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HAMILTON MEDICAL CENTER

PRACTITIONER HEALTH POLICY

Approved by Medical Executive Committee
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PRACTITIONER HEALTH POLICY

1. POLICY STATEMENT

1.A ***General Policy.*** Hamilton Medical Center and its Medical Staff (the "Medical Center") are committed to providing safe, quality care, which can be compromised if a Practitioner is suffering from a Health Issue as defined in this Policy that is not appropriately addressed. The Medical Center is also committed to assisting Practitioners in addressing Health Issues so they may practice safely and competently.

1.B Scope of Policy.

(1) This Policy applies to all Practitioners as defined in Section 1.D who provide patient care services at the Medical Center.

(2) All efforts undertaken pursuant to this Policy are part of the Medical Center's performance improvement and professional practice evaluation/peer review activities.

(3) A flow chart depicting the review process for concerns regarding Practitioner Health Issues is attached as **Appendix A** to this Policy.

1.C Definition of "Health Issue."

(1) ***Definition.*** A "Health Issue" means any physical, mental, or emotional condition that could adversely affect a Practitioner's ability to practice safely and competently.

(2) ***Examples.*** Examples of Health Issues may include, but are not limited to, the following:

(a) substance or alcohol abuse;

(b) use of any medication, whether prescription or over-the-counter, that can affect alertness, judgment, or cognitive function (such as, but not limited to, the use of pain or anti-anxiety medication following surgery);

(c) any temporary or ongoing mental health concern, including, but not limited to, bipolar disorders or disorders caused by a major family event (e.g., death of spouse or child, divorce) or a major job-related event (e.g., death or significant injury to patient);

(d) carotid, vertebral, or other brain artery surgery or intervention;

(e) chemotherapy with a drug known to effect neurotoxicity (brain) or to have cardiac or neurotoxicity (peripheral nerves);

(f) radiation therapy to head;

(g) medical condition (e.g., stroke or Parkinson's disease), injury, or surgery resulting in temporary or permanent loss of fine motor control or sensory loss;

(h) shoulder surgery, brachial plexus surgery, hand or carpal tunnel surgery for a surgeon;

(i) a back injury impacting ability to stand in the OR or other procedure lab;

(j) major surgery;

(k) infectious/contagious disease that could compromise patient safety or jeopardize other health care workers; and

(l) any form of diagnosed dementia (e.g., Alzheimer's disease, Lewy body dementia), or other cognitive impairment.

1.D Other Definitions.

(1) "Employed Practitioner" means a Practitioner who is employed by an Employer.

(2) "Employer" means:

(a) the Medical Center;

(b) a Medical Center-related entity that has a formal peer review/professional practice evaluation process and an established peer review committee, as evidenced by internal bylaws or policy; or

(c) a private entity that has: (i) a formal peer review/professional practice evaluation process and an established peer review committee, as evidenced by internal bylaws or policy, and (ii) information sharing provisions in a professional services contract or in a separate agreement with the Medical Center.

(3) "Medical Staff Leader" means any Medical Staff Officer, department chair, and committee chair.

(4) "Practitioner" means any individual who has been granted clinical privileges and/or membership by the Board, including, but not limited to, members of the Medical Staff and Allied Health Professionals.

(5) "Medical Staff/Quality Specialists" means the clinical and non-clinical staff who support the medical staff and/or professional practice evaluation ("PPE") process generally and the review of issues related to professionalism described in this Policy. This may include, but is not limited to, staff from the quality department, Medical Staff office, human resources, and/or patient safety department.

1.E Role of Leadership Council.

(1) Practitioner Health Issues shall be addressed by the Leadership Council as outlined in this Policy. The Leadership Council may request other Practitioners to assist it, on an ad hoc basis, if additional expertise or experience would be helpful in addressing the health concerns that are identified in a particular case.

(2) The Leadership Council shall recommend to the Medical Executive Committee educational materials that address Practitioner Health Issues and emphasize prevention, identification, diagnosis, and treatment of Health Issues. This Policy and any educational materials approved by the Medical Executive Committee shall be made available to Practitioners and Medical Center personnel. In addition, the Medical Executive Committee shall periodically include information regarding illness and impairment recognition issues in CME activities.

