department Chairman with (15) fifteen days of their meeting. The Department Chairman shall make a report of the findings and recommendations to the Credentials Committee at their next regularly scheduled meeting. The Credentials Committee's recommendations shall be taken to the Medical Executive Committee at their next regularly scheduled meeting. The recommendations from the MEC shall be forwarded to the Governing Board for final decision. The decision of the Governing Board shall be sent via certified mail to the applicant within (15) fifteen days after their regularly scheduled meeting.

7 HOSPITAL EMPLOYEES

Nothing in these Rules and Regulations shall be construed to interfere with the Hospital's right to terminate Hospital employees in accordance with Hospital personnel policies.

8 IMPAIRED ALLIED HEALTH PROFESSIONAL POLICY

For the purpose of these Bylaws the term impaired is hereby defined as any physical, mental or pharmacologically induced disability that interferes with a practitioner's ability to perform his

medical or administrative duties. If any individual working in the medical center has a reasonable suspicion that a practitioner appointed to the Allied Health Professional category exhibits signs of physical and/or mental impairment the following steps should be taken:

The individual who suspects the Practitioner of being impaired must give a written report to the Chief Executive Officer (CEO) and Chief of Staff (COS). The individual making the reports does not need to have definitive proof of the impairment, but a factual report must be submitted to include a description of the actions or incident(s) that led to the belief that a Practitioner might be impaired. The CEO will forward any reports received to the COS, and the COS will forward any reports received to the CEO for information. Initial informal resolution may be

attempted with the involvement of the COS and CEO, the Individual making the report and the Practitioner. If after discussion of the incident(s) with the parties involved, the COS believes there is enough information to warrant an investigation, an investigation shall be conducted and a report of the findings rendered by an investigating committee consisting of one of the following

- 1 The COS and appropriate Department Chairman
- 2 A sub-committee of the medical staff as appointed by the COS

The Practitioner will be notified in writing by the COS that an investigation will occur in connection with obtaining the facts of the investigation, the Practitioner shall have the opportunity for an interview with the investigating committee. At this meeting, the Practitioner will be informed of the nature of the matter(s) being investigated and shall be invited to discuss, explain, or refute the allegations.

The interview is considered part of the investigation of the facts and does not constitute a hearing. This interview is preliminary to the taking of any professional review action and the hearing procedural rules of the Fair Hearing and Appellate Review shall not apply to the interview. A written and/or audio tape recording of this interview shall be made. No video records will be made.

After the facts have been gathered and interview(s) conducted the committee will meet to take action on the results of the investigation. The committee's investigation report and recommendations will then be prepared.

If the investigation produces sufficient evidence that the Practitioner is impaired, the COS shall meet personally with that Practitioner or designate another appropriate individual to do so. The Practitioner shall be informed that the results of the investigation identified that the Practitioner suffers from an impairment that affects his clinical judgment and/or competence to provide quality patient care.

The Practitioner has the right to be informed of the substantive details of the specific incidents(s) in question. The name(s) of the individual(s) who filed the report will be kept confidential until such time as formal action is undertaken to address the incident or documented pattern of impairment.

A copy of the investigating committee's report and recommendations will be provided to the Practitioner, who will then be permitted to submit a response. If the Practitioner does not feel the report is a fair representation of the investigation, they may submit an addendum to be attached to the report.

The investigating committee will then submit its report and the Practitioner's response to the Medical Executive Committee (MEC). A copy of both documents will also be provided to the CEO.

Depending upon the severity of the problem and the nature of the impairment, the MEC may recommend one or more of the following actions:

- 1 Require the Practitioner to undertake a rehabilitation program as a condition of continued appointment and clinical privileges

- 2 Impose appropriate restrictions on the Practitioner's clinical practice
- 3 Immediately suspend the Practitioner's clinical privileges to the medical center until rehabilitation has been successfully accomplished
- 4 Accept the Practitioner's voluntary relinquishment of clinical privileges
- 5 Any other action which the MEC and/or the Board in consultation with the CEO, determines will best serve the interests of the Practitioner, medical staff, and/or medical center, and/or patients

A report shall be made to all administrative bodies as required bylaw/rules and regulations. The MEC shall seek the advice of the medical center's legal counsel to determine whether any conduct must be reported to the law enforcement authorities or other government agencies, and what further steps must be taken.

If an "adverse action" is recommended by the MEC with respect to the Practitioner's scope of practice, the practitioner is entitled to procedural rights defined in the Fair Hearing and Appellate Review section of the Rules & Regulations.

The original report and a description of the actions will be included in the Practitioner's file. If the investigation reveals that there is no merit to the report, all copies of the report and all pertinent documents shall be removed from the practitioner's file and destroyed. If the investigation reveals that there may be some merit to the report, but not enough to warrant immediate action, the report shall be included in the file and the Practitioner's activities and scope of practice shall be monitored until it can be established whether there is an impairment problem.

The COS shall notify the individual in writing that filed the report and any action taken. The COS shall inform the CEO when the notification has taken place.

Throughout this process, all parties shall avoid speculation, conclusions, gossip, and any discussions of this matter to anyone not involved in the investigation and review process described in this policy. All reports and information gathered during the course of the investigation and review process will be treated by all parties as strictly confidential.

Rehabilitation

If a program of rehabilitation is necessary, the COS or designee shall assist the Practitioner in locating a suitable rehabilitation program. The MEC shall not reinstate a Practitioner until it is established to the Board's satisfaction, that the Practitioner has successfully completed a rehabilitation program approved in writing by the MEC.

The MEC must be provided with a letter from the Medical Director of the rehabilitation program where the Practitioner was treated. This letter must be submitted monthly and must state,

- 1 whether the Practitioner is participating in the program,
- 2 whether the Practitioner is in compliance with all the terms of the program,
- 3 whether the Practitioner attends program meetings regularly (if appropriate), to what extent the Practitioner's behavior and conduct are monitored,
- 4 whether, in the opinion of the Medical Director of the rehabilitation program the Practitioner is rehabilitated,

- 5 whether an after-care program has been recommended to the Practitioner and, if so, a description of the after-program
- 6 whether, in the Medical Director's opinion the Practitioner is capable of resuming their scope of practice and providing continuous, competent care to patients

The Practitioner must inform the MEC of the name, address and phone number of his primary care physician, and must authorize the physician to provide the MEC with information regarding their condition and treatment. The MEC has the right to require an opinion from other physician consultants of their choice.

The MEC shall request the primary care physician to provide information regarding the precise nature of the Practitioner's condition and treatment as it related to the impairment.

Failure to comply with all of the above conditions may result in suspension or revocation of the Practitioner's medical staff privileges.

Reinstatement

If the MEC is satisfied that the Practitioner has successfully completed a rehabilitation program the MEC may recommend to the Board consideration of the reinstatement of the Practitioner to the AHP category.

When considering an impaired Practitioner for reinstatement the MEC and the Board must consider interests concerning the quality of patient care to be paramount.

If all information received by the MEC indicates that a Practitioner is rehabilitated and capable of resuming patient care, the Board must take the following additional precautions when considering restoration of their scope of practice.

The Practitioner's sponsoring physician(s) must be willing to certify, in writing, their willingness to assume responsibility for the care of the Practitioner's patients in the event the Practitioner is unable or unavailable to care for them.

The MEC shall require the Practitioner to provide periodic reports from the Practitioner's primary care physician, for a period of time specified by the CEO and the COS, stating that the Practitioner is continuing treatment or therapy, as appropriate, and their ability to treat and care for patients in the medical center is not impaired.

The Department Chairman or a medical staff member appointed by the department chairman that should monitor the Practitioner's scope of practice in the medical center. The MEC shall determine the nature of the monitoring after reviewing all of the circumstances.

The Practitioner must agree to submit to an alcohol, blood, or other substance screening test appropriate to the impairment at the request of the COS, or designee, if there is reasonable suspicion that the Practitioner may be under the influence of drugs, alcohol or other substance.

Failure to comply with all the above conditions may result in suspension or revocation of the Practitioner's scope of practice.

All requests for information concerning the impaired Practitioner shall be forwarded to the COS for response

9 **CATEGORIES OF ALLIED HEALTH PROFESSIONAL STAFF**

A **Dentist**

1 **Basic Qualifications**

An applicant for dental privileges in the Hospital must meet the general eligibility criteria in Article III, Section 2 of the Medical Staff Bylaws. An applicant for dental privileges must hold a DDS or equivalent degree issued by a dental school approved at the time of issuance of such degree by the Board of Dental Examiners of South Carolina and must also hold a valid, unrevoked and unsuspended certificate to practice dentistry issued to him by the Board of Dental Examiners of South Carolina.

2 **Particular Rules & Regulations**

A A Dentist with clinical privileges may initiate the admission of a patient only jointly under the names of the dentist and a physician who is an active member of the Medical Staff of the Hospital. Patients admitted to the Hospital for dental care shall receive the same basic medical appraisal as patients admitted for other services. This includes the performance by a physician of an admission history and physical examination and an evaluation of the overall medical risk. The dentist shall be responsible for that part of the history and physical examination that is related to dentistry.

B Dentists shall have the right to pursue and practice clinical and surgical privileges as designed on an individual basis and within the scope of their licensure. Surgical procedures performed by dentists shall be under the overall supervision of the chairman of the Department of Surgery or his designee. A physician member of the Medical Staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization and shall determine the risk and effect of the proposed surgical procedure on the total health status of the patient.

C Dentists may write orders and prescribe medications within the limits of their licensure and of the Medical Staff Bylaws, Rules and Regulations.

B **Clinical Psychologists**

1 **Basic Qualifications**

An applicant for clinical psychology privileges in the Hospital must meet the general eligibility criteria in Article III, Section 2 of the Medical Staff Bylaws. An applicant for clinical psychology privileges must hold a Ph.D. in clinical psychology from a program approved by the American Psychological Association, hold a current certification by the Board of Examiners of

Psychologist in the state of South Carolina and have satisfactorily completed approved postgraduate training of at least twelve (12) months

2 Particular Rules & Regulations

A Functions to be performed by the clinical psychologist in the Hospital will be limited to those clinical functions approved by the Medical Staff and the Governing Body. Clinical psychologists granted privileges to provide specific services in the Hospital will be assigned to the Department of Medicine. The overall responsibility for supervision of the clinical psychologist rests with the Chairman of the Department of Medicine, however, direct supervision rests solely with the physician requesting the service of the clinical psychologist. Clinical psychologists may not admit patients to the Hospital. They must sign all entries made in the medical record. Clinical psychologist may not write orders for medications or treatment of any type or assume primary responsibility for the clinical care of patients. Lastly, no physician may delegate the ultimate responsibility for diagnosis or therapy to a clinical psychologist. Medical services rendered to a patient by a clinical psychologist shall be, with respect to the obligation of the physician, the same as if such services had been rendered directly by the physician to the patient.

C Advanced Practice Nurses

1 Basic Qualifications

An applicant may request privileges in this Hospital as one of the following:

- a) Certified Registered Nurse Anesthetist (CRNA)
- b) Certified Nurse Midwife (CNM)
- c) Clinical Nurse Specialist (CNS)
(Types of CNS Adult Psychiatric and Mental Health, Child and Adolescent Psychiatric and Mental Health, Community Health, Home Health, Medical , Surgical and Gerontology Nursing)
- d) Adult Nurse Practitioner (ANP)
- e) Acute Care Nurse Practitioner (ACNP)
- f) Family Nurse Practitioner (FNP)
- g) Gerontological Nurse Practitioner (GNP)
- h) Gynecological Nurse Practitioner (GYNP)
- i) Neonatal Nurse Practitioner (NNP)
- j) Obstetric Nurse Practitioner (ONP)
- k) Pediatric Nurse Practitioner (PNP)
- l) School Nurse Practitioner (SNP)
- m) Women's Health Nurse Practitioner (WHNP)
- n) Registered Nurse First Assistant (R N F A)

The above named practitioners must meet the general eligibility criteria in Article III, Section 2 of the Medical Staff Bylaws. An applicant for an Advanced Nurse position must be a registered nurse (RN) graduate from an accredited school of nursing, hold an active license in this state, hold an official recognition from this state as an Advanced

Practice Nurse, and may hold a prescriptive privileges license. The above state recognition with the South Carolina Department of Labor, Licensing and Regulations and the South Carolina State Board of Nursing all require that the Advanced Practice Nurse hold a certificate in his specialty area(s) of practice from an accredited or approved educational program, preferably a Masters or higher nursing degree and have passed a nationally recognized credentialing exam accepted by the board.

2 Common Rules and Regulations for all Advanced Practice Nurses

- a) At all times the Advanced Practice Nurse acts under the protocols developed by the sponsoring physician or his designee who must be a member of the Medical Staff and have clinical privileges to practice in the appropriate department.
- b) The Advanced Practice Nurse will submit a list of approved orders and protocols and have the supervising physician submit these to the appropriate Department for review and approval and then forward the recommendation to the Medical Executive Committee.
- c) At no time may the Advanced Practice Nurse be allowed to assume primary responsibility for the patient that is hospitalized. Once hospital privileges are approved by the department in which their sponsoring physician serves, the Medical Executive Committee, the Advanced Practice Nurse must provide specific documentation as to the types of patient admissions one could process.
- d) Patients shall be seen by the attending physician upon admission and an admission note written by the physician within twelve (12) hours. If the patient is critically ill, the attending physician shall see the patient within four (4) hours of admission. The attending physician shall countersign the history and physical within twenty-four (24) hours.
- e) Following the admission evaluation, the management of the patient is performed collaboratively with the Advanced Practice Nurse Practitioner and the attending physician who must remain available.
- f) The Advanced Practice Nurse may order appropriate laboratory studies in accordance with approved protocols. All orders must be countersigned within twenty-four (24) hours by the attending physician.
- g) In consultation with the attending physician, the Advanced Practice Nurse may manage the immediate and normal hospital stay. The attending physician will evaluate the patient for discharge, sign the discharge summary and write the appropriate orders and prescriptions.

D Certified Registered Nurse Anesthetists (CRNA)

1 Basic Qualifications

An applicant for CRNA privileges in the Hospital must meet the general eligibility criteria in Article III, Section 2 of the Medical Staff Bylaws. A CRNA must be a graduate of an accredited school of nursing and a graduate of an accredited school of nurse anesthesiology. Additionally, the applicant must hold a current South Carolina license as a registered nurse and a registered nurse anesthetist.

2 Particular Rules & Regulations

A. A CRNA functions at all times under the direction of an anesthesiologist and as such falls within the purview of the Chairman of the Department of Surgery. A CRNA is allowed to administer intravenous, spinal and other anesthetics to persons to render them insensible to pain during surgical procedures, deliveries, or other medical and dental procedures as specified by the Department of Surgery. A CRNA may make notations on the anesthesia record or other portions of the medical record as appropriate. All such entries must be reviewed and countersigned by an anesthesiologist. A CRNA may not conduct the preoperative or the post operative anesthesia visit. A CRNA may administer preoperative medications to patients, such medications having been prescribed by a physician.

E Certified Nurse Midwife (CNM)

1 Basic Qualifications

An applicant for CNM privileges in the Hospital must meet the general eligibility criteria in Article III, Section 2 of the Medical Staff Bylaws. A CNM applicant must be a graduate from an accredited school of nursing and a graduate of a nurse-midwifery educational program accredited by the American College of Nurse-Midwives. The applicant must hold a current South Carolina license as a registered nurse-midwife. Additionally, the applicant must provide evidence of having passed the American College of Nurse-Midwives National Board certifying exams for Certified Nurse-Midwives.

2 Particular Rules & Regulations

The following are particular rules and regulations pertaining to nurse-midwives:

a) At all times, the CNM acts under the supervision of the sponsoring physician or his designee who must also be a member of the staff and have clinical privileges to practice OB-GYN. The pre-admission record shall have a note by the attending physician recording risk status. Following admission evaluation, the management of labor is performed collaboratively with the CNM and the attending physician who must remain immediately available.

b) The pre-admission record shall have a note by the attending physician recording risk status. The history & physical shall be countersigned by the attending physician and an admission note entered into the record by the attending physician.

c) The CNM may perform physical examinations, including pelvic exams, for her patients. Any deviation from low risk normal pregnancy, labor or delivery requires immediate notification and attendance by the attending physician.

d) All progress notes will be co-signed by the attending physician within twenty-four (24) hours.

e) A list of approved orders and protocols will be submitted by the attending physician and approved by the Department of OB/GYN/Pediatrics and the Medical Executive Committee.

f) A CNM may order appropriate laboratory studies in accordance with an approved protocol. All orders are to be countersigned within twenty-four (24) hours by the attending physician.

g) Ultrasound tests are to be ordered by the attending physician.

h) CNMs may conduct spontaneous vaginal deliveries of vertex presentation term infants, perform and repair midline episiotomies and repair minor lacerations. Fourth degree lacerations or episio-proctosomies are to be repaired by the attending physician or under his direct supervision.

i) Anesthesia consultation for epidural anesthesia must be obtained from the attending physician and not by the CNM.

j) The attending physician will be present in the hospital during normal delivery. He will be present in the delivery room for all labors complicated by meconium-stained fluid and conduct the initial newborn stabilization and or resuscitation. It remains clear that the attending physician is in charge of the neonate until arrival of the pediatrician in complicated cases or until stabilization occurs.

k) In consultation with the attending physician, the CNM may manage the immediate postpartum period and normal hospital stay. The attending physician will evaluate the patient for discharge, will co-sign the appropriate orders and prescriptions.

l) Patients who are to be evaluated in the Emergency Department will be seen by the attending physician. The CNM may act only under his direct supervision in the Emergency Room. The CNM may perform labor checks in consultation with the attending physician.

m) CNMs may first assist in cesarean births, as long as the OB/GYN guidelines are followed which state, "If a cesarean section is performed at East Cooper Regional Medical Center two physicians must be present in addition to the anesthesiologist. In addition to the primary surgeon, the second physician may be a Pediatrician who will take care of the infant. In this situation, the assistant may be a non-physician, furnished by ECRMC. If a Pediatrician is not available, then a second physician must be present so that the infant may receive the proper care. In cases where, in the judgment of the attending Obstetrician,

the life or health of the infant or mother would be jeopardized by waiting for a physician assistant to arrive, he may proceed without a physician assistant

n) In consultation with the attending physician and upon appropriate documentation in the medical record, the CNM may manage the administration of Oxytocin augmentation

F Family Nurse Practitioner

1 Basic Qualifications

An applicant for Nurse Practitioner privileges in the Hospital must meet the general eligibility criteria in Article III, Section 2 of the Medical Staff Bylaws. An applicant must be a graduate of an accredited school of nursing and have a current South Carolina license as a registered nurse. Applicants must also provide proof of completion of a course of study leading to the designation of Nurse Practitioner, such course to be approved by a recognized national board or college.

2 Particular Rules & Regulations

a) A nurse practitioner will function at all times under the supervision of their sponsoring physician or his designee who must also be a member of the Medical Staff of the Hospital. They shall be assigned to the department in which their sponsoring physician serves. It is the responsibility of the sponsoring physician to develop protocols outlining the duties, responsibilities, and limitations of the nurse practitioner's function within the Hospital. The protocols are subject to approval of the Department, MEC, and Hospital Administration. At no time may the Nurse Practitioner be allowed to assume primary responsibility for the care of any patient.

b) The physician does not have to be physically on site but must be available for consultation by phone and no further than forty-five (45) miles away from the Hospital. Since the scope and practice of the Family Nurse Practitioner is vast, each job description and the particular rules section will be individualized to the Nurse Practitioner/physician practice. While the majority of patient visits will be in the physician's office, occasional hospitalizations may occur.

c) When a patient does either present to the emergency room or present to the office and then have to be transported to the emergency room, the Nurse Practitioner will be allowed to see the patient with standing orders or see the patient in the emergency room until they are stable enough to be discharged or can return to the primary practice site for further care. Patients, who are to be evaluated in the Emergency Department, will be seen in collaboration with the sponsoring physician.

G Registered Nurse First Assistant

1 Basic Qualifications

A Registered Nurse First Assistant (R N F A) must hold a current South Carolina nurse's license, hold certification as a perioperative nurse (CNOR) or other designated nursing specialty certification. In addition two (2) years experience, as a perioperative nurse is required. The R N F A must have successfully completed a structured R N F A course including the required hours/cases of proctoring. Clinical privileges will be reviewed and approved by the Department of Surgery Chairman. The R N F A must complete acknowledgment/sponsorship statement for each Surgeon they assist. The R N F A must abide by the Surgical Services Department policy regarding First Assistants.

2 Particular Rules & Regulations

R N F A are allowed to perform the tasks approved under South Carolina law that are then delineated on their clinical privilege form.

H Other Advanced Practice Nurses

Each Advanced Practice Nurse must submit written protocols and specific duties to the Medical Staff Office upon submission of their application. These documents will be reviewed and approved by the appropriate department and the Medical Executive Committee.

I Physician Assistant

1 Basic Qualifications

These applicants must meet the general eligibility criteria in Article III, Section 2 of the Medical Staff Bylaws. An applicant must be a graduate of an accredited by the American Academy of Physician Assistants and hold a current South Carolina license as a Physician Assistant in good standing.

2 Particular Rules & Regulations

Physician Assistants will function at all times under the supervision of their sponsoring physician, or his designee who must also be a member of the active Medical Staff of this Hospital. Physician Assistants will be assigned to the department under which their sponsoring physician serves. It will be the responsibility of the Physician Assistant to provide a copy of his approved South Carolina Physician Assistant application outlining the duties, responsibilities, and limitations of the Physician Assistant functions within the state of South Carolina. The application is subject to the approval of the MEC, and the Hospital Administration. At no time may the Physician Assistant assume primary responsibility for the care of any patient.

J Other AHP Practitioners

(Certified Scrub Technicians (CST), Operating Room Technicians (ORT), Dental Assistants, Speech Pathologist, Audiologist, Enterostomal Therapists,

Certified Medical Assistants (CMA), Certified Ophthalmology Technicians, Licensed Professional Counselors, Social Workers)

1 Basic Qualifications

These applicants must meet the general eligibility criteria in Article III, Section 2 of the Medical Staff Bylaws. An applicant must be a graduate of an accredited program and hold a current South Carolina license or certificate to practice in his designated profession.

2 Particular Rules & Regulations

All Other AHPs will function at all times under the supervision of their sponsoring physician, or his designee who must also be a member of the active Medical Staff of this Hospital. All Other AHPs will be assigned to the department under which their sponsoring physician serves. It will be the responsibility of that department to develop protocols outlining the duties, responsibilities, and limitations of the Other AHPs' functions within the Hospital. The protocols are subject to the approval of the MEC, and the Hospital Administration. At no time may the Other AHP be allowed to assume primary responsibility for the care of any patient.

XV RESIDENTS & INTERNS & MEDICAL STUDENTS

A The term "resident" and "intern" (hereinafter referred to collectively as "resident") as used in these rules and regulations, refers to Practitioners who are currently enrolled in a graduate medical education program approved by the MEC and the Governing Body, and who, as part of their education program, will provide health care services at the Hospital. Residents shall not be considered independent Practitioners, shall not be eligible for clinical privileges or Medical Staff membership, and shall not be entitled to any of the rights, privileges, or to the hearing or appeal rights under these Bylaws, Rules and Regulations. In compliance with federal laws, it shall not be necessary to submit a query to the National Practitioner Data Bank prior to permitting a resident to provide services at this Hospital. Residents may render patient care services at the Hospital only pursuant to and limited to the following:

- 1 applicable provisions of the Hospital licensing laws of this state,
- 2 the written affiliation agreement between the Hospital and the sponsoring medical school or training program, such agreement shall identify the individual or entity responsible for providing professional liability insurance coverage for residents in amounts of \$100,000/ \$300,000 and with a carrier approved by the Medical Staff of this Hospital, and
- 3 the protocols established by the MEC, in conjunction with the sponsoring school or training program, regarding the scope of the resident's authority, direction and supervision of the resident, and other conditions imposed upon the resident by this Hospital or its Medical Staff.

- B** While functioning at this Hospital, residents shall abide by all provisions of the Medical Staff Bylaws, Rules and Regulations, and Hospital and Medical Staff policies, and shall be subject to limitations or termination of their ability to function at the Hospital at any time in the discretion of the Administrator or the Chief of Staff. Residents may perform only those services set forth in the training protocols developed by the applicable training program to the extent that such services do not exceed or conflict with the Rules and Regulations of the Medical Staff or Hospital policies. Residents shall be responsible and accountable at all times to a member of the Medical Staff and shall be under the supervision and direction of a member of the Medical Staff of this Hospital. In the Operating Suite, a Resident must be supervised by the attending physician throughout the procedure. Residents who write medical record entries must have their supervising physician countersign the entry within twenty-four (24) hours. Residents shall not be required to attend Medical Staff meetings and may not be appointed to Medical Staff committees.
- C** Prior to the resident's rotation to the Hospital, the resident must furnish a copy of his medical license to the Medical Staff Office. The sponsoring medical school or training program must submit a list of residents to the Medical Staff Office in advance. The resident is responsible for calling the Medical Staff Office to ensure the proper procedures have been performed prior to his rotation at the Hospital.
- D** Medical students will function at all times under the constant supervision of their sponsoring physician staff member. Medical students are permitted to perform basic tasks (i.e. admission history and physical) as assigned by their sponsoring physician. The sponsoring physician must supervise all such tasks and any subsequent medical record entries initiated by medical student must be countersigned by the physician sponsor within twenty-four (24) hours.

XVI SEXUAL HARASSMENT POLICY

Harassment by a medical staff member against any individual (e.g., against another medical staff member, house staff, hospital employee, visitor, or patient) on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex or sexual orientation shall not be tolerated. "Sexual harassment" is unwelcome verbal or physical conduct of a sexual nature which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and visual harassment (such as the display of derogatory cartoons, drawings, pictures, or posters, or the inappropriate touching on oneself or other in another's presence). Sexual harassment includes unwelcome advances, requests for sexual favors, and any other verbal, visual, or physical conduct of a sexual nature when (1) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion, or other aspects of employment, or (2) this conduct substantially interferes with the individual's employment or creates an intimidating, hostile, or offensive work environment. Sexual harassment also includes conduct that indicates that employment and/or employment benefits are conditioned upon acquiescence in sexual activities. All allegations of sexual harassment shall be investigated by the medical staff and, if confirmed, will result in appropriate corrective action, from reprimands up to including termination of medical staff privileges or membership, if warranted by the facts.

These Rules and Regulations were updated for printing on


CHIEF OF STAFF

12/14/07
DATE


PRESIDENT/CEO

12/14/07
DATE


CHAIRMAN OF THE BOARD

12/14/07
DATE

STATE OF SOUTH CAROLINA)
)
COUNTY OF CHARLESTON) C A NO 2010-CP-10-3410

Defendants

Affidavit of Donald Pocock, M D

3 From 2001 to 2005, I was Chief Medical Officer at Roper Saint Francis
Health Care in Charleston, South Carolina, where I had responsibility for two medical
staffs with credentialing of over 250 physicians annually. In this capacity, I worked

closely with other area Hospitals such as Trident Medical Center and East Cooper Medical Center and am familiar with their bylaws and physician appointment processes

4 I know the Charleston, South Carolina, healthcare industry from my experience there, and know the local standards applied to medical staff membership eligibility, granting of privileges, and reappointment I am also familiar with national standards and practices regarding Medical Staff Bylaws and Physician Credentialing

5 I have reviewed the following materials in this case Dr Holmes' Complaint, the Defendants' Answer, the 2006 and 2007 Medical Staff Bylaws for East Cooper Medical Center, the 2006 and 2008 credentials files of Dr Holmes, including Dr Holmes' application for reappointment to the Medical Staff in 2006 and 2008, supporting documents and correspondence regarding these reappointments, as well as documents relating to the hearing on Dr Holmes's 2006 reappointment application, all attached as exhibits to the Affidavit of Elaine Meuli

6 As an expert witness in a previous lawsuit brought by Dr Holmes against these same Defendants and others, I am familiar with pertinent materials arising from that lawsuit as well Dr Holmes's arguments arising from the previous lawsuit are substantially the same as the arguments she asserts in the present lawsuit In both lawsuits, Dr Holmes argues the Defendants breached a previous Settlement Agreement by not following the Bylaws in reviewing her applications for reappointment to the Medical Staff of East Cooper Medical Center (the "Hospital"), including her requests for advancement in staff category from the Consulting Medical Staff to the Associate Medical Staff, as well as her requests for surgical privileges

7 It is my expert opinion, within a reasonable degree of certainty in the area of Hospital Medical Staff Bylaws and Physician Credentialing, that the Hospital was in compliance with their own Medical Staff Bylaws and the local and national standard of care in the field of Physician Credentialing in their actions regarding Dr Holmes' 2006 and 2008 reappointment applications, as explained in the subsequent paragraphs

8 The Medical Staff Bylaws for East Cooper Medical Center (the "Bylaws") clearly define eligibility for membership by category

9 The Bylaws clearly place the responsibility on the applicant for producing all information needed to assess current clinical competence The Bylaws in effect during Dr Holmes's reappointment applications in 2006 and 2008 emphasize the applicant's burden to produce evidence of current competence multiple times For example, this requirement is included in Article V, Section 3 C (p 27) of the Bylaws applicable to Dr Holmes's 2006 reappointment application (the "2006 Bylaws") and in the same subsection (Article V, Section 3 C, p 29) of the Bylaws applicable to her 2008 reappointment application (the "2007 Bylaws")

10 In her 2006 and 2008 reappointment applications, Dr Holmes requested a change in status from a Consulting member to an Associate member of the Medical Staff This is exactly the same request she made in her 2004 reappointment application, resulting in a previous lawsuit against Defendants in which I offered expert testimony

11 The Consulting Medical Staff consists of physicians who do not admit patients to the Hospital but who desire privileges to provide consultative services to patients at the request of Active or Courtesy staff physicians Consulting staff members

are not eligible to admit patients, perform surgery, vote, or hold office See 2006 Bylaws, Art IV, §5 (p 18), 2007 Bylaws, Art IV, §5 (p 19), attached as Exhibits D and E, respectively, to the Affidavit of Elaine B Meuli

12 The 2006 Bylaws define the Associate Medical Staff as practitioners who meet all the criteria for Active Medical Staff membership except the minimum required number of in-hospital patient contacts per year In order to allow adequate medical peer review of the smaller number of patient contacts by members of the Associate Medical Staff, all in-hospital patient contacts for Associate staff members are reviewed by the Department to which the practitioner is assigned In addition, if the applicant desires privileges for surgical or invasive medical procedures, the applicant will be required to submit documentation of current clinical competence to the satisfaction of the appropriate Department Chairman and Credentials Committee 2006 Bylaws, Art IV, §3 A (p 17)

13 In December 2007, the Hospital changed certain provisions relating to staff category, including the provision defining an Associate Medical Staff Member, in order to better ensure patient safety 2007 Bylaws, Art IV, §3 A (p 18) The 2007 Bylaws define the Associate Medical Staff as practitioners who (i) do not have privileges at any other hospital, but who (ii) meet all the criteria for active staff membership except the minimum number of admissions, procedures, or in-hospital patient contacts per year or preceding 12-month period 2007 Bylaws, Art IV, §3 A (p 18) Further, surgical privileges were restricted to members of the Active Medical Staff only At the time of initial appointment and at all times subsequent thereto, a member of the Associate Medical Staff shall meet all of the threshold criteria for exercising Core Privileges in his

or her respective Department 2007 Bylaws, Art IV, §3 A (p 18) The threshold criteria, which are identified by the Department and approved by the MEC, relate to minimum formal training, board certification, professional experience within the preceding twelve months and clinical references 2007 Bylaws, Art IV, §3 A (p 18) In order to facilitate ongoing professional practice evaluation, all patient admissions, procedures and patient contacts by members of the associate staff are reviewed by the Department to which the Practitioner is assigned 2007 Bylaws, Art IV, §3 A (p 18)

14 As shown in her 2006 and 2008 reappointment applications, Dr Holmes sought to be admitted as an Associate member of the Department of Surgery, with a specialty in Ophthalmology Core Privileges for a member of the Associate Medical Staff specializing in ophthalmology surgery in 2006 and 2008 would include "the performance of surgical procedures on patients of all ages presenting with illnesses, injuries, and disorders of the eye, including its related structures and visual pathways " Thus, any applicant for reappointment to the Hospital's Medical Staff seeking advancement to the Associate Medical Staff with a specialty in Ophthalmology was required to submit documentation of her current clinical competence to the satisfaction of the Chairman of the Department of Surgery and the Credentials Committee See 2006 Bylaws, Art IV, §3 A (p 17), 2007 Bylaws, Art IV, §3 A (p 18) This was required as part of Dr Holmes' 2004 reappointment application as set forth in the Bylaws in effect at the time

2006 Reappointment Process

15 With respect to Dr Holmes's 2006 reappointment application, the reappointment process was spelled out in Article V, §3 of the 2006 Bylaws (pp 26-28)

An application for reappointment to the Medical Staff is required to include objective evidence of the applicant's clinical competence based on peer review activities 2006 Bylaws, Art V, §3 A (p 26) The applicant bears the burden of producing adequate information for a proper evaluation of the applicant's current competence in terms of the applicant's ability to practice in the area in which privileges were sought 2006 Bylaws, Art V, §3 C (p 27) The department chairman, here the Chairman for the Department of Surgery, conducts an initial review and recommendation of the application, including any clinical privileges requested 2006 Bylaws, Art V, §3 E (p 28) The Hospital's Credentials Committee reviews all pertinent information and makes a written recommendation to the Hospital's Medical Executive Committee ("MEC") concerning the member's reappointment and clinical privileges delineation 2006 Bylaws, Art V, §3 F (p 28)

16 After receipt of the recommendation of the Credentials Committee, the MEC submits its recommendation to the Hospital's Governing Body regarding membership, staff category, and clinical privileges 2006 Bylaws, Art V, §2 H (p 24) The MEC may take action by recommending that the Governing Body reject the applicant's request for membership and/or privileges 2006 Bylaws, Art V, §2 H (p 24) When the recommendation of the MEC is adverse to the applicant, the applicant must be informed of the decision and advised of her hearing and appeal rights under the Bylaws 2006 Bylaws, Art V, §2 H (p 24) The Governing Body will not act upon an adverse recommendation of the MEC until after the affected individual has exercised or waived her right to a hearing and appeal under the Bylaws 2006 Bylaws, Art V, §2 H (p 24)

17 The applicant's hearing and appeal rights regarding an adverse recommendation (including the denial of a request for change in staff category) are set forth in Article VIII of the 2006 Bylaws. The affected practitioner has thirty (30) days following the date notice of the MEC's action is given in which to request a hearing. 2006 Bylaws, Art. VIII, §2 A (p 47). The hearing is held before a panel known as a Medical Review Committee ("MRC") with a hearing officer appointed to run the hearing. 2006 Bylaws, Art. VIII, §2 D and §2 F (p 49). The hearing procedure is governed by Article VIII, Section 3 of the 2006 Bylaws (pp 50-54). The affected practitioner has the burden of proving, by clear and convincing evidence, that the action or recommendation of the body whose decision prompted the hearing is arbitrary, capricious, or unreasonable. 2006 Bylaws, Art. VIII, §3 H (p 53). The MRC shall render and deliver a written report and decision. 2006 Bylaws, Art. VIII, §4 (p 54). Pursuant to Article VIII, Section 6 of the 2006 Bylaws (pp 57), the affected practitioner may then appeal the MRC's decision to the Governing Body. The grounds for the appeal are limited to substantial and prejudicial failure of the MRC or the MEC to comply with the Bylaws or to afford due process or a fair hearing, the action or recommendation that prompted the hearing, or any substantial part thereof was arbitrary and capricious or the MRC's decision or any substantial part was clearly contrary to the weight of the evidence. 2006 Bylaws, Art. VIII, §6 C (p 55). The Governing Body's written final decision will then be issued. 2006 Bylaws, Art. VIII, §6 F (p 57).

18 With respect to Dr. Holmes's 2006 reappointment application, the Chairman of the Department of Surgery recommended that she be reappointed to the Consulting Medical Staff due to lack of adequate documentation that she was currently

clinically competent for the Associate category and surgical privileges requested. The Credentials Committee then reviewed Dr. Holmes's application, including the supporting documentation of management of 25 patients in her office practice. The Credentials Committee noted that the documentation did not have patient names or dates and did not contain any evidence of surgical procedures performed by her. Dr. Holmes also had no such activity at the Hospital since 1998. As a result, the Credentials Committee determined that Dr. Holmes did not provide adequate documentation of surgical expertise to support her request for advancement to the Associate Medical Staff, which would have included Core Privileges in ophthalmologic surgery. The recommendation of the Credentials Committee was unanimous.

19 The MEC then reviewed Dr. Holmes's 2006 reappointment application. The MEC agreed with the Credentials Committee that Dr. Holmes's application and accompanying information were insufficient to support her request for advancement to the Associate Medical Staff or for the Core privileges incident thereto. The MEC also unanimously voted to recommend reappointment to the Consulting Medical Staff.

20 Dr. Holmes was advised of the MEC's recommendation that she be reappointed to the Consulting Medical Staff by letter, in compliance with the 2006 Bylaws. See 2006 Bylaws, Art. V, §2 H (p. 24), 2006 Bylaws, Art. VIII, §2 A (p. 47). Dr. Holmes requested a hearing by letter dated January 15, 2007. She received a hearing in front of the MRC with a hearing officer. Upon my review of the hearing documents relating to Dr. Holmes's 2006 reappointment application, as well as the processes set forth in Article VIII of the 2006 Bylaws, it is my expert opinion, within a reasonable degree of certainty in the area of Hospital Medical Staff Bylaws and Physician

Credentialing, that the Hospital was in compliance with the 2006 Bylaws and the local and national standard of care in the field of Physician Credentialing in their actions regarding the hearing rights provided to Dr Holmes with respect to her 2006 reappointment application. Contrary to the allegations in her complaint, Dr Holmes was provided a fair hearing by the Hospital. She was given appropriate notice of the hearing, allowed input on the selection of the hearing officer, allowed to and did present written briefs, information, objections and argument in support of her position, and was allowed to and did examine witnesses.

21 After the MRC upheld the MEC's recommendation, Dr Holmes requested and received an appeal to the Governing Board. The Governing Board's final decision affirmed the recommendation of the Department Chairman, Credentials Committee, MEC, and MRC to reappoint her to the Consulting Medical Staff. It is my expert opinion, within a reasonable degree of certainty in the area of Hospital Medical Staff Bylaws and Physician Credentialing, that Dr Holmes's appeal and the Governing Body's decision in this regard were in compliance with the 2006 Bylaws and the local and national standard of care in the field of physician credentialing.

22 The filings by Dr Holmes in support of her appeal of the recommendation of the MEC to reappoint her to the Consulting Medical Staff, in particular her Supplemental Hearing Submission dated April 28, 2007, lead me to conclude that her objections to the Hospital's actions in the present lawsuit arise from the same set of facts as her previous lawsuits—meeting minutes and other facts she alleges arose during a Credentials Committee meeting in 1997. Dr Holmes's reappointment applications in 2004 and 2006 are substantially similar, involve almost identical

provisions in the version of the Bylaws in effect in 2004 and the 2006 Bylaws, and involve substantially similar issues and arguments raised by her

23 In particular, in her appellate submissions, Dr Holmes submitted what she claims are minutes from a 1997 meeting of the MEC to support her position that she should be advanced to the Associate Medical Staff. It is my expert opinion, within a reasonable degree of certainty in the area of Hospital Medical Staff Bylaws and Physician Credentialing, that these submissions made by Dr Holmes, including references to litigation against the defendants and others going back to 1999, have nothing to do with whether Dr Holmes is competent to perform surgery on the eye. In other words, they are not grounds for granting her request for advancement in staff category or surgical privileges.

24 Upon my review of Dr Holmes' 2006 credentials file, as well as the 2006 Bylaws and hearing documents, it is my expert opinion, within a reasonable degree of certainty in the area of Hospital Medical Staff Bylaws and Physician Credentialing, that the Hospital was in compliance with the 2006 Bylaws and the local and national standard of care in the field of physician credentialing in their actions with respect to Dr Holmes 2006 reappointment application.

2008 Reappointment

25 As previously discussed, Dr Holmes's reappointment application in 2008 was similar to her 2006 and 2004 applications, but, in contrast Dr Holmes also failed to complete the required Delineation of Privileges form.

26 In September of 2007 the MEC instituted a requirement that all applicants and reapplicants to the Medical Staff were required to complete a Delineation of Privileges form as part of their application process to identify what privileges were being sought 2007 Bylaws, Art VI, §2 A (p 37) This form set forth the threshold requirements for Core Privileges for the applicant's specialty Core privileges is the grouping of basic procedures physicians are taught in his or her specific training program and should be qualified to perform into a single privilege for that category or specialty Additional procedures that go beyond the Core and require additional training or experience are listed separately and specific criteria are developed to qualify for procedures that fall outside core privileges During the time of Dr Holmes's reappointment application in 2008, the Core Privileges for Ophthalmology included the admission, work-up, diagnosis, and the performance of surgical procedures on patients of all ages presenting with illnesses, injuries, and disorders of the eye, including its related structures and visual pathways To be eligible for Core privileges within the specialty of ophthalmology, reapplicants must demonstrate that they had performed at least 48 ophthalmologic surgical procedures in the preceding 24 months in a hospital or surgical outpatient setting See Ex B to Affidavit of Elaine B Meuli, 2008 Credentials File for Dr Holmes, Delineation of Privileges form

27 As shown in her 2008 reappointment application, Dr Holmes's 2006 reappointment as a member of the Consulting Medical Staff would end on November 13, 2008 A practitioner who fails to return an application or supply all of the required information within thirty (30) days prior to the expiration of the practitioner's current appointment period shall be deemed to have resigned the practitioner's medical staff

membership. A practitioner who is deemed to resign in this manner shall not be entitled to the hearing and appeal rights under the Bylaws. 2007 Bylaws, Art V, §3 B (p 29)

28 Despite the provision in the 2007 Bylaws requiring the reappointment application be completed within thirty (30) days prior to the expiration of her current appointment period, the Hospital did not receive Dr. Holmes's reappointment application until November 6, 2008. In her application, Dr. Holmes requested advancement from the Consulting Medical Staff to the Associate Medical Staff. Dr. Holmes failed to complete the required Delineation of Privileges portion of her application attesting, among other things, that she had performed at least 48 ophthalmologic surgical procedures in the preceding 24 months. In lieu thereof, Dr. Holmes arbitrarily and unilaterally attached an outdated "laundry list" of surgical procedures she wished to be granted.

29 Because of her failure to complete this portion of her application, the Hospital returned the application to Dr. Holmes as incomplete on November 11, 2006, and provided her explicit instructions on how to complete the form. See Exhibit O to Defs.' Answer. The letter returning the application was hand-delivered to Dr. Holmes on November 12, 2008, with a warning that it needed to be completed on or before November 13, 2008, to comply with the 2007 Bylaws. Ex. O to Defs.' Answer. As documented in her 2008 credentials file, multiple efforts were made to contact Dr. Holmes regarding the incomplete form, and Dr. Holmes initially communicated that the form was to be submitted as is.

30 On November 13, 2008, Dr. Holmes delivered a revised application for reappointment. The revised application ignored the explicit instructions in the

November 12, 2008 letter, and the only change from the previous application was to state and document that Dr Holmes had completed more than 90 hours of continuing medical education. The revised application did not include a current and complete Delineation of Privileges form as requested, nor did it provide evidence that Dr Holmes had performed sufficient ophthalmologic surgical procedures in the previous 24 months in a hospital or surgical setting. In addition, Dr Holmes's application contained no information whatsoever that she had recently performed or was currently clinically competent for Core privileges in the area of Ophthalmology and Associate status. According to the Hospital's files, Dr Holmes had not admitted or surgically treated any patients at the Hospital since 1998 and her application did not contain any information that she had ever admitted patients or performed surgery at that or any other hospital or accredited surgical facility.

31 Upon my review of Dr Holmes's 2008 credentials file, as well as the 2007 Bylaws, it is my expert opinion, within a reasonable degree of certainty in the area of Hospital Medical Staff Bylaws and Physician Credentialing, that the Hospital was in compliance with the 2007 Bylaws and the local and national standard of care in the field of physician credentialing in their actions with respect to Dr Holmes's 2008 reappointment application. Dr Holmes was not entitled to a hearing or appeal rights as a result of the Hospital's action on her 2008 reappointment application, which was incomplete on its face.

32 The process for reappointment at the Hospital in the 2006 and the 2008 Bylaws mirrors those at similar facilities locally and nationally. It is clearly both an industry and local standard to require the applicant to provide adequate documentation

of current clinical competency for the medical staff status and privileges requested. Given the information provided by Dr. Holmes in both her 2006 and 2008 reappointment applications, I believe had she been a Consulting Medical Staff member at any healthcare facility in the country and had she requested similar changes as she did in her 2006 and 2008 reappointment applications, her applications would have been handled in exactly the same manner as the Hospital handled them.

33 It is my expert opinion, within a reasonable degree of certainty in the area of Hospital Medical Staff Bylaws and Physician Credentialing, that Dr. Holmes failed to provide sufficient information to demonstrate her current clinical competence to support her request for surgical privileges in 2006 as required in the 2006 Bylaws. In fact, none of the documentation Dr. Holmes submitted in support of her 2006 application demonstrated that she had current or recent hands-on experience in the surgical procedures for which she was requesting privileges.

34 While Dr. Holmes's 2006 reappointment application includes what appear to be notes regarding office examinations of her patients, the notes were undated, did not contain identifying patient information, were not compiled in a hospital or accredited surgical facility setting, and did not demonstrate that she had recently performed or had the ability to competently perform the surgical procedures requested. Moreover, Dr. Holmes's records failed to show that she had recently admitted or surgically treated any patients at the Hospital or any other hospital or accredited surgical facility.

35 Likewise, Dr. Holmes's 2008 reappointment application failed to include even the insufficient office notes submitted by her as part of her 2006 reappointment application. The documents I've reviewed show Dr. Holmes was given the opportunity

to supplement her applications in 2006 and 2008 with information sufficient to demonstrate her current clinical competency, but she failed to do so

36 Dr Holmes's 2006 reappointment application was deemed insufficient to establish her clinical competence to perform surgery on the eye Dr Holmes requested and was afforded an appeal and hearing on this determination in conformity with the 2006 Bylaws The appeal was decided against Dr Holmes and her reappointment to the Consulting Medical Staff was affirmed

37 Dr Holmes's 2008 application was deemed incomplete for, among other things, her failure to complete the required Delineation of Privileges form As a result, because her application was incomplete in 2008, it was deemed voluntarily withdrawn and, consequently, Dr Holmes was also deemed to have resigned from the Medical Staff

38 I am familiar with the immunity provided by the laws of South Carolina and by federal law for physician credentialing and peer review activities through my experience referenced earlier in my Affidavit It is my opinion to a reasonable degree of certainty in the field of Hospital Medical Staff Bylaws and Physician Credentialing that there is no evidence of malice on the part of the defendants concerning Dr Holmes's 2006 and 2008 reappointment processes, that the Hospital made a reasonable effort to obtain the facts relating to her application, and that the Hospital acted in the belief that the action taken was warranted by the facts known to them In my expert opinion, Dr Holmes's 2006 and 2008 reappointment applications and her administrative appellate process regarding her 2006 reappointment were conducted in accordance with the

Hospital's Bylaws and the standard of care in the healthcare industry applicable to the credentialing of physicians

Donald A. Pocock

Donald Pocock, M D

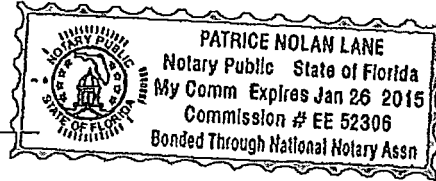
Sworn to before me this 27 day

of June, 2011,

Patrice Nolan Lane

NOTARY PUBLIC FOR Florida

My Commission Expires 1-26-15



7-5-11

STATE OF SOUTH CAROLINA) IN THE COURT OF COMMON PLEAS
COUNTY OF CHARLESTON) C A NO 2010-CP-10-3410

Dr Cynthia Holmes M D ,
Plaintiff,

vs

East Cooper Community Hospital Inc
and Tenet HealthSystem Medical Inc ,
Defendants

Defendants' Memorandum in Support of
Motion for Summary Judgment

Plaintiff Cynthia Holmes, M D ("Plaintiff") is a medical doctor specializing in the field of ophthalmology, as well as an attorney licensed to practice law in South Carolina under the name Cynthia Collie, Esq. This lawsuit constitutes at least the sixth lawsuit filed by the Plaintiff against Defendants East Cooper Community Hospital, Inc., Tenet HealthSystem Medical, Inc., (collectively "Defendants") and others concerning her medical staff privileges at East Cooper Medical Center (hereinafter referred to as the 'Hospital'). The dispute began in 1997 and has resulted in over twelve (12) years of more or less continuous litigation. As shown in previous filings attached to the Defendants' Answer in this lawsuit, the Plaintiff has been warned or sanctioned by appellate and trial courts multiple times in these lawsuits.

The present lawsuit is a continuation of the Plaintiff's previous litigation activities. Specifically, the Plaintiff alleges that Defendants breached a contract or breached a covenant of good faith and fair dealing in denying her 2006 and 2008 applications for medical staff privileges with the Hospital. Essentially, the Plaintiff applies for reappointment to the Hospital's medical staff every two (2) years and files suit against the Defendants when her simultaneous requests for an advancement in staff category

and surgical privileges are denied. When the Plaintiff alleged in a previous lawsuit filed in 2005 that Defendants breached the exact same contract and the exact same covenant in denying her 2002 and 2004 applications for identical privileging requests, the Honorable R. Markley Dennis, Jr. held, in two separate orders, that the circuit court lacks jurisdiction to review the privileging decision of a private, for-profit hospital. In one of these orders, Judge Dennis sanctioned the Plaintiff and awarded Defendants a judgment of \$90,000.00.

This Court should grant summary judgment to Defendants in the present lawsuit for the identical reason, namely, the circuit court respectfully lacks jurisdiction to consider the privileging decisions of a private, for-profit hospital. Moreover, since the Plaintiff previously argued that the exact same contract somehow waived the circuit court's lack of subject matter jurisdiction and since Judge Dennis previously rejected this argument, Judge Dennis's previous orders operate as *res judicata* and collateral estoppel against the Plaintiff in this lawsuit. Defendants are entitled to summary judgment on either basis.

