
# MEDICAL STAFF

# BYLAWS,

# RULES & REGULATIONS

Revised: MSB 2/6/23
General R&Rs 2/6/23
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Service R&Rs 9/8/20

# MEDICAL STAFF BYLAWS
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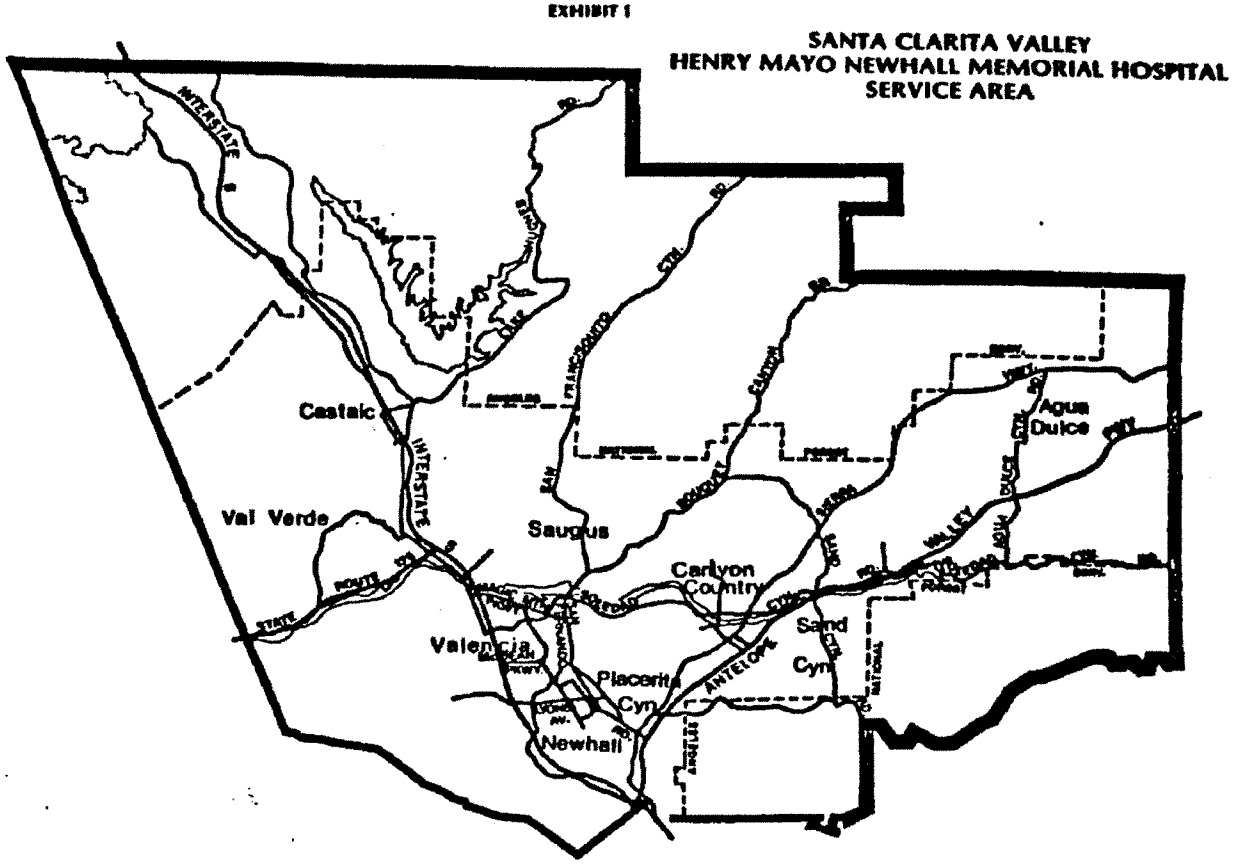


## ARTICLE I: PURPOSE AND TERMS

Section 1. Name

The name of this organization shall be "Medical Staff of Henry Mayo Newhall Memorial Hospital."

Section 2. Purpose

The purpose of this organization shall be:

1. To encourage the best possible medical care for all patients admitted to the Hospital or treated as outpatients;

2. To provide a means whereby problems of a medico-administrative nature may be discussed by the Medical Staff with the Board of Directors and the Administration;

3. To initiate and maintain rules and regulations for governance of the Medical Staff;

4. To provide education and to maintain educational standards;

5. To limit membership in the Medical Staff to those individuals who are qualified by training, ethical standards and licensing.

Section 3. Definitions

1. For the purpose of these Bylaws, the term "Medical Staff' shall be interpreted to include all physicians, dentists and podiatrists holding unlimited licenses.

2. The term "Board of Directors" means the Board of Directors of the Hospital.

3. The term "Medical Executive Committee" means the Medical Executive Committee of the Medical Staff.

4. The term "Department" means that group of practitioners who have clinical privileges in one or more of the general areas of medicine and/or surgery.

5. The term "Practitioner" means an appropriately licensed medical physician or dentist or podiatrist.

6. The term "Chief or Chairman of Department" means the Medical Staff member duly appointed or elected in accordance with these Bylaws to serve as the head of a department.

7. The term "Chief Executive Officer" means the individual appointed by the Board of Directors to act in its behalf in the overall management of the Hospital. His title is President.

8. The term "Hospital" means the Henry Mayo Newhall Memorial Hospital.

9. The term "Chief of Staff" means the Medical Staff member elected by the Medical Staff to serve as chief administrative officer of the Medical Staff.

10. The term "Deputy Chief of Staff" means the Medical Staff member elected by the Medical Staff in December of every even year to serve in that capacity for one year prior to a two year term as Chief of Staff followed by an additional year as Deputy Chief of Staff

11. The terms "Allied Health Professional" (AHP) or Specified Professional Personnel means a health care professional, other than a physician, dentist, or podiatrist who holds a license or other legal credential, as required by California law, to provide certain professional services.

12. All reference to the masculine gender means the masculine or feminine gender.

13. The term "Primary Service Area" shall mean the service area of the Hospital as defined on the service map, Exhibit I.

14. The term "Local Office" shall mean a business location with a local phone number and mailing address where a health care practitioner is personally present (not merely on call) at an office is located in the Hospital's primary service area providing professional medical services to patients on an average of not less than one half day per calendar week, not counting time when the practitioner is away from his practice due to vacation, holidays, illness, continuing education or personal business."

15. The term "Residency Training Program" means a training program accredited by the Accreditation Council for Graduate Medical Education.

16. The term "Medical Staff year" means a calendar year beginning on January 1st and ending December 31st.

17. The term "Professional Services" means serving as the attending physician, consultant, or principal surgeon.

18. The term "in good standing" shall be defined as a practitioner who has current medical malpractice insurance, current medical license, current certificates and not on medical record suspension.

## ARTICLE II: MEMBERSHIP

Section 1. Membership a Privilege

Membership on the staff of the Henry Mayo Newhall Hospital is a privilege which shall be extended only to those physicians, surgeons (M.D. and D.O.), podiatrists and dentists who are in good standing and strictly meet and continue to meet the standards and requirements set forth in these Bylaws.

No physician, dentist, podiatrist, allied health professional, including those in a medical administrative position by virtue of a contract with the Hospital, shall admit or provide medical or health-related services to patients in the Hospital unless the practitioner is a member of the Medical Staff and has been granted privileges in accordance with the procedures set forth in these Bylaws. Appointment to the Medical Staff shall confer only such clinical privileges and prerogatives as have been granted in accordance with these Bylaws.

All members of the Medical Staff, except those in the Provisional-C, Courtesy, Consulting and Honorary Medical Staff categories, shall continually maintain a Local Office within the Primary Service area of the Hospital, unless otherwise excepted by the Bylaws, or Rules and Regulations by virtue of their routine presence at the Hospital.

Section 2. Basic Responsibilities of Medical Staff Membership.

Members of the Medical Staff are responsible for performing, if granted the requisite privileges, or arranging for the performance of, a history and physical on every patient he/she admits. A medical history and physical examination shall be completed no more than 30 days before, or 24 hours after, admission or registration, but prior to surgery or a procedure requiring anesthesia services. When the medical history and physical examination is completed within 30 days before admission or registration, the physician must complete and document an updated examination of the patient within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The updated examination of the patient, including changes in the patient's condition, must be completed and documented by a physician, an oral maxillofacial surgeon, or other qualified licensed individual in accordance with state law and Hospital policy.

Section 3. Qualifications for Membership

(a) Physicians. An applicant for physician membership in the Medical Staff must hold an MD or DO degree or their equivalent and a valid and unsuspended certificate to practice medicine issued by the Medical Board of California or the California Board of Osteopathic Examiners of the State of California. For the purpose of this section, "or their equivalent" shall mean any degree (i.e., foreign) recognized by the California Board of Osteopathic Examiners of the State of California.

(b) Limited License Practitioners.

(1) Dentists. An applicant for dental membership in the Medical Staff, except for the honorary staff, must hold DDS degree and a valid unsuspended certificate to practice dentistry issued by the California Board of Dental Examiners.

(2) Podiatrists. An applicant for podiatric membership on the Medical Staff, except for the honorary, must hold a DPM degree and a valid and unsuspended certificate to practice podiatry issued by the Medical Board of California.

(3) Allied Health Professionals. An applicant for allied health practitioner membership on the Medical Staff, except for honorary staff, must hold a valid and

unsuspended certificate to practice issued by the appropriate licensing board of California.

(c) Pledge to provide continuous care to his or her patients.

Section 3.1. Additional Qualifications for Membership

In addition to meeting the basic standards, the practitioner must:

(a) Document his or her:

(1) Adequate education, training and experience in the requested privileges;

(2) Current professional competence;

(3) Good clinical judgment; and

(4) Adequate physical and mental health status to demonstrate to the satisfaction of the Medical Staff that he or she is professionally and ethically competent so that patients can reasonably expect to receive the generally recognized professional level of quality of care for this community.

(b) Be determined to:

(1) Adhere to the lawful ethics of his or her profession;

(2) Be able to work cooperatively with others in the hospital setting so as to not adversely affect patient care; and

(3) Be willing to participate in and properly discharge Medical Staff responsibilities.

Section 3.2. Basic Responsibilities of Medical Staff Membership

(a) Performing, if granted the requisite privileges, or arranging for the performance of, a history and physical on every patient he/she admits. As detailed in the Medical Staff Rules/Regulations, a medical history and physical examination shall be completed no more than 30 days before, or 24 hours after, admission or registration, but prior to surgery or a procedure requiring anesthesia services. When the medical history and physical examination is completed within 30 days before admission or registration, the physician must complete and document an updated examination of the patient within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The history and physical (including updated examinations and changes in the patient's condition) must be completed and documented by a physician, an oral maxillofacial surgeon, or other qualified licensed individual in accordance with state law and Hospital policy as further defined in the general rules and regulations.

Section 4. Terms of Appointment

Appointments and reappointments shall be made by the Board of Directors of the Hospital only after recommendations of the Medical Executive Committee. Initial appointments shall be for the period of two years from the date of approval by the Board of Directors.

Before the end of the appointment or reappointment term, the Medical Executive Committee shall submit to the Board of Directors, through the Chief Executive Officer, the recommendations for reappointment of members of the Medical Staff for a further period of two years, together with recommendations concerning the privileges to be accorded each member.

Appointments to the Medical Staff shall confer on the appointees only such privileges as may be provided in these Bylaws, Rules and Regulations of the Medical Staff. Applicants for membership shall be practicing within a reasonable distance of the Hospital and agree to accept staff committee assignments as well as provide emergency care and consultation for any patients admitted to the Hospital in accordance with said Rules and Regulations.

Section 5. Standards of Conduct

Non-discrimination. No person shall be denied Medical Staff membership or particular clinical privileges on the basis of sex, race, age, religion, color, or national origin, or any other criterion lacking professional justification.

Harassment by a Medical Staff member against any individual (e.g., against another Medical Staff member, hospital employee 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, or posters).

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 which indicates that employment and/or employment benefits are conditioned upon acquiescence in sexual activities.

All allegations of sexual harassment shall be immediately investigated by the Medical Staff and, if confirmed, will result in appropriate corrective action, from reprimands up to and including termination of Medical Staff privileges or membership, if warranted by the facts.

It is the policy of the Medical Staff that all patients, their families, employees, volunteers, visitors, and members of the Medical Staff and Allied Health Professional Staff shall be treated courteously, respectfully, and with dignity. Discrimination or harassment because sex, race, color

ancestry, religious creed, national origin, physical disability (including HIV and AIDS), mental disability, medical condition, age, sexual orientation, or marital status is prohibited by Federal and/or State law, as well as by the Medical Staff and Hospital. Similarly prohibited is outrageous conduct, which includes all behavior that goes beyond the bounds of decency in a civilized society.

For the purposes of this policy, "sexual harassment" is unwelcome or unwanted advances, requests for sexual favors and any other verbal, visual, or physical conduct of 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 an individual's employment or creates an intimidating, hostile or offensive work environment. Violations regarding discrimination or harassment are grounds for corrective action in accordance with the Medical Staff Bylaws. No corrective action may be taken in contravention of the provisions of the Medical Staff Bylaws, nor may the proceedings or records of such corrective action be disclosed except as permitted under the Medical Staff Bylaws or required by law.

5.1 Reporting

Complaints involving discrimination or harassment where the person who is the alleged harasser is a member of the Medical Staff or the Allied Health Professional Staff, by whoever received shall be referred immediately to the Chief of Staff. All such complaints shall be investigated and addressed as set forth in this policy. Nothing in this policy would preclude the Chief of Staff and/or Chief Executive Officer from attempting to informally resolve complaints of discrimination or harassment, made by patients or other individuals, before initiating the Hospital Investigative Procedures or a Medical Staff Corrective Action Investigation. Requests by a reporting party that nothing be done about the event, and that it is for "information only" will not be granted.

Complaints involving discrimination or harassment, where the person who is the alleged harasser is a Hospital employee, by whomever received, should be referred immediately to the Vice President of Human Resources and will be investigated and addressed in accordance with Hospital policies, except that if the complainant is a member of the Medical Staff or Allied Health Professional Staff, the Chief of Staff or designee shall be kept apprised of the status of the investigation.

5.2 Initial Review Mutually Acceptable Resolution

An initial review of each discrimination or harassment complaint made by a patient will be made by the Chief of Staff or his designee. All patient complaints will be investigated in accordance with the Medical Staff Bylaws.

An initial review of all other discrimination or harassment complaints will be made by the Vice President of Human Resources or his designee. If any of these individuals is the alleged harasser, the Chief Executive Officer will appoint another individual to conduct the review. The Chief of Staff or designee shall be kept apprised of the status of the initial review.

The initial review of non-patient complaints shall consist of interviewing the parties involved in the dispute. The individual who has made the complaint will be assured that confidentiality will be maintained to the extent permitted by law and that no retaliation will be permitted. However, the complainant shall be told that the complaint will have to be shared with the physician or Allied Health Professional who is alleged to have engaged in the inappropriate conduct.

The physician or Allied Health Professional who is accused of discrimination or harassment will be advised of the Hospital's and Medical Staff's strict policy against discrimination or harassment, and informed that the Hospital will not tolerate any retaliation against or intimidation of any individual who has registered a discrimination or harassment complaint or who has cooperated in connection with the investigation, and that any violation of this policy will be considered an independent cause for discipline, regardless of the merits of the underlying discrimination or harassment charge.

The individual registering the complaint will be informed: that he should contact the Vice President of Human Resources immediately if he believes that any further violation of the policy against discrimination or harassment has occurred, or if retaliation occurs.

The purpose of the interview with the complainant and the person, who is the alleged harasser, is to determine whether the problem can be appropriately resolved to the satisfaction of both individuals without further investigation. If the parties can agree to a mutually acceptable resolution the investigation can stop at this point. On the other hand, if the parties cannot agree to a mutually acceptable resolution, or if the Vice President of Human Resources does not believe that resolution is appropriate then the problem should be resolved in accordance with Informal Investigative Procedures set forth in Section 3.

If the investigation stops at this point, the Chief of Staff and Chief Executive Officer should be informed of the resolution of the dispute. A written summary of the resolution of the dispute shall be prepared by the Vice President of Human Resources. This written summary should be limited to a brief factual statement setting forth the resolution of the problem. The written summary, plus all interview notes, shall be maintained in the Medical Staff Office. Although there may exist circumstances that allow this written summary and interview notes to be privileged under Evidence Code Section 1157, such writings may not be protected under this Evidence Code, and such writings should therefore be prepared with care.

Whenever feasible the Initial Review should be completed within four (4) business days (excluding weekends and holidays) after receipt of complaint. In any event, the Initial Review should be completed as soon as reasonably possible.

In all cases where the Initial Review appears to have resolved the issue, the Chief of Staff shall, at his discretion, monitor the situation for an appropriate period to ensure continued resolution. The form of such monitoring will be as the Vice President of Human Resources determines the most effective and may include follow-up interview if appropriate. Any recurrence will be immediately reported to the Medical Executive Committee and referred for formal investigation.

## 5.3 Informal Investigative Procedures

When a non-patient harassment or discrimination complaint cannot be resolved to the mutual satisfaction of the parties the matter should be investigated by a Hospital Investigating Committee. The Hospital Investigating Committee shall consist of the Vice President of Human Resources or designee, two other individuals designated by the Chief Executive Officer, and four Medical Staff members appointed by the Chief of Staff. One of the Medical Staff members appointed shall serve as the chairman of the Hospital Investigating Committee. The chairman is entitled to vote upon any issue before the Hospital Investigating Committee. If the complainant is a hospital employee, then the Chief Executive Officer shall appoint a hospital employee to the Hospital Investigating Committee. When the complaint involves a hospital employee, the Vice President of Human Resources may be required to conduct a parallel investigation. The Hospital Investigating Committee shall include at least one member of each gender. If the Vice President of Human Resources is unavailable, or is the subject of the complaint, the Chief Executive Officer will appoint another individual to the Hospital Investigating Committee for purposes of addressing that specific complaint. If the Chief of Staff is unavailable, or is the subject of the complaint, the Deputy Chief of Staff will appoint another individual to the Hospital Investigating Committee for the purposes of addressing that specific complaint.

The initial review shall consist of interviewing separately each party involved, including witnesses. The interviews shall begin with introductions and an explanation/overview of the mediation and corrective action procedures and goals. The importance of maintaining confidentiality of the information exchanged during the discussions shall be emphasized. The individual who has made the complaint will be assured that, in any event, confidentiality will be maintained to the extent possible and that no retaliation will be permitted against the complainant. The complainant will also be told that the complaint will be shared with the member of the Medical Staff or Allied Health Professional who is alleged to have engaged in the inappropriate conduct.

The member of the Medical Staff or Allied Health Professional who is accused of discrimination or harassment will be reminded of the Hospital's and Medical Staff's strict policy against discrimination or harassment, and informed that the Hospital and Medical Staff will not tolerate any retaliation against or intimidation of any individual who has registered a discrimination or harassment complaint or who has cooperated in connection with the Hospital's and Medical Staff's investigation. The person who is the subject of the complaint shall also be informed that any violation will be considered an independent cause of discipline, regardless of the merits of the underlying discrimination or harassment charge.

The individual registering the complaint will be informed that he or she should contact the Chairman of the Hospital Investigating Committee immediately if he believes that any further violation against discrimination or harassment has occurred, or any retaliation has occurred.

Written documentation of the investigation and any resulting recommendation will be maintained throughout the process. The Hospital Investigating Committee shall have access to the notes and written summaries compiled during the initial Review.

The investigation shall consist initially of a private interview of the complainant with the Hospital Investigating Committee. Whenever feasible this interview should occur within four (4) working days after the appointment of the Hospital Investigating Committee to learn the factual allegations, to determine whether there are any witnesses and to assess what kind of remedial action the complainant is requesting. In any event this interview should be completed as soon as reasonably possible.

The Hospital Investigating Committee should interview any individuals who may have information pertinent to the matter being investigated. The physician or the Allied Health Professional who is the subject of the investigation may be interviewed to obtain his account of events. The physician or Allied Health Professional may not be required to attend an interview; however the investigation will proceed notwithstanding the refusal to be interviewed.

Once the investigation is completed, the Hospital Investigating Committee will present its findings and recommendations in writing to the Chief of Staff and the Chief Executive Officer. Any decision of the Hospital Investigating Committee shall be based on a majority vote. The Hospital Investigating Committee may make a determination that no inappropriate conduct occurred and that no further action is required. The Hospital Investigating Committee may make a determination that inappropriate conduct occurred, but that the parties have agreed to a mutual resolution of the problem including certain remedial actions. (Recommended remedial measures could include, but not be limited to, written admonition, letter of education, censure, reprimand or warning; written, private or public apology; agreed upon remedial actions. Any written warning will describe the unacceptable conduct and specify the improvement and actions (e.g., attendance at a sensitivity training seminar) needed, as well as the consequences for further problem behavior.) This recommendation will be sent to the Chief Executive Officer of the Hospital and the Chief of the Medical Staff.

Alternatively, the Hospital Investigating Committee may make a determination that inappropriate conduct occurred but that the parties could not reach a mutually acceptable resolution to the problem. In that case, the Chief Executive Officer should refer the written findings and recommendations of the Hospital Investigating Committee to the Medical Executive Committee. The Medical Executive Committee shall determine what, if any, remedial actions should be taken. Although there may exist circumstances that allow this written summary and interview notes to be privileged under Evidence Code section 1157, such writings may not be protected under this Evidence Code, and such writings should therefore be prepared with care. Any such remedial action shall be reported to the Hospital's Board of Directors.

The person filing the complaint and the physician or Allied Health Professional against whom the complaint was filed will be informed of the findings and recommendations of the Hospital Investigating Committee.

In all cases where the informal investigation appears to have resolved the issue, the Chief of Staff shall monitor the situation for an appropriate period to ensure continued resolution. The form of such monitoring will be that which the Hospital Investigating Committee determines will be most effective and may include follow-up interviews if appropriate. Any alleged recurrence of harassment will be immediately referred to the Medical Executive Committee for possible corrective action.

Whenever feasible, the informal investigative process outlined in this section should be completed within ten (10) to fifteen (15) working days, except for follow-up activities and monitoring, which shall continue as long as is deemed necessary by the Hospital Investigating Committee. In any event the informal investigative process should be completed as soon as reasonably possible.

A hospital employee who makes false allegations of discrimination or harassment against a member of the Medical Staff or Allied Health Professional shall be subject to discipline, including the possibility of termination. A Medical Staff member or Allied Health Professional who makes false allegations of discrimination or harassment against another member of the Medical Staff or Allied Health Professional or against a hospital employee shall be subject to discipline, including the possibility of Medical Staff membership termination, in accordance with the Medical Staff Bylaws.

Even where the dispute appears to have been fully resolved by the informal investigation, the Medical Staff shall be free to continue to investigate and/or to take any further corrective action which it may deem appropriate.

5.4 Formal Corrective Action

All complaints involving patients will be investigated in accordance with the Medical Staff Bylaws.

Where the dispute has not been resolved via the initial review or informal investigation process set forth above, or if there is recurrence of a dispute that was earlier deemed to be resolved, the Hospital Investigating Committee will present a report in writing on the investigative efforts and the Committee's current findings and recommendations to the Chief Executive Officer of the Hospital and the Medical Executive Committee. In that case, the Medical Executive Committee shall determine what, if any, remedial actions should be taken.

Appropriate remedial actions may range from letters of admonition, censure, reprimand or warning; imposition of terms of probation or special limitations upon continued Medical Staff membership; written, private or public apology; and medical/psychiatric evaluation by a professional of Medical Executive Committee's choice; to restriction, suspension or revocation of Medical Staff or Allied Health Professional membership.

In the event that it is determined that the conduct was so serious that it warrants placing formal restrictions upon staff membership or privileges, such as would provide grounds for a hearing under Medical Staff Bylaws, the Medical Executive Committee shall follow the procedures outlined in Article V, Corrective Action, of the Medical Staff Bylaws when the alleged harasser is a Medical Staff member. In that event, the investigation/mediation conducted by the Hospital Investigating Committee, as set forth above, may substitute for the investigative process set forth in Article V, Section 1, unless the Medical Executive Committee determines that additional investigation is required. When the conduct involves a member of the Allied Health Professional Staff the procedures set forth in Article V, Section 1 of the Medical Staff Bylaws shall be followed, except that the investigation/mediation of the Hospital Investigating Committee may

substitute for any required initial investigation, unless it is determined that additional investigation is required.

Except for the final decision, all documents created as part of the formal corrective action investigation, as well as any subsequent appeal shall be considered the proceedings and records of a Medical Staff committee and they will be immune from discovery under Section 1157 of the Evidence Code.

Any formal corrective action taken shall be reported to the Hospital's Board of Directors, and when formal corrective action has been pursued, the person filing the compliant and the member of the Medical Staff or Allied Health Professional against whom the complaint was brought will be informed of the final decision of the Hospital's Board of Directors.

Section 6. Dues

Dues shall be determined annually by the Medical Executive Committee and paid by the Active, Associate, Courtesy, Consulting, Provisional, or Provisional-C Staff, Allied Health Professionals and General Dentist members. If dues are unpaid by April 1, membership shall automatically terminate, but will be reinstated on payment of dues before December 31, of that year.

Practitioners approved for a leave of absence for education and/or training purposes will be excluded from paying annual dues until their return. These practitioners will pay annual dues for year of return. There will be no refund for dues already paid.

Section 7. Release of Information

All applicants, as well as members of the Medical Staff, consent to the release of information for any purpose set forth in these Bylaws and release from liability and agree to hold harmless any person or entity furnishing or releasing such information concerning his application or Medical Staff status.

Section 8. Administrative Agreements

A medico-administrative physician, surgeon, dentist or podiatrist must be a member of the Medical Staff. His clinical privileges must be delineated in accordance with these Bylaws. Neither the Medical Staff membership nor the clinical privileges of Medico-Administrative Medical Staff member or his practitioner associates shall be terminated without the same hearing and appellate review opportunities as are provided for other Medical Staff members, unless otherwise provided in the agreement between the Hospital and such Medical Staff member. A physician, surgeon, dentist or podiatrist employed by the Hospital in a purely administrative capacity with no clinical duties or privileges is subject to the regular personnel policies of the Hospital and to the terms of his contract or other conditions of employment and shall not be a Medical Staff member.

Section 9. Disaster Privileges

Physicians, dentists, podiatrists and allied health professionals who do not possess Medical Staff membership and clinical privileges or task authorizations at the Hospital, but are licensed to

practice in California or in other States, may be allowed to work at the Hospital during a disaster situation.

The Chief Executive Officer of the Hospital (or designee) with the concurrence of the Chief of Staff of the Medical Staff (or designee) shall initiate disaster privileging procedures when the emergency management plan has been activated and Hospital organization is unable to meet immediate patient needs.

(a) A physician, dentist, podiatrist or allied health professional may present to the Hospital and request disaster privileges.

(b) The volunteer practitioner will be directed to the Medical Staff Office to process disaster privileges or disaster authorizations. A request for Temporary Disaster Privileges or Temporary Disaster Authorization and a Consent, Acknowledgment and Release of Information Form must be completed. A copy of the Medical Staff Bylaws, Rules and Regulations shall be made available to the volunteer practitioner.

(c) The volunteer practitioner must present a valid photo I.D. issued by a state, federal or regulatory agency and at least one of the following:

(1) A current picture hospital I.D. card clearly identifying professional designation;

(2) A current license to practice medicine and primary source verification of the license; or

(3) Identification that indicates that the volunteer practitioner is a member of a Disaster Medical Assistance Team ("DMAT"), or Medical Reserve Corps ("MRC"), Emergency System for Advance Registration of Volunteer Health Professional ("ESAR-VHP"), or other recognized state or federal organizations or groups.

(4) Evidence of current professional liability insurance coverage in not less than the minimum amounts as required by law.

(5) Documented confirmation from a current Medical Staff member with personal knowledge regarding the volunteer practitioner's ability to act as a qualified practitioner during a disaster.

(d) The Hospital representative will record the request for disaster privileges or disaster authorization, the key identification document provided, name of current hospital affiliations, and the name of the professional liability carrier.

(e) If possible, copies should be made of the license and photo identification.

(f) Current professional licensure of volunteer practitioners providing care under disaster authorizations is verified from the primary source as soon as the immediate emergency situation is under control or within 72 hours from the time the volunteer physician, dentist, podiatrist or allied health professional presents himself or herself to the Hospital, whichever

comes first. Inquiries shall be made to the National Practitioner Data Bank ("NPDB") and the Office of Inspector General ("OIG") as soon as technologically feasible. If primary source verification cannot be completed within 72 hours of the volunteer practitioner's arrival due to extraordinary circumstances, the Hospital representative shall document all of the following:

(1) The reason(s) verification could not be performed within 72 hours of the volunteer practitioner's arrival;

(2) Evidence of the volunteer practitioner's demonstrated ability to continue to provide adequate care, treatment and services; and

(3) Evidence of an attempt to perform primary source verification as soon as possible.

(g) An on-site responsible person, in accordance with the Hospital's emergency management plan, shall interview the volunteer practitioner to determine the appropriate scope of assigned responsibilities.

(h) With approval of the Chief Executive Officer (or designee) and Chief of the Medical Staff or department chair (or their designees), temporary disaster privileges or disaster authorizations may be granted.

(i) Approval shall be noted in writing that the volunteer practitioner has been granted disaster privileges or disaster authorization for a period of time not to exceed 72 hours. Such approval may be renewed if necessary.

(j) The volunteer practitioner shall be issued a temporary identification badge indicating his/her name, status as an approved volunteer, and notation of his/her partner, as described in Section 9.1 below.

(k) Disaster privileges may be terminated at any time, with or without cause or reason by the Chief of the Medical Staff, department chair, the Chief Executive Officer, or their designees. Any such termination shall not give rise to any rights of review, hearing, appeal or other grievance mechanism.

9.1 Supervision

Members of the Medical Staff shall oversee those granted disaster privileges. An allied health practitioner affiliated with the Hospital may oversee a similarly licensed allied health practitioner who has been granted a disaster authorization. The volunteer practitioner shall be partnered with a member of similar specialty. The partnering information shall be recorded with all other information regarding the volunteer practitioner.

## ARTICLE III: APPOINTMENT AND REAPPOINTMENT

General

Except as otherwise specified herein, no person (including persons engaged by the Hospital in administratively responsible positions) shall exercise clinical privileges in the Hospital unless and until that person applies for and receives appointment to the Medical Staff as set forth in these Bylaws, or, with respect to allied health practitioners, has been granted a service authorization or privileges under applicable Medical Staff policies. By applying to the Medical Staff for appointment or reappointment, the applicant acknowledges responsibility to first review these Bylaws and General Medical Staff Rules and Regulations and policies, and agrees that throughout any period of membership that person will comply with the responsibilities of Medical Staff as they exist and as they may be modified from time to time. Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted in accordance with these Bylaws.

Section 1. Appointment

(a) General

Every application for staff appointment shall be signed by the applicant and shall contain the applicant's specific acknowledgment to provide continuous care and supervision of his patients, to abide by the Hospital Bylaws, and the Medical Staff Bylaws and Rules and Regulations.

(b) Burden of Producing Information

The applicant shall have the burden of producing adequate information for proper evaluation of his competence, character, ethics and qualifications and for resolution of any questions about such qualifications.

(c) Appointment Authority

Any physician, podiatrist or dentist in applying for membership, does thereby signify his willingness to appear before and be examined by the Executive Committee, and permit the Executive Committee to consult with any and all members of Medical Staffs of other hospitals with which applicant has been associated, concerning applicant's professional qualifications and competence as well as other persons or entities that may have information bearing on his competence or ethical qualifications, and further consents to the inspection of any and all records made at such hospitals or other entities which would be material to an evaluation of applicant's professional qualifications and competence to carry out the privileges he requests. The Chief Executive Officer or designee shall forward the application, information and references to the appropriate clinical department chairman. As indicated above, the applicant bears the burden of resolving any question regarding his competence or ethical qualifications to perform the medical and surgical privilege he seeks to perform.

The Credentials Committee shall investigate the character, professional competence, qualifications and ethical standing of the applicant and shall verify, through references given by the applicant and other sources available to it, that he meets all the necessary qualifications set

forth in Article II and III, Section 1, of these Bylaws. The clinical department chairman shall review all information available on the application regarding documentation of current competence and the privileges requested to determine his recommendation regarding delineation of privileges, as well as offering any pertinent information related to the applicant's qualifications for membership on the Medical Staff. Following evaluation by the clinical department chairman, the Credentials Committee shall report its findings and recommendations to the Medical Executive Committee.

(d) Duration of Appointment

Within three months after receipt of the completed application for membership, the Executive Committee shall make a written report of its investigation to the Board of Directors through the Chief of Staff recommending that the applicant be provisionally accepted, deferred or rejected.