1.F ***Health Issues Identified During Credentialing Process.*** A Health Issue that is identified during the credentialing process shall be addressed pursuant to the Medical Staff Credentials Policy. If a determination is made that the Practitioner is qualified for appointment and privileges, but has a Health Issue that should be monitored or treated, the matter shall be referred to the Leadership Council for ongoing monitoring or oversight of treatment pursuant to this Policy.

1.G ***Patient Care and Safety.*** Nothing in this Policy precludes immediate referral to the Medical Executive Committee or the elimination of any particular step in the Policy if necessary to address a situation that may compromise patient care and safety.

1.H ***Delegation of Functions.*** When a function under this Policy is to be carried out by a member of Medical Center management, by a Medical Staff Leader, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a Practitioner or Medical Center employee (or a committee of such individuals). Any such

designee must treat and maintain all information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of this Policy. The delegating individual or committee is responsible for ensuring the designee performs the function as required by this Policy.

1.I No Legal Counsel or Recordings During Collegial Meetings.

(1) To promote the collegial and educational objectives of this Policy, all discussions and meetings with a Practitioner shall generally involve only the Practitioner and the appropriate Medical Staff Leaders and Medical Center personnel. No counsel representing the Practitioner or the Medical Staff or the Medical Center shall attend any of these meetings. In their discretion, Medical Staff Leaders may permit a Practitioner to invite another Practitioner to the meeting. In such case, the invited Practitioner may not participate in the discussion or in any way serve as an advocate for the Practitioner under review, must sign a Confidentiality Agreement, and may be required to leave the meeting at any time.

(2) No recording (audio or video) of a meeting shall be permitted or made. Smart phones, iPads, and similar devices must be left outside the meeting room.

1.J ***Supervising Physicians and Allied Health Professionals.*** A physician who is the primary supervising or collaborating physician pursuant to a written agreement with an Allied Health Professional shall be notified when a Health Issue involving the Allied Health Professional is referred for review under this Policy. However, details regarding the nature of the Health Issue shall not be disclosed to the supervising/collaborating physician unless the Allied Health Professional signs an authorization permitting such disclosure.

2. REPORTS OF POTENTIAL HEALTH ISSUES

2.A Duty to Self-Report.

(1) ***General Duty.*** Practitioners who have a Health Issue (as defined in this Policy) are required to report it to the President of the Medical Staff, Chief Medical Officer ("CMO"), or another Medical Staff Leader.

(2) ***Exception.*** The duty to self-report does not apply to:

(a) a Health Issue that will be fully resolved before the Practitioner next exercises his or her clinical privileges; or

(b) a Health Issue that was evaluated as part of a Practitioner's application for appointment or reappointment to the Medical Staff.

2B *Reports of Suspected Health Issues by Others.*

(1) ***General.*** Any Practitioner or Medical Center employee who is concerned that a Practitioner may be practicing while having a Health Issue, or who is told by a patient, family member, or other individual of a concern, shall report the concern to the President of the Medical Staff, CMO, or another Medical Staff Leader. Individuals filing a report do not need to have "proof" of a potential Health Issue, but should describe the facts that form the basis for their concern.

(2) ***Anonymous Reports***. Practitioners and employees may report concerns anonymously. However, all individuals are encouraged to identify themselves when making a report so that Medical Staff/Quality Specialists may contact the reporter for additional information, if necessary.

(3) ***Warning Signs.*** Warning signs of a potential Health Issue include, but are not limited to:

- problems with judgment or speech;
- emotional outbursts;
- alcohol odor;
- behavior changes and mood swings;
- diminishment of motor skills;
- unexplained drowsiness or inattentiveness;
- progressive lack of attention to personal hygiene;
- unexplained frequent illness;
- patients with pain out of proportion to charted narcotic dose;
- arrests for driving under the influence; and
- increased quality problems.