In addition, even if the circuit court had subject matter jurisdiction over the Plaintiff's claims, Defendants would be entitled to summary judgment because they unequivocally complied with the plain language of the contract the Plaintiff alleges was breached. Specifically, the Plaintiff failed to produce evidence sufficient to create a genuine issue of material fact that the Defendants breached a contract to consider her 2006 and 2008 applications in accordance with the Bylaws. To the contrary, the Defendants complied with the Bylaws in effect during each application, as a matter of law.

Finally, Defendants are entitled to immunity under state and federal law, which protect hospitals from suits such as this one brought by the Plaintiff. Summary judgment should alternatively be granted on this basis.

Factual and Procedural Background

As an initial matter, the evidence produced by the Defendants in support of this Motion arises from two (2) general sources. First, the Defendants attached a significant amount of Court Orders and previous filings by the Plaintiff to their Answer to the Plaintiff's Complaint. **See Defs' Answer filed on 09/17/2010 ("Answer")**. These will be referenced herein as Exhibits to the Answer.

Second, the Defendants produced and filed with the Court several affidavits in support of their Motion, which were served on the Plaintiff at least ten (10) days prior to the date of the hearing of this Motion. These affidavits include the Affidavit of Elaine B. Meuli (Meuli Aff'), who has served as the Director of Medical Staff Services for the Hospital at all times pertinent hereto, the Affidavit of Donald Pocock, M.D. (Pocock Aff'), an expert in medical staff bylaws and physician credentialing, and the Affidavits of members of the Hospital's committees that evaluated the Plaintiff's applications in 2006 and 2008. The Plaintiff's pertinent applications, hearing files, and the applicable Medical Staff Bylaws have been attached to Meuli's Affidavit.

The following constitutes a synopsis of the evidence produced in this matter, viewed in a light most favorable to the non-moving party, i.e. the Plaintiff. Defendant East Cooper Community Hospital, Inc., owns, operates and does business as East Cooper Medical Center (Hospital'), a private, for-profit hospital in Mount Pleasant,

South Carolina, and is a subsidiary of Defendant Tenet HealthSystem Medical, Inc
Answer, ¶2

Plaintiff practices ophthalmology in Sullivan's Island, South Carolina **Plt's Compl ("Compl") ¶4** Although she has been in practice since 1994, she is not Board-certified in ophthalmology, does not have admitting or surgical privileges at any healthcare facility and, upon information and belief, has not performed surgery in any hospital or accredited surgical facility since 1998 **Ex A to Meuli Aff, Plt's 2006 Credentials File ("2006 Credentials File"), p 3, §15, Bagwell Aff ¶14, Narang Aff ¶18, Stroud Aff ¶16, Darby Aff ¶15** As discussed below, this lawsuit constitutes her fourth action against the Hospital and her sixth suit arising from the same chain of events

I The First Lawsuit

The Plaintiff was initially granted medical staff privileges by the Hospital in January 1994 **Ex A to Answer, p 30 (Plt's Am Compl in 1999 Lawsuit, ¶8)** In 1997, a dispute arose between the Plaintiff and the Hospital over her staff category and privileges at the Hospital **Id p 36, ¶¶29-30** Plaintiff filed a federal lawsuit against the Defendants and others arising from this dispute, alleging, inter alia that the Defendants breached a contract by their application of the Medical Staff Bylaws to the Plaintiff **Id** While the federal judge initially provided Plaintiff with injunctive relief, he later dissolved the injunction and chastised the Plaintiff for her conduct

The federal judge eventually granted the Defendants summary judgment on the Plaintiff's claims arising under federal law and declined to exercise jurisdiction over her

state law claims **Ex A to Answer, p 73** The Fourth Circuit Court of Appeals affirmed, and the United States Supreme Court denied certiorari review

II The Second Lawsuit

The Plaintiff later filed a legal malpractice action in state court against the attorneys who represented her in federal first lawsuit **Ex A to Answer, pp 146-164** The Honorable Thomas L. Hughston, Jr., granted the defendants in this legal malpractice action a directed verdict and awarded them \$200,000.00 in sanctions against the Plaintiff under the South Carolina Frivolous Civil Proceedings Sanctions Act **Ex B to Answer, Order on Post-Trial Motions filed Nov. 18, 2009 in Case No. 2007-CP-10-1444**

III The Third Lawsuit

In 2000, the Plaintiff filed an action in state court against the Defendants herein and others, again alleging that the Defendants breached a contract in their application of the Medical Staff Bylaws to the Plaintiff **Ex A to Answer, pp 74-97** On October 28, 2002, the parties reached a settlement, which included the Plaintiff's reappointment to the consulting category of the medical staff for a two year term beginning in December 2002 **Ex A to Answer, pp 20-26 (the "Settlement Agreement")** The agreement consummating the settlement of this lawsuit provides, in pertinent part "Dr. Holmes shall have the right to apply for a change in status in accordance with the Bylaws" **Settlement Agreement, pp 1-2** It is this provision of the Settlement Agreement that the Plaintiff alleges was breached in her current lawsuit **Compl., ¶¶6, 12**

IV The Fourth Lawsuit

The Plaintiff also sued the attorneys who represented her in the above-referenced third lawsuit filed in state court **Ex A to Answer, pp 131-145** On December 2, 2009, the Supreme Court of South Carolina issued an Order denying the Plaintiff's petition for certiorari in an appeal of that lawsuit, explaining "[T]his action is just one in a number of frivolous actions petitioner has filed relating to the revocation of her medical staff privileges at East Cooper Community Hospital *in 1997*" **Ex B to Answer, Order of Supreme Court of South Carolina filed Dec 2, 2009 in Case No 2007-CP-10-4351** (emphasis in original) "Because we find the petitioner has engaged, and continues to engage in, vexatious litigation related to that issue, we hereby direct the Clerks of Court in this state to refuse to accept further filings from petitioner in actions related in any way to the revocation of her medical staff privileges at East Cooper Community Hospital unless they are filed by an attorney, other than petitioner, licensed to practice law in this state " **Id** In a footnote, the Court quoted extensively to Judge Hughston's Order sanctioning the Plaintiff in the second lawsuit, referenced above as follows

Throughout the history of this case, Dr Holmes has proven herself to be profoundly litigious Since being assigned to Courtesy Staff at East Cooper Hospital in 1997, Dr Holmes engaged in a lengthy, albeit fruitless, administrative appeal of the Hospital's decision She then sued the Hospital in federal court, and failing there, in state court She sued Mr Becker and Mr Grier and their law firm over the handling of the federal case She sued two Tennessee lawyers in both South Carolina and Tennessee state courts over their role in achieving a settlement of her state court case against the Hospital In 2005, Dr Holmes sued the Hospital in a second action, alleging a wide array of complaints against the Hospital and several physicians, the gist of which was that the Hospital continued to refuse to increase her level of

privileges In Dr Holmes' 2005 case against East Cooper Hospital, which the Court deemed to be barred by her settlement of the 2000 case, the Court imposed a \$90,000 sanction for violation of the [South Carolina Frivolous Proceedings] Act In each of the cases Plaintiff has filed *pro se* since settling her 2000 state court case against East Cooper Hospital, Plaintiff has asserted baseless and frivolous claims for which she lacked any evidentiary support She has launched numerous pointless appeals, every one of which has been resolved in favor of the respondents Throughout, Plaintiff has made baseless, maybe scandalous, allegations against numerous physicians and lawyers without care, and in absence of evidentiary support Her tactics have been dilatory, vexatious, that is brought without sufficient grounds, oppressive and unreasonable

Plaintiff's conduct through the case appears to have been nothing but vexatious, that is, brought without sufficient grounds, and the maintenance of this completely frivolous claim can only be characterized as unreasonable As before, Dr Holmes was the losing party in a lawsuit a decade ago She has persisted in pursuing this case for nearly a decade yet has never adduced a shred of evidence that anything the Defendants did made any difference in the outcome of the federal court action about which she complains

Clearly, Plaintiff has abused the judicial system generally, and these Defendants in particular, with her unreasonable and ill considered frivolous lawsuit Throughout this matter, and in her other cases, Dr Holmes has repeatedly shown that she is unwilling and unable to evaluate the merits of her own cases, and that she is unable to present any evidence to support her claims She has evidenced a pattern of abusing the legal process in bringing frivolous actions and the potential remains for her to continue that practice unless severe sanctions are levied against her

Id at note 2 In another footnote, the Supreme Court specifically pointed to Cynthia Holmes, M D v East Cooper Community Hospital, Inc , Tenet Healthsystem Medical, Inc , John Grady M D , Paul Yantis, M D (2005-CP-10-5113) as one of the Plaintiff's frivolous lawsuits Id at note 3

V The Fifth Lawsuit

The case referenced in the Court's footnote, designated as Case No 2005-CP-10-5113, was the fifth lawsuit directly arising from the 1997 dispute Id at note 3, **Ex C to Answer, Plt 's Am Compl in Case No 2005-CP-10-5113, filed April 13,2006 ("2005 Am Compl ")** The Plaintiff's current attorney, Chalmers C Johnson, represented her through the summary judgment stage of that lawsuit, and through her first of several appeals of the Court's orders in that lawsuit Id

In 2005, the Plaintiff filed a complaint against Defendants and others, concerning her 2002 and 2004 reappointments to the Hospital's Medical Staff Id at ¶15 In this fifth case, the Plaintiff filed a cause of action for breach of contract, alleging not only that the Defendants breached its Medical Staff Bylaws during these reappointments, but that these reappointments were in breach of the subject Settlement Agreement Id at ¶30, **Ex D to Answer, Plt 's Response to Defs ' Mot to Dismiss filed 11/06/2006 in Case No 2005-CP-10-5113, p 1 ("Plt 's Response")** The circuit court initially dismissed all claims in this action arising from the Plaintiff's 2002 application because these claims had been resolved in the subject Settlement Agreement **Ex E to Answer, Order Pursuant to Defs ' Mot to Dismiss filed 11/29/2006 in Case No 2005-CP-10-5113** The circuit court later granted summary judgment to the Defendants on the Plaintiff's remaining claims regarding her 2004 reappointment **Ex H to Answer, Order filed 05/23/2007 in Case No 2005-CP-10 5113 ("Summary Judgment Order")** The circuit court held that it lacked jurisdiction to consider the privileging decisions of a private, for-profit hospital and, in any event, the Plaintiff failed to produce evidence sufficient to create a genuine issue of material fact as to any of her claims Id at pp 3 4

The circuit court then sanctioned the Plaintiff pursuant to the South Carolina Frivolous Civil Proceedings Sanctions Act, awarding the Defendants in this fifth case \$90,000 in attorneys' fees as a sanction **Ex B to Answer, Order Awarding Sanctions filed 08/06/2009 in Case No 2005-CP-10-5113 ("Sanctions Order")** The Plaintiff's appeal of the order sanctioning her was also dismissed and remitted by the South Carolina Court of Appeals The South Carolina Supreme Court refused to grant certiorari review to the decision of the Court of Appeals in this respect **Ex B to Answer, Order of Supreme Court of South Carolina filed July 8, 2010 in Case No 2005-CP-10-5113**

In addition, and true to form, the Plaintiff appealed the circuit court's order granting summary judgment to the Defendants three (3) separate times, and each time the appeal was dismissed and remitted

VI The Sixth Lawsuit

The Plaintiff's sixth lawsuit is the present lawsuit, which again alleges that the Defendants breached the Settlement Agreement and the Medical Staff Bylaws **Compl ¶¶14-21** Specifically, the present lawsuit alleges that the Defendants breached the Settlement Agreement by failing to process the Plaintiff's applications for reappointment in accordance with the Bylaws in 2006 and 2008 **Compl ¶¶12-21** As shown in a filing in the Plaintiff's above-referenced fifth lawsuit, this is the same allegation she made in that lawsuit with respect to her 2004 application—that the Defendants breached the Settlement Agreement by failing to consider her 2004 application in accordance with the Bylaws **Plt's Response, p 1** Further, the Plaintiff's filings associated with her 2006 application show that she again seeks to re-hash previous disputes beginning in 1997

See Ex C to Meuli Aff , Plt's 2006 Hr'g File, Plt's Suppl Hr'g Submission dated 04/28/2007, Background Section

Standard of Review

"Summary judgment is appropriate when there is no genuine issue of material fact such that the moving party must prevail as a matter of law " David v McLeod Reg'l Med Ctr, 367 S C 242, 247, 626 S E 2d 1, 3 (2006) "In determining whether any triable issues of fact exist, the court must view the evidence and all reasonable inferences that may be drawn from the evidence in the light most favorable to the non-moving party " Id "The purpose of summary judgment is to expedite disposition of cases which do not require the services of a fact finder " George v Fabri, 345 S C 440, 452, 548 S E 2d 868, 874 (2001)

Under Rule 56(c), the party seeking summary judgment has the initial responsibility of demonstrating the absence of a genuine issue of material fact Sides v Greenville Hosp Sys, 362 S C 250, 255, 607 S E 2d 362, 364 (Ct App 2004) With respect to an issue upon which the nonmoving party bears the burden of proof, this initial responsibility may be discharged by "showing'-that is, pointing out to the trial court-that there is an absence of evidence to support the nonmoving party's case Id The moving party need not support its motion with affidavits or other similar materials *negating* the opponent's claim Id Once the moving party carries its initial burden, the opposing party must come forward with specific facts that show there is a genuine issue of fact remaining for trial Id

"[W]hen plain, palpable, and indisputable facts exist on which reasonable minds cannot differ, summary judgment should be granted " Hedgepath v Am Tel & Tel Co,

348 S C 340, 355, 559 S E 2d 327, 336 (Ct App 2001) "A court considering summary judgment neither makes factual determinations nor considers the merits of competing testimony, however, summary judgment is completely appropriate when a properly supported motion sets forth facts that remain undisputed or are contested in a deficient manner ' David, 367 S C at 250, 626 S E 2d at 5 'A complete failure of proof concerning an essential element of the non-moving party's case necessarily renders all other facts immaterial " Gauld v O'Shaugnessy Realty Co., 380 S C 548, 559, 671 S E 2d 79, 85 (Ct App 2008)

"The question of subject matter jurisdiction is a question of law for the court, not a jury question " Chew v Newsome Chevrolet, Inc., 315 S C 102, 104, 431 S E 2d 631, 631 (Ct App 1993) "If the facts which give rise to a jurisdictional issue are in dispute, the court, not a jury, must find the facts " Id Likewise, '[t]he construction of a clear and unambiguous contract presents a question of law for the court " S C Dep't of Transp v M & T Enterprises of Mt Pleasant, LLC, 379 S C 645, 655, 667 S E 2d 7, 13 (Ct App 2008)

Law/Analysis

I The Court respectfully lacks subject matter jurisdiction to review the privileging decisions of a private, for-profit hospital

Initially, as Judge Dennis ruled in the Plaintiff's previous lawsuit, containing almost identical allegations, the circuit court respectfully lacks jurisdiction to review the privileging decisions of a private, for-profit hospital

"Generally speaking, subject matter jurisdiction is the power to hear and determine cases of the general class to which the proceedings in question belong " Metts v Mims, 384 S C 491, 498, 682 S E 2d 813, 817 (2009) "Claims of lack of

subject matter jurisdiction may be raised at any time, and subject matter jurisdiction may not be waived by filing responsive pleadings or otherwise consenting to the jurisdiction of a particular court ” Eldridge v City of Greenwood, 331 S C 398, 408, 503 S E 2d 191, 196 (Ct App 1998)

‘It is well settled in South Carolina, and throughout the country, that it is improper for the courts to review the decisions of governing boards of private hospitals concerning the staff privileges of practitioners ” Wood v Hilton Head Hosp , Inc., 292 S C 403, 405, 356 S E 2d 841, 842 (1987) Thus, “the implementation of the regulations of a private hospital which are initiated to restrict a practitioner's practices are not subject to judicial review ” Id., Gowan v St Francis Cmty Hosp, 275 S C 203, 204, 268 S E 2d 580, 581 (1980) (“Here we are not persuaded respondent's implementation of such regulations to the restriction of appellant's practice in its hospital requires us to depart from the long-standing principle that such action is not subject to judicial review ”), see also Strauss v Marlboro County Gen Hosp, 185 S C 425, 194 S E 65, 65 (1937) (‘It is conceded, we understand, that if Marlboro County General Hospital is a private institution, the action must fail and the appeal be dismissed ”)

In the instant case, it is undisputed that the Hospital is a private, for-profit hospital Moreover, one need not go beyond the Plaintiff's Complaint to determine that the Plaintiff's claims would necessitate that the Court review the 2006 and 2008 privileging decisions of the Hospital with respect to the Plaintiff in order to grant the Plaintiff any relief In fact, the Plaintiff's entire lawsuit is grounded upon the following allegation “Defendants breached this duty by attempting (successfully to date) to block Plaintiff from being able to seek review of its decision *to deny her application for*

advancement in staff privileges in violation of the letter and the spirit of the applicable bylaws ' **Compl ¶14** (emphasis added) Plaintiff continues on to allege "The Credentials Committee then denied the Plaintiff's application, an act which should have given Plaintiff the right to pursue an appeal, under the applicable bylaws" **Compl ¶16** (double emphasis added)

Moreover, while the Plaintiff appears to allege that the Settlement Agreement somehow conferred subject matter jurisdiction on this Court to review the Hospital's future privileging decisions, this allegation should be roundly rejected for alternative reasons. First, nothing in the plain language of the Settlement Agreement purports to confer subject matter jurisdiction on the Court to review future privileging decisions of the Hospital. **See Settlement Agreement**. See, e.g., Ecclesiastes Prod Ministries v Outparcel Assocs., LLC, 374 S C 483, 497, 649 S E 2d 494, 501 (Ct App 2007) ("A release is a contract and contract principles of law should be used to determine what the parties intended"), Schulmeyer v State Farm Fire & Cas. Co., 353 S C 491, 495, 579 S E 2d 132, 134 (2003) ("If the contract's language is clear and unambiguous, the language alone determines the contract's force and effect")

Second, even if the Settlement Agreement unambiguously stated that the parties consented to this Court reviewing the Hospital's future privileging decisions (which it does not), the agreement would be void and of no effect because parties cannot, by contract or otherwise, confer subject matter jurisdiction on the Court. See, e.g., GNOC Corp v Estate of Rhyne, 312 S C 86, 88, 439 S E 2d 274, 275 (1994) ("The question of lack of subject matter jurisdiction may be raised at anytime during the action and *cannot be waived or conferred by consent*') (emphasis added), 20 Am Jur 2d Courts

§ 95 ('In general, the jurisdiction of courts is a public matter that cannot be affected by a private agreement, and the jurisdiction of a court can neither be acquired nor lost as a result of an agreement of the parties '), 21 C J S Courts § 84 ("[A]s a general rule, where the court has no jurisdiction of the cause of action or subject matter involved in a particular case, such jurisdiction cannot be conferred by consent, agreement, contract, stipulation, or by other conduct or action of the parties ")

As the Supreme Court of South Carolina has clearly stated, "it is improper for the courts to review the decisions of governing boards of private hospitals concerning the staff privileges of practitioners ' Wood, 292 S C at 405, 356 S E 2d at 842 This holds true regardless of whether there is a contract providing otherwise Notably, the Settlement Agreement does not provide otherwise in this case Accordingly, this action should be dismissed pursuant to Rule 12(b)(1), SCRPC

II Defendants are entitled to summary judgment on the basis of res judicata or collateral estoppel because many of the issues raised by the Plaintiff in this action have been previously litigated and decided

In the 2005 lawsuit against Defendants, as in the instant matter, the Plaintiff alleged, among other things, that the Hospital breached the Settlement Agreement in its review of her applications for medical staff privileges **Plt's Response, p 1** Nevertheless, this Court granted summary judgment to the Defendants, recognizing that the Court did not have jurisdiction to review the Hospital's 2002 and 2004 privileging decisions with respect to the Plaintiff **Summary Judgment Order, pp 3-4** This Court also sanctioned the Plaintiff for her frivolous argument on this point **Sanctions Order, pp 14-16** Both orders were upheld on appeal and, accordingly, this Court should

respectfully grant Defendants' motion for summary judgment on the grounds of res judicata and/or collateral estoppel

"In a subsequent suit between the same parties on a different claim, the former judgment is conclusive as to those issues actually determined in the prior action " Pye v Aycock, 325 S C 426, 433, 480 S E 2d 455, 458 (Ct App 1997) "A plea of *res judicata* applies to those matters actually adjudicated in the former action " Id 'Under the doctrine of collateral estoppel, when an issue of fact or law is actually litigated and determined by a valid and final judgment, and the determination is essential to the judgment, the determination is conclusive in a subsequent action between the parties, whether on the same or a different claim " Carman v S C Alcoholic Beverage Control Comm'n 317 S C 1, 6, 451 S E 2d 383, 386 (1994)

In her 2005 lawsuit against the Defendants, the Plaintiff alleged that the Defendants breached a contract and a covenant of good faith and fair dealing in considering the Plaintiff's 2002 and 2004 applications for medical staff privileges **2005 Am Compl** The allegations relating to these causes of action in the 2005 lawsuit are almost identical to the allegations supporting her present lawsuit

2005 Lawsuit	2010 Lawsuit
The Plaintiff and Defendant [sic] were and are parties to a contractual agreement, the terms of which are set forth in the Medical Staff Bylaws, Rules, Regulations, and related documents 2005 Am Compl ¶¶19, 30(1), 31(2) ¹	The Plaintiff and Defendant [sic] were and are parties to a contractual arrangement, the terms of which are set forth as part of a settlement agreement Compl ¶12
As with every contractual relationship, this contract involved an implied covenant of	As with every contractual relationship, this contract involved an implied covenant of

¹ The Plaintiff's Amended Complaint in the 2005 lawsuit includes two separate paragraphs labeled 30, 31, 32, 34, and 36 The parenthetical next to the referenced paragraph indicates whether the citation is to the first such paragraph (1) or the second (2)

good faith and fair dealing 2005 Am Compl ¶32(2)	good faith and fair dealing Compl ¶13
That the Defendant [sic] breached this duty by attempting (successfully to date) to block Plaintiff from being able to seek review of its decision to deny her application for advancement in staff privileges by claiming, fraudulently, that Plaintiff's application for privileges was incomplete, when it was not 2005 Am Compl ¶33(2)	That the Defendant [sic] breached this duty by attempting (successfully to date) to block Plaintiff from being able to seek review of its decision to deny her application for advancement in staff privileges in violation of the letter and the spirit of the applicable bylaws Compl ¶14
In 2002 and 2004 (in each of the two years), Plaintiff submitted an application for advancement in staff privileges, which was complete on its face 2005 Am Compl ¶34(2)	In 2006-2007 and 2008-2009 (in each of two years), Plaintiff submitted an application for advancement in staff privileges, which was complete on its face Compl ¶15
The Credentials Committee then denied the Plaintiff's application, an act which should have given Plaintiff the right to pursue an appeal, under the Contract 2005 Am Compl ¶36(2)	The Credentials Committee then denied the Plaintiff's application, an act which should have given the Plaintiff the right to pursue an appeal, under the applicable bylaws Compl ¶16

With respect to her allegation in the 2005 lawsuit that the Plaintiff and Defendants were parties to a contractual agreement "the terms of which are set forth in the Medical Staff Bylaws, Rules and Regulations, *and related documents*," the Plaintiff later confirmed in the 2005 lawsuit that these "related documents" included the Settlement Agreement—the same contract she alleges was breached in the present case

The defendant [sic] claims that a settlement agreement executed by the parties which required that the Plaintiff be reappointed to the consulting staff in 2002 precludes Plaintiff from suing in this case because she was, actually, reappointed to the consulting staff in 2002. The Defendant [sic] misinterprets the complaint, which should be clear on its face. Plaintiff was given two rights under the former agreement. One was to be reappointed to the consulting staff in 2002 for two years. The other, as Defendant [sic] explains in its own brief, was that the Plaintiff would have the right to apply for a change in status pursuant to the by-laws

It is the denial of the Plaintiffs right to apply for a change in status pursuant to the by-laws which is the basis of her claims in this case

Plt 's Response, p 1 (double emphasis added)

As previously discussed, in the 2005 lawsuit, this Court granted summary judgment to Defendants **Summary Judgment Order** In addressing the allegations set forth above relating to the Plaintiff's 2004 application, which are almost identical to the claims set forth in the current case relating to the Plaintiff's 2006 and 2008 applications, this Court held, in pertinent part

The Plaintiffs Amended Complaint seeks judicial determination of whether the decisions regarding her credentialing and privileges at East Cooper Hospital were reasonable and in compliance with the Hospital's Bylaws Specifically, she requests the Court to review whether the failure to process and consider her application for associate status and surgical privileges, her reappointment to the consulting staff, and the denial of an administrative hearing were reasonable decisions made in accordance with the Bylaws The Plaintiff's claims all arise out of the peer review process at East Cooper Hospital and, as such, are not subject to judicial review The Court does not have jurisdiction to determine these issues and the Plaintiff has presented no evidence or reason to persuade the Court to depart from the long-standing principle that such actions are not subject to judicial review

Summary Judgment Order, p 4 (double emphasis added) Plaintiff appealed this order to the South Carolina Court of Appeals three separate times, and the Court of Appeals dismissed and remitted the appeal each time

This Court re-emphasized its ruling in a subsequent order sanctioning Plaintiff for litigating the issue

Despite clear case law to the contrary, the Plaintiff filed this action seeking judicial determination of whether the decisions regarding her credentialing and privileges were

)

reasonable and in compliance with the Hospital's Bylaws

Specifically, she sought the Court to review whether the failure to process and consider her application for associate status and surgical privileges, her reappointment to the consulting staff, and the denial of an administrative hearing were reasonable decisions made in accordance with the Bylaws. The Plaintiff's claims all arose out of the peer review process and, under South Carolina law, are not subject to judicial review, and the Plaintiff presented no evidence or reason to persuade the Court to depart from this long-standing principle.

Sanctions Order, p 15 (double-emphasis added) This order was also appealed by the Plaintiff. The Court of Appeals dismissed and remitted her appeal.

The present lawsuit is more of the same. The Plaintiff alleges, as she did in 2005, that the Defendants breached the Settlement Agreement in reviewing her applications for medical staff privileges. **Compl** The Court considered this argument and rejected it in two separate orders. **Summary Judgment Order, Sanctions Order** The appellate courts effectively affirmed these orders. Based on the foregoing, the Plaintiff should not be permitted to re-litigate the issues of whether the Court has subject matter jurisdiction to review the privileging decisions of a private, for-profit hospital or whether the Settlement Agreement somehow confers subject matter jurisdiction on the Court when it otherwise lacks such jurisdiction. Accordingly, Defendants respectfully request that the Court grant their motion for summary judgment on the basis of res judicata and/or collateral estoppel.

III As a matter of law, the Defendants complied with the bylaws applicable to the Plaintiff's 2006 and 2008 applications

Defendants should also be awarded summary judgment because they complied with the Settlement Agreement and because they reviewed the Plaintiff's 2006 and 2008 applications in accordance with the applicable bylaws, as a matter of law. The

Settlement Agreement provides, in pertinent part "Dr Holmes shall have the right to apply for a change in status in accordance with the Bylaws " **Settlement Agreement, pp 1-2** The construction of a clear and unambiguous contract is a question of law for the court Gardner v Mozingo 293 S C 23, 25, 358 S E 2d 390, 392 (1987)

A physician seeking to become a member of the Hospital's medical staff must first seek appointment **See 2006 Bylaws, Art V, §1 (p 19), 2007 Bylaws, Art V, §1 (p 20)**² A physician who is already a member of the medical staff must apply for reappointment at least every two years **See 2006 Bylaws, Art V §1 (p 19), 2007 Bylaws, Art V, §1 (p 20)** The Bylaws provide a detailed procedure for applicants seeking appointment or reappointment to the medical staff **2006 Bylaws, Art V, §§2-3 (pp 19-28), 2007 Bylaws, Art V, §§2-3 (pp 21-30)** An applicant for reappointment to the medical staff must provide specified information, including "at least objective evidence of the individual's *clinical competence* " **2006 Bylaws, Art V, §3 A (p 26)** (emphasis added), **2007 Bylaws, Art V, §3 A (p 28)** (emphasis added)

An applicant must also seek reappointment to a specified category within the medical staff **2006 Bylaws, Art V, §3 A 2 (p 26), 2007 Bylaws, Art V, §3 A 2 (p 28)** Pursuant to the Bylaws, the medical staff is divided into five categories, including, in pertinent part, associate staff and consulting staff **2006 Bylaws, Art IV, §1 (p 16), 2007 Bylaws, Art IV, §1 (p 16)** In addition to the foregoing, an applicant for reappointment to the medical staff must specify any clinical privileges he or she seeks **2006 Bylaws, Art V, §3 A 2 (p 26), 2007 Bylaws, Art V, §3 A 2 (p 28)**

² The 2006 Bylaws are attached as Exhibit D to the Affidavit of Elaine B Meuli, served on the Plaintiff and filed with the Court on June 28, 2011 The 2007 Bylaws are attached as Exhibit E to Meuli's Affidavit

In her 2006 and 2008 reappointment applications, the Plaintiff requested a change in status from a Consulting member to an Associate member of the Medical Staff **Meuli Aff ¶4, Ex A to Meuli Aff , Ex B to Meuli Aff** The Consulting Medical Staff consists of physicians who do not admit patients to the Hospital but who desire privileges to provide consultative services to patients at the request of Active or Courtesy staff physicians **See 2006 Bylaws, Art IV, §5 (p 18), 2007 Bylaws, Art IV, §5 (p 19)** Consulting staff members are not eligible to admit patients, perform surgery, vote, or hold office **See 2006 Bylaws, Art IV, §5 (p 18), 2007 Bylaws, Art IV, §5 (p 19)**

The 2006 Bylaws define the Associate Medical Staff as practitioners who meet all the criteria for Active Medical Staff membership except the minimum required number of in-hospital patient contacts per year **2006 Bylaws, Art IV, §3 A (p 17)** In order to allow adequate medical peer review of the smaller number of patient contacts by members of the Associate Medical Staff, all in-hospital patient contacts for Associate staff members are reviewed by the Department to which the practitioner is assigned **2006 Bylaws, Art IV, §3 A (p 17)** In addition, if the applicant desires privileges for surgical or invasive medical procedures, the applicant will be required to submit documentation of current clinical competence to the satisfaction of the appropriate Department Chairman and Credentials Committee **2006 Bylaws, Art IV, §3 A (p 17)**

In December 2007, the Hospital changed certain provisions relating to staff category, including the provision defining an Associate Medical Staff Member, in order to better ensure patient safety **2007 Bylaws, Art IV, §3 A (p 18)** These Bylaws define the Associate Medical Staff as practitioners who (i) do not have privileges at any

other hospital, but who (ii) meet all the criteria for active staff membership except the minimum number of admissions, procedures, or in-hospital patient contacts per year or preceding 12-month period **2007 Bylaws, Art IV, §3 A (p 18)** Further, surgical privileges were restricted to members of the Active Medical Staff only

Pursuant to the 2007 Bylaws, at the time of initial appointment and at all times subsequent thereto, a member of the Associate Medical Staff is required to meet all of the threshold criteria for exercising Core Privileges in his or her respective Department **2007 Bylaws, Art IV, §3 A (p 18)** The threshold criteria, which are identified by the Department and approved by the MEC, relate to minimum formal training, board certification, professional experience within the preceding twelve months and clinical references **2007 Bylaws, Art IV, §3 A (p 18)** In order to facilitate ongoing professional practice evaluation, all patient admissions, procedures and patient contacts by members of the Associate staff are reviewed by the Department to which the practitioner is assigned **2007 Bylaws, Art IV, §3 A (p 18)**

As shown in her 2006 and 2008 reappointment applications, the Plaintiff sought to be admitted as an Associate member of the Department of Surgery, with a specialty in Ophthalmology **Ex A to Meuli Aff, 2006 Credentials File, p 1, Ex B to Meuli Aff, 2008 Credentials File, p 1** Core Privileges for a member of the Associate Medical Staff specializing in ophthalmology surgery in 2006 and 2008 would include "the performance of surgical procedures on patients of all ages presenting with illnesses, injuries, and disorders of the eye, including its related structures and visual pathways" **2006 Credentials File, Delineation of Privileges Form, 2008 Credentials File, Delineation of Privileges Form, Stroud Aff ¶9** Thus, any applicant for

reappointment to the Hospital's Medical Staff seeking advancement to the Associate Medical Staff with a specialty in Ophthalmology was required to submit documentation of her current clinical competence to the satisfaction of the Chairman of the Department of Surgery and the Credentials Committee See 2006 Bylaws, Art IV, §3 A (p 17), 2007 Bylaws, Art IV, §3 A (p 18) This was also required as part of the Plaintiff's 2004 reappointment application, as set forth in the Bylaws in effect at the time **Pocock Aff** ¶14

A 2006 Reappointment Process

With respect to the Plaintiff's 2006 reappointment application, the reappointment process was spelled out in Article V, §3 of the 2006 Bylaws (pp 26-28) **Pocock Aff** ¶15 An application for reappointment to the Medical Staff is required to include objective evidence of the applicant's clinical competence based on peer review activities **Pocock Aff** ¶15, **2006 Bylaws, Art V, §3 A (p 26)** The applicant bears the burden of producing adequate information for a proper evaluation of the applicant's current competence in terms of the applicant's ability to practice in the area in which privileges were sought **Pocock Aff** ¶15, **2006 Bylaws, Art V, §3 C (p 27)** The department chairman, here the Chairman for the Department of Surgery, conducts an initial review and recommendation of the application, including any clinical privileges requested **Pocock Aff** ¶15, **2006 Bylaws, Art V, §3 E (p 28)** The Hospital's Credentials Committee reviews all pertinent information and makes a written recommendation to the Hospital's Medical Executive Committee ("MEC") concerning the member's reappointment and clinical privileges delineation **Pocock Aff** ¶15, **2006 Bylaws, Art V, §3 F (p 28)**

After receipt of the recommendation of the Credentials Committee, the MEC submits its recommendation to the Hospital's Governing Body regarding membership, staff category, and clinical privileges **Pocock Aff ¶16, 2006 Bylaws, Art V, §2 H (p 24)** The MEC may take action by recommending that the Governing Body reject the applicant's request for membership and/or privileges **Pocock Aff ¶16, 2006 Bylaws, Art V, §2 H (p 24)** When the recommendation of the MEC is adverse to the applicant, the applicant must be informed of the decision and advised of her hearing and appeal rights under the Bylaws **Pocock Aff ¶15, 2006 Bylaws, Art V, §2 H (p 24)** The Governing Body will not act upon an adverse recommendation of the MEC until after the affected individual has exercised or waived her right to a hearing and appeal under the Bylaws **Pocock Aff ¶15, 2006 Bylaws, Art V, §2 H (p 24)**

The applicant's hearing and appeal rights regarding an adverse recommendation (including the denial of a request for change in staff category) are set forth in Article VIII of the 2006 Bylaws **Pocock Aff ¶17** The affected practitioner has thirty (30) days following the date notice of the MEC's action is given in which to request a hearing **Pocock Aff ¶17, 2006 Bylaws, Art VIII, §2 A (p 47)** The hearing is held before a panel known as a Medical Review Committee ("MRC") with a hearing officer appointed to run the hearing **Pocock Aff ¶17, 2006 Bylaws, Art VIII, §2 D and §2 F (p 49)** The hearing procedure is governed by Article VIII, Section 3 of the 2006 Bylaws (pp 50-54) **Pocock Aff ¶17** The affected practitioner has the burden of proving, by clear and convincing evidence, that the action or recommendation of the body whose decision prompted the hearing is arbitrary, capricious, or unreasonable **Pocock Aff ¶17, 2006**

Bylaws, Art VIII, §3 H (p 53) The MRC shall render and deliver a written report and decision **Pocock Aff ¶17, 2006 Bylaws, Art VIII, §4 (p 54)**

Pursuant to Article VIII, Section 6 of the 2006 Bylaws (pp 57), the affected practitioner may then appeal the MRC's decision to the Governing Body **Pocock Aff ¶17** The grounds for the appeal are limited to substantial and prejudicial failure of the MRC or the MEC to comply with the Bylaws or to afford due process or a fair hearing, the action or recommendation that prompted the hearing, or any substantial part thereof was arbitrary and capricious or the MRC's decision or any substantial part was clearly contrary to the weight of the evidence **Pocock Aff ¶17, 2006 Bylaws, Art VIII, §6 C (p 55)** The Governing Body's written final decision will then be issued **Pocock Aff ¶17, 2006 Bylaws, Art VIII, §6 F (p 57)**

With respect to the Plaintiff's 2006 reappointment application, the Chairman of the Department of Surgery recommended that she be reappointed to the Consulting Medical Staff due to lack of adequate documentation that she was currently clinically competent for the Associate category and surgical privileges requested **Pocock Aff ¶18** The Credentials Committee then reviewed the Plaintiff's application, including the supporting documentation of management of 25 patients in her office practice **Pocock Aff ¶18, Bagwell Aff ¶14** The Credentials Committee noted that the documentation did not have patient names or dates and did not contain any evidence of surgical procedures performed by her **Pocock Aff ¶18, Narang Aff ¶18, Bagwell Aff ¶14** The Plaintiff also had no such activity at the Hospital since 1998 **Pocock Aff ¶18, Narang Aff ¶18, Bagwell Aff ¶14** As a result, the Credentials Committee determined that the Plaintiff did not provide adequate documentation of surgical expertise to support

her request for advancement to the Associate Medical Staff, which would have included Core Privileges in ophthalmologic surgery **Pocock Aff ¶18, Narang Aff ¶18, Bagwell Aff ¶4** The recommendation of the Credentials Committee was unanimous **Pocock Aff ¶18, Narang Aff ¶18**

The MEC then reviewed the Plaintiff's 2006 reappointment application **Pocock Aff ¶19, Narang Aff ¶18, Bagwell Aff ¶15** The MEC agreed with the Credentials Committee that the Plaintiff's application and accompanying information were insufficient to support her request for advancement to the Associate Medical Staff or for the Core Privileges incident thereto **Pocock Aff ¶19, Narang Aff ¶18, Bagwell Aff ¶15** The MEC also unanimously voted to recommend reappointment to the Consulting Medical Staff **Pocock Aff ¶19, Narang Aff ¶18**

The Plaintiff was advised of the MEC's recommendation that she be reappointed to the Consulting Medical Staff by letter, in compliance with the 2006 Bylaws **Pocock Aff ¶20, Bagwell Aff ¶16, see 2006 Bylaws, Art V, §2 H (p 24), 2006 Bylaws, Art VIII, §2 A (p 47)** She requested a hearing by letter dated January 15, 2007, and received a hearing in front of the MRC with a hearing officer **Pocock Aff ¶20, Bagwell Aff ¶16** The Hospital was in compliance with the 2006 Bylaws and the local and national standard of care in the field of Physician Credentialing in its actions regarding the hearing rights provided to the Plaintiff with respect to her 2006 reappointment application **Pocock Aff ¶20** Contrary to the allegations in her complaint, the Plaintiff was provided a fair hearing by the Hospital **Pocock Aff ¶20, Narang Aff ¶21, Bagwell Aff ¶17** She was given appropriate notice of the hearing, allowed input on the selection of the hearing officer, allowed to and did present written

briefs, information, objections and argument in support of her position, and was allowed to and did examine witnesses **Pocock Aff ¶20, Bagwell Aff ¶17**

After the MRC upheld the MEC's recommendation, the Plaintiff requested and received an appeal to the Governing Board **Pocock Aff ¶21, Narang Aff ¶21, Bagwell Aff ¶19** The Governing Board's final decision affirmed the recommendation of the Department Chairman, Credentials Committee, MEC, and MRC to reappoint her to the Consulting Medical Staff **Pocock Aff ¶21, Narang Aff ¶20, Bagwell Aff ¶19** The Plaintiff's appeal and the Governing Body's decision in this regard were in compliance with the 2006 Bylaws and the local and national standard of care in the field of physician credentialing **Pocock Aff ¶21**

The filings by the Plaintiff in support of her appeal of the recommendation of the MEC to reappoint her to the Consulting Medical Staff, in particular her Supplemental Hearing Submission dated April 28, 2007, show that her objections to the Hospital's actions in the present lawsuit arise from the same set of facts as her previous lawsuits—meeting minutes and other facts she alleges arose during a Credentials Committee meeting in 1997 **Pocock Aff ¶22** Her reappointment applications in 2004 and 2006 are substantially similar, involve almost identical provisions in the version of the Bylaws in effect in 2004 and the 2006 Bylaws, and involve substantially similar issues and arguments raised by her **Pocock Aff ¶22**

In particular, in her appellate submissions, the Plaintiff submitted what she claims are minutes from a 1997 meeting of the MEC to support her position that she should be advanced to the Associate Medical Staff **Pocock Aff ¶23, 2006 MRC Hr'g File** These submissions made by the Plaintiff, including references to litigation against the

defendants and others going back to 1999, have nothing to do with whether she is competent to perform surgery on the eye **Pocock Aff ¶23** In other words, they are not grounds for granting her request for advancement in staff category or surgical privileges **Pocock Aff ¶23** The Hospital was in compliance with the 2006 Bylaws and the local and national standard of care in the field of physician credentialing in their actions with respect to the Plaintiff's 2006 reappointment application **Pocock Aff ¶24**

B 2008 Reappointment Process

The Plaintiff's reappointment application in 2008 was similar to her 2006 and 2004 applications, but in contrast, the Plaintiff also failed to complete the required Delineation of Privileges form attached to her application **Pocock Aff ¶25, Darby Aff ¶¶13-14, Stroud Aff ¶¶15-16, Meuli Aff ¶¶6-7** In September 2007, the MEC instituted a requirement that all applicants and reapplicants to the Medical Staff were required to complete a Delineation of Privileges form as part of their application process to identify what privileges were being sought **Pocock Aff ¶26, Darby Aff ¶12, Stroud Aff ¶9, 2007 Bylaws, Art VI, §2 A (p 37)** This form set forth the threshold requirements for Core Privileges for the applicant's specialty **Pocock Aff ¶26, Darby Aff ¶12, Stroud Aff ¶9** Core Privileges are the grouping of basic procedures physicians are taught in their specific training program and should be qualified to perform into a single privilege for that category or specialty **Pocock Aff ¶26, Stroud Aff ¶9** Additional procedures that go beyond the Core Privileges and require additional training or experience are listed separately, and specific criteria are developed to qualify for procedures that fall outside Core Privileges **Pocock Aff ¶26, Stroud Aff ¶9**

During the time of the Plaintiff's reappointment application in 2008, the Core Privileges for Ophthalmology included the admission, work-up, diagnosis, and the performance of surgical procedures on patients of all ages presenting with illnesses, injuries, and disorders of the eye, including its related structures and visual pathways **Pocock Aff ¶26, Stroud Aff ¶9** To be eligible for Core Privileges within the specialty of ophthalmology, applicants were required demonstrate that they had performed at least 48 ophthalmologic surgical procedures in the preceding 24 months in a hospital or surgical outpatient setting **Pocock Aff ¶26, Darby Aff ¶12, Stroud Aff ¶9, 2008 Credentials File, Delineation of Privileges Form**

As shown in her 2008 reappointment application, the Plaintiff's 2006 reappointment as a member of the Consulting Medical Staff would end on November 13, 2008 **Pocock Aff ¶27, Darby Aff ¶13, Stroud Aff ¶15, Meuli Aff ¶6, 2008 Credentials File, p 1** A practitioner who fails to return an application or supply all of the required information within thirty (30) days prior to the expiration of the practitioner's current appointment period shall be deemed to have resigned the practitioner's medical staff membership **Pocock Aff ¶27, Darby Aff ¶8, Stroud Aff ¶6, 2007 Bylaws, Art V, §3 B (p 29)** A practitioner who is deemed to resign in this manner shall not be entitled to the hearing and appeal rights under the Bylaws **Pocock Aff ¶27, Darby Aff ¶8, Stroud Aff ¶6, 2007 Bylaws, Art V, §3 B (p 29)**

Despite the provision in the 2007 Bylaws requiring the reappointment application be completed within thirty (30) days prior to the expiration of her current appointment period, the Hospital did not receive the Plaintiff's reappointment application until November 6, 2008 **Pocock Aff ¶28, Darby Aff ¶13, Stroud Aff ¶15, Meuli Aff ¶6**

In her application, the Plaintiff again requested advancement from the Consulting Medical Staff to the Associate Medical Staff, however, she failed to complete the required Delineation of Privileges portion of her application attesting, among other things, that she had performed at least 48 ophthalmologic surgical procedures in the preceding 24 months **Pocock Aff ¶28, Darby Aff ¶13, Stroud Aff ¶15, Meuli Aff ¶6** In lieu thereof, the Plaintiff arbitrarily and unilaterally attached an outdated “laundry list” of surgical procedures she wished to be granted **Pocock Aff ¶28, Darby Aff ¶13, Stroud Aff ¶15, Meuli Aff ¶6**

Because of her failure to complete this portion of her application, the Hospital returned the application to the Plaintiff as incomplete on November 11, 2008, and provided her explicit instructions on how to complete the form **Pocock Aff ¶29, Darby Aff ¶14, Stroud Aff ¶15, Meuli Aff ¶7, Ex O to Answer** The letter returning the application was hand-delivered to the Plaintiff on November 12, 2008, with a warning that it needed to be completed on or before November 13, 2008, to comply with the 2007 Bylaws **Pocock Aff ¶29, Darby Aff ¶14, Stroud Aff ¶15, Meuli Aff ¶7, Ex O to Answer** As documented in her 2008 credentials file, multiple efforts were made to contact the Plaintiff regarding the incomplete form, and the Plaintiff initially communicated that the form was to be submitted as is **2008 Credentials File, Pocock Aff ¶29, Darby Aff ¶14, Stroud Aff ¶15, Meuli Aff ¶7, Ex O to Answer**

On November 13, 2008, the Plaintiff delivered a revised application for reappointment **Pocock Aff ¶30, Darby Aff ¶15, Stroud Aff ¶16, Meuli Aff ¶8** The revised application ignored the explicit instructions in the November 12, 2008 letter, and the only change from the previous application was to state and document that the

Plaintiff had completed more than 90 hours of continuing medical education **Pocock Aff ¶30, Darby Aff ¶15, Stroud Aff ¶16, Meuli Aff ¶8** The revised application did not include a current and complete Delineation of Privileges form as requested, nor did it provide evidence that the Plaintiff had performed sufficient ophthalmologic surgical procedures in the previous 24 months in a hospital or surgical setting **Pocock Aff ¶30, Darby Aff ¶15, Stroud Aff ¶16, Meuli Aff ¶8** In addition, the Plaintiff's application contained no information whatsoever that she had recently performed or was currently clinically competent for Core Privileges in the area of Ophthalmology or for Associate status **Pocock Aff ¶30, Stroud Aff ¶16**

According to the Hospital's files, the Plaintiff had not admitted or surgically treated any patients at the Hospital since 1998, and her application did not contain any information that she had ever admitted patients or performed surgery at that or any other hospital or accredited surgical facility **Pocock Aff ¶30, Darby Aff ¶15, Stroud Aff ¶16, Meuli Aff ¶8** The Hospital was in compliance with the 2007 Bylaws and the local and national standard of care in the field of physician credentialing in their actions with respect to the Plaintiff's 2008 reappointment application **Pocock Aff ¶31** The Plaintiff was not entitled to a hearing or appeal rights as a result of the Hospital's action on her 2008 reappointment application, which was incomplete on its face **Pocock Aff ¶31**

The process for reappointment at the Hospital in the 2006 and the 2007 Bylaws mirrors those at similar facilities locally and nationally **Pocock Aff ¶32** It is clearly both an industry and local standard to require the applicant to provide adequate documentation of current clinical competency for the medical staff status and privileges

requested **Pocock Aff ¶32** Given the information provided by the Plaintiff in both her 2006 and 2008 reappointment applications, had she been a Consulting Medical Staff member at any healthcare facility in the country and had she requested similar changes as she did in her 2006 and 2008 reappointment applications, her applications would have been handled in exactly the same manner as the Hospital handled them **Pocock Aff ¶32**

The Plaintiff failed to provide sufficient information to demonstrate her current clinical competence to support her request for surgical privileges in 2006 as required in the 2006 Bylaws **Pocock Aff ¶33** In fact, none of the documentation the Plaintiff submitted in support of her 2006 application demonstrated that she had current or recent hands-on experience in the surgical procedures for which she was requesting privileges **Pocock Aff ¶33**

While the Plaintiff's 2006 reappointment application includes what appear to be notes regarding office examinations of her patients, the notes were undated, did not contain identifying patient information, were not compiled in a hospital or accredited surgical facility setting, and did not demonstrate that she had recently performed or had the ability to competently perform the surgical procedures requested **Pocock Aff ¶34**. Moreover, the Plaintiff's records failed to show that she had recently admitted or surgically treated any patients at the Hospital or any other hospital or accredited surgical facility **Pocock Aff ¶34**

The Plaintiff's 2008 reappointment application failed to include even the insufficient office notes submitted by her as part of her 2006 reappointment application **Pocock Aff ¶35** The Plaintiff was given the opportunity to supplement her

applications in 2006 and 2008 with information sufficient to demonstrate her current clinical competency, but she failed to do so **Pocock Aff ¶35**

The Plaintiff's 2006 reappointment application was deemed insufficient to establish her clinical competence to perform surgery on the eye **Pocock Aff ¶36** She requested and was afforded an appeal and hearing on this determination in conformity with the 2006 Bylaws **Pocock Aff ¶36** The appeal was decided against her and her reappointment to the Consulting Medical Staff was affirmed **Pocock Aff ¶36**

The Plaintiff's 2008 application was deemed incomplete for, among other things, her failure to complete the required Delineation of Privileges form **Pocock Aff ¶37** As a result, because her application was incomplete in 2008, it was deemed voluntarily withdrawn and, consequently, the Plaintiff was also deemed to have resigned from the Medical Staff **Pocock Aff ¶37**

The Plaintiff's 2006 and 2008 reappointment applications and her administrative appellate process regarding her 2006 reappointment were conducted in accordance with the Hospital's Bylaws and the standard of care in the healthcare industry applicable to the credentialing of physicians **Pocock Aff ¶38** As a result, because the Plaintiff failed to produce any evidence demonstrating that the Defendants failed to comply with the Bylaws in considering the Plaintiff's 2006 or 2008 reappointment applications, and because the only evidence in the record shows to the contrary, the Defendants are respectfully entitled to summary judgment

IV State regulatory standards and accreditation agencies require the Plaintiff to reapply for reappointment periodically in accordance with the Hospital's Bylaws and emphasize that physicians are not entitled to membership on the medical staff or clinical privileges

Plaintiff appears to contend that, by virtue of her previous appointment to the Consulting Medical Staff, she has a "lifetime" right to membership on such staff. This contention defies state regulatory requirements, as well as national standards.