Any recommendation for initial provisional appointment may include probationary conditions relating to privileges. When a recommendation is made to defer for further consideration or investigation, it must be followed up within three months by a recommendation to accept or reject the applicant. The Secretary of the Medical Staff shall notify the applicant by mail of any recommendation to reject or defer consideration of the applicant within ten days after such a decision is made. When a recommendation is made to defer for further consideration or investigation, the reasons for such recommendation shall be stated.

(e) Notice of Decision

The Board of Directors, at its next regular meeting after receipt of the final report and recommendations of the Medical Staff on any initial application for membership, shall consider same and take action on the application, stating the reasons therefore. The following procedure shall apply with respect to the Board of Directors' action on the application:

Favorable Recommendation. If the recommendation of the Medical Executive Committee is favorable and:

(1) The action of the Board of Directors is to concur in that recommendation, the decision of the Board of Directors shall be deemed the final action.

(2) The action of the Board of Directors does not concur in that recommendation, the Chief Executive officer shall give the applicant written notice of the action of the Board and the applicant shall be entitled to the procedural rights set for in Article VI. If the applicant waives his procedural rights, the action of the Board of Directors shall be final.

Unfavorable Recommendation. If the recommendation of the Medical Executive Committee is unfavorable to the applicant, the procedural rights set forth in Article VI shall apply, and:

(1) If the applicant waives his procedural rights, the recommendations of the Executive Committee shall be forwarded to the Board of Directors for final action, which

shall affirm the recommendation of the Medical Executive Committee if the Medical Executive Committee's decision is supported by substantial evidence.

(2) If the applicant requests a hearing following the unfavorable Medical Executive Committee recommendation pursuant to Sections 4(a) and (b) of this Article, the Board of Directors shall take final action only after the applicant has exhausted his procedural rights as established by Article VI. In such a case, after exhaustion of the procedures set forth in Article VI, the Board of Directors shall make a final decision and shall affirm the decision of the Judicial Review Committee if the Judicial Review Committee's decision is supported by substantial evidence, following a fair procedure. The Board of Directors' decision shall be in writing and shall specify the reasons for the action taken.

When the Board of Directors has taken final action on any application for membership on the Medical Staff, the Board, acting through the Chief Executive Officer, shall notify the Secretary of the Medical Staff and the applicant of the action taken. If the applicant is provisionally accepted, the Chief Executive Officer shall secure his signed agreement to be governed by the Bylaws and Rules and Regulations.

(f) Reapplication after Adverse Appointment Decision

An applicant who has received a final adverse decision regarding appointment shall not be eligible to reapply to the Medical Staff for a period of two (2) years. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as may be required by the Medical Executive Committee to demonstrate that the basis for the earlier adverse action no longer exists.

Section 2. Reappointment

(a) General

Reappointments will be for a period up to two years. The Staff member shall submit an application for reappointment providing all information which the Executive Committee deems necessary to do a complete review of the applicant's eligibility for reappointment, including his health status and continuing medical education and must be in good standing.

Reapplication Process

At least ninety (90) days prior to the expiration of the current appointment or reappointment, the appropriate Medical Staff department chairman shall undertake the review of all information available on the members of the Medical Staff who are scheduled to be reappointed, for the purpose of determining justification for their reappointment to the Medical Staff for up to 2 years. Specific consideration shall be given to each member with respect to his professional competency and clinical judgment in the treatment of his patients, his ethics and conduct, his attendance at Medical Staff meetings and participation in Staff affairs, cooperation with Hospital authorities and personnel, use of the Hospital's facilities for his patients, and relationship with other staff members. The clinical department Chairman's recommendation shall be submitted to the Credentials Committee.

b) Notice of Decision

At least fifteen (15) days prior to the termination of the reappointment term, the Medical Executive Committee of the Medical Staff shall make its report to the Board of Directors recommending the reappointment or non-reappointment and privileges (including increase or curtailment) of each member of the Medical Staff for up to two years. Where non-reappointment or curtailment of privileges is recommended or a requested increase in privileges is not recommended, the reasons therefore shall be stated.

Thereafter, the procedure of the Board of Directors for reappointment or non-reappointment shall be the same as set forth in Article III, of these Bylaws and shall not be effective until such action is taken.

Section 3. Leave of Absence

General

At the discretion of the Medical Executive Committee, a Medical Staff member, who is in good standing and not on medical record suspension, may obtain a voluntary leave of absence from the staff upon submitting a written request to the Medical Executive Committee stating the approximate period of time desired, which may not exceed two (2) years except for medical leave of absence which may not exceed a period of two (2) years. During the period of leave, the member shall not exercise clinical privileges at the Hospital, and membership rights and responsibilities shall be inactive, but the obligation to pay dues shall continue. Staff members who are approved for a leave of absence for training and/or education and/or medical, will be excluded from paying dues until year of return.

Failure to request reinstatement by the leave of absence expiration date, will result in an automatic voluntary resignation from the Medical Staff.

3.1 Medical Leave of Absence

The Medical Executive Committee shall determine the circumstances under which a particular Medical Staff member shall be granted a leave of absence for the purpose of obtaining treatment for a medical condition or disability. At the discretion of the Medical Executive Committee, unless accompanies by a reportable restriction of privileges, the leave shall be deemed a "medical leave" which is not granted for a medical disciplinary cause or reason.

3.2 Military Leave of Absence

Requests for leave of absence to fulfill military service obligations shall be granted upon notice and review by the Medical Executive Committee. Reactivation of membership and clinical privileges previously held shall be granted, notwithstanding the provisions of Article III, Section 4, but may be granted subject to monitoring and/or proctoring as determined by the Medical Executive Committee.

3.3 Educational/Training Leave of Absence

Requests for leave of absence for further medical education or training shall be granted upon notice and review by the Medical Executive Committee. The Medical Executive Committee shall make a recommendation concerning the reinstatement of the member's privileges upon a written request by the member. Member approved for this leave of absence for training and/or education, will be excluded from paying dues until year of return.

3.4 Termination of Leave of Absence

At least 30 days prior to the termination of the leave of absence, or at any earlier time, the Medical Staff member may request reinstatement of privileges by submitting a written notice to that effect to the Medical Executive Committee. The Medical Executive Committee shall make a recommendation concerning the reinstatement of the member's privileges prerogatives, and the procedure provided in Section III, Appointment and Reappointment.

Section 4. Temporary Privileges.

4.1 Circumstances

Upon conference with the Chief of Staff, or in his absence the Deputy Chief of Staff or his designate, the Chief Executive Officer or his designate may grant temporary privileges in the following circumstances:

(a) Pendency of Application for permanent Medical Staff membership. After receipt of an application for staff appointment, including a request for specific temporary privileges, an appropriately licensed applicant, may be granted temporary privileges only upon the Medical Executive Committee's recommendation to the Board of Directors to approve the complete application for permanent Medical Staff membership of the applicant. In exercising such privileges, the applicant shall act under the supervision of the department chairman to which the applicant is assigned and in accordance with the conditions specified in Article IV, Section 2. Proctoring of such practitioner shall be instituted by such department chairman.

(b) Care of Specific Patients. Upon receipt of a written request for specific temporary consulting privileges, an appropriately licensed practitioner of documented competence who is not an applicant for Staff membership may be granted temporary privileges for the care of specific patients. Said practitioner cannot be the primary attending physician for these patients. Such privileges shall be restricted to the treatment of not more than four (4) patients in any one (1) year. Said practitioner shall be required to apply for membership to the Medical Staff before being allowed to attend additional patients. Such practitioner shall not be entitled to admit patients to the Hospital, and shall be required to have concurrent proctoring at the discretion of the Chairman of the Department in which the practitioner is practicing.

(c) Locum tenens. Upon receipt of a written request and letter of sponsorship for specific locum tenens privileges from the member of Staff who is requesting a practitioner to cover for him, an appropriately licensed practitioner of documented competence who has successfully completed a residency training program approved by ACGME in his specialty or a completed fellowship in his specialty when applicable, may, without applying for membership

on the Medical Staff, be granted those temporary privileges for no more than 30 consecutive days and no more than 60 aggregate days per calendar year, or said practitioner shall be required to apply for membership to the Medical Staff. Such privileges shall be limited to treatment of the patients in the specialty of the practitioner for whom he is serving as locum tenens. Proctoring of such practitioner shall be at the direction of the chairman of the department in which the practitioner is practicing.

4.2 Conditions.

Temporary privileges shall be granted only when the information available reasonably supports a favorable determination regarding the requesting practitioner's qualifications, ability, judgment, and current competence to exercise the privileges requested. Granting of temporary privileges shall in no way confer or infer the granting of permanent privileges or appointment to the Medical Staff as provided under these Bylaws. Special requirements of supervision and reporting maybe imposed by the departmental chairman concerned with any practitioner granted temporary privileges. Temporary privileges shall be immediately terminated by the Chief Executive Officer, Chief of Staff, Deputy Chief of Staff, or their designees, upon notice of any failure by the practitioner to comply with such special conditions.

Section 5. Emergency Privileges

In the case of emergency, any physician, podiatrist, or dentist member of the Medical Staff, to the degree permitted by his license and regardless of service or Staff status or lack of it, shall be permitted and assisted to do everything possible to save the life or limb of a patient, using every facility of the Hospital necessary, including the calling for any consultation necessary or desirable. When an emergency situation no longer exits, such physician, podiatrist, or dentist must request the privileges necessary to continue to treat the patient. 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. For the purpose of this section, an "emergency" is defined as a condition in which without immediate attention, serious permanent harm or aggravation of injury or disease is likely to result to a patient, or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

In the case of emergency, the Medical Executive Committee elects to delegate the authority to the Chief of Staff or his designee and to the Chief Executive Officer of the Hospital or his designee to render initial appointment, reappointment, and renewal or modification of clinical privileges decisions under the governing body/Board of Directors.

Section 6. Leave of Absence and Reappointment

Any member of the Medical Staff may request, in writing, a leave of absence for a period not to exceed two (2) years and such request may be recommended by the Medical Executive Committee to the Board of Directors.

During a leave of absence, the Staff member shall pay Medical Staff dues, but his privileges and other responsibilities shall be suspended during that period.

Such member may apply for reappointment and be considered in a manner similar to an annual reappointment upon the submission of a written report or other documentation of his professional or other activities during his absence.

## ARTICLE IV: CATEGORIES OF THE MEDICAL STAFF

Section 1. The Medical Staff

The Medical Staff shall be divided into the categories of Provisional, Associate, Active, Courtesy, Consulting, and Honorary. On its own, upon recommendation of the Credentials Committee, or pursuant to a request by a member under Article III, Section 5, or upon direction of the Board of Directors as set forth in Article V, the Executive Committee may recommend a change in the Medical Staff category of a member consistent with the requirements of the Bylaws.

Section 2. The Provisional Medical Staff

(a) Composition. The Provisional Medical Staff shall consist of practitioners who have been accepted for membership and who have not yet fulfilled all the requirements for Associate, Courtesy, or Consulting membership. After at least six (6) consecutive months of membership on the Provisional Staff, the Staff member may request to be referred to the Credentials Committee for review for advancement to another Staff category. If the member does not qualify for advancement, he or she will be notified of the deficiencies delaying his or her advancement.

Membership in the Provisional Staff shall be limited to two (2) years; thereafter, members shall qualify to be advanced to another category or may be removed from the Medical Staff in accordance with Article VI, "Hearing and Appeal Procedures", unless said advancement is tabled by the Medical Executive Committee for reasons of good cause, as in the case of an extended illness.

(b) Duties and Privileges. The members of the Provisional Staff are not eligible to vote for election of officers or amendments to the Bylaws or hold office, but may serve upon committees. They shall be entitled to attend meetings of the Medical Staff and department of which that person is a member, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment.

(c) Dues. The members of the Provisional Staff shall pay dues as determined by the Medical Executive Committee.

Section 3. The Courtesy Medical Staff

(a) Composition. The Courtesy Medical Staff shall consist of practitioners who have served at least six (6) consecutive months on the Provisional Staff.

Courtesy Staff members have a minimum of six (6) and maximum of forty-eight (48) patient contacts in the Hospital during the most recent two-year reappointment period.

Courtesy staff members who provide professional services (as defined in the General Rules and Regulations) for more than forty-eight (48) patients in the Hospital during the most recent two-year reappointment period may, at the time of their reappointment to the Medical Staff and upon review of the Medical Executive Committee, be considered for appointment to the appropriate staff category.

Courtesy Staff members shall be expected to be members in good standing of the Active or Associate Medical Staff of another hospital licensed in the state of California and accredited by the Joint Commission on Accreditation of Health care Organizations, except that this requirement shall not preclude an otherwise qualified out of state practitioner from appointment within the limitations of California Business and Professions Code Section 2060.

(b) Duties and Privileges. Members of the Courtesy Staff are not eligible to vote for election of officers or amendments to the Bylaws or hold office. Courtesy Staff members shall have accepted and fulfilled committee assignments as may be required by these Bylaws or the Medical Executive Committee. They shall be entitled to attend meetings of the Medical Staff and department of which that person is a member, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment.

(c) Dues. The members of the Courtesy Staff shall pay dues as determined by the Executive Committee.

Section 4. The Associate Medical Staff

(a) Composition. The Associate Medical Staff shall consist of practitioners who are being considered for advancement to the Active Medical Staff. Members of the Medical Staff become eligible for this category after serving at least six (6) consecutive months on the Provisional Staff.

Associate Staff members are expected to provide professional services for at least twenty-four (24) patients in the Hospital during each two (2) year reappointment period. At the time of his or her reappointment to the Medical Staff, a member of the Associate Staff who did not provide professional services for at least twenty-four (24) patients in the Hospital during the current reappointment period, shall seek appointment to the appropriate category for which the member is qualified.

(b) Duties and Privileges. Members of the Associate Staff are not eligible to vote for election of officers and amendments to the Bylaws or hold office. Associate Staff members are required to accept and fulfill committee assignments as may be required by these Bylaws or the Medical Executive Committee. They shall be entitled to attend meetings of the Medical Staff and department of which that person is a member, including open committee meetings and educational programs, but shall have no right to vote, except at meetings of the member's department, and within committees when the right to vote is specified at the time of appointment. Failure to meet these requirements may result in a transfer to the appropriate category at the discretion of the Medical Executive Committee.

(c) Dues. Members of the Associate Staff shall pay dues as determined by the Executive Committee.

Section 5. Active Medical Staff

(a) Composition. The Active Medical Staff shall consist of practitioners who have served at least six (6) consecutive months on the Provisional Staff and two (2) years on the Associate Medical Staff.

(b) Duties and Privileges. Only members of the Active Medical Staff shall be eligible to vote and hold office and shall be requested to conduct the business of the Medical Staff. Members of the Active Medical Staff are required to accept and fulfill committee assignments to the satisfaction of the Medical Executive Committee. Failure to meet these requirements may result in reduction to Associate Staff membership at the discretion of the Medical Executive Committee.

Membership on the Active Medical Staff will be extended to Associate Medical Staff members upon fulfilling the following requirements:

(1) The member submits a written application to the Executive Committee of the Medical Staff.

(2) The member has served on the Associate Medical Staff for two (2) years and has participated in Staff activities and has accepted and fulfilled committee assignments to the satisfaction of the Medical Executive Committee.

(3) The member has attended at least two (2) of four (4) General Medical Staff meetings held, and at least three (3) of six (6) of his or her Department meetings held per annum. Subcommittee and peer review meetings held for his or her department may be counted towards the requisite number of Department meetings.

(4) The member has regularly admitted patients to, or has otherwise been regularly involved in the care of patients in the Hospital.

(5) Actively participate as requested by Chair of Department in at least one (1) Medical Staff committee or subcommittee for the performance functions, quality assurance, quality improvement activities, supervision of provisional appointees, evaluation and monitoring of Medical Staff members, or discharging other Medical Staff functions. This participation is duty derived from the privilege of Active Staff membership.

(c) Dues. Members of the Active Staff shall pay dues as determined by the Medical Executive Committee.

Section 6. The Consulting Medical Staff

(a) Composition. The Consulting Medical Staff shall consist of practitioners in the various specialized fields of medical practice and of recognized professional ability who are

active in the Hospital or who have signified willingness to accept such appointment, and who have served on the Provisional Staff for a period of at least six (6) months.

Consulting staff members have a minimum of six (6) patient contacts in the hospital during the most recent two-year reappointment period.

(b) Duties and Privileges. The members of the Consulting Medical Staff shall have the obligation of providing consultation in those cases where consultation is required by the Rules and Regulations of the Medical Staff and where such consultation is requested by a member of the Medical Staff. Consulting Staff members shall be qualified and have been granted privileges to provide consultations in their specialty. Consulting Staff members may not admit, are not eligible to vote for election of officers and amendments to the Bylaws, Rules and Regulations or hold office.

(c) Dues. Members of the Consulting Staff shall pay dues as determined by the Executive Committee.

Section 7. The Honorary Medical Staff

(a) Composition. The Honorary Medical Staff shall consist of practitioners who are not active in the Hospital and who are honored by emeritus positions. These may be:

(1) Practitioners who have retired from active hospital services;

(2) Practitioners of outstanding reputation not necessarily residents in the community.

Honorary Staff members need not have served as Provisional or Provisional-C Staff members.

(b) Duties and Privileges. Honorary Medical Staff members are not eligible to vote or hold office, and do not admit or care for patients and shall have no assigned duties.

(c) Dues. Honorary Medical Staff members do not pay dues.

(d) Application. Application shall consist of a signed curriculum vitae.

## ARTICLE V: CORRECTIVE ACTION

Section 1. Routine Corrective Action

(a) Criteria for Initiation. Whenever the activities or professional conduct of any practitioner with clinical privileges are below the standards of the Medical Staff, detrimental to patient safety or to the delivery of quality patient care, or are disruptive to Hospital operations, corrective action against such practitioner may be initiated by any officer of the Medical Staff, by any department chief, by the chairman of any standing committee of the Medical Staff, by the Chief Executive Officer, or by the Board of Directors.

(b) Requests and Notices. All requests for corrective action shall be in writing, be submitted to the Medical Executive Committee, and be supported by reference to the specific activities or conduct which constitute the grounds for the request. The Chairman of the Medical Executive Committee shall promptly notify the Chief Executive Officer in writing of all requests for corrective action received by the Committee and shall continue to keep the Chief Executive Officer fully informed of all action taken in conjunction therewith.

(c) Investigation by Clinical Department. The Medical Executive Committee shall forward the request for corrective action to the chairman of the department in which the questioned activities or conduct occurred. The chairman of such department shall immediately investigate the matter. Within sixty (60) days after the receipt of the request, the chairman of the department shall forward a written report of the investigation to the Medical Executive Committee.

Prior to the making of such report, the practitioner against whom corrective action has been requested may request an interview by the department. He shall be informed of the general nature of the charges against him and shall be invited to discuss, explain or refute them. No such investigative process shall be deemed to be a "hearing" as that term is used in Article VI.

(d) Preliminary Appearance Before Executive Committee. Within ten (10) days following a report from a department which results in a request for corrective action involving any of the actions set forth in Article VI, Section 1. (a), (1), (2), (3), (4), (5), (6), (7), (8), (9), (10) or (11), the Medical Executive Committee may conduct an interview of the affected practitioner prior to its taking action on such request. Neither this appearance nor the appearance before the department shall constitute hearings; they shall be preliminary in nature and none of the procedural rules provided in these Bylaws with respect to hearings shall apply thereto. The Medical Executive Committee and the department shall be responsible for recording minutes of the interviews.

(e) Medical Executive Committee Action. With sixty (60) days following receipt of the report of the department, the Medical Executive Committee shall take action upon the request. Such action may include, without limitation;

(1) Rejecting the request for corrective action.

(2) Issuing a warning, a letter of admonition, or a letter of reprimand.

(3) Recommending any of the actions set forth in Article VI, Section 1. (a), (1), (2), (3), (4), (5), (6), (7), (8), (9), (10) or (11).

(f) Procedural Rights. Any action of the Medical Executive Committee provided in Section 1. (e) (3) of this Article shall entitle the practitioner to the procedural rights as provided in Article VI. In such cases, the Chief of Staff shall give the practitioner written notice of the adverse recommendation and of his right to request a hearing in the manner specified in Article VI.

(g) Other Action.

(1) If the Medical Executive Committee's recommended action is as provided in Section 1. (e), (1) or (2), of this Article, such recommendation, together with all supporting documentation, shall be transmitted to the Board of Directors.

(2) So long as the recommendation as provided in Section 1. (e), (1) or (2) of this Article is supported by substantial evidence, the recommendation of the Medical Executive Committee shall be adopted by the Board of Directors as final action. If the member requests a hearing, the final decision shall be determined as set forth in Article VI.

(h) Initiation by Board of Directors. Should the Board of Directors determine that the Medical Executive Committee's failure to investigate, or initiate disciplinary action, is contrary to the weight of the evidence, the Board of Directors may direct the Medical Executive Committee to initiate an investigation or disciplinary action, but only after consultation with the Medical Executive Committee. In the event the Executive Committee fails to take action in response to a direction from the Board of Directors, the Board of Directors, after notifying the Medical Executive Committee in writing, may take action on its own initiative.

If such action is one of those set forth in Article VI, the Board of Directors shall give the practitioner written notice of the adverse recommendation and his right to request a hearing in the manner specified in Article VI.

Section 2. Summary Suspension

(a) Criteria and Initiation. The Chief of Staff or the Medical Executive Committee shall have the authority to summarily suspend the Medical Staff membership status or all or any portion of the clinical privileges of a practitioner. When no person authorized by the Medical Staff is available to summarily suspend or restrict clinical privileges, the Board of Directors or the Chief Executive Officer may immediately suspend a practitioner's clinical privileges; provided however that the Board of Directors or Chief Executive Officer made reasonable attempts to contact the Executive Committee. A suspension by the Board of Directors or Chief Executive Officer which has not been ratified by the Medical Executive Committee within two (2) working days, excluding weekends and holidays, after the suspension, shall automatically terminate. Such a suspension may only be imposed when a practitioner willfully disregards these Bylaws or other Hospital policies, or whenever his conduct requires that immediate action be taken to protect the life of any patient(s) or to reduce the substantial likelihood of immediate injury or the damage to the health or safety of any patient presently in the Hospital or likely to be admitted, or an employee or other person present in the Hospital. Such a summary suspension shall become effective immediately upon imposition. Thereafter, the Chief Executive Officer shall, on behalf of the imposer of such suspension, promptly give special notice thereof to the practitioner, Board of Directors, and Executive Committee.

(b) Medical Executive Committee Action. Within ten (10) days after such summary suspension, a meeting of the Medical Executive Committee shall be convened to review and consider the action taken. The Medical Executive Committee may recommend modification, continuation, or termination of the terms of the summary suspension and any further or additional corrective action, and it shall give the practitioner written notice of its decision. This

shall not constitute a hearing under Article VI and the provisions of said Article shall not apply to this Medical Executive Committee meeting.

(c) Procedural Rights. Unless the Medical Executive Committee recommends immediate termination to the suspension and cessation of all further corrective action, the practitioner shall be entitled to the procedural rights provided in Article VI. The terms of the summary suspension as sustained or as modified by the Medical Executive Committee shall remain in effect pending a final decision by the Board of Directors.

(d) Alternative Medical Coverage for Patients. Immediately upon the imposition of a summary suspension, the Chief of Staff shall have the authority to provide for alternative medical coverage for the patients of the suspended practitioner still in the Hospital at the time of such suspension. The wishes of the patients shall be considered in the selection of such alternative practitioner.

Section 3. Automatic Suspension

(a) License. A practitioner, whose license, certificate or other legal credentials authorizing him to practice in this State is revoked or suspended, shall immediately and automatically be suspended from practicing in the Hospital.

(b) Drug Enforcement Administration ("DEA") Number. A practitioner whose DEA number is revoked or suspended shall immediately and automatically be divested of his right to prescribe medications covered by such number. As soon as possible after such automatic suspension, the Executive Committee shall convene to review and consider the facts under which the DEA number was revoked or suspended. The Medical Executive Committee may then take such further corrective action as is appropriate to the facts disclosed in its investigation.

(c) Failure to Satisfy Special Appearance Requirement. Failure of a practitioner to appear at any meeting with respect to which he has given such special notice shall, unless excused by the Medical Executive Committee upon a showing of good cause, result in an automatic suspension of all or such portion of the practitioner's clinical privileges as the Executive Committee may direct. Such suspension shall remain in effect until the matter is resolved by subsequent action of the Medical Executive Committee or of the Board of Directors, or through corrective action, if necessary.

(d) Medical Records. An automatic suspension shall be imposed after warning of delinquency, for failure to complete medical records within fourteen (14) days after the patient's discharge. Such suspension shall take the form of withdrawal of a practitioner's admitting prerogative or consulting privileges and of his clinical privileges, and shall be effective until medical records are completed.

If after 90 consecutive days of suspension said practitioner has not completed subject charts, termination of membership on the Staff may be initiated.

(e) Conviction of a Felony. A practitioner who has been convicted of a felony may be automatically suspended by the Medical Executive Committee from practicing in the Hospital. Such suspension shall become effective immediately upon such conviction regardless

of whether or not an appeal is taken or pending from said judgment. Such suspension shall remain in effect until the matter is resolved by subsequent action of the Board of Directors, or through corrective action, if necessary.

Section 4. Protection From Liability

All members of the Medical Staff, other practitioners, all appropriate Hospital personnel, including members of the Board of Directors and Hospital management shall have absolute immunity from any civil liability to the fullest extent permitted by law as follows:

(a) Requested by Health Care Facility. Such immunity shall extend to any act, communication, report recommendation, or disclosure, with respect to any practitioner, performed or made in good faith and without malice and at the request of an authorized representative of this or any other health care facility, for the purpose of achieving and maintaining quality patient care in this or any other health care facility.

(b) In Connection with Health Care Institution Activity. Such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care institution's activities related, but not limited to:

(1) Applications for appointment or clinical privileges,

(2) Periodic reappraisals for reappointment or clinical privileges,

(3) Corrective action, including summary suspension,

(4) Hearings and appellate reviews,

(5) Medical care evaluations,

(6) Utilization reviews, and

(7) Other hospital, departmental, service or committee activities related to the quality of patient care and inter-professional conduct.

## ARTICLE VI: HEARING AND APPEAL PROCEDURES

Section 1. Request For Hearing

(a) Grounds for Hearing. Any one or more of the following actions shall constitute grounds for a hearing:

(1) Denial of Medical Staff membership.

(2) Denial of requested advancement in Medical Staff membership.

(3) Denial of Medical Staff reappointment.

(4) Demotion to lower Staff category.

(5) Suspension of Medical Staff membership.

(6) Expulsion from Medical Staff membership.

(7) Denial of requested privileges.

(8) Reduction in privileges.

(9) Suspension of privileges.

(10) Termination of privileges.

(11) Imposition of proctoring, consultation, co-admission, or monitoring requirements (excluding monitoring incidental to provisional status).

(b) Notice of Decision. In all cases in which a practitioner is entitled to a hearing as set forth herein, he shall have ten (10) days following the date of receipt of written notice of the action giving rise to the right to the hearing, sent registered or certified mail, within which to request a hearing by the Judicial Review Committee hereinafter referred to. Said request shall be by written notice sent certified or registered mail to the Chief Executive Officer.

The notice shall include action, if adopted under Section 1. (a), (1), (2), (3), (4), (5), (6), (7), (8), (9) or (10), shall be reported to the Medical Board of California pursuant to Section 805 of the California Business and Professions Code.

In the event the practitioner does not request a hearing within the time and in the manner herein above set forth, he shall be deemed to have waived his right to a hearing and to any appellate review to which he might otherwise have been entitled and to have accepted the action involved, and it shall thereupon become effective immediately.

(c) Time and Place for Hearing. Upon receipt of a request for hearing, the Chief Executive Officer shall deliver such request to the Executive Committee. The Executive Committee or Chief Executive Officer shall, within ten (10) days after receipt of such request, schedule and arrange for a hearing.

The date of the hearing shall be not less than fifteen (15) days nor more than sixty (60) days from the date of the receipt of the request for hearing by the Chief Executive Officer; provided, however, that when the request is received from a member who is under suspension which is then in effect, the date of the hearing shall be held as soon as the arrangements may reasonably be made, but not to exceed forty-five (45) days from the date of receipt of the request for hearing.

(d) Notice of Charges. The Chief Executive Officer shall give notice to the affected practitioner of the time, place and date of the hearing. The notice of hearing shall state in concise language the acts or omissions with which the practitioner is charged, a list of any charts under question, by chart number or, where the issue involved any of the actions set out in Section 1. (a), (1) of Article VI, the reasons for the denial of the request of the applicant or Medical Staff member.

(e) Judicial Review Committee. When a hearing is requested, the Executive Committee shall appoint a Judicial Review Committee which shall be composed of not less than five (5) members of the Active Medical Staff who shall gain no financial benefit from the outcome, and who have not acted as accuser, investigator, fact finder, or initial decision maker in the matter before the Judicial Review Committee. The members of the Judicial Review Committee shall not have actively participated in the consideration of the matter involved at any previous level. Such appointment shall include designation of the chairman.

Knowledge of the matter involved shall not preclude an individual from serving as a member of the Judicial Review Committee. In the event that it is not possible to appoint a fully qualified Judicial Review Committee from the Active Medical Staff, the Executive Committee may appoint qualified practitioners from the Associate Staff or practitioners outside the Staff. Membership on the Judicial Review Committee, where feasible, shall include an individual practicing the same specialty as the practitioner.

(f) Postponements and Extensions. Postponements and extensions of time beyond the times expressly permitted in these Bylaws may be requested by anyone but shall be permitted by the Judicial Review Committee only on a showing of good cause.

Section 2. Hearing Procedure

(a) Prehearing Procedure.

(1) If either side to the hearing requests in writing a list of witnesses, within ten (10) days of such request, each party shall furnish to the other a written list of the names and addresses of the individuals, so far as is then reasonably known or anticipated, who are anticipated to give testimony or evidence in support of that party at the hearing. The practitioner shall have the right to inspect and copy documents or other evidence upon which the charges are based, and shall also have the right to receive, at least thirty (30) days prior to the hearing, a copy of the evidence forming the basis of the charges which is reasonably necessary to enable the practitioner to prepare a defense, including all evidence which was considered by the Executive Committee in determining whether to proceed with the adverse action, any exculpatory evidence in the possession of the Hospital or Medical Staff, and all evidence which will be made available to the Judicial Review Committee.

(2) The Executive Committee shall have the right to inspect and copy at its expense, any documents or other evidence relevant of the charges which the practitioner has in his possession or control, as soon as practicable after receiving the request.

(3) Unless waived in writing by the other party, the failure by either party to provide access to the information set forth in this Section 2. (a) at least thirty (30) days before the hearing shall constitute good cause for a continuance. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable members, other than the member under review.

(4) The hearing officer shall consider and rule upon any request for access to information and may impose any safeguards the protection of the peer review process and justice requires. In so doing, the hearing officer shall consider:

(a) Whether the information sought may be introduced to support or defend the charges;

(b) The exculpatory or inculpatory nature of the information sought, if any;

(c) The burden imposed on the party in possession of the information sought, if access is granted; and

(d) Any previous requests for access to information submitted or resisted by the parties to the same proceeding.

(5) It shall be the duty of the member of the Executive Committee, or its designee, to exercise reasonable diligence in notifying the Presiding Officer of the Judicial Review Committee of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any prehearing decisions may be succinctly made at the hearing.

(b) Personal Presence Mandatory. Under no circumstances shall the hearing be conducted without the personal presence of the person requesting the hearing unless he has waived such appearance or has failed without good cause to appear after appropriate notice. Such failure to appear shall be deemed to constitute voluntary acceptance of the recommendations or actions involved which shall become final and effective immediately.

(c) Representation. The affected practitioner shall be entitled to be accompanied and/or represented at the hearing by a member of the Medical Staff in good standing. Since the hearings provided for in these Bylaws are for the purpose of intra-professional resolution of matters bearing on professional competency or conduct, neither the practitioner requesting the hearing, nor the Executive Committee, nor the Board of Directors shall be represented in any phase of the hearing by an attorney at law unless the Judicial Review Committee, in its discretion, permits both side to be represented by legal counsel. The Executive Committee shall appoint a representative from the Medical Staff to present its recommendations in support thereof and to examine witnesses and to present evidence.

(d) The Presiding Officer. The Presiding Officer shall act to insure that all participants in the hearing have a reasonable opportunity to be heard and to present all oral and documentary evidence, and that decorum is maintained. He shall determine the order or procedure during the hearing, and shall have the authority and discretion, in accordance with these Bylaws, to make all rulings on questions which pertain to matters of law and to the admissibility of evidence. The Presiding Officer shall gain no financial benefit from the outcome and must not act as a prosecuting officer, as an advocate for the Hospital, Board of Directors or Medical Executive Committee, or body whose action prompted the hearing. If

requested by the Judicial Review Committee, he may participate in the deliberation of such body and be a legal advisor to it, but he shall not be entitled to vote.