(4) ***Treatment Relationships.*** A Practitioner who becomes aware of a Health Issue affecting another Practitioner as a result of his or her treatment relationship with that Practitioner is not expected to report the Health Issue internally pursuant to this Policy. However, the treating Practitioner should encourage the Practitioner to self-report the issue to the extent required by Section 2.A of this Policy.

In addition, the treating Practitioner should consider whether a mandatory report is required under Georgia law to the applicable licensing board or any other state agency. If the treating Practitioner believes a mandatory report is necessary pursuant to Georgia law, he or she should notify the Practitioner and encourage the Practitioner to self-report prior to making the mandatory report. The treating Practitioner may consult with the CMO for assistance and resources in such matters, but should not disclose to the CMO information that identifies the Practitioner.

2.C ***Logging of Reports and Creation of Confidential Health File.*** The Medical Staff/Quality Specialists will log any report of a Health Issue and create a Confidential Health File that is maintained separately from the credentials or quality files (see Section 9 of this Policy for more information on Confidential Health Files).

2.D ***Notification to Leadership Council and Employed Practitioner Triage.***

(1) The Leadership Council shall be notified of any report of a suspected Health Issue.

(2) If the report involves an Employed Practitioner, the Leadership Council will consult with appropriate representatives of the Employer and then determine which of the processes described in this section will be used for the review. A form that may be used to document this decision is attached as **Appendix B.**

(3) The potential Health Issue may be reviewed under either the Medical Staff process or the Employer's process, as follows:

(a) If the matter will be reviewed using the Medical Staff process as set forth in this Policy, an appropriate representative of the Employer will be invited to attend relevant portions of committee meetings involving the Practitioner, as well as participate in any interventions that may be necessary following the review. The chair of the applicable committee may recuse the representative of the Employer during any deliberations or vote on a matter. Documentation from the Medical Staff process will not be disclosed to the Employer for inclusion in the employment file, but the Employer will be permitted access to such documentation as needed to fulfill its operational and legal responsibilities; or

(b) If the matter will be reviewed by the Employer pursuant to its policies and/or the relevant contract:

(i) the Medical Staff process shall be held in abeyance and the Leadership Council notified;

(ii) the Medical Staff/Quality Specialists will assist the Employer with witness interviews, document review, data compilation, and similar fact-finding. Documentation of such fact-finding will be maintained in the Practitioner's Confidential Health File consistent with the state peer review law, but the Employer will be permitted access to such documentation as needed to fulfill its operational and legal responsibilities. However, any health assessment obtained by the Employer will be maintained in a confidential manner in the Employer's personnel files as required by the Americans with Disabilities Act;

(iii) the Leadership Council will be kept informed of the progress and outcome of the review by the Employer; and

(iv) the Leadership Council may choose, at any time and in its sole discretion, that the matter shall also be reviewed pursuant to this Policy. However, neither such a review by the Leadership Council nor any other provision of this Policy shall be interpreted to affect the right of the Employer to take any action authorized by the relevant contract with the Practitioner.

(4) For purposes of this Section, an "appropriate representative of the Employer" includes Medical Center representatives with employment responsibilities (if the Medical Center is the Employer), or a peer review committee within the Employer (if the Employer is a Medical Center-related entity or a qualifying private entity).

2.E ***Gathering Information.*** The person receiving a report or the Medical Staff/Quality Specialists may request the reporting individual to provide a written description of the events that led to the concern or may prepare a written description based on receipt of a verbal report. As necessary, the person receiving the report or the Medical Staff/Quality Specialists may also interview the reporting individual and gather any other relevant facts, including speaking with any other individuals who may have relevant information.

2.F ***Follow-up with Individual Who Filed Report.*** The Medical Staff/Quality Specialists or CMO shall follow up with individuals who file a report by:

(1) thanking them for reporting the matter and participating in the Medical Center's culture of safety and quality care;

(2) informing them that:

(a) the matter will be reviewed in accordance with this Policy and that they may be contacted for additional information;

(b) no retaliation is permitted against any individual who raises a concern and they should immediately report any retaliation or any other incidents of inappropriate conduct;

(c) due to confidentiality requirements under state law, it is important that they maintain confidentiality and only discuss the matter with individuals who are a formal part of the review process; and

(d) due to those same confidentiality requirements, the Medical Center is not permitted to disclose the outcome of the review to them, but they can be assured a thorough review will be conducted.