Both state and federal regulations, as well as the standards of the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO") and the Health Care Facilities Accreditation Program ("HCFAP"), specify that physicians may not provide care in most hospitals without a grant of clinical privileges by the hospital's board of directors. For instance, according to state regulatory provisions, "[e]ach hospital must have a single organized medical staff that has the overall responsibility for the quality of medical care provided to patients." S.C. ADC 61-16 §301. "The medical staff shall be appointed by the governing authority *in accordance with the hospital's bylaws*." Id. (emphasis added). "Prior to a physician's initial appointment and periodic reappointment, the governing authority shall assure itself that the physician is qualified and competent to practice in his profession." Id.

"To be eligible for membership on a staff an applicant must be licensed to practice in his profession in the State of South Carolina, competent in his respective field, worthy in character and in matters of professional ethics, *and meet the requirements of the hospital's bylaws*." S.C. ADC 61-16 §302 (emphasis added). "No individual is automatically entitled to membership on the medical staff or to the exercise of any clinical privilege merely because he is licensed to practice in any state, because he is a member of any professional organization, because he is certified by any clinical examining board, or because he has clinical privileges or staff membership at another hospital without meeting the criteria for membership established by the governing body."

of the respective hospital” Id. (emphasis added) “If accepted, an applicant shall be appointed periodically by the governing board and assigned as active staff, associate staff, consulting staff, courtesy staff, honorary staff, resident staff or similar staff classifications ’ SC ADC 61-16 §304

In this case, as has been previously discussed, the Plaintiff applied for reappointment to the medical staff in 2006 and 2008, as well as advancement to the Associate Medical Staff and surgical privileges. In both cases, her application was reviewed in accordance with the Bylaws, which required the Plaintiff to prove her current competence to perform ophthalmologic surgery. In 2006, she failed to meet her burden. In 2008, she failed to submit any evidence of current clinical competence.

As Donald Pocock emphasized, it is clearly both an industry and local standard to require the applicant to provide adequate documentation of current clinical competency for the medical staff status and privileges requested. **Pocock Aff ¶32** This standard is reinforced by applicable state regulations. Given the information provided by the Plaintiff in both her 2006 and 2008 reappointment applications, had she been a Consulting Medical Staff member at any healthcare facility in the country and had she requested similar changes as she did in her 2006 and 2008 reappointment applications, her applications would have been handled in exactly the same manner as the Hospital handled them. **Pocock Aff ¶32** Consequently, Defendants are entitled to summary judgment, as a matter of law.

V Defendants are entitled to immunity from this lawsuit under state and federal law

Section 40-71-10(c) and (c) of the South Carolina Code protects defendants from ‘monetary liability’ and “causes of action for damages” arising from the decision of an

appointed committee acting pursuant to written bylaws approved by a hospital's governing board if the committee members act without malice, have made a reasonable effort to obtain the facts relating to the matter under consideration, and act in the belief that the action taken by them is warranted by the facts known. The Executive Committee of a hospital's medical staff is a "committee" as defined in section 40-71-70(b). McGee v. Bruce Hosp. Sys., 312 S.C. 58, 61, 439 S.E.2d 257, 259 (1993).

Similarly, the Health Care Quality Improvement Act (the "Act") protects a "professional review body," including a hospital, from liability for damages in conducting a "professional review action," including the review of applications for clinical privileges or for membership with the hospital, if the action meets certain standards enumerated in the Act. See 42 U.S.C.A. § 11111. "The Health Care Improvement Act grants immunity to doctors engaging in peer review activities if the activities are, among other things, taken 'in the reasonable belief that they are in furtherance of quality health care.'" Imperial v. Suburban Hosp. Ass'n, Inc., 37 F.3d 1026, 1030 (4th Cir. 1994) (quoting 42 U.S.C.A. § 1112(a)(1)).

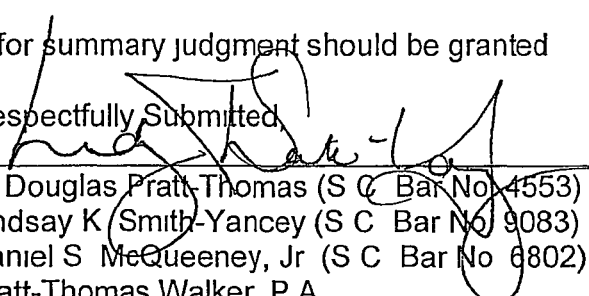
"The Act provides that "[a] professional review action shall be presumed to have met the preceding standards necessary for the protection set out in section 11111(a) of this title *unless the presumption is rebutted by a preponderance of the evidence*." 42 U.S.C.A. § 11112(a) (emphasis added). Thus, the Plaintiff bears the burden of showing the Defendants failed to comply with these standards. See Johnson v. Nyack Hosp., 964 F.2d 116, 123 (2d Cir. 1992) ("A hospital's review is presumed to have met these standards unless the physician rebuts the presumption by a preponderance of the evidence.")

As explained above, the Hospital's Governing Board, MRC, MEC, and Credentials Committee all complied with the Bylaws. Further, the only evidence produced in this case shows the Governing Board, MRC, MEC, and Credentials Committee all reviewed the Plaintiff's 2006 application and found that she failed to demonstrate her competence to perform surgery on the eye. Moreover, the only evidence produced in this case shows the Plaintiff failed to complete her 2008 application in a timely manner and, therefore, was deemed to have resigned from the medical staff under the Bylaws. Accordingly, Defendants are immune from suit as a matter of law.

Conclusion

This Court respectfully lacks subject matter jurisdiction to review the privileging decisions of a private hospital. This premise has not only been emphasized in several appellate court decisions, but this Court has also explained the proposition to Plaintiff in two separate orders. Further, Defendants plainly complied with the Settlement Agreement. Finally, Defendants are immune from this lawsuit under state and federal law. Based on the foregoing, the present action should be dismissed for lack of subject matter jurisdiction and Defendants' motion for summary judgment should be granted.

Respectfully Submitted,


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Attorneys for Defendants

Charleston, South Carolina
July 5, 2011

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF CHARLESTON	)	C A 2010-CP-10-3410
	)	
DR CYNTHIA HOLMES, M D ,	)	
	)	
Plaintiff,	)	
	)	
Vs	)	PLAINTIFF'S RESPONSE TO
	)	DEFENDANTS' MOTION
EAST COOPER COMMUNITY	)	FOR SUMMARY JUDGMENT
HOSPITAL, INC , TENET	)	
HEALTHSYSTEM MEDICAL,	)	
INC	)	
	)	
Defendant	)	
	)	

The Plaintiff hereby responds to the Defendants' motion for summary judgment

STATUS OF THE CASE

The Plaintiff filed the Complaint in this case on April 26, 2010 Defendant filed An answer, then an amended answer, counterclaims, and motion to dismiss on September 17, 2010 In the motion to dismiss, the Defendant moved to dismiss on several grounds, including the identical grounds and arguments submitted in the Defendant's motion for Summary Judgment The pertinent motions included a request for dismissal of the case based on 1) Lack of subject matter jurisdiction (On the grounds that this Court lacks subject matter jurisdiction to address a private hospital's staffing or privileging decisions" (Amended Answer/ Motion to Dismiss, Paragraph 49), 2) Failure to state a cause of action recognizable under S C law "South Carolina law does not recognize a cause of action against a private hospital for its credentialing decisions concerning its medical staff " (Amended Answer, paragraph 50), 3) Collateral Estoppel (Amended Answer, Paragraph 51), 4) Res Judicata (Amended Answer, Paragraph 52), 5) Immunity under the SC statute and the Health Care Quality Improvement Act, "Plaintiff's claims

are barred under S C Code ann 40-71-10 and the Health Care Quality Improvement Act which provide immunity to the Defendants under the circumstances herein ” (Amended Answer, Paragraph 56) All of the these defenses were briefed extensively by Defendant and argued before Judge Dennis on December 16, 2010 The Judge, Having considered the briefs of the parties and oral argument as to the Defendant’s motions to dismiss, denied the motions to dismiss On December 22, 2010, the Defendants filed a motion for reconsideration as to Judge Dennis’ decision to deny the motion to dismiss based on subject matter jurisdiction (Defendant’s Motion for Reconsideration, 12-22-10) In the motion for reconsideration, the Defendants specifically raised the argument that “It is improper for the Courts to review decisions of governing boards of private hospitals concerning the staff privileges of practitioners” (Defendant’s Motion for Reconsideration 12-22-10) Judge Dennis held a hearing on this motion on March 8, 2011 Whereas, in the December hearing, the Court found that the issues raised called for review of material outside of the pleadings, Judge Dennis gave what can only be interpreted as a final ruling on the issue of jurisdiction, stating

THE COURT I can help you You’ve got a ground for appeal Mr Johnson, I assume you want me to deny the Motion to reconsider?

MR JOHNSON That’s correct, Your Honor

THE COURT It’s denied Thank you Thank you very much Have a great day (Transcript of Hearing, 3-8-22, Exhibit # 1)

It seems clear that the Court intended the decision as to jurisdictional issues to be a final and binding decision Otherwise, why would he have told the Defendant he was helping them by giving them a ground for appeal? Notably, the Defendant has not appealed the

Judge's denial of their claim that there is a lack of subject matter jurisdiction

Thereafter, the Defendant has opted not to engage in discovery. No interrogatories, requests for Production, or requests for admission were served. The Defendant has not noted any depositions. The Defendant then moved for Summary Judgment. That motion is now before the Court.

STANDARD OF REVIEW

The purpose of summary judgment is to expedite the disposition of cases not requiring the services of a fact finder. *George v. Fabri*, 345 S.C. 440, 452, 548 S.E.2d 868, 874 (2001). Summary judgment is appropriate when there is no genuine issue of material fact such that the moving party must prevail as a matter of law. Rule 56(c), SCRCP. In determining whether any triable issues of material fact exist, the court must view the evidence and all reasonable inferences that may be drawn from the evidence in the light most favorable to the non-moving party. *Fleming*, 350 S.C. at 493-94, 567 S.E.2d at 860.

ARGUMENT

I Defendant's references to five prior lawsuits and ensuing appeals with the Plaintiff should not be considered by the Court as judicial findings of fact from one trial constitute hearsay when offered for admission in the context of another trial.

In reviewing a motion for Summary Judgment, the Court properly consider only "such facts as would be admissible in evidence." Rule 56(e), SCRCP, *Hall v. Fedor*, 349 S.C. 169, 175, 561 S.E.2d 654, 657 (Ct. App. 2002) (stating "materials used to support or refute a motion for summary judgment must be those which would be admissible in evidence"). The Defendants spend roughly twenty one of the thirty six pages of their brief in support of Summary Judgment discussing orders and appellate orders from prior cases

with Plaintiff Defendants candidly admit that “the evidence produced by the Defendants in support of this motion arises from two (2) general sources First, the Defendants attached a significant amount of Court Orders and Previous filings by the Plaintiff to their Answer to the Plaintiff’s Complaint ” (Defendant’s Memorandum in support of Summary Judgment, July 5, 2011) It should also be noted that Plaintiff has a pending motion to strike this content from the Answer Whether or not that motion is granted, the Court should consider all of the orders and filings submitted from the Defendant which refer to other cases between the parties as inadmissible hearsay, and should not consider them on Summary Judgment

The South Carolina Supreme Court has stated

“We find persuasive the jurisprudence developed by the Fourth Circuit and other federal courts which have recognized that judicial findings of fact from one trial constitute hearsay when offered for admission in the context of another trial See *Nipper v Snipes*, 7 F 3d 415 (4th Cir 1993), *U S Steel, LLC v Tieceo, Inc* , 261 F 3d 1275 (11th Cir 2001), *U S v Jones*, 29 F 3d 1549 (11th Cir 1994), *Blue Cross and Blue Shield v Phillip Morris, Inc* , 141 F Supp 2d 320 (E D N Y) [8] In *Nipper*, the Fourth Circuit held that judicial findings constitute hearsay and do not fall within any of the exceptions to the hearsay rule, including the exception of public records, Rule 803(8), FRE *Nipper* The Fourth Circuit made clear that its holding was firmly rooted in the common law Id (Citing John H Wigmore, *Wigmore on Evidence* 1671a (James H Chadbourn rev 1974) citations omitted)) ” *Mizell v Glover*, 351 S C 392, 570 S E 2d 176 (S C 2002)

The “significant amount of Court Orders and previous filings” that the Defendant has asked this Court to review as part of its Summary Judgment motion constitute inadmissible hearsay Their relevance ended when Judge Dennis made his ruling as to Defendants’ motions to dismiss based on collateral estoppel and Res Judicata Under Rule 56, they should not be considered by the Court in determining whether Summary Judgment is appropriate in this case, and should be stricken from the Defendant’s Answer pursuant to Plaintiff’s motion to strike, which is before the Court

II The Plaintiff's complaint should not be dismissed for lack of jurisdiction

A The issue of Jurisdiction has already been decided in this case

As set forth above, in the "STATEMENT OF THE CASE," the Court has already decided the issue of subject matter jurisdiction in this case in a final decision, specifically indicated by the Judge's statement to the Defendant that, by denying their motion, he had now given them a ground for appeal. The denial of a motion to dismiss for lack of subject matter jurisdiction is immediately appealable. *Woodard v. Westvaco Corp.*, 315 S.C. 329, 433 S.E.2d 890, 894 (S.C. App. 1993). Defendants did not appeal. It has been more than 30 days since the issuance of the order. *Judy v. Martin*, 381 S.C. 455, 459, 674 S.E.2d 151, 153 (2009) ("[A]n unappealed ruling becomes the law of the case and precludes further consideration of the issue on appeal.") The Plaintiff urges the Court to find that the issues brought before the Court under Rule 12(b)(1) in this case have been decided, and that, as a matter of the law of the case 1) the Common Pleas Court does have subject matter jurisdiction in this case, 2) Defendants are not entitled to immunity under statute.

B Strauss v. Marlboro County General Hospital and its progeny do not preclude subject matter jurisdiction over the Plaintiff's claims

Should the Court find that the issue of subject matter jurisdiction was not decided by Judge Dennis' ruling on the Defendants' motion for reconsideration, the Plaintiff hereby asserts her arguments as to the Defendant's stance on subject matter jurisdiction. The Defendant has asserted, as a motion, that South Carolina law does not grant subject matter jurisdiction to the Courts "to address a private hospital's staffing or privileging decisions." As is argued below, the line of cases to which Defendant is

referring should not apply to deprive the Plaintiff of the right to pursue a breach of contract claim alleging that the Defendant has not allowed her to participate in the credentialing process in violation of a private settlement agreement that was signed some time ago Plaintiff's complaint does not put the Court or a jury in the position of reviewing a credentialing decision based on a private hospital's bylaws for due process The finder of fact will be asked to determine whether a private settlement agreement constitutes a contract, and whether the Defendant's refusal to allow the Plaintiff to participate in the credentialing process constitutes a breach of that agreement This is not the kind of claim to which Strauss v Marlboro County General Hospital and its progeny apply

In Strauss v Marlboro County General Hospital, 185 S C 425, 194 S E 65 (1937), the Court finds that a private hospital does not owe the due process rights to a doctor in regards to privileges that a public hospital does In case after case, the Court reiterates that the by-laws of a hospital which is a private entity can not be reviewed, judicially, for fairness, as could the same by-laws if set forth by a public institution This makes sense, as the due process right does not come into play unless the entity seeking to deprive a citizen of a property right is a public entity The line of cases culminates, so to speak, with Gowan v St Francis Community Hospital, 275 S C 203, 268 S E 2d 580 (1980) , and Wood v Hilton Head Hospital, Inc 292 S C 403, 356 S E 2d 841 (S C 1987), where the Court reiterates the finding "we affirmed our view that the implementation of the regulations of a private hospital which are initiated to restrict a practitioner's practices are not subject to judicial review We stated that we would not "depart from the longstanding principle that such action [by the hospital] is not subject to

judicial review (citations omitted) " Id

The Defendant, Tenet HealthSystem Medical, Inc owns and operates East Cooper, it alleges, as a privately owned, for profit business The by-laws, therefore, are not subject to a judicial, due process review In Lee v Chesterfield General Hosp , Inc , 289 S C 6, 13, 344 S E 2d 379, 383 (Ct App 1986) , the Court addresses the Gowan case and its line, and explains why a doctor's claim challenging whether the by-laws have been followed is not the same thing as a due process challenging and requesting a judicial review of the fairness of the rules themselves

The Hospital first argues the demurrers should have been sustained because internal rules governing the practice of a physician's assistant in a private hospital are not subject to judicial review

1, 2 We agree that a private hospital is free, in the absence of controlling legislation or regulatory provisions, to decide the nature and extent of medical practice permitted to persons it grants staff privileges Ordinarily, such decisions involve matters of expert medical judgment not subject to judicial review See Gowen v St Francis Community Hospital, 275 S C 203, 268 S E (2d) 580 (1980), *cert denied*, 449 U S 1062, 101 S Ct 786, 66 L Ed (2d) 605 (1980), Hoffman v Garden City Hospital-Osteopathic, 115 Mich App 773, 321 N W (2d) 810 (1982) A medical professional has no right, simply because he is licensed by state authority to perform certain procedures, to claim unrestricted staff privileges in a hospital See Yeargin v Hamilton Memorial Hospital, 225 Ga 661, 171 S E (2d) 136 (1969), *cert denied*, 397 U S 963, 90 S Ct 997, 25 L Ed (2d) 255 (1970) Within the confines of the law, a hospital may set professional standards for staff according to its own conception of good medical practice

These principles are not dispositive of the present cases, however In ruling on the demurrers, the circuit court did not conduct a judicial review of internal hospital rules The question to be decided is not whether the rules are valid or reasonable or medically sound, but whether the rules were imposed in furtherance of a conspiracy, the primary purpose of which was to injure the plaintiffs If the complaints, liberally construed, allege such a conspiracy, it is irrelevant that the Hospital has the legal right to restrict staff privileges and that its rules are not subject to judicial review

Lee v Chesterfield General Hosp , Inc , 289 S C 6, 344 S E 2d 379, 383 (Ct App 1986)

In this case, the Plaintiff's cause of action for breach of contract is **not** a challenge to the hospital's right to create and impose rules and regulations, nor is plaintiff asking for a due process review. Plaintiff has alleged that, pursuant to a settlement agreement, she was entitled to apply for and be considered for privileges, just like everyone else who applied, through the credentialing process set forth in the by-laws. A separate agreement, settling a prior lawsuit, guaranteed her an unbiased opportunity to participate in the credentialing process. A review of the Complaint makes it clear that this is about the breach of a settlement agreement, not a breach of the bylaws, and not a request for review of the due process or fairness of a decision that the hospital is authorized to make under the bylaws. Thus, South Carolina's decision to eschew the review of decisions made by private hospitals concerning credentialing done pursuant to their bylaws for due process infringements should not bar the Plaintiff's claims in this case.

C The terms of the settlement agreement set forth the jurisdiction for resolution of disputes under the settlement agreement

Defendant mentions, as part of its argument, that a private contract can not confer subject matter jurisdiction where subject matter jurisdiction does not exist. While Plaintiff does not dispute that this is valid law, in principal, the Plaintiff in this case, as is argued above, is not attempting to re-litigate or appeal a decision of a hospital under the bylaws. What the Plaintiff has been working to make abundantly clear, from the beginning of this case, is that this is a lawsuit about a breach of a settlement agreement. The settlement agreement (Exhibit # 2), states "Dr. Holmes shall have the right to apply for a change in status according to the bylaws." Dr. Holmes is claiming that the Defendants breached a duty of good faith and fair dealing, which is inherent in every

contract, by going out of its way to make sure she did not have access to the application procedure or the protections and due process which would have been afforded her under the by-laws, if she had been allowed to apply for privileges. This is the argument that Plaintiff made at the motion to dismiss and reconsideration heard by Judge Dennis, and the basis on which he found that the jurisdictional exclusions did not apply. The settlement agreement does call for South Carolina jurisdiction for settling disputes under the contract by stating that the agreement "shall be construed and interpreted in accordance with the laws of the State of South Carolina." *Id.* The Plaintiff is not asking the Court to find that the settlement agreement confers jurisdiction upon the Court to make a judgment on whether the bylaws were followed or whether they afforded proper due process, as written, only that the Court has jurisdiction over the question of whether the Settlement agreement's implied covenant of good faith and fair dealing has been breached.

II Res Judicata and Collateral Estoppel

Res judicata is a rule that a final judgment rendered by a court of competent jurisdiction on the merits is conclusive as to the rights of the parties and, as to them, constitutes an absolute bar to a subsequent action. Black's Law Dictionary 1174 (5th ed 1979). To establish *res judicata*, the following elements must be shown: (1) identities of the parties, (2) identity of the subject matter, and (3) adjudication of the issue in the former suit. *See Riedman Corp v Greenville Steel Structures, Inc*, 308 S.C. 467, 469, 419 S.E.2d 217, 218 (1992).

Judge Dennis, who granted the former motions for Summary Judgment and Dismissal in the previous cases (to which Defendant refers as a basis for its assertion of

the doctrines of res judicata and collateral estoppel) found, at the hearing on this case, that the allegations were dissimilar enough that res judicata and collateral estoppel would not apply, at least at the motion to dismiss. The orders dismissing the prior cases all find a lack of subject matter jurisdiction. In his Order of August 6, 2009, Judge Dennis awarded sanctions against Dr. Holmes based on a finding that the Court did not have jurisdiction to decide her prior cases. (Exhibit # 3 Order of August 6, 2009, page 14-15) Res judicata, as does collateral estoppel, requires that the matter before have involved the same issues and that it be resolved upon the merits. The Plaintiff was, of course, very aware of Judge Dennis' prior findings as to jurisdiction when the instant suit was begun. The Complaint has been thoughtfully worded and the claims specifically plead and prosecuted to avoid the jurisdictional issues raised in the prior suits. Judge Dennis even recognizes this in an admonition to the undersigned at the end of the motion to dismiss hearing in December of 2010. The instant suit raises the issues of the 2006 reappointment and the 2008 reappointment. The Court should note, that the Defendant's argument for the application of collateral estoppel mentions cases involving only applications prior to the 2006 application. Even if this case involves similar arguments from Defendant, it clearly this case does not involve the same issues raised in the earlier cases. Furthermore, as the Court has ruled in the past that it was prevented from hearing the case based on lack of subject matter jurisdiction, there can not have been a final judgment on the merits. Collateral Estoppel and the Doctrine of Res Judicata should not apply in this case.

III There is a genuine issue of material fact as to whether the Defendant breached a covenant of good faith and fair dealing under the 2003 settlement agreement when it declined to consider Dr. Holmes' 2006 and 2008 applications for a change in status.

The Complaint in this case specifically brings a claim for a breach of the covenant of good faith and fair dealing, which is inherent in all contracts. There is only one cause of action. The relevant portion of the Complaint reads:

**FOR A FIRST CAUSE OF ACTION
BREACH OF CONTRACT/ BREACH OF COVENANT OF GOOD
FAITH AND FAIR DEALING**

- 11 Paragraphs one (1) through ten (10) are hereby incorporated verbatim
12 The Plaintiff and Defendant were and are parties to a contractual
agreement, the terms of which are set forth as part of a settlement
agreement.
13 As with every contractual relationship, this contract involved an
implied covenant of good faith and fair dealing.
14 That the Defendant breached this duty by attempting (successfully to
date) to block Plaintiff from being able to seek review of its decision to
deny her application for advancement in staff privileges in violation of
the letter and the spirit of the applicable bylaws.
15 In 2006-2007 and 2008-2009 (in each of the two years), Plaintiff
submitted an application for advancement in staff privileges, which was
complete on its face.
16 The Credentials Committee then denied the Plaintiff's application, an
act which should have given Plaintiff the right to pursue an appeal,
under the applicable bylaws.
17 When Plaintiff did timely pursue an appeal, the Defendants, in bad
faith, denied her access to a complete, fair and full review.
18 The Defendant's actions were taken in bad faith, and in willful and
knowing violation of the implied covenant of good faith and fair
dealing, with the purpose of denying the Plaintiff access to the
administrative process, and in an attempt to restrict Plaintiff from
seeking a judicial remedy for the denial of her application for
advancement in staff privileges through appropriate litigation.
19 That, as a direct and proximate result of the Defendants' breach of
contract, the Plaintiff has suffered actual damages and special damages,
in the form of lost income, and loss of business to her practice, as she
has been unable to admit any patients to the hospital to perform medical
procedures from 2007 through the date of the filing of this Complaint,
and continuing presently.
20 The damages and injury suffered by Plaintiff were the foreseeable
result of the Defendants' willful and knowing breach of contract, and
breach of the covenant of good faith and fair dealing.
(Complaint April 26, 2010)

Plaintiff's claim is essentially a very simple one. She is not seeking a Court

review of whether the proper procedure was followed or whether the By-laws were necessarily "fair." Instead, she is focusing on the conduct of the Defendant after the 2003 settlement of her claims against it. Dr. Holmes claims that, taken as a whole, a jury could find that the Defendants' actions in finding ways to deny her access to the application process shows that they were not really giving her a fair chance at gaining privileges at the hospital. The Plaintiff argues that, if the Jury is finally allowed to consider this case on its merits, reasonable minds could find that, overall, the hospital has, again and again, found excuses to make sure that Dr. Holmes never got a fair shot at getting privileges.

"There exists in every contract an implied covenant of good faith and fair dealing." *Parker v. Byrd*, 309 S.C. 189, 193-94, 420 S.E.2d 850, 853 (1992) (internal citations omitted). Furthermore, [N]either law nor equity requires every term or condition to be set forth in a contract. Where an implied term is necessary to effectuate the intention of the parties, the law will supply it. The unexpressed provision may be inferred from the language of the contract itself, or by looking to the external facts and circumstances surrounding the bargain, or by proving a general custom and usage of including certain terms as part of similar contracts. *Maccaro v. Andrick Dev. Corp.*, 280 S.C. 96, 100, 311 S.E.2d 91, 94 (Ct. App. 1984) (internal citations omitted). In support of this argument, the Plaintiff has submitted her own testimony, the affidavit of Dr. Majeski, and the affidavit of her expert witness, Dr. Shershow. Plaintiff is taking the deposition of a former administrator of the hospital at 5pm on July 6th, and may be supplementing the record with that transcript. At the time of the drafting of this response, the deposition has not been taken. Based on the testimony presented, the Plaintiff believes that there is a genuine issue of material fact as to whether Defendant has been acting in bad faith to

deny Dr Holmes access to the rights that she would have under the bylaws by continually rejecting her application before it can even be considered To clarify, if the application is not "considered" then it can not be "rejected " If it is not "rejected" then Dr Holmes' access to any kind of appeal within the by-laws and, ultimately, to a proper court review, is denied

A Affidavit of Dr Shershow

Dr Shershow (Affidavit attached as Exhibit # 4) is an expert witness who has been qualified as an expert in Courts to testify on matters involving all aspects of hospital administration, staffing, Joint Commission accreditation, and physician credentialing and privileging (Affidavit of Shershow) Dr Shershow has reviewed the documentation concerning Dr Holmes' applications to participate in the 2008 credentialing process His expert opinion is that

"Based on review of Dr Holmes' credentialing file, the reappointment applications, the ECCH Medical Staff Bylaws, and a letter from Janie Sinacore-Jaberg to Dr Holmes on December 19, 2008, it is my expert opinion that Dr Holmes' 2008 application for re-appointment and change in medical staff status was not properly responded to by ECCH " (Affidavit of Shershow)

Dr Shershow also opines

"it is my opinion that Dr Holmes was denied fair hearing rights as explicitly required by these bylaws and by the joint commission standards "

He goes on to support Dr Holmes' allegations that the denial of her access to the process has resulted in a denial of the due process rights she would have been afforded under the applicable by-laws

"Further, by denying Dr Holmes fair hearing rights, per the applicable provisions of the ECCH Medical Staff Bylaw, ECCH prevented Dr Holmes from her due process rights, mandated by both the joint commission, and the EECCG[sic] Medical Staff By-Laws "

(Affidavit of Shershow)

B Affidavit of Dr Majeski

Dr Majeski is a doctor, recently retired, who was a surgeon on staff at the Defendant's hospital in 2006, when Dr Holmes applied for a change in staff status His affidavit is attached as Exhibit # 5 As a staff surgeon, Dr Majeski was frequently asked to fill out a peer reference form, recommending physicians who were seeking privileges at the hospital through the credentialing process In 2006, Dr Holmes asked Dr Majeski to fill out one of these recommendations to accompany her application for a change in staff privileges Dr Majeski, who apparently thought well of Dr Holmes and supported her candidacy for surgical privileges at the hospital, gave a positive recommendation for re-appointment Shortly thereafter, Dr Majeski was contacted by John Langley, an administrator with the hospital, who questioned the doctor about the form Dr Majeski testifies that this was out of the ordinary and was "not the usual procedure for processing reappointment applications " (Affidavit of Majeski)

C Affidavit of Dr Holmes

(Note, Dr Holmes' deposition was served on Defendants on July 6th, but was not

available to attach to this response, and will be filed separately) Dr Holmes disputes the Defendants' claim that the application she submitted in 2008 was not complete Defendant's expert, Pocock, points to a form called the "delineation of privileges" form to argue that the application was incomplete because Dr Holmes did not mark one of the prepared boxes showing which privileges she was seeking Pocock states that Dr Holmes, instead, attached a "laundry list" of documents and simply dismisses the attachment as irrelevant

Dr Holmes explains that the form which Defendant claims was not complete actually allows for the applicant to alternatively attach a separate written request with supporting documents if the candidate is seeking a position not specifically delineated on the form She explains that she did follow these instructions, and that, therefore, the application was complete The Delineation of Privileges form, which Defendant claims was incomplete asked the candidate to mark a box indicating the privileges sought, but "If the condition/privilege you are interested in is not included on this form, please provide a separate written request and appropriate documentation of training/or experience " Plaintiff testifies that this is what she did Defendant's expert, Pocock, refers to this attachment as a "laundry list," acknowledging that the Plaintiff did submit attachments, but simply dismissing them as not relevant Clearly, a jury could find that, where, on the face of the application, it calls for an attachment without specifying, in any way, the format for the attachment, any format would be acceptable, at least in determining whether the application was "complete" and whether it should be submitted for consideration One need not have an expert to see that Combining Dr Holmes' s testimony with the expert opinion of Dr Shershow, and adding in the glaring fact of

Pocock's simply dismissing the attachment without addressing the clear instructions on the delineation of privileges form, it is clear that there is a genuine issue of material fact as to whether the 2008 application was complete. Evidence that the Defendant, even now, is refusing to read and claiming disingenuously to fail to understand the simple instructions on its own form gives credence to Dr. Holmes' claim that the Defendant has continuously engaged in bad faith by finding refusing to allow her to even participate in the process for requesting a change in privilege status at the hospital.

CONCLUSION

The issues of subject matter jurisdiction, collateral estoppel, and res judicata have already been decided against the Defendant in this case. Dr. Holmes' claims do not ask the Court to determine whether the hospital affords due process through its by-laws. To the contrary, her claim assumes that the by-laws comply with applicable standards and do afford due process. Her complaint is that the Defendant settled a prior case with her, concerning her attempts to gain privileges, and then, in bad faith, precluded her from participating in the process through which she could apply for privileges at the hospital. The evidence in the record to date presents a genuine issue of material fact as to whether the Defendant has breached the covenant of good faith and fair dealing implied and inherent in its 2003 settlement agreement with Dr. Holmes. The Plaintiff respectfully requests that the Court deny the Defendant's motion for summary judgment and allow this case to continue on to a trial on the merits.



Chalmers C. Johnson
S C # 11583
523 So. G Street, Apt 402
Tacoma, WA 98405
(425) 999-0900

July 6, 2011

Index of Exhibits

- 1 Transcript of hearing 3-8-22
2. Settlement Agreement
- 3 Sanctions Order, August 6, 2009 pages 1, and
14-15
- 4 Dr Shershow affidavit
- 5 Dr Majeski Affidavit

1. Transcript of hearing 3-8-22

STATE OF SOUTH CAROLINA	)	
	)	COURT OF COMMON PLEAS
COUNTY OF CHARLESTON	)	
Cynthia Holmes, M D	)	
	)	
Plaintiff,	)	
	)	
vs	)	Case No 05-CP-10-5113
	)	
East Cooper Community Hospital,	)	
Inc , Tenet HealthSystems Medical,	)	
Inc , John Grady, M D , and Paul	)	
Yantis,	)	
	)	
Defendants	)	

TRANSCRIPT OF HEARING

The within Hearing in the above-captioned case was heard on March 8, 2011, before The Honorable R Markley Dennis, Jr in Courtroom 4B of the Charleston County Courthouse, 100 Broad Street, Charleston, South Carolina, attended by Counsel, as follows

APPEARANCES

Chalmers Johnson, Esq (via phone)
 Cynthia Collie, Esq
 P O Box 187
 Sullivans Island, SC 29482-0187
 Appearing for Plaintiff Cynthia Collie

Chip McQueeney, Esq
 PRATT THOMAS EPTING & WALKER
 P O Drawer 22247
 Charleston, SC 29413
 Appearing for Defendant

DEBORAH GARRISON
Circuit Court Reporter - 9th Judicial Circuit
 Post Office Box 901
 Johns Island, South Carolina 29457
dGarrison@sccourts.org

Cynthia Holmes, M D v East Cooper Community Hospital et al
Case No 05-CP 10-5113
Hearing of March 8 2011
Before The Honorable R Markley Dennis, Jr

2

1 THE COURT Do we have the phone?

2 CLERK Yes

3 THE COURT We need to get Mr

4 Johnson on the phone The number that I have
5 is 425-999-0900

6 CLERK (Places conference call)

7 MR JOHNSON This is Chalmers
8 Johnson

9 THE COURT Good morning, Chambers
10 This is Markley Dennis How are you this
11 morning?

12 MR JOHNSON Morning, Judge,
13 doing fine, how are you'all?

14 THE COURT Fine Thank you I
15 have everyone here Mr McQueeney, this is
16 your Motion for reconsideration I will be
17 happy to hear from you

18 MR McQUEENEY Yes, Your Honor
19 My name is Chip McQueeney I represent the
20 defendants in this action, East Cooper
21 Community Hospital, Inc and Tenant Health
22 System Medical, Inc

23 Your Honor, I think is familiar with
24 this case The plaintiff, Dr Cynthia Holmes,
25 M D , is here with us today and filed this

1 action against the defendants relating to the
2 denial of her medical staff privileges at East
3 Cooper Regional Medical Center in 2006 and
4 2008

5 The defendants filed an Answer and
6 moved to dismiss both under 12(b)(6) and
7 under 12(b)(1) for lack of subject matter
8 jurisdiction

9 Your Honor denied the Motion and we
10 move to reconsider with respect to the 12(b)(1)
11 Motion to dismiss for lack of subject matter
12 jurisdiction The grounds for that really are
13 that -- as far as subject matter jurisdiction
14 is concerned, that's a Rule 12(b)(1) Motion
15 The case law says that it cannot be converted
16 into a Motion for summary judgment, so it's
17 more appropriately raised as a 12(b)(1) Motion

18 Secondly, under *Eldrich v City of*
19 *Greenwood*, the plaintiff -- not the defendant
20 -- in an action bears the burden of proving
21 jurisdiction when the defendant challenges it

22 Thirdly, *Wood v Hilton Head Hospital*
23 states that it is well settled in South
24 Carolina ---

1 THE COURT I can help you You've
2 got a ground for appeal Mr Johnson, I assume
3 that you want me to deny the Motion to
4 reconsider?

5 MR JOHNSON That's correct, Your
6 Honor

7 THE COURT It's denied Thank you
8 Thank you very much Have a great day

9 (HEARING CONCLUDED)

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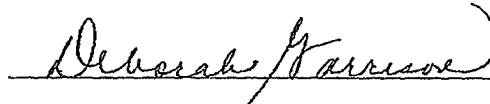
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CERTIFICATE OF REPORTER

I, the undersigned, Deborah Garrison,
official court reporter for the 9th Judicial
Circuit of the State of South Carolina, do
hereby certify that the foregoing is a true,
accurate and complete transcript of the hearing
held before The Honorable R Markley Dennis,
Jr , on March 8, 2011,

I further certify that I am neither kin nor
counsel to any of the parties and have no
interest in the outcome of this action


Deborah Garrison
Circuit Court Reporter
9th Judicial Circuit

Charleston, South Carolina

March 29, 2011

2. Settlement Agreement

STATE OF SOUTH CAROLINA)
) SETTLEMENT AGREEMENT &
COUNTY OF CHARLESTON) GENERAL RELEASE IN FULL

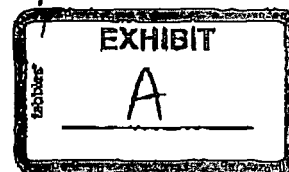
THIS SETTLEMENT AGREEMENT & GENERAL RELEASE IN FULL is entered into by C Holmes, M D , (hereinafter at times referred to as "Releasor") to Tenet HealthSystem Medical, Inc , East Cooper Community Hospital, Inc , John Grady, M D , Paul Yantis, M D , and William Cone, and their insurance carrier (hereinafter 'Releasees')

WHEREAS, C Holmes, M D , filed a Complaint against Tenet HealthSystem Medical, Inc , East Cooper Community Hospital, Inc , John Grady, M D , Paul Yantis, M D , and William Cone, in the Court of Common Pleas for the State of South Carolina, County of Charleston, said case bearing Civil Action Number 00-CP-10-1888, which Complaint arose out of certain alleged causes of action and/or theories of liability as against the Releasees In the Complaint, Releasor sought to recover equitable and monetary damages sustained by Releasor arising out of incidents as set forth in said Complaint, and,

WHEREAS, the parties recognize that serious controversies and disputes exist and that if the Releasor's claims and questions of responsibility therefore, if any, be litigated that such would involve serious and extensive questions insofar as the parties are concerned, in consequence of which the parties have agreed in consideration of the amounts and terms hereinafter recited to settle any and every claim which the Releasor has asserted, might assert, or which Releasor may have against the Releasees in this case, it being recognized and agreed that the controversies and disputes that exist are adequate consideration for final settlement of all the claims in accordance with this Settlement Agreement & General Release in Full

NOW, THEREFORE, KNOW ALL MEN BY THESE PRESENTS, in consideration of the payment of ~~the sum of \$10,000.00~~ to the Releasor in hand paid by and on behalf of the Releasees, and in consideration of the following agreement among the parties, to wit

- (1) That Dr Holmes has been reappointed to consulting status for a term of two (2) years Dr Holmes shall have the right to



apply for a change in status in accordance with the Bylaws,

- (2) That Releasees agree that they, their agents, servants, and employees shall not say or do anything detrimental to the Releasor obtaining privileges elsewhere. If asked, they will say about this dispute that there came a time when the Releasor did not have a sufficient number of contacts, that this resulted in a change of status to consulting, and that this had nothing to do with professional competence,

that all parties, Releasor and Releasees, hereby completely release and forever discharge each other from any and all claims, demands, obligations, causes of action, rights, damages, costs, losses of services, fees, expenses and compensation of any nature whatsoever, whether based on a tort, contract, or other theory of recovery, which the parties now have, or which may hereafter accrue or otherwise be acquired, on account of, or may in any way grow out of, or which are the subject of the Complaint (and all related pleadings) including, without limitation, any and all known or unknown claims for injuries and damages to the parties which may have resulted, or may result from any alleged acts or omissions of the parties which are the subject of the Complaint (and all related pleadings)

IT IS FURTHER UNDERSTOOD AND AGREED THAT this release and discharge shall also apply to Releasor's and Releasees' past, present, and future officers, directors, stockholders, attorneys, agents, servants, representatives, employees, subsidiaries, parent corporations, affiliates, partners, predecessors, successors in interest, assigns, and all other persons, firms, or corporations with whom any of the former have been, are now, or may hereafter be affiliated

The Releasor and Releasees acknowledge and agree that the respective release and discharge by all parties set forth above is a general release. The Releasor and Releasees expressly waive and assume the risk of any and all claims for damages arising out of Civil Action Number 00-CP-10-1888, but of which the parties do not know or suspect to exist, whether through ignorance, oversight, error, negligence, or otherwise, and which, if known, would materially affect the parties' decision to enter into this Settlement Agreement & General Release in Full. The parties further agree that the parties have accepted the

consideration specified herein as a complete compromise of matters involving disputed issues of law and fact. It is understood and agreed to by all parties that this settlement is a compromise of a disputed claim and the payments are not to be construed as an admission of liability on the part of any party.

IT IS EXPRESSLY UNDERSTOOD AND AGREED that each party hereto shall bear all attorney's fees and costs arising from the actions of their own counsel in connection with the lawsuit, this Settlement Agreement & General Release in Full, and the matters and documents referred to herein, the filing of an Order of Dismissal with prejudice of the Complaint, and all related matters.

IT IS FURTHER UNDERSTOOD AND AGREED that concurrently with the execution of this Settlement Agreement & General Release in Full, counsel for the Releasor shall deliver to the counsel for the Releasees an executed Order of Dismissal with prejudice of the Complaint. Releasor hereby authorizes counsel for the Releasees to file said Order of Dismissal with prejudice with the Court and enter it as a matter of record.

In entering into this Settlement Agreement & General Release in Full the parties represent that each has had the advice of their respective attorneys, who are attorneys of each party's own choice, concerning the legal consequences of this Settlement Agreement & General Release in Full, that the terms of this Settlement Agreement & General Release in Full have been completely read and explained to each party by each party's attorney, and that the terms of this Settlement Agreement & General Release in Full are fully understood and accepted by each party.

Releasor and Releasees represent and warrant that no other person or entity has, or has had any interest in the claims, demands, obligations, or causes of action referred to in this Settlement Agreement & General Release in Full, further, the Releasor and the Releasees agree to indemnify and hold harmless the other party or parties, their respective agents, servants, employees, directors, stockholders, attorneys, representatives, employees, subsidiaries, parent corporations, affiliates, partners, predecessors, successors in interest, and assigns for any costs, fees, and/or judgment which may be suffered by said party or parties upon the bringing of any claim by any person claiming damages as the result of said party or parties having sold, assigned, transferred, conveyed, or otherwise disposed of any claims, demands, obligations, or

causes of action referred to in this Settlement Agreement & General Release in Full

The parties agree that neither they nor their attorneys nor representatives shall reveal to or discuss with anyone, other than as may be mutually agreed to in writing, or as may be ordered by a court of competent jurisdiction, any of the monetary terms of this Settlement Agreement & General Release in Full or any of the amounts, numbers, or terms and conditions of any sums payable to the Releasor

This Settlement Agreement & General Release in Full shall be construed and interpreted in accordance with the laws of the State of South Carolina

This Settlement Agreement & General Release in Full contains the entire agreement between the Releasor and Releasees and shall be binding upon and inure to the benefit of the executors, administrators, personal representatives, heirs, successors, and assigns of each

This Settlement Agreement & General Release in Full shall become effective immediately following execution by each of the parties

ATTORNEY'S CERTIFICATE

As attorney for C Holmes, M D , I have explained the meaning of this Settlement Agreement & General Release in Full to Dr Holmes and have recommended the acceptance of its terms and conditions

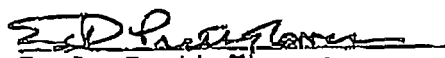
Mendith C Bond
M C Bond
Dated 6/12/03

WITNESSES

Yvette L. L. L.
Frederick L. L.

C Holmes
C Holmes, M D
Dated 6/14/03


J. Dusenbery, Chief
Executive Officer,
East Cooper
Community Hospital, Inc
Dated 1/20/03


E. D. Pratt-Thomas
As Attorney for Releasees
Dated 1/20/03

3. Sanctions Order, August 6, 2009 pages 1, and 14-15

STATE OF SOUTH CAROLINA) IN THE COURT OF COMMON PLEAS
COUNTY OF CHARLESTON) C A NO 05 CP-10 5113

Dr Cynthia Holmes, M D)
Plaintiff)

vs)

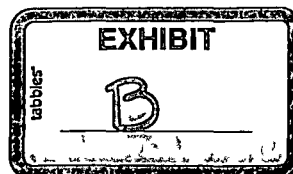
East Cooper Community Hospital Inc)
Tenet HealthSystem Medical, Inc , John)
Grady M D , Paul Yantis, M D ,)
Defendants)

ORDER AWARDING SANCTIONS

2009 AUG -6 PM 2 43
JUL 11 11 22 AM '09
CLERK OF COURT
JUL 11 11 22 AM '09
JUL 11 11 22 AM '09

This matter came before the Court on motion of Defendants pursuant to S C Code Ann §15-36-10 known as the South Carolina Frivolous Civil Proceedings Sanctions Act (hereinafter referred to as 'the FCPSA" or "the Act") A hearing on Defendants' motion was held on December 3, 2008, during which the parties presented oral argument memoranda of law affidavits and other materials to the Court for consideration In addition, Plaintiff was allowed to and did make additional submittals following the hearing which the Court has also considered in making its ruling As indicated fully below this Court grants Defendants motion and issues sanctions against the Plaintiff in the amount of \$90 000 00 (Ninety Thousand and No/100ths Dollars) payable to Defendants for partial reimbursement of attorneys' fees incurred in the defense of this action

The Plaintiff herein is a medical doctor specializing in the field of ophthalmology Her Complaint alleges causes of action for breach of contract breach of contract accompanied by a fraudulent action breach of the covenant of good faith and fair dealing and civil conspiracy concerning her medical staff privileges at Defendant East Cooper Community Hospital Inc (hereinafter referred to as East Cooper Hospital) This is the third lawsuit filed by the Plaintiff arising out of her medical staff privileges at



Defendants refuted the Plaintiff's allegations of Dr. Grady's involvement in her 2002 and 2004 reappointment processes, the Plaintiff continued to assert unfounded claims of conspiracy resulting in Defendants' unnecessary expenditures of attorneys' fees and costs. This Court recognized the Plaintiff's lack of evidentiary support for her position in its order granting summary judgment, stating

There is no evidence that Defendant Dr. Grady was a member of, participated in, influenced or had any role in the determinations made by the Credentials Committee, the Medical Executive Committee or the Governing Board of East Cooper Hospital regarding the Plaintiff's reappointment application. Likewise, there is no evidence that there was any consideration of Dr. Grady or his medical practice in these determinations.

The foregoing in addition to the record in this matter shows that the Plaintiff failed to make a reasonable investigation or research the facts or law prior to the filing and during the prosecution of this action. A reasonable investigation would have precluded the filing of this action or at the least warranted its voluntary dismissal upon the discovery of facts completely inconsistent with Plaintiff's causes of action. The Plaintiff's failure to conduct any discovery on Dr. Grady's alleged role in her credentialing process is evidence of her blatant disregard for the truth surrounding these events and her continuation of this action despite evidence to the contrary is evidence that this action was intended merely to harass and injure the Defendants.

C Plaintiff's efforts to have this Court consider matters over which it has no jurisdiction is contrary to South Carolina law and sanctionable under the Act

South Carolina courts have consistently held that private hospitals are free in the absence of regulatory provisions to decide the nature and extent of medical practice permitted to persons it grants medical staff privileges. A private hospital is free to adopt reasonable regulations for the conduct of its affairs. *Gowan v. St. Francis Community Hospital*, 275 S.C. 203, 268 S.E.2d 580, 581 (1980). It is well settled law in S.C. that the courts do not have jurisdiction to review the decisions of the medical staff of a private

hospital concerning the membership and credentialing of its physicians *Strauss v Marlboro County General Hospital*, 185 S C 425 194 S E 65 (1937), *Wood v Hilton Head Hosp , Inc* , 292 S C 403 356 S E 2d 841 *Gowan vs St Francis Community Hospital*, 275 S C 203, 268 S E 2d 580 (1980)

It is undisputed and the Plaintiff never contested that the Defendant Hospital is a private for-profit Hospital governed by a Board of Directors It is also undisputed that the Hospital's medical staff operates pursuant to written Medical Staff Bylaws, Rules and Regulations which have been approved by the Governing Board of the Hospital by which all physicians receiving staff privileges at the Hospital agree to be bound

Despite clear case law to the contrary the Plaintiff filed this action seeking judicial determination of whether the decisions regarding her credentialing and privileges were reasonable and in compliance with the Hospital's Bylaws Specifically she sought the Court to review whether the failure to process and consider her application for associate status and surgical privileges her reappointment to the consulting staff, and the denial of an administrative hearing were reasonable decisions made in accordance with the Bylaws The Plaintiff's claims all arose out of the peer review process and, under South Carolina law are not subject to judicial review and the Plaintiff presented no evidence or reason to persuade the Court to depart from this long-standing principle

Plaintiff's interpretation and reliance on *Lee v Chesterfield General Hospital*, 289 S C 6 344 S E 2d 379 (Ct App 1986) in an effort to justify her quest to have the Court review the decisions regarding her credentialing is without merit In *Lee* the Court confirmed the decision reached in *Gowan* but found subject matter jurisdiction where the Plaintiff did not seek to conduct a judicial review of internal hospital rules but claimed that the Bylaws were imposed in furtherance of a conspiracy the purpose of which was to injure the Plaintiff *Lee* at 10 Here the Plaintiff asked the Court to review the basis for the credentialing decisions and substitute its judgment for the Hospital and its review

RMD7/15

4. Dr. Shershow affidavit

*John C. Shershow, M.D.
240 Central Park South
Suite #2H
New York, NY 10019
(800) 388-9299
Fax: (516) 706-0671
JShershow@GMail.com*

July 5, 2011

STATE OF NEW YORK)

COUNTY OF New York)

AFFIDAVIT

Personally came and appeared before me, Notary Public, John Shershow, M D ,
who upon being duly sworn did depose and say the following

1) I am over the age of eighteen (18) years and am competent to state the matters
herein

2) My Curriculum Vitae is attached and documents my experience in all aspects of
hospital administration, staffing, and quality of care as well as *JOINT COMMISSION*
accreditation, hospital care standards, medical staff affairs, physician credentialing and
privileging, and medical quality assessment and review

- 3) I have been certified as an expert in state courts on these matters
- 4) In providing this affidavit, I affirm that, to the best of my knowledge, I am not related to any party to this action. I am informed and believe that I do not know any of the parties to this action.
- 5) My expert opinion follows and in rendering this opinion, I have relied on a large number of documents supplied to me by Dr. Holmes, consisting of the East Cooper Community Hospital (ECCH) Medical Staff Bylaws, as well as a large number of credentialing and privileging documents of Dr. Holmes, from approximately 1994 to 2009.
- 6) The *Joint Commission* is an organization which accredits hospitals based on national quality of care standards. My understanding is that at all times pertinent to the matter herein, ECCH is and has been accredited by the *Joint Commission*.
- 7) As part of those standards, the *Joint Commission* requires hospitals to have bylaws and, as part of those bylaws, to provide fair hearing rights to physicians. Those standards are national and local standards.
- 8) Based on review of Dr. Holmes' credentialing file, the reappointment applications, the ECCH Medical Staff Bylaws, and a letter from Jamie Sinacore-Jaberg to Dr. Holmes on December 19, 2008, it is my expert opinion that Dr. Holmes's 2008 application for re-appointment and change in medical staff status was not properly responded to by ECCH.