(e) Appointment and Qualifications. The Presiding Officer shall be appointed by the Chief of Staff. Said Officer may or may not be a physician, a member of this Medical Staff or an attorney.

(f) Record of Hearing. The Judicial Review Committee must maintain a record of the hearing by one of the following methods: a shorthand reporter present to make a record of the hearing, or a recording. The cost of such shorthand reporter's appearance shall be borne by the Hospital and the party requesting the hearing, provided the cost of transcribing the record of the hearing shall be borne by the party requesting the transcription. The Judicial Review Committee may, but shall not be required to order that oral evidence shall be taken only on oath or affirmation administered by any person designated by such body and entitled to notarize documents in the State of California.

(g) Rights of the Parties. At a hearing, both the affected practitioner and the body whose action prompted the hearing shall have the following rights: to ask Judicial Review Committee members and the Presiding Officer questions which are directly related to determining whether they are biased and to challenge the impartiality of any member or Presiding Officer, to call and examine witnesses, to introduce exhibits, to cross-examine any witness on any matter relevant to the issues, to impeach any witness, to rebut any evidence and to be provided with all information made available to the Judicial Committee. If the affected practitioner does not testify in his own behalf, he may be called and examined as if under cross-examination.

The Presiding Officer in the exercise of his discretion may limit testimony that is cumulative. Any challenge directed at one or more members of the Judicial Review Committee or Presiding Officer shall be ruled on by the Presiding Officer prior to the continuation of the proceedings.

(h) Admissibility of Evidence. The hearing shall not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant evidence shall be admitted by the Presiding Officer if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Each party shall have the right to submit written argument and the Judicial Review Committee may request such a writing to be filed following the close of the hearing. The Judicial Review Committee may interrogate the witnesses or call additional witnesses if it deems it appropriate.

(i) Official Notice. The Presiding Officer shall have the discretion to take official notice of any matters either technical or scientific, relating to the issues under consideration which could have been judicially noticed by the courts of this State. Participants in the hearing shall be informed of the matters to be officially noticed and they shall be noted in the record of the hearing. The person requesting the hearing shall have the opportunity to request that a matter be officially noticed or to refute the noticed matters by evidence or by written or oral presentation of authority. Reasonable or additional time shall be granted, if requested, to present written rebuttal of any evidence admitted on official notice.

(j) Burden of Proof.

(1) At the hearing, the Executive Committee shall have the initial duty to present evidence for each case or issue in support of its action or recommendation. The practitioner shall be obligated to present evidence in response.

(2) An applicant shall bear the burden of persuading the Judicial Review Committee, by preponderance of the evidence, of his qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning his current qualifications for membership and privileges. An applicant shall not be permitted to introduce information requested by the Medical Staff but not produced during the application process unless the applicant established that the information could not have been produced previously in the exercise of reasonable diligence.

(3) Except as provided above for applicants, throughout the hearing, the Executive Committee shall bear the burden of persuading the Judicial Review Committee, by a preponderance of the evidence, that its action or recommendation was reasonable and warranted.

(k) Basis of Decision. The decision of the Judicial Review Committee shall be based on the evidence produced at the hearing. This evidence may consist of the following:

(1) Oral testimony of witnesses;

(2) Briefs or written or oral arguments presented in connection with the hearing;

(3) Any material contained in the Medical Staff's personnel files regarding the person who requested the hearing;

(4) Any and all applications, references and accompanying documents;

(5) All officially noticed matters;

(6) Any other evidence deemed admissible under Section 2. (h) of this Article.

(l) Adjournment and Conclusion. The Presiding Officer may adjourn the hearing and reconvene the same at the convenience of the participants without special notice. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Judicial Review Committee shall thereupon, within the time limit specified in Section 2. (m), of this Article, outside of the presence of any other person, conduct its deliberations and render a decision and accompanying report as provided by Section 2. (m), of this Article.

(m) Decision of the Judicial Review Committee. Within thirty (30) days after final adjournment of the hearing, the Judicial Review Committee shall render a decision which shall be accompanied by a report in writing and shall be delivered to the Executive Committee. If the member is currently under suspension, however, the time for the decision and report shall be

fifteen (15) days. A copy of said decision also shall be forwarded to the Chief Executive Officer, the Board of Directors, and to the practitioner by certified mail. The report shall contain a concise statement of the reasons in support of the decision, including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the conclusion reached. Both the practitioner and the Executive Committee shall be provided a written explanation of the procedure for appealing the decision.

(n) Right to Appeal. The decision of the Judicial Review Committee shall be subject to such rights of appeal as set forth in Section 3. (a) of this Article, whereupon the decision shall be affirmed by the Board of Directors as the final action, if it is supported by substantial evidence, following a fair procedure.

Section 3. Appeal to Board of Directors

(a) Time for Appeal. Within ten (10) days after receipt of the decision of the Judicial Review Committee, either practitioner or Executive Committee may request an appellate review by the Board of Directors. The request shall be delivered to the Chief Executive Officer in writing and delivered either in person, or be certified or registered mail. If such appellate review is not requested within such period, both sides shall be deemed to have accepted the action involved and it shall thereupon be affirmed by the Board of Directors as the final action, if it is supported by substantial evidence, following a fair procedure.

(b) Grounds for Appeal. The written request for appeal shall include a brief statement as to the grounds upon which the appeal is made. The grounds for appeal from the hearing shall be: (1) substantial failure of the Judicial Review Committee, Medical Executive Committee or Board of Directors to comply with the procedures required by this Article or by the Hospital and/or Medical Staff Bylaws in the conduct of hearing and decisions upon hearings so as to deny a fair procedure; (2) action taken which is not supported by substantial evidence. If no such grounds are stated, the Board of Directors may deny the appeal.

(c) Time, Place and Notice. In the event of any appeal to the Board of Directors as set forth in the preceding Section, the Board of Directors shall, within ten (10) days after receipt of such notice of appeal, schedule a date for such review. The Board of Directors, through the Chief Executive Officer, shall notify the affected practitioner by certified or registered mail of the time, place and date of the appellate review.

The date of appellate review shall not be less than fifteen (15) days, nor more than sixty (60) days from the date of receipt of the request for appellate review, provided however, that when a request for appellate review is from a practitioner who is under suspension which is then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made and not to exceed fifteen (15) days from the date of receipt of the request for appellate review unless additional time is required to complete the record. The time for appellate review may be extended by the Chairman of the Board of Directors for good cause.

(d) Presiding Officer. The Board of Directors may appoint a Presiding Officer to exercise control over its hearing who may be the same or a different Presiding Officer as the one who governed over the hearing of the Judicial Review Committee. The same rules set forth

above with respect to the Presiding Officer for the Judicial Review Committee shall apply to the Presiding Officer for the hearing before the Board of Directors.

(e) Nature of Appellate Review. The proceedings by the Board of Directors shall be in the nature of an appellate hearing based upon the record of the hearing before the Judicial Review Committee, provided that the Board of Directors may, in its sole discretion, accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the original hearing. Each party shall have the right to be represented by any other representative designated by that party in connection with the appeal and to present, at least ten (10) days prior to the date of the review, a written statement in support of his position on appeal. The Board of Directors shall allow each party or representative to personally appear and make oral argument and may limit such argument as to time and issues. At the conclusion of oral argument, if allowed, the Board of Directors may thereupon at a time convenient to itself, conduct deliberations outside the presence of the appellant and respondent and their representatives.

(f) Final Decision. Within thirty (30) days after the conclusion of the appellate review or within ten (10) days in the event the petitioner is currently under suspension, the Board of Directors shall render a final decision and shall affirm the decision of the Judicial Review Committee, if the Judicial Review Committee's decision is supported by substantial evidence, following a fair procedure.

The Board of Directors may modify or reverse the decision of the Judicial Review Committee, or remand the matter back to the Judicial Review Committee or the Executive Committee for further review and recommendation. If the matter is so remanded, said committee shall conduct its review and make its recommendations to the Board of Directors in accordance with the instructions given by the Board of Directors within thirty (30) days.

The final decision of the Board of Directors shall be in writing, shall specify the reasons for the actions taken, and shall be forwarded to the Chief of Staff, Executive Committee, Credentials Committee, Chief Executive Officer and the affected practitioner in person or by certified or registered mail. The final decision of the Board of Directors following the appeal shall be effective immediately and shall not be subject to further administrative review.

(g) Right to One Hearing Only. Except as otherwise provided in this Article, an affected practitioner shall be entitled as a matter of right to only one hearing before the Judicial Review Committee and one hearing before the Board of Directors on any single matter which maybe the subject of an appeal without regard to whether such subject is the result of action by the Executive Committee or the Board of Directors, or a combination of acts of such bodies.

## ARTICLE VII: MEDICAL STAFF SERVICES

Section 1. Organization of Services

The Medical Staff shall be organized into clinical services and administrative services. The clinical services provided shall be medicine, surgery, primary care, dentistry and podiatry. The administrative services shall be quality assurance, continuing medical education and general administration. Other services may be added from time to time at the direction of the Executive

Committee. At the annual meeting, there shall be elected a Chief of Staff who shall be a member of the Active Staff. He shall be responsible for the functioning of clinical and administrative services of the Medical Staff.

Section 2. Chairmen of Departments of Medicine, Surgery and Primary Care

(a) The Medical Staff shall be organized into the Clinical Departments of Medicine, Surgery and Primary Care. Staff members shall be assigned by the Medical Executive Committee to one of these departments consistent with Sections 3, 4 and 5 of this Article. The Medical Staff shall also be organized into the Administrative Departments of Quality Assurance, Continuing Medical Education and Administrative Services. The Chief of Staff, with the consultation of the department chairman, shall appoint an assistant chairman of each department.

In the absence of the chairman, the assistant chairman of the respective department shall assume all duties of the chairman, including attendance and voting privileges at Medical Executive Committee meetings. The chairman and assistant chairman shall be members of the Active Staff.

(b) The Chairmen of the clinical Departments of Medicine, Surgery, and Primary Care shall:

(1) Be accountable to the Chief of Staff and the Medical Executive Committee for all professional and administrative activities within his department;

(2) Be a member of the Medical Executive Committee, giving guidance on the overall medical policies of the Hospital and making specific recommendations and suggestions regarding his own department in order to assure quality patient care;

(3) Recommend clinical privileges for each member of the department;

(4) Maintain continuing review of the professional performance of all practitioners with clinical privileges in his department and report regularly thereon to the Medical Executive Committee;

(5) Be responsible for the implementation of the initial phase of patient care review required by these Bylaws;

(6) Be responsible for enforcement of the Hospital Bylaws and the Medical Staff Bylaws, Rules and Regulations within his department;

(7) Be responsible for implementation within his department of actions taken by the Medical Executive Committee;

(8) Transmit to the Credentials Committee his department's recommendations concerning the Medical Staff classification, the reappointment, and the delineation of clinical privileges for all practitioners in his department;

(9) Participate in every phase of administration of the department, including maintaining a quality control program, as appropriate, recommending a sufficient number

of qualified and competent persons to provide care, treatment and services, and space and other resources needed by the department; cooperation with the nursing service and the Hospital administration, in matters affecting patient care including, but not limited to personnel (including assisting in determining the qualifications and competence of department personnel who are not licensed independent practitioners and who provide patient care services), supplies, special regulations, standing orders and techniques; and

(10) Assist in the preparation of such annual reports including budgetary planning, pertaining to his department, as may be required by the Medical Executive Committee, the Chief Executive Officer or the Board of Directors; and

(11) Assess and recommend to the Board of Directors off-site sources for needed patient care, treatment, and services not provided by the department or the Hospital.

The Chairmen of the Departments of Medicine, Surgery and Primary Care shall be members of the Active Medical Staff qualified by training, ability and experience for the positions.

They shall be appointed by the Chief of Staff for one (1) year terms and may be removed during office by a two thirds (2/3) vote of all Active Staff Members of their respective departments. They shall conduct regular meetings of their departments and shall review all privilege cards biannually for membership of the Medical Staff and upon application of a prospective member of the Staff. They shall have the authority in grave or unusual circumstances to recommend summary suspension of the privileges of a member of their respective departments, in accordance with Section 2 of Article V of these Bylaws.

Section 3. Department of Surgery

The Surgical Department shall be organized as a separate part of the Medical Staff and consists of the services of surgery and its subspecialties, anesthesiology, obstetrics and gynecology, dentistry, pathology, and podiatry. The Department of Surgery shall assume the responsibility for the following committees: Tissue Transfusion and Laboratory, Obstetrics and Gynecology, Peer Review and Anesthesia.

Section 4. Department of Medicine

The Medical Department shall be organized as a separate part of the Medical Staff and consists of the following services: internal medicine and sub-specialties, of cardiovascular disease, endocrinology, gastroenterology, hematology/oncology, infectious disease, nephrology, pulmonary, and rheumatology and the specialties of allergy/immunology, dermatology, nuclear medicine, physical medicine/rehabilitation, psychiatry, neurology, and radiology. Members of the Medical Department may also have special expertise in adolescent medicine, clinical cardiac electrophysiology, critical care medicine, clinical and laboratory immunology, geriatric medicine, and sports medicine. The Department shall have a chairman who shall be responsible for the overall supervision of the clinical work in his department. The Department of Medicine shall assume responsibility for the following committees: Behavioral Health, Pharmacy and Therapeutics, Infection Control, Critical Care, and Peer Review.

Section 5. Department of Primary Care

The Department of Primary Care shall be organized as a department of the Medical Staff and shall consist of the following services: Family Practice, Newborn/Pediatrics, and Emergency Medicine. The Department shall assume the responsibility for the following committees: Peer Review, Newborn/Pediatrics Committee.

Section 6. Function of the Departments

The Departments of Medicine, Surgery and Primary Care shall:

(a) Review and act upon each practitioner's request for medical/surgical privileges and make recommendations to the Executive Committee regarding such privileges after due consideration, according to the practitioner's training and/or experience;

(b) Meet at least quarterly to review and analyze the clinical work of the department.

(c) Report to the Executive Committee at each regular meeting, detailing pertinent transactions within the department.

(d) Draft and review its rules and regulations subject to the approval of the Executive Committee.

Section 7. Dental Services

(a) All Dental Services shall be under the direct supervision of the Department of Surgery.

(b) Dentists applying for privileges shall do so in accordance with the established Bylaws of the Medical Staff, and those accepted shall adhere to these Bylaws, Rules and Regulations.

(c) The dental applicants for Staff membership must be legally licensed to practice in the state of California and must conform to general standards established by the Medical Staff including ethical and moral codes.

(d) An adequate medical history, physical examination and indicated laboratory work by a physician member of the Medical Staff shall be required before dental surgery and/or within 24 hours of admission. This information shall be on the patient's chart, or dictated before the patient is allowed to enter surgery.

(e) Indicated consultations with Medical Staff shall be required in all complicated cases.

(f) An appropriate dental history and examination by the dentist shall be done and included in the patient's chart within 24 hours of admission and/or prior to surgery.

(g) Progress notes shall be written by the dentist in accordance with the Rules and Regulations of the Medical Staff. The attending physician may write progress notes if the patient's condition or treatment dictates.

(h) Patients may be discharged by either the dentist or physician, and either may dictate the discharge summary.

(i) By order of the Los Angeles County Department of Licensure and against the advice of the Medical Staff, a physician and surgeon M.D. is no longer required to admit the patient or required to be present in the operating room during surgery.

Section 8. Podiatry Services

(a) All Podiatry Services shall be under the direct supervision of the Department of Surgery.

(b) Podiatrists applying for privileges shall do so in accordance with the established Bylaws of the Medical Staff, and those accepted shall adhere to these Bylaws, Rules and Regulations.

(c) The podiatric applicants for Staff membership must be legally licensed to practice in the State of California and must conform to general standards established by the Medical Staff including ethical and moral codes.

(d) An adequate medical history, physical examination and indicated laboratory work shall be required before any podiatry surgery and/or within 24 hours of admission. This information shall be on the patient's chart, or dictated before the patient is allowed to enter surgery.

(e) Indicated consultations with Medical Staff shall be required in all complicated cases.

(f) An appropriate podiatric history and examination by the podiatrist shall be done and included in the patient's chart within 24 hours of admission.

(g) Progress notes shall be written by the podiatrist in accordance with the Rules and Regulations of the Medical Staff. The attending physician may write progress notes if the patient's condition or treatment dictates.

(h) Patients may be discharged by either the podiatrist or physician and either may dictate the discharge summary.

(i) By order of the Los Angeles County Department of Licensure and against the advice of the Medical Staff, a physician and surgeon M.D. is no longer required to admit the patient or required to be present in the operating room during surgery.

Section 9. Administrative Departments.

Quality Performance Council, Continuing Medical Education and Administrative Services are administrative departments of the Medical Staff. The Quality Performance Council administrative department consists of the Quality Performance Council and Appropriateness Review Committees. The Continuing Medical Education administrative department consists of the Continuing Medical Education/Library. The Administrative Services department consists of the Credentials Committee. All committee compositions, duties, and meeting requirements are described in Article XII. Committees.

## ARTICLE VIII: DETERMINATION OF QUALIFICATIONS AND PRIVILEGES

Section 1. Classification of Privileges

Privileges granted to physicians, dentists or podiatrists who have been appointed to the Medical Staff shall be recommended by the chairman of department to which the practitioner is assigned after appropriate verification of information.

Section 2. Determination of Privileges

(a) Determination of initial privileges shall be based upon an applicant's training, experience, and demonstrated competence. Privileges, including the ability to perform consultations, maybe granted within the scope of the applicant's residency training program. If the applicant requests privileges outside of the scope of his residency training program, he shall provide documentation of experience, including a resume of cases or other appropriate documentation, and documentation of demonstrated competence for the requested privileges.

(b) Determination of extension of further privileges shall be based upon a practitioner's training, experience and demonstrated competence which shall be evaluated by review of the practitioner's credentials, direct observation by the Active Medical Staff and review of reports by the appropriate department.

If the practitioner requests privileges outside of the scope of his residency training program, or the practitioner did not complete a residency training program, he shall provide sufficient documentation of his experience and demonstrated competence, including a resume of cases or other appropriate documentation for the requested privileges.

(c) Privileges shall be determined as follows:

(1) Applicants and members of the Medical Staff shall apply for privileges to the Executive Committee on the prescribed forms.

(2) The chairman of the clinical department shall evaluate the privileges requested and make recommendations to the Executive Committee.

(3) The Medical Executive Committee shall evaluate the privileges requested and make recommendations to the Board of Directors.

(4) The Board of Directors shall make the final decision concerning the granting of privileges but shall not unreasonably withhold privileges approved by the Executive Committee.

Section 3. Documentation and Records Requirements

1. The attending practitioner is responsible for the preparation of a complete medical record for each patient which will include:

a) Identification data

b) History

c) Physical examination

d) Special reports, e.g. as determined by the Appropriateness Review Committee

e) Provisional diagnosis

f) Medical/surgical treatment

g) Pathological findings

h) Progress notes

i) Final diagnosis

j) Condition on discharge

k) Summary or discharge note x-rays, consultations, clinical lab, etc.

l) Follow up and autopsy reports when available

2. No medical record shall be filed until it is complete, except upon the order of the Appropriateness Review Committee.

3. Progress notes shall be written at least daily on all patients in ICU, DOU, other critically ill patients, and those where there is difficulty in diagnosis or management of the clinical problem, and at least every two (2) days on other patients.

3.1 In the Acute Rehabilitation Unit, the Medical Director or his designee or the admitting rehabilitation physician shall see the patient and write a progress note at least five (5) days a week. The attending physician medically managing the patient will write progress notes as required by the patient's medical condition.

4. A clinically appropriate history and physical examination shall in all cases be written or dictated within 24 hours after admission of the patient and in all cases prior to surgery. If

a history and a physical examination has been performed within 30 days before admission, a durable, legible copy of this report may be used in the patient's medical record, provided any changes that may have occurred are recorded in the medical record at the time of admission or prior to surgery.

Any doctor responsible for an inpatient is authorized to authenticate the admitting order if the author of the original order is unavailable.

4.1 An appropriate medical history for an inpatient shall include a chief complaint, history of present illness, past medical history, medication history, family history, social history, allergies and review of systems.

An appropriate physical examination for an inpatient shall include a current assessment of head-eyes-ear-nose-throat (HEENT), neck, respiratory system, cardiovascular system, abdomen, extremities, and neurovascular system. When clinically indicated, the assessment shall include a rectal and genital examination for males, and breast, pelvic, rectal and genital examination for females.

4.2 An appropriate history and physical examination for an outpatient must be appropriate for the patient's clinical condition and procedures to be performed.

4.3 A history and physical examination written by a physician (medical doctor or doctor of osteopathy) who does not have privileges at the Hospital or written by a Physician Assistant is acceptable as long as the patient's attending physician counter-signs the document indicating his concurrence.

5. Operative reports – the short operative report shall be written within one (1) hour after surgery and dictated no later than 24 hours after the performance of surgery.

5.1 Operative reports shall include:

a) Date of the surgery;

b) Pre and post op Dx;

c) Procedures(s) performed;

d) Operating practitioner's name;

e) Type of anesthesia;

f) Estimated blood loss;

g) Findings/complications noted at surgery;

h) Appropriate description of the procedure(s).

i) Specimens removed;
j) Drains.

6. Consultations shall be written or dictated no later than the end of the day following the day of request.

7. Those history and physical examinations not written or dictated within 24 hours of admission, or those operative reports not written or dictated within 24 hours of procedure, shall be considered delinquent.

8. All charts are to be completed with regard to final diagnosis, discharge summary and final signatures within fourteen (14) days following discharge of the patient from the hospital.

9. Those charts not completed within 14 days of discharge shall be considered to be delinquent. One to seven (1-7) days post discharge; the practitioner will be notified in writing of incomplete charts by the Chief of Staff. Eight to fourteen (8-14) days post discharge the practitioner receives a second notification of incomplete charts from the Chief of Staff. The practitioner will then have one (1) week within which to complete the delinquent records. If the charts are not completed in this time frame, staff privileges shall be suspended.

10. Suspension of privileges shall include the ability to schedule admissions, schedule surgeries and/or procedures, admit patients, perform surgery and/or procedures, assist in surgery and/or procedures, provide consultations, induce anesthetics, and interpret test results. Suspension of privileges due to incompletion of charts shall not be the cause for exclusion from participation on the ED Backup Panel, unless the Executive Committee has determined that this suspension is due to medical disciplinary cause or reason. Exceptions to suspension are the treatment of patients currently hospitalized and bona fide emergency patients.

11. Those charts not completed within 14 days of discharge shall be considered to be delinquent. One to seven (1-7) days post discharge; the practitioner will be notified in writing of incomplete charts by the Chief of Staff. Eight to fourteen (8-14) days post discharge the practitioner receives a second notification of incomplete charts from the Chief of Staff. The practitioner will then have one (1) week within which to complete the delinquent records. If the charts are not completed in this time frame, staff privileges shall be suspended.

12. Suspension of privileges shall include the ability to schedule admissions, schedule surgeries and/or procedures, admit patients, perform surgery and/or procedures, admit through the Emergency Department following a 14 day grace period, assist in surgery and/or procedures, provide consultations, induce anesthetics, and interpret test results. Suspension of privileges due to incompletion of charts shall be cause for exclusion from participation on the ED Backup Panel. Exceptions to suspension are the treatment of patients currently hospitalized.

13. Once privileges have been suspended for failure to complete medical records, the completion of all delinquent charts will automatically reinstate those privileges.

14. If a practitioner has accumulated one-hundred and twenty (120) or more suspension days in a two (2) year period due to failure to complete delinquent medical records and there are extenuating circumstances acceptable to the Medical Executive Committee, the practitioner's appointment term will be limited to a one (1) year period, rather than a full two (2) year period.
If the practitioner has accumulated additional suspension days in excess of forty-five (45) days without acceptable extenuating circumstances during this one (1) year appointment term, the practitioner shall have deemed to have resigned his Medical Staff membership and privileges. If there is documented illness, the practitioner's appointment term will be a full two (2) year period.

15. When rubber-stamped or computer keyed signatures are authorized for completion of medical records in lieu of a practitioner's signature, the individual who signature the stamp or computer key represents, places in the administrative offices of this Hospital, a signed statement to the effect that he is the only one who has the stamp or computer key and is the only one who will use it. There is no delegation of the use of such a stamp or computer key to another individual.

## ARTICLE IX: OFFICERS

Section 1. Officers

The officers of the Medical Staff shall be the Chief of Staff, the Deputy Chief of Staff, the Secretary and the Treasurer. These individuals shall be elected at the annual meeting of the Medical Staff.

Every even year the Medical Staff shall elect in December, a Deputy Chief of Staff who shall serve in that capacity for one (1) year following election, then serve a two (2) year term as Chief of Staff followed by an additional one (1) year as Deputy Chief of Staff.

The Secretary and Treasurer shall be elected for one (1) year terms. The Secretary and Treasurer cannot succeed themselves for more than two (2) terms without one (1) year intervening.

Section 2. Qualifications of Officers

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

Section 3. Election of Officers and Members of Medical Executive Committee at Large

(a) Officers shall be elected at the annual meeting of the Medical Staff. Only members of the Active Medical Staff shall be eligible to vote.

(b) The Nominating Committee shall offer one (1) or more nominees for the following positions:

(1) Deputy Chief of Staff (every even year, to serve as Chief of Staff-elect)

(2) Secretary

(3) Treasurer

(4) Members of Executive Committee at Large

(c) The slate shall be publicized to the voting members of the Medical Staff at least thirty (30) days prior to the annual meeting. At the annual meeting, the report of the Nominating Committee shall be received and nominations invited from the floor. Nominations from the floor may be made by any voting member of the Staff. After nominations are closed, a secret ballot shall be taken at that meeting or the Chief of Staff may entertain a motion to elect the nominees by acclamation for those offices for which there is only one nominee. Only Active Staff members shall have a vote.

(d) The two nominees for the office of Member Executive Committee at Large receiving the most valid votes cast by the Active Staff present shall be elected to that office. A nominee, other than for the office of Member Executive Committee at Large, shall be elected upon receiving a majority of the valid votes cast by the Active Staff present. If no candidate for the office receives a majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes. In the case of a tie on the second ballot, the majority vote of the Medical Executive Committee shall decide the election by secret written ballot at its next meeting or a special meeting called for that purpose.

Section 4. Term of Office

Elected officers shall be officially notified of their election by the Chief of Staff. The officers elected as Secretary and Treasurer shall hold office until the next annual meeting or until a successor is elected. Each of those shall be elected for a one (1) year term. The office of Deputy Chief of Staff shall be elected for a one (1) year term, following which he shall serve as Chief of Staff for a two (2) year term, and Deputy Chief of Staff for another one (1) year term. Offices of Secretary and Treasurer may serve a maximum of two (2) consecutive terms in the same position.

Section 5. Vacancies in Office

Vacancies on the Executive Committee or in any office of the Medical Staff, however caused, shall be filled by appointment by the Chief of Staff with approval of the Executive Committee. If there is a vacancy in the office of the Chief of Staff, the Deputy Chief of Staff shall serve out the remaining term.

A vacancy shall be deemed to exist in any office of the Medical Staff or in membership on the Executive Committee when any such officer or member shall be absent from attendance at the meeting of the Executive Committee three (3) consecutive times, or four (4) times in any six (6)

month period, without excuse provided to and accepted by the Executive Committee. Appointment to fill any such vacancy shall be for the unexpired term only.

Section 6. Duties of Officers

(a) Chief of Staff. The Chief of Staff shall serve as the Chief Administrative Officer of the Medical Staff to:

(1) be responsible for the functioning of the medical organization of the Hospital;

(2) act in coordination and cooperation with the Chief Executive Officer in all matters of mutual concern within the Hospital;

(3) call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;

(4) serve on the Executive Committee;

(5) serve as ex-officio member of all other Medical Staff committees without vote;

(6) serve as ex-officio member with right to vote of the Board of Directors;

(7) be responsible for the enforcement of Medical Staff Bylaws, Rules and Regulations, for implementation of sanctions where these are indicated, and for the Medical Staffs compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner;

(8) appoint committee chairmen as provided by these Bylaws;

(9) represent the views, policies, needs and grievances of the Medical Staff to the Board of Directors and to the Chief Executive Officer;

(10) receive and interpret the policies of the Board of Directors to the Medical Staff and report to the Board of Directors on the performance/maintenance of quality with respect to the Medical Staffs delegated responsibility to provide medical care;

(11) be the spokesman for the Medical Staff in its external professional and public relations;

(12) be empowered to request consultation in those cases where such consultation is judged to be in the best interest of the patient.

(b) Deputy Chief of Staff. In the absence of the Chief of Staff, the Deputy Chief of Staff shall assume all duties and have the authority of the Chief of Staff. The Deputy Chief of Staff shall be a member of the Executive Committee and Chairman of the Bylaw and Accreditation Committee and the Quality Performance Council. The Deputy Chief of Staff shall

perform such duties as may be assigned by the Chief of Staff and shall function as the Chief of Staff Elect prior to the two (2) year term of office as Chief of Staff, and as Immediate Past Chief of Staff the year immediately following the term as Chief of Staff.

(c) Secretary. The Secretary shall be a member of the Executive Committee of the Medical Staff. In the capacity of Secretary, he or she shall keep accurate and complete minutes of all Medical Staff meetings, call Medical Staff meetings on order of the Chief of Staff, attend to all correspondence, and perform such other duties as ordinarily pertain to the Office.

(d) Treasurer. The Treasurer shall be a member of the Executive Committee of the Medical Staff. The Treasurer shall be accountable for all funds entrusted to the Treasurer and shall perform such other duties as shall usually pertain to the Office of the Treasurer.

Section 7. Removal of Elected Officer

Conditions for removal of an elected Medical Staff Officer shall include but not be limited to:

(a) Expulsion or suspension from the Medical Staff by the Executive Committee, or

(b) Removal by the Medical Staff as outlined below.

Except as otherwise provided, removal of a Medical Staff Officer may be initiated by the Executive Committee or shall be initiated by a petition signed by at least twenty percent (20%) of the members of the Medical Staff eligible to vote for officers. Removal may be considered at a special meeting called for that purpose or at the next regularly scheduled General Medical Staff meeting. Removal shall require a two-thirds vote of the Medical Staff members eligible to vote for Medical Staff officers who actually cast vote in person at the meeting.

## ARTICLE X: MEDICAL STAFF MEETINGS

Section 1. The Annual Meeting

The annual meeting of the Staff shall be the last meeting before the end of each calendar year. At this meeting, the retiring officers and committees shall make such reports as may be desirable and officers for the ensuing year shall be elected.

Section 2. General Staff Meetings

The objective of staff meetings is improvement in the care and treatment of patients in the Hospital. Regular meetings of the Medical Staff shall be held four times a year with one meeting occurring in each quarter. The meeting dates shall be set by the Chief of Staff. They may be changed by a majority vote of the Medical Executive Committee with four (4) weeks prior notification to the members of the Medical Staff.

Section 3. Special Meetings

(a) Special meetings of the Medical Staff may be called at any time by the Chief of Staff on the request of the Board of Directors or any twenty-five percent (25%) of the members

of the Active Medical Staff. At any special meeting, no business shall be transacted except that stated in the notice calling the meeting.

(b) 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 Medical 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 Medical Staff member at his address as it appears on the records of the Hospital. The attendance of a member of the Medical Staff at a meeting shall constitute a waiver of notice of such meeting.

Section 4. Attendance at Meetings

The Active Staff must attend fifty per cent (50%) of the General Medical Staff and departmental meetings held for the year. Active Staff members shall attend meetings of the department to which they are assigned. Practitioners who are members of the Active Staff on March 12, 1998 may meet the attendance requirement by attending the meetings of any department.

Unless excused by the Executive Committee, for exceptional conditions such as sickness or absence from the community, failure to attend fifty percent (50%) of such meetings shall be considered as resignation from the Active Medical Staff and shall automatically place the absentee on the Associate Medical Staff. The procedure for reinstatement will be the same as in the case of advancement to Active Staff.

(a) All other categories of Staff membership shall be encouraged to attend meetings with the same regularity as members of the Active Staff, except as provided in Article IV, Section 5.

(b) A member of any category of the Staff who has attended a case that is to be presented for discussion at a meeting shall be notified and shall be encouraged to be present. Should any member of the Staff be absent from any meeting at which a case that he has attended is to be discussed, it shall be presented, nevertheless, unless the member is unavoidably absent and has requested that discussion be postponed. In no case shall postponement be granted for a period longer than that until the next regular meeting.

Section 5. Quorum

Fifty percent (50%) of the total membership of the Active Medical Staff shall constitute a quorum at any meeting of the Medical Staff.