A letter or e-mail that can be used for this purpose is attached as **Appendix C**. As an alternative to sending a letter or e-mail, the content of **Appendix C** and the provisions outlined in this section may be used as talking points to discuss these issues verbally with the individual who reported a concern.

3. RESPONSE TO IMMEDIATE THREATS

3.A ***Scope of Section.*** This section applies if a potential Health Issue is reported that raises immediate concerns and either:

(1) the Practitioner is providing services at the Medical Center at that time; or

(2) the Practitioner is expected to provide services in the very near future such that the Leadership Council would not have time to meet prior to the Practitioner's provision of services.

By way of example and not limitation, this section applies if a Practitioner seems disoriented or is demonstrating other cognitive difficulties while rounding on patients, or is suspected of being under the influence of drugs or alcohol immediately prior to commencing a surgical procedure.

3.B ***Assessment.*** If a report covered by this section suggests that a Practitioner may have a Health Issue that poses an immediate threat to patients or others, the President of the Medical Staff, CMO, or another Medical Staff Leader shall immediately and personally assess the Practitioner. The Practitioner may be required to submit to a blood, hair, or urine test, or other appropriate evaluation, to determine his or her ability to safely practice. Failure of the Practitioner to undergo such testing upon request will result in the automatic relinquishment of

the Practitioner's clinical privileges pending Leadership Council review of the matter. (See Section 8 for additional information on automatic relinquishment.)

3.C ***Protection of Patients and Others.*** If the individual who assesses the Practitioner believes the Practitioner may have a Health Issue and that action is necessary to protect patients and others, the Practitioner should be asked to voluntarily refrain from exercising his or her clinical privileges or agree to conditions on his or her practice while the matter is being reviewed. Such a request may be made to the Practitioner either before or after any tests or evaluations regarding the Practitioner have been completed.

(1) If the Practitioner agrees to voluntarily refrain from exercising his or her privileges, the Medical Staff President may assign the Practitioner's patients to another individual with appropriate clinical privileges or to the appropriate Practitioner on the Emergency Department call roster. Affected patients shall be informed that the Practitioner is unable to proceed with their care due to an emergency situation. Any wishes expressed by patients regarding a covering Practitioner will be respected to the extent possible. The Practitioner's agreement to voluntarily refrain should be documented in a letter or other correspondence to the Practitioner that is maintained in the Practitioner's Confidential Health File.

(2) If the Practitioner will not agree to voluntarily refrain from exercising his or her privileges, an individual authorized by the Credentials Policy to impose a precautionary suspension will consider whether a precautionary suspension or some other measure is necessary as a safeguard while the Health Issue is assessed.

3.D ***Referral to Leadership Council.*** Following the immediate response described above, the matter shall be referred to the Leadership Council for review pursuant to this Policy.

4. LEADERSHIP COUNCIL REVIEW

4.A ***Initial Review.*** The Leadership Council shall act expeditiously in reviewing concerns regarding a potential Health Issue referred to it. As part of its review, the Leadership Council may meet with the individual who initially reported the concern, as well as any other individual who may have relevant information. **Appendix D** contains a script that may be used for interviews, along with sample interview questions.

4.B ***Individuals Participating in Review.*** If the Leadership Council determines that it would be necessary or helpful in addressing the reported concern, it may consult with or include in the review a relevant subject matter expert (e.g., an addictionologist or psychiatrist) or the relevant department chair. Any individual

who participates in a review is an integral part of the Medical Center's review process, and shall be governed by the same responsibilities and legal protections (e.g., confidentiality, indemnification, etc.) that apply to other participants in the process.

4.C **_Meeting with Practitioner._** If the Leadership Council believes that a Practitioner may have a Health Issue, the Leadership Council shall meet with the Practitioner. At this meeting, the Practitioner should be told that there is a concern that his or her ability to practice safely and competently may be compromised by a Health Issue and advised of the nature of the concern. **Appendix E** includes talking points that may be used to help the Leadership Council prepare for and conduct such meetings.