Article VI, Section 5, of the ECCH Medical Staff Bylaws ("Change in

Membership, Privileges or Staff Category”), states

A staff member may, at any time, request a change of staff category (from consulting staff to associate or other staff category as in this case) by submitting a written notification to the Medical Staff Office. The Medical Staff Office will issue a letter requiring the physician to read and sign the letter stating the requirements of the provisional change in status. The request will be forwarded to the Department Chairman, then to the Credentials Committee. The Credentials Committee will recommend to the MEC the request, and the MEC will forward their recommendation to the Board of Directors for final approval. After final approval, the medical staff office will notify the physician of the final decision. The Medical Staff Office will track the provisional change for one (1) year and the Credentials Committee will evaluate the physician at that time to determine if he meets the necessary requirements set forth by the requested status change (Emphasis supplied)

Article V, Section 3, of the ECCH Medical Staff Bylaws (“Reappointment Process”) lays out 12 requirements for reappointment to the medical staff. Notably in this section it is stated

[The application for reappointment will be delivered to the applicant and] must be completed and returned within 30 days to the Medical Staff Office for review. A late fee will be charged for the continued processing of the application past the 30 day deadline.

Article IV, Section 3, of the ECCH Medical Staff Bylaws (“Associate”) lays out

the qualifications for the Associate status *[the candidate must meet all the criteria for active staff membership] except the minimum required number of admissions, procedures, or patient contact per year or preceding 12-month period "* (emphasis added)

9) Pursuant to the ECCH Medical Staff bylaw provisions quoted above, and on the attached *Joint Commission* flow sheet, it is my opinion that Dr Holmes requests for change in staff category would and should have been granted This is based upon (1) Dr Holmes clearly submitted "a written notification to the Medical Staff Office," (see attached Medical Staff Reappointment Application), (1) Dr Holmes provided information relevant to the requirements of licensure, training, education, and health status In addition, Dr Holmes received the highest ratings from peers for skill, competence, and quality of care, (3) Dr Holmes maintains that she submitted the reappointment application within the required time frame, however even if she did not, the Bylaws impose only a "late fee," not a denial of privileges, (4) If Dr Holmes application for change in status to Associate had been approved, the Bylaws are clear that she is exempt from "required number of admissions, procedures, or patient contact per year or preceding 12-month period "

10) Both the ECCH Medical Staff Bylaws, and *Joint Commission* Standards mandate a fair hearing process when adverse credentialing decisions are made by the medical staff and hospital Governing Board Based upon my review of Dr Holmes' credentialing files, and the ECCH Medical Staff Bylaws, it is my opinion that Dr Holmes was denied fair hearing rights as explicitly required by these bylaws and by the *Joint Commission* standards

Under Article VIII, Section 2B, of the ECCH Medical Staff Bylaws the grounds

for fair hearing are specified as follows

B Grounds for Hearing

Except as otherwise provided in these Bylaws the taking or recommending of any one or more of the following actions when based on the member's professional conduct or competence, unless taken in compliance with a policy decision of the hospital (e g, closing a department or service or physical plant changes), shall constitute grounds for a hearing pursuant to this Article

- 1 denial of initial appointment to the medical staff,*
- 2 denial of staff reappointment,*
- 3 reduction or suspension of staff membership or clinical privileges for more than 30 days,*
- 4 termination, revocation, or reduction of staff category,*
- 5 denial or termination of clinical privileges,*
- 6 summary suspension of clinical privileges for more than thirty (30) days,*
- 7 significant consultation or co-admitting requirements other than in compliance with the Medical Staff Bylaws, Rules and Regulations or departmental rules and regulations,*
- 8 denial of requested advancement in staff category,*
- 9 denial of requested service affiliation*

(emphasis added)

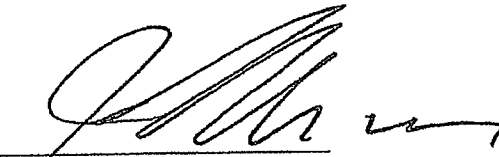
11) Privileges have value to a physician. A denial of privileges may lead to loss of income and/or adverse effects on professional standing and reputation

12) In view of Dr Holmes request for change in staff category not being processed properly and fairly by ECCH in terms of the applicable ECCH Medical Staff Bylaw provisions, Dr Holmes was denied the opportunity for a change in status. Denial of access to the process under the plain language of the bylaws for requesting change in

staff category and denial of the right to participate in that process causes harm to any physician's practice, reputation, and ability to earn a livelihood

13) Further, by denying Dr. Holmes fair hearing rights, per the applicable provisions of the ECCH Medical Staff Bylaw, ECCH prevented Dr. Holmes from her due process rights, mandated by both the Joint Commission, and the ECCG Medical Staff Bylaws

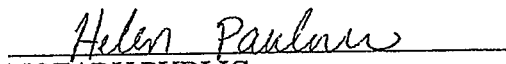
FURTHER THE AFFIANT SAITH NOT


John Shershow, M.D.

Subscribed and sworn to before me,

Notary Public, this 5 day

of July, 2011


NOTARY PUBLIC

My commission expires April 18, 2015

SEALED

HELEN PAULINO
Notary Public - State of New York
No. 01PA6239073
Qualified in Queens County
My Commission Expires April 18, 2015

John C. Shershow, M.D.
240 Central Park South #2H
New York, NY 10019
(800) 388-9299
Fax: (646) 514-7195
JShershow@gmail.com

CURRICULUM VITAE

JOHN C SHERSHOW, M D

Professional Experience

- *JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS (JCAHO)* (1989-2003)
Surveyor and Senior Teaching Faculty, for the preeminent hospital and ambulatory care accreditation organization in the United States
- *PERFORMANCE IMPROVEMENT COMPANY, INC* (1996 – present)
Founder and President of this national hospital and healthcare consulting firm
Primary activities are consulting, lecturing, and providing educational courses to hospitals, ambulatory centers, and other healthcare organizations, on healthcare quality, peer review, performance measurement, medical staff credentialing, and preparation for JCAHO and other regulatory inspections In addition, provides expert testimony on medical litigation
- *PRIVATE PRACTICE, JOHN C SHERSHOW, MD, PC* (2010 – present)
Private medical practice in Manhattan, New York City
- *PRESIDENT, URGENT CARE OF WYOMING, INC* (2003 – present)
Owner of an urgent care clinic in Wyoming
- *THE JOURNAL OF URGENT CARE MEDICINE* (2006 – 2008)
On the editorial board of this medical journal

- *CHECKUPS, USA, INC* (2006 – 2007)
Chief Operating Officer and Medical Director of a company developing primary cares clinics for retail environments
- *URGENT CARE ASSOCIATION OF AMERICA* (2005-06)
Director of Accreditation of the national urgent care organization
- *NORTHWEST COVENANT MEDICAL CENTER* (1995-1996)
Medical Director of a major New Jersey hospital
- *DOWNSTATE MEDICAL CENTER* (1992-1995)
Associate Dean and Associate Provost of New York State's largest medical school
- *KINGS COUNTY HOSPITAL CENTER* (1992-1995)
Medical Director of one of the largest hospitals in the United States
- *JOHN C SHERSHOW, M D AND ASSOCIATES, INC* (1977-1989)
Founder and President of one of the largest private medical groups in Massachusetts
- *ARBOUR HOSPITAL* (1978-1989)
Attending staff at one of Boston's leading private hospitals, President of the Medical Staff 1985-1989
- *HARVARD MEDICAL SCHOOL* (1970-2000)
On the teaching faculty in numerous capacities
- *MASSACHUSETTS GENERAL HOSPITAL* (1970-2000)
Served in various capacities, including Inpatient Director (1973-77) and on the teaching faculty (1970-2000) for this internationally known hospital
- *US ARMY RESEARCH INSTITUTE OF ENVIRONMENTAL MEDICINE* (1970-1973)
A senior medical corps officer at one of the nation's largest military environmental research organizations

Academic Appointments

- Clinical Instructor, *Harvard Medical School* (1970-2000)
- Assistant Professor, *Downstate Medical School* (1992-1995)

Education

- Residency, *Yale University* (1969-1970)
- Residency, *University of Southern California* (1967-1969)
- Rotating Internship, *Los Angeles County Hospital* (1966-1967)
- M D *University of Southern California* (1966)
- B A (Magna cum Laude), *Harvard College* (1962)

Certification and Licensure

- *National Board of Medical Examiners* (1967)
- Board Certified, *American Board of Psychiatry and Neurology* (1972)
- Past Licensure California, Massachusetts, New Hampshire
- Current Licensure New York, New Jersey

Memberships

- Distinguished Fellow, *American Psychiatric Association*

Publications

- 2 Books and numerous articles (detailed list available upon request)

5. Dr. Majeski Affidavit

STATE OF SOUTH CAROLINA)
)
COUNTY OF CHARLESTON)

AFFIDAVIT

Personally came and appeared before me, Notary Public,
James Majeski, M D , Ph D , who upon being duly sworn did
depone and say the following

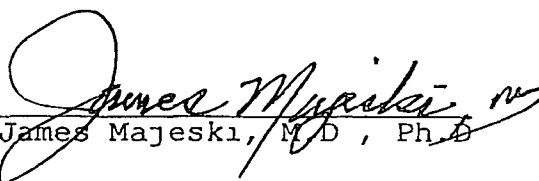
- 1) This affidavit is submitted on behalf of the plaintiff,
Dr Holmes It is based on my personal knowledge I am over
the age of eighteen (18) years and am competent to state the
matters herein
- 2) Recently, I retired from private practice of surgery
- 3) In 2006, I was on staff at East Cooper Community
Hospital (ECCH) At that time, I was asked to complete a
peer reference form for the plaintiff This form was the
type of form which is required at ECCH as part of the
reappointment application process Completing this type of
form on behalf of fellow physicians is a frequent
occurrence I have completed many over the past thirty
years
- 4) I was happy to complete the form, to positively
recommend Dr Holmes, and to support Dr Holmes'
reappointment application
- 5) Shortly thereafter, the hospital called and Dr John

Langley, employed full-time with ECCH administration, questioned me about the form. It was not a usual or customary call. I called Dr. Holmes at that time to notify her of Dr. Langley's phone call.

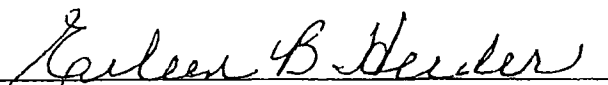
6) Over the years, I have participated in the processing of reappointment applications through Department Chairmanship, membership on the Credentials Committee, and membership on the Medical Executive Committee. That phone call was not the usual procedure for processing reappointment applications.

6) I affirm that, to the best of my knowledge, I am not related to any party to this action.

FURTHER THE AFFIANT SAITH NOT


James Majeski, M.D., Ph.D.

Subscribed and sworn to before me,
Notary Public, this 30th day
of June, 2011


NOTARY PUBLIC

My commission expires 10-22-18

Process for Privileging and Reprivileging

Does the organization have or plan to have the resources necessary to support the privilege?

Has the credential verification process established that the applicant has the licensure training, education, and ability to perform the privilege?

Does the applicant currently perform the privilege sought at the organization?

Does data collected through the ongoing professional practice evaluation validate competency?

Grant privilege with focused practice evaluation

Initiate focused professional practice evaluation

Privilege is not granted

Privilege is restricted or modified

Privilege is granted

7-5-11

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	NINTH JUDICIAL CIRCUIT
COUNTY OF CHARLESTON	)	CASE NO 10-CP-10-3410
	)	
Dr Cynthia Holmes, M D ,	)	
	)	
	)	
Plaintiff,	)	
	)	
-VS-	)	
	)	AFFIDAVIT
	)	
	)	
East Cooper Community	)	
Hospital, Inc , and Tenet	)	
HealthSystem Medical, Inc ,	)	
	)	
	)	
	)	
Defendants	)	
_____	)	

Personally came and appeared before me, Notary Public, C Holmes, M D , who upon being duly sworn did depose and say the following

- 1) I am the plaintiff I am over the age of eighteen (18) years and am competent to state the matters herein
- 2) This affidavit is submitted in opposition to defendants' motion for summary judgment and is based on personal knowledge

3) The plaintiff is a physician who requested an application for privileges at defendants' hospital on completion of ophthalmology residency. Defendants sent the hospital bylaws to the petitioner along with the application as an inducement to apply. Defendants represented that they would treat the plaintiff fairly and would follow the bylaws including its Fair Hearing provisions. In reliance on defendants' representations and to the plaintiff's detriment, the plaintiff did apply for privileges at defendants' hospital and did forego application at other facilities. Thereafter, the plaintiff was credentialed, was granted full privileges, and satisfied the provisional requirements under the bylaws.

Without notice or opportunity to be heard, defendants at the behest of the plaintiff's direct economic competitor, Dr. John Grady, terminated the plaintiff's privileges claiming violation of a non-existent bylaw provision. Dr. Paul Yantis misused his role as perennial head of the credentials committee to make good on his threat: "With managed care, there's a smaller pie, and some doctors (*indicating the plaintiff*) are going to be left behind." (Emphasis supplied.) #1-See Defendants' Minutes. Dr. Grady has admitted performing outdated large incision cataract surgery using an almost 180 degree incision to remove the swollen cataractous lens whole. He has admitted inability to master the more sophisticated, safer, and the standard-of-care small incision procedure. Dr. Grady misused his position at the hospital to eliminate his direct economic competitor and impede patient access to modern technology and the safer procedure with superior visual results. #2-See Dr. Grady's Advertisement attached. Defendants have admitted that plaintiff's termination was not exigent and involved no adverse patient care. Defendants failed to follow the

bylaws causing foreseeable damages to the plaintiff. The physician is well-trained, fully licensed, fully insured, and has established patients who need the procedures which require access to defendants' facility.

This matter involves a cause of action for breach of contract. Defendants filed a general denial, counterclaim, and motion to dismiss. Defendants' motion to dismiss based on Rule 12(b)(1), SCRCF, for lack of subject matter jurisdiction, res judicata, collateral estoppel, and judgment on the pleadings was denied by Judge Dennis. #3-See excerpt from transcript. Defendants' motion to reconsider was denied as well. Plaintiff through counsel filed a denial and a motion to dismiss counterclaims and motion to dismiss extraneous matter and hearsay. The petitioner seeks a full and fair hearing at trial by jury.

4) In 2002 (codified in 2003), East Cooper Community Hospital entered into a settlement agreement providing that "Dr. Holmes shall have the right to apply for a change in status in accordance with the bylaws." #4-See attached.

5) That settlement agreement was based on the economic expert's evaluation of damages with a smaller amount if privileges were returned and a larger amount if privileges were not returned. In the spirit of reconciliation and letting bygones be bygones, the smaller amount was accepted based on defendants' express promise to follow the bylaws. Instead, defendants did the same thing, played fast and loose with the bylaws, breached the bylaws, and certainly did not act in good faith nor live up to their agreement. As for the settlement amount, it did not even cover attorneys' fees, taxes, and costs.

6) Thereafter, my reappointment applications were not processed properly under the

bylaws, Article VI, Section 5 for Change in Staff Category from consulting to associate or other staff category

Article VI, Section 5, states

A staff member may, at any time, request a change of staff category by submitting a written notification to the Medical Staff Office. The Medical Staff Office will issue a letter requiring the physician to read and sign the letter stating the requirements of the provisional change in status. The request will be forwarded to the Department Chairman, then to the Credentials Committee. The Credentials Committee will recommend to the MEC the request, and the MEC will forward their recommendation to the Board of Directors for final approval. After final approval, the medical staff office will notify the physician of the final decision. The Medical Staff Office will track the provisional change for one (1) year and the Credentials Committee will evaluate the physician at that time to determine if he meets the necessary requirements set forth by the requested status change.

7) Based on the attached JCAHO flow sheet (#4a) provided by ECH, the ECH bylaws, and the reappointment applications, the reappointment applications were complete and qualified for the requested change to associate staff category under Article VI, Section 5 - Change in Staff Category (see above). The physician established the requirements of licensure, training, education, and health status. In addition, the physician provided evidence of current competence and attached documentation of additional education/training including hands-on. Also, objective evidence of the physician's skill and competence was submitted with the reappointment applications in the form of references from peers. The physician receives the highest ratings from peers for skill, competence, and quality of care. #5-See attached. If the reappointment applications had been processed properly under the applicable bylaws, the request should have been granted.

8) Pursuant to the 2006 bylaws, the physician qualified for reappointment to associate staff category which specified a requirement of management of 25 patients (not

of 25 patients

“Reappointment Demonstrates that one has maintained competence by showing evidence that they have managed at least 25 patients in the past 24 months ”

The physician did provide documentation of management of 25 patients in the previous 24 months with the reappointment application and offered to provide the documentation in any format preferred by ECCH #6-See 2006 form with attached summaries for 25 surgical patients But for ECCH’s wrongdoing, those 25 surgical procedures would not have had to be referred ECCH’s wrongdoing caused damages including lost income But for ECCH’s wrongdoing, the physician would have had more than 25 procedures

9) Further, under the revised 2007 ECCH bylaws, the physician should have been “grandfathered” under the provision, “Physicians awarded surgical clinical privileges prior to November 7, 2007, shall be permitted to maintain these privileges ” Article IV, Section 3, Revised December 2007 - #7 see attached “Grandfathered” is a term for fair treatment of physicians under the bylaws when the bylaws are changed It indicates that it is unfair to apply adverse changes in bylaws to physicians similarly-situated like the plaintiff who are already on staff

10) East Cooper Community Hospital (ECH) failed to provide a fair hearing as timely requested by the plaintiff after denial at reappointments as early as 1996 #8-See attached requests for appeal and fair hearing Had the physician been afforded a fair hearing at a meaningful time, the physician’s privileges should not have been terminated then or now and we would not have to be here today

Under Article VIII, Section 2B, the grounds for hearing are specified

B Grounds for Hearing

Except as otherwise provided in these Bylaws, the taking or recommending of any one or

more of the following actions when based on the member's professional conduct or competence, unless taken in compliance with a policy decision of the hospital (e g , closing a department or service or physical plant changes), shall constitute grounds for a hearing pursuant to this Article

- 1 denial of initial appointment to the medical staff,
 - 2 **denial of staff reappointment,**
 - 3 reduction or suspension of staff membership or clinical privileges for more than thirty (30) days,
 - 4 termination, revocation, or reduction of staff category,
 - 5 denial or termination of clinical privileges,
 - 6 summary suspension of clinical privileges for more than thirty (30) days,
 - 7 significant consultation or co-admitting requirements other than in compliance with the Medical Staff Bylaws, Rules and Regulations or departmental rules and regulations,
 - 8 **denial of requested advancement in staff category,**
- and
- 9 Denial of requested service affiliation

11) Wrongful termination of the plaintiff's privileges caused loss of income and/or adversely affected professional standing causing damages

12) Termination of privileges, denial of request for change of status at reappointments, denial of access to the process for change of status, and/or denial of fair hearing rights caused damages to the plaintiff and to the plaintiff's practice as well

13) Also, as specified in the attached JCAHO excerpt (#9) provided by ECCH, ECCH and Tenet represent that they comply with these JCAHO fair hearing standards

14) Current competence is regulated by statute in the State of South Carolina #10-See attached South Carolina Statute At all times pertinent to the matter herein, the plaintiff complied with the statute Also, objective evidence of the physician's skill and competence was submitted with the reappointment applications in the form of references from peers The physician receives the highest ratings from peers for skill, competence, and quality of care

15) One method of denying a physician access to the process and to the fair hearing rights is to claim that the application is incomplete. Falsely claiming that the application is incomplete is not good faith. The applications were complete for the requested change under the applicable provision, Article 6, Section 5.

16) With regard to the 2008 reappointment application, the physician requested associate staff category. Initial appointment requirements are not applicable because Dr. Holmes' initial appointment was granted and regularly completed thereafter. As such, the request by ECH for 48 patient contacts is inconsistent with the bylaws for reappointment to associate staff. In fact, the bylaws prohibit associate staff from having active privileges at another hospital. Yet, one would have to be active at another facility in order to comply with the requirement of 48 patient contacts. The applicable bylaw provision is Article VI, Section 5, which states

A staff member may, at any time, request a change of staff category by submitting a written notification to the Medical Staff Office. The Medical Staff Office will issue a letter requiring the physician to read and sign the letter stating the requirements of the provisional change in status. The request will be forwarded to the Department Chairman, then to the Credentials Committee. The Credentials Committee will recommend to the MEC the request, and the MEC will forward their recommendation to the Board of Directors for final approval. After final approval, the medical staff office will notify the physician of the final decision. The Medical Staff Office will track the provisional change for one (1) year and the Credentials Committee will evaluate the physician at that time to determine if he meets the necessary requirements set forth by the requested status change.

Accordingly, Dr. Holmes reappointment application was complete under the applicable bylaw provision, Article VI, Section 5.

17) Also with regard to the 2008 reappointment application, the physician did comply and did submit the requested form for reappointment to associate staff indicating a request

of 25 patients

“Reappointment Demonstrates that one has maintained competence by showing evidence that they have managed at least 25 patients in the past 24 months ”

The physician did provide documentation of management of 25 patients in the previous 24 months with the reappointment application and offered to provide the documentation in any format preferred by ECCH #6-See 2006 form with attached summaries for 25 surgical patients But for ECCH's wrongdoing, those 25 surgical procedures would not have had to be referred ECCH's wrongdoing caused damages including lost income But for ECCH's wrongdoing, the physician would have had more than 25 procedures

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10) East Cooper Community Hospital (ECH) failed to provide a fair hearing as timely requested by the plaintiff after denial at reappointments as early as 1996 #8-See attached requests for appeal and fair hearing Had the physician been afforded a fair hearing at a meaningful time, the physician's privileges should not have been terminated then or now and we would not have to be here today

Under Article VIII, Section 2B, the grounds for hearing are specified

B Grounds for Hearing

Except as otherwise provided in these Bylaws, the taking or recommending of any one or

for renewal of the same privileges as previously approved and granted along with documentation of additional training and experience including hands-on

18) As one example, new surgical procedures are constantly evolving, being modified, and/or added. Even if a physician has not done a particular new procedure before, so long as the licensure, training, education, and ability in terms of health status are demonstrated, a request to perform that procedure is granted with review after a certain time period such as one year

19) Turning now to defendants' expert, D Pocock, M D , swears under oath that his statements are based on personal knowledge, yet his affidavit documents that he was not in Charleston during the time periods (2006 and 2008) on which he opines. To my knowledge, he has never met me. The affidavit is facially insufficient and should be dismissed.

20) The expert has been badly misinformed by ECCH and Tenet just as a former Tenet hospital administrator was misinforming my patients and referral sources stating that Dr Holmes "bought her medical degree." ECCH and Tenet are now misinforming and making misrepresentations to their expert #11-See attached copy of 2008 reappointment form documenting the expiration date as December 13, 2008. This expert gives his opinion that the application was incomplete based on the falsehood that the date of the term's expiration was November 13, 2008, as well as other misinformation and hearsay. If he had personal knowledge, he would and should have known the correct date. The affidavit should be dismissed as hearsay.

21) Further, in paragraph 6 and throughout the affidavit, the expert offers his opinion on the law. First, he opines that the two different lawsuits are the same. Nevermind, that the current matter is different, as just one example, because it includes a claim for wrongful termination. Moreover, the affiant fails to disclose that the reappointments at 2004 and 2006 are different as reflected on the attached forms for 2004 and 2006 (#6 and #12). His resume includes no expertise in the law, therefore, his "expert" opinion should

be stricken. This fact conclusively demonstrates that he is rendering opinions outside his expertise. His affidavit should be dismissed as unreliable.

22) Further, his opinion is based on material misrepresentations of material fact by ECCH and Tenet. Consulting staff members indeed have operative privileges as stated in Article IV, Section 5, "Consulting staff members may render assistance in the operating room at the specific request of a surgeon who has admitting and operative privileges at East Cooper Regional Medical Center." If he had personal knowledge, he would and should have known this fact. The affidavit should be dismissed as hearsay.

23) In addition, his opinion is based on material misrepresentations by defendants regarding plaintiff's surgical patients since 1998. Defendants' own Director of Health Information disputes defendants' misinformation. #13-See letter dated February 12, 2007. Moreover, that letter is itself inaccurate. #14-See attached documentation of just some of the patient contacts through the plaintiff's last reappointment cycle before wrongful termination. These documents establish the inaccuracies. If he had personal knowledge instead of relying on defendants' misinformation, he would and should have known this fact. The affidavit should be dismissed as unreliable and based on hearsay.

24) With respect to paragraph 12 of the expert's affidavit, his opinion is based on error of material fact because the 2006 reappointment application states that the requirement is management of 25 cases, not 25 surgeries. The plaintiff did demonstrate management of 25 cases and offered to provide more documentation on request. Yantis and ECCH wrongfully refused to allow the plaintiff's application to be considered. Yantis has testified under oath that chart review and other forms of information are appropriate documentation. The plaintiff's application was not processed or even considered.

25) Regarding paragraph 13, the expert fails to disclose that the change in the bylaw provision goes on to "grandfather" in all physicians similarly-situated with the plaintiff. Had ECCH processed the plaintiff's application properly, associate privileges would and should have been granted and the plaintiff would and should have been "grandfathered."

with other similarly-situated physicians

26) Paragraph 14 is unintelligible as it confuses 2006 and 2008 reappointment applications with the 2004 reappointment application. With respect to 2004, the reappointment application was approved by the Department of Surgery and the Department of Surgery Chairman. #15-See attached delineation of privileges forms indicating Department of Surgery approval from 2000 forward

27) Paragraph 15 states that the Medical Staff Office (MSO) is responsible for determining if the application is complete because when the application is complete, the MSO forwards it to the Department Chairperson. Thus, as was done in 2000 through 2004, the MSO determined that the application was complete as evidenced by the fact that the MSO forwarded the completed application to the Department of Surgery Chairman. As noted on all the forms from 2000 through 2004, the Department of Surgery Chairman approved the plaintiff's request just as any other similarly-situated physician's request would have been approved.

28) Also, as stated in Paragraph 15, the application is then forwarded to the credentials committee. It was only after the perennial chairman of the credentials committee, Dr Yantis, derailed the application that it was denied. The perennial chairman of the credentials committee has been asked to comply with the bylaws requiring rotation of the chairmanship every two years. After his refusal, more than fifty (50) physicians on staff at ECCH signed a petition to change the bylaws to require that the committee chairman including credentials committee be rotated every 2 years. #16-See attached. Despite the overwhelming lack of support for Dr Yantis, he elected to grandfather himself in and remains the never-ending, perennial chairman of the credentials committee.

29) As to paragraph 23, the plaintiff submits that the circumstances surrounding defendants' wrongdoing are facts relevant to the matter herein. It is not surprising that defendants would want to avoid their sordid acts and dirty dealing. Documenting the facts as to why we are here today is relevant. But for defendants' continued wrongdoing we

would not have to be here today

30) With respect to the remaining paragraphs 25 to 38 regarding the 2008 reappointment, the expert's affidavit proves that he has no personal knowledge because he was not in Charleston. Accordingly, the affidavit is insufficient to prove the truth of the matter asserted and should be dismissed.

31) Regarding paragraph 26, the expert is badly misinformed and materially misrepresents that the Delineation of Privileges form with core privileges was first introduced in September of 2007. Also, the referenced 2007 Bylaw provision of Art. VI, Section 2 A, is materially misrepresented to be newly instituted at that time. In fact, it is identical to the 2005 Bylaw provision of Art. VI, Section 2 A. #15-The attached Delineation of Privileges forms show core privileges with Department of Surgery approval of the plaintiff's requests for 2000 and going forward. The plaintiff's requests for change in staff category should have been granted.

32) Paragraph 27 contains an error of material fact because the 2008 reappointment application shows that the term's expiration date was December 13, 2008 (see #17), not November 13, 2008, as was misrepresented. Based on this error of material fact, the expert erroneously opines that the application was incomplete. If he had personal knowledge, he would and should have known the correct date. The affidavit is unreliable, is based on hearsay, and should be excluded.

33) Paragraph 28 acknowledges that ECCH received the plaintiff's Delineation of Privileges form and that ECCH understood that the plaintiff was requesting renewal of the same privileges which the plaintiff had already been granted and which ECCH had already documented and verified.

34) As for paragraph 31, the completed 2008 delineation form is attached (#18) and includes the "documentation to support" renewal of privileges as stated in the last paragraph just above the signature. The last entry on the form has no box to check and states "If the condition/privilege you are interested in is not included on this form, please

provide a separate written request and appropriate documentation of training and/or experience ” That is exactly what the plaintiff did The form is complete on its face In paragraph 28, the expert acknowledges receipt of plaintiff’s separate written request and unprofessionally characterizes it as a “laundry list” suggesting that the expert is unaware that it is ECCH and Tenet’s own form for privileges already granted

35) Further, the 2008 delineation form is unusual in that the initial appointment requires half the number of procedures as reappointment does Moreover, on the 2008 form, initial appointment is expressly allowed to have less than the minimum number, but reappointment is not

36) With the next paragraphs, the expert jumps back to 2006 without disclosing that the 2006 form itself requests documentation of management of 25 patients for reappointment (not 25 procedures) which the plaintiff provided Defendants wrongfully refused to consider the plaintiff’s documentation and the plaintiff offered to provide the information in a format specified by ECCH and Tenet

37) In paragraph 38, the expert again engages in the unauthorized practice of law by opining “there is no evidence of malice” and by opining that defendants are immune The affidavit reflects lack of reliability due to the expert’s opinions outside his expertise His resume lists no expertise in the law The affidavit should be stricken as unreliable and hearsay

38) In his affidavit, the expert claims that the 2008 form was incomplete because the plaintiff did not check one certain box The expert fails to disclose that the form allows for other requests and for additional documentation which the plaintiff included The application was timely submitted on November 13, 2008, within thirty (30) days prior to expiration on December 13, 2008 #18-See attached 2008 delineation form The last entry states “If the condition/privilege you are interested in is not included on this form, please provide a separate written request and appropriate documentation of training and/or experience ” The plaintiff did timely provide the written request and the expert in

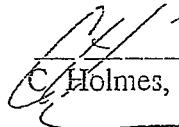
Paragraph 28 acknowledges that the written request was received and that ECCH understood it was a request

39) The 2008 reappointment application was sent on or about Thursday, October 30, 2008 Yet, ECCH did not acknowledge receipt until Thursday, November 6, 2008 (Paragraph 28 and 29) In Paragraph 31, the expert claims that on Thursday, November 6, 2008, the application was incomplete on its face Yet, ECCH waited until Wednesday, November 12, 2008, to hand-deliver the application to the plaintiff on the day before it was due, suggesting ECCH and Tenet were on a mission to delay the timely submission of the application, to claim the application was late, and to rush to judgment falsely claiming the application was incomplete thereby avoiding fair hearing rights Falsely claiming the application is incomplete is not good faith

40) As for W Stroud, M D , his affidavit fails to disclose that, on information and belief, he is employed by ECCH administration and Tenet Moreover, the conflict referenced in the attached letter dated 1997 remains #19-See attached Further, his affidavit is based on material misrepresentations made by ECCH and Tenet The affidavit is unreliable and should be dismissed as hearsay

41) Dr Majeski has provided an affidavit His C V is attached See #20 He signed Dr Holmes provisional form documenting completion of all provisional requirements See #21

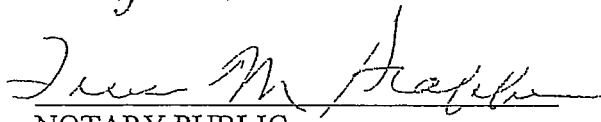
FURTHER THE AFFIANT SAITH NOT


C. Holmes, M D

Subscribed and sworn to before me,

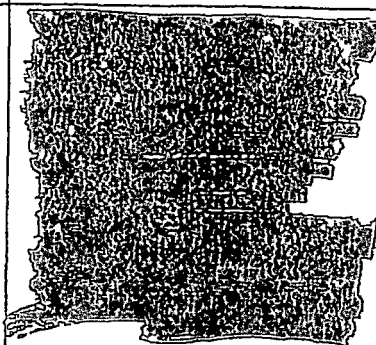
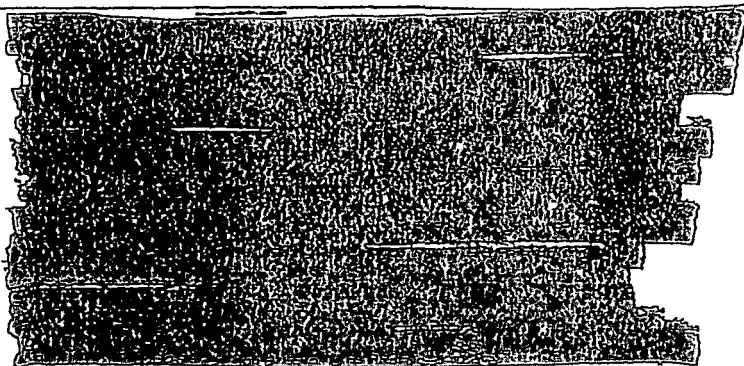
Notary Public this 5th day

of July 2011


NOTARY PUBLIC

My commission expires 3/5/12

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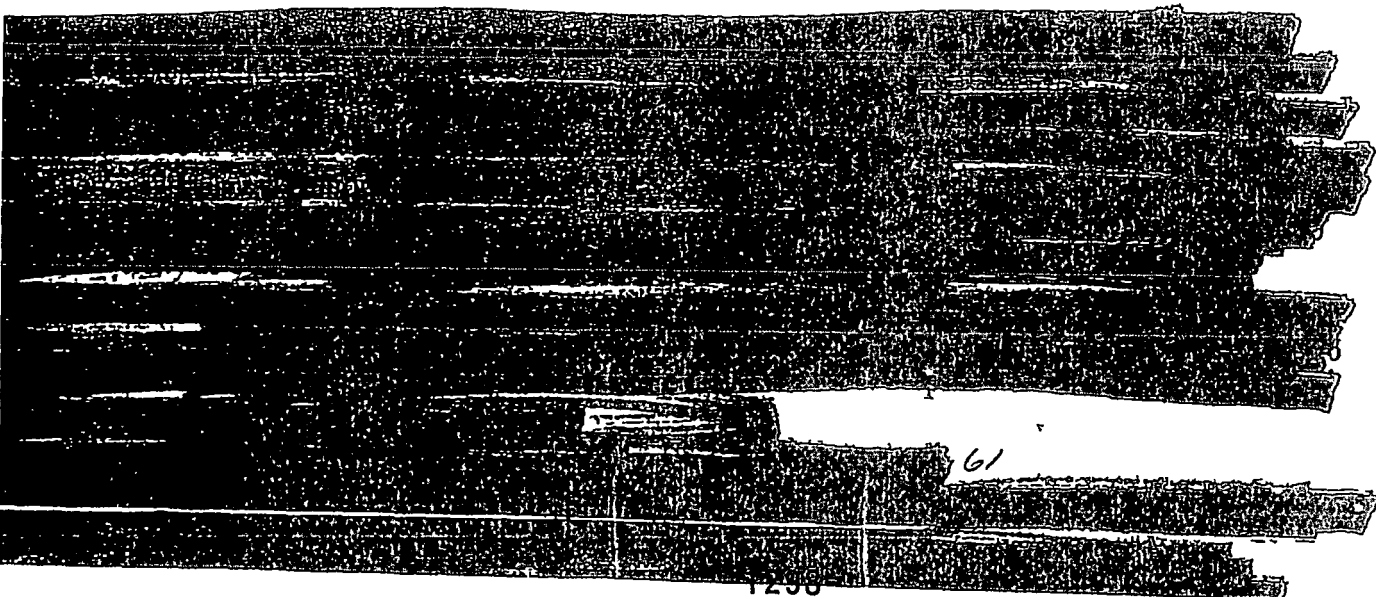


71

Dr Cynthia Holmes

Dr Yantis stated that Dr Holmes one year provisional review was up for review and asked Dr Grady to comment on her provisional year Dr Grady stated that Dr Holmes has met her meeting attendance but has not met the patient contact requirement According to the report pulled from medical records Dr Holmes has had five contacts The committee discussed the issue and decided to send Dr Holmes a letter stating that she didn't meet the requirements of active status and will be appointed to the consulting staff As a member of the consulting staff Dr Holmes can not admit patients Unless Dr Holmes can document that she is active at another local hospital in order to maintain courtesy privileges, she will have to go to consulting staff.

Kara will send Dr Holmes a letter A motion was made to appoint Dr Holmes to the consulting staff.



GRADY, JOHN L , M D , P A

Your vision is precious That's why Dr Grady takes time to get to know each patient so that they are comfortable and knowledgeable before any procedure is performed Practicing for over 26-years, Dr Grady brings a wealth of wisdom and experience to his patients, and the most current proven technology including Lasik, laser vision correction surgery Dr Grady is the only full time ophthalmologist in Mt Pleasant treating medical and surgical diseases of the eye Dr Grady is here to help you because a solution is in sight! ✦ Cataract Surgery ✦ Lasik - Laser Vision Correction Surgery ✦ Board Certified
900 Bowman Rd Suite 303, Mt Pleasant / ph 884 2015

Cynthia Holmes, M D v East Cooper Community Hospital et al
Case No 05 CP-10-5113
Hearing of December 16 2010
Before The Honorable R Markley Dennis, Jr

4

#3

1 CYNTHIA COLLIE HOLMES I do not

2 THE COURT Do we have a cell phone

3 that she can use, see if it can be arranged

4 with that -- or give us another number

5 (BRIEF RECESS)

6 CLERK (Places conference call)

7 MR JOHNSON Chalmers

8 THE COURT Good morning, Mr

9 Johnson This is Judge Dennis How are you?

10 MR JOHNSON Good morning, Judge

11 Dennis Thanks for calling me

12 THE COURT Sure Glad to do it I

13 have Ms Smith-Yancey here, and Dr Holmes is

14 here as well We are on -- is it your Motion,

15 Ms Smith-Yancey?

16 LINDSEY SMITH-YANCEY It is

17 THE COURT All right Be happy to

18 hear from you

19 LINDSEY SMITH-YANCEY Thank you

20 May it please the Court Your Honor, as you

21 know, I am Lindsey Smith-Yancey and I represent

22 the defendant in the new lawsuit, the 2010

23 lawsuit

24 (We have filed a Motion to dismiss this

25 lawsuit based on Rule 12(b)(1) for lack of

1 subject matter jurisdiction and we also move
2 for a dismissal based on the principles of *res*
3 *judicata* and collateral estoppel We have also
4 moved for a judgment on the pleadings

5 We have filed a pretty extensive
6 memorandum of law in support of -- and which
7 contains legal authorities -- our Motions I
8 would large rely on that

9 THE COURT It is incorporated in
10 the record of this proceeding for the purposes
11 of review
-- --

#4

STATE OF SOUTH CAROLINA)
)
COUNTY OF CHARLESTON)

SETTLEMENT AGREEMENT &
GENERAL RELEASE IN FULL

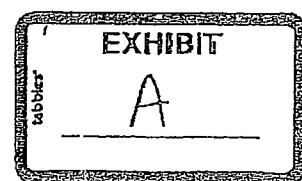
THIS SETTLEMENT AGREEMENT & GENERAL RELEASE IN FULL is entered into by C Holmes, M D , (hereinafter at times referred to as 'Releasor') to Tenet HealthSystem Medical, Inc East Cooper Community Hospital, Inc John Grady, M D Paul Yantis, M D , and William Cone, and their insurance carrier (hereinafter Releasees')

WHEREAS, C Holmes, M D , filed a Complaint against Tenet HealthSystem Medical, Inc East Cooper Community Hospital, Inc, John Grady, M D Paul Yantis, M D and William Cone, in the Court of Common Pleas for the State of South Carolina, County of Charleston, said case bearing Civil Action Number 00-CP-10-1888, which Complaint arose out of certain alleged causes of action and/or theories of liability as against the Releasees In the Complaint, Releasor sought to recover equitable and monetary damages sustained by Releasor arising out of incidents as set forth in said Complaint and,

WHEREAS, the parties recognize that serious controversies and disputes exist and that if the Releasor's claims and questions of responsibility therefore, if any, be litigated that such would involve serious and extensive questions insofar as the parties are concerned, in consequence of which the parties have agreed in consideration of the amounts and terms hereinafter recited to settle any and every claim which the Releasor has asserted, might assert, or which Releasor may have against the Releasees in this case, it being recognized and agreed that the controversies and disputes that exist are adequate consideration for final settlement of all the claims in accordance with this Settlement Agreement & General Release in Full

NOW, THEREFORE, KNOW ALL MEN BY THESE PRESENTS, in consideration of the payment of ~~_____~~ to the Releasor in hand paid by and on behalf of the Releasees, and in consideration of the following agreement among the parties, to wit

- (1) That Dr Holmes has been reappointed to consulting status for a term of two (2) years Dr Holmes shall have the right to



apply for a change in status in accordance with the Bylaws,

- (2) That Releasees agree that they, their agents, servants, and employees shall not say or do anything detrimental to the Releasor obtaining privileges elsewhere. If asked, they will say about this dispute that there came a time when the Releasor did not have a sufficient number of contacts, that this resulted in a change of status to consulting, and that this had nothing to do with professional competence,

that all parties, Releasor and Releasees, hereby completely release and forever discharge each other from any and all claims, demands, obligations, causes of action, rights, damages, costs, losses of services, fees, expenses and compensation of any nature whatsoever, whether based on a tort, contract, or other theory of recovery, which the parties now have or which may hereafter accrue or otherwise be acquired, on account of, or may in any way grow out of, or which are the subject of the Complaint (and all related pleadings) including, without limitation, any and all known or unknown claims for injuries and damages to the parties which may have resulted, or may result from any alleged acts or omissions of the parties which are the subject of the Complaint (and all related pleadings)

IT IS FURTHER UNDERSTOOD AND AGREED THAT this release and discharge shall also apply to Releasor's and Releasees' past, present, and future officers, directors, stockholders, attorneys, agents, servants, representatives, employees, subsidiaries, parent corporations, affiliates, partners, predecessors, successors in interest, assigns, and all other persons, firms, or corporations with whom any of the former have been, are now, or may hereafter be affiliated

The Releasor and Releasees acknowledge and agree that the respective release and discharge by all parties set forth above is a general release. The Releasor and Releasees expressly waive and assume the risk of any and all claims for damages arising out of Civil Action Number 00-CP-10-1888, but of which the parties do not know or suspect to exist, whether through ignorance, oversight, error, negligence, or otherwise, and which, if known, would materially affect the parties' decision to enter into this Settlement Agreement & General Release in Full. The parties further agree that the parties have accepted the

consideration specified herein as a complete compromise of matters involving disputed issues of law and fact. It is understood and agreed to by all parties that this settlement is a compromise of a disputed claim and the payments are not to be construed as an admission of liability on the part of any party.

IT IS EXPRESSLY UNDERSTOOD AND AGREED that each party hereto shall bear all attorney's fees and costs arising from the actions of their own counsel in connection with the lawsuit, this Settlement Agreement & General Release in Full, and the matters and documents referred to herein, the filing of an Order of Dismissal with prejudice of the Complaint, and all related matters.

IT IS FURTHER UNDERSTOOD AND AGREED that concurrently with the execution of this Settlement Agreement & General Release in Full, counsel for the Releasor shall deliver to the counsel for the Releasees an executed Order of Dismissal with prejudice of the Complaint. Releasor hereby authorizes counsel for the Releasees to file said Order of Dismissal with prejudice with the Court and enter it as a matter of record.

In entering into this Settlement Agreement & General Release in Full the parties represent that each has had the advice of their respective attorneys, who are attorneys of each party's own choice, concerning the legal consequences of this Settlement Agreement & General Release in Full, that the terms of this Settlement Agreement & General Release in Full have been completely read and explained to each party by each party's attorney, and that the terms of this Settlement Agreement & General Release in Full are fully understood and accepted by each party.

Releasor and Releasees represent and warrant that no other person or entity has, or has had any interest in the claims, demands, obligations, or causes of action referred to in this Settlement Agreement & General Release in Full further, the Releasor and the Releasees agree to indemnify and hold harmless the other party or parties, their respective agents, servants, employees, directors, stockholders, attorneys, representatives, employees, subsidiaries, parent corporations, affiliates, partners, predecessors, successors in interest, and assigns for any costs, fees, and/or judgment which may be suffered by said party or parties upon the bringing of any claim by any person claiming damages as the result of said party or parties having sold, assigned, transferred, conveyed, or otherwise disposed of any claims, demands, obligations, or

causes of action referred to in this Settlement Agreement & General Release in Full

The parties agree that neither they nor their attorneys nor representatives shall reveal to or discuss with anyone, other than as may be mutually agreed to in writing, or as may be ordered by a court of competent jurisdiction, any of the monetary terms of this Settlement Agreement & General Release in Full or any of the amounts, numbers, or terms and conditions of any sums payable to the Releasor

This Settlement Agreement & General Release in Full shall be construed and interpreted in accordance with the laws of the State of South Carolina

This Settlement Agreement & General Release in Full contains the entire agreement between the Releasor and Releasees and shall be binding upon and inure to the benefit of the executors, administrators, personal representatives, heirs, successors, and assigns of each

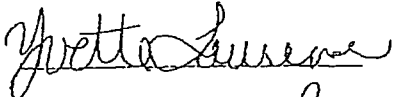
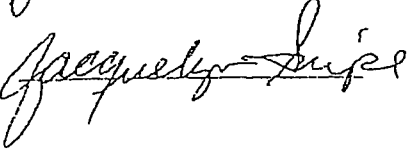
This Settlement Agreement & General Release in Full shall become effective immediately following execution by each of the parties

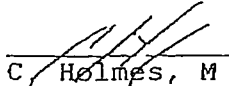
ATTORNEY'S CERTIFICATE

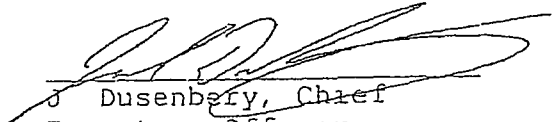
As attorney for C Holmes, M D , I have explained the meaning of this Settlement Agreement & General Release in Full to Dr Holmes and have recommended the acceptance of its terms and conditions

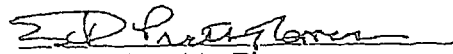

M/ C Bond
Dated 1/12/03

WITNESSES


C Holmes, M D
Dated 1/14/03

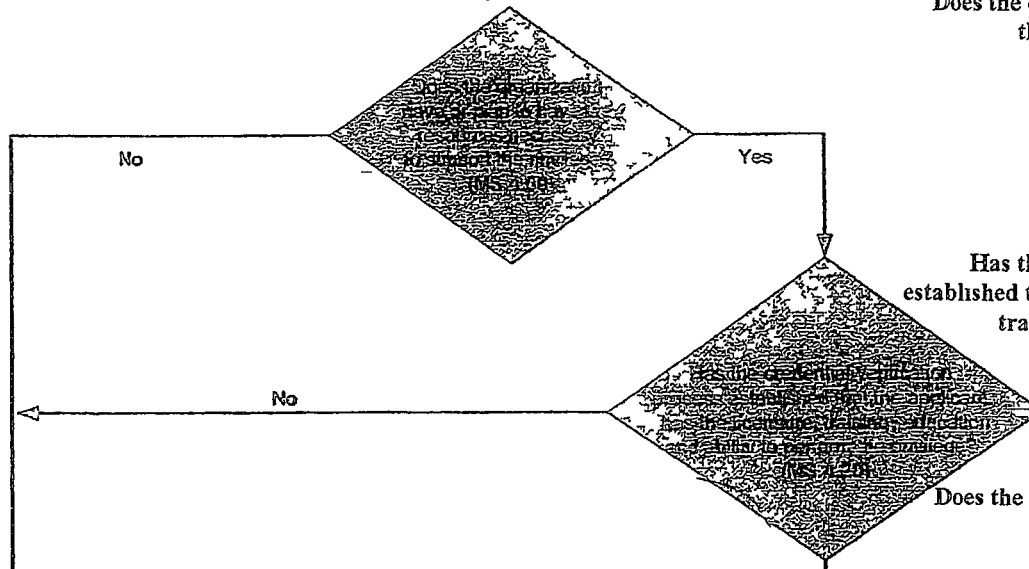

J Dusenbery, Chief
Executive Officer,
East Cooper
Community Hospital, Inc
Dated 1/20/03


E D Pratt-Thomas
As Attorney for Releasees
Dated 1/20/03

#4a

Process for Privileging and Reprivileging

Does the organization have or plan to have the resources necessary to support the privilege?



Has the credential verification process established that the applicant has the licensure, training education, and ability to perform the privilege?

Does the applicant currently perform the privilege sought at the organization?

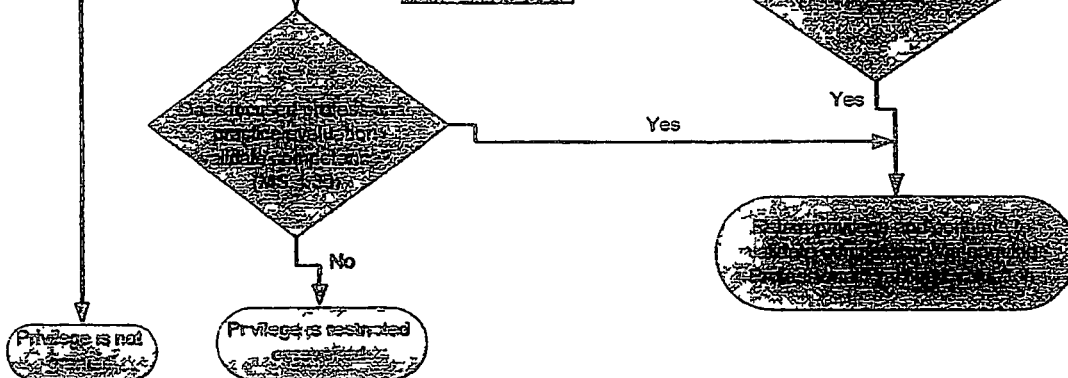
Grant privilege with focused practice evaluation



Initiate focused professional practice evaluation



Does data collected through the ongoing professional practice evaluation validate competency?