Section 6. Agenda

(a) The agenda at any regular Medical Staff meeting shall include:

Business:

(1) Call to Order

(2) Reading of the Minutes of the last regular and of all special meetings

(3) Committee Reports as required

(4) Unfinished Business

(5) New Business

(6) Adjournment

(b) The agenda at special meetings shall include:

(1) Reading of the Notice calling the meeting

(2) Transaction of the Business for which the meeting was called

(3) Adjournment

Section 7. Rules of Order

Roberts Rules of Order shall govern matters not otherwise provided.

## ARTICLE XI: COMMITTEE AND DEPARTMENT MEETINGS

Section 1. Regular Meetings

Committees and departments may, by resolution, provide the time for holding regular meetings without notice other than such resolution.

Section 2. Special Meetings

A special meeting of any committee or department may be called by or at the request of the chairman of the department or committee thereof, or by the Chief of Staff.

Section 3. Notice of Meetings

Written or oral notice stating the place, day and hour of any special meeting or of any regular meeting not held pursuant to resolution, shall be given to each member of the committee or department not less than twenty-four (24) hours before the time of such meeting, by the person or persons calling the meeting. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

Section 4. Quorum

The presence of ten percent (10%) of the members of a committee or department shall constitute a quorum at any meeting. The presence of fifty percent (50%) of the voting members of the Executive Committee shall constitute a quorum at any meeting of that Committee.

Section 5. Rights of Ex-Officio Members

Persons serving under these Bylaws as ex-officio members of a committee shall have all rights and privileges of regular members except they shall not be counted in determining the existence of a quorum, nor may they vote.

Section 6. Minutes

Minutes of each regular and special meeting of a committee or department shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall be signed by the presiding officer. Each committee and department shall maintain a permanent file of the minutes of each meeting.

## ARTICLE XII: COMMITTEES

Section 1. Organization of Committees

There shall be the following standing committees of the Medical Staff: Medical Executive, Quality Performance Council, Bylaws and Accreditation, Nominating, Credentials, Obstetrics and Gynecology, Tissue, Transfusion and Laboratory, Infection Control, Pharmacy and Therapeutics, Critical Care Committee, Newborn/Pediatrics, Emergency Services Committee, Appropriateness Review, Continuing Medical Education/Library, Trauma, Cancer, Anesthesia, Physician Well-Being and Ethics Committees.

Section 2. Committee Appointments

The Chief of Staff shall appoint, at the beginning of the Medical Staff year, the Chairmen of the Departments of Medicine, Surgery and Primary Care, and the Chairmen of Continuing Medical Education, Administrative Services, Nominating, Ethics, Physician Well-Being and Cancer Committees. The Chairman of the Department of Medicine shall appoint the Chairmen of the Behavioral Health, Critical Care, Pharmacy and Therapeutics, and Infection Control Committees; the Chairman of the Department of Surgery shall appoint the Chairmen of the Obstetrics and Gynecology, Anesthesia, Tissue, Transfusion and Laboratory, and Trauma Committees; the Chairman of the Department of Primary Care shall appoint the Chairmen of the Newborn/Pediatric and Emergency Services Committees; and the Chairman of the Chairman of the Quality Performance Council Committee shall appoint the Chairmen of the Appropriateness Review Committee. The Chairman of Administrative Services shall appoint the Chairman of the Credentials Committee. The Chairman of Continuing Medical Education shall appoint the Chairman of the Continuing Medication/Library Committee. Upon their appointment, the chairmen of each committee shall appoint all members of their respective committees.

Chairmen of standing committees and subcommittees may be requested to attend the Medical Executive Committee at the request of the Chief of Staff. In such cases, the committee or subcommittee chairman shall be ex-officio without vote. All committees and subcommittees shall be chaired by a member of the Active or Associate Medical Staff, except as otherwise provided in these Bylaws. Committee or subcommittee members may be non-staff members, provided that they are ex-officio without vote.

Section 3. Medical Executive Committee

(a) Composition. The Medical Executive Committee shall be a standing committee and shall consist of the Chief of Staff as Chairman, the Deputy Chief of Staff, the Chairmen of the Departments of Medicine, Surgery and Primary Care, two (2) Active Medical Staff Members-at-Large elected by the Medical Staff, the Secretary of the Medical Staff and the Treasurer of the Medical Staff, the Chairmen of the Departments of Quality Assurance, Continuing Medical Education and Administrative Services, provided that if such persons are not members of the Active Medical Staff, they shall be without vote.

(b) Duties. The duties of the Medical Executive Committee shall be:

(1) to represent and to act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws;

(2) to coordinate the activities and general policies of the various departments;

(3) to receive and act upon department and committee report recommendations;

(4) to implement policies of the Medical Staff not otherwise the responsibility of the departments;

(5) to provide liaison between Medical Staff and Chief Executive Officer and the Board of Directors;

(6) to recommend action to the Chief Executive Officer on matters of a medico- administrative nature;

(7) to make recommendations on Hospital management matters to the Board of Directors;

(8) to fulfill the Medical Staff's accountability to the Board of Directors for the medical care rendered to patients in the Hospital;

(9) to ensure that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of the Hospital;

(10) to be responsible for conducting the annual Staff meeting and any other special meetings of the Staff, and with the Chief of Staff, to present an annual report to the Staff of Medical Staff activities;

(11) to receive recommendations from departments regarding the credentials, classifications of all Medical Staff membership and delineation of clinical privileges for all applicants, and, after review to recommend appropriate action to the Board of Directors;

(12) to review periodically all information available regarding the performance and clinical competence of Medical Staff members and other practitioners with clinical privileges and as a result of such reviews, to make recommendations for reappointments and renewal or changes in clinical privileges;

(13) to take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all members of the Medical Staff, including the initiation of and/or participation in Medical Staff corrective or review measures when warranted;

(14) to formulate Bylaws, Rules and Regulations governing the Medical Staff and from time to time shall propose, as it deems necessary, amendments to such Bylaws, Rules and Regulations, subject always to the requirement that any Bylaws amendment so proposed shall be subject to approval of both the Medical Staff and the Board of Directors, while any amendment of the Rules and Regulations shall be subject to approval of the Board of Directors;

(15) to review the audit findings, reports and recommendations from the medical and ancillary audits for the purpose of evaluating the quality of medical care and to assure corrective measures are taken in response to the audits findings;

(16) to review and approve the policies and recommendations of the Quality Assurance, Bylaw and Accreditation, Credentials, and Nominating Committees and the policies and recommendations of other committees as appropriate;

(17) to have authority to levy assessments for special purposes should the need arise for additional revenue;

(18) to function as a Disaster, Safety and Radiology Committee;

(19) to make recommendations as appropriate to the Board of Directors.

(c) Meetings. The Executive Committee shall endeavor to meet once a month shall meet not less than ten (10) times per year and shall maintain a permanent record of its proceedings and actions.

Section 4. Quality Performance Council Committee.

(a) Composition. Quality Performance Council shall be a standing committee and shall consist of the Deputy Chief of Staff as Chairman, one (1) member of the Active Staff of the Department of Surgery, one (1) member of the Active Staff of the Department of Medicine, one (1) member of the Active Staff of the Department of Primary Care (all of whom shall be elected by vote of the Active Medical Staff at the annual meeting of the Medical Staff), the Chairman of the Appropriateness Review Committee or his designee, the Chairman of the Patient Care Committee of the Board of Directors, the Chief Executive Officer of the Hospital, the Chief Operating Officer/Nursing Executive, the Chief Financial Officer, and the Vice President of Professional Services. The Director of Quality Resource Management shall serve as a non-voting member.

(b) Duties. The Quality Performance Council shall be responsible for the establishment, maintenance and support of an ongoing Performance Improvement Program. The Program shall include written plans which assure the comprehensiveness and integration of the Program and the delegation of responsibilities for activities which contribute to performance improvement. The specific duties of the Committee shall include:

(1) Identification of important or potential problems in the care of patients.

(2) Assessment of the cause and scope of problems, including priorities for resolving such problems.

(3) Recommendation for assignment of actions which are designed to eliminate, insofar as possible, such problems.

(4) Monitoring activities designed to assure that the desired solution to such problems has been achieved and sustained.

(5) Documentation reasonably substantiating the effectiveness of the Program to enhance patient care and to assure sound clinical performance.

(6) Annual reappraisal of the Program, including identification of components of the Program which need to be instituted, altered or deleted.

(c) Meetings. The Quality Performance Council shall meet at least quarterly, shall maintain a permanent record of its meetings and shall report thereon to the Executive Committee and the Board of Directors.

Section 5. Bylaw and Accreditation Committee

(a) Composition. The Committee shall be a standing committee, chaired by the Deputy Chief of Staff and shall be composed of at least three (3) members of the Active Medical Staff. The Committee shall report to the Executive Committee.

(b) Duties. The Committee shall survey the Medical Staff Bylaws to assure their compliance with Federal and State law, recommendations of TJC and the changing needs of the Medical Staff. If necessary, the Committee shall recommend amendments to the Executive Committee.

(c) Meetings. The Committee shall meet at least once per year, shall maintain a permanent record of its meetings and shall report thereon to the Executive Committee.

Section 6. Nominating Committee

(a) Composition. The Committee shall be a standing committee, chaired by a member of the Executive Committee and shall be composed of at least three (3) members of the Active Medical Staff. It shall report to the Executive Committee.

(b) Duties. The Committee shall present a slate of prospective Medical Staff officers to the Executive Committee for presentation to the annual Medical Staff meeting.

(c) Meetings. The Committee shall meet at least once per year prior to the Executive Committee meeting preceding the annual Medical Staff meeting.

Section 7. Credentials Committee

(a) Composition. The Committee shall consist of a chairman who is a member of the Active Medical Staff and members of the Medical Staff appointed on a basis that will ensure representation of the Departments of Medicine, Primary Care, and Surgery.

(b) Duties. The duties of the Committee shall be:

(1) to review the credentials of all applicants, to make recommendations for membership to the Medical Staff and to assure that delineation of clinical privileges for applicants by the chairman of the clinical departments of Medicine, Surgery and Primary Care are received by the Executive Committee in a timely fashion.

(2) to review and recommend to the Executive Committee on a bi-annual basis, all information available regarding the competence of Medical Staff members and as a result of such review, to make recommendations for the granting of privileges, reappointments, and the assignment of practitioners to the various departments for services as provided in Articles III and IV of the Bylaws.

(c) Meetings. The Committee shall endeavor to meet at least every three months, shall meet not less than four (4) times per year and shall maintain a permanent record of its proceedings and actions.

Section 8. Appropriateness Review Committee

(a) Composition. The Committee shall be comprised of at least four (4) members of the Medical Staff with at least one (1) member from each clinical department. The Committee shall report to the Quality Performance Council.

(b) Duties. The duties of the Committee shall be:

(1) to conduct utilization review studies designed to evaluate the appropriateness of admissions to the Hospital, lengths of stay, discharge practices, use of medical and Hospital services and all related factors which may contribute to the effective utilization of Hospital and physician services;

(2) to analyze the effect of utilization of each of the Hospital's services on quality of patient care, study patterns of care and obtain criteria relating to average or normal lengths of stay by specific disease categories, and evaluate systems of utilization review employing such criteria;

(3) to work toward the assurance of proper continuity of care upon discharge, accomplished through discharge planning following physician evaluation/referral for services, to improve or maintain patient's status;

(4) to make recommendations for the optimum utilization of Hospital resources and facilities commensurate with the quality of patient care and safety;

(5) to formulate and review annually, a written Appropriateness Review Plan for the Hospital. Such Plan, as approved by the Medical Staff and Board of Directors, must be in effect at all times;

(6) to evaluate the medical necessity for continued Hospital services for particular patients, where appropriate.

(7) to assure that the medical records reflect realistic documentation of medical events.

(8) to conduct a quarterly review of currently maintained medical records to assure that they properly describe the condition and progress of the patient the therapy provided, the results thereof, the identification of responsibility for all actions taken, and that they are sufficiently complete in the event of transfer of a practitioner's responsibility for patient care.

(9) to conduct a review of records of discharged patients to determine the promptness, pertinence, adequacy, and completeness thereof.

(10) to review and approve all proposed forms and revisions to forms which will be used by the Medical Staff and/or placed in the medical record.

(c) Meetings. The Committee shall meet at least quarterly, shall maintain a permanent record of its proceedings and actions and shall report regularly to the Quality Performance Council.

Section 9. Continuing Medical Education/Library Committee

(a) Composition. The Continuing Medical Education/Library Committee is an administrative department consisting of at least three (3) representatives of the Medical Staff representing the clinical departments. The members of the Committee shall serve staggered terms in order to assure continuity. The Chairman of the Committee shall be appointed to serve for at least two (2) years. The Committee shall report to the Executive Committee.

(b) Duties.

(1) The Committee shall be responsible for overseeing the continuing education of the Medical Staff, including development, planning or participation in programs and continuing education that are designed to keep the Medical Staff informed of significant new developments and new skills in medicine and that are responsive to

patient care monitoring and evaluation findings, including accreditation by the California Medical Association for Category 1 credit.

(2) Evaluation of the effectiveness of educational programs through the findings of the Quality Performance Council Committee.

(3) Functions relating to the professional library, including analyses of the changing needs of the library's service, deletion of outmoded materials and acquisition of new materials such as journals, periodicals and reference texts.

(c) Meetings. The Committee shall schedule one annual committee meeting and additional meetings as required to manage the CME program, shall maintain a record of its proceedings and actions and shall report regularly to the Medical Executive Committee.

Section 10. Tissue, Transfusion and Laboratory Committee

(a) Composition. The Committee shall be a standing committee of the Medical Staff and shall be composed of at least three (3) Medical Staff members. It shall report to the Department of Surgery.

(b) Duties. The duties of the Tissue, Transfusion and Lab Committee shall be:

(1) to correlate pathological diagnoses with surgical reports, consents and physical findings and report discrepancies to the Department of Surgery;

(2) to review all transfusions of blood and blood byproducts and to review all reactions thereto;

(3) to assure proper utilization of transfusions of blood and blood by products;

(4) to assure that blood transfusion policies and procedures conform to the American Association of Blood Banks Standards for blood banks and transfusion services;

(5) to oversee activities of and develop and make recommendations regarding activities of the Hospital laboratory.

(c) Meetings. The Committee shall meet at least quarterly and shall maintain a permanent record of its findings, proceedings and actions and shall make regular reports thereof to the Department of Surgery.

The Committee shall send reports to the Departments of Medicine, Primary Care, or Surgery, as appropriate, regarding all subjects which require review or recommendation by such Departments.

Section 11. Obstetrics and Gynecology Committee

(a) Composition. The Committee shall be a standing committee, chaired by an Active or Associate Medical Staff member in the Obstetrics and Gynecology Service and shall consist of at least five (5) members. It shall report to the Department of Surgery.

(b) Duties. The Committee shall establish policies and procedures concerning deliveries, including labor rooms, cesarean sections, sterilization, therapeutic abortions, induction of labor and all other procedures and studies in use in the Obstetrical and Gynecological Service.

(c) Meetings. The Committee shall meet at least quarterly and shall maintain a permanent record of its meetings.

Section 12. Infection Control Committee

(a) Composition. The Committee shall be a standing committee composed of at least five (5) members. The Chairman shall be a member of the Associate or Active Medical Staff, having special interest or experience in infection control. At least one (1) member shall be from the Pathology Service. There shall be a non-voting member from: Hospital Administration and Nursing Services. It shall report to the Department of Medicine and shall report its findings and recommendations to the Nursing Department as well.

(b) Duties. The duties of the Infection Control Committee shall include:

(1) Surveillance of Nosocomial Hospital infection potentials;

(2) Provision of standard criteria for reporting all types of infections;

(3) Review and analysis of actual infections;

(4) Promotion of a preventative and corrective program designed to minimize infection hazards;

(5) Supervision, review and analysis of:

- sterilization procedures by heat, chemicals or otherwise;
- isolation procedures and disposal of infectious materials;
- prevention of cross-infection by anesthesia apparatus or inhalation therapy equipment;
- cultures of personnel or the environment;
- results of anti-microbial susceptibility/resistance trend studies;
- antibiotic usage;
- pertinent related findings from other Hospital committees.
- other situations as requested or referred by the Departments of Medicine, Surgery or Primary Care.

(c) Meetings. The Committee shall meet at least quarterly and shall maintain a permanent record of its proceedings and actions.

Section 13. Pharmacy and Therapeutics Committee

(a) Composition. The Committee shall be a standing committee composed of at least five (5) members. At least one (1) non-voting member shall be from each of the following: Pharmaceutical Services, Nursing Services, and Hospital Administration. It shall report to the Department of Medicine.

(b) Duties. The Committee shall be responsible for the development and surveillance of all drug utilization policies and practices within the Hospital in order to assure optimum clinical results and minimum potential for hazard. The Committee shall assist in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs in the Hospital. It shall also perform the following specific functions:

- serve as an advisory group to the Medical Staff and the pharmacists on matters pertaining to the choice of available drugs;
- make recommendations concerning drugs to be stocked on the nursing unit floors and by other services;
- develop and review periodically a formulary or drug list for use in the Hospital; and,
- Establish standards concerning the use and control of investigational drugs and research in the use of recognized drugs.

(c) Meetings. The Committee shall meet at least quarterly and shall maintain a permanent record of its proceeding and actions.

Section 14. Critical Care Committee

(a) Composition. The Committee shall be a standing committee, chaired by an Associate or Active Medical Staff member and shall consist of at least four (4) members, including members of the Emergency Services Staff, Surgery and Medicine, a representative of Hospital Administration and representatives of Critical Care and Emergency Nursing. It shall report to the Department of Medicine.

(b) Duties. The Committee shall be responsible for presentation and discussion of problems relative to ICU/DOU and Emergency Services and for the development of ICU/DOU and Emergency Services policies and practices within the Hospital. It shall assure that ICU/DOU and Emergency Services are:

(1) Integrate with other units and departments of the Hospital.

(2) Personnel are prepared for their responsibilities, through orientation in service training and continuing education.

(3) Obtain and retain equipment sufficient to facilitate safe and effective care.

(c) Meetings. The Committee shall meet at least quarterly and shall maintain a permanent record of its proceedings and actions.

Section 15. Newborn/Pediatric Committee

(a) Composition. The Committee shall be a standing committee, chaired by an Associate or Active Medical Staff member in the practice of Pediatrics, and shall be composed of at least three (3) Medical Staff members, at least two (2) of whom are in the practice of Pediatrics. It shall report to the Department of Primary Care.

(b) Duties. The Committee shall review practices and procedures concerning newborns and the operation of the Nursery, status of Nursery equipment, and newborn charts, treatment and complications. The Committee shall report and make recommendations to the Department of Primary Care when appropriate.

(c) Meetings. The Committee shall meet at least quarterly and shall maintain a permanent record of its meetings.

Section 16. Cancer Committee

(a) Composition. The Committee shall be a standing committee, composed of the cancer liaison physician, and one (1) physician member of the Medical Staff from at least each of the following specialties: Radiology, Pathology, General Surgery, Oncology/Hematology, and Radiation Therapy, Non-physician members without vote shall include the cancer registrar, administration, nursing, social services and a quality assurance representative. It shall report to the Executive Committee. The Chairman shall be an Associate or Active member of the Medical Staff.

(b) Duties. The Cancer Committee shall review and make recommendations regarding the entire spectrum of care for cancer patients admitted to the Hospital, including:

(1) Develops and evaluates the annual goals and objectives for the clinical, educational, and programmatic activities related to cancer;

(2) Promotes a coordinated, multidisciplinary approach to patient management;

(3) Insures that educational and consultative cancer conferences cover all major sites and related issues;

(4) Ensures that an active supportive care system is in place for patients, families, and staff;

(5) Monitors quality management and improvement through completion of quality management studies that focus on quality, access to care, and outcomes;

(6) Promotes clinical research;

(7) Supervises the cancer registry and ensures accurate and timely abstracting, staging, and follow-up reporting;

(8) Performs quality control of registry data;

(9) Encourages data usage and regular reporting;

(10) Ensures content of the annual report meets requirements;

(11) Publishes the annual report by November 1 of the following year; and

(12) Upholds medical ethical standards;

(c) Meetings. The Committee shall meet at least quarterly and shall maintain a permanent record of its proceedings.

Section 17. Trauma Committee

(a) Composition. The Committee shall be a standing committee of the Medical Staff and shall report to the Department of Surgery.

It shall be chaired by a member of the Active or Associate Medical Staff who shall be appointed by the Chairman of the Department of Surgery and consist of at least five (5) other members of the Medical Staff to include the Trauma Services Director, the Paramedic Liaison physician and the Director of Anesthesiology. Ex-officio members shall include the Trauma Nurse Coordinator, Head Nurses from ICCU, Emergency and Surgery, and the Trauma Administrator.

(b) Duties. The Committee shall oversee activities of and develop and make recommendations regarding the implementation and review of the policies and procedures regarding trauma patient care at the Hospital and assure that:

(1) Trauma services are integrated with the Emergency Services, physician panel and other units and departments of the Hospital.

(2) Trauma services are designed and equipped to facilitate immediate, safe and effective care of patients.

(3) Established policies and procedure related to trauma patient care are followed.

(4) All trauma charts, including those of patients who expired in the Emergency Department are reviewed and tracked for timeliness and adequacy of care rendered to trauma patients.

(5) That a retrospective morbidity and mortality review occurs at least every two months.

(c) Meetings. The Committee shall endeavor to meet monthly, shall meet at least ten (10) times per year, and shall maintain a permanent record of proceedings.

Section 18. Physician Well Being Committee

(a) Purpose. The Physicians Well Being Committee is created as an advisory committee for the purpose of assisting members of the Medical Staff and other health professional affiliates granted clinical practice privileges whose functions may be impaired by chemical dependency, mental illness, or physical handicap. Its further purpose shall be to educate members of the Medical Staff and health professional affiliates concerning the functions of the Committee and the types of problems for which it is available to provide assistance.

(b) Composition. The Committee shall consist of at least five (5) Active members of the Medical Staff, three (3) of whom will be standing members. Standing members shall include a past Chief of Staff who shall serve as chairman. It is preferred that a second standing member be a psychiatrist. Two (2) members shall be selected by the physician being reviewed. Each standing member shall serve for a term of two (2) years, and the initial terms shall be staggered to achieve continuity. Insofar as possible, members of this Committee shall not serve as active participants on other peer review or quality assurance committees while serving on the Committee.

(c) Duties. The Committee may receive reports, through self-referral by a practitioner or referral by other organization staff, related to the health, well-being, or impairment of Medical Staff members and, as it deems appropriate, may investigate such reports for the credibility of the complaint, allegation, or concern. With respect to matters involving individual Medical Staff members, the Committee may, on a voluntary basis, provide such advice, counseling, or referrals to the appropriate professional internal or external resources for diagnosis and treatment of the condition or concern, as may seem appropriate. Such activities shall be confidential; however in the event information received by the Committee clearly demonstrates that the health or known impairment of a Medical Staff member poses an unreasonable risk or harm to patients, that information may be referred for corrective action, and as required by law. The Committee shall monitor the affected practitioner and the safety of patients until the rehabilitation or any disciplinary process is complete. The Committee shall also consider general matters related to the health and well-being of the Medical Staff and, with the approval of the Medical Executive Committee, develop educational programs about illness and impairment recognition issues specific to Medical Staff practitioners.

(d) Meetings. The Committee shall meet as often as necessary, but at least quarterly. It shall maintain only such record of its proceedings as it deems advisable, but shall report on its activities on a routine basis to the Executive Committee.

Section 19. Anesthesia Committee

(a) Composition. The Committee shall be a standing committee chaired by an Active or Associate Medical Staff member and shall consist of all members of the Anesthesia service.

(b) Duties. The duties of the Anesthesia Committee shall be:

(1) Establish policies and procedures regarding anesthesia care including general, spinal, or other major regional anesthesia and/or intravenous intramuscular, or

inhalation sedation/ analgesia that, in the manner used in the Hospital may result in the loss of the patient's protective reflexes.

(2) Assure the effective monitoring and evaluation of the quality and appropriateness of anesthesia care provided by individuals in any service of the Hospital.

(3) Make recommendations regarding purchase and use of equipment pertaining to the specialty and will serve as general liaison for any anesthesia-related business within the Medical Staff committee structure and with Hospital Administration.

(c) Meetings. The Committee shall meet at least quarterly and shall maintain a permanent record of proceedings and shall report to the Department of Surgery.

Section 20. Ethics Committee

(a) Composition: The Committee shall be a standing committee composed of two (2) physicians, the Senior Vice President of Operations/Director of Nursing, the Chaplain, two (2) community representatives (one representing clergy), a representative of the Board of Directors, and representatives from Social Services, Critical Care, Education and Risk Management.

(b) Duties: The committee shall be responsible for intra-institutional and community education, to serve in an advisory role in decision making to practitioners, as a resource to evaluate Hospital biomedical ethics policies, to review cases retrospectively for education purposes, as a forum for airing and resolving disagreements among staff, patients, and families regarding bioethical issues.

(c) Meetings: The Committee shall meet at least twice a year and shall report thereon to the Medical Executive Committee.

Section 21. Behavioral Health Committee

(a) Composition: The Committee shall be a standing committee chaired by an Active or Associate Medical Staff member of the Behavioral Health Service and shall consist of all members of Behavioral Health Services. The Committee membership shall also include at least on behavioral health allied health professional.

(b) Duties: The duties of the Behavioral Health Committee shall be:

(1) Establish policies and procedures regarding psychiatric care in the Hospital.

(2) Assure monitoring and appropriateness of psychiatric care.

(3) Review requests for psychiatry/behavioral science privileges and make recommendations to the Department of Medicine.

(c) Meetings: The Committee shall meet at least quarterly and shall maintain a permanent record of proceedings.

Section 22. Emergency Services Committee

(a) Composition: The Committee shall be a standing committee chaired by an Active or Associate Medical staff member and shall consist of at least three (3) members representing Emergency Services Staff, Surgery and Medicine. It shall report to the Department of Primary Care.

(b) Duties: The Committee shall oversee activities of and develop and make recommendations regarding the implementation and review of the policies and procedures regarding emergency patient care at the Hospital and assure that:

(1) Emergency Services are integrated with other units and departments of the Hospital.

(2) Personnel prepared for emergency care receive appropriate training and educational programs.

(3) Emergency services are designated and equipped to facilitate safe and effective care of patients.

(4) The Chairman of the Emergency Services Committee or his designee shall be present at the Department of Surgery and Department of Medicine meetings to report relevant issues or problems relating to the Departments of Surgery and Medicine for action.

(c) Meetings: The Committee shall meet at least quarterly and shall maintain a permanent record of its meetings.

Section 23. Ad Hoc Dispute Resolution Committee

All disputes between the Governing Board/Administration and the Medical Staff ("Parties"), relating to the Medical Staff's rights of self-governance as set forth in California Business & Professions Code section 2282.5 ("Disputes"), which have not been resolved by informal meetings and discussions, shall be addressed and resolved in accordance with the meet and confer process of an Ad Hoc Dispute Resolution Committee ("AHDRC"), as described in this section. In the event either Party determines that a Dispute exists, such Party shall give written notice to the other Party, stating the nature of the Dispute. Within thirty (30) days following receipt of such notice, both Parties shall appoint representatives to an AHDRC, as provided below. A separate AHDRC shall be established for each Dispute for which notice is given pursuant to this section. Accordingly, more than one AHDRC may be operative at a time. Neither party shall initiate any legal action related to the Dispute until this Committee has completed its efforts to resolve the dispute.

(a) Composition. An Ad Hoc Dispute Resolution Committee (AHDRC) shall be composed of three (3) members appointed by the Governing Board and three (3) members appointed by the Medical Executive Committee. The six (6) members may appoint a seventh member. The seventh member will not be a voting member of the Committee, but function of a mediator. In even numbered years the AHDRC chair shall be designated by the Chair of the

Governing Board and in odd numbered years the AHDRC chair shall be designated by the Chief of the Medical Staff.

(b) Duties. When formed, an AHDRC shall promptly receive and review written requests for initiation of the meet and confer/dispute resolution process. The AHDRC, with such assistance and input as it may request, shall then meet in good faith to recommend a resolution of the dispute. Such efforts shall continue, as necessary, for up to sixty (60) days. The AHDRC shall report the results of its efforts and its recommendations to both the Medical Executive Committee and the Governing Board. Both parties are obligated to consider the AHDRC recommendations carefully and to give them great weight. Unless requested by the Parties to continue its deliberations, the AHDRC shall dissolve thirty (30) business days following the reporting of its results and recommendations.

(c) Expenses. Each Party shall bear its own legal expenses. Unless the Parties agree otherwise, approved expenses of the AHDRC (such as consulting fees or expenses related to the appointment of the mediator) shall be paid by the parties equally.

## ARTICLE XIII: CONFIDENTIALITY

All members of the Medical Staff acknowledge that by accepting membership on the Medical Staff, they agree to respect and maintain the confidentiality of discussion, deliberations, proceedings and activities of Medical Staff committees and departments which have the responsibility for evaluating and improving the quality of care in the Hospital.

Such information shall not be disclosed voluntarily to anyone, except to persons authorized to receive it in the conduct of such Medical Staff affairs or as directed by the Executive Committee or the Hospital's Board. Any questions regarding whether information is confidential shall be resolved by the Chief of Staff and the Hospital Administration.

Any violation of this provision may subject the member to corrective action, including summary suspension, as provided in Article V.

## ARTICLE XIV: RULES AND REGULATIONS

Section 1. Adoption and Effect of General Rules and Policies and Procedures.

The Medical Executive Committee is hereby authorized to establish Medical Staff rules and policies as provided in this Article. Rules and policies shall be reviewed every two (2) years.

Section 2. General Rules

The Medical Executive Committee, following notice to the members of the Active Staff may propose the adoption, amendment or repeal of General Medical Staff Rules for approval by the Board of Directors. If a majority of the members of the Active Staff sign a petition objecting to the proposed General Medical Staff Rule and Regulation, the Medical Executive Committee-Medical Staff Dispute Resolution process provided in Article XVII of these Bylaws will be followed. General Medical Staff Rules shall become effective when approved by the Board of Directors – which approval shall not be unreasonably withheld. If the Board of Directors withholds its approval for a General Rule recommended by the Medical Executive Committee, the Medical Executive Committee may submit the matter to an Ad Hoc Dispute Resolution Committee for mediation as provided in Article XII, Section 24.

Section 3. Clinical Department Rules

A clinical department may propose rules applicable to that department to the Medical Executive Committee. Clinical department rules shall become effective upon approval by the Medical Executive Committee and the Board of Directors. The Board of Directors shall not unreasonably withhold its approval. If the Board of Directors does not approve a proposed clinical department rule, the Medical Executive Committee may submit the matter to an Ad Hoc Dispute Resolution Committee for mediation as provided in Article XII, Section 24.

Section 4. Initiation of General Rules or Policies by Active Staff Members' Written Petition

Voting members of the Active Staff may propose adoption, amendment or repeal of General Rules or of Medical Staff policies by following the process provided in Article XV, Section 1(b), below.

Section 5. Urgent Amendment of Rules

The Medical Executive Committee, with the approval of the Board of Directors, may adopt amendments to General Medical Staff Rules provisionally without notice to the General Medical Staff upon a documented need for an urgent amendment to comply with applicable law or regulation. Following notice of such action, members of the Active Staff, by petition signed by a majority of such members, may ask the Medical Executive Committee to reconsider such changes.

Section 6. Exclusivity

Neither the Medical Staff nor the Board of Directors shall unilaterally amend the rules or policies. Applicants and members of the Medical Staff shall be governed by such rules and policies as are properly initiated and adopted. If there is a conflict between the Bylaws and the rules or policies, the Bylaws shall prevail. The mechanisms described herein shall be the sole methods for the initiation, adoption, amendment, or repeal of the Medical Staff rules and policies.

## ARTICLE XV: ADOPTION AND AMENDMENT OF BYLAWS

Section 1. Adoption, Amendment or Repeal of Bylaws

Proposals to adopt, amend or repeal the Bylaws may be initiated by any of the following methods:

(a) Medical Executive Committee. The Medical Executive Committee, with the recommendation of the Bylaws Committee, or on its own motion, may recommend adoption, amendment or repeal of the Bylaws to the voting members of the Medical Staff as provided in this Article.

(b) Written Petition. The members of the Active Staff, by a written petition signed by a majority of the Active Staff members, may petition the Medical Executive Committee to initiate a proposal to adopt, amend or repeal these Bylaws. Such petition shall identify exact language to be added, changed or deleted. If the Medical Executive Committee agrees with the proposed change, it may recommend the change as provided in subsection 1(a) of this Article XV. If the Medical Executive Committee does not agree with the proposed change, the Medical Executive Committee shall initiate the Medical Executive Committee-Medical Staff Dispute Resolution process set forth in Article XVII of these Bylaws. If the disagreement has not been resolved within ninety (90) days after the date on which the proposal was delivered to the Medical Executive Committee, the Chief of Staff shall call a special meeting of the Active Staff, as provided below, to consider the proposal.