4.D Identity of Reporter.

(1) **_General Rule._** Since this Policy does not involve disciplinary action or "restrictions" of privileges, the specific identity of the individual reporting a concern or otherwise providing information about a matter (the "reporter") generally will not be disclosed to the Practitioner.

(2) _Exceptions._

(a) **_Consent._** The Leadership Council may, in its discretion, disclose the identity of the reporter to the Practitioner if the reporter specifically consents to the disclosure (with the reporter being reassured that he or she will be protected from retaliation).

(b) **_Medical Staff Hearing._** The identity of the reporter shall be disclosed to the Practitioner if information provided by the reporter is used to support an adverse professional review action that results in a Medical Staff hearing.

(3) **_Practitioner Guessing the Identity of Reporter._** This section does not prohibit the Leadership Council from notifying a Practitioner about a concern that has been raised even if the description of the concern would allow the Practitioner to guess the identity of the reporter (e.g., where the reporter and the Practitioner were the only two people present when an incident occurred). In such case, the Leadership Council will not confirm the identity of the reporter, and will pay particular attention to reminding the Practitioner to avoid any action that could be perceived as retaliation.

4.E Assessment of Health Status.

(1) The Leadership Council may require the Practitioner to do one or more of the following to facilitate an assessment of the Health Issue:

(a) undergo a physical or mental examination or other assessment (e.g., neurocognitive, motor skills, sensory capacity, vision, hearing, infectious disease) by another individual;

(b) submit to an alcohol or drug screening test (blood, hair, or urine);

(c) be evaluated by a physician or organization specializing in the relevant Health Issue, and have the results of any such evaluation provided to it; and/or

(d) obtain a letter from his or her treating physician confirming the Practitioner's ability to safely and competently practice, and authorize the treating physician to meet with the Leadership Council.

(2) The Leadership Council shall select the health care professional or organization to perform the examination, testing, or evaluation, but may seek input from the Practitioner. More than one health care professional or organization may be asked to perform an examination, test, or evaluation, and this may occur either concurrently or serially (e.g., a substance abuse assessment following a positive drug screen). The Practitioner shall be responsible for any costs associated with obtaining this health status information.

(3) A form authorizing the Medical Center to release information to the health care professional or organization conducting the evaluation is attached as **Appendix F**. A form authorizing the health care professional or organization conducting the evaluation to disclose information about the Practitioner to the Leadership Council is attached as **Appendix G**. A Health Status Assessment Form that may be used to document the results of an evaluation is attached as **Appendix H**.

(4) If a Practitioner refuses to obtain a health assessment or provide the results to the Leadership Council, the process outlined in Section 8.A of this Policy ("Automatic Relinquishment/Resignation") will be followed.

4.F ***Interim Safeguards.*** If a Practitioner agrees to obtain an assessment, the Leadership Council may recommend that the Practitioner voluntarily take one or more of the following actions while the assessment is pending:

(1) agree to specific conditions on his or her practice, which could include obtaining assistance from other Practitioners during patient care activities;

(2) refrain from exercising some or all privileges at the Medical Center and at other practice locations as may be appropriate;

(3) take a leave of absence; or

(4) relinquish certain clinical privileges.

If a Practitioner does not agree to take a temporary voluntary action recommended by the Leadership Council while the assessment is pending, the matter shall be referred to the Medical Executive Committee for review and further action pursuant to the Medical Staff Credentials Policy.

4.G ***Determination That No Health Issue Exists.*** At any point during its review, the Leadership Council may determine that a report is unfounded and that the Practitioner does not have a Health Issue. In such case, the matter shall be closed. The individual who filed the report may be notified that the report was not substantiated, at the discretion of the Leadership Council. As noted in Section 2.B of this Policy, individuals filing a report do not need to have "proof" of a potential Health Issue. However, intentionally false reports will be grounds for disciplinary action. False reports by Practitioners will be reviewed by the Leadership Council pursuant to the Medical Staff Professionalism Policy, while false reports by Medical Center employees will be referred to human resources.