**East Cooper Regional Medical Center
Physician Performance / Peer Competency Form**

#5

This form must be completed by a "peer" who maintains medical staff privileges at East Cooper Regional Medical Center. Please have the individual completing this form fax it to the Medical Staff Office or send in a sealed confidential envelope to ECRMC - Attention MSO 1200 Johnnie Dodds Blvd Mt Pleasant, SC 29464 / fax (843) 881-4396. The South Carolina Code Section 40-71-20 protects this information from discovery.

Practitioner's Name Cynthia Holmes Specialty Ophthalmology

How long have you known the applicant? 11 yrs

In what capacity have you known the applicant? as a colleague

Please explain any "Yes" responses on a separate sheet if necessary

☒ No ☐ Yes

To the best of your knowledge, has this physician's privileges at a health care facility ever been suspended, revoked or reduced, either voluntarily or involuntarily?

☒ No ☐ Yes

To the best of your knowledge, has this physician been subject to any disciplinary action by a health care facility or any licensing board medical organization during the past two years either voluntarily or involuntarily?

☒ No ☐ Yes

To the best of your knowledge, has the physician's license to practice and/or DEA registration been challenged, placed under suspension or removed, voluntarily or involuntarily, during the last two years?

☒ No ☐ Yes

To the best of your knowledge has this physician been excluded from participation in any federal health programs, including any exclusions or other sanction(s) imposed or recommended by the federal Department of Health and Human Services?

☒ No ☐ Yes

To the best of your knowledge, has this physician been subject to any pending or final malpractice litigation during the last two years?

☒ No ☐ Yes

To the best of your knowledge, does this physician have any mental/physical health or other problem, which would interfere with his/her ability to exercise their clinical privileges?

☒ No ☐ Yes

To the best of your knowledge, is there any reason (not explained above) why this applicant should not be appointed to the East Cooper Regional Medical Center Medical Staff?

Based on your professional/personal knowledge of this applicant, please rate his/her current clinical competence in the following areas. Please complete all areas.

	Excellent	Satisfactory	Problem	No Information
Clinical Competence	☒			
Technical Skill	☒			
Judgment	☒			
Relevant training of experience in Clinical specialty	☒			
Pharmacology	☒			
Medical Record Compliance	☒			
Quality of Care Provided	☒			
Relationship with Peers	☒			
Relationship with Subordinates	☒			

☒ I would recommend this physician for membership to East Cooper Regional Medical Center

☐ I would not recommend this physician for membership to East Cooper Regional Medical Center

East Cooper Regional Medical Center
Physician Performance / Peer Competency Form

This form must be completed by a "peer," who maintains medical staff privileges at East Cooper Regional Medical Center. Please have the individual completing this form fax it to the Medical Staff Office or send in a sealed confidential envelope (ECRMC - Attention: MSO 1200 Johnnie Dodds Blvd Mt Pleasant, SC 29464 / fax (843) 881-4396). The South Carolina Code Section 40-71-20 protects this information from discovery.

Practitioner's Name Dr Cynthia Holmes Specialty Opt 41

How long have you known the applicant? 9 years

In what capacity have you known the applicant? co-worker / share office / consultant

Please explain any "Yes" responses on a separate sheet if necessary

- ☒ No ☐ Yes To the best of your knowledge, has this physician's privileges at a health care facility ever been suspended, revoked or reduced, either voluntarily or involuntarily?
- ☒ No ☐ Yes To the best of your knowledge, has this physician been subject to any disciplinary action by a health care facility or any licensing board, medical organization during the past two years, either voluntarily or involuntarily?
- ☐ No ☐ Yes To the best of your knowledge, has the physician's license to practice and/or DEA registration been challenged, placed under suspension or removed, voluntarily or involuntarily, during the last two years?
- ☐ No ☐ Yes To the best of your knowledge, has this physician been excluded from participation in any federal health programs, including any exclusions or other sanction(s) imposed or recommended by the federal Department of Health and Human Services?
- ☒ No ☐ Yes To the best of your knowledge, has this physician been subject to any pending or final malpractice litigation during the last two years?
- ☐ No ☐ Yes To the best of your knowledge, does this physician have any mental/physical health or other problem, which would interfere with his/her ability to exercise their clinical privileges?
- ☐ No ☐ Yes To the best of your knowledge, is there any reason (not explained above) why this applicant should not be appointed to the East Cooper Regional Medical Center Medical Staff?

Based on your professional/personal knowledge of this applicant, please rate his/her current clinical competence in the following areas. Please complete all areas.

	Excellent	Satisfactory	Problem	No Information
Clinical Competence	☒			
Technical Skill	☒			
Judgment	☒			
Relevant training or experience in Clinical specialty	☒			
Pharmacology	☒			
Medical Record Compliance	☒			
Quality of Care Provided	☒			
Relationship with Peers	☒			
Relationship with Subordinates	☒			

- ☒ I would recommend this physician for membership to East Cooper Regional Medical Center
- ☐ I would not recommend this physician for membership to East Cooper Regional Medical Center

East Cooper Regional Medical Center
Physician Performance / Peer Competency Form

This form must be completed by a peer who maintains medical staff privileges at East Cooper Regional Medical Center. Please have the individual completing this form fax it to the Medical Staff Office or send in a sealed confidential envelope (ECRMC - Attention MSO 1200 Johnnie Dodds Blvd Mt Pleasant, SC 29464 / fax (843) 881-4396. The South Carolina Code Section 40-71-20 protects this information from discovery.

Practitioner's Name Cynthia Holmesfeld Specialty Ophthalmology

How long have you known the applicant? 3 years

In what capacity have you known the applicant? is an ophthalmology colleague

Please explain any "Yes" responses on a separate sheet if necessary

☒ No ☐ Yes

To the best of your knowledge, has this physician's privileges at a health care facility ever been suspended, revoked or reduced, either voluntarily or involuntarily?

☒ No ☐ Yes

To the best of your knowledge, has this physician been subject to any disciplinary action by a health care facility or any licensing board, medical organization during the past two years, either voluntarily or involuntarily?

☒ No ☐ Yes

To the best of your knowledge, has the physician's license to practice and/or DEA registration been challenged, placed under suspension or removed, voluntarily or involuntarily during the last two years?

☒ No ☐ Yes

To the best of your knowledge, has this physician been excluded from participation in any federal health programs, including any exclusions or other sanction(s) imposed or recommended by the federal Department of Health and Human Services?

☒ No ☐ Yes

To the best of your knowledge, has this physician been subject to any pending or final malpractice litigation during the last two years?

☒ No ☐ Yes

To the best of your knowledge, does this physician have any mental/physical health or other problem, which would interfere with his/her ability to exercise their clinical privileges?

☒ No ☐ Yes

To the best of your knowledge, is there any reason (not explained above) why this applicant should not be appointed to the East Cooper Regional Medical Center Medical Staff?

Based on your professional/personal knowledge of this applicant, please rate his/her current clinical competence in the following areas. Please complete all areas.

	Excellent	Satisfactory	Problem	No Information
Clinical Competence	☒			
Technical Skill	☒			
Judgment	☒			
Relevant training or experience in Clinical specialty	☒			
Pharmacology	☒			
Medical Record Compliance	☒			
Quality of Care Provided	☒			
Relationship with Peers	☒			
Relationship with Subordinates	☒			

☒ I would recommend this physician for membership to East Cooper Regional Medical Center

☐ I would not recommend this physician for membership to East Cooper Regional Medical Center

East Cooper Region I
Medical Center

Tenet

NAME Cynthia E Holmes MD -

OPHTHALMOLOGY SURGERY DELINEATION OF PRIVILEGES			
Minimum threshold criteria to apply for ophthalmology privileges			
1	Education MD or DO		
2	Minimum formal training Successful completion of an ACGME/AOA accredited residency training program in ophthalmology program		
3	Board Certification Must be achieved within 5 years of residency/fellowship training or as noted by their respective board Acceptable board certification in only through the ABMS		
4	Required previous experience Applicants must be able to demonstrate that they have provided surgical ophthalmology treatment to at least 25 ophthalmologic surgical procedures in the past 24 months		
5	References Letters of reference must come from the residency and/or fellowship director or the Chief of Ophthalmology in which the applicant has successfully completed training and/or the applicant has been affiliated with for the last two years Two letters must come from an anesthesiologist and primary care physician who have known the applicant at least two years and are acquainted with the applicants current professional status medical practice and involvement in the field of ophthalmology		
6	Reappointment Demonstrates that one has maintained competence by showing evidence that they have managed at least 25 patients in the past 24 months		
The above minimum threshold criteria must be met in order to request core privileges			
		REQUESTED	APPROVED
CORE PRIVILEGES FOR OPHTHALMOLOGY SURGERY			
Core privileges include admission work up diagnosis and the performance of surgical procedures on patients of all ages presenting with illnesses injuries and disorders of the eye including its related structures and visual pathways These privileges include the provision of consultation as well as the ordering of diagnostic studies and procedures related to the ophthalmologic problems The use of CO2 YAG and KTP laser as trained in residency		#6 ASUZE	
Special procedures that are not routinely part of training and require additional documentation of competency training and experience			
SPECIAL PROCEDURES			
Penetrating keratoplasty			
Lamellar keratoplasty			
Radial keratoplasty			
Epikeratophakia			
Placement of external radiotherapeutic sources			
Other - If the condition/privilege you are interested in is not included on this form please provide a separate written request and appropriate documentation of training and/or experience			

Cynthia E Holmes MD

009031

C Holmes, MD

PO Box 187
Sullivan's Island SC 29482-0187

843 883 3176

October 1 2006

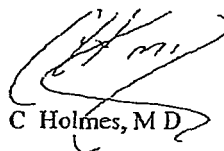
MSO - ECCH
1200 Johnnie Dodds Blvd
Mt Pleasant SC 29464

Dear Sir/Madam

I am writing to request reappointment to Associate staff category and continuation of the attached privileges. Also attached, please find documentation of management of 25 patients for reappointment.

Thanking you in advance for your kind attention, I am

Sincerely yours,


C Holmes, MD

EAST COOPER COMMUNITY HOSPITAL

CLINICAL PRIVILEGES SHEET

OPHTHALMOLOGY

R Holmes

		<u>Class 0</u>			<u>Class IV</u>
<u>1</u>		<u>Life-threatening emergency</u> At the time of a clinical emergency any practitioner may render whatever care he believes to be indicated	<u>1</u>	<u>2</u>	Vitreous surgery
					Corneal transplant surgery
					Neuro Ophthalmology surgery
<u>✓</u>	<u>2</u>	<u>Class I</u>		<u>✓</u>	Retinal surgery (including lasers)
		— Vision acuity screening		<u>✓</u>	Glaucoma surgery
		— Tonometry/Tonography		<u>✓</u>	Pediatric Ophthalmology
		— Optical measurement (i.e. pupillary distance, near point of convergence accommodation)		<u>✓</u>	Electrophysiologic studies
		— Color vision testing			
		— Surgical assisting with ophthalmologist			
		— External eye examination			
		— Fundus examination of posterior pole			
		— Treatment of uncomplicated conjunctivitis			
		— Removal of foreign bodies on cornea or conjunctiva			
		— Treatment of corneal abrasions			
		— Eye irrigation			
		— Order x-rays to rule out retained foreign body or fracture			
<u>✓</u>	<u>2</u>	<u>Class II</u>			
		— Refractions, manifest			
		— Orthoptic exercises			
		— Visual field testing			
		— Contact lens fitting			
		— Contact lens modifications			
<u>✓</u>	<u>2</u>	<u>Class III</u>			
		— Treatment of all ophthalmic conditions			
		— Treatment of neoplasms of orbit, eye and adnexa			
		— Intra and extraocular surgery			

East Cooper Regional Medical Center
Tenet

Page 8

PEER REFERENCES

At the time of reappointment, three (3) peer recommendations are required. Name three (3) medical or health care professionals who have firsthand, personal knowledge of your current clinical abilities, ethical character, health status, and ability to work cooperatively with others, and who will provide specific written comments on these matters upon request from hospital representatives. The named individuals must have acquired the requisite knowledge through recent observation of your professional practice over a reasonable period of time.

Please do not use the references listed on your previous application - which we have listed below (if available).

Previous References:
Musc OB/GYN

List 3 new references

1. Reference Name / Title	Phone Number	FAX Number
DR. DURST	883 3176	883 3459
Address		
306 STATION 22 1/2		
City	State	Country
SULLY'S ISLAND, SC		
		Postal Code
		29482
Nature of contact with you (eg, Partner, Peer, Director)		
PEER		

2. Reference Name / Title	Phone Number	FAX Number
DR. MAJESKI	884 7991	849-7874
Address		
900 BOWMAN RD		
City	State	Country
MT PLEASANT, SC		
		Postal Code
		29464
Nature of contact with you (eg, Partner, Peer, Director)		
PEER		

3. Reference Name / Title	Phone Number	FAX Number
DR. BOTECHNO	884 1777	
Address		
929 BOWMAN RD		
City	State	Country
MT PLEASANT, SC		
		Postal Code
		29464
Nature of contact with you (eg, Partner, Peer, Director)		
PEER		

Cynthia E Holmes MD

Physician CME Attestation Form

Physician's Name Cynthia E Holmes MD

Specialty Ophthalmology

Current Appointment Period 12/16/2004 through 12/16/2006

I attest that I have completed 40 hours AMA Category I CME specific to my specialty in the two years since my last appointment / reappointment to the medical staff at East Cooper Regional Medical Center. I will provide documentation of specific certificates and hours upon request by the Medical Staff.

A percentage of appointment and reappointment forms will be reviewed each cycle to corroborate attested CME hours. Those physicians whose forms are reviewed will be required to present copies of CME certificates and hours earned. If a physician cannot provide documentation of the hours to which he attested, he will lose staff privileges on the grounds of falsification of their application / reappointment process.

105 + 125 = 230 [Signature] 10/1/06
Applicant Signature Cynthia E Holmes MD Date

Please return this completed form to the Medical Staff Office
with your reappointment application

Cynthia E Holmes MD

C Holmes, MD

PO Box 187
306 Station 22 1/2
Sullivan's Island SC 29482-0187

Phone 843 883 1176

Dx Visually Significant Nuclear Sclerotic Cataract (NSC) OD

This 73 y/o WF presents with decreased visual acuity OD. Past ocular history is negative for glaucoma. Past medical history (PMH) is positive for hypertension (htn) and negative for diabetes mellitus (DM). Past surgical history (PSH) is positive for hysterectomy in 1986. Family history (FH) is negative for diabetes and positive for hypertension. She is on Lotrel, HCTZ, Clonidine, Aerobid, Nasocort, and NSAIDs PRN. She is allergic to PCN and mycins. Review of Systems (ROS) is non-contributory (NC).

On exam, the patient's distance visual acuity (VA) with correction was 20/50 OD and 20/25 OS. Best corrected visual acuity (BCVA) OD was 20/50.

On external exam, there was dermatochalasis bilaterally (OU). The conjunctiva was white OU. The pupils were equally round and reactive to light. There was no relative afferent pupillary defect (RAPD). Extraocular muscle movements (EOMs) were intact OU.

On slit lamp exam, the conjunctiva was quiet OU. The cornea was clear OU. The anterior chamber was deep and quiet OU. There was no neovascularization of the iris. The intraocular pressure (IOP) was normal OU at 3:50 PM: 16 mm Hg OD (right eye) and 13 mm Hg OS (left eye).

On dilated fundus exam, there was nuclear sclerotic cataract OS greater than OD. The vitreous was clear. There was A-V nicking OU consistent with hypertension. Otherwise, the disc and macula were within normal limits OU. By indirect ophthalmoscopy, the peripheral fundus was negative for hemorrhages, holes, tears, or masses OU.

In summary, the patient was diagnosed with visually significant nuclear sclerotic cataract OD. The patient received patient education regarding diagnosis, treatment, and prognosis. The patient has elected to have cataract extraction by phacoemulsification and is scheduled for pre-operative A-scan measurements in order to determine the appropriate lens power for the artificial lens implant. Thereafter, elective surgery will be scheduled in coordination with her primary care physician.

000048

C Holmes, M D

PO Box 187
306 Station 22 1/2
Sullivan's Island SC 29482-0187

Phone 843 883 3176

Dx Posterior Capsular Opacification OD and Visually Significant Nuclear Sclerotic
 Cataract OS

This 67 y/o WF presents with decreased visual acuity OD. Past ocular history (POH) is significant for cataract extraction OD approximately 18 months earlier. Past medical history is negative for hypertension and diabetes mellitus and positive for hypercholesterolemia, arthritis of the hands and feet, and hypothyroidism. She is on Thyroxin, Lipitor, and NSAIDs PRN. She is allergic to Neosporin.

On exam, the patient's distance visual acuity with correction was 20/40 OD and 20/50 OS. The patient's best corrected visual acuity was 20/40 OD and 20/50 OS.

On external exam, there was dermatochalasis bilaterally (OU). The conjunctiva was white OU. The pupils were equally round and reactive to light. There was no relative afferent pupillary defect (RAPD). Extraocular muscle movements (EOMs) were intact OU.

On slit lamp exam, the conjunctiva was quiet OU. There was superficial punctate keratitis (SPK) OU consistent with dry eye syndrome. Otherwise, the cornea was clear OU. The anterior chamber was deep and quiet OU. There was no neovascularization of the iris. The intraocular pressure (IOP) was normal OU at 4:40 PM: 11 mm Hg OD (right eye) and 10 mm Hg OS (left eye).

On dilated fundus exam, there was a well-centered posterior chamber intraocular lens with 2+ posterior capsular opacification OD. There was a visually significant nuclear sclerotic cataract OS. There were vitreous floaters consistent with benign vitreous degeneration OU. The disc, macula, and vessels were within normal limits OU. By indirect ophthalmoscopy, the peripheral fundus was negative for hemorrhages, holes, tears, or masses OU.

In summary, the patient was diagnosed with dry eye syndrome, posterior capsular opacification OD, and visually significant nuclear sclerotic cataract OS. The patient received patient education regarding diagnosis, treatment, and prognosis. Dry eye syndrome will be treated conservatively with preservative-free lubricants OU QID, hs, and PRN. The patient will be seen in follow-up for response to therapy, monitoring comfort and visual acuity as superficial punctate keratitis can degrade vision. If there is no improvement, prescription eye medications such as cyclosporine, NSAID, and other ophthalmic drops will be considered. Absent visual improvement, posterior capsular opacification is treated with YAG laser capsulotomy. After maximizing visual acuity OD, cataract extraction by phacoemulsification OS will be considered.

C Holmes, M.D

PO Box 187
306 Station 22 1/2
Sullivan's Island, SC 29482-0187

Phone 843 883 3176

Dx Visually Significant Nuclear Sclerotic Cataract (NSC) OD

This 59 y/o WM presents with decreased visual acuity OD. Past medical history (PMH) is positive for hypertension (htn) and negative for diabetes mellitus (DM). He is on Hyzaar and Penostat. Past surgical history (PSH) is positive for remote appendectomy. He is allergic to PCN.

On exam, the patient's distance visual acuity (VA) with correction was 20/100 OD and 20/30 OS. Best corrected visual acuity (BCVA) OD was 20/60 and 20/30 OS.

On external exam, there was dermatochalasis bilaterally (OU). The conjunctiva was white OU. The pupils were equally round and reactive to light. There was no relative afferent pupillary defect (RAPD). Extraocular muscle movements (EOMs) were intact OU.

On slit lamp exam, the conjunctiva was quiet OU. The cornea was clear OU. The anterior chamber was deep and quiet OU. There was no neovascularization of the iris. The intraocular pressure (IOP) was normal OU at 12:30 PM: 19 mm Hg OD (right eye) and 17 mm Hg OS (left eye).

On dilated fundus exam, there was nuclear sclerotic cataract OD greater than OS. The vitreous was clear. The optic nerve cup-to-disc ratio was within normal limits. There was A/V nicking OU consistent with hypertension. There were mild retinal pigment epithelial (RPE) changes at the macula OU. By indirect ophthalmoscopy, the peripheral fundus exam was negative for hemorrhages, tears, or masses OU.

In summary, the patient was diagnosed with visually significant nuclear sclerotic cataract OD. The patient received patient education regarding diagnosis, treatment, and prognosis. Pre-operative A-scan measurements were obtained in order to determine the appropriate lens power for the artificial lens implant. In coordination with the patient's primary care physician, cataract surgery was scheduled. The patient had successful cataract extraction by phacoemulsification with improved visual acuity OD.

000050



C Holmes MD

PO Box 187
306 Station 22 1/2
Sullivan's Island SC 29482-0187

Phone 843 883 3176

Dx Visually Significant Nuclear Sclerotic Cataract (NSC) OD

This 72 y/o WM presents with decreased visual acuity OD. Past ocular history is negative for glaucoma but positive for trauma OD secondary to a BB gun accident as a child. Past medical history (PMH) is negative for hypertension (htn) and diabetes mellitus and positive for hypercholesterolemia. Past surgical history (PSH) is negative. Family history is positive for hypertension and negative for diabetes mellitus. He is on Lipitor and NSAIDs PRN. He has NKDA. Review of Systems (ROS) is non contributory (NC).

On exam, the patient's distance visual acuity (VA) with correction was 20/50 OD and 20/50 OS. There was no improvement with manifest refraction.

On external exam, there was dermatochalasis bilaterally (OU). The conjunctiva was white OU. The pupils were equally round and reactive to light. There was no relative afferent pupillary defect (RAPD). Extraocular muscle movements (EOMs) were intact OU.

On slit lamp exam, the conjunctiva was quiet OU. The cornea was clear OU. The anterior chamber was deep and quiet OU. There was no neovascularization of the iris. There was a 10 degree area of iris dialysis at 12 00 OD. There was no apparent phacodonesis OD. The intraocular pressure (IOP) was normal OU at 11 45 am. 19 mm Hg OD (right eye) and 18 mm Hg OS (left eye).

On dilated fundus exam, there was a traumatic cataract OD with posterior subcapsular changes superiorly. There were nuclear sclerotic lens changes OU. The vitreous was clear OU. Otherwise, the disc, macula, and vessels were within normal limits OU. By indirect ophthalmoscopy, the peripheral fundus exam was negative for hemorrhages, holes, tears, or masses OU.

In summary, the patient was diagnosed with visually significant traumatic cataract OD. The patient received patient education regarding diagnosis, treatment, and prognosis. Traumatic cataracts require careful attention to lens zonules with possible dehiscence in order to avoid complications at surgery. In coordination with the patient's primary care physician, the patient elected to have cataract extraction by phacoemulsification OD after pre-operative A scan measurements to determine the appropriate lens power for artificial lens implant.



C. Holmes, MD

PO Box 187
306 Station 22 1/2
S. H. and Island, SC 29482-0187

Phone 843 883 3176

Dx Visually Significant Nuclear Sclerotic Cataract (NSC) OS

This 81 y/o WF presents with decreased visual acuity OS. Past ocular history is negative for glaucoma but positive for posterior subcapsular cataract extraction OD X 5 years. Past medical history (PMH) is positive for hypertension (htn) and hypercholesterolemia but negative for diabetes mellitus. Past surgical history (PSH) is positive for hysterectomy X years. Family history is positive for hypertension and diabetes mellitus. She is on Lipitor, Hyzaar, and Fosamax. She has NKDA. Review of Systems (ROS) is non-contributory (NC).

On exam, the patient's distance visual acuity (VA) with correction was 20/25 OD and 20/60 OS. There was no improvement with manifest refraction.

On external exam, the lids were flat bilaterally (OU). The conjunctiva was white OU. The pupils were equally round and reactive to light. There was no relative afferent pupillary defect (RAPD). Extraocular muscle movements (EOMs) were intact OU.

On slit lamp exam, the conjunctiva was quiet OU. The cornea was clear OU. The anterior chamber was deep and quiet OU. There was no neovascularization of the iris. The intraocular pressure (IOP) was normal OU at 11:10 am: 17 mm Hg OD (right eye) and 18 mm Hg OS (left eye).

On dilated fundus exam, there was a well-centered posterior chamber intraocular lens OD; there was a nuclear sclerotic cataract OS. The vitreous was clear OU. Otherwise, the disc, macula, and vessels were within normal limits OU. By indirect ophthalmoscopy, the peripheral fundus exam was negative for hemorrhages, tears, or masses OU.

In summary, the patient was diagnosed with visually significant nuclear sclerotic cataract OS. The patient received patient education regarding diagnosis, treatment, and prognosis. In coordination with the patient's primary care physician, the patient has elected to have cataract extraction by phacoemulsification OS after pre-operative A-scan measurements to determine the appropriate lens power for artificial lens implant.



C Holmes, MD

PO Box 187
306 Station 22 1/2
Sullivan's Island, SC 29482-0187

Phone 843 883 3176

Dx Visually Significant Nuclear Sclerotic Cataract (NSC) OS

This 70 y/o WM presents with decreased visual acuity OS. Past ocular history is negative for glaucoma and eye trauma but positive for cataract extraction OD X 3 years. Past medical history (PMH) is positive for hypercholesterolemia but negative for diabetes mellitus and hypertension (htn). Past surgical history (PSH) is positive for hernia repair. Family history is negative for hypertension and diabetes mellitus. He is on Lipitor. He has NKDA. Review of Systems (ROS) is non-contributory (NC).

On exam, the patient's distance visual acuity (VA) with correction was 20/25 OD and 20/80 OS. There was no improvement with manifest refraction.

On external exam, the lids were flat bilaterally (OU). The conjunctiva was white OU. The pupils were equally round and reactive to light. There was no relative afferent pupillary defect (RAPD). Extraocular muscle movements (EOMs) were intact OU.

On slit lamp exam, the conjunctiva was quiet OU. The cornea was clear OU. The anterior chamber was deep and quiet OU. There was no neovascularization of the iris. The intraocular pressure (IOP) was normal OU at 2:05 PM: 14 mm Hg OD (right eye) and 15 mm Hg OS (left eye).

On dilated fundus exam, there was a well-centered posterior chamber intraocular lens OD; there was a nuclear sclerotic cataract OS. The vitreous was clear OU. There were peripapillary myopic crescents OU; otherwise, the disc, macula, and vessels were within normal limits OU. By indirect ophthalmoscopy, there was a 1 disc-diameter chororetinal nevus located at the temporal peripheral retina; otherwise, peripheral fundus exam was negative for hemorrhages, tears, or masses OU.

In summary, the patient was diagnosed with visually significant nuclear sclerotic cataract OS. The patient received patient education regarding diagnosis, treatment, and prognosis. In coordination with the patient's primary care physician, the patient elected to have cataract extraction by phacoemulsification OS with artificial lens implant based upon pre-operative A-scan measurements.

C Holmes, MD

PO Box 187
306 Station 22 1/2
Sullivan's Island SC 29482-0187

Phone 843 883.3176

Dx Visually Significant Nuclear Sclerotic Cataract (NSC) OS

This 76 y/o WM presents with decreased visual acuity OS. Past ocular history is negative for glaucoma but positive for Presumed Ocular Histoplasmosis Syndrome (POHS). Past medical history (PMH) is negative for diabetes mellitus but positive for hypertension and Parkinson's Disease. Past surgical history (PSH) is positive for appendectomy and cholecystectomy. Family history is positive for hypertension and negative for diabetes mellitus. He is on Tenomin, Carbidopa, Levodopa, and Sinemet. He is allergic to Penicillin (PCN). Review of Systems (ROS) is non-contributory (NC).

On exam, the patient's distance visual acuity (VA) with correction was 20/40 OD and 20/50- OS. There was no improvement with manifest refraction.

On external exam, the lids were flat bilaterally (OU). The conjunctiva was white OU. The pupils were equally round and reactive to light. There was no relative afferent pupillary defect (RAPD). Extraocular muscle movements (EOMs) were intact OU.

On slit lamp exam, the conjunctiva was quiet OU. The cornea was clear OU. The anterior chamber was deep and quiet OU. There was no neovascularization of the iris. The intraocular pressure (IOP) was normal OU at 9:10 am: 12 mm Hg OD (right eye) and 11 mm Hg OS (left eye).

On dilated fundus exam, there was nuclear sclerotic cataract OU. The vitreous was clear OU. There was inactive peripapillary histoplasmosis, chorioretinal atrophy OU, as well as peripheral lesions. Otherwise, the disc, macula, and vessels were within normal limits OU. By indirect ophthalmoscopy, the peripheral fundus exam was negative for hemorrhages, tears, or masses OU.

In summary, the patient was diagnosed with visually significant nuclear sclerotic cataract OS. The patient received patient education regarding diagnosis, treatment, and prognosis. In coordination with the patient's primary care physician, the patient has elected to have cataract extraction by phacoemulsification OS after pre-operative A-scan measurements to determine the appropriate correction for the artificial lens implant.

C Holmes, MD

PO Box 187
306 Station 22 1/2
Sullivan's Island SC 29482-0187

Phone 843 883 3176

Dx Visually significant Nuclear Sclerotic Cataract (NSC) OS

This 76 y/o WM presents with decreased visual acuity OS. Past ocular history is negative for glaucoma but positive for rosacea. Past medical history (PMH) is positive for hypertension (htn) but negative for diabetes mellitus. Family history is positive for hypertension and diabetes mellitus. He is on HCTZ, Dapsone per Dermatology, and NSAIDs PRN. He has NKDA. Review of Systems (ROS) is non-contributory (NC).

On exam, the patient's distance visual acuity (VA) with correction was 20/40 OD and 20/50 OS. There was no improvement with manifest refraction.

On external exam, the lids were flat bilaterally (OU). There was blepharitis OU. There was trace injection of the conjunctiva OU. The pupils were equally round and reactive to light. There was no relative afferent pupillary defect (RAPD). Extraocular muscle movements (EOMs) were intact OU.

On slit lamp exam, there was trace non-specific hyperemia (NSH) of the conjunctiva OU. The cornea was clear OU. The anterior chamber was deep and quiet OU. There was no neovascularization of the iris. The intraocular pressure (IOP) was normal OU at 10:30 am: 10 mm Hg OD (right eye) and 10 mm Hg OS (left eye).

On dilated fundus exam, there was nuclear sclerotic cataract OU. The vitreous was clear OU. Otherwise, the disc, macula, and vessels were within normal limits OU. By indirect ophthalmoscopy, the peripheral fundus exam was negative for hemorrhages, tears, or masses OU.

In summary, the patient was diagnosed with visually significant nuclear sclerotic cataract OS. The patient received patient education regarding diagnosis, treatment, and prognosis. In coordination with the patient's primary care physician, the patient has elected to have cataract extraction by phacoemulsification OS after pre-operative A-scan measurements to determine the appropriate intraocular lens implant.



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Dx Visually Significant Nuclear Sclerotic Cataract (NSC) OS

This 79 y/o WM presents with decreased visual acuity OS. Past ocular history is positive for glaucoma and rosacea. Past medical history (PMH) is positive for hypertension (htn), non insulin dependent diabetes mellitus (NIDDM), rosacea, and hypercholesterolemia. Past surgical history (PSH) is positive for carotid endarterectomy after presenting here with amaurosis fugax in 2000. Family history is positive for hypertension and diabetes mellitus. He is on HCTZ Hytrin, an oral hyperglycemic agent, Zocor, and topical agents per Dermatology. He is on Xalatan ophthalmic drops OU q day. He has NKDA. Review of Systems (ROS) is non contributory (NC).

On exam, the patient's distance visual acuity (VA) with correction was 20/40 OD and 20/60 OS. There was no improvement with manifest refraction.

On external exam, the lids were flat bilaterally (OU). There was blepharitis OU. There was trace injection of the conjunctiva OU. The pupils were equally round and reactive to light. Extraocular muscle movements (EOMs) were intact OU.

On slit lamp exam, there was trace non specific hyperemia (NSH) of the conjunctiva OU. The cornea was clear OU. The anterior chamber was deep and quiet OU. There was no neovascularization of the iris. The intraocular pressure (IOP) was normal OU at 10:45 am: 14 mm Hg OD (right eye) and 17 mm Hg OS (left eye).

On dilated fundus exam, there was nuclear sclerotic cataract OU. The vitreous was clear OU. The optic nerve cup-to-disc ratio was enlarged OU, consistent with glaucoma. Otherwise, the macula and vessels were within normal limits OU. By indirect ophthalmoscopy, the peripheral fundus exam was negative for hemorrhages, tears, or masses OU.

In summary, the patient was diagnosed with visually significant nuclear sclerotic cataract OS. The patient received patient education regarding diagnosis, treatment, and prognosis. In coordination with the patient's primary care physician, the patient elected to have cataract extraction by phacoemulsification OS after pre-operative A-scan measurements to determine the appropriate intraocular lens implant.



000056

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Phone 843 883 3176

Dx Visually significant Nuclear Sclerotic Cataract (NSC) OS

This 66 y/o WF presents with decreased visual acuity OS. Past ocular history is positive for glaucoma. Past medical history (PMH) is positive for hypercholesterolemia but negative for diabetes mellitus and hypertension (htn). Past surgical history (PSH) is positive for remote tonsillectomy. Family history is unknown due to adoption. She is on Crestor and Actonel. She has NKDA. Review of Systems (ROS) is non-contributory (NC).

On exam, the patient's distance visual acuity (VA) with correction was 20/40 OD and 20/50 OS. There was no improvement with manifest refraction.

On external exam, the lids were flat bilaterally (OU). The conjunctiva was white OU. The pupils were equally round and reactive to light. There was no relative afferent pupillary defect (RAPD). Extraocular muscle movements (EOMs) were intact OU.

On slit lamp exam, the conjunctiva was quiet OU. The cornea was clear OU. The anterior chamber was deep and quiet OU. There was no neovascularization of the iris. The intraocular pressure (IOP) was normal OU at 11:15 am: 19 mm Hg OD (right eye) and 18 mm Hg OS (left eye).

On dilated fundus exam, there was nuclear sclerotic cataract OU. The vitreous was clear OU. There were peripapillary myopic crescents OU; otherwise, the disc, macula, and vessels were within normal limits OU. By indirect ophthalmoscopy, peripheral fundus exam was negative for hemorrhages, tears, or masses OU.

In summary, the patient was diagnosed with visually significant nuclear sclerotic cataract OS. The patient received patient education regarding diagnosis, treatment, and prognosis. In coordination with the patient's primary care physician, the patient elected to have cataract extraction by phacoemulsification OS with artificial lens implant based upon pre-operative A-scan measurements.

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Phone 843 883 3176

Dx Visually Significant Nuclear Sclerotic Cataract (NSC) OS

This 55 y/o WF presents with decreased visual acuity OS. Past ocular history is negative for glaucoma and eye trauma. Past medical history (PMH) is negative for diabetes mellitus and hypertension (htn). Past surgical history (PSH) is positive for hysterectomy X years. Family history is negative for hypertension and diabetes mellitus. She is on prescription medications. She is allergic to Codeine (rash). Review of Systems (ROS) is non-contributory (NC).

On exam, the patient's distance visual acuity (VA) with correction was 20/20 OD and 20/100 OS. With manifest refraction, best-corrected visual acuity (BCVA) was 20/50 OS.

On external exam, the lids were flat bilaterally (OU). The conjunctiva was white OU. The pupils were equally round and reactive to light. There was no relative afferent pupillary defect (RAPD). Extraocular muscle movements (EOMs) were intact OU.

On slit lamp exam, the conjunctiva was quiet OU. The cornea was clear OU. The anterior chamber was deep and quiet OU. There was no neovascularization of the iris. The intraocular pressure (IOP) was normal OU at 4:45 PM: 16 mm Hg OD (right eye) and 18 mm Hg OS (left eye).

On dilated fundus exam, there was a nuclear sclerotic cataract (NSC) OS greater than OD. The vitreous was clear OU. The disc, macula, and vessels were within normal limits OU. By indirect ophthalmoscopy, peripheral fundus exam was negative for hemorrhages, tears, or masses OU.

In summary, the patient was diagnosed with visually significant nuclear sclerotic cataract (NSC) OS. The patient received patient education regarding diagnosis, treatment, and prognosis. In coordination with the patient's primary care physician, the patient elected to have cataract extraction by phacoemulsification OS with artificial lens implant.

000058

C Holmes, MD

PO Box 187
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Dx Visually Significant Nuclear Sclerotic Cataract (NSC) OD

This 64 y/o WM presents with decreased visual acuity OD. Past ocular history is negative for glaucoma and eye trauma. Past medical history (PMH) is negative for diabetes mellitus and hypertension (htn) and positive for COPD. Family history is negative for diabetes mellitus and positive for hypertension. He is on Flovent, Albuterol, Coumadin, Plavix, Neurotin, Lexapro, and Ambien. He is allergic to Cephalosporins. Review of Systems (ROS) is non-contributory (NC).

On exam, the patient's best-corrected distance visual acuity (BCVA) was 20/60 OD and 20/40 OS.

On external exam, the lids were flat bilaterally (OU). The conjunctiva was white OU. The pupils were equally round and reactive to light. There was no relative afferent pupillary defect (RAPD). Extraocular muscle movements (EOMs) were intact OU.

On slit lamp exam, the conjunctiva was quiet OU. The cornea was clear OU. The anterior chamber was deep and quiet OU. There was no neovascularization of the iris. The intraocular pressure (IOP) by Tonopen was normal OU at 10:30 am: 20 mm Hg OD (right eye) and 20 mm Hg OS (left eye).

On dilated fundus exam, there was a nuclear sclerotic cataract (NSC) OD greater than OS. The vitreous was clear OU. The disc, macula, and vessels were within normal limits OU. By indirect ophthalmoscopy, peripheral fundus exam was negative for hemorrhages, tears, or masses OU.

In summary, the patient was diagnosed with visually significant nuclear sclerotic cataract (NSC) OD. The patient received patient education regarding diagnosis, treatment, and prognosis. In coordination with the patient's primary care physician, the patient elected to have cataract extraction by phacoemulsification OD with posterior chamber artificial lens implant.

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Dx Visually Significant Nuclear Sclerotic Cataract (NSC) OD

This 76 y/o WM presents with decreased visual acuity OD. Past ocular history is negative for glaucoma and eye trauma but positive for possible mild amblyopia OD and uneventful cataract extraction by phacoemulsification OS. Past medical history (PMH) is negative for diabetes mellitus and hypertension (htn). Family history is negative for hypertension and diabetes mellitus. He has NKDA. Review of Systems (ROS) is non-contributory (NC).

On exam, the patient's distance visual acuity (VA) with correction was 20/50 OD and 20/25 OS. There was no improvement with manifest refraction OD.

On external exam, the lids were flat bilaterally (OU). The conjunctiva was white OU. The pupils were equally round and reactive to light. There was no relative afferent pupillary defect (RAPD). Extraocular muscle movements (EOMs) were intact OU.

On slit lamp exam, the conjunctiva was quiet OU. The cornea was clear OU. The anterior chamber was deep and quiet OU. There was no neovascularization of the iris. The intraocular pressure (IOP) by Tonopen was normal.

On dilated fundus exam, there was nuclear sclerotic cataract (NSC) OD and a well-centered posterior chamber intraocular lens implant OS. The vitreous was clear OU. The disc, macula, and vessels were within normal limits OU. By indirect ophthalmoscopy, peripheral fundus exam was negative for hemorrhages, tears, or masses OU.

In summary, the patient was diagnosed with visually significant nuclear sclerotic cataract (NSC) OD. The patient received patient education regarding diagnosis, treatment, and prognosis. In coordination with the patient's primary care physician, the patient elected to have cataract extraction by phacoemulsification OD with posterior chamber artificial lens implant.

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Phone 843 883 3176

Dx Visually Significant Nuclear Sclerotic Cataract (NSC) OD

This 79 y/o WM presents with decreased visual acuity OD. Past ocular history is negative for glaucoma and eye trauma and positive for uncomplicated cataract extraction by phacoemulsification OS. Past medical history (PMH) is negative for diabetes mellitus and hypertension (htn). Family history is positive for hypertension and diabetes mellitus. He is on no prescription medications. He has NKDA. Review of Systems (ROS) is non-contributory (NC).

On exam, the patient's best-corrected distance visual acuity (BCVA) was 20/40 OD and 20/25 OS.

On external exam, the lids were flat bilaterally (OU). The conjunctiva was white OU. The pupils were equally round and reactive to light. There was no relative afferent pupillary defect (RAPD). Extraocular muscle movements (EOMs) were intact OU.

On slit lamp exam, the conjunctiva was quiet OU. The cornea was clear OU. The anterior chamber was deep and quiet OU. There was no neovascularization of the iris. The intraocular pressure (IOP) by Tonopen was normal OU.

On dilated fundus exam, there was nuclear sclerotic cataract (NSC) OD and a well-centered posterior chamber intraocular lens OS. The vitreous was clear OU. There were mild retinal pigment epithelial changes at the macula OU. Otherwise, the disc, macula, and vessels were within normal limits OU. By indirect ophthalmoscopy, peripheral fundus exam was negative for hemorrhages, tears, or masses OU.

In summary, the patient was diagnosed with visually significant nuclear sclerotic cataract (NSC) OD. The patient received patient education regarding diagnosis, treatment, and prognosis. The patient elected to have cataract extraction by phacoemulsification OD with posterior chamber artificial lens implant.

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Dx Visually Significant Nuclear Sclerotic Cataract (NSC) OD

This 74 y/o WM presents with decreased visual acuity OD. Past ocular history is negative for glaucoma and but positive for high myopia OU and retinal detachment (RD) repair OS X 14 years and recent cataract extraction OS. Past medical history (PMH) is positive for insulin-dependent diabetes mellitus (IDDM), hypertension (HTN) and hypercholesterolemia. Family history is positive for glaucoma, hypertension and diabetes mellitus. He is on Insulin, Lipitor, Niaspan, Norvasc, Hydrochlorothiazide (HCTZ) and Coreg. He has NKDA. Review of Systems (ROS) is non-contributory (NC).

On exam, the patient's best-corrected distance visual acuity (BCVA) was 20/60 OD and 20/100 OS.

On external exam, the lids were flat bilaterally (OU). The conjunctiva was white OU with conjunctival scarring temporally OS secondary to RD surgery. The pupils were equally round and reactive to light. Extraocular muscle movements (EOMs) were intact OU.

On slit lamp exam, the conjunctiva was quiet OU with conjunctival scarring temporally OS. The cornea was clear OU. The anterior chamber was deep and quiet OU. There was no neovascularization of the iris. The intraocular pressure (IOP) by Tonopen was normal OU at 9-10 AM: 11 mm Hg OD (right eye) and 15 mm Hg OS (left eye).

On dilated fundus exam, there was nuclear sclerotic cataract OD with a well-centered posterior chamber intraocular lens implant OS. The vitreous was clear OU. There was background diabetic retinopathy (BDR) OU. There were peripapillary myopic crescents OU. There were retinal pigment epithelial (RPE) changes at the macula OU consistent with myopic degeneration. Otherwise, the disc, macula and vessels were within normal limits OU. By indirect ophthalmoscopy, peripheral fundus exam was negative for holes, tears or masses OU.

In summary, the patient was diagnosed with visually significant nuclear sclerotic cataract OD. The patient received patient education regarding diagnosis, treatment and prognosis. Due to the patient's history of retinal detachment OS and high myopia, a retinal consult was obtained in order to evaluate and treat any retinal pathology prior to cataract extraction. In coordination with the patient's primary care physician, the patient elected to have cataract extraction by phacoemulsification OD with posterior chamber artificial lens implant based upon pre-operative A-scan measurements.

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Dx. Visually Significant Posterior Subcapsular Cataract (PSC) OD

This 55 y/o WM presents with decreased visual acuity OD. Past ocular history is negative for glaucoma and positive for cataract extraction OS. Past medical history (PMH) is negative for diabetes mellitus and positive for hypertension (htn) and hypercholesterolemia. Family history is positive for hypertension and negative for diabetes mellitus. He is on Vytonn Hydrochlorothiazide (HCTZ) and Nasonex. He has NKDA. Review of Systems (ROS) is non-contributory (NC).

On exam, the patient's best-corrected distance visual acuity (BCVA) was 20/40 OD and 20/25 OS.

On external exam, the lids were flat bilaterally (OU). The conjunctiva was white OU. The pupils were equally round and reactive to light. There was no relative afferent pupillary defect (RAPD). Extraocular muscle movements (EOMs) were intact OU.

On slit lamp exam, the conjunctiva was quiet OU. The cornea was clear OU. The anterior chamber was deep and quiet OU. There was no neovascularization of the iris. The intraocular pressure (IOP) by Tonopen was normal OU.

On dilated fundus exam, there was posterior subcapsular cataract OD and a well-centered posterior chamber intraocular lens implant OS. The vitreous was clear OU. The disc, macula, and vessels were within normal limits OU. By indirect ophthalmoscopy, peripheral fundus exam was negative for hemorrhages, tears, or masses OU.

In summary, the patient was diagnosed with visually significant posterior subcapsular cataract OD. The patient received patient education regarding diagnosis, treatment, and prognosis. In coordination with the patient's primary care physician, the patient elected to have cataract extraction by phacoemulsification OD with artificial lens implant based upon pre-operative A scan measurements.

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Phone 843 883 3176

Dx Visually Significant Posterior Subcapsular Cataract (PSC) and Nuclear Sclerotic Cataract OS

This 70 y/o WM presents with decreased visual acuity OS. Past ocular history is negative for glaucoma. Past medical history (PMH) is negative for diabetes mellitus and positive for hypertension (htn). Family history is positive for glaucoma and hypertension and negative for diabetes mellitus. He is on Lotensin, Digoxin, Lasix, and Zyrtec. He has NKDA. Review of Systems (ROS) is non-contributory (NC).

On exam, the patient's best-corrected distance visual acuity (BCVA) was 20/40 OD and 20/70 OS.

On external exam, the lids were flat bilaterally (OU). The conjunctiva was white OU. The pupils were equally round and reactive to light. There was no relative afferent pupillary defect (RAPD). Extraocular muscle movements (EOMs) were intact OU.

On slit lamp exam, the conjunctiva was quiet OU. The cornea was clear OU. The anterior chamber was deep and quiet OU. There was no neovascularization of the iris. The intraocular pressure (IOP) by Tonopen was normal OU at 11:20 AM: 13 mm Hg OD (right eye) and 15 mm Hg OS (left eye).

On dilated fundus exam, there was nuclear sclerotic cataract OU and posterior subcapsular cataract OS. The vitreous was clear OU. The disc, macula, and vessels were within normal limits OU. By indirect ophthalmoscopy, peripheral fundus exam was negative for hemorrhages, tears, or masses OU.

In summary, the patient was diagnosed with nuclear sclerotic cataract OU and visually significant posterior subcapsular cataract OS. The patient received patient education regarding diagnosis, treatment, and prognosis. In coordination with the patient's primary care physician, the patient elected to have cataract extraction by phacoemulsification OS with artificial lens implant based upon pre-operative A-scan measurements.

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Dx Visually Significant Posterior Subcapsular Cataract (PSC) OS

This 55 y/o WM presents with decreased visual acuity OS. Past ocular history is negative for glaucoma. Past medical history (PMH) is negative for diabetes mellitus and positive for hypertension (htn) and hypercholesterolemia. Family history is positive for hypertension and negative for diabetes mellitus. He is on Vytonn Hydrochlorothiazide (HCTZ) and Nasonex. He has NKDA. Review of Systems (ROS) is non-contributory (NC).

On exam, the patient's best-corrected distance visual acuity (BCVA) was 20/30 OD and 20/50 OS.

On external exam, the lids were flat bilaterally (OU). The conjunctiva was white OU. The pupils were equally round and reactive to light. There was no relative afferent pupillary defect (RAPD). Extraocular muscle movements (EOMs) were intact OU.

On slit lamp exam, the conjunctiva was quiet OU. The cornea was clear OU. The anterior chamber was deep and quiet OU. There was no neovascularization of the iris. The intraocular pressure (IOP) by Tonopen was normal OU at 9:40 AM: 12 mm Hg OD (right eye) and 12 mm Hg OS (left eye).

On dilated fundus exam, there were early lens changes OD and posterior subcapsular cataract OS. The vitreous was clear OU. The disc, macula, and vessels were within normal limits OU. By indirect ophthalmoscopy, peripheral fundus exam was negative for hemorrhages, tears, or masses OU.

In summary, the patient was diagnosed with visually significant posterior subcapsular cataract OS. The patient received patient education regarding diagnosis, treatment, and prognosis. In coordination with the patient's primary care physician, the patient elected to have cataract extraction by phacoemulsification OS with artificial lens implant based upon pre-operative A-scan measurements.

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Phone 843 883 3176

Dx Visually Significant Nuclear Sclerotic Cataract OD

This 71 y/o WM presents with decreased visual acuity OD. Past ocular history is negative for glaucoma and positive for uncomplicated cataract surgery OS. Past medical history (PMH) is negative for diabetes mellitus and positive for hypertension (htn). Family history is positive for glaucoma and hypertension and negative for diabetes mellitus. He is on Lotensin, Digoxin, Lasix, and Zyrtec. He has NKDA. Review of Systems (ROS) is non-contributory (NC).

On exam, the patient's best-corrected distance visual acuity (BCVA) was 20/40 OD and 20/20 OS.

On external exam, the lids were flat bilaterally (OU). The conjunctiva was white OU. The pupils were equally round and reactive to light. There was no relative afferent pupillary defect (RAPD). Extraocular muscle movements (EOMs) were intact OU.

On slit lamp exam, the conjunctiva was quiet OU. The cornea was clear OU. The anterior chamber was deep and quiet OU. There was no neovascularization of the iris. The intraocular pressure (IOP) by Tonopen was normal OU at 9:25 AM: 13 mm Hg OD (right eye) and 11 mm Hg OS (left eye).

On dilated fundus exam, there was nuclear sclerotic cataract OD and a well-centered posterior chamber intraocular lens implant (PCIOL) OS. The vitreous was clear OU. The disc, macula, and vessels were within normal limits OU. By indirect ophthalmoscopy, peripheral fundus exam was negative for hemorrhages, tears, or masses OU.