However, should the Executive Committee determine that an amendment to these Bylaws is required by any law or regulation of the state of California, then the foregoing procedure of amendments shall not be required and the following emergency procedure shall apply. In using the emergency procedure, the Executive Committee shall have the right to adopt such an amendment at any regular meeting or special meeting called for that purpose provided the members of the Executive Committee have been given at least five days written notice of the proposed action. A two-thirds majority of those present shall be required for adoption. Further, the resolution adopting the amendment shall clearly and concisely state the reason for using the emergency procedure. Amendments made by the use of either procedure shall be effective when approved by the Board of Directors, but must be ratified by a two-thirds majority of the Active Staff present at a regularly scheduled general Medical Staff Meeting.

Section 2. Action By The Active Staff

If a proposal is initiated as provided above, the Chief of Staff shall inform the members of the Active Staff that the text of the proposed change to the Bylaws can be obtained from the Medical Staff office. Not less than sixty (60) days, and not more than ninety (90) days, from the date of such notice, the Chief of Staff shall call a special meeting of the Medical Staff to consider the proposed change.

To be adopted, a proposed change to the Bylaws must be approved by two-thirds of the members of the Active Staff voting in person or by written ballot at the special Medical Staff meeting.

Section 3. Approval by the Board of Directors

Upon approval by the Active Staff as provided above, the proposed Bylaws change shall be submitted to the Board of Directors for approval. The Board of Directors shall give appropriate weight to the Active Staff's proposed change. If no action on the proposed change is taken by the Board of Directors within sixty (60) days, the proposed change shall be deemed to have been approved by the Board of Directors. The Board of Directors may not unreasonably withhold its approval from the Active Staff's recommended change. If the Board of Directors votes to disapprove any part of the recommended change, the Board of Directors' Chair shall give the Chief of Staff of the Medical Staff written notice of the reasons for non-approval within ten business days from the Board of Directors' action. At the request of the Medical Executive Committee, the Board of Directors' disapproval shall be submitted to the Ad Hoc Dispute Resolution Committee for mediation as provided in Article XII, Section 24.

Section 4. Consistency with Hospital Bylaws

The Medical Staff and the Hospital Bylaws shall be consistent. Neither the Medical Staff nor the Board of Directors may unilaterally amend these Bylaws. The mechanisms described herein shall be the sole methods for the initiation, adoption, amendment, or repeal of the Medical Staff Bylaws.

## ARTICLE XVI: INDEMNIFICATION

The Hospital shall provide a defense and shall indemnify the Medical Staff and all Medical Staff members and invited participants in peer review activities, Medical Staff operations or Medical Staff self-governance against any liability, claims, costs or expenses brought or relating to or arising out of the Medical Staffs or any such individual's participation in a peer review activity or other Medical Staff self-governing activities at the facility. Upon request, the Hospital shall provide the Medical Executive Committee with documentation sufficient to assure that it has sufficient insurance coverage or other resources to discharge its obligations under this Article. All issues regarding assurances, coverage, indemnification or defense arising from this Article shall be resolved by an Ad Hoc Dispute Resolution Committee described in these Bylaws.

At the first meeting of each calendar year, the Chief Executive Officer shall provide evidence of insurance coverage or other resources with which the Hospital could discharge its obligations under this article.

## ARTICLE XVII: MEDICAL EXECUTIVE COMMITTEE-MEDICAL STAFF DISPUTE RESOLUTION PROCESS

Disputes between the Medical Executive Committee and voting members of the Active Staff, as defined in Article XIV and XV of these Bylaws, shall be resolved as follows:

(a) If a majority of the members of the Active Staff sign a petition proposing a change to these Bylaws or the General Medical Staff Rules and Regulations or policies, or objecting to an action of the Medical Executive Committee relating to these Bylaws, General Medical Staff Rules and Regulations, policies or other official Medical Executive Committee

actions, such petition shall be transmitted to the Medical Executive Committee via the Chief of Staff or the Medical Staff Office.

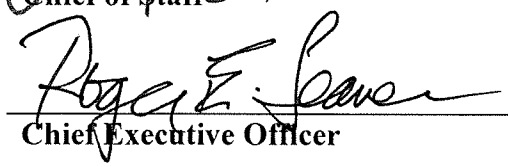
(b) The Medical Executive Committee shall, within sixty (60) days after it receives such petition via the Chief of Staff or Medical Staff Office, meet with representatives of those who have signed the petition to discuss and attempt to resolve the matter by mutual agreement.

(c) If the Medical Executive Committee and such representatives cannot agree on the subject matter of such petition, a consultant or a mediator may be engaged, by mutual agreement of the Medical Executive Committee and such representatives, to assist in resolving the dispute. If such a consultant or a mediator is engaged, the parties shall share equally in the costs of such consultant or mediator, provided however, that in no event shall the consultant or mediator be the Board of Directors or a representative thereof.

(d) If a matter relating to these Bylaws or the General Medical Staff Rules and Regulations or policies is not resolved within ninety (90) days after such matter was transmitted to the Medical Executive Committee via the Chief of Staff or Medical Staff Office, the Medical Executive Committee and such representatives shall prepare separate written statements of their respective positions and submit them to the Board of Directors within no more than thirty (30) days thereafter, to be considered by the Board of Directors for final decision.

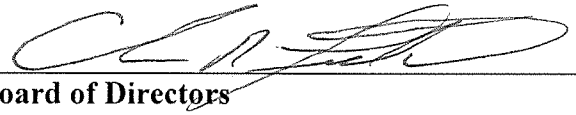
2/6/23

**Chief of Staff** **Date**



2/6/23

**Chief Executive Officer** **Date**



2/6/23

**Board of Directors** **Date**

ADOPTED BY THE ACTIVE MEDICAL STAFF OF HENRY MAYO NEWHALL MEMORIAL HOSPITAL ON APRIL 7, 1975.

APPROVED BY THE BOARD OF TRUSTEES OF HENRY MAYO NEWHALL MEMORIAL HOSPITAL ON APRIL 9, 1975.

| | |
|---|---|
| AMENDED: | May 3, 1976 |
| AMENDED: | November 10, 1976 |
| AMENDED: | November 9, 1977 |
| AMENDED: | October 11, 1978 |
| AMENDED: | October 9, 1979 |
| AMENDED: | September 3, 1980 |
| AMENDED: | September 14, 1981 |
| AMENDED: | February 1, 1982 |
| AMENDED: | September 13, 1982 |
| AMENDED: | December 5, 1983 |
| AMENDED: | February 6, 1984 |
| AMENDED: | November 8, 1984 |
| AMENDED: | October 10, 1985 |
| AMENDED: | March 13, 1986 |
| AMENDED: | January 8, 1987 |
| AMENDED: | April 9, 1987 |
| AMENDED: | November 12, 1987 |
| AMENDED: | October 13, 1988 |
| AMENDED: | January 11, 1990 |
| AMENDED: | July 12, 1990 |
| AMENDED: | November 8, 1990 |
| AMENDED: | April 11, 1991 |
| AMENDED: | February 13, 1992 |
| AMENDED: | April 11, 1997 |
| AMENDED: | March 12, 1998 |
| AMENDED: | December 12, 1998 |
| AMENDED: | July 8, 1999 |
| AMENDED: | June 6, 2002 |
| AMENDED: | September 26, 2005 |
| AMENDED: | January 23, 2006 |
| AMENDED: | April 2, 2012 |
| AMENDED: | May 3, 2014 |
| AMENDED: | February 6, 2017 |
| AMENDED: | August 8, 2017 |
| AMENDED: | February 6, 2023 |

See Rules & Regulations Index for additional amendments to Bylaws

# GENERAL RULES & REGULATIONS

# HMNH MEDICAL STAFF RULES AND REGULATIONS

## PREAMBLE

The Medical Staff shall initiate and adopt such rules and regulations as it may deem necessary for the proper conduct of its work and shall periodically review and revise its rules and regulations to comply with current medical staff practice. Rules and regulations shall be adopted, amended or repealed in accordance with the procedures specified in the Medical Staff Bylaws.

Following adoption, such rules and regulations shall become effective following approval by the Board of Directors, which approval shall not be withheld unreasonably.

Applicants and members of the Medical Staff shall be governed by such rules and regulations as are properly initiated and adopted. If there is a conflict between the Bylaws and the rules and regulations, the Bylaws shall prevail.

Violation of these rules and regulations shall be grounds for disciplinary action in accordance with the Medical Staff Bylaws.

# I. GENERAL RULES AND REGULATIONS

## I.A. Acute Rehabilitation Unit

1. The Acute Rehabilitation Unit is established to provide those rehabilitation services that restore an ill or injured person to the highest level of self-sufficiency or gainful employment of which he is capable in the shortest possible time, compatible with his physical, intellectual and emotional or psychological capabilities and in accord with planned goals and objectives. Seventy-five percent (75%) of all admissions to the Acute Rehabilitation Unit will have one of the following diagnoses: stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, fractured bones, brain injury, polyarthritis, degenerative neurological disorders, and burns. Other diagnoses can be considered by the Medical Director or his designee, providing the patient meets established criteria for admission.

2. All patients will have a pre-screening evaluation completed by the Medical Director/designee of the Acute Rehabilitation Unit to assess a patient's ability to meet the Acute Rehabilitation Unit's admission criteria. There shall be a history and physical examination within 24 hours after admission of the patient to the Acute Rehabilitation Unit. A history and physical done within thirty (30) days prior to admission to the Acute Rehabilitation Unit is acceptable as long as the attending physician, Medical Director or his designee does an interval history and physical examination reflecting any changes.

3. Any physician who is a member of the Medical Staff or who has been granted temporary privileges may admit patients who meet the Unit's admission criteria to the Acute Rehabilitation Unit.

4. All Acute Rehabilitation Unit patients will be followed by a rehabilitation physician, defined as a licensed physician with specialized training and experience in inpatient rehabilitation at Henry Mayo Newhall Hospital.

5. All rehabilitation physicians providing professional services at Henry Mayo Newhall Hospital's Acute Rehabilitation Unit must:

   a. Have appropriate Medical Staff membership and be a licensed physician with specialized training and experience in inpatient rehabilitation.

   b. Be board certified or board eligible in their respective specialty.

6. Each managing rehabilitation physician shall provide a monthly on call coverage list to the Nursing Director of the Acute Rehabilitation Unit of all rehabilitation physicians who will provide coverage for his/her patients in their absence.

7. Each managing or covering rehabilitation physician shall be on site a minimum of 5 days a week to review, evaluate, and document the clinical management of each patient under his/her care.

8. Each managing or covering rehabilitation physician must attend and participate in the weekly Acute Rehabilitation Unit's patient care planning performance improvement conferences.

9. Each rehabilitation physician shall participate in the clinical supervision of non-physician personnel involved in the care of his/her patients.

## I.B. Admission, Care, Transfer of Care and Discharge of Patients

1. The hospital shall admit patients suffering from all types of disease except those types of disease specifically banned by law, the Medical Staff of the Board of Directors. Patients may be treated only by practitioners who have submitted proper credentials and have been duly appointed to membership on the Medical Staff or granted temporary privileges for the care of such patients.

2. All admissions to the hospital shall be on direction of the patient's own private physician. Emergency cases who do not have a private physician shall be assigned to a member of the staff in accordance with these rules and regulations Section III-A-2.5.

3. Except in emergency, no patient shall be admitted to the hospital until after a provisional diagnosis has been stated. In case of emergency, the provisional diagnosis shall be stated as soon after admission as possible.

4. Practitioners admitting private patients shall be held responsible for giving such information as may be necessary to assure the protection of the other patients from those who are a source of danger from any cause whatever.

5. A member of the Medical Staff shall only arrange for coverage of his practice by a practitioner with approved privileges at this hospital and who is willing and available to provide service to patients at this hospital.

6. In cases that unavailability of a practitioner impedes patient care, the Chief of Staff or his designee shall have the authority to call any member of the Medical Staff to intervene should he deem it necessary.

6.1 In an emergency, when neither the attending physician nor his designee can be reached or are available, the nurse in charge may call one of the facility's Emergency Department physicians.

7. The care of the patient may be transferred from the admitting practitioner to another practitioner during the course of an admission. This may be because the admitting physician was providing coverage for the attending physician, by patient request or by the request of a legally responsible person acting on the patient's behalf. In all cases, the attending practitioner shall state the reason for transferring care, condition/stability of the patient at the time of transfer, the name of accepting practitioner and any appropriate documentation regarding continued plan of care.

8. When the care of the patient is transferred from an HMNH physician to a physician of another facility, the following criteria must be addressed:

8.1 The reason for transfer.

8.2 The stability of the patient at the time of transfer as addressed in the Emergency Department Directive, Emergency Patient Evaluation and Interfacility Transfers.

8.3 The name of the accepting organization and practitioner and documentation that they have accepted the patient, bed availability and ability to care for the patient, and

8.4 Who is responsible for the care of the patient during the transfer.

8.5 All forms must be completed in accordance with above ED Directive including Patient Transfer Acknowledgment, Physician Certification and Authorization for Transfer, and other forms as appropriate such as Transfer for Non-Medical Reasons, patient Refusal of Transfer, and Patient Request for Transfer or Discharge.

9. Patients shall be discharged only on order of the attending practitioner. The attending practitioner shall see that the record is complete, state his final diagnosis, and sign the record, as outlined in these rules and regulations.

## I.C. Allied Health Professionals

1. Pursuant to Article II, Section 4 of the Bylaws of Henry Mayo Newhall Hospital, Allied Health Professionals (AHP) means individuals who are neither physicians, dentists, podiatrists, who are privileged to assist members of the Medical Staff in the care of the patients within the limits of the skills and scope of their lawful practice. AHP are not eligible for Medical Staff membership, but may be granted privileges consistent with the Medical Staff Bylaws. AHP who meet prescribed requirements will be granted Hospital privileges following screening and approval by the Medical Staff and Hospital. Each AHP will be allowed to render medical services in the Hospital only in accordance with such AHP's granted privileges.

2. The applicant requesting privileges to practice at Henry Mayo Newhall Hospital will complete an application and submit the following information:

2.1 Educational background

2.2 Description of clinical experience

2.3 Evidence of certification, when applicable

2.4 Evidence of current California licensure, when applicable

2.5 Evidence of professional liability coverage. Hospital liability insurance shall constitute evidence of professional coverage for hospital employees.

2.6 Professional liability claims, if any, filed against the practitioner.

2.7 List of privileges desired

2.8 List of professional references

2.9 Membership in professional societies

2.10 Staff memberships, privileges, licensure, and certifications

2.11 If the applicant is an employee of a sponsoring practitioner, a statement must be signed by the sponsoring practitioner outlining the duties that the applicant is qualified to perform and agreeing that the sponsoring practitioner will:

a) Be responsible for the actions of the applicant;

b) Maintain professional liability insurance to cover the acts or omissions of the AHP, and

c) Indemnify and hold harmless the Hospital from and against any liability and expense arising from or in connection with the acts or omissions of the AHP.

3. AHP shall be individually assigned to an appropriate clinical department, and shall carry out their duties subject to the department policies and procedures.

4. Medical Staff Office is responsible for verification of information on application. This information is submitted to the:

4.1 Medical Staff Credentials Committee is responsible for reviewing and making recommendations regarding membership in the AHP category.

5. The Board of Directors is responsible for granting or denying of all privileges for AHP.

6. Temporary privileges may be granted during the pendency of processing the AHP's application for AHP privileges, if recommended by the Chairman of the appropriate Department for non-nursing AHP, and the Chief of Staff, and approved by the President.

7. The Nursing Department will assume responsibility for orienting the AHP who has been granted Hospital privileges to the Hospital's physical environment, chart forms and key personnel.

8. When applicable, AHP granted Hospital privileges are expected to document all patient

interactions on appropriate Hospital forms, and to provide appropriate Hospital personnel with ongoing feedback about the patients' needs and responses to hospitalization and treatment.

9. Every two years all AHP must request reappointment.

10. If, at any time, the AHP desires to expand the original list of approved privileges, a new statement, signed, outlining the extended duties must be submitted.

11. Any AHP requiring a sponsoring practitioner who is no longer associated with the sponsoring practitioner must notify the Medical Staff Office immediately and update his file with the name of a new sponsoring practitioner.

12. If misrepresentation or fraud exists in an AHP's application, the AHP's privileges may be denied, immediately withdrawn, or amended upon discovery of such misrepresentation or fraud.

13. AHP shall not inhibit or in any way interfere with the responsibilities of Hospital employees.

14. The sponsoring practitioner and/or employer of the AHP shares the responsibility for ensuring that the AHP does not exceed his or her privileges. Members of the Medical Staff shall not order an AHP to perform or participate in any activity which exceeds the scope of the AHP's licensure or privileges at the Hospital.

15. The AHP's privileges may be withdrawn or modified by the Chairman of the Department to which the AHP is assigned or, by the Chief of Staff. For Registered Nurse First Assistants, Registered Nurses certified for 5150 involuntary detention and Marriage and Family Therapists certified for 5150 involuntary detention privileges may be withdrawn or modified by the Interdisciplinary Practice Committee. The AHP's sponsoring practitioner and/or employer will be notified of such action.

16. Each AHP shall participate as appropriate in performance improvement and other quality review, evaluation, and monitoring activities required of AHP, in proctoring of AHP in his occupation or profession, or of a lesser occupation or profession, and in discharging such other functions as may be required from time to time.

17. At least seven (7) months prior to expiration of each AHP's reappointment term, the Medical Staff Office personnel sends each AHP a Reappointment Application packet. The Reappointment Application packet includes the following:

17.1 AHP Reapplication cover letter

17.2 AHP Reapplication

17.3 Privilege Request Form

17.4 Behavioral Health Privilege card (for behavioral health practitioners)

17.5 Authorization for Liability Insurance Verification

17.6 Claim Information forms

18. Requests for reappointment to the AHP staff are processed in the same manner by the same committees as requests for initial appointment.

19. Nothing contained in the Medical Staff Bylaws, Rules & Regulations shall be interpreted to entitle an AHP to the procedural rights set forth in Article VI except when an action is taken against a clinical psychologist that must be reported to the state licensing board, in which case the clinical psychologist shall be entitled only to the procedural rights set forth in Article VI. However, an AHP shall have the right to challenge any action that would constitute grounds for a hearing under Article VI of the Medical Staff Bylaws by filing a written grievance with the Executive Committee within fifteen (15) days of such action. Upon receipt of such a grievance, the Executive Committee or its designee shall conduct an investigation that shall afford the AHP an opportunity for an interview concerning the grievance. Any such interview shall not constitute a "hearing" as established by Article VI of the Medical Staff Bylaws and shall not be conducted according to the procedural rules applicable to such hearings. Before the interview, the AHP shall be informed of the general nature and circumstances giving rise to the action, and the AHP may present information relevant thereto at the interview. A record of the interview shall be made. The Executive Committee or its designee shall make a decision based on the interview and all other information available to it.

20. Any AHP's privileges shall automatically terminate, without review pursuant to Section I, C, 19 or any other section of these Medical Staff Bylaws, Rules & Regulations, in the event [that]:

20.1 The Medical Staff membership of the supervising practitioner is terminated, whether such termination is voluntary or involuntary, except for Registered Nurse First Assistants, Registered Nurses certified for 5150 detention and Marriage Family Therapist certified for 5150 involuntary detention who are employed by the hospital.

20.2 The supervising practitioner no longer agrees to act as the supervising practitioner for any reason, or the relationship between the AHP and the supervising Practitioner is otherwise terminated, regardless of the reason therefore, except for Registered Nurse First Assistants, Registered Nurses certified for 5150 detention and Marriage Family Therapist certified for 5150 involuntary detention who are employed by the hospital.

20.3 The AHP's certification or license expires, is revoked, or is suspended.

20.4 The AHP's employment with the hospital is terminated or suspended.

21. The rights afforded by this section shall not apply to any decision regarding whether a

category of AHP shall or shall not be eligible for practice privileges and the terms, prerogatives, or conditions of such decision. Those questions shall be submitted for consideration to the Board of Directors, which has the discretion of decline to review the request or to review using any procedure the Board of Directors deems appropriate.

## I.D. Appointment to the Medical Staff

1. In accordance with Article III of the Medical Staff Bylaws, a physician, podiatrist or dentist initially applying for membership on the Medical Staff shall file with the Chief Executive Officer a written application which shall set forth in detail his professional qualifications, past practice and hospital staff affiliations, board certification status, license and registration status, health status, professional liability actions, professional liability insurance, continuing medical education and his personal and professional references which shall include the recommendations from three (3) persons on the Medical Staff or three (3) persons who have had extensive experience in observing and working with the applicant if he is from a different geographical area.

2. Every application for staff appointment shall be signed by the applicant and shall contain the applicant's specific acknowledgment of every Medical Staff member's obligations to provide continuous care and supervision of his patients, to abide by the Bylaws, Rules and Regulations and policies of the Hospital and Medical Staff, and understanding and agreement that the applicant agrees to submit any reasonable evidence of health status that may be requested by the Medical Executive Committee.

3. Medical Staff membership appointment and clinical privileges delineation for each applicant must be based on, at a minimum, the following:

(a) Current medical licensure, DEA registration, and professional liability insurance (all verified with the primary sources) and continuing medical education.

(b) Health status, including any reasonable evidence of current health status that may be requested by the Executive Committee of the Medical Staff. The applicant's statement that no health problems exist that could affect his or her practice is confirmed by the director of a training program, by the chief of services or chief of staff at another hospital at which the applicant holds privileges, or by a currently licensed physician designated by the hospital.

(c) Professional qualifications, including relevant training and/or experience (verified with the primary sources whenever feasible).

(d) Clinical and technical skills, judgment, ethics and conduct, and current competence as determined by the applicant's medical knowledge, reliability and availability. Information shall be obtained directly from primary source(s) in the form of letters from authoritative sources, which contain informed opinions on each applicant's scope and level of performance.

4. Sex, race, creed and/or national origin are not used in making decision regarding the

granting or denying of Medical Staff membership of clinical privileges.

5. The Medical Staff Assistant of Medical Staff Services will:

5.1 Forward a pre-application package upon request to the applicant.

5.2 Forward an application appointment package to the applicant upon request.

5.3 Date-stamp the Medical Staff application, initiate the HMNH application checklist and verify that all required information has been included by the applicant.

5.4 If all items on the application are not completed (or accompanied by an explanation as to why answers are unavailable) or all requested information (as identified in the application and accompanying cover letter) is not received, the application will be deemed incomplete and shall be returned to the applicant. Any applications so returned will be sent Certified Mail or Email, Return Receipt Requested.

6. The Medical Staff Assistant sends out reference letters to verify licensure (Medical Board of California), medical education, internship, residency, fellowship, Board Certification, hospital affiliations, professional references and licensure and malpractice insurance histories, noting dates of actions on the Application Checklist.

7. The Medical Staff Assistant forwards requests for privileges with the appropriate documentation to the applicant's clinical department chairman for evaluation and recommendation of privilege delineation.

8. Within forty-five (45) days of receipt of the completed application for membership, the Medical Staff Assistant forwards all documentation to the Credentials Committee for evaluation and recommendation of membership.

9. The application for membership and privileges will be forwarded to the Medical Executive Committee within three (3) months of receipt of all documentation, with the recommendation of the clinical department chairman and Credentials Committee.

10. The Medical Executive Committee forwards the recommendation to the Board of Directors' next regular meeting, through the Chief Executive Officer.

11. The applicant requesting appointment has the burden of producing adequate information for proper evaluation of his competency, character, ethics and qualifications. The applicant must:

11.1 Complete, sign and return all documents outlined in the application "Cover Letter."

11.2 Assist Medical Staff Medical Staff Assistant/Assistant in obtaining any recommendations from training programs, hospital affiliates, etc., which may be delaying application processing.

11.3 Produce adequate information to resolve any questions related to his qualifications for staff membership and/or privileges.

12. The Credentials Committee will:

12.1 Review all information available regarding the competence and qualifications of the applicant, and submit a recommendation to the Executive Committee within two (2) months of receipt of the completed application for membership.

13. The chairmen of the clinical departments are responsible for reviewing all information available on the applicant for the purpose of determining justification of his request for privileges for the provisional period, as well as offering any pertinent information related to his qualifications for membership on the Medical Staff.

14. The Medical Executive Committee is responsible for submitting a report to the Board of Directors recommending the provisional appointment (acceptance), deferral or rejection, and privileges, with any probationary conditions related to privileges, of each applicant.

14.1 The Medical Executive Committee will follow-up a recommendation of deferral (for further consideration of investigation) within three (3) months with a recommendation to accept or reject the applicant.

15. The Secretary of the Medical Staff is responsible for notifying the applicant by mail of any recommendation to reject or defer consideration of the applicant within ten (10) days after such a decision is made. The reasons for a recommendation to defer for further consideration for investigation shall be stated.

16. The Board of Directors is responsible for the final decision, based on the Medial Staff's recommendations regarding each applicant's membership appointment and clinical privileges delineation. The Board of Directors will either recommend favorably or unfavorably, according to Article III, Section 4, (a) and (b) of the Medical Staff Bylaws.

17. Appointments are for a period not to exceed two (2) years, to coincide with the date of expiration of the new member's California medical license.

## I.E. Clinical Departments

1. Each member of the Medical Staff is assigned to a clinical department. Each clinical department shall meet at least quarterly to review and analyze the clinical work of the department. A member of the Medical Staff may only vote at meetings of his assigned clinical department. Only a member of the Active or Associate Staff categories shall be eligible to vote at meetings of his clinical department. A Provisional or Honorary staff member or a practitioner with temporary privileges is not eligible to vote at the clinical department meetings.

1.1 To be eligible to be Deputy Chief, a Medical Staff member shall have served as the Chairman of the Department of Medicine, Primary Care, Surgery, the Chairman of a Department Peer Review Committee or have been a member of the Medical Executive Committee for more than one year.

2. On an annual basis, the Chief of Staff shall appoint the clinical department chairmen. The Chief of Staff, with the consultation of the department chairman, shall appoint an assistant chairman of each department.

3. The Chairman of each clinical department is a member of the Active Staff and is certified by an appropriate specialty board or affirmatively establishes, through the privilege delineation process that he is possessed of comparable competence.

3.1 The Hospital and Medical Staff shall determine relevance of the board certification to the individual's responsibilities. For example, board certification in pathology may have no relevance for an individual to serve as the chairman of the Primary Care Department.

3.2 Board certification shall only be accepted by a specialty board recognized by the American Board of Medical Specialties, the Council of Post-Secondary Accreditation (in Dentistry) or the American Osteopathic Association.

3.3 In the absence of board certification, the Medical Staff shall establish through the privilege delineation process that a candidate for chairmanship possess competence comparable to that accomplished by identifying the knowledge and skills expected of a board-certified individual and determining that the candidate has such knowledge base.

## I.F. Committee/Department Letters

1. Medical Staff committees and departments may send letters to other committees or departments, to Medical Staff members, to Allied Health Professionals (AHPs), or members of Hospital Administration for "Education" purposes. Copies of "Education" letters shall not be filed in the practitioner's credentials files.

2. Medical Staff committees and department may send letters to other committees or departments, Medical Staff members, AHP, or members of Hospital Administration requesting information or input. Such letters will request a response within thirty (30) days.

2.1 Upon receipt of a response, the committee or department shall determine if the care, service or behavior reviewed was appropriate. If appropriate, no letter shall be filed in the practitioner's credentials file.

2.2 If a response is not received within thirty (30) days, a second letter will be sent by certified mail requesting a response within fifteen (15) days.

2.3 If a response is not received to the second letter, a third letter will be sent by certified mail requesting a response within thirty (30) days.

2.4 If a response is not received to the third letter within thirty (30) days, the committee shall send a letter by certified mail to the practitioner, with a copy to his/her credentials file, if the care, service, or behavior reviewed was considered to be inappropriate. Also, a letter will be sent to the Credentials Committee recommending that the practitioner not be reappointed.

## I.G. Communication Plan

1. In accordance with Article IX of the Medical Staff Bylaws, the Chief of Staff shall receive and interpret the policies of the Board of Directors to the Medical Staff. The Chief of Staff shall communicate to the Medical Staff the results of their recommendations to the Board regarding amendments to the Medical Staff Bylaws, Rules and Regulations, and privilege cards. He shall provide this communication via a monthly memo to the clinical departments and through the quarterly Medical Staff Newsletter.

## I.H. Complaints, Physician Related

1. Hospitals are required to inform anyone that makes a formal written complaint about a physician, surgeon or podiatrist that the respective board (Medical Board of California or the Board of Podiatric Medicine) is the only authority that can take disciplinary action against the practitioner's license (Senate Bill 916).

2. A standardized letter will be sent to all individuals who register a formal written complaint about a physician or podiatrist on the Medical Staff of the Hospital.

3. Complaints must pertain to services rendered within the Hospital facilities. Some general guidelines as to the types of complaints which fall under this policy include:

3.1 Complaints involving professional competence or integrity.

3.2 Complaints relating to the qualification, fitness or character of a practitioner.

3.3 Complaints or information indicating that the practitioner may be guilty of unprofessional conduct or may be impaired because of drug or alcohol abuse or mental illness.

4. A copy of the letter will be sent to the physician or podiatrist involved.

## I.I. Confidentiality of Medical Staff Records and Committee Proceedings

1. It shall be the policy of the Medical Staff, Administration and Board of Directors of Henry Mayo Newhall Hospital that all records and proceedings of Medical Staff committees that are responsible for evaluating and improving the quality of care provided in the Hospital, including credential files of applicants for Medical Staff membership and of Medical Staff

members, shall be retained in strict confidence in the Medical Staff Office. This action is in concert with the actions of the California legislature which, recognizing the importance of protecting the confidentiality of Medical Staff records and proceedings of committees, enacted Section 1157 of the Evidence Code.

2. Disclosure to Applicant or Medical Staff Member

2.1 An applicant for Medical Staff membership or a Medical Staff member, who wishes to review any portion of his credential file or any other record or proceeding of a Medical Staff committee, shall submit a written request that specifies the item(s) he wishes to see. Requests to review any portion of the files that conform to the restrictions set forth below may generally be granted, but may be denied in unusual circumstance by the Chief of Staff or the Administrator.

2.2 An applicant or member may inspect only his own credential file (unless he is authorized to review another applicant's or member's file in accordance with the provisions set forth in Section 3 below) and may review only the following in the credentials file:

a) Documents or correspondence the applicant or member personally prepared and submitted (e.g., application to staff or letters).

b) Documents or correspondence addressed and sent directly to the applicant or member.

c) Public documents, such as copies of the applicant's or member's license to practice medicine.

2.3 Copies of any item contained in the credentials file or records and proceedings of any other Medical Staff Committee shall not be made for an applicant or member unless:

a) Pursuant to paragraph 2.2 above, the applicant or member may inspect the item, and

b) Approval for such copy to be made has been secured from the Chief of Staff or the Administrator.

2.4 Except as provided above in paragraphs 2.2 and 2.3, applicants and members may not have access to any item or document contained in the credential file or in the records and proceedings of any Medical Staff committee except when disclosure is required by law, including the situations discussed in paragraph a) below, and approved by the Administrator or the Chief of Staff.

a) In order to provide an applicant or member with an opportunity to prepare his defense for a Judicial Review committee hearing, the Administrator or the Chief of Staff may approve the disclosure of documents contained within the credential file or other records and proceedings of Medical Staff committees that formed the basis of the adverse recommendation to the applicant or member.

3. Disclosure to Medical Staff Officers, Committee and Department Chairman and Committee Members and Ex-Officio Members

3.1 The contents of the credential files (of applicants for Medical Staff membership and Medical Staff members) or records and proceedings of any other Medical Staff committees may be disclosed as appropriate and if relevant to the issue being review, to Medical Staff officers including but not limited to the Chief of Staff and Chairman of the department in which the practitioner seeks or has clinical privileges, to Medical Staff committee chairmen or members and ex-officio committee members, if approved by the committee's chairman.

a) Disclosure to such persons or entities shall occur whenever necessary to enable them to carry out the committee's responsibilities of evaluating and improving the quality of care rendered in the Hospital.

b) Credentials files and records or proceedings of any other Medical Staff committee may be disclosed to persons or committees responsible for recommending appointment or reappointment to the Medical Staff and/or which, if any clinical privileges shall be granted; for investigating any request for corrective action or recommending what corrective action should be taken; and for quality performance improvement and peer review activities at the request of the Executive Committee or appropriate department chairman.