5. PARTICIPATION IN A TREATMENT PROGRAM

In some instances, the assessment described in Section 4 of this Policy will lead to a recommendation by the Leadership Council that the Practitioner enter a treatment program. In other instances, the need for a Practitioner to enter a treatment program will be self-evident, and each of the steps required in Section 4 may not be required. In either case, the Leadership Council will, as requested, assist the Practitioner in identifying an appropriate program.

6. REINSTATEMENT/RESUMING PRACTICE

6.A Request for Reinstatement or to Resume Practicing.

(1) ***Requests When a Leave of Absence was Granted.*** If a Practitioner was granted a formal leave of absence to participate in a treatment program or otherwise address a Health Issue, the Practitioner must apply for reinstatement of privileges using the process set forth in the Medical Staff Credentials Policy. However, prior to applying for reinstatement through the process outlined in the Credentials Policy, the Practitioner must first submit a written request to the Leadership Council for clearance to apply for reinstatement and be granted written permission by the Leadership Council.

(2) ***Requests When a Leave of Absence was <u>not</u> Granted.*** In all other circumstances where the Practitioner refrained from practicing (e.g., voluntary agreement between Practitioner and Leadership Council;

Practitioner was absent from Medical Staff duties while participating in a treatment program or otherwise addressing a Health Issue), the Practitioner must submit a written request to the Leadership Council and receive written permission to resume exercising his or her clinical privileges.

6.B *Additional Information.* Before acting on a Practitioner's request for clearance to apply for reinstatement or to resume practicing, the Leadership Council may request any additional information or documentation that it believes is necessary to evaluate the Practitioner's ability to safely and competently exercise clinical privileges. This may include requiring the Practitioner to undergo a health assessment conducted by a physician or entity chosen by the Leadership Council in order to obtain a second opinion on the Practitioner's ability to practice safely and competently.

6.C Determination by Leadership Council.

(1) If the Leadership Council determines that the Practitioner is capable of practicing safely and competently without conditions, this decision will be documented. The Practitioner may then: (i) proceed with the reinstatement process outlined in the Medical Staff Credentials Policy, if a leave of absence was taken; or (ii) resume practicing, if no leave of absence was taken.

(2) If the Leadership Council determines that conditions should be placed on a Practitioner's practice as a condition of reinstatement or resuming practice, it will consult with the Practitioner in developing any necessary conditions.

7. CONDITIONS OF CONTINUED PRACTICE

7.A *General.* The Leadership Council may ask the Practitioner to agree to comply with certain conditions in order to receive clearance to apply for reinstatement of privileges from a leave of absence or to otherwise resume practicing. If the Practitioner does not agree to such conditions, the matter will be referred to the Medical Executive Committee as set forth in Section 8 of this Policy. By way of example and not of limitation, such conditions may include:

(1) *Coverage.* The Practitioner may be asked to identify at least one Practitioner who is informed of the Health Issue and is willing to assume responsibility for the care of his or her patients in the event of the Practitioner's inability or unavailability.

(2) *Changes in Practice.* The Practitioner may be asked to make certain changes to his or her practice, such as changing the frequency and/or schedule with which the Practitioner takes call, limiting inpatient census to

a manageable number, or beginning elective procedures prior to a certain time of day.

(3) ***Ongoing Monitoring.*** The Practitioner's exercise of clinical privileges may be monitored. The individual to act as monitor shall be appointed by the Leadership Council or the department chair. The nature of the monitoring shall be determined by the Leadership Council in consultation with the department chair.

(4) ***Periodic Reports of Health Status.*** If the Practitioner is continuing to receive medical treatment or to participate in a substance abuse rehabilitation or after-care program, the Leadership Council may ask the Practitioner to agree to submit periodic reports from his or her treating physician or the substance abuse rehabilitation/after-care program. If applicable, reports regarding compliance with the conditions outlined in an agreement with the Georgia Physician's Health Program may also be obtained. The nature and frequency of these reports will be determined on a case-by-case basis depending on the Health Issue.