In summary, the patient was diagnosed with nuclear sclerotic cataract OD. The patient received patient education regarding diagnosis, treatment, and prognosis. In coordination with the patient's primary care physician, the patient had cataract extraction by phacoemulsification OD with artificial lens implant based upon pre-operative A-scan measurements.

C Holmes, M D.

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Phone 843 883 3176

Dx Visually Significant Nuclear Sclerotic Cataract (NSC) OD

This 74 y/o WM presents with decreased visual acuity OD. Past ocular history is positive for glaucoma suspect status with thick corneas. Past medical history (PMH) is positive for hypertension (htn) and non insulin dependent diabetes mellitus (NIDDM). Family history is positive for hypertension and diabetes mellitus. He is on HCTZ, Lipitor, and Glucophage. He has NKDA. Review of Systems (ROS) is non-contributory (NC).

On exam, the patient's distance visual acuity (VA) with correction was 20/60 OD and 20/40 OS. There was no improvement with manifest refraction.

On external exam, the lids were flat bilaterally (OU). The conjunctiva was white (OU). The pupils were equally round and reactive to light. There was no relative afferent pupillary defect (RAPD). Extraocular muscle movements (EOMs) were intact (OU).

On slit lamp exam, the conjunctiva was quiet (OU). The cornea was clear (OU). The anterior chamber was deep and quiet (OU). There was no neovascularization of the iris. The intraocular pressure (IOP) by Tonopen was normal (OU) at 10/20 AM: 21 mm Hg OD and 20 mm Hg OS.

On dilated fundus exam, there was nuclear sclerotic cataract OD greater than OS. The vitreous was clear (OU). The disc was mildly asymmetric OD greater than OS. Otherwise, the macula and vessels were within normal limits (OU). By indirect ophthalmoscopy, the peripheral fundus exam was negative for hemorrhages, holes, tears, or masses (OU).

In summary, the patient was diagnosed with visually significant nuclear sclerotic cataract OD. The patient received patient education regarding diagnosis, treatment, and prognosis. In coordination with the patient's primary care physician, the patient elected to have cataract extraction by phacoemulsification OD after pre-operative A-scan measurements to determine the appropriate intraocular lens implant.

C Holmes M.D.

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Phone 843 883 3176

Dx Visually Significant Posterior Subcapsular and Nuclear Sclerotic Cataract (NSC)
OS

This 74 y/o WM presents with decreased visual acuity OS. Past ocular history is negative for glaucoma and but positive for high myopia OU and retinal detachment (RD) repair OS X 14 years. Past medical history (PMH) is positive for insulin-dependent diabetes mellitus (IDDM), hypertension (htn) and hypercholesterolemia. Family history is positive for glaucoma, hypertension and diabetes mellitus. He is on Insulin, Lipitor, Niaspan, Norvasc, Hydrochlorothiazide (HCTZ) and Coreg. He has NKDA. Review of Systems (ROS) is non-contributory (NC).

On exam, the patient's best-corrected distance visual acuity (BCVA) was 20/60 OD and 20/100 OS.

On external exam, the lids were flat bilaterally (OU). The conjunctiva was white OU with conjunctival scarring temporally OS secondary to RD surgery. The pupils were equally round and reactive to light. Extraocular muscle movements (EOMs) were intact OU.

On slit lamp exam, the conjunctiva was quiet OU with conjunctival scarring temporally OS. The cornea was clear OU. The anterior chamber was deep and quiet OU. There was no neovascularization of the iris. The intraocular pressure (IOP) by Tonopen was normal OU at 9-10 AM: 11 mm Hg OD (right eye) and 15 mm Hg OS (left eye).

On dilated fundus exam, there was nuclear sclerotic cataract OU with posterior subcapsular cataract OS. The vitreous was clear OU. There was background diabetic retinopathy (BDR) OU. There were peripapillary myopic crescents OU. There were retinal pigment epithelial (RPE) changes at the macula OU consistent with myopic degeneration. Otherwise, the disc, macula, and vessels were within normal limits OU. By indirect ophthalmoscopy, peripheral fundus exam was negative for holes, tears, or masses OU.

In summary, the patient was diagnosed with visually significant posterior subcapsular and nuclear sclerotic cataract OS. The patient received patient education regarding diagnosis, treatment, and prognosis. Due to the patient's history of retinal detachment OS and high myopia, a retinal consult was obtained in order to evaluate and treat any retinal pathology prior to cataract extraction. In coordination with the patient's primary care physician, the patient elected to have cataract extraction by phacoemulsification OS with posterior chamber artificial lens implant based upon pre-operative A scan measurements.

C. Holmes, M D

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Dx Visually Significant Nuclear Sclerotic Cataract (NSC) OS

This 74 y/o WM presents with decreased visual acuity OS. Past ocular history is positive for glaucoma suspect status with thick corneas and uncomplicated cataract extraction OS. Past medical history (PMH) is positive for hypertension (htn) and non insulin dependent diabetes mellitus (NIDDM). Family history is positive for hypertension and diabetes mellitus. He is on HCTZ, Lipitor and Glucophage. He has NKDA. Review of Systems (ROS) is non-contributory (NC).

On exam, the patient's distance visual acuity (VA) with correction was 20/60 OD and 20/25 OS. There was no improvement with manifest refraction.

On external exam, the lids were flat bilaterally (OU). The conjunctiva was white OU. The pupils were equally round and reactive to light. There was no relative afferent pupillary defect (RAPD). Extraocular muscle movements (EOMs) were intact OU.

On slit lamp exam, the conjunctiva was quiet OU. The cornea was clear OU. The anterior chamber was deep and quiet OU. There was no neovascularization of the iris. The intraocular pressure (IOP) by Tonopen was normal OU.

On dilated fundus exam, there was nuclear sclerotic cataract OS. There was a well-centered posterior chamber intraocular lens OD. The vitreous was clear OU. The disc was mildly asymmetric, OD greater than OS. Otherwise, the macula and vessels were within normal limits OU. By indirect ophthalmoscopy, the peripheral fundus exam was negative for hemorrhages, tears, or masses OU.

In summary, the patient was diagnosed with visually significant nuclear sclerotic cataract OS. The patient received patient education regarding diagnosis, treatment, and prognosis. In coordination with the patient's primary care physician, the patient elected to have cataract extraction by phacoemulsification OS after pre-operative A-scan measurements to determine the appropriate intraocular lens implant.

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Dx Visually Significant Nuclear Sclerotic Cataract (NSC) OS

This 76 y/o WM presents with decreased visual acuity OS. Past ocular history is negative for glaucoma and eye trauma but positive for possible mild amblyopia OD. Past medical history (PMH) is negative for diabetes mellitus and hypertension (htn). Family history is negative for hypertension and diabetes mellitus. He has NKDA. Review of Systems (ROS) is non-contributory (NC).

On exam, the patient's distance visual acuity (VA) with correction was 20/50 OD and 20/70 OS. There was no improvement with manifest refraction OS.

On external exam, the lids were flat bilaterally (OU). The conjunctiva was white OU. The pupils were equally round and reactive to light. There was no relative afferent pupillary defect (RAPD). Extraocular muscle movements (EOMs) were intact OU.

On slit lamp exam, the conjunctiva was quiet OU. The cornea was clear OU. The anterior chamber was deep and quiet OU. There was no neovascularization of the iris. The intraocular pressure (IOP) by Tonopen was normal OU at 3:30 PM: 14 mm Hg OD (right eye) and 12 mm Hg OS (left eye).

On dilated fundus exam, there was nuclear sclerotic cataract (NSC) OS greater than OD. The vitreous was clear OU. The disc, macula, and vessels were within normal limits OU. By indirect ophthalmoscopy, peripheral fundus exam was negative for hemorrhages, holes, tears, or masses OU.

In summary, the patient was diagnosed with visually significant nuclear sclerotic cataract (NSC) OS. The patient received patient education regarding diagnosis, treatment, and prognosis. In coordination with the patient's primary care physician, the patient elected to have cataract extraction by phacoemulsification OS with posterior chamber artificial lens implant.

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Dx Visually Significant Nuclear Sclerotic Cataract (NSC) OS

This 64 y/o WM presents with decreased visual acuity OS. Past ocular history is negative for glaucoma and eye trauma and positive for uncomplicated cataract extraction by phacoemulsification OD. Past medical history (PMH) is negative for diabetes mellitus and hypertension (htn) and positive for COPD. Family history is negative for diabetes mellitus and positive for hypertension. He is on Flovent, Albuterol, Coumadin, Prilosec, Neurotin, Lexapro, and Ambien. He is allergic to Cephalosporins. Review of Systems (ROS) is non-contributory (NC).

On exam, the patient's best-corrected distance visual acuity (BCVA) was 20/25 OD and 20/40 OS.

On external exam, the lids were flat bilaterally (OU). The conjunctiva was white OU. The pupils were equally round and reactive to light. There was no relative afferent pupillary defect (RAPD). Extraocular muscle movements (EOMs) were intact OU.

On slit lamp exam, the conjunctiva was quiet OU. The cornea was clear OU. The anterior chamber was deep and quiet OU. There was no neovascularization of the iris. The intraocular pressure (IOP) by Tonopen was normal OU.

On dilated fundus exam, there was a well-centered posterior chamber intraocular lens implant OD and nuclear sclerotic cataract (NSC) OS. The vitreous was clear OU. The disc, macula, and vessels were within normal limits OU. By indirect ophthalmoscopy, peripheral fundus exam was negative for hemorrhages, tears, or masses OU.

In summary, the patient was diagnosed with visually significant nuclear sclerotic cataract (NSC) OS. The patient received patient education regarding diagnosis, treatment, and prognosis. In coordination with the patient's primary care physician, the patient elected to have cataract extraction by phacoemulsification OS with posterior chamber artificial lens implant.

#7

he will be placed on Courtesy or Consulting staff until his next reappointment

SECTION 3 - ASSOCIATE

A Qualifications The Associate staff category shall consist of practitioners who 1) do not have privileges at any other hospital, but who 1) meet all the criteria for active staff membership except the minimum required number of admissions, procedures or patient contacts per year or preceding 12-month period No surgical privileges will be granted in this category Physicians awarded surgical clinical privileges prior to November 7, 2007 shall be permitted to maintain these privileges in accordance with the criteria set forth below

At the time of initial appointment and at all time subsequent thereto, a member of the associate staff shall meet all of the threshold criteria for exercising Core Privileges in his respective Department The threshold criteria, which shall be identified by the Department and approved by the Medical Executive Committee, shall relate to minimum formal training, current board certification within five years of completing residency or fellowship training, professional experience within the preceding twelve months and clinical references

In order to facilitate ongoing professional practice evaluation, all patient admissions, procedures and patient contacts by members of the associate staff will be reviewed by the Department to which the Practitioner is assigned Members of the associate staff must fulfill all requirements of the Active staff including, when appropriate, emergency service care, disaster plan assignment, and consultation assignments They may serve on medical staff departmental and Governing Body committees Departmental meeting attendance will be determined by each department Attendance at departmental meetings shall be required for a member of the associate medical staff when one of that member's cases is being reviewed or when the member is assigned to review cases of his peers Members of the Associate staff shall be eligible to vote at departmental and assigned committee meetings only They may not vote at Quarterly Medical Staff meetings Associate staff will be required to participate in the Emergency Room call schedule if their specialty has one Associate staff members shall participate in the performance improvement activities of the medical staff

If the number of admissions, procedures or patient contacts exceeds 24 or more in any 12-month period, the Associate staff practitioner will be advanced to Active staff membership If the practitioner should attain Active staff privileges at any other hospital, he will be placed on Courtesy staff

SECTION 4 - COURTESY STAFF

A Qualifications The Courtesy staff category shall consist of Practitioners who 1) are located (primary or satellite office) within a reasonable distance and/or travel time to the Hospital to provide continuous care for their patients, and 1) are members of the active or associate active staff of another hospital in which their regular participation in

the requirements The requesting physician will read and sign the letter and return it back to the Medical Staff Office The request will be forwarded to the Credentials Committee, Medical Executive Committee and the Board of Directors for final approval If after one year the physician fails to meet the requirements set forth in the Bylaws for Active staff, he will be placed on Courtesy or Consulting staff until his next reappointment

SECTION 3 - ASSOCIATE

A Qualifications The Associate staff category shall consist of practitioners who meet all the criteria for Active staff membership except the minimum required number of patient's contacts per year These practitioners shall not have active privileges at any other hospital

In order to allow adequate medical peer review of the smaller number of patient contacts by members of the Associate staff, all patient contacts will be reviewed by the department to which the practitioner is assigned In addition, if the applicant desires privileges for surgical or invasive medical procedures he will be required to submit documentation of current clinical competence to the satisfaction of the appropriate Department Chairman and Credentials Committee Members of the Associate staff must fulfill all requirements of the Active staff including, when appropriate, emergency service care, disaster plan assignment, and consultation assignments They may serve on medical staff departmental and Governing Body committees and shall attend not less than 50% of the Quarterly Medical Staff meetings Departmental meeting attendance will be determined by each department Attendance at departmental meetings is required for a member of the medical staff when one of the member's cases is being reviewed or when the member is assigned to review cases of his peers Members of the Associate staff shall be eligible to vote at departmental and assigned committee meetings only They may not vote at Quarterly Medical Staff meetings Associate staff will be required to participate in the Emergency Room call schedule if their specialty has one Associate staff members shall participate in the performance improvement activities of the medical staff

If their number of patient's contacts should be 24 or more in any calendar year the Associate staff practitioner will be advanced to Active staff membership If the practitioner should attain Active staff privileges at any other hospital he will be placed on Courtesy staff

SECTION 4 - COURTESY STAFF

A Qualifications The Courtesy staff category shall consist of Practitioners who are located (primary or satellite office) within a reasonable distance and/or travel time to the Hospital to provide continuous care for their patients but who do not admit or provide services other than written consultation for more than twenty-four (24) patient contacts per calendar year Patient care services of more than the specified number of patients in a year by any member will require that the member be appointed to the active staff category Courtesy staff members shall be members of the active or associate active staff of another hospital in which their regular participation in performance improvement

#8

CYNTHIA HOLMES M D
PO BOX 187
306 STATION 22/
SULLIVANS ISLAND SC 29482
TELEPHONE (803) 883 3176

RECEIVED

SEP 18 1996

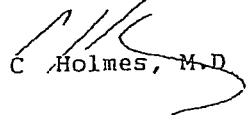
September 17, 1996

John F Holland President
E C C H
1200 Johnnie Dodds Blvd
Mt Pleasant, SC 29464

Dear Mr Holland

I am writing to appeal and reserve benefit of counsel in
the denial of my request regarding twelve (12) patient contacts per
year

Sincerely,


C Holmes, M.D

CH mp

000719

EAST COAST
Regional Medical Center

Tenet HealthSystem

October 22, 1996

1200 West New Road Blvd
Mt Pleasant SC 29464
Tel 303 881 3100

Certified Mail
Return Receipt Requested

Cynthia Holmes M D
306 Station 22 1/2
Sullivan's Island, S C 29482

Dear Dr Holmes

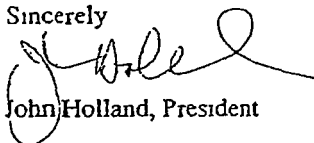
This letter is in response to your correspondence of September 17, 1996, in which you appeal and reserve benefit of counsel in denial of [your] request regarding twelve (12) patient contacts per year. The letter is somewhat unclear as to whether you are seeking a fair hearing or requesting an amendment to the Medical Staff Bylaws (Bylaws')

Assuming that your letter is a request for a fair hearing pursuant to Article IX of the Bylaws the underlying circumstances do not entitle you for a fair hearing, Article IX Section (2)(A) lists fourteen different specific actions which entitle a practitioner to a fair hearing. Inasmuch as the Governing Board granted your request for Associate Active privileges in accordance with the terms outlined in the Bylaws no adverse action has been taken which entitles you to a fair hearing.

In reference to your intermination of twelve (12) rather than the required twenty four (24) contacts per year on Kara Melin's correspondence to you dated June 11, 1996, please be advised that the Governing Board could not grant you Associate Active privileges with a requirement of twelve patient contacts per year because that would be in contravention of the express terms of the Bylaws. It also could not grant you Consulting Staff privileges in accordance with Article IV, Section 4 of the Bylaws because you do not maintain active privileges at another local hospital as required.

If your letter is a request for the Medical Staff to consider a Bylaw amendment which would permit Associate Active privileges to be maintained by a practitioner who only has twelve patient contacts per year at the Hospital, please be advised that Article XVII states that proposed Bylaw amendments must be submitted to the Executive Committee. The adoption of an amendment requires a two-thirds (2/3) vote of the active medical staff members present. If you wish to request the Executive Committee to consider an amendment of the Bylaws please forward your proposed amendment in writing to Delinda Terry, M D Chairperson, Executive Committee, in care of the Hospital.

Sincerely



John Holland, President

EAST COOPER
Regional Medical Center
Tenet HealthSystem

1200 John W. Dodds Blvd
Mt Pleasant SC 29464
Tel 803 881 0100

August 19 1997

CERTIFIED MAIL RETURN RECEIPT REQUESTED

Cynthia Holmes, M D
P O Box 187
306 Station 22 1/2
Sullivans Island, SC 29482

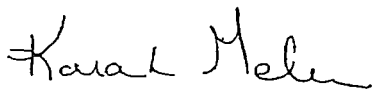
Dear Dr Holmes

The Credentials Committee reviewed your activity during your one year provisional review at its last meeting. Your physician profile showed the proper meeting attendance but failed to show the appropriate number of patient contacts as required for active staff. During your provisional year it was reported that you had five (5) patient contacts.

The Committee has asked that you supply information that you maintain active privileges at another local hospital. Please remember that our Medical Staff Bylaws require physicians on courtesy staff to maintain active privileges at another local facility (Current Bylaws, Article IV section 4). Because you have not met qualifications for active or courtesy staff, you have been appointed to the consulting staff.

Please forward the requested information to the Medical Staff Office at your earliest convenience.
Thank you

Sincerely



Kara L. Mehm, RRA
Medical Staff Coordinator

seen
back to
file

RECEIVED

SEP 02 1997

THE STEINBERG

PLANNING & CONSULTING
LLP

ECRMC
Medical Staff Office

61 Broad St P O Box 9

Charleston SC 29402-0009

Telephone (803) 720-2800

Fax (803) 722 1190

NORTH AREA OFFICE
118 GOOSE CREEK BLVD SOUTH
P O BOX 1028
GOOSE CREEK, SC 29445
TELEPHONE (803) 572-0700
FAX (803) 572 1871

MT PLEASANT OFFICE
1473 STUART ENSALS BLVD
P O BOX 1365
MT PLEASANT SC 29465
TELEPHONE (803) 881 7000
FAX (803) 881-8665

HUGO M. SPITZ (SC & FL)
CHARLES S. GOLDBERG
DAVID T. PEARLMAN
J. KEVIN HOLMES
THOMAS H. WHITE
DENNIS E. O'HEILL
DALE E. VAN SLAMBROOK
MALCOLM M. CROSLAND JR.
STEVEN E. GOLDBERG
IRVING J. BERG (1902-1980)

August 28, 1997

John F. Holland, President
E C C H
1200 Johnnie Dodds Boulevard
Mt Pleasant, SC 29464

CERTIFIED MAIL - RETURN RECEIPT
REQUESTED

Dear Mr. Holland

I am writing on behalf of Cynthia Holmes. I am
requesting an appeal regarding the letter which was received August
21, 1997.

Please notify me of the appeal at the address above.

Sincerely,

J. Kevin Holmes

JKH mp

EAST COOPER
Regional Medical Center
Tenet HealthSystem

1700 Johnnie Dodds Blvd
Mt Pleasant, SC 29464
Tel 803 881 0100

September 4 1997

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Cynthia Holmes MD
P O Box 187
306 Station 22 1/2
Sullivan's Island, SC 29482

Dear Dr Holmes

On September 2 1997 we received a letter from J Kevin Holmes Esq dated August 28 1997 requesting 'an appeal regarding the letter (you) received August 21 1997 ' The purpose of this letter is to clear up any misunderstanding that may have resulted from the August 21, 1997 letter signed by Ms Kara Melm

Ms Melm's August 21st letter was not meant to advise you of any adverse action under the bylaws To date no adverse action, as defined in the hospital's medical staff bylaws has occurred

Ms. Melm's letter was meant to inform you of the need for proof of your compliance with the bylaws requirement for either active or courtesy staff. We regret leaving the impression that you had in fact been placed on consulting staff. As of the date of this letter you are still on provisional staff

Please be advised, however that the Medical Executive Committee will meet on September 10th. At that time the committee will likely take final action on your permanent staff category. I would recommend, therefore that prior to that meeting you advise the Medical Executive Committee concerning the information required by the bylaws and described in Mrs Melm's letter which is pertinent to your eligibility for active and courtesy staff.

Without proof that you have met the complete requirements for either active or courtesy staff, the Medical Executive Committee ultimately will have no choice but to assign you to consulting staff.

HUGO M. SPITZ (SC & FL)
CHARLES S. GOLDBERG
DAVID T. PEARLMAN
J. KEVIN HOLMES
THOMAS M. WHITE
DENNIS E. O'NEILL
DALE E. VAN SLAMBROOK
MALCOLM M. CROSLAND JR.
STEVEN E. GOLDBERG
IRVING STEINBERG (1902-1980)

THE STEINBERG
ATTORNEYS AT LAW
LLP

61 Broad St. P.O. Box 9
Charleston, SC 29402-0009
Telephone (803) 720-2800
Fax (803) 722-1190

RECEIVED

SEP 30 1997

ECRMC
Medical Staff Office

NORTH AREA OFFICE
118 GOOSE CREEK BLVD. SOUTH
P.O. BOX 1028
GOOSE CREEK, SC 29445
TELEPHONE (803) 572-0700
FAX (803) 572-1571
MT PLEASANT OFFICE
1473 STUART ENGELS BLVD
P.O. BOX 1365
MT PLEASANT, SC 29465
TELEPHONE (803) 881-0000
FAX (803) 881-8665

September 26, 1997

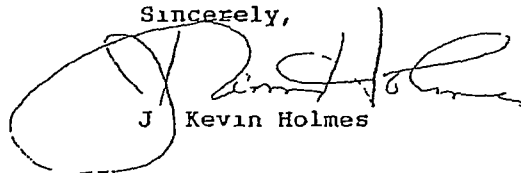
John F. Holland, President
E C C H
1200 Johnnie Dodds Boulevard
Mt Pleasant, SC 29464

Return Receipt Requested

Dear Mr. Holland

As you know, I have filed an appeal on behalf of Dr. Holmes from the adverse decision made by the Committee. One of Dr. Holmes' established patients needs surgery and Dr. Holmes would like to schedule the surgery in your hospital. Please advise immediately whether she will be denied the right to continue her practice pending her appeal. If she will be allowed to schedule the surgery, please advise the name and telephone number of the person she should contact to post the case.

Sincerely,


J. Kevin Holmes

JKH mp

RECEIVED
SEP 29 1997

000637

EAST COOPER
Regional Medical Center
Tenet HealthSystem

1200 Johnne Dodds Blvd
Mt Pleasant SC 29464
Tel 803 881 0100

October 1 1997

VIA FACSIMILE AND CERTIFIED MAIL/RETURN RECEIPT REQUESTED

J Kevin Holmes Esquire
The Steinberg Law Firm, LLP
61 Broad Street
Post Office Box 9
Charleston SC 29402 0009

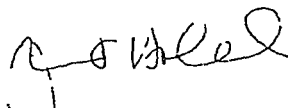
Dear Mr Holmes

I am in receipt of your letter dated September 26 1997 in which you indicate that Dr Cynthia Holmes would like to schedule surgery at the East Cooper Regional Medical Center (Hospital)

On September 16 1997 Dr Holmes was notified that her request for advancement to either Active or Courtesy Staff had been denied and that she had been appointed to the Consulting Staff. This letter also advised that the denial and appointment constituted an adverse action under Article IX of the Medical Staff Bylaws. Pursuant to Article IX Section 2 B this adverse action became effective on the date that the action was taken and shall remain effective pending Dr Holmes hearing and any subsequent appellate procedures.

Dr Holmes current staff category is Consulting Staff Pursuant to Article IV Section 5 of the Medical Staff Bylaws Dr Holmes is not eligible to admit patients and may not perform surgery in any capacity as the primary surgeon. As such we regret to inform you that Dr Holmes cannot admit patients to the Hospital for surgery pending her appeal.

Sincerely


John F. Holland
President

EAST COOPER
Regional Medical Center
Tenet HealthSystem

1200 Johnnie Dodds Blvd
Mt Pleasant SC 29464
Tel 803 881 0100

November 20 1997

CERTIFIED LETTER RETURN RECEIPT REQUESTED

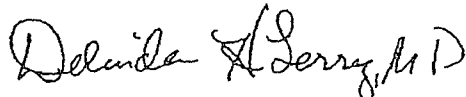
Cynthia Holmes M D
306 Station 22 1/2
Sullivan's Island SC 29482

Dear Dr Holmes

Pursuant to the reappointment process at East Cooper Regional Medical Center your Medical Staff membership was recently reviewed, including your staff category of Associate Active. Because you failed to have twenty four (24) patient contacts during the prior twelve (12) months, you were not eligible for reappointment to the Active staff category. Because you do not have active privileges at another local hospital, you were not eligible for reappointment to the Courtesy staff category.

On September 16 1997 the Medical Executive Committee recommended the reduction in your Associate Active staff category to Consulting staff category. That recommendation does not relate to professional competence or conduct.

Sincerely,



Delinda Terry M D
Chief of Staff

SINKLER & BOYD, P A

ATTORNEYS AT LAW

THE PALMETTO CENTER

1426 MAIN STREET SUITE 1200 (29201 2834)

POST OFFICE BOX 11889 (29211 1889)

COLUMBIA SOUTH CAROLINA

TELEPHONE 803 779 3080

FACSIMILE 803 765 1243

OTHER OFFICES
CHARLESTON SOUTH CAROLINA
GREENVILLE, SOUTH CAROLINA

*Spoke w J Becker
stated would write
Robert response or
have Mark II rege*

JAMES Y BECKER
DIRECT DIAL NUMBER 803 540 7708
E-MAIL ADDRESS JBECKER@sinklerboyd.com

January 15 1999

VIA FACSIMILE and U.S. MAIL

Mr Jack Dusenbery
CEO
East Cooper Regional Medical Center
1200 Johnnie Dodds Boulevard
Mt Pleasant, South Carolina 29464

*1/15/99
Elizabeth Carpenter
(Sinkler Boyd)
No longer w firm
Now working for
State Treasury Dept*

RE Cynthia Collie Holmes MD v East Cooper River
Regional Medical Center
S&B File No 9976 1

Dear Mr Dusenbery

Pursuant to the East Cooper Regional Medical Center Medical Staff Bylaws dated October 9, 1997, Article VIII Section 2 Dr Holmes appeals from the decision denying her application for appointment to the active staff, and the decision to appoint her to the consulting medical staff as stated in your letter notice of December 21 1998 Dr Holmes further reserves her right to representation by counsel in this appeal, and requests legal representation as permitted by Article VIII Section 3 D

With kind regards I am

Very truly yours,

James Y Becker
James Y Becker

JYB/bhm
cc Cynthia C Holmes, MD

 East Cooper
Regional Medical Center
Tenet HealthSystem

1200 J h Dodds Bl d
Wt Plea o SC 29464
el 803 681 0100

January 18 1999

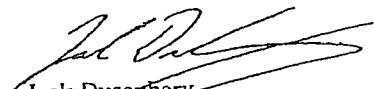
James Becker Esquire
Sinkler & Boyd P A
Post Office Box 11889
Columbia, South Carolina 29211-1889

Dear Mr Becker

As a follow up to our recent conversation and your January 15 1999 correspondence attached please find a copy of the Final Decision of the Governing Body in the Matter of Cynthia Holmes, M D

Pursuant to the East Cooper Regional Medical Center Bylaws, the Governing Body's decision was final and became effective immediately. The Bylaws allow for no further appeals.

Sincerely


Jack Dusenbery
Chief Executive Officer

 TENET

000564

C Holmes, MD

PO Box 187
Sullivan's Island SC 29482-0187

MDJD2K@aol.com

December 17 2004

Certified Return Receipt Requested

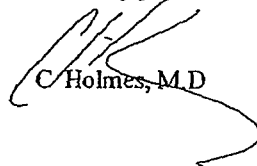
MSO - ECCH
1200 Johnnie Dodds Blvd
Mt Pleasant, SC 29464

Dear Sir/Madam

In response to your letter dated December 15 2004 I am writing to provide
notice of appeal and reservation of counsel

Thanking you for your kind attention, I am

Sincerely yours


C Holmes, MD

RECEIVED

DEC 27 2004

ECRMC
MEDICAL STAFF OFFICE

 East Cooper
Regional Medical Center

Tenet South Carolina

1200 Johnnie Dodds Blvd
Mt Pleasant SC 29464
Tel 843 881 0100
www.eastcoopermedctr.com

February 7 2005

CERTIFIED MAIL R/R/R Article# 7004 1350 0001 8367 3699

Cynthia Holmes MD
306 Station 22 1/2
Sullivans Island SC 29482

Dear Dr Holmes

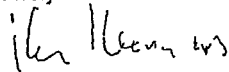
We have received your letter of 12/17/04 addressed to the Medical Staff Office in which you state In response to your letter of December 15 2004 I am writing to provide notice of appeal and reservation of counsel We assume this letter was a request by you to attempt to initiate the Hearing and Appellate Review process as contained in Article VIII of the Medical Staff Bylaws

This letter is being sent in response to your request Your recent reappointment to the consulting medical staff does not give rise to a right to a hearing under the Medical Staff Bylaws as no adverse action was taken as defined in Article VIII Section 2(b) of the Medical Staff Bylaws

As you were previously advised by the Medical Staff Office by letter dated 11/09/04 your application for a change in medical staff status from the consulting medical staff to the associate active medical staff and for surgical privileges could not be processed by the Credentials Committee as you did not provide sufficient information to confirm your current clinical competence Since your request could not be processed there was no adverse action taken on your request and therefore there are no grounds for a hearing or appeal under Article VIII of the Medical Staff Bylaws

I would suggest that it would be beneficial if you met with the Credentials Committee to discuss your request for a change in medical staff status and the clinical privileges you desire to insure that there are no misunderstandings and so any questions that either you or the Credentials Committee may have can be timely addressed The Credentials Committee stands ready to meet with you If you are desirous to do so please call Carol Boatwright at the Medical Staff Office upon your receipt of this letter to schedule an appointment with the Credentials Committee

Sincerely



Kevin Keenan MD
Chief of Staff

cc Paul L. Yantis III MD Chairman of Credentials



000084

East Cooper
Regional Medical Center

1200 Johnnie Dodds Blvd
Mt Pleasant SC 29464
Tel 843 881 0100
www.eastcoopermedctr.com

December 20 2006

VIA CERTIFIED MAIL R/R/R Article # 7005 1160 0005 4451 8797

Cynthia Holmes M D
P O Box 187
Sullivans Island SC 29482

Dear Dr Holmes



Your application for reappointment to the Medical Staff of East Cooper Regional Medical Center has been received and processed. Please be informed that the Medical Executive Committee (MEC) has recommended to the Governing Body that your application for associate status and surgical privileges be denied based upon inadequate documentation of current clinical competency. Under the Medical Staff Bylaws every applicant has the burden of producing adequate information for a proper evaluation of his or her current clinical competence to practice in the area of requested privileges. Also under the Medical Staff Bylaws the Hospital is required to confirm an applicant's current clinical competence. The MEC believes that the documentation of management of patients submitted with your application is inadequate to show clinical competency for the privileges requested in that the information is not dated, does not contain identifying patient information, was not compiled in a hospital or accredited surgical facility setting, and does not demonstrate your ability to competently perform the surgical procedures requested. Further, according to our records, you have not admitted or surgically treated any patients at East Cooper Regional Medical Center since 1998 and therefore there are no in-house records by which to evaluate your current clinical competency. The MEC however, has determined that your application meets the requirements of consulting staff status and has recommended to the Governing Body that you be reappointed to the consulting Medical Staff.



Please be advised that pursuant to Article VIII of the Medical Staff Bylaws you have the right to request a hearing to appeal the action recommended by the MEC regarding the denial of associate status and surgical privileges. Accordingly, this letter will serve as a Notice of Adverse Recommendation. A request for hearing must be made in writing and received by me as Administrator of East Cooper Regional Medical Center within thirty (30) days of your receipt of this Notice. You have the right to representation by an attorney or other person of your choice should you request a hearing. Any request for legal representation must be made at the time a hearing request is made. Your hearing rights under the Medical Staff Bylaws also include the right to voir dire and challenge the impartiality of the Medical Review Committee (MRC) members or Hearing Officer presiding over the hearing. You will be provided with all information made available to the MRC, call and examine witnesses on relevant evidence, cross-examine

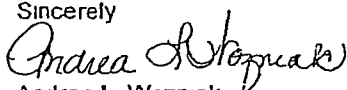


Cynthia Holmes MD
Page Two
December 20 2006

witnesses present evidence that tends to impeach any witness subject to the limitations set forth in the Medical Staff Bylaws and submit a written statement at the close of the presentation of evidence

Failure to request a hearing within the time frame and manner set forth above shall be deemed an acceptance of the recommendation of the MEC and a waiver of hearing and appellate rights under the Medical Staff Bylaws. If the action recommended by the MEC is formally adopted by the Governing Body, the action may be reported to the National Practitioner Data Bank if so required by law. By copy of this letter, the Notice of Adverse Recommendation has been forwarded to the Governing Body for its information.

Sincerely



Andrea L. Wozniak
Chief Executive Officer

cc Board of Directors East Cooper Regional Medical Center



{
{



/

C Holmes, M D

122
J F 000

PO Box 187
Sullivan's Island, SC 29482-0187

January 15, 2007

By Hand

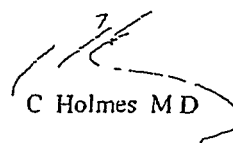
Ms Andrea Wozniak
ECCH
1200 Johnnie Dodds Blvd
Mt Pleasant, SC 29464

Dear Madam

I am writing to provide notice of appeal, request for hearing and reservation of counsel

Further I am writing to notify you of multiple inaccuracies and falsehoods contained in your letter. As you know your application requested documentation of management of 25 patients which was provided. Your application did not specify any particular format. If you preferred an alternate format, it could have been specified. Nor did you inform the applicant that you needed another format which could have been provided upon request. In addition, your records are incorrect as patients have indeed been admitted since 1998. Your wrongful acts are consistent with economic credentialing at its worst. Your wrongful conduct is in contravention of your own by laws.

Sincerely


C Holmes M D

 East Cooper
Regional Medical Center

January 21 2009

CERTIFIED MAIL

Cynthia E. Holmes, M.D.
P.O. Box 187
Sullivan's Island, SC 29482-0187

Re Notice of Appeal and Request for Hearing

Dear Dr. Holmes

I have received your letter, dated January 6, 2009, stating that you want 'to provide notice of appeal, request for hearing, and reservation of counsel

As I explained in my letter to you, dated December 19, 2008 your application for reappointment was determined to be incomplete because you did not submit a current and complete delineation of privileges form and because you did not submit any evidence of having performed at least 48 ophthalmologic surgical procedures in the past 24 months in a hospital or surgical setting. Such documentation is required for a practitioner who is seeking associate staff status as you were.

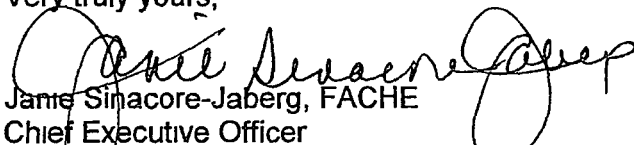
Article V, Section 3 B of the Medical Staff Bylaws states that a practitioner who 'fails to return the form or to supply all of the required information within thirty (30) days prior to the expiration of the current appointment period or respond in a timely manner to a request for information shall be deemed to have resigned his Medical Staff membership, effective as of the date of the expiration of his current appointment.' The Bylaws state further that a practitioner who is deemed to have resigned voluntarily under this section 'shall not be entitled to the hearing and appeal rights under the Bylaws.

Based on the plain language of the Bylaws, the Hospital cannot accommodate your request for hearing.

You may submit a new application for medical staff membership and clinical privileges that will be processed as such. Please be aware, however, that a physician submitting a new application will not be eligible for medical staff membership and clinical privileges unless he/she is board certified or, if not, can achieve board certification within five years from the time of completion of residency training. In addition, ophthalmologists seeking active or associate staff privileges must submit evidence of having performed at least 48 ophthalmologic surgical procedures in the past 24 months in a hospital or surgical setting.

In the meantime, the Hospital will consider this matter closed.

Very truly yours,


James Sinacore-Jaberg, FACHE
Chief Executive Officer

cc Chief of Staff
Chairman, Board of Directors

Scoring Grid

- 0 Insufficient compliance
1 Partial compliance
2 Satisfactory compliance
NA Not applicable

Comprehensive Accreditation Manual for Hospitals The Official Handbook

#9

A

0	1	2	NA

Elements of Performance for MS 4 45

- 1 The organization based on recommendations by the organized medical staff and approval by the governing body, has a clearly defined process for collecting, investigating and addressing clinical practice concerns (see Standard RI 1 120 regarding complaints received from patients and families)
- 2 Reported concerns regarding a privileged practitioner's professional practice are uniformly investigated and addressed as defined by the organization and applicable law

B

0	1	2	NA

Fair Hearing and Appeal Process for Adverse Privileging Decisions

- ☐ Compliant
☐ Not Compliant

Standard MS 4 50

There are mechanisms including a fair hearing and appeal process for addressing adverse decisions regarding reappointment denial reduction suspension or revocation of privileges that may relate to quality of care treatment and services issues

Rationale for MS 4 50

Mechanisms for fair hearing and appeals processes are designed to allow the affected individual a fair opportunity to defend herself or himself regarding the adverse decision to an unbiased hearing body of the medical staff and an opportunity to appeal the decision of the hearing body to the governing body The purpose of a fair hearing and appeal is to assure full consideration and reconsideration of quality and safety issues and under the current structure of reporting to the NPDB allow practitioners an opportunity to defend themselves

Elements of Performance for MS 4 50

The organized medical staff has developed a fair hearing and appeal process addressing quality of care issues that has the following characteristics

B

0	1	2	NA

- 1 Is designed to provide a fair process that may differ for members and non members of the medical staff

B

0	1	2	NA

- 2 Has a mechanism to schedule a hearing of such requests

B

0	1	2	NA

- 3 Has identified the procedures for the hearing to follow

B

0	1	2	NA

- 4 Identifies the composition of the hearing committee as a committee that includes impartial peers

B

0	1	2	NA

- 5 With the governing body provides a mechanism to appeal adverse decisions as provided in the medical staff bylaws

Appointment to Membership on the Medical Staff

- ☐ Compliant
☐ Not Compliant

Standard MS 4 60

The organized medical staff provides oversight for the quality of care treatment and services by recommending members for appointment to the medical staff

Elements of Performance for MS 4 60

A

0	1	2	NA

- 1 The organized medical staff develops criteria for medical staff membership

C

0	1	2	NA

- 2 The professional criteria are designed to assure the medical staff and governing body that patients will receive quality care treatment, and services

40-47-40 Continued Competency

#10

The continued professional competency of a physician holding a permanent license must be demonstrated in the following manner

- (1) For renewal of a permanent license initially issued during a biennial renewal period compliance with all educational examination and other requirements for the issuance of a permanent license is sufficient for the first renewal period following initial licensure
- (2) For renewal of an active permanent license biennially documented evidence of at least one of following options during the renewal period is required
 - (a) forty hours of Category I continuing medical education sponsored by the American Medical Association American Osteopathic Association or another organization approved by the board as having acceptable standards for courses it sponsors at least thirty hours of which must be related directly to the licensee's practice area,
 - (b) certification of added qualifications or recertification after examination by a national specialty board recognized by the American Board of Medical Specialties or American Osteopathic Association or another approved specialty board certification
 - (c) completion of a residency program or fellowship in medicine in the United States or Canada approved by the Accreditation Council on Graduate Medical Education or American Osteopathic Association
 - (d) passage of the Special Purpose Examination or Comprehensive Osteopathic Medical Variable Purpose Examination or
 - (e) successful completion of a clinical skills assessment program approved by the board such as the Institute for Physician Evaluation or the Center for Personalized Education for Physicians
- (3) For reinstatement or reactivation of a permanent license from lapsed or inactive status of less than four years, documented evidence of at least one of the following options within the preceding two years is required
 - (a) forty hours of Category I continuing medical education sponsored by the American Medical Association American Osteopathic Association or another organization approved by the board as having acceptable standards for courses it sponsors at least thirty hours of which must be directly related to the licensee's practice area,
 - (b) certification of added qualifications or recertification after examination by a national specialty board recognized by the American Board of Medical Specialties or American Osteopathic Association or another approved specialty board certification
 - (c) completion of a residency program or fellowship in medicine in the United States or Canada approved by the Accreditation Council on Graduate Medical Education or American Osteopathic Association
 - (d) passage of the Special Purpose Examination or Comprehensive Osteopathic Medical Variable Purpose Examination or
 - (e) successful completion of a clinical skills assessment program approved by the board such as the Institute for Physician Evaluation or the Center for Personalized Education for Physicians
- (4) For reinstatement or reactivation of a permanent license from lapsed or inactive status of four years or more documented evidence of at least one of the following options within the preceding two years is required
 - (a) certification of added qualifications or recertification after examination by a national specialty board recognized by the American Board of Medical Specialties or American Osteopathic Association or another approved specialty board certification
 - (b) completion of a residency program or fellowship in medicine in the United States or Canada approved by the Accreditation Council on Graduate Medical Education or American Osteopathic Association
 - (c) passage of the Special Purpose Examination or Comprehensive Osteopathic Medical Variable Purpose Examination or
 - (d) successful completion of a clinical skills assessment program approved by the board such as the Institute for Physician Evaluation or the Center for Personalized Education for Physicians
- (5) For reinstatement or reactivation of a lapsed or an inactive status of a permanent license of a licensee who has been in active practice in another state compliance with any of the requirements of this section within the preceding two years is sufficient

East Cooper Regional Medical Center

Medical Staff Office
1200 Johnnie Dodds Boulevard
Mt Pleasant SC 29464
(843) 881-4350 Phone
(843) 375-5238 Fax

MEDICAL STAFF REAPPOINTMENT APPLICATION

Please check one of the following

- ☒ I wish to be reappointed to the Medical Staff of East Cooper Regional Medical Center
☐ I do not wish to be reappointed

If you have checked the second statement, do not continue Sign below and fax IMMEDIATELY to (843) 375-5238

Applicant Signature Cynthia E Holmes, MD

Date _____

In order to process your reappointment to the Medical Staff, we ask that you provide the following information. A non-refundable \$25.00 reappointment fee must accompany this application. If your application is not received within thirty (30) days upon receipt, a late fee of \$100.00 will be charged for the continued processing of your application past the thirty (30) day deadline. If you have questions please contact the MSO or e-mail me at Elena.giordano@tenethealth.com

Please return this form to the Medical Staff Office within 30 days of receipt

Below is your data currently stored in our database. Review carefully and mark any changes on this sheet.

PERSONAL IDENTIFICATION DATA

Name	Cynthia E Holmes, MD	Department	Surgery
Specialty	Ophthalmology	Present Status	Consulting
PLEASE CHANGE MY STAFF CATEGORY TO ☐ Active ☐ Courtesy ☐ Consulting ☒ Associate			
Last Reappointment Date	12/13/2006	Privileges Expire	12/13/2008

PRIMARY OFFICE

☒ No change since appointment or last reappointment

Practice Name C. HOLMES, MD

Primary Office 306 STATION 22 1/2, SI, SC 29482 0187

Primary Address PO Box 187 Sullivans Island SC 29482

883 3176

(843) 883-9030

Primary Ofc
Phone

Primary Ofc Fax

728 2733

Beeper

E-mail

MRS MARY FLETCHER
Office Manager

883 3176 EXT 6
Direct Line or Extension

NPI 1023222734

-1360-

112

E Cooper Regional Medical Center
OPHTHALMOLOGY
DELINEATION OF PRIVILEGES

NAME C. Holmes

DATE 9/25/04

THE MINIMUM EDUCATION, TRAINING, AND EXPERIENCE QUALIFICATIONS FOR CORE PRIVILEGES ARE AS DELINEATED IN EACH HOSPITAL'S MEDICAL STAFF BYLAWS, RULES & REGULATIONS, OR POLICIES. PLEASE CONSULT THESE DOCUMENTS TO DETERMINE YOUR ELIGIBILITY.

TO REQUEST CORE PRIVILEGES, PLEASE PLACE AN "X" IN THE SPACE PROVIDED

CORE PRIVILEGES	
Ophthalmology privileges will be extended to physicians who have completed an accredited residency in Ophthalmology. Applicants must meet the requirement to be either board eligible or board certified by the American Board of Ophthalmology. If board certification requirements are not met within five (5) years from the date of completion of an approved residency training program in Ophthalmology, clinical privileges will be terminated according to the Medical Staff Bylaws. Core privileges include admission history & physical diagnosis, ordering and prescribing medication, ordering diagnostic tests, as well as surgical and non-surgical treatment of patients of all ages presenting with any illnesses, injuries and disorders of the eye, including its related structures and visual pathways. The use of CO2, YAG, and KTP lasers as trained in residency. The successful applicant must be able to demonstrate that he or she has provided surgery for at least 25 patients during the past 24 months.	

TO REQUEST SPECIAL PROCEDURES, PLEASE PLACE AN "X" IN THE APPROPRIATE COLUMN

	SPECIAL PROCEDURE	APPROVE	DENY
	Procedures that are not routinely part of training and may require proof of training or experience		
	Moderate Sedation		
	Radial Keratotomy		
	Vitreo canulostomy		
X	OTHER (If the condition/privileges you are interested in is not included on this form, please provide a separate written request and appropriate documentation of training and/or experience.)	✓	

I UNDERSTAND THAT (A) IN EXERCISING CLINICAL PRIVILEGES GRANTED, I AM CONSTRAINED BY EACH HOSPITAL'S MEDICAL STAFF BYLAWS, RULES & REGULATIONS, AND (B) ANY RESTRICTION ON THE CLINICAL PRIVILEGES GRANTED TO ME IS WAIVED IN AN EMERGENCY SITUATION AND IN SUCH SITUATION MY ACTIONS ARE GOVERNED BY THE APPLICABLE SECTION OF EACH HOSPITAL'S MEDICAL STAFF BYLAWS.

APPLICANT'S SIGNATURE

DATE

DEPARTMENT CHAIRMAN'S SIGNATURE

DATE

C Holmes, M D

PO Box 187
Sullivan Island SC 29482-0187

MDJD2K@aol.com

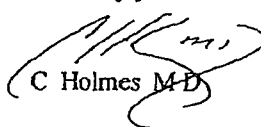
September 25, 2004

MSO ECCH
1200 Johnnie Dodds Blvd
Mt Pleasant, SC 29464

I am requesting continuation of the attached documented privileges and Associate Active status

Thanking you for your kind attention, I am

Sincerely yours


C Holmes M.D.

EAST COOPER COMMUNITY HOSPITAL

CLINICAL PRIVILEGES SHEET

OPHTHALMOLOGY

R. Holmes

<u>Class O</u>		<u>Class IV</u>	
<u>1</u>		<u>1</u>	<u>2</u>
	<u>Life-threatening emergency</u> At the time of a clinical emergency any practitioner may render whatever care he believes to be indicated		Vitreous surgery
			Corneal transplant surgery
			Neuro Ophthalmology surgery
<u>✓</u>	<u>Class I</u>	<u>✓</u>	Retinal surgery (including lasers)
<u>1</u>	<u>2</u>		Glaucoma surgery
	Vision acuity screening	<u>✓</u>	Pediatric Ophthalmology
	Tonometry/Tonography	<u>✓</u>	Electrophysiologic studies
	Optical measurement (i.e., pupillary distance near point of convergence accommodation)		
	Color vision testing		
	Surgical assisting with ophthalmologist		
	External eye examination		
	Fundus examination of posterior pole		
	Treatment of uncomplicated conjunctivitis		
	Removal of foreign bodies on cornea or conjunctiva		
<u>✓</u>	Treatment of corneal abrasions		
	Eye irrigation		
	Order x-rays to rule out retained foreign body or fracture		
<u>✓</u>	<u>Class II</u>		
<u>1</u>	<u>2</u>		
	Refractions, manifest		
	Orthoptic exercises		
	Visual field testing		
	Contact lens fitting		
	Contact lens modifications		
<u>✓</u>	<u>Class III</u>		
<u>1</u>	<u>2</u>		
	Treatment of all ophthalmic conditions		
	Treatment of neoplasms of orbit eye and adnexa		
	Intra and extraocular surgery		

CME	DATE	CME HOURS
HMP Communications – Arresting Glaucoma's Advance	9/00/04	1
SLACK – Improved Outcomes in Cataract Surgery	9/01/04	3
Postgraduate Institute for Medicine – Contemporary Issue in Glaucoma Diagnosis and Therapy	9/04/04	1.5
European Society of Cataract and Refractive Surgeons	9/18/04 – 9/11/04	
Tailoring Glaucoma Treatment To Your Patient's Priorities	10/00/04	1
NY Eye And Ear Infirmary – The Impact of Hyperemia on Compliance, Costs & Medical Practice	9/01/04	1.5
TOTAL 2004		51.75

2002 37
 2003 41.5
 2004 51.75 (estimate)

Total 130.25

#13

 East Cooper
Regional Medical Center

Tenet South Carolina

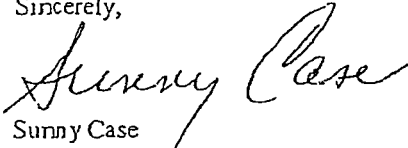
1200 Johnnie Dodds Blvd
Mt Pleasant SC 29464
Tel 843 881 0100
www.eastcoopermedctr.com

February 12 2007

Re Dr Cynthia Holmes

This letter is to verify that Dr Cynthia Holmes has not had any patient contacts at East Cooper Regional Medical Center since August 2004

Sincerely,


Sunny Case
HIM Director



000011

C Holmes, M.D.