3.2 Disclosure to Medical Staff officers, committee chairmen and members and ex-officio members shall occur within the Medical Staff committee meeting or in the Medical Staff Office, except in exceptional instances which shall be determined by the Administrator or Chief of Staff.

a) Copies of any portion of the credential files or other records or proceedings of Medical Staff committees shall not be made or distributed to such Medical Staff members or committees except as outlined in 3.2(b) below or as determined by the Administrator or Chief of Staff.

b) Copies of agenda packets, including portions of credentials files or records or proceedings of Medical Staff committees, may be distributed to a member of the Executive Committee, Performance Improvement Committee, or other committees, as determined by the Chief of Staff and Administrator, if the member has a signed Confidentiality Agreement on file. Agenda packets may be distributed before committee meeting solely for the purpose of allowing the committee member to review the material in preparation for the meeting.

c) All portions of such documents described in 3.2(a) and (b) above reviewed by officers or committee chairmen, members or ex-officio members, shall be returned to and maintained by the Medical Staff Office.

4. Disclosure to the Hospital Board of Directors

4.1 Contents of the credential files or any other records or proceedings of a Medical Staff committee may be disclosed to the Board of Directors or any individual Board member, insofar

as is necessary to enable the Board of Directors or member of the Board to properly fulfill their legal responsibilities.

4.2 Disclosure shall be limited to the member(s) of the Board or member(s) of Board committee(s) that is/are responsible for evaluating and analyzing such information.

a) Any portion of a credential file or other records or proceeding of a Medical Staff committee that is reviewed by members of the Board of Directors shall not be included in or maintained as part of the Board records or minutes.

b) Actions by the Board of Directors shall refer, as appropriate, in summary fashion and by reference to any credential file or other record or proceeding material.

c) Copies of agenda packets including portions of credentials files or records or proceedings of Medical Staff committees may be distributed to a member of the Board or Board committee, if the member has a signed Confidentiality Agreement on file. Agenda packets may be distributed before committee meetings solely for the purpose of allowing the committee member to review the material in preparation for the meeting.

d) All portions of credential files or other records or proceedings of Medical Staff committees reviewed by the Board of Directors shall be returned to and maintained by the Medical Staff Office.

5. Disclosure of contents of credentials files to outside entities. Upon written authorization of the practitioner, a standardized form letter which contains the following information may be released to outside entities:

a) Dates of affiliation

b) Specialty

c) Staff category

d) Practitioner is a member of the Medical Staff and is in good standing

e) No action required to be reported pursuant to California Business and Professions Code, Section 805 or pursuant to the Health Care Quality Improvement Act (the National Practitioner Data Bank) has been taken by this Hospital against the practitioner.

If release of the standardized form letter would be inaccurate, the request for information shall be forwarded to the Chief of Staff and President for resolution.

5.1 Unless required by law, the only information other than that listed in section 5 above which may be released, upon written authorization of the practitioner specifying exactly which documents are to be released, are documents or correspondences that the practitioner personally

prepared and submitted (i.e. application to staff, letters, professional liability insurance certificate, or professional liability claim information forms), documents or correspondences addressed and sent directly to the applicant or member, or public documents (i.e. copy of the practitioner's license to practice, Drug Enforcement Administration certificate, documentation of board certification) or proctoring reports.

5.2 Copies of the Medical Staff and/or Allied Health Professional roster may be released to an outside entity. The only information which may be included on these rosters is:

a) Names of practitioners

b) Address

c) Phone number

d) FAX number

e) Specialty

f) Staff category

g) Dates of affiliation

## I.J. Conflict of Interest

1. A conflict of interest in any Medical Staff committee activity should be avoided. It is the responsibility of all Medical Staff committee members to excuse themselves from participation in any committee activity if there is a direct conflict of interest or a conflict of interest can be perceived on their part.

2. Excuse from participation in Medical Staff committee activity will be noted in minutes of the meeting.

3. Examples of conflict of interest which may occur at the Medical Staff committee level include:

3.1 Peer review of a practitioner by:

a) His partner practitioner

b) His spouse who is a practitioner on the HMNH Medical Staff.

c) His relative (such as father, son, mother, daughter) who is a practitioner on the HMNH Medical Staff.

d) The spouse or relative of the partner physician.

3.2 Committee review of product or service in which the practitioner, his spouse, his/her partner or his relative have financial interest in the product or service.
3.3 Approval for credentialing of a practitioner by a-d above.

## I. K. Consents

1. The patient and/or responsible party shall sign a written consent for the medical treatment of the patient. Should the patient and/or the responsible party not agree to some aspect of this regimen, medical consequences shall be explained by the physician. The patient and/or responsible party shall then sign a release for ill effects which may result from lack of such treatments.

2. No elective surgery or special diagnostic or therapeutic procedure may be performed in the hospital unless a signed consent has been obtained from the patient or the person legally responsible for the patient.

3. The consent must specifically name the procedure or procedures if more than one is to be performed, and the name of the practitioner performing the procedure. The consent must include the date and time of obtaining consent and the signature of at least one witness.

4. The consent will not be valid if it is obtained while the patient or responsible party is under the influence of any sedative or narcotic pre-operative medication.

5. Consent for medical or surgical treatment should be obtained by telephone only if the person having legal capacity to consent for the patient is not otherwise available. The responsible practitioner must provide the patient's legal representative with the information he would disclose if the person were present.

5.1 Hospital staff must verify that the patient's legal representative and practitioner have discussed the patient's condition and the recommended treatment and that the patient's representative has, in fact, given consent.

5.2 The discussion between the patient's legal representative and the hospital personnel should be witnessed by a responsible hospital employee and the exact time and nature of the consent given should be carefully documented and signed by both employees. The patient's representative must be informed that another employee will be listening to the discussion.

5.3 Immediate steps should be taken to procure a confirmation of consent by telegram or by letter whenever possible.

6. In case of emergency, when the patient or responsible party is unable to give consent, the following procedure shall be followed:

6.1 The patient's practitioner must determine whether the treatment appears to be immediately required and necessary to prevent the patient's death, severe disability or deterioration or aggravation of the patient's condition, or to alleviate severe pain.

6.2 If such an emergency condition exists, consent is implied by law, and treatment for the emergency condition may be provided.

6.3 Two practitioners should document the emergency medical condition and the necessity for the emergency medical treatment in the chart.

7. In no case shall any procedure specifically refused by the patient or responsible party be performed in the hospital.

## I.L. Consultations

1. It is the duty of the Medical Staff through the appropriate department and the Executive Committee, to see that members of the staff do not fail in the matter of calling consultants as needed. Where circumstances are such as to justify such action, the chairman of a service, chairman of a department or his designee, or the Chief of Staff or his designee may himself request a consultation.

2. The consultant must be well-qualified to give an opinion in the field in which his opinion is sought. A satisfactory consultation includes examination of the patient and the record and a written opinion signed by the consultant which is made part of the record. When operative procedures are involved, the consultation note, except in emergency, shall be recorded prior to operation.

3. Consultations with another qualified practitioner are required for the following inpatient conditions:

3.1 Seriously ill patients in whom the diagnosis is not certain.

3.2 Patients who are not considered good risks for any contemplated operation or treatment.

3.3 Unusually complicated situations where specific skills or other practitioners may be needed.

3.4 Required treatment is outside of the attending physician's privileges.

3.5 Pediatric consultation for patients under the age of two (2) years and under the age of five (5) years with IV therapy.

4. All initial emergency and trauma consults will be performed by a physician.

5. Advanced Practice Providers may perform initial non-emergent routine consultations

under physician supervision. The supervising physician is required to see the patient within 24 hours of time of initial request.

## I.M. Credentials File

1. A credentials file is maintained for each member of the Medical Staff and each Allied Health Professional (AHP) in accordance with the HMNH Medical Staff Bylaws, Title 22 regulations, and the standards of the Joint Commission on Accreditation of Healthcare Organizations, and the California Medical Association. The credentials file contains all information pertinent to a member of the Medical Staff as it pertains to his appointment and reappointment to the Medical Staff and his privileges. The credentials file of an AHP contains all information pertinent to his privileges.

2. Information in the credentials files is protected by Evidence Code 1157 and shall not be released upon receipt of a subpoena.

3. The credentials files shall include the following:

3.1 The completed and verified application for Medical Staff membership or AHP application, including information on training, experience, references, interviews, current licensure, Drug Enforcement Administration (DEA) registration (if applicable), professional liability coverage and experience, past or pending disciplinary actions, health status, and request for clinical privileges.

3.2 Evidence that the Medical Staff evaluated and acted upon the above information.

3.3 Evidence of proctoring of initial and additional privileges.

3.4 Specific and current clinical privileges recommended by the Medical Staff and approved by the Board of Directors.

3.5 Data pertinent to reappraisal and reappointment, including current licensure, DEA registration (if applicable), continuing medical education, attendance at required meetings, current professional liability coverage and experience, completion of medical records, participation in Medical Staff activities, utilization of the facility, past or pending disciplinary actions, professional performance and clinical judgment and patterns of adverse clinical outcomes, ethics and professional integrity, compliance with Medical Staff Bylaws, Rules and Regulations and Hospital policies and procedures, professional relations with patients, families, hospital staff, peers, and health status.

a) Professional liability claims information forms, as necessary.

b) Letters sent to practitioner from committees/ departments of the HMNH Medical Staff.

   i) Letters reflecting final resolution of a committee/department review of patient

care or practitioner behavior concerns are placed in the credentials files if care or behavior was deemed to be inappropriate.

ii) Letters from a committee/department to a practitioner requesting a response and for which there has been no response, are placed in the credentials files.

iii) Note: "Education" letters are not placed in the credential files.

c) HMNH Medical Staff peer review/quality improvement.

d) HMNH patient activity.

e) Documentation of patient activity and Medical Staff standing at other facilities, if less than twenty-four (24) patient contacts at HMNH over previous two (2) years.

4. Evidence that the Medical Staff critically evaluated the above information and assessed the current clinical competence for privileges requested, as well as evidence that appropriate action was taken on reappointment and renewal of privileges.

5. A Medical Staff member or AHP may request correction or deletion of information in his credentials file. Such request shall be addressed to the Chief of Staff and the Administrator in writing and shall include a statement of the basis for the action requested.

5.1 The Chairman of Administrative Services shall review such a request within sixty (60) days and shall recommend to the Executive Committee, after such review, whether or not to make the correction or deletion requested. The Executive Committee, when so informed, shall either ratify or initiate action contrary to this recommendation.

5.2 The member shall be notified promptly in writing, of the decision of the Executive Committee.

6. A member of the Medical Staff or AHP has the right to add information to his credentials file at any time, upon the approval of the Executive Committee.

## I.N. Exclusive Departments

1. All services provided in the departments holding exclusive contracts, i.e., Radiology, Pathology, Anesthesiology and Emergency Room, shall be the responsibility of the Medical Director of the Department. Other members of the Medical Staff who have had the privileges granted by their clinical departments may perform the procedures in these departments only at the discretion and under the direction of the Medical Director.

## I.O. Medical Executive Committee Composition

1. The Medical Executive Committee is empowered to act for the Medical Staff in the

intervals between Medical Staff meetings.

2. The Medical Executive Committee shall be a standing committee and shall consist of:

2.1 Chief of Staff as Chairman,

2.2 Deputy Chief of Staff who shall serve as the Chairman of the Quality Performance Council,

2.3 Chairman of the Department of Medicine,

2.4 Chairman of the Department of Surgery,

2.5 Chairman of the Department of Primary Care,

2.6 Two (2) Active Staff members-at-large elected by the Medical Staff,

2.7 Secretary of the Medical Staff,

2.8 Treasurer of the Medical Staff,

2.9 Chairman of Continuing Medical Education,

2.10 Chairman of Administrative Services.

3. All members of the Executive Committee must be members of the Active Staff, with the exception of the Chairman of Continuing Medical and the Chairman of Administrative Services who may be members of the Active or Associate Staff. If the Chairman of Continuing Medical Education and/or the Chairman of Administrative Services is an Associate Staff member, he shall be without vote at the Executive Committee.

4. The President/Chief Executive Officer of the Hospital or his designee attends each Executive Committee meeting on an ex-officio basis, without vote.

5. Duties of the Executive Committee are outlined in the Medical Staff Bylaws, Article X, Section 3.

## I.P. IV Procedural Anesthesia Privileges

Requirements for Intravenous procedural anesthesia privileges include:

1. Completion of an approved residency program with a letter from the program director indicating that the practitioner is qualified for IV procedural anesthesia privileges; or

2. Documentation of specific experience in providing IV procedural anesthesia to five (5)

patients; or

3. Documentation of attendance at a California Medical Association (CMA) and/or American Medical Association (AMA) approved two (2) hour IV procedural anesthesia course.

## I.Q. Medical Board of California

1. As required by Section 805 and 805.5, California Business and Professions Code, a "Request for License Verifications" (form Number 07M-106) must be completed and mailed to the Medical Board of California prior to granting initial privileges or renewing privileges at the time of appointment and reappointment for all Medical Staff applicants and members (physicians, podiatrists and clinical psychologists).

2. Decisions regarding medical staff privileges are at the discretion of the Board of Directors of the Hospital with the recommendation of the Medical Executive Committee. However, information from the Medical Board of California, which includes reports from other facilities must be obtained prior to any final decision with the noted exception.

3. Failure to request this information on the required form is a misdemeanor.

4. Definitions in Section 805 of Business and Professions Code:

4.1 "Staff Privileges" is any arrangement under which a licensed practitioner is allowed to practice in or provide care for patients in a health facility. Such arrangements include the usual categories of medical staff privileges, as well as all categories of temporary medical staff privileges, and contractual arrangements to provide professional services.

4.2 A "denial or termination of privileges" includes failure or refusal to renew a contract or to renew, extend or re-establish any staff privileges when the action is based on medical disciplinary cause or reason.

4.3 "Medical disciplinary cause or reason" is that aspect of a licensed practitioner's competence or professional conduct which is reasonably likely to be detrimental to patient safely or to the delivery of patient care.

4.4. "Summary suspension" is a restriction or suspension of privileges, without a hearing, when determined necessary to protect against an imminent danger to the health of any individual.

5. Actions of medical disciplinary cause or reason reportable to the Medical Board of California include:

5.1 Practitioner's application for staff privileges or membership is denied or rejected.

5.2 Practitioner's membership, staff privileges or employment is terminated or revoked.

5.3 Restrictions are imposed, or voluntarily accepted, on staff privileges, membership or employment for a cumulative total of thirty (30) days or more for any 12-month period.

5.4 A practitioner is summarily suspended from staff privileges, membership or employment for more than fourteen (14) days.

5.5 A practitioner voluntarily resigns or takes a leave of absence from membership, staff privileges or employment following notice of an impending investigation based on information indicating a medial disciplinary cause or reason may exist.

5.6 A practitioner's privileges are denied or restricted because he is deemed not sufficiently competent to exercise the requested privileges based on receipt of information concerning the practitioner's performance.

5.7 Proctoring is conducted for thirty (30) days or more as mandatory consultation, imposed as a formal act to discipline a practitioner such as restricting operating without an assistant or requiring a consult prior to provision of care.

6. An 805 report should NOT be filed, even though the matter may result in an adverse action against a practitioner for the following non-medical causes or reasons:

6.1 Failure to pay medical staff dues.

6.2 Failure to maintain required malpractice insurance.

6.3 Failure to attend required medical staff meetings.

6.4 Failure to meet objective criteria for performing certain procedures.

6.5 Denial or restriction of privileges due to equipment or personnel constraints at the facility.

6.6 Privileges are denied or restricted because the practitioner fails to meet objective criteria, such as educational or residency requirements established by the Medical Staff to perform certain procedures.

7. If a peer review body takes action for a medical disciplinary cause or reason, an 805 report must be filed:

7.1 The report must not be made until all appeal rights granted by the peer review body to a practitioner exercising his fair hearing rights are completed, except in a case involving summary suspension, which must be reported if in effect more than fourteen (14) days, regardless of whether fair hearing rights have been exercised. The report must be mailed within thirty (30) days of effective date of a reportable denial, termination, restriction, resignation or leave of absence.

7.2 A copy of the required reporting form and a notice advising the practitioner of his right to submit additional statements or other information must be sent by the peer review body to the practitioner named in the report.

7.3 The practitioner is entitled to a written notice of the charges and the opportunity for a hearing.

7.4 A supplemental report must be made within thirty (30) days following the date the practitioner is deemed to have satisfied any terms, conditions or sanctions imposed in disciplinary action by the reporting peer review body.

## I.R. Meeting Attendance Requirements

1. According to Article X, Section 5 of the Medical Staff Bylaws, the Active Staff must attend at least two (2) of the four (4) General Medical Staff and at least three (3) of six (6) of his departmental meetings held per annum. Subcommittee and peer review meetings held for his or her Department may be counted towards the requisite number of Department meetings. Practitioners who are members of the Active Staff on March 12, 1998, may meet the departmental meeting attendance requirement by attending the meetings of any Medical Staff committee. Members may request the Chief of Staff, Deputy Chief of Staff, or department chairman to approve an excused absence from any meeting. The excused absence will be counted as attendance at that meeting. Unless excused by the Medical Executive Committee, Chief of Staff, Deputy Chief of Staff, or department chairman for exceptional conditions such as sickness or absence from the community, a failure to meet attendance requirements of such meetings shall be considered as resignation from the Active Medical Staff and shall automatically place the absentee on the Associate Medical Staff. The procedure for reinstatement will be the same as in the case of advancement to Active Staff.

2. In July of each year, the Medical Staff Assistant will calculate meeting attendance of the first six months of the current calendar year.

3. Send this information to each Active and Associate Staff member.

4. At the first meeting of the Credentials Committee after the first of the year, any Active Staff member who hasn't met the meeting attendance requirement shall be recommended for assignment to the Associate Staff.
5. To be reinstated to the Active Staff, this Associate Staff member must meet the meeting attendance requirements noted.

## I.S. National Practitioner Data Bank

1. The Hospital must query the National Practitioner Data Bank (NPDB) when screening applicants for Medical Staff appointment or for clinical privileges (temporary or otherwise). A query is also required every two (2) years for physicians, dentists, and other health care

practitioners currently on the Medical Staff or with clinical privileges.

2. The Hospital must report adverse privilege information on the NPDB Adverse Action Report from on physicians and dentists to the state medical or dental board within fifteen (15) days following the final action. Hospitals do not submit reports directly to the NPDB. Hospitals submit the white, yellow or pink copies of the Adverse Action Report to the State Medical or Dental Board.

3. The Hospital may report adverse actions on other licensed non-physician health care practitioners but should keep in mind that immunity provisions as established apply only to those adverse actions taken against physicians and dentists.

## I.T. Orders, Therapies and Tests

1. All orders for treatment shall be in writing and signed by the ordering practitioner. Orders transmitted by facsimile machines are acceptable, except orders for Schedule II drugs (ie. morphine, meperidine, hydromorphine). Original signatures are required in the medical record for orders for Schedule II drugs.

2. Verbal orders shall be accepted only as follows:

2.1. Verbal orders for other than drugs may be received by any licensed, registered, or nationally certified health professional provided that the orders received relate to the licensed, certified, or registered area of competence of the individual receiving the orders. This includes registered nurses, licensed vocational nurses, audiologist, cardiopulmonary/ pulmonary technologists/ technician, dieticians, laboratory technologists, occupational therapists, physical therapists, radiological technologists, respiratory technologists, respiratory therapists, and speech pathologists.

2.2 Verbal orders for administration of medications may be received and recorded by licensed health professionals who are expressly authorized under their practice acts to receive orders to administer drugs. This includes registered nurses, licensed vocational nurses, pharmacists, physicians, physical therapists (for certain topical drugs only), and respiratory therapists (when the order relates specifically to respiratory therapy.)

2.3 The person receiving the verbal order shall promptly record the order in the appropriate section of the patient's medical record noting the name of the person giving the verbal order and the signature of the individual receiving the order.

2.4 The ordering practitioner shall sign verbal orders for medications in the acute Hospital, including Acute Rehabilitation Unit and Behavioral Health Unit within forty-eight (48) hours. Verbal orders for behavioral restraints or seclusion shall be signed within 24 hours. All other orders in the acute Hospital shall be signed within fourteen (14) days of discharge.

2.5 Orders dictated over the telephone to a recording machine or through any other person as

an intermediary of the practitioner are not acceptable.

2.6 The order for "No Code" should be written by the attending physician and/or his physician designee whenever possible and must be accompanied by an appropriate entry on the progress notes.

a) When a "No Code" order is important for the implementation of appropriate patient care and the physician is unable to actually write the order, a verbal "No Code" telephone order can be given to licensed nurse with a second licensed nurse witnessing the order on another telephone line. The physician needs to sign the telephone order within 24 hours.

3. Standing orders shall be formulated by conference between the medical staff and the nursing administrative staff. The standing orders shall be initially and on an annual basis reviewed by the Pharmacy and Therapeutics Committee. They may be changed only after conference with nursing administration and the medical staff and with the approval of both parties. These orders shall be signed by the ordering practitioner.

4. The automatic stop order policy relating to dangerous drugs is as follows:

| Acute/Behavioral Health | |
|---|---|
| Heparin | 3 days |
| Antibiotics | 7 days |
| Narcotics | 7 days |
| Sedatives and Hypnotics | 7 days |
| Routine Medications (acute) | 14 days |

Includes, sedatives, tranquilizers and barbiturates.

4.1 The physician shall be notified before the medication is discontinued so that no interruption would occur in its administration, should the physician order further use of the medication.

5. Pharmaceuticals brought with the patient at admission or by visitors at some time during the patient's stay shall not be accepted for use or storage unless they meet all of the following conditions:

5.1 Drugs have been ordered by the patient's attending physician with a written entry made in the patient's medical record.

5.2 Medication containers are clearly and properly labeled.

5.3 Medications are examined and identified by the Hospital pharmacist and approved for use.

6. The hospital laboratory shall ensure as complete a service as possible. Examinations

which cannot be made by the hospital laboratory shall be referred to an approved outside laboratory.

## I.U. Outside Education for Medical Staff Members

1. The Medical Staff and Hospital will share in the cost of specific outside education seminars for practitioners on the Medical Staff. This request for funding must meet pre-approved criteria and be approved by the Executive Committee of the Medical Staff and the Hospital Administration.

2. The Medical Staff will include in its annual budget, if possible, money for Medical Staff members' attendance at outside education session.

3. The Hospital will include in its annual budget, if possible, money for Medical Staff members' attendance at outside education sessions.

4. Members of the Medical Staff who request that the Medical Staff and Hospital cover expenses for their attendance at an outside education session must submit this request in writing to the Executive Committee and the Hospital Administration.

5. Approval of the request for funding will be dependent on the following criteria:

5.1 Cash is available.

5.2 The Medical Staff member's attendance at the outside education session will provide direct benefit to the Medical Staff and Hospital.

6. Depending on the particulars of the outside educational seminar, the Executive Committee and/or Hospital may defray either the entire cost of the seminar (tuition, travel, lodging and food) or parts thereof (such as tuition only).

## I.V. Peer Review

1. The following committees of the Medical Staff have been authorized to perform peer review functions on behalf of the Medical Staff:

1.1 All departments of the Medical Staff.

1.2 All Ad Hoc committees of the Medical Staff assigned peer review functions.

1.3 All quality review subcommittees of any department of the Medical Staff.

1.4 Medical Executive Committee, Quality Performance Council Committee, Credentials Committee, Appropriateness Review Committee, Tissue, Transfusion and Laboratory Committee, Obstetrics and Gynecology Committee, Infection Control Committee, Pharmacy and

Therapeutics Committee, Critical Care Committee, Newborn/Pediatric Committee, Cancer Committee, Anesthesia Committee, Behavioral Health Committee, Ethics Committee, Trauma Committee and Emergency Services Committee.

2. All discussions or other related peer review functions are to occur only during official meetings of Medical Staff peer review committees or through official communication between practitioners and the Medical Staff peer review committees. Discussion of any peer review information outside of the Medical Staff office, Medical Staff department/committee structure shall not be tolerated. Any breach of this confidentiality shall be acted upon by the Medical Staff pursuant to Article XIII, of the Medical Staff Bylaws.

3. Subject to the Medical Staff Bylaws, peer review committees of the Medical Staff are empowered to perform the following functions:

3.1 Develop indicators, focus review, critical pathway analysis or other criteria-based studies to be utilized to evaluate and improve performance related to key patient processes.

3.2 Establish mechanism for collection of data necessary to perform functions described in "3.1".

3.3 Review aggregate event (peer review information which consists of an egregious or unexpected behavior or outcomes) and trended (peer review information which consists of collected, rate-based data indicating peer review) information related to functions described in "3.1".

3.4 Recommend to the Quality Performance Council specific topics for organizational or process improvement team studies.

3.5 Identify and evaluate those cases or groups of cases that require practitioner specific event analysis and peer review.

3.6 Review both qualitative and quantitative information pertinent to the credentialing process and recommend membership, category of membership, department assignment and clinical privileges for practitioners at the time of appointment and reappointment.

4. When performing practitioner-specific review related to patient care or other quality issue, the peer review committees are empowered to:

4.1 Interview the involved practitioner and discuss aspects of patient care with the practitioner in the peer review committee setting.

4.2 Request a written reply from a practitioner related to clinical aspects of care or other quality related issues involving a particular patient or group of patients.

4.3 Discuss with the practitioner in the peer review committee setting, specific issues related

to patient care or other quality related issues and make recommendations that are educational in nature.

4.4 Send to a practitioner educational letters, signed by the practitioner's department chairman, related to patient care or other quality related issues.

4.5 Recommend to the Executive Committee that the practitioner be sent a letter of warning, admonition or reprimand.

4.6 Recommend and perform intensified monitoring of a specific practitioner related to patient care or quality related issues.

4.7 Evaluate data and following review with the practitioner, send to the department chairperson and/or Executive Committee a request for a formal investigation of a practitioner pursuant to Article V of the Medical Staff Bylaws.

5. Subject to the Medical Staff Bylaws, the following shall be rights of practitioners related to peer review process:

5.1 Practitioner must be notified either verbally in a Medical Staff meeting or through written documentation, of any practitioner specific adverse peer review information that shall be collected as part of a peer review/quality assessment profile. This requirement for notification does not include the routine collection of data for rate-based review, aggregate information or volume/quantitative information.

5.2 If a practitioner reviews the information and feels that the information to be collected is inappropriate, the practitioner may submit in writing his specific concerns and request a reevaluation of the information by the peer review committee.

5.3 If a practitioner believes that the re-evaluation by the peer review committee has not resolved the issues in question, the practitioner may request an evaluation of the information by the Executive Committee prior to final insertion of the information into a practitioner-specific peer review/quality assessment profile contained in the practitioner's credentials file. The decision of the Executive Committee shall be final. The practitioner may, however, submit a letter of explanation regarding the occurrence for inclusion in the practitioner's Medical Staff credential file.

5.4. Requests for corrective action will be handled in accordance with Articles V and VI of the Medical Staff Bylaws.

6. Storage and retrieval of practitioner-specific peer review/quality assessment information:

6.1 Information related to routine monitoring and evaluation and practitioner-specific profiles shall be stored on a data base program in the Quality and Resource Management Department.

Access to this information is limited to the following persons:

a) Chief of Staff

b) Deputy Chief of Staff

c) Department Chairpersons (limited to those members within their department)

d) Chief Medical Officer/Vice President of Professional Services.

6.2 Access to information contained in these files shall be available pursuant to the Medical Staff Bylaws, Rules and Regulations.

6.3 A practitioner may request a review of the summary information contained in the data base file by contacting the Quality and Resource Management Department and arranging an appropriate time for such review. This review shall be of summary information only and shall not include primary source documentation. No copies of this information shall be allowed and the practitioner may not in any way record information from this file.

6.4 If information contained in the file is believed to be invalid, the practitioner would follow the process as outlined in 5.2, 5.3 and 5.4 of this section.

7. Insertion of peer review information into Medical Staff credentials files:

7.1 Any department, committee or section chairperson may request that reports related to specific peer review information be inserted into a practitioner's credentials file. The Executive Committee shall review the information and determine whether the request for inclusion of peer review information is valid. If the request is determined to be valid, the Executive Committee shall insert the information in the practitioner's credentials file.

7.2 Only the Medical Executive Committee shall have the authority to insert reports related to specific peer review information into a practitioner's credentials file.

7.3 The practitioner shall be informed of the nature of information to be inserted into his or her credentials file. The practitioner shall have rights as described in 5.2, 5.3 and 5.4 of this section.

7.4 All routine correspondence, letters of inquiry or requests for information to a specific practitioner from the Medical Executive Committee shall also be recorded in the practitioner's credentials file.

7.5 In addition to such peer review information which may be properly recorded in the practitioner's credentials file, all final actions of the Medical Executive Committee related to a specific practitioner shall be recorded in the practitioner's credentials file.

8. This Medical Staff Rule and Regulation shall not apply to nor in anyway restrict members of the Hospital's Administration or members of the Hospital's Board of Directors from carrying out their respective duties and obligations.

## I.W. Polysomnography

1. Polysomnography privileges must be requested through the practitioner's clinical department. Basic requirements for polysomnography privileges include:

1.1 Completion of an approved pulmonary medicine or sleep medicine fellowship or neurology residency training program with a letter from the program director indicating that the practitioner is qualified for the privilege, or

1.2 Completion of an approved pulmonary medicine fellowship or neurology residency training program and completion of forty (40) hours of training in polysomnography accredited by the American Medical Association.

2. A practitioner must have a minimum of his first three (3) polysomnogram interpretations proctored on a retrospective basis.

## I.X. Pre-Application, Medical Staff

1. When physicians, dentists or podiatrists express interest in applying to the Medical Staff of Henry Mayo Newhall Hospital, he shall be sent a Medical Staff Application Request Form in order to verify his compliance with the minimum standards for membership. Minimum standards for membership include:

1.1 Current California medical, dental or podiatric license,

1.2 Current Drug Enforcement Administration (DEA) certificate (if applicable),

1.3 Current professional liability insurance certificate including the name of the carrier, type and amount of coverage provided, and date of expiration of the policy,

2. The potential applicant will complete the Application Request Form and return it to the Medical Staff Services Department with all the required attachments.

3. The Medical Staff Services Department staff will review the information provided and send the potential applicant an Application to the HMNH Medical Staff.

## I.Y. Proctoring

1. All practitioners granted temporary privileges, and all provisional members of the Medical Staff, will have their performance monitored in a manner deemed appropriate by the practitioner's assigned department, and approved by the Executive Committee.

2. Existing members of the Medical Staff, regardless of specialty or category of membership, who are granted additional privileges, shall have their performance in those privileges monitored as determined by the department to which the member is assigned and as approved by the Executive Committee.

3. Existing members of the Medical Staff shall have their performance monitored, whenever deemed necessary by the appropriate department chairman or his designee, by the Executive Committee, the Chief of Staff or the Deputy Chief of Staff.

4. Qualifications of the proctors are as follows:

4.1. Status as an Active, Associate, or Consulting member;

4.2. Sufficient experience to judge the quality of work being performed;

4.3. The proctor needs to have privileges for the procedures he is proctoring. In situations where a proctor cannot be found in the sub-specialty, a waiver of this rule may be granted by the Department Chairman.

4.4. The proctor will not receive a fee for proctoring;

4.5. The proctor shall not be associated in practice with the applicant.

4.6 The proctor will be free of conflict of interest.

5. Department chairmen appoint proctors and by doing so, also automatically appoints the proctor to be a member of the departmental peer review committee.

6. Proctoring shall include direct observation of selected procedures by qualified and designated members of the Medical Staff, and by concurrent or retrospective chart review and the monitoring of diagnostic and treatment techniques.

7. Retrospective evaluation of performance may supplement but not substitute for direct observation. Proctoring involves evaluation of all aspects of the management of any case.

8. Each new provisional member and practitioner granted temporary privileges will be notified of his obligation for review under the proctoring program. He will be provided with the names of at least two Medical Staff members who shall act as proctors.

9. It is the responsibility of the practitioner being proctored to contact his proctors for concurrent observation prior to the admission or scheduling of surgery of each patient, as required.

10. In the case where an applicant is unable to obtain one of the assigned proctors, the

applicant shall contact the appropriate service or department chairman for assignment of a new proctor.

11. Proctoring forms will be supplied to the practitioner to forward to his proctor after initial information is completed. In the case of surgeons, proctoring forms are forwarded to the Department Director of the Surgery Department and filed in his office for completion by the proctor.

12. Proctoring forms are confidential. They shall not become a part of the patient's medical record. They will be maintained in the practitioner's credentials file and should be taken into consideration at the time the new staff member is considered for advancement from the Provisional Staff category, or prior to granting of privileges in the case of new or existing members requesting additional privileges.

13. Proctors are required to review the patient's chart upon discharge and shall then complete, sign and date the proctoring forms for each observed procedure or case. These forms will be forwarded to the Medical Staff Office for submission to the appropriate department chairman for review and approval. A report will be made to the Executive Committee following this review and approval.

14. Charts deemed unsatisfactory by the proctors shall be forwarded along with a brief written statement of the deficiencies noted to the appropriate department chairman for further evaluation.

## I. Z. Professional Liability Insurance

1. The Henry Mayo Newhall Hospital, effective January 1, 1994, requires that each practitioner who is a member of the Medical Staff shall maintain in force professional liability insurance in not less than the minimum amounts determined by the Board of Directors in accordance with the classification of privileges granted in the credentialing process.