(5) ***Random Alcohol or Drug Screens.*** A Practitioner who has undergone treatment for substance abuse may be asked to submit to random alcohol or drug screening tests at the request of any member of the Leadership Council.

7.B ***Reasonable Accommodations.*** Reasonable accommodations may be made consistent with Medical Center policy to assist the Practitioner in resuming his or her practice. Examples of reasonable accommodations include, but are not limited to, providing assistive technology or equipment or removing architectural barriers. The Leadership Council will consult with Medical Center executive personnel to determine whether reasonable accommodations are feasible.

7.C ***Voluntary Agreement Not a "Restriction."*** A Practitioner's voluntary agreement to conditions similar to those set forth in this section generally does not result in a "restriction" of that Practitioner's privileges. Accordingly, such a voluntary agreement generally does not require a report to the National Practitioner Data Bank ("NPDB") or to any state licensing board or other government agency, nor would it entitle a Practitioner to a hearing under the Medical Staff Credentials Policy. However, the Leadership Council will assess each situation independently. If there is concern in a given situation that a condition may be reportable to the NPDB or a state licensing board or agency, the Leadership Council will consult with Medical Center counsel and communicate with the Practitioner about the matter.

8. NONCOMPLIANCE

&A Automatic Relinquishment/Resignation.

(1) If a Practitioner refuses to undergo testing or an assessment when there are immediate concerns about patient safety as described in Section 3, the refusal will result in the immediate and automatic relinquishment of the Practitioner's clinical privileges pending the Leadership Council's review of the matter.

(2) If a Practitioner fails or refuses to provide information requested by the Leadership Council or any individual authorized by this Policy to request such information (including a request for a medical assessment), the Practitioner will be required to meet with the Leadership Council. The purpose of the meeting is to discuss the Practitioner's obligation to participate in the review process, permit the Practitioner to explain why the information was not provided, and inform the Practitioner of the consequences of continuing to not provide the information. Failure of the Practitioner to either:

(a) meet with the Leadership Council and persuade it that the requested information or meeting is not necessary; or

(b) provide the requested information prior to the date of the Leadership Council meeting,

will result in the automatic relinquishment of the Practitioner's clinical privileges. Such automatic relinquishment will continue until the Practitioner either meets with the Leadership Council and persuades it that the written information is not necessary or provides the requested information.

(3) If the Leadership Council requests that the Practitioner attend a meeting with it or a designated individual to discuss a Health Issue or obtain the Practitioner's verbal input, and the Practitioner fails or refuses to attend such a meeting, the Practitioner's clinical privileges will be automatically relinquished until the meeting occurs.

(4) If the Practitioner fails to meet with or provide information requested by the Leadership Council within thirty (30) days of the automatic relinquishment, the Practitioner's Medical Staff membership and clinical privileges will be deemed to have been automatically resigned.

(5) Generally, the automatic relinquishment or resignation of appointment and/or clinical privileges described in this section are administrative actions that occur by operation of this Policy. They are not professional

review actions that must be reported to the NPDB or to any state licensing board or agency, nor do they entitle the Practitioner to a hearing or appeal.

(6) Notwithstanding the foregoing, if the Leadership Council or Medical Executive Committee determines that a Practitioner's refusal to provide information or attend a meeting is a deliberate attempt to avoid review of a Health Issue, the Practitioner's action may be viewed as a resignation to avoid an investigation, and is thus reportable to the NPDB and a state licensing board or agency. Medical Center counsel shall be consulted in making such determinations.

8.B ***Referral to Medical Executive Committee.*** A matter may be immediately referred to the Medical Executive Committee for its review and action pursuant to the Medical Staff Credentials Policy if the Practitioner fails to:

(1) agree to the interim patient safeguards described in Section 4.F while a health assessment is pending;

(2) obtain an agreed-upon physical or mental examination or other health assessment, or to complete any treatment or rehabilitation program;

(3) agree to conditions requested by the Leadership Council to receive clearance to apply for reinstatement of privileges from a leave of absence or to otherwise resume practicing;

(4) continually comply with any agreed-upon condition of reinstatement or continued practice; or

(5) cooperate in the monitoring of his or her practice.