PO Box 187
306 Station 22 1/2
Sullivan's Island, SC 29482-0187

Phone 843.883.3176
Fax 843.883.3459

December 1 2000

Mrs Nancy Arnold
Medical Staff Coordinator
ECH
1200 Johnnie Dodds Blvd
Mt Pleasant, SC 29464

Dear Nancy

I am writing in response to your letter dated 11/3/00. Per that letter, you made two requests:

- a) the privileges form, and
- b) information regarding current clinical competence.

Enclosed please find copies of the privileges form which were previously delivered to you.

Regarding current clinical competence, I have provided your Health Information Director, Greg Bellamy, with the names of 11 "hands-on" patient contacts: phacoemulsification, cataract extract, and for I

Enclosed please find copies of the Operative Note for the two most recent patients as they may not be in the database yet. Mr. Bellamy stated he has forwarded the other information to your office. If you have not received it, please contact me and I will follow up to make sure it is in your hands.

I am also offering 14 consultations with the hospital (more consultations are available if required) which charts I am ready, willing, and able to provide for your review. These 25 patient contacts (or more if needed) are provided under the Bylaws. Please note that the Bylaws allow non-surgical as well as surgical contacts.

Although the State of South Carolina has not required CME and ECH has not enforced CME in the past, I have completed more than 40 hours of category 1 CME. According to my records, you should have received certification for 38 hours of CME. The AMA is forwarding certification for the remaining two hours which will be submitted upon receipt. In addition, I will be happy to attend AMA CME programs of your choice.

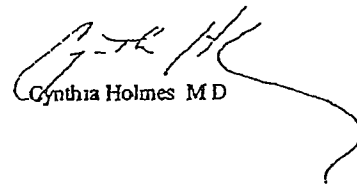
Further, I have scheduled

at _____ with these cases. As you know, _____ cornea and cataract sub-specialist trained at Manhattan Eye and Ear Hospital.

I am requesting active privileges in order to provide the requested services to my patients. I am a good physician practicing full-time and providing quality health care to my patients. I have provided documentation of current clinical competence under the Bylaws. I am not aware of any evidence to the contrary, and if you believe there is evidence to the contrary under the Bylaws, I request the opportunity to respond.

In closing, I am hoping that this matter can be resolved. Thanking you in advance for your consideration I am

Very truly yours,


Cynthia Holmes M.D.

EAST COOPER REGIONAL MEDICAL CENTER
1200 Johnnie Dodds Blvd
Mt Pleasant, SC 29464

REPORT OF OPERATION

Patient Name
DOB

MRN
Pt Class Outpatient Room/Bed OJ

Surgeon C HOLMES MD

Date of Operation 11/22/00

~~Assistants DR LOWERY~~
DR LALLY

Anesthesia MAC
Anesthetist

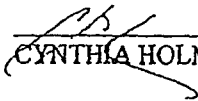
Preoperative Dx Visually significant posterior subcapsular cataract right eye

Postoperative Dx Same

Operation Title Phacoemulsification with IOL implant right eye

INTERPRETATION Complications none

PROCEDURE Therapeutic options were discussed with the patient preoperatively including a discussion of risks and benefits of surgery. Informed consent was obtained. The patient was brought to the OR and placed on the table in the supine position. IV line and sternal cardiac monitoring were established. The patient was prepped and draped in the usual fashion. Topical anesthesia and intercameral Lidocaine were used as anesthesia. The patient received a clear corneal groove superiorly. The super blade was used to create a paracentesis site and viscoelastic was instilled into the anterior chamber. The 3 mm blade was used to enter the anterior chamber and a capsulorhexis was performed. BSS on a cannular was used for hydrodissection. In situ phacoemulsification was performed. Cortical material was removed with the irrigation aspiration unit. The wound was opened to the extent of the groove. Viscoelastic was instilled to open the capsular bag. A posterior chamber IOL was inserted and securely positioned within the capsular bag. Viscoelastic and remaining cortical material were removed with the irrigation aspiration unit. Miochol was instilled to constrict the pupil. The wound was closed with 10-0 nylon suture. No leakage was present at the completion of the procedure. The wire lid speculum was removed. Antibiotic was instilled. The patient was discharged from the operating room without complications. The patient tolerated the procedure well.


CYNTHIA HOLMES, MD

Dictated on Nov 22 2000 12 00A Transcribed By VM on Nov 27 2000

EAST COOPER REGIONAL MEDICAL CENTER
1200 Johnnie Dodds Blvd
Mt Pleasant, SC 29464

REPORT OF OPERATION

Patient Name
DOB

MRN
Pt Class Outpatient Room/Bed OJ-

Surgeon C HOLMES, MD

Date of Operation 11/22/00

~~Assistant~~ DR. LOWERY
AR LALLY

Anesthesia MAC

Anesthetist \

Preoperative Dx Visually significant nuclear sclerotic cataract right eye

Postoperative Dx Same

Operation Title Phacoemulsification with IOL implant right eye

INTERPRETATION Complications none

PROCEDURE Therapeutic options were discussed with the patient preoperatively including a discussion of risks and benefits of surgery. Informed consent was obtained. The patient was premedicated, brought to the OR, and placed on the table in the supine position. IV line and sternal cardiac monitoring were established. A peribulbar injection was administered with 2% Xylocaine with epinephrine and 0.75% Marcaine. After adequate anesthesia and akinesia, the patient was prepped and draped in the usual fashion. A wire lid speculum was inserted and the microscope was positioned. A clear corneal groove was created superiorly. The super blade was used to create a paracentesis site and viscoelastic was instilled into the anterior chamber. The 3 mm blade was used to enter the anterior chamber and a capsulorhexis was performed. BSS on a cannula was used for hydrodissection. In situ phacoemulsification was performed. Cortical material was removed with the irrigation aspiration unit. The wound was opened to the extent of the corneal groove. Viscoelastic was instilled to open the capsular bag. A posterior chamber IOL was inserted and securely positioned within the capsular bag. Viscoelastic and remaining cortical material were removed with the irrigation aspiration unit. Miochol was instilled to constrict the pupil. The wound was closed with 10-0 nylon suture. No leakage was present at the completion of the procedure. The wire lid speculum was removed. Antibiotic was instilled and the patient received a gentle pressure patch and fox shield. The patient was discharged from the OR without complications. The patient tolerated the procedure well.


CYNTHIA HOLMES, MD

Dictated on Nov 22 2000 12:00A Transcribed By VM on Nov 27 2000

MODEL SA60AT
POWER 20 5 D
LENGTH(Ø_T) 13 0mm
OPTIC(Ø_B) 6 0mm
SN 875846 001

EXP DATE
2009-12
UV
SINGLE
PIECE IOL
Alcon Laboratories Inc

EAST COOPER REGIONAL MEDICAL CENTER



014129662 MR# 001199319

DOB 10/16/1918 M
06/23/2005
PT 0 FC 40



883.3176

Consulting Physician and/or Service Cynthia Holmes / Ophthalmology

Reason for Request TRANSIENT BLINDNESS

☐ ASAP ☐ Urgent ☐ At Your Convenience ☐ Other _____

Date Requested 2/9/07 Requested by Dr [REDACTED]

Date and Time Office or Service Notified 2/9/07 849AM Blae
Date Time By Whom

2/9/07 Dr Rebecca

46 y/o F c/o ↓ V A on Adm Hx / extending w/ R/L
MRI @ infant @ medulla oblongata
meds Aggrenox, HCT2, Clonidine, maling 27
All NKDA
pm H @ htm, @ dm
POH - @ glaucoma LEE ~ 1 yr
✓ EC CF

TONO 23

N 20/50

PLS

LCC - demux chelars' 05700

C uen

C chon

K - chon

P - PRRL, @ @ AD

AC - deep cu

Eons full on

I - @ NVION

L - NSCON

φ FE 2° lens 015 - 00

VFI Tension on OD

- FTC 05

① glaucoma on - Truwater 11

② Transient ↓ V A resolved per pt.

Consider vertebrobasilar insufficiency. Consider
cardiovascular w/you, carotid studies, cervical
spine compression w/you follow w/you

2/9/07
Date of Consultation

[Signature]
Consultant

MD

CONSULTATION RECORD



DOB [REDACTED]

02/08/2007

PT1 FC 40

ACCT#015200157 MR# [REDACTED]

East Cooper Regional Medical Center
DELINEATION OF PRIVILEGES
OPHTHALMOLOGY

RECEIVED

NOV 27 2000

#15

NAME C. Holmes

EL-2
 Medical Staff Office
 DATE 9/6/00

THE MINIMUM EDUCATION TRAINING AND EXPERIENCE QUALIFICATIONS FOR CORE PRIVILEGES ARE AS DELINEATED IN EACH HOSPITAL'S MEDICAL STAFF BYLAWS RULES & REGULATIONS OR POLICIES PLEASE CONSULT THESE DOCUMENTS TO DETERMINE YOUR ELIGIBILITY

TO REQUEST CORE PRIVILEGES, PLEASE PLACE AN "X" IN THE APPROPRIATE COLUMN

CORE PRIVILEGES	
Ophthalmology privileges will be extended to physicians who have completed an accredited residency in Ophthalmology. Applicants must meet the requirement to be either board eligible or board certified by the American Board of Ophthalmology. If board certification requirements are not met within five (5) years from the date of completion of an approved residency training program in Ophthalmology, clinical privileges will be terminated according to the Medical Staff Bylaws. Core privileges include admission, history & physical, diagnosis, ordering and prescribing medication, ordering diagnostic tests as well as surgical and non-surgical treatment of patients of all ages presenting with any illnesses, injuries and disorders of the eye including its related structures and visual pathways. The use of CO2 YAG and KTP lasers as trained in residency. The successful applicant must be able to demonstrate that he or she has provided surgery for at least 25 patients during the past 24 months.	

TO REQUEST SPECIAL PROCEDURES, PLEASE PLACE AN "X" IN THE APPROPRIATE COLUMN

	SPECIAL PROCEDURE-	APPROVE	DENY
	Procedures that are not routinely part of training, and may require proof of training or experience		
	Conscious Sedation		
	Radial Keratotomy		
	Vitreo cannulotomy		
X	OTHER (If the condition/privileges you are interested in is not included on this form, please provide a separate written request and appropriate documentation of training and/or experience.)	/	

I UNDERSTAND THAT (A) IN EXERCISING CLINICAL PRIVILEGES GRANTED I AM CONSTRAINED BY EACH HOSPITAL'S MEDICAL STAFF BYLAWS RULES & REGULATIONS, AND (B) ANY RESTRICTION ON THE CLINICAL PRIVILEGES GRANTED TO ME IS WAIVED IN AN EMERGENCY SITUATION AND IN SUCH SITUATION MY ACTIONS ARE GOVERNED BY THE APPLICABLE SECTION OF EACH HOSPITAL'S MEDICAL STAFF BYLAWS.

APPLICANT'S SIGNATURE [Signature] DATE 9/6/00

DEPARTMENT CHAIRMAN [Signature] DATE 11/5/00

CREDENTIALS CHAIRMAN [Signature] DATE 12/4/00

EXECUTIVE COMMITTEE CHAIRMAN [Signature] DATE 12/8/00

BOARD OF DIRECTORS CHAIRMAN [Signature] DATE 12/8/00

X Requesting continuation of the following privileges
which have been documented and verified

Class 1

Vision acuity screening
Tomometry/Topography
Optical measurement (i.e., pupillary distance, near point of
convergence, accommodation)
Color vision testing
Surgical assisting with ophthalmologist
External Eye examination
Fundus examination of posterior pole
Treatment of uncomplicated conjunctivitis
Removal of foreign bodies on cornea or conjunctiva
Treatment of corneal abrasions
Eye irritation
Order x-rays to rule out retained foreign body or fracture

Class 2

Refractions, manifest
Orthoptic exercises
Visual field testing
Contact lens fitting
Contact lens modifications

Class 3

Treatment of all ophthalmic conditions
Treatment of neoplasms of orbit, eye and adnexa
Intra and extraocular surgery

Class 4

Retinal laser surgery
Glaucoma surgery (including lasers)
Pediatric Ophthalmology
Electrophysiologic studies

Forty hours of CME have been completed. Additional AMA
acknowledgment forms will be forwarded upon receipt.

RECEIVED

NOV 27 2000

Medical Staff Office

East Cooper Regional Medical Center
OPHTHALMOLOGY
DELINEATION OF PRIVILEGES

NAME C HOLMES, MD

DATE 11/1/02

THE MINIMUM EDUCATION TRAINING AND EXPERIENCE QUALIFICATIONS FOR CORE PRIVILEGES ARE A DELINEATED IN EACH HOSPITAL'S MEDICAL STAFF BYLAWS, RULES & REGULATIONS OR POLICIES PLEASE CONSULT THESE DOCUMENTS TO DETERMINE YOUR ELIGIBILITY

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CORE PRIVILEGES	
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TO REQUEST SPECIAL PROCEDURES, PLEASE PLACE AN "X" IN THE APPROPRIATE COLUMN.

	SPECIAL PROCEDURE	APPROVE	DENY
	Procedures that are not routinely part of training and may require proof of training or experience		
	Moderate Sedation		
	Radial Keratotomy		
	Visco canulostomy		
✓	OTHER (If the condition/privileges you are interested in is not included on this form, please provide a separate written request and appropriate documentation of training and/or experience.)	✓	

I am requesting continuation of privileges as noted on the attached form.

I UNDERSTAND THAT (A) IN EXERCISING CLINICAL PRIVILEGES GRANTED, I AM CONSTRAINED BY EACH HOSPITAL'S MEDICAL STAFF BYLAWS, RULES & REGULATIONS, AND (B) ANY RESTRICTION ON THE CLINICAL PRIVILEGES GRANTED TO ME IS WAIVED IN AN EMERGENCY SITUATION AND IN SUCH SITUATION MY ACTIONS ARE GOVERNED BY THE APPLICABLE SECTION OF EACH HOSPITAL MEDICAL STAFF BYLAWS

[Signature]
 APPLICANT'S SIGNATURE

11/1/02
 DATE

[Signature]
 DEPARTMENT CHAIRMAN'S SIGNATURE

12/2/02
 DATE

OPHTHALMOLOGY

<u>Class O</u>		<u>Class IV</u>	
<u>1</u>		<u>1</u>	<u>2</u>
	Life-threatening emergency At the time of a clinical emergency any practitioner may render whatever care he believes to be indicated		Vitreous surgery
			Corneal transplant surgery
			Neuro Ophthalmology surgery
<u>1</u>	<u>Class I</u>		Retinal surgery (including lasers)
<u>2</u>			Glaucoma surgery
	Vision acuity screening		Pediatric Ophthalmology
	Tonometry/Tonography		Electrophysiologic studies
	Optical measurement (i.e., pupillary distance, near point of convergence, accommodation)		
	Color vision testing		
	Surgical assisting with ophthalmologist		
	External eye examination		
	Fundus examination of posterior pole		
	Treatment of uncomplicated conjunctivitis		
	Removal of foreign bodies on cornea or conjunctiva		
	Treatment of corneal abrasions		
	Eye irrigation		
	Order x-rays to rule out retained foreign body or fracture		
<u>1</u>	<u>Class II</u>		
<u>2</u>			
	Refractions, manifest		
	Orthoptic exercises		
	Visual field testing		
	Contact lens fitting		
	Contact lens modifications		
<u>1</u>	<u>Class III</u>		
<u>2</u>			
	Treatment of all ophthalmic conditions		
	Treatment of neoplasms of orbit, eye and adnexa		
	Intra and extraocular surgery		

E. Cooper Regional Medical Center
OPHTHALMOLOGY
DELINEATION OF PRIVILEGES

NAME C. Holmes DATE 9/25/04

THE MINIMUM EDUCATION TRAINING AND EXPERIENCE QUALIFICATIONS FOR CORE PRIVILEGES ARE AS
DELINEATED IN EACH HOSPITAL'S MEDICAL STAFF BYLAWS RULES & REGULATIONS, OR POLICIES PLEASE
CONSULT THESE DOCUMENTS TO DETERMINE YOUR ELIGIBILITY

TO REQUEST CORE PRIVILEGES, PLEASE PLACE AN "X" IN THE SPACE PROVIDED

CORE PRIVILEGES	
Ophthalmology privileges will be extended to physicians who have completed an accredited residency in Ophthalmology. Applicants must meet the requirement to be either board eligible or board certified by the American Board of Ophthalmology. If board certification requirements are not met within five (5) years from the date of completion of an approved residency training program in Ophthalmology, clinical privileges will be terminated according to the Medical Staff Bylaws. Core privileges include admission history & physical diagnosis, ordering and prescribing medication, ordering diagnostic tests, as well as surgical and non surgical treatment of patients of all ages presenting with any illnesses, injuries and disorders of the eye including its related structures and visual pathways. The use of CO₂, YAG and KTP lasers as trained in residency. The successful applicant must be able to demonstrate that he or she has provided surgery for at least 25 patients during the past 24 months.	

TO REQUEST SPECIAL PROCEDURES PLEASE PLACE AN "X" IN THE APPROPRIATE COLUMN

	SPECIAL PROCEDURE	APPROVE	DENY
	Procedures that are not routinely part of training and may require proof of training or experience		
	Moderate Sedation		
	Radial Keratotomy		
	Visco canulostomy		
X	OTHER (If the condition/privileges you are interested in is not included on this form please provide a separate written request and appropriate documentation of training and/or experience)	✓	

I UNDERSTAND THAT (A) IN EXERCISING CLINICAL PRIVILEGES GRANTED, I AM CONSTRAINED BY EACH HOSPITAL'S MEDICAL STAFF BYLAWS RULES & REGULATIONS AND (B) ANY RESTRICTION ON THE CLINICAL PRIVILEGES GRANTED TO ME IS WAIVED IN AN EMERGENCY SITUATION AND IN SUCH SITUATION MY ACTIONS ARE GOVERNED BY THE APPLICABLE SECTION OF EACH HOSPITAL'S MEDICAL STAFF BYLAWS

APPLICANT'S SIGNATURE

DATE 9/25/04

DEPARTMENT CHAIRMAN'S SIGNATURE

DATE 11/29/04

C Holmes, MD

PO Box 187
Sullivan's Island SC 29482-0187

MDJD2K@aol.com

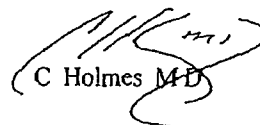
September 25 2004

MSO ECCH
1200 Johnnie Dodds Blvd
Mt Pleasant, SC 29464

I am requesting continuation of the attached documented privileges and Associate Active status

Thanking you for your kind attention, I am

Sincerely yours,


C Holmes MD

EAST COOPER COMMUNITY HOSPITAL

CLINICAL PRIVILEGES SHEET

OPHTHALMOLOGY

Dr Holmes

<u>Class O</u>		<u>Class IV</u>	
<u>1</u>		<u>1</u>	<u>2</u>
	Life-threatening emergency At the time of a clinical emergency any practitioner may render whatever care he believes to be indicated		Vitreous surgery
			Corneal transplant surgery
			Neuro Ophthalmology surgery
<u>✓</u>	<u>Class I</u>	<u>✓</u>	<u>Retinal surgery (including lasers)</u>
<u>1</u>	<u>2</u>	<u>✓</u>	<u>Glaucoma surgery</u>
	Vision acuity screening	<u>✓</u>	<u>Pediatric Ophthalmology</u>
	Tonometry/Tonography	<u>✓</u>	<u>Electrophysiologic studies</u>
	Optical measurement (i.e. pupillary distance, near point of convergence accommodation)		
	Color vision testing		
	Surgical assisting with ophthalmologist		
	External eye examination		
	Fundus examination of posterior pole		
	Treatment of uncomplicated conjunctivitis		
	Removal of foreign bodies on cornea or conjunctiva		
<u>✓</u>	Treatment of corneal abrasions		
	Eye irrigation		
	Order x-rays to rule out retained foreign body or fracture		
<u>✓</u>	<u>Class II</u>		
<u>1</u>	<u>2</u>		
	Refractions, manifest		
	Orthoptic exercises		
	Visual field testing		
	Contact lens fitting		
	Contact lens modifications		
<u>✓</u>	<u>Class III</u>		
<u>1</u>	<u>2</u>		
	Treatment of all ophthalmic conditions		
	Treatment of neoplasms of orbit, eye and adnexa		
	Intra and extraocular surgery		

**East Cooper Regional
Medical Center**

Tenet

NAME Cynthia E Holmes MD

OPHTHALMOLOGY SURGERY DELINEATION OF PRIVILEGES			
Minimum threshold criteria to apply for ophthalmology privileges			
1	Education MD or DO		
2	Minimum formal training Successful completion of an ACGME/AOA accredited residency training program in ophthalmology program		
3	Board Certification Must be achieved within 5 years of residency/fellowship training or as noted by their respective board Acceptable board certification in only through the ABMS		
4	Required previous experience Applicants must be able to demonstrate that they have provided surgical ophthalmology treatment to at least 25 ophthalmologic surgical procedures in the past 24 months		
5	References Letters of reference must come from the residency and/or fellowship director or the Chief of Ophthalmology in which the applicant has successfully completed training and/or the applicant has been affiliated with for the last two years Two letters must come from an anesthesiologist and primary care physician who have known the applicant at least two years and are acquainted with the applicant's current professional status medical practice and involvement in the field of ophthalmology		
6	Reappointment Demonstrates that one has maintained competence by showing evidence that they have managed at least 25 patients in the past 24 months		
The above minimum threshold criteria must be met in order to request core privileges			
	REQUESTED	APPROVED	COMMENTS
CORE PRIVILEGES FOR OPHTHALMOLOGY SURGERY			
Core privileges include admission work up diagnosis and the performance of surgical procedures on patients of all ages presenting with illnesses injuries and disorders of the eye including its related structures and visual pathways These privileges include the provision of consultation as well as the ordering of diagnostic studies and procedures related to the ophthalmologic problems The use of CO2 YAG and KTP laser as trained in residency		#6 A3002	
Special procedures that are not routinely part of training and require additional documentation of competency training and experience			
SPECIAL PROCEDURES			
Penetrating keratoplasty			
Lamellar keratoplasty			
Radial keratoplasty			
Epikeratophakia			
Placement of external radiotherapeutic sources			
Other - If the condition/privilege you are interested in is not included on this form please provide a separate written request and appropriate documentation of training and/or experience			

Cynthia E. Holmes MD

000031

C Holmes, MD

PO Box 187
Sullivan's Island, SC 29482-0187

843 882 3176

October 1 2006

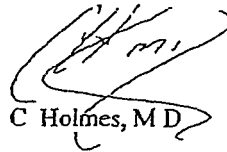
MSO - ECCH
1200 Johnnie Dodds Blvd
Mt Pleasant, SC 29464

Dear Sir/Madam

I am writing to request reappointment to Associate staff category and continuation of the attached privileges. Also attached, please find documentation of management of 25 patients for reappointment.

Thanking you in advance for your kind attention I am

Sincerely yours,


C Holmes, MD

EAST COOPER COMMUNITY HOSPITAL

CLINICAL PRIVILEGES SHEET

OPHTHALMOLOGY

R Holmes

<u>Class 0</u>		<u>Class IV</u>	
<u>1</u>		<u>1</u>	<u>2</u>
	Life-threatening emergency At the time of a clinical emergency any practitioner may render whatever care he believes to be indicated		Vitreous surgery
			Corneal transplant surgery
			Neuro Ophthalmology surgery
<u>✓</u>	<u>Class I</u>	<u>✓</u>	<u>Retinal surgery (including lasers)</u>
<u>1</u>	<u>2</u>		<u>Glaucoma surgery</u>
	Vision acuity screening		<u>Pediatric Ophthalmology</u>
	Tonometry/Tonography		<u>Electrophysiologic studies</u>
	Optical measurement (i e , pupillary distance near point of convergence accommodation)		
	Color vision testing		
	Surgical assisting with ophthalmologist		
	External eye examination		
	Fundus examination of posterior pole		
	Treatment of uncomplicated conjunctivitis		
	Removal of foreign bodies on cornea or conjunctiva		
	Treatment of corneal abrasions		
	Eye irrigation		
	Order x-rays to rule out retained foreign body or fracture		
<u>✓</u>	<u>Class II</u>		
<u>1</u>	<u>2</u>		
	Refractions, manifest		
	Orthoptic exercises		
	Visual field testing		
	Contact lens fitting		
	Contact lens modifications		
<u>✓</u>	<u>Class III</u>		
<u>1</u>	<u>2</u>		
	Treatment of all ophthalmic conditions		
	Treatment of neoplasms of orbit eye and adnexa		
	Intra and extraocular surgery		

Physician CME Attestation Form

Physician's Name Cynthia E Holmes, MD

Specialty Ophthalmology

Current Appointment Period 12/16/2004 through 12/16/2006

I attest that I have completed 40 hours AMA Category I CME specific to my specialty in the two years since my last appointment / reappointment to the medical staff at East Cooper Regional Medical Center. I will provide documentation of specific certificates and hours upon request by the Medical Staff.

A percentage of appointment and reappointment forms will be reviewed each cycle to corroborate attested CME hours. Those physicians whose forms are reviewed will be required to present copies of CME certificates and hours earned. If a physician cannot provide documentation of the hours to which he attested, he will lose staff privileges on the grounds of falsification of their application / reappointment process.

100+ HRS.
Applicant Signature Cynthia E Holmes, MD

12/7/06
Date

Please return this completed form to the Medical Staff Office
with your reappointment application

East Cooper Regional Medical Center DELINEATION OF PRIVILEGES

SPECIALTY: Ophthalmology

NAME C. Holmes - SEE ATTACHED

Please print ADDITIONAL TRAINING AND EXPERIENCE

☐ Initial ☐ Change in Privileges ☒ Renewal of Privileges Date 10/30/08

To be eligible to request these clinical privileges, the applicant must meet the following threshold criteria

Basic Education	M D or D O
Minimum formal training	Successful completion of an ACGME/AOA accredited residency training program in ophthalmology
Board Certification	Must be achieved within 5 years of residency/fellowship training or as noted by the respective board Acceptable board certification is only through the ABMS or AOA
Required Previous Experience	Applicants must demonstrate that they have performed at least 24 ophthalmologic surgical procedures in the past 12 months in a hospital or surgical outpatient setting Recent residency or fellowship training experience may be applicable Proctorship may be requested if applicant cannot demonstrate minimum number of cases
Clinical Reference	Letters of reference must come from the residency and/or fellowship director or the Chief of Service in which the applicant has successfully completed training and/or the applicant has been affiliated with for the last two years
Reappointment	Applicants must demonstrate that they have performed at least 48 ophthalmologic surgical procedures in the past 24 month in a hospital or surgical outpatient setting

Applicant Place a check in the (R) column for each privilege requested

(R)	CORE PRIVILEGES - OPHTHALMOLOGY
☐	Core privileges include admission, work up, diagnosis, and the performance of surgical procedures on patients of all ages presenting with illnesses, injuries, and disorders of the eye, including its related structures and visual pathways These privileges include the provision of consultation as well as the ordering of diagnostic studies and procedures related to the ophthalmologic problems as well as the use of CO2, YAG and KTP laser as trained in residency
☐	REMOVAL FROM CORE The following procedures are "deselected" from the core listing above Applicant and/or MEC must document reasons for "deselection"

Special procedures are not routinely part of training and require additional documentation of competency, training and experience

(R)	SPECIAL PROCEDURES
☐	Moderate sedation
☐	Penetrating keratoplasty
☐	Lamellar keratoplasty
☐	Radial keratoplasty
☐	Epikeratophakia
☐	Placement of external radiotherapeutic sources
	Additional Privileges If the condition/privilege you are interested in is not included on this form, please provide a separate written request and appropriate documentation of training and/or experience

I certify that I meet the minimum threshold criteria to request the above privileges and have provided documentation to support my eligibility to request each group of procedures requested I understand that in making this request, I am bound by the applicable Bylaws and/or policies of the Hospital and Medical staff

Applicant's Signature

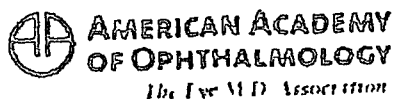
Date

NOTE In the case of an emergency any individual who has been granted clinical privileges is permitted to do everything possible within the scope of license to save a life or to save a patient from serious harm regardless of staff status or privileges granted

CLINICAL PRIVILEGES SHEET

OPHTHALMOLOGY

<u>Class O</u>		<u>Class IV</u>	
<u>1</u>		<u>1</u>	<u>2</u>
	Life-threatening emergency At the time of a clinical emergency any practitioner may render whatever care he believes to be indicated		Vitreous surgery
			Corneal transplant surgery
			Neuro Ophthalmology surgery
<u>✓</u>	<u>Class I</u>		<u>✓</u>
<u>1</u>	<u>2</u>		Retinal surgery (including lasers)
	Vision acuity screening		<u>✓</u>
	Tonometry/Tonography		Glaucoma surgery
	Optical measurement (i e., pupillary distance, near point of convergence, accommodation)		<u>✓</u>
	Color vision testing		Pediatric Ophthalmology
	Surgical assisting with ophthalmologist		<u>✓</u>
	External eye examination		Electrophysiologic studies
	Fundus examination of posterior pole		
	Treatment of uncomplicated conjunctivitis		
	Removal of foreign bodies on cornea or conjunctiva		
	Treatment of corneal abrasions		
	Eye irrigation		
	Order x-rays to rule out retained foreign body or fracture		
<u>✓</u>	<u>Class II</u>		
<u>1</u>	<u>2</u>		
	Refractions, manifest		
	Orthoptic exercises		
	Visual field testing		
	Contact lens fitting		
	Contact lens modifications		
<u>✓</u>	<u>Class III</u>		
<u>1</u>	<u>2</u>		
	Treatment of all ophthalmic conditions		
	Treatment of neoplasms of orbit, eye and adnexa		
	Intra and extraocular surgery		



Certificate of Attendance

The American Academy of Ophthalmology is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians

The American Academy of Ophthalmology certifies that

C HOLMES

Has participated in the educational activity titled
2008 Joint Meeting
in Atlanta, Georgia, November 8-11, 2008,
and has claimed 4 *AMA PRA Category 1 Credits™*

Ethics Credits Entered	0
Pain Credits Entered	0

H Dunbar Hoskins Jr MD
Executive Vice President

David W Parke II MD
President

Physician

Please retain this document for your records

912356



AMERICAN ACADEMY
OF OPHTHALMOLOGY
The Eye M D Association

American Academy of Ophthalmology
P O Box 7424 San Francisco CA 94120 USA

Page 1 of 1

INVOICE

Bill To 000000404336-0

C Holmes MD
PO Box 187
Sullivans Island, SC 29482 0187

Order Number 1003388138
Order Date 08-Nov 2008
Invoice Number 0030311755

Product	Fulfil Status	Status	Qty	Unit Price	Unit Discount	Coupon	Adjustment	Total
AM08-2008 Joint Meeting	Active	Active	1	975 00	0 00	0 00	0 00	975 00
AM08/LAB178A Morrison, John C Glaucoma Filtration Surgery	Active	Active	1	175 00	0 00	0 00	0 00	175 00
AM08/LEC178A Cioffi George A Glaucoma Filtration Surgery	Active	Active	1	75 00	0 00	0 00	0 00	75 00
Shipping								0 00
Tax								0 00
Total								1 225 00
Paid To Date								1,225 00
Current Amount Due								0 00

ASCRS

AMERICAN SOCIETY OF CATARACT
AND REFRACTIVE SURGERY

C. Collie, MD

has successfully completed the following educational activity

Storm Eye/ASCRS Clinical Update 2008

Kiawah Island, South Carolina

Program Chairs: Kerry D. Solomon, MD and M. Edward Wilson, Jr., MD
May 29-June 1, 2008

and is awarded 11 75 AMA PRA Category 1 Credits™

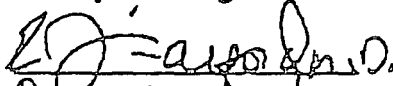
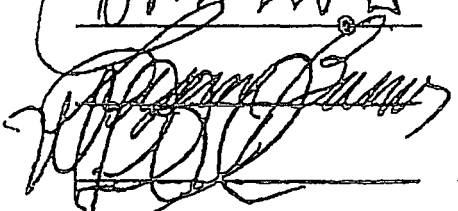
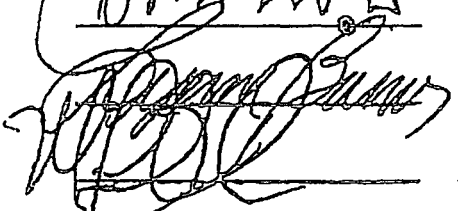
The American Society of Cataract and Refractive Surgery certifies that this educational activity was planned in accordance with the requirements of the Accreditation Council for Continuing Medical Education, and it meets the criteria for award of CME credit

#110

The undersigned physicians who are members of East Cooper Hospital Medical Staff recommend the following addition to East Cooper Regional Medical Center Bylaws, Rules and Regulations

Addition to Article XI—Committees and functions, Section I—General Considerations

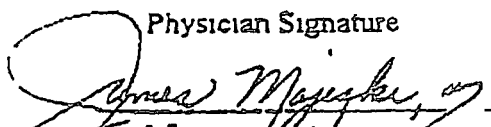
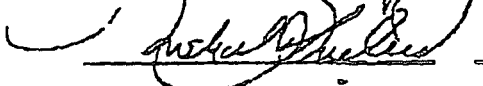
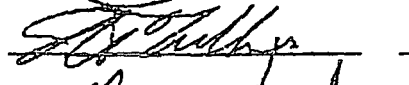
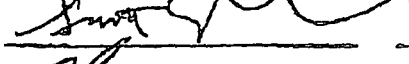
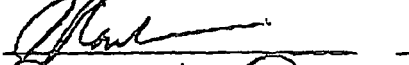
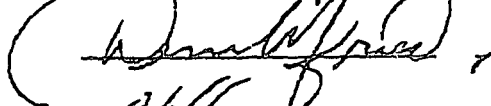
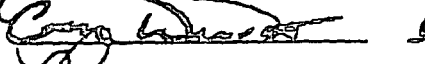
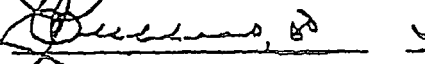
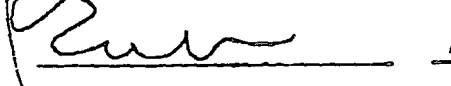
"H Medical Staff Committee Chairperson The chairperson of each medical staff committee will change every two (2) years. A physician may not succeed himself/herself as the chairperson of any medical staff committee "

Physician Signature	Physician printed Name	Date of Signature
	E. Jenkins-Alford	1/24/02
Daniel Ravenel, MD	Daniel Ravenel	1/24/02
Waddell Gilmore	WADDELL GILMORE	1/26/02
DAVID MORROW	DAVID MORROW	1/26/02
	LYNNE BARNES MD	2/2/02
	M. DAVID NAWABI	2/2/02
Ed Tagge	Ed Tagge	2/2/02
CHARLES GUDAS	CHARLES GUDAS	2/2/02
Rebecca T Newell	Rebecca T Newell	2/4/02
Amy T S Kirshtein MD	Amy T S Kirshtein MD	2/8/02
Elizabeth Shorge	Elizabeth Shorge	2/8/02
Charlene M Grice	Charlene M Grice	2-11-02
Scott Davidson	Scott Davidson	2-11-02
FRED MICHAEL	FRED MICHAEL	2/12/02
John R Mann	John R Mann	2/15/02
Kimberly L Davis-Seyler	Kimberly L Davis-Seyler	2/19/02

The undersigned physicians who are members of East Cooper Hospital Medical Staff recommend the following addition to East Cooper Regional Medical Center Bylaws, Rules and Regulations

Addition to Article XI-Committees and functions, Section I - General Considerations

"H Medical Staff Committee Chairperson The chairperson of each medical staff committee will change every two (2) years A physician may not succeed himself/herself as the chairperson of any medical staff committee "

Physician Signature	Physician printed Name	Date of Signature
	JAMES MAJESKI	1/17/2002
	F. Cleave Ham	1/17/2002
	Gerald H. R. [unclear]	01/17/2002
	Michael D. [unclear]	1/17/02
	James H. Phillips	1/18/02
	JEFFREY K. SHORT	1/18/02
	KAREN D. THOMAS	1/18/02
	Scott [unclear]	1/18/02
	James [unclear]	1/18/02
	David S. Goltz	1/19/02
	M. C. Bryan	1/21/02
	Dennis A. Friest	1/21/02
	C. HOLMES	1/21/02
	George D. [unclear]	1/21/02
	Jennifer S. Pullano	1/21/02
	Rochelle Rutledge	1-21-02

The undersigned physicians who are members of East Cooper Hospital Medical Staff recommend the following addition to East Cooper Regional Medical Center Bylaws, Rules and Regulations

Addition to Article XI-Committees and functions, Section I - General Considerations

"H Medical Staff Committee Chairperson The chairperson of each medical staff committee will change every two (2) years A physician may not succeed himself/herself as the chairperson of any medical staff committee"

Physician Signature	Physician printed Name	Date of Signature
<u>John F. Sonnen</u>	John F. Sonnen	1/22/02
<u>B. Emms Jr.</u>	B. Emms Jr.	1/22/02
<u>J. Wade Strong</u>	J. Wade Strong	1/22/02
<u>William J. Grossman</u>	William J. Grossman	1/22/02
<u>Scott Thompson</u>	Scott Thompson	1/22/02
<u>R.W. Smith</u>	R.W. Smith	1-22-02
<u>John Mitchell</u>	John Mitchell	1-24-02
<u>DAVID O'DAY</u>	DAVID O'DAY	1-22-02
<u>Gregory Miller</u>	Gregory Miller	1/22/02
<u>E G Johnson</u>	E G Johnson	1/23/02
<u>P. W. Schumann</u>	P. W. Schumann	1/23/02
<u>RICHARD L. LIND</u>	RICHARD L. LIND	1/23/02
<u>JK Wingate</u>	JK Wingate	1/23/02
<u>Tom Lyles</u>	Tom Lyles	1/23/02
<u>J. M. Harman</u>	J. M. Harman	23 Jan 02
<u>Steven Pollett</u>	Steven Pollett	1/24/02

#17

East Cooper Regional Medical Center

Medical Staff Office
1200 Johnnie Dodds Boulevard
Mt Pleasant SC 29464
(843) 881-4350 Phone
(843) 375-5238 Fax

MEDICAL STAFF REAPPOINTMENT APPLICATION

Please check one of the following

- ☒ I wish to be reappointed to the Medical Staff of East Cooper Regional Medical Center
☐ I do not wish to be reappointed

If you have checked the second statement, do not continue Sign below and fax IMMEDIATELY to (843) 375-5238

Applicant Signature Cynthia E Holmes, MD

Date _____

In order to process your reappointment to the Medical Staff we ask that you provide the following information. A non-refundable \$25.00 reappointment fee must accompany this application. If your application is not received within thirty (30) days upon receipt, a late fee of \$100.00 will be charged for the continued processing of your application past the thirty (30) day deadline. If you have questions please contact the MSO or e-mail me at Elena.giordano@tenethealth.com

Please return this form to the Medical Staff Office within 30 days of receipt

Below is your data currently stored in our database. Review carefully and mark any changes on this sheet.

PERSONAL IDENTIFICATION DATA

Name <u>Cynthia E Holmes, MD</u>	Department <u>Surgery</u>
Specialty <u>Ophthalmology</u>	Present Status <u>Consulting</u>
PLEASE CHANGE MY STAFF CATEGORY TO ☐ Active ☐ Courtesy ☐ Consulting ☒ Associate	
Last Reappointment Date <u>12/13/2006</u>	Privileges Expire <u>12/13/2008</u>

PRIMARY OFFICE

☒ No change since appointment or last reappointment

Practice Name C. HOLMES, MD
Primary Office 306 STATION 22 1/2, S I, SC 29482 0187
Primary Address PO Box 187 Sullivans Island SC 29482
883 3176
AND (843)883 9030
Primary Ofc Phone 728 2733 Primary Ofc Fax Beeper E-mail _____

MRS MARY FLETCHER
Office Manager

883 3176 EXT 6
Direct Line or Extension

NPI 1023222734

East Cooper Regional Medical Center DELINEATION OF PRIVILEGES

SPECIALTY: Ophthalmology

NAME C. HUGHES - SEE ATTACHED

Please print ADDITIONAL TRAINING AND EXPERIENCE

☐ Initial

☐ Change in Privileges

☒ Renewal of Privileges

Date: 10/30/08

To be eligible to request these clinical privileges, the applicant must meet the following threshold criteria

Basic Education	M D or D O
Minimum formal training	Successful completion of an ACGME/AOA accredited residency training program in ophthalmology
Board Certification	Must be achieved within 5 years of residency/fellowship training or as noted by the respective board Acceptable board certification is only through the ABMS or AOA
Required Previous Experience	Applicants must demonstrate that they have performed at least 24 ophthalmologic surgical procedures in the past 12 months in a hospital or surgical outpatient setting. Recent residency or fellowship training experience may be applicable. Proctorship may be requested if applicant cannot demonstrate minimum number of cases.
Clinical Reference	Letters of reference must come from the residency and/or fellowship director or the Chief of Service in which the applicant has successfully completed training and/or the applicant has been affiliated with for the last two years.
Reappointment	Applicants must demonstrate that they have performed at least 48 ophthalmologic surgical procedures in the past 24 month in a hospital or surgical outpatient setting.

Applicant Place a check in the (R) column for each privilege requested

(R)	CORE PRIVILEGES - OPHTHALMOLOGY
☐	Core privileges include admission, work up, diagnosis, and the performance of surgical procedures on patients of all ages presenting with illnesses, injuries, and disorders of the eye, including its related structures and visual pathways. These privileges include the provision of consultation as well as the ordering of diagnostic studies and procedures related to the ophthalmologic problems as well as the use of CO2, YAG and KTP laser as trained in residency.
☐	REMOVAL FROM CORE The following procedures are "deselected" from the core listing above. Applicant and/or MEC must document reasons for "deselection". _____ _____ _____

Special procedures are not routinely part of training and require additional documentation of competency, training and experience

(R)	SPECIAL PROCEDURES
☐	Moderate sedation
☐	Penetrating keratoplasty
☐	Lamellar keratoplasty
☐	Radial keratoplasty
☐	Epikeratophakia
☐	Placement of external radiotherapeutic sources
	Additional Privileges If the condition/privilege you are interested in is not included on this form, please provide a separate written request and appropriate documentation of training and/or experience.

I certify that I meet the minimum threshold criteria to request the above privileges and have provided documentation to support my eligibility to request each group of procedures requested. I understand that in making this request, I am bound by the applicable Bylaws and/or policies of the Hospital and Medical staff.

[Signature]
Applicant's Signature

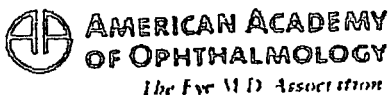
10/30/08
Date

NOTE In the case of an emergency any individual who has been granted clinical privileges is permitted to do everything possible within the scope of license to save a patient's life or to save a patient from serious harm regardless of staff status or privileges granted.

CLINICAL PRIVILEGES SHEET

OPHTHALMOLOGY

<u>Class O</u>		<u>Class IV</u>	
<u>1</u>		<u>1</u>	<u>2</u>
	Life-threatening emergency At the time of a clinical emergency any practitioner may render whatever care he believes to be indicated		Vitreous surgery
			Corneal transplant surgery
			Neuro Ophthalmology surgery
<u>✓</u>	<u>Class I</u>	<u>✓</u>	<u>Retinal surgery (including lasers)</u>
<u>1</u>	<u>2</u>	<u>✓</u>	<u>Glaucoma surgery</u>
	Vision acuity screening	<u>✓</u>	<u>Pediatric Ophthalmology</u>
	Tonometry/Tonography	<u>✓</u>	<u>Electrophysiologic studies</u>
	Optical measurement (i.e., pupillary distance, near point of convergence, accommodation)		
	Color vision testing		
	Surgical assisting with ophthalmologist		
	External eye examination		
	Fundus examination of posterior pole		
	Treatment of uncomplicated conjunctivitis		
	Removal of foreign bodies on cornea or conjunctiva		
	Treatment of corneal abrasions		
	Eye irrigation		
	Order x-rays to rule out retained foreign body or fracture		
<u>✓</u>	<u>Class II</u>		
<u>1</u>	<u>2</u>		
	Refractions, manifest		
	Orthoptic exercises		
	Visual field testing		
	Contact lens fitting		
	Contact lens modifications		
<u>✓</u>	<u>Class III</u>		
<u>1</u>	<u>2</u>		
	Treatment of all ophthalmic conditions		
	Treatment of neoplasms of orbit, eye and adnexa		
	Intra and extraocular surgery		



Certificate of Attendance

The American Academy of Ophthalmology is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians

The American Academy of Ophthalmology certifies that

C HOLMES

Has participated in the educational activity titled
2008 Joint Meeting
in Atlanta, Georgia, November 8-11, 2008,
and has claimed 4 *AMA PRA Category 1 Credits*TM

Ethics Credits Entered	0
Pain Credits Entered	0

H Dunbar Hoskins Jr MD
Executive Vice President

David W Parke II MD
President

Physician

Please retain this document for your records

912356

C. Collie, MD

has successfully completed the following educational activity

Storm Eye/ASCRS Clinical Update 2008

Kiawah Island, South Carolina

Program Chairs: Kerry D. Solomon, MD and M. Edward Wilson, Jr., MD
May 29-June 1, 2008

and is awarded 11.75 AMA PRA Category 1 Credits™

The American Society of Cataract and Refractive Surgery certifies that this educational activity was planned in accordance with the requirements of the Accreditation Council for Continuing Medical Education, and it meets the criteria for award of CME credit

East Cooper Regional Medical Center

Physician CME Attestation Form

Physician's Name Cynthia E Holmes, MD

Specialty Ophthalmology

Current Appointment Period 12/13/2006 through 12/13/2008

MORE THAN 90 HOURS

I attest that I have completed ⁴⁰ hours, AMA, Category I CME specific to my specialty in the two years since my last appointment / reappointment to the medical staff at East Cooper Regional Medical Center. I will provide documentation of specific certificates and hours upon request by the Medical Staff.

A percentage of appointment and reappointment forms will be reviewed each cycle to corroborate attested CME hours. Those physicians whose forms are reviewed will be required to present copies of CME certificates and hours earned. If a physician cannot provide documentation of the hours to which he attested, he will lose staff privileges on the grounds of falsification of their application / reappointment process.


Applicant Signature Cynthia E Holmes, MD

12/30/08
Date

Please return this completed form to the Medical Staff Office
with your reappointment application

#19

BUIST MOORE SMYTHE & MCGEE P A

ATTORNEYS AT LAW

P O BOX 999
FIVE EXCHANGE STREET
CHARLESTON S.C. 29402

803/722 3400
FACSIMILE 803/723-7398

HENRY BUIST (1895-1977)
E. ALLSTON MOORE (1900-1988)
AUGUSTINE T. SMYTHE (1918-1991)

CABLE CONFERENCE
TELEX 57-8488

INTERNET E MAIL ADDRESS
bmsm@lawyer.sc.com

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OCT 08 1997

ECRMC
Medical Staff Office

October 7 1997

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HENRY B. SMYTHE, JR.
SUSAN M. SMYTHE
W. FOSTER CAILLARD
HENRY E. CRABALL
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DAVID B. MCCORMACK
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DWAYNE M. GREEN
THOMAS L. HARPER, JR.