2. Practitioners shall provide evidence of professional liability coverage that meets one of the following criteria:

a) Companies authorized to write insurance in California by the Department of Insurance in the State of California for any of the following lines:

1) Medical Malpractice
2) Eligible Surplus Line Suppliers
3) Other liability companies
4) Risk Retention Groups

b) Interindemnity arrangements organized under Section 1280.7 of the California Insurance Code that provides specific evidence of coverage for the practitioner to respond on behalf of the individual practitioner.

c) A Joint Powers Agreement (JPA) known as BETA Healthcare Group.

d) Self insurance programs that provide specific evidence of coverage for the practitioner and evidence of financial capability to respond on behalf of the individual practitioner.

3. Each new application or change by a member to coverage under paragraph 2(d) above will require review of coverage and financial capability of the entity by the Hospital prior to processing the application. If recommended for approval or recommended for denial by the Hospital, the Medical Staff will be asked to concur. Disputes, if any, between the Hospital and the Medical Staff will be referred to the normal dispute resolution process.

## I. AA. Reappointment to the Medical Staff

1. Any member of the Medical Staff applying for reappointment to the Medical Staff shall file with the Chief Executive Officer a written application for reappointment providing all information which the Medical Executive Committee deems necessary to do a complete review of the applicant's eligibility for reappointment, including his board certification status, license and registration status, health status, professional liability actions, professional liability insurance, and continuing medical education.

2. Every application for staff reappointment shall be signed by the applicant and shall contain the applicant's specific acknowledgment of every Medical Staff member's obligations to provide continuous care and supervision of his patients, to abide by the Bylaws, Rules and Regulations and policies of the Hospital and Medical Staff, and understanding and agreement that the applicant agrees to submit any reasonable evidence of health status that may be requested by the Medical Executive Committee.

3. Reappointment and the renewal/revision of clinical privileges for each practitioner must be based on, at a minimum, the following:

(a) Current medical licensure, DEA registration, and professional liability insurance (all verified with the primary sources), and continuing medical education.

(b) Health status, including any reasonable evidence of current health status that may be requested by the Executive Committee of the Medical Staff. The applicant's statement that no health problems exist that could affect his or her practice is confirmed by the at least the countersignature by the department director.

(c) Professional qualifications, including relevant additional training and/or experience (verified with the primary sources whenever feasible).

(d) Clinical and technical skills, judgment, ethics and conduct, and current competence as determined by the applicant's medical knowledge, reliability and availability.

(e) Any previously successful or currently pending challenges, limitation or loss of license and/or registration, or the voluntary relinquishment of such licensure or registration.

(f) Any voluntary or involuntary limitation or loss of membership or privileges at other facilities.

(g) Professional liability actions, including pending cases\and final judgements or settlement.

(h) Departmental and peer recommendation.

(i) Results of performance improvement activities. Patterns in performance improvement activities are evaluated through the review of the computer print-out of HMNH Medical Staff peer review/quality improvement and the department chairman's review of letters sent to the practitioner from Medical Staff committees. If a pattern is noted, the department chairman shall refer this to the Medical Executive Committee for confirmation. If the Medical Executive Committee agrees that there is a pattern, this information will be forwarded to the Credentials Committee for consideration in the reappointment process.

(j) Compliance with Medical Staff Bylaws' requirement for meeting attendance, as applicable.

(k) Participation in the organized Medical Staff activities.

(l) Cooperation with hospital authorities and personnel.

(m) Relations with other Medical Staff members.

(n) General attitude toward member's practice, patients, the Hospital and the public.

(o) If a practitioner has accumulated one-hundred and twenty (120) or more suspension days in a two (2) year period due to failure to complete delinquent medical records and does not have either:

i. Extenuating circumstances, acceptable to the Medical Executive Committee, or

ii Documented illness, the practitioner's request for appointment to, reappointment to, or advancement in staff category in the Medical Staff, may be denied for failure to meet the standards and requirements of Medical Staff membership. Such determination will be made by the Medical Executive Committee.

If there are extenuating circumstances acceptable to the Medical Executive Committee, other than documented illness, the practitioner's reappointment term may be limited to a one (1) year period, rather than a full two (2) year period, as determined by the Medical Executive Committee. If the practitioner is reappointed for a one (1) year term, he shall be notified that an accumulation of additional suspension days in excess of forty-five (45)

days without acceptable extenuating circumstances during this one (1) year reappointment term may result in a reappointment for another one (1) year term. If there is documented illness, the practitioner's reappointment term will be a full two (2) year period.

4. The Medical Staff Assistant of Medical Staff Services/Medical Staff Assistant will:

4.1 At least eight (8) months prior to the expiration of each Medical Staff member's appointment term, the Medical Staff Assistant will gather data necessary for appropriate evaluation of the practitioner during the previous two year period including:

a) Number of patients for whom practitioner was attending Physician

b) Number of consultations

c) Number of surgeries and procedures in which the practitioner served as the prime surgeon or operator.

d) Meeting attendance

e) Number of suspension days

f) Peer review monitoring summary of cases reviewed for Courtesy Staff members, verification of Active or Association Staff standing on the medical staff of another hospital licensed by the State of California and accredited by the Joint Commission on Accreditation of Healthcare Organizations.

g) If there are less than twenty-four (24) patient contacts at HMNH over the previous two year period, the Medical Staff Assistant will provide this information to the practitioner. A letter will be sent to the practitioner requesting documentation of patient activity and medical staff standing at other facilities.

4.2 A reappointment application is sent to the practitioner, Email, Return Receipt Requested, noting the need for completion and return of all pertinent backup materials within thirty (30) days of receipt.

4.3 If the reappointments application is not received by the deadline, an initial reminder notice will be sent to the practitioner, requesting the reappointment application and documentation within thirty (30) days of receipt of the notice.

4.4 Thirty (30) days after the date of the receipt of the reminder note (4.3 above) has passed and the reappointment application is outstanding, a final notice signed by the Credentials Committee Chairman is sent to the practitioner, Certified, Return Receipt Requested, indicating the delinquency and requiring receipt of the completed form and documentation within fifteen (15) days of receipt of the notice. If the information is not received, the Credentials Committee

will recommend that the Executive Committee accept the practitioner's automatic, voluntary resignation from the Medical Staff.

4.5 If the reappointment application is returned within thirty (30) days, but without proper or complete documentation as required, a Reappointment Application Deficiencies letter signed by the Credentials Committee Chairman outlining the deficiencies is sent, Certified, Return Receipt Requested, requiring response within fifteen (15) days of receipt of the notice. If the information is not received, the Credentials Committee will recommend that the Executive Committee accept the practitioner's automatic, voluntary resignation from the Medical Staff.

4.6 The completed reappointment application will be forwarded to the Credentials Committee and the practitioner's clinical department chairman for evaluation and recommendation to the Executive Committee of the Medical Staff no later than sixty (60) days prior to expiration of the practitioner's reappointment term.

4.7 Within thirty (30) days, but no later than fifteen (15) days prior to the termination of the reappointment term, the Executive Committee of the Medical Staff will report to the Board of Directors, recommending reappointment or non-reappointment and privileges, including increase or curtailment, for each member of the Medical Staff for the ensuing two-year period.

4.8 The completed reappointment application will be forwarded to the appropriate Medical Staff committee and the practitioner's clinical department for evaluation and recommendation to the Executive Committee of the Medical Staff no later than sixty (60) days prior to expiration of the practitioner's reappointment term.

4.9 Within thirty (30) days, but no later than fifteen (15) days prior to the termination of the reappointment term, the Executive Committee of the Medical Staff will report to the Board of Directors, recommending reappointment or non-reappointment and privileges, including increase or curtailment, for each member of the Medical Staff for the ensuing two-year period.

5. The practitioner requesting reappointment will submit the following documentation:

5.1 The completed reapplication form, dated and signed.

5.2 Current copies of California medical license, Drug Enforcement Administration certificate, and any other pertinent certification (e.g., fluoroscopy, radiology), as requested.

5.3 Evidence of professional liability coverage (if requested), the completed and signed Authorization for Liability Insurance Verification and completed Claim Information form.

5.4 Newly completed and signed Privilege Request form and privilege cards, based on current competence, and including documentation of training and/or experience for any requested increase in privileges.

5.5 Copy of continuing medical education certificate.

5.6 Explanation to any questions on reappointment application answered "yes", as directed in the pertinent sections.

6. The Credentials Committee will:

6.1 Review all information available regarding the competence of Medical Staff members to be reappointed and submit a recommendation to the Executive Committee no later than sixty (60) days prior to the expiration of the reappointment term.

6.2 Submit a report to the Executive Committee outlining those applicants who failed to return their reappointment application within forty-five (45) days of the required date, after notification by Certified Return Receipt Mail, and recommend a voluntary resignation from the Medical Staff for those members.

6.3 Submit a report to the Executive Committee outlining those practitioners who have incomplete reappointment applications fifteen (15) days after the deadline, with documentation of notification by Certified, Return Receipt mail to the practitioner and recommend non-reappointment of those members.

7. The chairmen of the clinical departments are responsible for reviewing all information available on the practitioners who are scheduled to be reappointed, for the purpose of determining justification for their reappointment to the Medical Staff as well as privileges, including increase and/or curtailments thereto, for the ensuing two years. The chairman of the clinical department may refer requests for specific current or new privileges to an appropriate Medical Staff committee for review and recommendation. The clinical department chairman's recommendations will be forwarded to the Medical Executive Committee.

8. The Executive Committee is responsible for submitting a report to the Board of Directors recommending the reappointment or non-reappointment of each member of the Medical Staff and recommending privileges, including increase or curtailment for the ensuing two years.

9. Reappointments are for a period not to exceed two (2) years, and will be conducted on a monthly basis, based on the date of expiration of each practitioner's California medical license.

## I. BB. Release of Practitioner-Specific Information

1. Practitioner-specific information and data is contained in reports generated from computer software utilized by the Hospital. The reports generated include practitioner-specific clinical and financial data regarding patterns of practice, patient volume, utilization of resources, lengths of stay, treatment outcomes and other measures of performance and quality of care.

2. All practitioner-specific data shall be confidential and all necessary steps shall be taken to protect such data from discovery or admission into evidence in any judicial or administrative proceeding pursuant to California Evidence Code Section 1157 and California Health and Safety

Code Section 1370. Practitioner-specific data shall only be released by the Hospital in accordance with the procedures outlined in these Rules and Regulations. Practitioner-specific data may be reviewed by Medical Staff and Hospital committees. Individual practitioner-specific data may be released to the practitioner, upon receipt of a signed release and authorization from the practitioner, provided that the data released does not identify any other individual practitioners. Practitioner-specific data will not be released by the Hospital to any other party.

3. All requests for practitioner-specific data will be processed by the Decision Support staff or the Medical Staff Services staff, as appropriate, and handled as follows:

3.1 Disclosure to Medical Staff and Hospital Committees. Reports which include practitioner-specific data may be provided to Medical Staff and Hospital committees. These reports may also be provided to Hospital employees whose responsibility it is to support these committees.

3.2 Disclosure to an Identified Individual Practitioner. A practitioner may request reports containing data specific to himself by submitting a Practitioner Data Release Form or Authorization for Release of Information from Medical Staff Credentials File Form. Reports which include comparison data for more than one practitioner shall be displayed in such a way that the requesting practitioner can only identify data specific to himself; however in order to preserve confidentiality, the names and practitioner identification numbers of the other practitioners who may be included in the report will be deleted.

3.3 Disclosure to Any Other Party.

a) Any request for practitioner-specific data from any other party shall be forwarded to the Chief Medical Officer/Vice President of Professional Services or his designee who will forward a copy of the request and an authorization for release form to the specific practitioner.

b) The practitioner may indicate on the form whether the data is to be released or not, or whether he wants to review the data prior to making a decision about the release of data. The practitioner shall return the signed form to the Chief Medical Officer/Vice President of Professional Services or his designee. If the practitioner wishes to review the data prior to its release, the Chief Medical Officer/Vice President of Professional Services will forward the requested data to the practitioner for his review and/or correction. Upon review of the data, the practitioner shall notify the Chief Medical Officer/Vice President of Professional Services whether the data is to be released or not. If the practitioner does not authorize the release of data, the Chief Medical Officer/Vice President of Professional Services or his designee will send a letter to the requesting entity informing it that the Hospital is not authorized to release the requested information at this time. If the practitioner authorizes release of the data, the Chief Medical Officer/Vice President of Professional Services or his designee will send a letter to the requesting entity informing it that the Hospital shall release the information upon the entity's signing of the enclosed Confidentiality Agreement.

c) A practitioner may release such reports in accordance with his own wishes. Reports

which include comparison data for more than one practitioner shall be displayed in such a way that these entities can identify data specific only to the practitioner who has authorized the release of data; however, in order to preserve confidentiality, the names and practitioner identification numbers of the other practitioners who may be included in the report will be deleted.

3.4 Practitioner-Specific Data Not Subject to Disclosure. Reports containing practitioner-specific data shall not be released to an individual practitioner, if, despite deletion of the names and identification numbers of other practitioners, the requesting practitioner is able to implicitly identify other practitioners. For the purposes of this policy, "implicitly identify" means data so unique or numbers so small that identification of an individual practitioner would be obvious. Determinations of whether other practitioners may be "implicitly identified" from the data shall be made by the Decision Support staff. In lieu of practitioner-specific data, aggregate statistical data that does not explicitly or implicitly identify any individual practitioners may be released to an individual practitioner.

3.5 Notices to Accompany Disclosure.

All releases of practitioner-specific data to individual practitioners shall contain the following disclaimer: "The practitioner-specific data contained in the attached report has been provided to you pursuant to your written request. The data contained in this report must be maintained as confidential in accordance with California Evidence Code Section 1157 and California Health and Safety Code Section 1370. This data is to be used for the sole purpose of evaluating the quality of care rendered by the practitioner. The report has been generated from information in the computer data base of Henry Mayo Newhall Hospital using computer software licensed by the Hospital. While the Hospital makes every effort to ensure the accuracy and completeness of the data, the Hospital makes no representation or warranty that the data in the attached report is accurate or complete. Furthermore, the Hospital makes no representation or warranty regarding the report generated using the licensed software. As a result, no conclusions should be drawn or actions taken based solely on the attached report."

## I.CC. Standards of Conduct

1. It is the policy of the Medical Staff that all patients, their families, employees, volunteers, visitors, and members of the Medical Staff and Allied Health Professional Staff shall be treated courteously, respectfully, and with dignity. Discrimination or harassment because sex, race, color ancestry, religious creed, national origin, physical disability (including HIV and AIDS), mental disability, medical condition, age, sexual orientation, or marital status is prohibited by Federal and/or State law, as well as by the Medical Staff and Hospital. Similarly prohibited is outrageous conduct, which includes all behavior that goes beyond the bounds of decency in a civilized society.

For the purposes of this policy, "sexual harassment" is defined as unwelcome or unwanted advances, requests for sexual favors and any other verbal, visual, or physical conduct of 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 an individual's employment or creates an intimidating, hostile or offensive work environment. Violations of this policy regarding discrimination or harassment are grounds for corrective action in accordance with this policy and the Medical Staff Bylaws. No corrective action may be taken in contravention of the provisions of the Medical Staff Bylaws, nor may the proceedings or records of such corrective action be disclosed except as permitted under the Medical Staff Bylaws or required by law.

2. Reporting

2.1 Complaints involving discrimination or harassment where the person who is the alleged harasser is a member of the Medical Staff or the Allied Health Professional Staff, by whomever received shall be referred immediately to the Chief of Staff. All such complaints shall be investigated and addressed as set forth in this policy. Nothing in this policy would preclude the Chief of Staff and/or Chief Executive Officer from attempting to informally resolve complaints of discrimination or harassment, made by patients or other individuals, before initiating the Hospital Investigative Procedures or a Medical Staff Corrective Action Investigation. Requests by a reporting party that nothing is done about the event, and that it is for "information only" will not be granted.

2.2 Complaints involving discrimination or harassment, where the person who is the alleged harasser is a Hospital employee, by whomever received, should be referred immediately to the Vice President of Human Resources and will be investigated and addressed in accordance with Hospital policies, except that if the complainant is a member of the Medical Staff or Allied Health Professional Staff, the Chief of Staff or designee shall be kept apprised of the status of the investigation.

3. Initial Review Mutually Acceptable Resolution

3.1 An initial review of each discrimination or harassment complaint made by a patient will be made by the Chief of Staff or his designee. All patient complaints will be investigated in accordance with the Medical Staff Bylaws.

3.2 An initial review of all other discrimination or harassment complaints will be made by the Vice President of Human Resources or his designee. If any of these individuals is the alleged harasser, the President will appoint another individual to conduct the review. The Chief of Staff or designee shall be kept apprised of the status of the initial review.

3.3 The initial review of non-patient complaints shall consist of interviewing the parties involved in the dispute. The individual who has made the complaint will be assured that confidentiality will be maintained to the extent permitted by law and that no retaliation will be permitted. However, the complainant shall be told that the complaint will have to be shared with the physician or Allied Health Professional who is alleged to have engaged in the inappropriate conduct.

3.4 The physician or Allied Health Professional who is accused of discrimination or harassment will be advised of the Hospital's and Medical Staff's strict policy against discrimination or harassment, and informed that the Hospital will not tolerate any retaliation against or intimidation of any individual who has registered a discrimination or harassment complaint or who has cooperated in connection with the investigation, and that any violation of this policy will be considered an independent cause for discipline, regardless of the merits of the underlying discrimination or harassment charge.

3.5 The individual registering the complaint will be informed: that he should contact the Vice President of Human Resources immediately if he believes that any further violation of the policy against discrimination or harassment has occurred, or if retaliation occurs.

3.6 The purpose of the interview with the complainant and the person, who is the alleged harasser, is to determine whether the problem can be appropriately resolved to the satisfaction of both individuals without further investigation. If the parties can agree to a mutually acceptable resolution the investigation can stop at this point. On the other hand, if the parties cannot agree to a mutually acceptable resolution, or if the Vice President of Human Resources does not believe that resolution is appropriate then the problem should be resolved in accordance with Informal Investigative Procedures set forth in Section 4.

3.7 If the investigation stops at this point, the Chief of Staff and President should be informed of the resolution of the dispute. A written summary of the resolution of the dispute shall be prepared by the Vice President of Human Resources. This written summary should be limited to a brief factual statement setting for the resolution of the problem. The written summary, plus all interview notes, shall be maintained in the Medical Staff Office. Although there may exist circumstances that allow this written summary and interview notes to be privileged under Evidence Code Section 1157, such writings may not be protected under this Evidence Code, and such writings should therefore be prepared with care.

3.8 Whenever feasible the Initial Review should be completed within four (4) business days (excluding weekends and holidays) after receipt of complaint. In any event, the Initial Review should be completed as soon as reasonably possible.

3.9 In all cases where the Initial Review appears to have resolved the issue, the Chief of Staff shall, at his discretion, monitor the situation for an appropriate period to ensure continued resolution. The form of such monitoring will be as the Vice President of Human Resources determines will be most effective and may include follow-up interview if appropriate. Any recurrence will be immediately reported to the Medical Executive Committee and referred for formal investigation.

4. Informal Investigative Procedures

4.1 When a non-patient harassment or discrimination complaint cannot be resolved to the mutual satisfaction of the parties the matter should be investigated by a Hospital Investigating Committee. The Hospital Investigating Committee shall consist of the Vice President of Human

Resources or designee, two other individuals designated by the President, and four Medical Staff members appointed by the Chief of Staff. One of the Medical Staff members appointed shall serve as the chairman of the Hospital Investigating Committee. The chairman is entitled to vote upon any issue before the Hospital Investigating Committee. If the complainant is a hospital employee, then the President shall appoint a hospital employee to the Hospital Investigating Committee. When the complaint involves a hospital employee the Vice President of Human Resources may be required conduct a parallel investigation. The Hospital Investigating Committee shall include at least one member of each gender. If the Vice President of Human Resources is unavailable or is the subject of the complaint, the President will appoint another individual to the Hospital Investigating Committee for purposes of addressing that specific complaint.

4.2 The initial review shall consist of interviewing separately each party involved, including witnesses. The interviews shall begin with introductions and an explanation/ overview of the mediation and corrective action procedures and goals under this policy. The importance of maintaining confidentiality of the information exchanged during the discussions shall be emphasized.

The individual who has made the complaint will be assured that, in any event, confidentiality will be maintained to the extent possible and that no retaliation will be permitted against the complainant. The complainant will also be told that the complaint will be shared with the member of the Medical Staff or Allied Health Professional who is alleged to have engaged in the inappropriate conduct.

4.3 The member of the Medical Staff or Allied Health Professional who is accused of discrimination or harassment will be reminded of the Hospital's and Medical Staff's strict policy against discrimination or harassment, and informed that the Hospital and Medical Staff will not tolerate any retaliation against or intimidation of any individual who has registered a discrimination or harassment complaint or who has cooperated in connection with the Hospital's and Medical Staff's investigation. The person who is the subject of the complaint shall also be informed that any violation of this policy will be considered an independent cause of discipline, regardless of the merits of the underlying discrimination or harassment charge.

4.4 The individual registering the complaint will be informed that he or she should contact any member of the Hospital Investigating Committee immediately if he believes that any further violation of the policy against discrimination or harassment has occurred, or any retaliation has occurred.

4.5 Written documentation of the investigation and any resulting recommendation will be maintained throughout the process. The Hospital Investigating Committee shall have access to the notes and written summaries compiled during the initial Review.

4.6 The investigation shall consist initially of a private interview of the complainant with the Hospital Investigating Committee. Whenever feasible this interview should occur within four (4) working days after the appointment of the Hospital Investigating Committee to learn the factual

allegations, to determine whether there are any witnesses and to assess what kind of remedial action the complainant is requesting. In any event this interview should be completed as soon as reasonably possible.

4.7 The Hospital Investigating Committee should interview any individuals who may have information pertinent to the matter being investigated. The physician or the Allied Health Professional who is the subject of the investigation may be interviewed to obtain his account of events. The physician or Allied Health Professional may not be required to attend an interview; however the investigation will proceed notwithstanding the refusal to be interviewed.

4.8 Once the investigation is completed, the Hospital Investigating Committee will present its findings and recommendations in writing to the Chief of Staff and the President. Any decision of the Hospital Investigating Committee shall be based on a majority vote. The Hospital Investigating Committee may make a determination that no inappropriate conduct occurred and that no further action is required. The Hospital Investigating Committee may make a determination that inappropriate conduct occurred, but that the parties have agreed to a mutual resolution of the problem including certain remedial actions. (Recommended remedial measures could include, but not be limited to, written admonition, censure, reprimand or warning; written, private or public apology; agreed upon remedial actions. Any written warning will describe the unacceptable conduct and specify the improvement and actions (e.g., attendance at a sensitivity training seminar) needed, as well as the consequences for further problem behavior.)

Alternatively, the Hospital Investigating Committee may make a determination that inappropriate conduct occurred but that the parties could not reach a mutually acceptable resolution to the problem. In that case, the President should refer the written findings and recommendations of the Hospital Investigating Committee to the Medical Executive Committee. The Medical Executive Committee shall determine what, if any, remedial actions should be taken. Although there may exist circumstances that allow this written summary and interview notes to be privileged under Evidence Code section 1157, such writings may not be protected under this Evidence Code, and such writings should therefore be prepared with care. Any such remedial action shall be reported to the Hospital's Board of Directors.

4.9. The person filing the complaint and the physician or Allied Health Professional against whom the complaint was filed will be informed of the findings and recommendations of the Hospital Investigating Committee.

4.10 In all cases where the informal investigation appears to have resolved the issue, the Chief of Staff shall monitor the situation for an appropriate period to ensure continued resolution. The form of such monitoring will be that which the Hospital Investigating Committee determines will be most effective and may include follow-up interviews if appropriate. Any alleged recurrence of harassment will be immediately referred to the Medical Executive Committee for possible corrective action.

4.11 Whenever feasible, the informal investigative process outlined in this section should be completed within ten (10) to fifteen (15) working days, except for follow-up activities and

monitoring, which shall continue as long as is deemed necessary by the Hospital Investigating Committee. In any event the informal investigative process should be completed as soon as reasonably possible.

4.12 A hospital employee who makes false allegations of discrimination or harassment against a member of the Medical Staff or Allied Health Professional shall be subject to discipline, including the possibility of termination. A Medical Staff member or Allied Health Professional who makes false allegations of discrimination or harassment against another member of the Medical Staff or Allied Health Professional or against a hospital employee shall be subject to discipline, including the possibility of Medical Staff membership termination, in accordance with the Medical Staff Bylaws.

4.13 Even where the dispute appears to have been fully resolved by the informal investigation, the Medical Staff shall be free to continue to investigate and/or to take any further corrective action which it may deem appropriate.

5. Formal Corrective Action

5.1 All complaints involving patients will be investigated in accordance with the Medical Staff Bylaws.

5.2 Where the dispute has not been resolved via the initial review or informal investigation process set forth above, or if there is recurrence of a dispute that was earlier deemed to be resolved, the Hospital Investigating Committee will present a report in writing on the investigative efforts and the Committee's current findings and recommendations to the Hospital President and the Medical Staff's Executive Committee. In that case, the Medical Executive Committee shall determine what, if any, remedial actions should be taken.

5.3 Appropriate remedial actions may range from letters of admonition, censure, reprimand or warning; imposition of terms of probation or special limitations upon continued Medical Staff membership; written, private or public apology; and medical/psychiatric evaluation by a professional of Medical Executive Committee's choice; to restriction, suspension or revocation of Medical Staff or Allied Health Professional membership.

5.4 In the event that it is determined that the conduct was so serious that it warrants placing formal restrictions upon staff membership or privileges, such as would provide grounds for a hearing under Medical Staff Bylaws, the Medical Executive Committee shall follow the procedures outlined in Article V, Corrective Action, of the Medical Staff Bylaws when the alleged harasser is a Medical Staff member. In that event, the investigation/mediation conducted by the Hospital Investigating Committee, as set forth above, may substitute for the investigative process set forth in Article V, Section 1, unless the Medical Executive Committee determines that additional investigation is required. When the conduct involves a member of the Allied Health Professional Staff the procedures set forth in Article V, Section 1 of the Medical Staff Bylaws shall be followed, except that the investigation/mediation of the Hospital Investigating Committee may substitute for any required initial investigation, unless it is determined that

additional investigation is required.

5.5 Except for the final decision, all documents created as part of the formal corrective action investigation, as well as any subsequent appeal, shall be considered the proceedings and records of a Medical Staff committee and they will be immune from discovery under Section 1157 of the Evidence Code.

5.6 Any formal corrective action taken shall be reported to the Hospital's Board of Directors, and when formal corrective action has been pursued, the person filing the compliant and the member of the Medical Staff or Allied Health Professional against whom the complaint was brought will be informed of the final decision of the Hospital's Board of Directors.

**I.DD. Suspension, Automatic Due to California License or DEA Registration Non-Renewal**

1. Copies of current California medical, dental, podiatric, Allied Health Professional licenses and Drug Enforcement Administration (DEA) certificates must be maintained on file in the Medical Staff Office. Practitioners are responsible for renewing licenses and/or certificates in a timely manner, and for forwarding a copy to the Medical Staff Office immediately upon receipt of renewal.

2. If a copy of the current license is not received in the Medical Staff Office, or current licensure cannot be verified over the phone, or proof of renewal has not been submitted to the Medical Staff Office, and the expiration date has passed, the practitioner's clinical privileges will be automatically suspended until such time as a current copy of the license is presented to the Medical Staff Office representative or is verified by phone. Proof of renewal shall consist of a statement from the physician verifying that he submitted his renewal application and check prior to the date of his license expiration. The physician shall attach a copy of the renewal application and check to his statement.

3. If the license renewal paperwork is not complete or was mailed to the Medical Board after the date of license expiration, the physician cannot practice until renewal is complete. During the time the license is expired, the physician's clinical privileges shall be suspended.

4. If the check with which the license fee to the Medical Board of California bounces, the license is deemed to have expired from the date of recognition of the bad check. The physician will be considered to have had a valid license up to the time of recognition that the check was bad. The license will remain expired, and the physician's clinical privileges shall be suspended until the bad check is made good. This is based on the judgment that a bad check constitutes no payment and hence, the application for renewal is not complete. The exception to this is if the check was judged to be bad because of bank error.

5. Inasmuch as there is no grace period for renewals, if a copy of the current DEA certificate is not received in the Medical Staff Office or DEA certificate renewals cannot be verified over the phone, and the expiration date had passed, the practitioner's clinical privileges and/or

privilege to prescribe controlled substances will be automatically suspended until such time as a current copy of the certificate is presented to the Medical Staff Office representative or is verified by phone.

## I. EE. Temporary Privileges

1. Upon conference with the Chief of Staff, or in his absence, the Chief of Staff-Elect or his designee, the Chief Executive Officer or his designee may grant temporary privileges in the following circumstances: pendency of application, care of a specific patient, locum tenens or other because of other specified reasons.

2. The Medical Staff Services staff will be notified of the need for temporary privileges by the practitioner himself.

3. Practitioners requesting temporary membership and privileges during the Pendency of Application shall complete a Request for Temporary Membership and Privileges form at least thirty (30) days prior to the effective date of the effective privileges. Practitioners requesting temporary membership and privileges for care of a specific patient, locum tenens or other reasons shall complete a Request for Temporary Membership and Privileges form at least ten (10) days prior to the effective date of the requested privileges.

These periods may be waived in the event of an emergency. Emergency situations shall be described by the practitioner requesting the temporary membership and privileges and reviewed and approved by the clinical department chairman, the Chief of Staff or his designee, and the President or his designee.

4. The two hospital references listed shall be hospitals accredited by the Joint Commission on Accreditation of Healthcare Organizations.

5. The Medical Staff Services staff will verify current California licensure, status of license, DEA certificate, professional liability insurance and status, hospital references and completion of residency and training, as well as send a query to the National Practitioner Data Bank. The staff of Medial Staff Services shall prepare the appropriate Temporary Membership and Privileges Evaluation form.

6. The applicant shall act under the supervision of the department chairman to which the applicant is assigned.

7. If available, the department chairman for that specialty shall review the requested privileges and make recommendations regarding temporary membership and privileges and the proctoring requirements, taking into consideration the privileges approved at the hospital, references and the scope of practice of the residency program, if applicable.

8. Temporary membership and privileges pending application for membership to the Medical Staff:

8.1 Temporary membership and privileges shall only be granted to those practitioners who have completed a residency program approved by the Accreditation Council of Graduate Medical Education (hereinafter referred to as Residency Program.)

8.2 Specific temporary privileges shall only be granted within the scope of specialty for that residency program.

8.3 The applicant shall provide copies of approved privileges from two hospital references. For those newly-graduated practitioners who are not yet on staff at Joint Commission accredited hospitals, privilege reference checks must be made with their residency programs.

8.4 The staff of the Medical Staff Services Department will contact the chairman of the clinical department and the Chief of Staff for a recommendation regarding temporary membership and privileges when the following items have been verified:

a) Current California license and clear status: Phone verification or documentation from Medical Board of California is acceptable.

b) Current DEA certification: Copy of certificate is required.

c) Current professional liability insurance: Phone verification or documentation from insurance company is acceptable.

d) Completion of residency: Phone verification is acceptable.

e) Privilege cards from two JCAHO-accredited hospitals or privilege reference check with residency program: Receipt of privilege cards or documentation from residency director is required.

f) National Practitioner Data Bank status: Documentation from NPDB is required.

8.5 Temporary membership and privileges pending application shall be granted for an initial period of ninety (90) days or less with subsequent renewals not to exceed the pendency of the application.

8.6 The chairman of the clinical department in which the practitioner is practicing shall assure that appropriate proctors are appointed for each practitioner granted temporary membership and privileges during the pendency of application.

8.7 In accordance with the proctoring Rules and Regulations, a letter with instructions, guidelines, evaluation forms and assigned proctors will be sent immediately to the practitioner.

9. Temporary membership and privileges for care of specific patients:

9.1 Information regarding the name of the specific patient, the privileges requested and the surgery (if applicable), must be provided.

9.2 The practitioner requesting temporary membership and privileges cannot be the primary attending physician for these patients per Article III, Section 6 (a,2) of the Medical Staff Bylaws.

9.3 Such privileges shall be restricted to the treatment of not more than four (4) patients in any one year. The practitioner shall be required to apply for membership to the Medical Staff before being allowed to attend additional patients.

9.4 Temporary membership and privileges normally would not be granted for assisting at surgery or consultation if there is a practitioner of equal qualifications on the Medical Staff. If such a request is made, the requesting physician shall provide adequate documentation to confirm the need for these privileges.