Following its review, the Medical Executive Committee shall take appropriate action under the Medical Staff Credentials Policy. This may include, but is not limited to, initiating an investigation.

9. DOCUMENTATION

9.A ***Creation of Confidential Health File.*** Reports of potential Health Issues and documentation received or created pursuant to this Policy shall be included in the Practitioner's Confidential Health File, which shall be maintained by the Medical Staff Office as a separate file and shall not be included in the credentials file.

9.B *Information Reviewed at Reappointment.*

(1) The information reviewed by those involved in the reappointment process will not routinely include all documentation in a Practitioner's health file. Instead, the process set forth in this subsection will be followed.

(2) When a reappointment application is received from an individual who has a Health Issue that is currently being reviewed or monitored by the Leadership Council, or that has been reviewed and resolved in the past reappointment cycle, the Medical Staff Office shall contact the Leadership Council.

(3) The Leadership Council will prepare a confidential summary health report to the Credentials Committee. The summary health report shall be included in the credentials file, and will be reviewed by the Credentials Committee only after the Credentials Committee has determined that the applicant is otherwise qualified for clinical privileges.

(4) The Leadership Council's summary health report will state that it is actively monitoring, or has monitored in the past reappointment cycle, a Health Issue involving the Practitioner. The summary health report will also include a recommendation regarding the Practitioner's ability to perform the duties of Medical Staff membership and safely exercise clinical privileges. A sample summary health report is included as **Appendix I**.

(5) If the Credentials Committee, Medical Executive Committee, or Board of Trustees has any questions about the Practitioner's ability to safely practice, the relevant entity will discuss the issue with a member of the Leadership Council. If the relevant entity still believes additional information is necessary, members of that entity may review the Practitioner's Confidential Health File in the Medical Staff Office.

10. CONFIDENTIALITY, PEER REVIEW PROTECTION, AND REPORTING

10.A ***Confidentiality.*** The Leadership Council and Medical Executive Committee will handle Health Issues in a confidential manner. Throughout this process, all parties should avoid speculation, gossip, and any discussions of this matter with anyone other than those described in this Policy.

10.B ***Peer Review Protection.*** All minutes, reports, recommendations, communications, and actions made or taken pursuant to this Policy are intended to be covered by the provisions of the Health Care Quality Improvement Act of 1986, 42 U.S.C.A. 11101 et seq., and Georgia laws governing peer review. Furthermore, the committees or individuals charged with making reports, findings, recommendations or investigations pursuant to this Policy shall be

considered to be acting on behalf of the Medical Center and the Board of Trustees when engaged in such professional review activities and thus are "professional review bodies" as that term is defined in the Health Care Quality Improvement Act.

10.C ***Required Reporting; Contact with Law Enforcement Authorities or Governmental Agencies.*** The Medical Center Chief Executive Officer ("CEO") shall file reports with the appropriate Georgia licensing board or the NPDB, as may be required by applicable statutes or regulations. In addition, if at any time it becomes apparent that a particular matter cannot be handled internally, or jeopardizes the safety of the Practitioner or others, the CEO, CMO or the Medical Center's counsel may contact law enforcement authorities or other governmental agencies.

10.D ***Redisclosure of Drug/Alcohol Treatment Information.*** In the course of addressing a Health Issue pursuant to this Policy, the Medical Center may receive written or verbal information about the treatment of a Practitioner from a federally assisted drug or alcohol abuse program as defined by 42 C.F.R. Part 2. The Medical Center may not redisclose such information without a signed authorization from the Practitioner. **Appendix J** includes an authorization that may be used for this purpose.

10.E ***Requests for Information Concerning Practitioner with a Health Issue.*** All reference requests or other requests for information concerning a Practitioner with a Health Issue shall be forwarded to the CMO, President of the Medical Staff, or CEO for response.

Adopted by the Medical Executive Committee on June 12, 2019. Approved by the Board on June 27,2019.

Appendix A:Review Process for Practitioner Health Issues