Of Counsel
DAVID M. COLLINS

CLARENCE T. AUSTIN
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CLARENCE T. AUSTIN, JR. PRACTICE LAW SPECIALIST
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Direct Dial
(803) 720 4627

VIA FACSIMILE AND U S MAIL

J Kevin Holmes, Esq
Steinberg Law Firm
61 Broad Street
Charleston S C 29402

Re Cynthia E C Holmes, M D
East Cooper Regional Medical Center
BMSM File No 5499 0008

Dear Kevin

As I mentioned in our telephone conversation yesterday Delinda Terry M D, the Hospitals s Chief of Staff, appointed the following physicians to sit on the Judicial Review Committee (

I advised the Hospital that you as Dr Holmes husband and possible attorney, have a personal conflict with Dr Stroud The Chief of Staff is attempting to substitute for Dr Stroud

Helen Clawson has agreed to serve as the presiding officer

We are attempting to schedule the hearing as soon as possible You stated that the hearing must go forward promptly but that you would not insist on compliance with the 30 day time requirement stipulated in Article IX Section 3 as long as the Hospital in good faith was trying to expeditiously schedule the hearing The available dates for Judge Clawson and tentatively available

RECEIVED

Kevin Holmes Esq
October 7 1997
Page 2

OCT 08 1997

ECRMC
Medical Staff Office

for the members of the JRC are October 28th and 29th, and November 3rd 4th 10th 11th and 17th
Please promptly let me know if you have any problems with these dates

You stated that Dr Holmes desires to be represented by an attorney at the hearing Please
confirm this in writing Once the Judicial Review Committee is empaneled I will petition the
Judicial Review Committee pursuant to Article IX Section 4, C for permission for such
representation

With kind regards I am

Sincerely yours

BUIST MOORE SMYTHE & McGEE P.A



J Marshall Allen

JMA/srb
cc John Holland President

1 #20

CURRICULUM VITAE

<u>NAME</u>	James Anthony Majeski	
<u>DATE OF BIRTH</u>	January 29, 1945	
<u>EDUCATION</u>	The Citadel, Charleston, South Carolina B S Degree	1966
	University of South Carolina, School of Graduate Studies, Columbia, South Carolina M S Degree	1968
	Medical University of South Carolina, College of Graduate Studies, Charleston, South Carolina Ph D Degree	1971
	Medical University of South Carolina, College of Medicine, Charleston, South Carolina M D Degree	1974
	University of Cincinnati, Cincinnati, Ohio Surgical Internship	1974 - 1975
	University of Cincinnati, Cincinnati, Ohio Junior Resident (Surgery)	1975 - 1978
	University of Cincinnati, Cincinnati, Ohio Senior Resident (Surgery)	1978 - 1979
	University of Cincinnati, Cincinnati, Ohio Chief resident (Surgery)	1979 - 1980
<u>FELLOWSHIP</u>	Transplantation Surgery, University of Cincinnati, Cincinnati, Ohio	1980 - 1981
<u>CERTIFICATION</u>	American Board of Surgery American Board of Clinical Vascular Surgery	1991, 1999 1995
<u>MILITARY SERVICE</u>	First Lieutenant - U S Air Force Reserve (Honorable Discharge)	1966 - 1971
<u>SCHOLARSHIPS AND AWARDS</u>	Eagle Scout Award with Silver Palm Ad Altare Dei Award Teaching Assistantship, University of South Carolina Columbia, South Carolina National Science Foundation Summer Pre- Doctoral Fellowship Duke University Durham, North Carolina Research Traineeship, Medical University of South Carolina, Charleston, South Carolina Health Professions Scholarship, Medical University of South Carolina, Charleston, South Carolina Jefferson Research Award -South Carolina Academy of Science Mead Johnson Award, National Medical Student Research Forum	1957 1958 1967 - 1968 1968 1968 - 1971 1971 - 1972 1972 1972

CURRICULUM VITAE (James A. Majeski)

Page 2

First Place—Graduate Student Research Competition	1972
Medical University of South Carolina	
Charleston, South Carolina	
Mosby Scholarship Award	1973
Prize winner in the Resident Essay Contest of Ohio	1976 – 1981
Chapter, American College of Surgeons	
First Place	1976, 1978
Second Place	1978, 1980, 1981
Third Place	1977, 1979, 1980
Thomas and Shirley Roe Award, South Carolina	1990
Medical Association	
Fellow American College of Surgeons	1994
Sea Badge Award	1994
Fellow International College of Surgeons	1995
George Meany Award	1996
Spurgeon Award	1998
Scouter's Award of Merit	1999
Silver Beaver Award	2001
Department of V A Service Award—30 years	2010
Physician's Recognition Award with Commendation,	
AMA	1995 – Valid until July 01, 2013

BIOGRAPHEE

Who's Who in the Midwest	1982 1980
Who's Who in the South & Southwest	1986, 1984
Personalities of the South	1986
Who's Who of Emerging Leaders in America	1987
Who's Who in Society	1988
Outstanding People of the 20 th Century	1998
Guide to America's top Surgeons	2002 – 2012
Who's Who in America	2011, 2012

ACADEMICAPPOINTMENTS

Research Fellow in Pathology, Medical University of	1972 – 1974
South Carolina, Charleston, South Carolina	
Clinical Instructor in Surgery University of Cincinnati	1979 – 1981
Cincinnati, Ohio	
Fellow in Transplantation and Vascular Surgery,	
University of Cincinnati, Cincinnati, Ohio	1980 – 1981
Assistant Professor of Surgery, Medical University of	1981 – 1985
South Carolina, Charleston, South Carolina	
Chief—Vascular Surgery Service, Charleston	1981 – 1986
Veteran's Administration Hospital,	
Charleston, South Carolina	
Clinical Assistant Professor of Surgery, Medical	1985 – 1999
University of South Carolina, Charleston,	
South Carolina	

CURRICULUM VITAE (James A. Majeski)

Page 3

Clinical Associate Professor of Surgery, Medical University of South Carolina, Charleston, South Carolina	1999 – 2005
General and Vascular Surgeon Charleston Veteran's Administration Hospital, Charleston, South Carolina	1986 – 2010
Clinical Professor of Surgery, Medical University of South Carolina, Charleston, South Carolina	2005—Present

MEMBERSHIP IN PROFESSIONAL ORGANIZATIONS

American Board of Surgery
American Board of Clinical Vascular Surgery
American College of Surgeons
American Medical Association
American Society of Transplant Surgeons
Association for Academic Surgery
International College of Surgeons
Medical Society of South Carolina
Society of Sigma Xi
South Carolina Academy of Science
South Carolina Medical Association
Southern Medical Association
The Transplantation Society
University of Cincinnati Graduate Surgical Society

<u>EDITORIAL BOARD</u>	Section Editor Transplant Surgery, Reference and Index Services, Inc	1976 – 1990
	Journal of the South Carolina Medical Association	2003 – Present

AD HOC REVIEWER *Southern Medical Journal*
World Journal of Surgical Oncology
Indian Journal of Cancer
Archives of Gynecology and Obstetrics
Journal of Surgical Research
American Surgeon
American Journal of Surgery

<u>LICENSURE</u>	Ohio State License	1979 – 1998
	South Carolina State License	1981 – Present

<u>CLINICAL APPOINTMENT</u>	Chief of Surgery East Cooper Hospital Mount Pleasant, South Carolina	1994 – 1996

JAMES ANTHONY MAJESKI

CURRICULUM VITAE

PUBLICATIONS

- 1 Majeski, J A and Cowley, G T Effect of halogens on the growth of selected fungi South Carolina Academy of Science 30 42, 1968
- 2 Majeski, J A Effect of mitomycin C and 6-mercaptopurine on homotransplantation in mice Master's Thesis University of South Carolina Library 1968
- 3 Majeski, J A and Cole, B T Effect of mitomycin C and 6-mercaptopurine on homotransplantation in mice South Carolina Academy of Science 33 80, 1971
- 4 Majeski, J A, Fitts, C T, Graber, C D, and Sharbaugh, R J Lymphocyte depletion by generalized or selective filtration South Carolina Academy of Science 33 80, 1971
- 5 Fitts, C T, Graber, C D, Majeski, J A, and Sharbaugh, R J Lymphocyte depletion and immune response in calves utilizing closed system filtration Federation Abstracts 30 409, 1971
- 6 Majeski, J A Lymphocyte depletion by generalized or selective filtration Ph D Dissertation Medical University of South Carolina Library 1971
- 7 Fitts, C T, Sharbaugh, R J, Hargest, T S, Majeski, J A, and Graber, C D Closed-circuit extracorporeal filtration of thoracic duct lymph Surgery 70 786 - 789, 1971
- 8 Fitts, C T, Graber, C D, Majeski, J A, and Sharbaugh, R J Lymphocyte depletion and immune response in calves utilizing closed system filtration Journal of Dairy Science 54 1309 - 1340, 1971
- 9 Sharbaugh, R.J, Majeski, J A, and Garlick, N L Manifestations of systemic anaphylaxis in a calf American Journal of Veterinary Research 33 1067 - 1070, 1971
- 10 Fitts, C T, Majeski, J A, Sharbaugh, R J, Hargest, T S, Graber, C D, and Hennigar G R. Immunosuppression by thoracic duct filtration Transplantation 14 236 - 238, 1972
- 11 Sharbaugh, R.J, Fitts, C T, Majeski, J A, Wright, F A, and Hargest, T S The efficacy of closed-circuit extracorporeal filtration of thoracic duct lymph as a means of lymphocyte depletion Clinical and Experimental Immunology 12 255 - 262, 1972
- 12 Majeski, J A Lymphocyte Depletion by Generalized or Selective filtration Dissertation Abstracts International Vol 32 5884B - 5885B, 1972
- 13 Fitts, C T, Majeski, J A, Sharbaugh, R J, Graber, C D, and Hargest, T S Selective Immunosuppression Evaluation of Antigen-Coated Columns in an Extracorporeal Thoracic Duct Circulation Surgery 72 212 - 219, 1972
- 14 Sharbaugh, R.J, Fitts, C T, Majeski, J A, Wright, F A, and Hargest, T S Closed-Circuit Extracorporeal Filtration of Thoracic Duct Lymph in the Calf RES, J Reticuloendothelial Society 11 396, 1972

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PUBLICATIONS

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- 16 Majeski, J A Hennigar, G R. Garlick, N L, and Fitts, C T Pulmonary Eosinophilic Panarteritis Associated with High Level Administration of Antibiotics South Carolina Academy of Science 34 89, 1972
- 17 Majeski, J A, Fitts, C T, Sharbaugh, R J, Hennigar, G R., Graber, C D, and Garlick, N L Selective Immunosuppression Produced by Thoracic Duct Filtration South Carolina Academy of Science 34 89, 1972
- 18 Majeski, J A, Durst, G G, McKee, K T Acute Systemic Anaphylaxis Associated with an Ant Sting Southern Medical Journal 67 365 - 366, 1974
- 19 Majeski, J A and Colc, B T Immunosuppressive Effect of 6-Mercaptopurine and Mitomycin C Antimicrobial Agents and Chemotherapy 4 495 - 496, 1973
- 20 Majeski, J A and Upshur, J K Polysplenia Associated with a Congenital Diaphragmatic Defect Southern Medical Journal 68 1263 - 1265, 1975
- 21 Majeski, J A and Upshur, J K Polysplenic Syndrome in Association with a Rudimentary Spleen Southern Medical Journal 69 378 - 380, 1976
- 22 Majeski, J A, and Durst, G G Bite by spider Herphyllus Ecclesiasticus in South Carolina Toxicon 13 377, 1975
- 23 Majeski, J A, McClellan, M A, and Alexander, J W Evaluation of leukocyte chemotactic response in the presence of antibiotics Surgical Forum 26 83 - 85, 1975
- 24 Majeski, J A and Durst, G G Necrotic Arachnidism Southern Medical Journal 69 887 - 891, 1976
- 25 Majeski, J A, Fitts, C T, Sharbaugh, R J Selective elimination of the delayed hypersensitivity response by extracorporeal thoracic duct filtration Transplantation 21 477 - 482 1976
- 26 Majeski, J A and Durst, G G Loxoscelism The Journal of the South Carolina Medical Association 71 366 - 368 1975
- 27 Abe, P M, Majeski, J A, and Lennard, E S Pathological changes produced by fusobacterium Necrophorum in an experimental infection Journal of Comparative Pathology 86 365 - 369, 1976
- 28 Majeski, J A, McClellan, M A, and Alexander J W Effect of antibiotics on the in vitro neutrophil chemotactic response The American Surgeon 42 785 - 788, 1976

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PUBLICATIONS

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- 30 Majeski, J A, Fitts, C T , and Sharbaugh, R.J Architectural alteration of lymphatic tissue produced by extracorporeal thoracic duct filtration *Journal of Surgical Oncology* 9 155 – 162, 1977
- 31 Majeski, J A and Stinnett, J D Chemoattractant properties of Corynebacterium parvum and pyran copolymer for human monocytes and neutrophils *Journal of the National Cancer Institute* 58 781 – 783, 1977
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- 33 Majeski, J A and Alexander, J W Evaluation of tetracycline in the neutrophil chemotactic response *Journal of Laboratory and Clinical Medicine* 90 259 – 265, 1977
- 34 Majeski, J A, Stinnett, J D , Alexander, J W , and Durst, G G Action of venom from the brown recluse spider (Loxosceles Reclusa) on human neutrophils *Toxicon* 15 423 – 427, 1977
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- 41 Majeski, J A, Durst, Sr , G G , and Durst, Jr , G G Management of the infection prone patient—A guide for the family physician *The Journal of the South Carolina Medical Association* 75 15 – 17, 1979
- 42 Majeski, J A, Morris M J , and Alexander, J W Action of Cefoxitin and Cefamandole on human neutrophil function *The Journal of Antibiotics* 31 1059 – 1062, 1978

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CURRICULUM VITAE

PUBLICATIONS

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- 45 Majeski, J A, Schreiber, J T, Cotton, R, and MacMillan, B G Tracheoplasty for tracheal stenosis in the pediatric burn patient *Journal of Trauma* 20 81 - 86, 1980
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- 47 Majeski, J A, Alexander, J W, First, R, Munda, R, and Fidler, J P Transplantation of a horseshoe kidney *Journal of the American Medical Association* 242 1066, 1979
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- 54 Majeski, J A Mesenteric revascularization An operative decision *Southern Medical Journal* 74 1541 - 1542, 1981
- *55 Alexander, J W and Majeski, J A The gangrenes In Dubley, H.A F and Pories W J (eds) *Rob and Smith Operative Surgery General Principles, Breast and Extracranial Endocrines* Butterworth & Co Ltd, London Pp 203 - 209, 1982
- 56 Miller, S F, Cox, J A, and Majeski, J A Acute intestinal obstruction due to a peanut bezoar in a child *Southern Medical Journal* 74 1554, 1981

* Chapter in Textbook

JAMES ANTHONY MAJESKI

CURRICULUM VITAE

PUBLICATIONS

- 57 Majeski, J A, and Munda, R Hazard of percutaneous transluminal dilation in renal transplant arterial stenosis Archives of Surgery 116 1225 – 1226, 1981
 - 58 Majeski, J A Transplant surgery American Family Physician 24 157 – 160, 1981
 - 59 Majeski, J A, Paxton, E S , Wirman, J A , and Schreiber J T A thoracic benign mesenchymoma in association with hemihypertrophy American Journal of Clinical Pathology 76 827 – 832, 1981
 - 60 Majeski, J A, Alexander, J W , First, M R , Munda, R , Fidler, J P , and Craycraft, I K Transplantation of microbially contaminated cadaver kidneys Archives of Surgery 117 221 – 224, 1982
 - *61 Majeski, J A and Alexander, J W Surgical Wound Infections In Greenfield, L J (eds) Complications in Surgery and Trauma J B Lippincott, Philadelphia Pp 27 – 34, 1983
 - *62 Majeski, J A, and Fitts, C T Lesions of the umbilicus and the abdominal wall In Hardy J D (eds) Hardy's Textbook of Surgery, First Edition, J B Lippincott, Philadelphia Pp 738 – 743, 1983
 - 63 Cameron, D J., Rajagopalan, P R , Fitts, C T , and Majeski, J A Characterization of the preformed antibodies involved in the xenograft reaction Journal of Surgical Oncology 22 157 – 163, 1983
 - 64 Majeski, J A and Alexander, J W Early diagnosis, nutritional support and immediate extensive debridement improve survival in Necrotizing Fasciitis American Journal of Surgery 145 784 – 787, 1983
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 - 67 Majeski, J A, Hazard of a postendarterectomy intimal flap in carotid artery surgery Southern Medical Journal 78 359 – 360, 1985
 - *68 Majeski, J A Necrotizing fasciitis of the extremities In Alexander, J W (ed) , Problems in General Surgery—Difficult Surgical Infections J B Lippincott, Philadelphia 1 500 – 507, 1984
 - 69 Alexander, J W , First, M R , Majeski, J A, Munda, R , Fidler, J P , Morris, M J , and Suttman, M P The late adverse effect of splenectomy on patient survival following cadaveric renal transplantation Transplantation 37 467 – 470, 1984
- * Chapter in Textbook

JAMES ANTHONY MAJESKI

CURRICULUM VITAE

PUBLICATIONS

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- 72 Majeski, J.A. Necrotizing Fascitis American Family Physician 30 221 – 223 1984
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- 74 Majeski, J.A. Gastric paper bezoar Southern Medical Journal 78 1520, 1985
- 75 Majeski, J.A. Polyps of the gallbladder Journal of Surgical Oncology 32 16 – 18, 1986
- 76 Majeski, J.A. Forearm arterial venous shunt for hemodialysis The American Surgeon 51 630 – 631, 1985
- 77 Majeski, J.A., Stinnett, J D , Cameron, D J Suppressor T Cell activity in lymphoid Interstitial pneumonia Journal of Surgical Oncology 33 61 – 63, 1987
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- 79 Rajagopalan, P R , Kay, N.A , Fitts, C T , Majeski, J.A. Prevention of post-transplant acute tubular necrosis (ATN) The effect of pretransplant volume expansion of the recipient. Southern Medical Journal 79 972 – 974, 1986
- 80 Majeski, J.A. Rectus Sheath abscess Southern Medical Journal 79 1311, 1986
- 81 Cameron, D J , Durst, G G., Majeski, J.A. Macrophage and polymorphonuclear leukocyte function in patients with Alzheimer Disease Biomedicine and Pharmacotherapy 39 310 – 314, 1985
- 82 Cameron, D J , O'Brien, P , and Majeski, J.A. Effects of in vivo treatment with prostaglandin inhibitors on macrophage function in breast and colon cancer patients Journal of Clinical and Laboratory Immunology 20 23 – 28, 1986
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- 84 Majeski, J.A. Venous thromboembolism Journal of the South Carolina Medical Association 82 669 – 673, 1986

JAMES ANTHONY MAJESKI

CURRICULUM VITAE

PUBLICATIONS

- 85 Allison, J G , Brown, F.M, and Majeski, J.A Pillars in the colon A case report of Crohn's colitis with unusual endoscopic and morphological appearances Journal of Diseases of the Colon and Rectum 30 712 – 714, 1987
- 86 Cameron, D J and Majeski, J.A Inhibition of macrophage and neutrophil mediated Cytotoxicity by Varapamil Journal of Surgical Oncology 37 5 – 9, 1988
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- 88 Majeski, J.A, Rajagopalan, P R , Fitts, C T , Eddy G L , Holtz, G L , Turner, W , Henry, R , and Hearn, H B Necrotizing fasciitis in a renal transplant patient Southern Medical Journal 81 1315 – 1316 1988
- 89 Morgan, W R and Majeski, J.A Idiopathic arteriovenous renal vascular malformation treated by Ex Vivo repair Journal of South Carolina Medical Association 85 469 – 471, 1989
- 89 Clevenger, F W and Majeski, J.A External carotid endarterectomy Surgical Rounds 16 103 – 110, 1993
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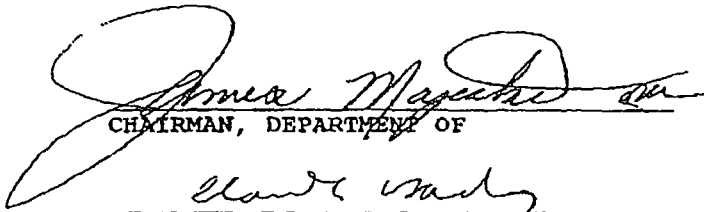
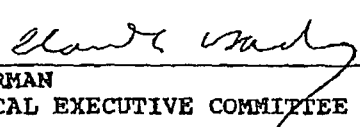
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4444 East Cooper Community Hospital

PHYSICIAN Dr Cynthia Holmes DATE Dec July 1995
PROVISIONAL TO COURTESY STAFF 11/95

The appointee meets all of the qualifications, has discharged all of the responsibilities, and has not exceeded or abused the prerogatives of the staff category to which he was appointed


CHAIRMAN, DEPARTMENT OF

CHAIRMAN
MEDICAL EXECUTIVE COMMITTEE

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF CHARLESTON	)	C A NO 2010-CP-10-3410
Dr Cynthia Holmes, M D ,	)	
	)	
Plaintiff,	)	
	)	
vs	)	<u>SUMMARY JUDGMENT ORDER</u>
	)	
East Cooper Community Hospital, Inc ,	)	
and Tenet HealthSystem Medical, Inc ,	)	
	)	
Defendants	)	
	)	

This action came before the undersigned on July 8, 2011, on Defendants' Motion for Summary Judgment. Counsel for Plaintiff and Defendants submitted Memoranda of Law, Affidavits, and oral argument, which have been considered by the Court and incorporated into the record. As explained more fully below, the Court finds there is no genuine issue of material fact as to Plaintiff's claims and that Defendants are entitled to summary judgment.

Undisputed Facts

Plaintiff is a medical doctor specializing in the field of Ophthalmology. Defendant East Cooper Community Hospital, Inc., owns, operates, and does business as East Cooper Medical Center (hereinafter referred to as the "Hospital") and is a wholly owned subsidiary of Defendant Tenet HealthSystem Medical, Inc.

At the times relevant herein, Plaintiff was a member of the Hospital's Consulting Medical Staff. All appointments to the Hospital's Medical Staff are for a limited two (2) year term. Plaintiff's 2004 appointment to the Medical Staff, which was the subject of previous litigation between the parties, was nearing expiration in October of 2006, at

which time Plaintiff submitted a reappointment application. In her application Plaintiff requested advancement in Medical Staff category and clinical privileges to perform surgery on the eye. The Hospital's Credentials and Medical Executive Committees found Plaintiff's application to contain insufficient evidence that she was currently clinically competent for the Medical Staff category and surgical privileges requested and recommended that she be reappointed to the Consulting Staff category. Plaintiff requested and was granted an administrative hearing of this recommendation. The Hospital's Governing Board upheld the recommendation and Plaintiff was reappointed to the Consulting Medical Staff for another two year term.

Prior to the expiration of this 2006 appointment, in or around October of 2008, Plaintiff submitted another reappointment application again requesting advancement in Medical Staff category and surgical privileges. The Hospital, through its Credentials Committee, Medical Executive Committee, and Governing Board, this time determined Plaintiff's application to be incomplete and a deemed voluntary resignation from the Medical Staff without appellate rights under the Medical Staff Bylaws.

On April 26, 2010, Plaintiff instituted this civil action against Defendants alleging causes of action for breach of contract and breach of the covenant of good faith and fair dealing. Plaintiff alleges the actions taken with respect to her 2006 and 2008 reappointment applications breached a Settlement Agreement among the parties arising from a previous lawsuit filed against these same Defendants also regarding her Medical Staff privileges at the Hospital. The Settlement Agreement, entered in 2003, called for Plaintiff's reappointment to the Hospital's Consulting Medical Staff from 2002 to 2004 with "the right to apply for a change in status in accordance with the Bylaws."

Standard of Review

Summary judgment is appropriate when it is clear that there is no genuine issue of material fact and the moving party is entitled to summary judgment as a matter of law Rule 56(c) S C R Civ P, City of Columbia v American Civil Liberties Union, 323 S C 384, 475 S E 2d 747 (1996) Summary judgment is proper where plain, palpable and indisputable facts exist on which reasonable minds cannot differ Byerly v Conner, 307 S C 441, 415 S E 2d 796 (1992) Summary judgment is not a “disfavored procedural shortcut,” but an important mechanism for weeding out “claims and defenses [that] have no factual basis ” Celotex Corp v Catrett, 477 U S 317, 327 (1986) The party seeking summary judgment has the burden of establishing the absence of a genuine issue of material fact McCall v State Farm Mut Auto Ins Co , 359 S C 372, 597 S E 2d 181 (Ct App 2004) Once the party moving for summary judgment meets the initial burden of showing an absence of evidentiary support for the opponent’s case, the opponent cannot simply rest on mere allegations contained in the pleadings Regions Bank v Schmauch, 354 S C 648, 582 S E 2d 432 (Ct App 2003) The nonmoving party must come forward with specific facts showing there is a genuine issue for trial Rife v Hitachi Constr Mach Co , Ltd , 363 S C 209, 609 S E 2d 565 (Ct App 2005) A party's response to the motion must set forth specific facts, admissible evidence, showing that there is a genuine issue for trial It is not sufficient that one create an inference which is not reasonable or an issue of fact that is not genuine Dickert v Metropolitan Life Ins Co , 306 S C 311, 411 S E 2d 672 (Ct App 1991)

I This Court lacks subject matter jurisdiction to review the actions of private hospitals concerning medical staff privileges

“Subject matter jurisdiction refers to the court’s power to hear and determine cases of the general class to which the proceedings in question belong ” Bunkum v Manor Properties, 321 S C 95, 100, 467 S E 2d 758, 761 (Ct App 1996) “Claims of lack of subject matter jurisdiction may be raised at any time, and subject matter jurisdiction may not be waived by filing responsive pleadings or otherwise consenting to the jurisdiction of a particular court ” Eldridge v City of Greenwood, 331 S C 398, 408, 503 S E 2d 191, 196 (Ct App 1998)

South Carolina courts have consistently held that private hospitals are free in the absence of regulatory provisions to decide the nature and extent of medical practice permitted to persons to whom it grants medical staff privileges “A private hospital is free to adopt reasonable regulations for the conduct of its affairs ” Gowan v St Francis Cmty Hosp, 275 S C 203, 204, 268 S E 2d 580, 581 (1980) It is well settled in South Carolina that the Court does not have jurisdiction to review the decisions of the medical staff of a private hospital concerning the membership and credentialing of its physicians Strauss v Marlboro County Gen Hosp, 185 S C 425, 194 S E 65, 65 (1937), Wood v Hilton Head Hosp, Inc, 292 S C 403, 405, 356 S E 2d 841, 842 (1987), Gowan, 275 S C at 204, 268 S E 2d at 581

It is undisputed that the Defendant Hospital herein is a private, for-profit hospital governed by a Board of Directors It is also undisputed that its Medical Staff operates pursuant to written Medical Staff Bylaws, Rules and Regulations, which have been approved by the Governing Board of the Hospital, and by which all physicians receiving

privileges at the Hospital agree to be bound as a condition of membership in the Medical Staff

Plaintiff alleges that her present lawsuit is not a challenge of the Hospital's implementation of the Medical Staff Bylaws, nor of the Hospital's credentialing decisions concerning her reappointment applications, but, rather, of the term of the previous Settlement Agreement allowing her the right to apply for a change in status in accordance with the Bylaws. Indeed, Plaintiff conceded at the hearing of this Motion that a challenge of the Hospital's implementation of its Bylaws and credentialing decisions are matters outside the scope of this Court's subject matter jurisdiction.

Despite Plaintiff's argument that her claim is one for breach of the Settlement Agreement, the Plaintiff's Complaint and the evidence in the record clearly show she is indeed seeking a judicial interpretation of the Hospital's implementation of its Medical Staff Bylaws and of the decisions regarding her Medical Staff privileges. Specifically, the Plaintiff requests this Court to review whether the Hospital's denial of advancement in Medical Staff category and surgical privileges in 2006, reappointment of her to the Consulting Medical Staff in 2006, refusal to accept her 2008 application as complete, refusal to process and consider her 2008 application for advancement in Medical Staff category and surgical privileges, and denial of an administrative hearing regarding her 2008 reappointment process were decisions made in accordance with the applicable Bylaws.

Though styled as a breach of contract action, as her multiple previous lawsuits against Defendants were, the Plaintiff's claims all arise out of the peer review process at the Hospital and, as such, are not subject to judicial review. Both the Plaintiff's

Complaint and the Affidavits submitted by the Plaintiff in opposition to summary judgment support this conclusion. In fact, the Affidavit of Plaintiff's expert witness contains a lengthy discussion and interpretation of the Bylaws, but omits any reference to the subject Settlement Agreement. This Affidavit unequivocally shows the Plaintiff's claims are dependent upon the issue of whether the Hospital properly applied the Bylaws in reviewing the Plaintiff's 2006 and 2008 reappointment applications, as this is the sole basis on which the expert opines. None of the evidence or testimony submitted by the Plaintiff demonstrates a genuine issue of material fact as to whether the subject Settlement Agreement was breached, but, rather, only challenges the decisions regarding her peer review processes. The Court does not have jurisdiction to determine these issues, and the Plaintiff has presented no evidence or reason to persuade the Court to depart from the long-standing principle that such actions are not subject to judicial review.

The Plaintiff contends that the Court has jurisdiction over this matter based on Lee v. Chesterfield General Hosp., 289 S.C. 6, 344 S.E.2d 379 (Ct. App. 1986). The Court declines to adopt the Plaintiff's interpretation of the Lee decision and, in any event, Lee applies only to actions for civil conspiracy, not claimed herein, rather than causes of action sounding in contract. In Lee, the Court of Appeals confirmed the decision reached by the Supreme Court in Gowan but found subject matter jurisdiction where the Plaintiff did not seek to conduct a judicial review of internal hospital rules, but claimed that the Bylaws were imposed in furtherance of a conspiracy, the purpose of which was to injure the Plaintiff. Id. In this case, Plaintiff asks the Court to review the basis for the Hospital's privileging decisions and substitute its judgment for the Hospital

and its review committees by determining that the decisions were inappropriately made. This is precisely the type of intervention that the Supreme Court of South Carolina in Strauss, Gowen, and Wood sought to prevent.¹

Finally, the Plaintiff's contentions that this Court has previously ruled on and agreed to accept subject matter jurisdiction of this controversy are without merit. Plaintiff argues the Court's previous denial of Defendants' Motion to Dismiss and Motion for Judgment on the Pleadings based, in part, on lack of subject matter jurisdiction, now confer subject matter jurisdiction on this Court. Plaintiff concedes that the Court's denial of said Motion was based upon prematurity of the issues rather than merit. Regardless, an Order denying a motion to dismiss for lack of subject matter jurisdiction is not immediately appealable and does not, as the Plaintiff contends, bind the parties. See Deskins v. Boltin, 319 S.C. 356, 357, 461 S.E.2d 395, 396 (1995) ("The denial of a motion to dismiss for lack of subject matter jurisdiction is not immediately appealable"), Woodard v. Westvaco Corp., 319 S.C. 240, 243, 460 S.E.2d 392, 394 (1995) overruled on other grounds by Sabb v. S.C. State Univ., 350 S.C. 416, 567 S.E.2d 231 (2002) ("An order *denying* a motion to dismiss for lack of subject matter jurisdiction does not *finally* determine anything.")

¹ In deciding this issue, this Court relies only on the Plaintiff's Complaint and the Plaintiff's own Affidavits in opposition to summary judgment. This Court does not rely on filings and orders from previous actions, however, at least two prior orders entered by The Honorable R. Markley Dennis, Jr., in a previous case between these parties operate as res judicata and/or collateral estoppel as to this issue, and these also support the Court's decision herein.

Conclusion

For the foregoing reasons, there is no genuine issue of material fact as to the causes of action asserted by the Plaintiff and Defendants' Motion for Summary Judgment is GRANTED

The Honorable Kristi Lee Harrington
Chief Administrative Judge
Ninth Judicial Circuit

July ___, 2011
Charleston, South Carolina

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF CHARLESTON	)	C A NO 2010-CP-10-3410
	)	
Dr Cynthia Holmes, M D ,	)	
	)	
Plaintiff,	)	
	)	
vs	)	<u>ORDER DENYING PLAINTIFF'S</u>
	)	<u>MOTION TO DISMISS</u>
East Cooper Community Hospital, Inc ,	)	
and Tenet HealthSystem Medical, Inc ,	)	
	)	
Defendants	)	
	)	

This action came before the undersigned on July 8, 2011, on Plaintiff's Motion to Dismiss Defendants' counterclaims and to strike certain material contained in and attached to Defendants' Answer pursuant to Rules 12(b)(6), (c) and (f) Counsel for Plaintiff and Defendants have submitted Memoranda of Law, legal authority, and oral argument which have been considered by the Court and incorporated into the record The Court denies Plaintiff's Motion for the following reasons

Initially, the Court finds the facts pled and materials referenced in Defendants' Answer sufficient to constitute the affirmative defenses and counterclaims pled, specifically Defendants' affirmative defenses of res judicata and collateral estoppel and Defendants' counterclaim for malicious prosecution See Restatement (Second) of Torts §679, Comment c ("[An action for malicious prosecution lies] when proceedings have been so terminated in favor of the person against whom they are brought as to make the matter res adjudicata and further proceedings are brought on the same claim In this case the termination of the first action in favor of the then defendant is normally

conclusive evidence that there is no probable cause for bringing the second proceeding and is evidence that it was brought for an improper purpose ”)

The Court further finds the materials and exhibits regarding Plaintiff's previous filings are not hearsay as alleged by Plaintiff See Rule 801(d)(2)(A), South Carolina Rules of Evidence (“A statement is not hearsay if—[t]he statement is offered against a party and is (A) the party's own statement in either an individual or a representative capacity ”) Moreover, the previous Orders attached to the Answer adjudicating the rights of the parties in other previous proceedings involving the Plaintiff's privileging at the Hospital are not hearsay, as they are not being submitted for the truth of the matters asserted therein, but rather to state facts sufficient to constitute Defendants' affirmative defense of res judicata and collateral estoppel that Plaintiff has already made similar or identical arguments as she has in this proceeding, as well as to show that these arguments were previously rejected See 2 McCormick On Evid § 298 (6th ed) (“Where the doctrines of res judicata, collateral estoppel, or claim or issue preclusion make the determinations in the first case binding in the second, a judgment in the first case is not only admissible in the second, but it is conclusive against the party as a matter of substantive law ”), see also Cawthon v Calvert Fire Ins Co., 218 S C 393, 399, 62 S E 2d 845, 847 (1951) (“A judgment is admissible against strangers to prove the fact and time of its rendition or entry and the legal consequences resulting therefrom ”)

Accordingly, this Court hereby denies the Plaintiff's Motion to Dismiss the Defendants' counterclaims and to strike the subject material from the Defendants' Answer

July ___, 2011
Charleston, South Carolina

The Honorable Kristi Lee Harrington
Chief Administrative Judge
Ninth Judicial Circuit

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF CHARLESTON	)	C A 2010-CP-10-3410
DR CYNTHIA HOLMES, M D ,	)	
	)	
Plaintiff,	)	
	)	
Vs	)	ORDER
	)	DENYING DEFENDANT'S MOTIONS TO
EAST COOPER COMMUNITY	)	DISMISS AND FOR SUMMARY JUDGMENT
HOSPITAL, INC , TENET	)	AND GRANTING PLAINTIFF'S MOTIONS
HEALTHSYSTEM MEDICAL,	)	TO DISMISS ON THE PLEADINGS AND
INC	)	MOTION TO STRIKE
	)	
Defendant	)	

This matter has come before the Court on the Plaintiff's motion for judgment on the pleadings and motion to strike a portion of the Answer, and the Defendant's motion for Summary Judgment. Having considered the parties' briefs, affidavits submitted, applicable portions of the record, and oral argument from both parties, the Court makes the following findings and Orders:

I Defendants' motion for summary judgment for lack of subject matter jurisdiction

The Defendants contend that this case raises the same claims Dr. Holmes has raised in previous cases which were dismissed by Judge Dennis for lack of subject matter jurisdiction. The question of how the instant case is different was put directly to Plaintiff's counsel by the Court during the hearing on Summary Judgment. Counsel's response was that the Complaint in the instant case alleges a breach of a settlement agreement entered into in 2002 (and codified in 2003) between the parties and does not seek judicial review of the Defendant's process for consideration of applications for a

change in physician staff category He asserted that the Plaintiff, Dr Holmes, is not seeking Court review of whether the rules of the hospital governing consideration of her request for a change in staff privileges are valid or reasonable, or whether the decisions made by the Defendant, East Cooper Hospital, are medically sound, but rather whether Defendant's conduct and actions after the signing of the settlement agreement breached the agreement

Counsel for the Plaintiff asserts the controlling case law as to whether the Court has subject matter jurisdiction in this matter is *Lee v Chesterfield General Hosp , Inc* , 289 S C 6, 13, 344 S E 2d 379, 383 (Ct App 1986) In *Lee*, the Plaintiffs were a Physician's assistant and a medical doctor, licensed to practice medicine in South Carolina Dr Holmes, the Plaintiff in this case, is also a licensed physician in South Carolina The Plaintiffs in *Lee* enjoyed privileges at Chesterfield General Hospital for some time *Id* At 380, as had Dr Holmes The Plaintiffs in *Lee* applied for reappointment *Id* At 380 Dr Holmes applied as well After reviewing Plaintiff's application, the credentialing committee granted Lee privileges, but restricted him from performing procedures he had asked for stating that the hospital's rules prohibited it *Id* 380-381 In Dr Holmes' case, her application in 2008 was simply rejected as incomplete and not afforded further consideration There is an issue of fact as to whether the by-laws were properly followed in doing so (affidavits from Dr Holmes and Dr Shershow, an expert, so attest)

Lee and Newsome filed suit In their complaint, they alleged the restrictions in question were imposed as part of a conspiracy to restrict their ability to compete with other medical professionals in the Chesterfield County area In the Complaint, Lee

proposed that the object of the conspiracy was “to dominate the practice of medicine by licensed physicians in Chesterfield County ” (Id At 381) The hospital in the Lee case demurred, citing a lack of subject matter jurisdiction under Strauss v Marlboro County General Hospital, 185 S C 425, 194 S E 65 (1937), the Circuit Court denied the demurrers The Hospital appealed and the Appellate Court affirmed the denial of the demurrers In doing so, the Appellate Court reasoned that because the Plaintiffs were not asking the Court to determine whether the by-laws were sound but rather alleged the rules were applied in such a way as to further a civil conspiracy, *Strauss v Marlboro County General Hospital* and its progeny did not deprive the Court of subject matter jurisdiction

The Hospital first argues the demurrers should have been sustained because internal rules governing the practice of a physician's assistant in a private hospital are not subject to judicial review

1, 2 We agree that a private hospital is free, in the absence of controlling legislation or regulatory provisions, to decide the nature and extent of medical practice permitted to persons it grants staff privileges Ordinarily, such decisions involve matters of expert medical judgment not subject to judicial review *See Gowen v St Francis Community Hospital*, 275 S C 203, 268 S E (2d) 580 (1980), *cert denied*, 449 U S 1062, 101 S Ct 786, 66 L Ed (2d) 605 (1980), *Hoffman v Garden City Hospital-Osteopathic*, 115 Mich App 773, 321 N W (2d) 810 (1982) A medical professional has no right, simply because he is licensed by state authority to perform certain procedures, to claim unrestricted staff privileges in a hospital *See Yeargin v Hamilton Memorial Hospital*, 225 Ga 661, 171 S E (2d) 136 (1969), *cert denied*, 397 U S 963, 90 S Ct 997, 25 L Ed (2d) 255 (1970) Within the confines of the law, a hospital may set professional standards for staff according to its own conception of good medical practice

These principles are not dispositive of the present cases, however In ruling on the demurrers, the circuit court did not conduct a judicial review of internal hospital rules **The question to be decided is not whether the rules are valid or reasonable or medically sound, but whether the rules were imposed in furtherance of a conspiracy, the primary purpose of which was to injure the plaintiffs If the complaints, liberally construed, allege such a conspiracy, it is irrelevant that the Hospital has the legal right to restrict staff privileges and that its rules are not subject to judicial review**

Lee v Chesterfield General Hosp , Inc , 289 S C 6, 344 S E 2d 379, 383 (Ct App 1986) (Emphasis added)

In this case, the Plaintiff's cause of action for breach of contract is not a challenge to the hospital's right to create and impose rules and regulations, nor is Dr Holmes asking for a due process review Dr Holmes, in her Complaint, has alleged that, pursuant to a settlement agreement struck in 2003, she was entitled to apply for and be considered for a change in staff category under the by-laws A review of the Complaint supports the assertion by Plaintiff's Counsel, that it was specifically and pointedly drafted to pursue a claim for a breach of the implied covenant of good faith and fair dealing by the hospital, not a breach of the bylaws, and not a request for review of the due process or fairness of a decision

The parties' settlement agreement was read into the record on October 29, 2002, and codified in 2003 The settlement agreement was read into the record This Court has subject matter jurisdiction to enforce the terms of the agreement "Subject matter jurisdiction is 'the power to hear and determine cases of the general class to which the proceedings in question belong '" *Dove v Gold Kist, Inc* , 314 S C 235, 237-38, 442 S E 2d 598, 600 (1994) (quoting *Bank of Babylon v Quirk*, 192 Conn 447, 472 A 2d 21, 22 (1984)) "Subject matter jurisdiction is met if the case is brought in the court which has the authority and power to determine the type of action at issue " *Washington v Whitaker*, 317 S C 108, 115, 451 S E 2d 894, 898 (1994) There is only one circuit in South Carolina and it has uniform subject matter jurisdiction throughout the State *Dove v Gold Kist*, 314 S C 235, 442 S E 2d 598, 600 (1994), see also S C Const art V, section 1 The circuit court has subject matter jurisdiction to adjudicate the breach of contract dispute *TTCI Media, Inc v NuVox Communications, Inc* , 2009-UP-004 (SSCA)

The facts surrounding the question of subject matter jurisdiction set before the Court in this case are identical to those set forth in *Lee v Chesterfield General Hosp , Inc* , 289 S C 6, 344 S E 2d 379, 383 (Ct App 1986) The Court finds that *Lee v Chesterfield* is controlling and that the Court has jurisdiction over the breach of contract claims that the Plaintiff has asserted in the Complaint

Moreover, the Court notes Judge Dennis' denial of the motion for reconsideration and his denial of the Rule 12(b)(1), SCRC motion to dismiss for lack of subject matter jurisdiction Accordingly, the Defendants' motion to dismiss for lack of subject matter jurisdiction is denied

II There is a genuine issue of material fact as to whether the Defendants breached a covenant of good faith and fair dealing under the settlement agreement

The Complaint in this case specifically brings a claim for a breach of the covenant of good faith and fair dealing, which is inherent in all contracts "There exists in every contract an implied covenant of good faith and fair dealing " *Parker v Byrd*, 309 S C 189, 193-94, 420 S E 2d 850, 853 (1992) [N]either law nor equity requires every term or condition to be set forth in a contract Where an implied term is necessary to effectuate the intention of the parties, the law will supply it The unexpressed provision may be inferred from the language of the contract itself, or by looking to the external facts and circumstances surrounding the bargain, or by proving a general custom and usage of including certain terms as part of similar contracts *Maccaro v Andrick Dev Corp* , 280 S C 96, 100, 311 S E 2d 91, 94 (Ct App 1984) (internal citations omitted) There is only one cause of action Dr Holmes' claim is essentially a very simple one She is not seeking a Court review of whether the proper procedure was followed or whether the By-

laws were necessarily “fair ” Instead, she is focusing on the conduct of the Defendant after the 2003 settlement of her claims against it

In support of her claims, the Plaintiff has submitted her own testimony, the affidavit of Dr Majeski, and the affidavit of her expert witness, Dr Shershow

The Defendant has also produced expert and lay testimony Defendant’s expert and lay witness testimony claim that all the applicable “rules” were followed to the letter, and that Dr Holmes’ was afforded a fair opportunity to participate in the review process Dr Holmes and her expert witness, Dr Shershow, state and opine the opposite Both parties cite to the by-laws, and each claims that its interpretation is the correct one

In considering a motion for Summary Judgment, the Court must consider all facts and inferences which could be drawn therefrom in a light most favorable to the non-moving party *Fleming v Rose*, 350 S C 488, 493-94, 567 S E 2d 857, 860 (2002)

The Plaintiff’s expert witness, Dr Shershow, offers

“Based on review of Dr Holmes’ credentialing file, the reappointment applications, the ECCH Medical Staff Bylaws, and a letter from Janie Sinacore-Jaberg to Dr Holmes on December 19, 2008, it is my expert opinion that Dr Holmes’ 2008 application for re-appointment and change in medical staff status was not properly responded to by ECCH ” (Affidavit of Shershow)

Dr Shershow also opines

“it is my opinion that Dr Holmes was denied fair hearing rights as explicitly required by these bylaws and by the joint commission standards ” Id

He goes on to support Dr Holmes’ allegations that the denial of her access to the process has resulted in a denial of the due process rights she would have been afforded under the applicable by-laws

“Further, by denying Dr Holmes fair hearing rights, per the applicable provisions of the ECCH Medical Staff Bylaw, ECCH prevented Dr Holmes from her due process rights,

mandated by both the joint commission, and the EECCG[sic] Medical Staff By-Laws ”
(Affidavit of Shershow)

If there is a genuine issue of material fact, Summary Judgment should be denied
The Court, in this case, finds that the Plaintiff has presented evidence which, if believed
by a jury, would support her claim of breach of the contract and the implied covenant of
good faith and fair dealing Defendant’s motion for Summary Judgment is therefore
denied

III Res Judicata and Collateral Estoppel

Res judicata is a rule that a final judgment rendered by a court of competent
jurisdiction on the merits is conclusive as to the rights of the parties and, as to them,
constitutes an absolute bar to a subsequent action Black's Law Dictionary 1174 (5th ed
1979) To establish *res judicata*, the following elements must be shown (1) identities of
the parties, (2) identity of the subject matter, and (3) adjudication of the issue in the
former suit *See Riedman Corp v Greenville Steel Structures, Inc* , 308 S C 467, 469,
419 S E 2d 217, 218 (1992)

Defendants point to two prior suits The first suit was filed in federal court
Although summary judgment was granted on the federal claims, the federal court denied
the Defendants’ request to dismiss the pendant state law claims The state court claims
were then pursued in state court and resolved in plaintiff’s favor, resulting in the
settlement agreement that the Plaintiff alleges was breached in this case

Defendant points to another case which include identical parties, however, each
prior suit refers to a different denial of Dr Holmes’ application A different ground was
given for each denial or refusal to consider the application Specifically, the 2008 denial

arises from the Defendant's claim that the application was incomplete, as opposed to other grounds for denial in the past Plaintiff alleges that each denial of privileges was a new breach of the settlement agreement To establish *res judicata*, the following elements must be shown (1) identities of the parties, (2) identity of the subject matter, and (3) adjudication of the issue in the former suit See *Riedman Corp v Greenville Steel Structures, Inc* , 308 S C 467, 469, 419 S E 2d 217, 218 (1992) Separate breaches of a contract are clearly separate subject matter, and should not be subject to the doctrine of *res judicata*

The instant suit includes the issues of the 2006 reappointment and the 2008 reappointment The Court notes that the Defendant's argument for the application of collateral estoppel and *res judicata* mentions cases involving only applications prior to Dr Holmes' 2006 application Even if this case evokes similar defensive strategies and arguments from Defendant, this case does not involve the same issues Because the elements of *res judicata* and Collateral Estoppel have not been shown, Collateral Estoppel and the Doctrine of Res Judicata do not apply in this case

IV Plaintiff's motion to dismiss Defendant's claims for Malicious prosecution on the pleadings

The Court finds that the Defendants' counterclaims fail to include an allegation that the instant action is terminated in its favor In fact, such an allegation would be impossible, as this action has not been concluded This is an element of malicious prosecution (See *Eaves v Broad River Elec Coop, Inc* , 277 S C 475, 479, 289 S E 2d 414, 416 (1982)) Therefore the Plaintiff's motion to dismiss the Defendants' claim for malicious prosecution, on the pleadings, is granted

V Plaintiff's motion to dismiss Defendant's claim under the S C Frivolous

Proceedings Sanctions Act

The Plaintiff correctly points out that S C Section 15-36-10(c)(1) is a motion which is meant to be brought at the conclusion of a trial, rather than a cause of action to be plead in a complaint or counterclaim

(C)(1) At the conclusion of a trial and after a verdict for or a verdict against damages has been rendered or a case has been dismissed by a directed verdict, summary judgment, or judgment notwithstanding the verdict, upon motion of the prevailing party, the court shall proceed to determine if the claim or defense was frivolous

S C Code section 15-36-10 (C)(1)

As it is not designed to be plead as a cause of action, and requires the conclusion of a case to be raised, it is not proper for assertion as a counterclaim Plaintiff's motion to dismiss Defendant's counterclaim under S C Code section 15-36-10(c)(1) is granted

VI Plaintiff's motion to strike Paragraphs 11 through 46 of the Defendant's Answer and Counterclaim pursuant to Rule 12(f), SCRPC

Dr Holmes has moved to strike paragraphs 11 through 46 from the Defendant's counterclaim These paragraphs include a listing, in detail, of prior cases between the parties, as well as details as to orders and findings of fact in those cases Plaintiff has presented a legal argument, asserting that the Material from an unrelated case is objectionable as hearsay Although Defendant points out that an allegation of a pattern of unsuccessful litigation initiated by Plaintiff against the Defendant in the past is supportive of its claim for abuse of malicious prosecution, the Court's finding that Malicious prosecution should be dismissed on the pleadings renders that argument moot

In *Mizell v Glover*, the South Carolina Supreme Court stated " We find persuasive the jurisprudence developed by the Fourth Circuit and other federal courts which have recognized that judicial findings of fact from one trial constitute hearsay

when offered for admission in the context of another trial See *Nipper v Snipes*, 7 F 3d 415 (4th Cir 1993), *US Steel, LLC v Tieco, Inc*, 261 F 3d 1275 (11th Cir 2001), *US v Jones*, 29 F 3d 1549 (11th Cir 1994), *Blue Cross and Blue Shield v Philip Morris, Inc*, 141 F Supp 2d 320 (E D N Y 2001) [8] In *Nipper*, the Fourth Circuit held that judicial findings constitute hearsay and do not fall within any of the exceptions to the hearsay rule, including the exception for public records, Rule 803(8), FRE *Nipper* The Fourth Circuit made clear that its holding was firmly rooted in the common law *Id* (Citing 5 John H Wigmore, Wigmore on Evidence § 1671a (James H Chadbourn rev 1974) (citations omitted))” *Mizell v Glover*, 351 S C 392, 570 S E 2d 176 (S C 2002)

“The federal courts addressing this issue point to the great weight and obvious prejudicial effect that credibility assessments of witnesses by judges have on subsequent juries See *Philip Morris*, 141 F Supp 2d 320 (denying admission of a judge's statement regarding credibility of expert witness for impeachment of that expert at a subsequent trial) Although *Philip Morris* involved the credibility assessment of a judge and not the assessment of a jury, the jury's factual finding introduced in this case is hearsay nonetheless, and we believe, is equally prejudicial See *US Steel v Tieco* (finding appellants were prejudiced by the admission of a previous judge's factual opinion into a subsequent trial because appellees relied on the opinion throughout the trial and advised the jury during closing argument to use the opinion to make their own credibility determinations)” *Mizell v Glover*, 351 S C 392, 570 S E 2d 176 (S C 2002)

Extrinsic material from unrelated matter is hearsay Plaintiff's motion to dismiss and/or strike extraneous material from other cases should be granted and Paragraphs 11 through 46 of the Defendant's Answer and Counterclaim shall be stricken pursuant to Rule 12(f) of the S C Rules of Civil Procedure

ORDERS OF THE COURT

IT IS HEREBY ORDERED THAT

1) Defendant's motion to dismiss for lack of subject matter Jurisdiction is DENIED

- 2) Defendant's motion for summary judgment is DENIED
- 3) Defendant's motion to dismiss based upon the doctrines of Res Judicata and Collateral Estoppel are DENIED
- 4) Plaintiff's motion to dismiss Defendant's counterclaim for malicious prosecution on the pleadings is GRANTED
- 5) Plaintiff's motion to dismiss Defendant's counterclaims under S C Code section 15-36-10(c)(1) is GRANTED
- 6) Plaintiff's motion to strike paragraphs 11 through 46 of the Defendant's counterclaim pursuant to rule 12(f) SCRCF is GRANTED Defendant may have leave to amend the answer and counterclaims to remove paragraphs 11 through 46

The Honorable Kristi Lea Harrington
Chief Administrative Judge
Ninth Judicial Circuit

Date _____

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

The Honorable Kristi Lee Harrington, Circuit Court Judge

RECEIVED
AUG 29 2011
SC Court of Appeals

Case No 2010-CP-10-3410

Dr Cynthia Holmes, M D

Appellant,

v

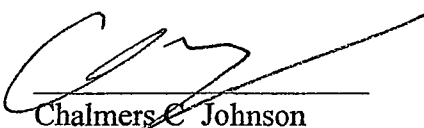
East Cooper Community Hospital, Inc ,
Tenet HealthSystem Medical, Inc ,

Respondents

NOTICE OF APPEAL

The Appellant appeals the Order of Judge Kristi Lee Harrington entered Filed July 29, 2011 A copy of the Order under appeal is attached

Dated August 24, 2011


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