10. Temporary membership and privileges for locum tenens:

10.1 For temporary membership and privileges for locum tenens, the name of the member of the Staff who is requesting that the practitioner cover for him and the date of coverage must be specified.

10.2 Temporary membership and privileges for locum tenens shall be granted for no more than thirty (30) consecutive days and no more than sixty (60) aggregate days for any one calendar year, or the practitioner shall be required to apply for membership on the Medical Staff.

10.3 Proctoring of the practitioner shall be by the Chairman of the Department in which the practitioner is practicing or his designees.

10.4 In accordance with the proctoring Rules and Regulations, a letter with instructions, guidelines, evaluation forms and assigned proctors will be sent immediately to the practitioner.

11. Temporary membership and privileges for other specified reasons.

11.1 This category of temporary membership and privileges may be utilized when temporary privileges are required for situations not described above, such as temporary privileges during the pendency of application to the Emergency Department Backup Panel or temporary privileges during the processing of a practitioner's request for an additional privilege.

12. The Chief of Staff shall review all the information and make a recommendation regarding the temporary membership and privileges to be granted.

13. The President of the Hospital shall review all the information and grant approval for temporary membership and privileges or provide an explanation to the Chief of Staff as to why the request for temporary privileges is being denied.

## I. FF. Temporary Privileges for Allied Health Professionals

1. Temporary privileges may be granted to AHP practitioners. These temporary privileges will be processed by the Medial Staff Services Department staff, reviewed and recommended by the chairman of the appropriate clinical department, the Chief of Staff, or his designee, and reviewed and approved by the Chief Executive Officer or his designee, on behalf of the Board of Directors.

2. The AHP will complete an application for privileges as an AHP.

3. Current licensure will be verified by the Medial Staff Services Department staff.

4. Current professional liability insurance will be verified by the Medical Staff Services Department staff.

5. Temporary privileges for AHPs requesting Behavioral Health privileges will be limited as follows:

5.1 For MFTs and LCSWs: Individual psychotherapy, group psychotherapy, family therapy.

5.2 For psychologists: Co-admission to the Behavioral Health Unit, individual psychotherapy, group psychotherapy, family therapy.

## I. GG. Termination of Medical Staff Membership/Privileges for Failure of Provisional Staff Member to Complete Proctoring

1. Membership on the Provisional Staff shall be limited to two (2) years, thereafter, member shall qualify to be advanced to another category or may be removed from the Medical Staff in accordance with Article VI, Hearing and Appeal Procedures, unless said advancement is tabled by the Executive Committee for reasons of good cause, as in the case of an extended illness.

2. Provisional Staff members are responsible for completing the requirements of proctoring as outlined in their clinical department's rules and regulations as promptly as possible, but prior to the end of their initial Provisional appointment period.

3. The Credentials Committee is responsible for:

3.1 Notifying the Provisional member at least thirty (30) days prior to the end of the Provisional appointment period of outstanding proctoring required.

3.2 Recommending to the Medical Executive Committee the advancement to another category or termination of membership and privileges of those Provisional members who did not complete proctoring requirements by the end of the Provisional period.

4. The Executive Committee is responsible for submitting a report to the Board of Directors,

recommending the advancement to another category or termination of membership and privileges of those Provisional members who did not complete proctoring by the end of the Provisional period, unless said advancement is tabled by the Executive Committee for reasons of good cause, as in the case of an extended illness.

5. The Board of Directors is responsible for the final decision to terminate a Provisional member's membership and privileges, based on the recommendation of the Medial Executive Committee, due to failure to complete proctoring by the end of the Provisional period.

## I.HH. Transport Teams

1. Physicians and allied health care professionals who are members of transport teams are not required to have temporary privileges at the Hospital in order to provide transportation of patients prior to admission to or after release from the Hospital.

2. Physicians and allied health care professionals who are members of transport teams are authorized to provide clinical care to transported patients at the Hospital under emergency circumstances described in Article III, Section 7 of the Hospital's Medical Staff Bylaws.

3. Except in such emergency circumstances, physicians and allied health care professionals who are members of transport teams are required to have clinical privileges at the hospital in order to provide clinical care to any Hospital patient after admission or prior to release from the Hospital.

## I. II. Organized Health Care Arrangement (OHCA)

1. In order to comply with the Health Insurance Portability and Accountability Act (HIPAA), effective April 14, 2003, a new notice of privacy practices form must be signed by the patient during admission. This privacy notice explains to the patient how Henry Mayo Newhall Hospital and the organized medical staff will use their protected health information (PHI)* for treatment, payment and operations.

2. Henry Mayo Newhall Hospital and the organized medical staff participate in an Organized Health Care Arrangement** (OHCA) to permit the sharing of this protected health information, for treatment, payment and operations. This OHCA will serve as the completion of the privacy notice for both the hospital and each member of the medical staff.

*Protected Health Information (PHI) – any individually identifiable health information collected or stored by a facility. Individually identifiable health information includes demographic information and any information that relates to past, present or future physical or mental condition of an individual.

** Organized Health Care Arrangement (OHCA) – A clinically integrated care setting in which individuals typically receive healthcare from more than one healthcare provider. The facility and its medical staff are an Organized Health Care Arrangement under the rule.

# DEPARTMENT RULES & REGULATIONS

## II. **Departmental Rules and Regulations**

## II. Departmental Rules and Regulations

## A. Department of Medicine

### 1. Privileges

1.1 Requests for privileges in the Department of Medicine shall be completed on the appropriate privilege delineation form and processed by the Department of Medicine. Privileges shall be granted in accordance with the Medical Staff Bylaws.

a) Privileges shall be reviewed by the Department of Medicine and recommended to the Executive Committee on the basis of training, experience and demonstrated ability. Such privileges shall be granted by the Board of Directors after review of the practitioner's credentials by the Executive Committee.

1.2 All practitioners in the Department of Medicine and related specialties shall have completed a residency in Internal Medicine, Allergy, Dermatology, Psychiatry, Neurology, Physical Medicine/Rehabilitation, or Radiology.

a) All practitioners requesting privileges in a subspecialty shall have completed an appropriate fellowship training program.

1.3 Basic requirements for privileges in the Department of Medicine include:

a) Verification by the director of the residency or fellowship program that the practitioner is qualified for the requested privileges.

b) If a practitioner requests privileges for procedures outside the scope of his residency or fellowship training program, he shall provide documentation of adequate training and experience in having performed the procedures independently with demonstrated competency.

c) All procedures requested for which documentation of training and/or experience is provided will be proctored in accordance with the DOM Rules and Regulations.

1.4 The Department may recommend to grant or deny all or part of the privileges requested, or may place such restrictions on the applicant as appropriate and as approved by the Executive Committee.

1.5 Requests for increase in privileges are made in writing to the Department stating the following:

a) Details of experience and further training;

b) References;

c) List of pertinent cases and any other pertinent factors such as certificates of completion of courses, as requested by the Department.

1.6 The Department may recommend to reject or may recommend to grant temporary privileges pending observation. The final decision may then be to recommend to reject, accept, or defer for a further period of observation as may be defined. Either the applicant or the Department Chairman may request the applicant's personal appearance before a departmental meeting.

1.7 In the case of Medical Staff members with established privileges requesting additional privileges, if any observation is recommended by the Department, only those additional privileges requested shall be

considered provisional until the observation requirement has been satisfied.

1.8 An applicant for privileges may appeal any decision to the Executive Committee.

1.9 Medical privileges for all members of the Department will be reviewed by the Department of Medicine prior to their reappointment to the Medical Staff. Any modifications recommended will be forwarded to the Executive Committee with the reasons for such modifications given. Said review will be completed two months before the termination of the practitioner's reappointment period.

1.10 Copies of the Medicine privilege cards will be kept in the practitioner's credentials file and in the Operating Room Office and Intensive Care Unit, under the supervision of the Department Director of Surgery and the Department Director of ICCU, along with surgical privileges, to ensure availability and confidentiality.

1.11 The privilege to assist at surgery may be recommended by the Department of Medicine using the guidelines in Section II,B,2 of the Department of Surgery Rules and Regulations.

## 2. **Proctoring Protocol**

2.1 Proctoring Categories.

a) All new Medical Staff members in the Department of Medicine shall be proctored.

b) Existing Medical Staff members in the Department of Medicine requesting an increase in clinical privileges shall be proctored.

c) All practitioners requesting temporary privileges in the Department of Medicine shall be proctored.

d) Existing members of the Medical Staff shall have their performance monitored whenever deemed necessary by the chairman of the Department of Medicine, Executive Committee, the Chief of Staff or the Deputy Chief of Staff.

2.2. Proctoring of Admissions and Consultations

a) The proctoring for new Medical Staff members in the Department of Medicine shall occur during the Provisional Staff status period. This period shall be at least six (6) months but no longer than two (2) years.

b) At least two proctors will be appointed to each physician requiring proctoring. If the physician is a subspecialist, at least one proctor will be of that subspecialty. This proctor cannot be an associate or partner of that person being proctored, except for contracted services. In situations where a proctor cannot be found in the subspecialty, a waiver of this rule may granted by the Department Chairman.

c) Proctoring shall include direct observation, concurrent chart review and the monitoring of diagnostic and treatment techniques. Retrospective evaluation of performance may supplement but not substitute for direct observation. Proctoring involves evaluation of all aspects of the management of any case.

d) A minimum of the FIRST five (5) cases will be reviewed for history and physicals and/or consultations and follow-up care of the patients during that particular hospital admission. If the physician is a subspecialist, at least three (3) proctored cases must be within the practitioner's subspecialty. The cases will be divided between two (2) of the proctors appointed to the practitioner.

e) The first Intensive/Coronary Care Unit admission or consultation for each physician will be concurrently proctored.

f) It is the responsibility of the physician to notify the appointed proctor of the cases to be proctored.

g) A proctoring evaluation form will be completed by the proctor and submitted to the Medical Staff Office.

h) Copies of the actual proctoring reports will be maintained in the new physician's credential file and will be taken into consideration at the time the practitioner is considered for advancement from the Provisional Staff category.

2.3 Proctoring of Procedures

a) Concurrent proctoring is required for all new Medical Staff members, practitioners requesting temporary privileges, and existing Medical Staff members requesting additional privileges, for all procedures identified by (p) on the Medicine privilege card.

b) Concurrent observation is required for all invasive and non-invasive procedures requiring proctoring.

c) Any Active, Associate, or Consulting member of the Department of Medicine who has been granted the privilege being proctored may serve as a proctor for a procedural privilege.

d) The first time that a practitioner does one of the procedures marked with a (p), the practitioner shall arrange for his proctor to observe him. The proctor may require additional proctoring in the procedure, to a maximum of five (5). If the proctor determines that proctoring needs to be extended for more than five (5) procedures, the proctor shall document the reason(s) on the evaluation form and submit the form to the Department for evaluation and recommendation.

e) If a similar, more difficult procedure in a specialty group has been proctored, proctoring may be waived for the less difficult procedure, at the discretion of the proctor.

f) A proctoring evaluation form will be completed by the proctor and submitted to the Medical Staff Services Department staff for review and recommendation of proctoring status by the Department.

g) At the time of scheduling a procedure, it is the responsibility of the practitioner to contact and inform the proctor of the date and time of the procedure. If a proctor is unable to observe the practitioner at the time of the scheduled procedure, the practitioner shall contact the Chairman of the Department of Medicine or his designee. The Chairman or his designee will determine if the practitioner will be able to do the procedure without a proctor present.

h) Emergency procedures will be excluded from concurrent proctoring. However, retrospective review of the procedure will be conducted to evaluate medical management and ascertain that the procedure was emergent.

2.4 Reciprocal Proctoring

Evidence of proctoring performed at other accredited hospitals may be accepted. The proctor must be a member of the Medical Staff of Henry Mayo Newhall Memorial Hospital (HMNMH) and at the other hospital,

and must be eligible to serve as a proctor at both hospitals. The same range and level of privileges must have been requested by the new medical staff member at both hospitals. No more than 50% of total proctoring shall be accepted from another hospital.

## 3. Gastroenterology Privileges

3.1 Gastroenterology Privileges must be requested through the Department of Medicine. All practitioners requesting privileges in gastroenterology shall have completed a gastroenterology fellowship training program.

3.2 Endoscopic Rubber Band Ligation of Esophageal Varices.

Requirements for these privileges include:

a) Compliance with section 4.1 above.

b) Approved privileges for Esophagogastroduodenoscopy (EGD) with variceal sclerotherapy at Henry Mayo Newhall Memorial Hospital and,

c) Documented training in endoscopic rubber band ligation of esophageal varices.

3.3 Esophageal Metal Stent Placement. Requirements for these privileges include:

a) Compliance with section 4.1 above.

b) Approved privileges for Esophagogastroduodenoscopy (EGD) with variceal sclerotherapy at Henry Mayo Newhall Memorial Hospital, and

c) Approved privileges for esophageal dilation with Malloney, Savory and Balloon dilators at Henry Mayo Newhall Memorial Hospital, and

d) Documented training in esophageal metal stent placement.

3.4 24 Hour pH Monitor

Requirements for this privilege include:

a) Compliance with Section 4.1 above,

b) Completion of a 24 Hour ph Monitor continuing medical education course accredited by the California Medical Association or the American Medical Association, or Training in 24 Hour pH Monitor interpretation as documented by a letter from the fellowship director indicating that the practitioner is qualified to interpret.

## 4. Covering Physician

A member of the Department of Medicine shall arrange for coverage of his practice only by a practitioner with approved privileges at this Hospital and who is willing and available to provide service to patients at this Hospital.

## 5. Laser Privileges

5.1 Laser privileges must be requested through the practitioner's clinical department. Requests will be

laser class-specific.

Basic requirements for laser privileges include:

a) Completion of an approved residency training program with a letter from the program director indicating that the Practitioner is qualified to use the specific class of laser requested or

b) Completion of a minimum of six (6) hours of continuing medical education accredited by the California Medical Association or the American Medical Association, to include laser fundamentals, tissue biophysics, and hands-on laboratory training.

c) The practitioner must have completed a minimum of two (2) hours of training for each additional class of laser.

5.2. The above qualifications for laser privileges shall be applied to all new applicants and to current Medical Staff members as they apply for privileges at the time of their reappointment.

5.3. A practitioner requesting laser privileges shall be proctored by direct observation of three (3) cases with the total number of cases to be divided between the two assigned proctors.

## 6. Transesophageal Echocardiography Privileges

6.1 Transesophageal echocardiography (TEE) privileges must be requested through the Department of Medicine.

Requirements for TEE privileges include:

a) Completion of an approved cardiology fellowship program with a letter from the program director indicating that the practitioner is qualified for TEE; or

b) Privileges to do transthoracic echocardiography at this Hospital; and

i) Documentation of experience in esophagogastric intubation in at least ten (10) patients; and

ii) Completion of a minimum of ten (10) hours of continuing medical education in TEE accredited by the California Medical Association or the American Medical Association.

6.2 A practitioner requesting TEE privileges must have a minimum of his first three (3) TEE procedures proctored by an experienced transesophageal echocardiographer. Proctoring reports shall be submitted to the Department of Medicine.

## 7.0 Ventilator Management - Short Term or Prolonged

7.1 Ventilator Management, Short Term or Prolonged, privileges must be requested through the Department of Medicine.

Qualifications for the privilege of Ventilator Management - Short Term include:

a) Training and/or experience to treat patients with acute problems or chronic problems with acute exacerbation, where short-term intubation (<48 hours) is anticipated.

Qualifications for the privilege of Ventilator Management - Prolonged include:

a) Specialty in critical care Medicine and Cardiothoracic or documented special training and competence in this area and

b) Training and/or experience to treat patients with chronic cardiopulmonary problems or patients with acute significant problems requiring intubation, with a high probability of prolonged ventilator need, or short term patients that cannot be successfully weaned and extubated within 48 hours.

## 8.0 **Bronchoscopy Privileges**

8.1 Bronchoscopy privileges must be requested through the practitioner's clinical department. Final review and recommendation for these privileges shall be the responsibility of the Department of Medicine.

Basic requirements for bronchoscopy privileges include:

a) Completion of an approved fellowship program in pulmonary/critical care medicine or a residency training program in cardiovascular surgery, or thoracic surgery, or critical care surgery and

b) Documentation of the satisfactory performance of a minimum of 50 bronchoscopies including or at least 20 cases involving transbronchial lung biopsy as well as procedures on patients receiving mechanical ventilation.

## II. DEPARTMENTAL RULES AND REGULATIONS

### B. Department of Surgery

### 1. Privileges

1.1 Requests for privileges in the Department of Surgery shall be completed on the appropriate privilege delineation form(s) and processed by the appropriate service, if applicable, prior to processing by the Department. Privileges shall be granted in accordance with the Medical Staff Bylaws.

1.2 Privileges shall be reviewed by the Department of Surgery and recommended to the Executive Committee on the basis of training, experience and demonstrated ability. Such privileges shall be granted by the Board of Directors after review of the practitioner's credentials by the Executive Committee.

1.3 A resume of the number of specific procedures performed in other accredited hospitals by the applicant during the immediately preceding three years may be required in support of an application for privileges.

1.4 The department may recommend to grant or deny all or part of the privileges requested, or may place such restrictions on the applicant as appropriate and as approved by the Executive Committee.

1.5 The Department may recommend observation of certain procedures to be performed in the case of an applicant or new member. Privileges shall be granted for a provisional period and until such time as appropriate proctoring reports are available for review, prior to recommendation for advancement from the Provisional category of staff. This period shall be at least six (6) months but no more than two (2) years.

1.6 Requests for increase in privileges are made in writing to the Department stating the following:

a) Details of experience or further training;

b) References;

c) List of pertinent cases and any other pertinent factors such as certificates of completion of courses, as requested by the department.

1.7 The Department may recommend to reject the request or may grant temporary privileges pending observation. The final decision may then be to recommend to reject, accept or defer for a further period of observation as may be defined. Either the applicant or the Department Chairman may request the applicant's personal appearance before a departmental meeting.

1.8 In the case of Medical Staff members with established privileges requesting additional privileges, if any observation is recommended by the Department, only those additional privileges requested shall be considered provisional until the observation requirement is satisfied.

1.9 An applicant for privileges may appeal any decision in accordance with the Medical Staff Bylaws.

1.10 Surgical privileges for all members shall be reviewed by the Surgery Department prior to their reappointment to the Medical Staff, and any modifications recommended shall be forwarded to the Executive Committee with the reasons for such modifications given. Said review will be completed at least two months before the termination of the practitioner's reappointment period.

1.11 Copies of the surgery privilege cards shall be kept in the practitioners credentials file and in the Operating Room offices of the Hospital building and The Surgery Center, under the supervision of the

appropriate Department Director of Surgery or the Department Director of Ambulatory Care Surgery, along with copies of medicine privilege cards. Physician preference cards will be completed at the time of application. Preference cards will be reviewed and updated by each physician at reappointment.

## 2. Assistants in Surgery

2.1 The ability to assist at surgery is considered a privilege which practitioners must request on a privilege request card.

2.2 Only licensed physicians and surgeons and RN First Assistants and Physician Assistants may apply for "assisting at surgery" privileges, except that podiatrists and dentists may apply for "assisting at surgery" privileges within the scope of their specialties.

2.3 Qualifications for the privilege of "assisting at surgery" shall be documentation of training and/or experience in assisting at surgery. Documentation of training or experience shall be as follows:

a) Completion of an approved residency training program with a letter from the program director indicating that the practitioner is qualified to assist at surgery, or

b) Documentation that the physician has been an assistant surgeon on at least five (5) cases with letters of support from at least two (2) surgeons.

c) RN First Assistants request for "Assisting at Surgery" privileges will require to document their training and experience and a letter from the program director of their training program. RN First Assistants also need to meet the requirements specified in the HMNMH Hospitalwide Administrative Manual policy, Registered Nurse First Assistant – Standardized Procedure."

2.4 The above qualifications for the "assisting at surgery" privilege shall be applied to all new applicants as of February 3, 2009. Current Medical Staff members who have assisted or currently have "Assisting in Surgery" privileges will be exempt from the above qualifications.

2.5 Ultimately, it is the responsibility of the principal surgeon to select who would be an appropriate assistant for a specific case, provided that this assistant meets the qualifications outlined above and has been granted the privileges for "assisting at surgery".

2.6 The surgeon will be in attendance at the time the surgical procedure is undertaken. Where a surgical assistant is required, when the portion of the surgery requiring an assistant is substantially complete, the surgeon may dismiss the assistant.

## 3. Scheduling

3.1 A provisional diagnosis and type of operation intended to be performed is required when surgery is being scheduled.

3.2 Elective surgery on inpatients and outpatients shall be scheduled with the scheduling secretary of the Operating Room in the Hospital building or the Surgery Center.

3.3 Surgeons are encouraged to schedule all outpatient cases in the Outpatient Surgery Center. Exceptions may be made if:

a) The surgeon has inpatient procedures scheduled in the Hospital operating room on the same day with the outpatient procedure falling in the middle of his schedule;

b) The surgeon anticipates that the patient may require inpatient status;

c) The surgeon anticipates that the patient would require recovery time beyond the time that the Surgery Center is open; or,

d) The outpatient procedure will occur at a time beyond the time that the Surgery Center is open.

e) There is time available in the Hospital operating room, and the same time is not available in the Surgery Center operating room.

f) If the patient has requested a specific anesthesiologist, and that anesthesiologist is scheduled to be in the Hospital operating room on that day.

3.4. Elective inpatient and outpatient procedures may be scheduled Monday through Saturday; the first case of the day is 0730. At the request of the operating surgeon, the first scheduled case could start at 0700. Elective cases shall be scheduled no later in the day than as outlined below:

Hospital Building

| | O.R. 1 | O.R. 2 | O.R. 3 | O.R. 4 |
|---|---|---|---|---|
| Mon-Fri | 0730<br>to finish by<br>1500 | 0730<br>to finish by<br>1900 | 0730<br>to finish by<br>1900 | 0730<br>to finish by<br>1900 |
| Sat | 0730<br>to finish by<br>1900 | 0730<br>to finish by<br>1900 | | |
| Sun | 0730-0730<br>(24 hrs)<br>Emergency Cases | Emergency<br>(Urgent, Emergent & inpatient cases)<br>to finish by 1500 | | |

This does not preclude the addition of "add-on" cases during regularly staffed hours to the surgery schedule after the completion of elective cases.

Ambulatory Care Center

| | O.R. 1 | O.R. 2 | O.R. 3 | O.R. 4 |
|---|---|---|---|---|
| Mon-Fri | 0700<br>to finish<br>surgery by<br>1500<br>to finish<br>recovery by<br>1800 | 0700<br>to finish<br>surgery by<br>1500<br>to finish<br>recovery by<br>1800 | 0700<br>to finish<br>surgery by<br>1500<br>to finish<br>recovery by<br>1800 | 0700<br>to finish<br>surgery by<br>1500<br>to finish<br>recovery by<br>1800 |

3.5 The only guaranteed starting time is the first case of the day. All other cases are scheduled on a "to follow" basis. Example: A surgeon may book a case at 1300; however, if another surgeon calls wishing to book a case in the interim time, the surgeon scheduled at 1300 would be given the opportunity to move up his time or take the chance that the inserted procedure may extend beyond 1300, and it is understood that the original designated time is therefore no longer guaranteed.

3.6 Cases should be booked so they can be completed by the expected completion time noted.

3.7 Emergency operations may be scheduled at any time in the Hospital building operating room and they shall take precedence over elective surgical cases. As a Level II Trauma Center, the Hospital is obligated to have an operating room (OR) staffed and available within 15 minutes when a trauma code is called.

a) Upon activation of a trauma code, an OR suite will be held until it is determined that it is not immediately needed for the trauma patient.

b) In the event that an OR suite being held for a trauma patient is needed immediately for any in-house/emergency department patient, the life-threatening emergency case will take precedence over any trauma patient in the field who has not yet arrived at the Hospital and for whom the OR suite is being held.

c) If an OR suite is being held for a trauma patient and a surgeon would like to use this room for a short case while the trauma surgeon is evaluating the trauma patient, the surgeon shall discuss this possibility with the trauma surgeon who will make the decision as to whether to release the room for the short case.

d) If two in-house immediately life-threatening emergencies are declared, one of which may be the newly arrived trauma patient, the first case to go to the OR will be determined by discussion between the surgeons with the final decision made by the Medical Director of Anesthesia Services or his designee. If the determination is made that the non-trauma life-threatening emergency case takes precedence over the trauma case, the next available operating room will be held for the trauma patient until released by the trauma team.

In addition, if the Medical Director of Anesthesia Services or his designee makes the determination on the order of the cases because the surgeons cannot reach an agreement, the cases may be referred to and reviewed by Department of Surgery Peer Review Committee for appropriateness of the priority determination of the cases.

3.8 Cases may be added to The Surgery Center surgery schedule provided there is time available on the surgery schedule. Under no circumstances will a scheduled case be "bumped" to accommodate an "add-on" case. In the event of an emergency outpatient procedure, refer to 3.7 above.

3.9. Start times for scheduled cases will take priority over add-on cases;

a) First case 0700 – 0730 (see 5.2)

b) If subsequent start times cannot be kept due to delays in the OR, the OR is to notify the surgeon as soon as possible prior to the scheduled start time.

c) If the surgeon cannot keep the scheduled time he/she is to notify the OR as soon as possible but no later than 15 minutes prior to the arranged time, in which case, the room may be held for up to 30 minutes after the scheduled start time after which the room will be released. The Charge Nurse will make every effort to accommodate case.

d) If the surgeon just doesn't show, the room may be released within 20 minutes after the scheduled start time.

e) a and d can be modified at the discretion of the first call anesthesiologist or his designee.

f) Surgeons are required to be present in the operating suite fifteen (15) minutes prior to commencement of the first case.

g) Anesthesiologists are required to be present in the operating suite thirty (30) minutes prior to commencement of the first case.

## 4. Preparation for Surgery and Operating Room Protocols

4.1 Outpatients and A.M. admit patients shall be referred to outpatient centers/laboratories for pre-op lab and x-rays to be done within one week prior to surgery.

a) In the case of A.M. admissions for Inpatient surgery, the patient must be admitted at least two (2) hours prior to scheduled time of surgery.

b) Outpatients must be admitted at least one (1) hour prior to surgery to allow for evaluation by the anesthesiologist and the operating room staff. If an outpatient has not had his preoperative laboratory and x-rays done prior to the day of surgery, the patient shall arrive at least two (2) hours prior to the scheduled time of surgery.

4.3 The time of admission shall be prearranged and confirmed by the Patient Registration Department staff at the time of the initial processing of the patient. Patients who arrive late may have their surgery canceled at the discretion of the anesthesiologist, surgeon, Chairman of the Department, or the Department Director of Surgery or Director of The Surgery Center.

4.4 The anesthesiologist shall be responsible for the usual anesthetic, pre- and post-operative evaluations and documentation of those, as well as for the care of all patients whom he attends.

4.5 In emergency situations, the surgeon may bring his patient to the operating room before the anesthesiologist is present. In these cases, the surgeon shall remain in the operating room with the patient until the anesthesiologist is present.

4.6 Operating Room or Recovery Room personnel shall perform preoperative assessment and administer preoperative medications as ordered by the surgeon or the anesthesiologist.

4.7 For the main OR and the Surgery Center (ACC), the surgeon must identify the patient and the surgical site in the pre-op area and request the patient be taken into the surgical suite. At the surgeon's discretion, the assistant surgeon does not need to be present when the patient is being induced.

4.8 No outpatient shall be discharged from the recovery room except by order of the attending surgeon or anesthesiologist. If the patient cannot be discharged by the close of usual recovery room hours, the attending surgeon shall arrange for admission to the hospital.

4.9 All outpatients shall be examined by a physician prior to discharge from either the Hospital building or The Surgery Center.

4.10 Outpatients who have had general or spinal anesthesia must be discharged to the care of a responsible adult who will transport the patient from the hospital.

4.11 No person shall enter the operating suites in street clothing. Persons scheduled to work in the operating suites are required to change their clothes and put on scrub suits and shoe covers or designated operating room footwear in the dressing areas provided. If someone must leave the operating suite, he is to wear a gown and shoe covers over designated operating room shoes or change into street shoes.

4.12 Caps and masks must be worn upon entering a sterile area. Masks are to be changed following each operation. Masks must cover the nose and mouth.

4.13 All surgeons, assistant surgeons, and scrub nurses are required to scrub with an antiseptic soap for an adequate period of time prior to each case, as determined by community standard.

4.14 All gloves must be thoroughly cleansed of powder with a wet cloth.

4.15 Only radiopaque sponges are to be used in the operating suites.

4.16 Sponge and needle counts must be taken on all major cavity surgeries or procedures involving deep tissue dissection.

4.17 In the case of incorrect sponge or needle count, an appropriate roentgenographic procedure is to be carried out promptly.

4.18 No visitors are permitted in the operating room during surgery except with the specific consent of the attending surgeon, assistant surgeon, anesthesiologist, patient and operating room supervisor. Objections by any one of the aforementioned parties shall be sufficient to prohibit a visitor in the operating suite, except as modified by subsection rules and regulations. All visitors must wear appropriate surgical attire.

## 5. Rules and Procedures for Operating

5.1 Elective procedures are to be completed during standard operating room hours and not during emergency standby hours. Rooms are available as noted in Section II-B-3.4, and the recovery room will close as noted.

5.2 Surgeons must be in the operating suite and ready to commence surgery at the time scheduled for the first scheduled case. In no case will the operating suite be held for the first scheduled case longer than 30 minutes after the time scheduled. After 15 minutes the operating room Supervisor or designee in conference with the Department of Anesthesiology Chairman or his designee shall have the option of releasing that time. Start time is defined as the time the patient passes the portal into the operating room.

a) For the first case of the day, 7:00 a.m. or 7:30 a.m., if surgeon calls prior to the scheduled start time, the room will be held a maximum of 30 minutes from the scheduled time. If the surgeon does not call, the room will be eligible to be released after 15 minutes from the scheduled time.

b) When the surgeon is more than 10 minutes late for the first case of the day, 7:00 a.m. or 7:30 a.m., more than three (3) times in a rolling three (3) months from the first occurrence, the surgeon will not be eligible to schedule a first case of the day for the next three (3) months.

5.3 Anesthesiologists are required to be in the operating suite at least 15 minutes prior to the scheduled time of the operation. Anesthesiologists who are late for their operations shall be subject to disciplinary action by the Medical Director of Anesthesiology and the Department of Surgery.

5.4 An assistant surgeon does not violate Section 5.5. of the Rules and Regulations in cases that an assistant surgeon is not required as determined by the Rules and Regulations.

5.5 Elective surgical procedures which require an assistant surgeon shall not be performed unless such assistant is present.

The Department Director of Surgery has the authority to cancel such surgeries in these cases and shall provide written notice of action to the Chairman of the Department.

5.6 Surgeons must be familiar with the instrumentation and/or equipment which will be used intraoperatively for the scheduled procedure. If the surgeon is not familiar with the instrumentation and/or equipment, he must obtain education regarding the use of the equipment prior to the procedure. The surgeon may contact the Department Director of Surgery or the Department Director of Outpatient Surgery for assistance in contacting a physician on the Staff with privileges for the specific procedure or the vendor for the equipment to arrange to receive this education.

## 6. Specimens for Pathology

6.1 All tissues and specimens removed at the time of surgery with the exceptions noted in the Laboratory Department Policy must be sent to the pathologist for gross and/or histological description and diagnosis. Said tissue shall become the property of the Hospital.

6.2. Frozen section diagnosis by the Hospital pathologist shall be available to the attending surgeon at his request.

6.3. If possible, the surgeon shall schedule the frozen section at the time the surgical case is scheduled with the operating room personnel.

## 7. Proctoring

7.1. Procedures selected for observation shall not be scheduled unless the proctor can be present. Exceptions are emergencies or procedures scheduled with prior approval of the Chairman of the Department.

7.2. The applicant shall be responsible to be proctored on a minimum number of cases, as determined by the Department outlined below:

a) Direct observation of at least (3) different major cases (or as modified by service rules and regulations) by two different proctors;

One case to be a laparoscopic procedure if applicant is requesting laparoscopic privileges.

b) Review of at least four (4) different cases for chart review related to completeness and adequacy of documentation of care rendered.

7.3. Evidence of proctoring from a reliable accredited hospital may be accepted in place of actual observation on the premises if the proctoring is approved by the Department Chairman and the Executive Committee.

a) The proctor must be a member of the Medical Staff of both hospitals.

b) The proctor must be eligible to serve as proctor at this hospital.

c) The same range and level of privileges must have been requested by the applicant at both hospitals.

7.4 The proctoring requirements for pathologists are as follows:

25 Surgical pathology cases, including frozen section correlation,
25 Cytopathology cases with history correlation,
5 Fine Needle Aspirations,

3 Bone marrow cases,
2 Autopsies.

The proctoring will be performed by the Medical Director of Pathology or his designee.

8. **Preoperative Tests**

8.1 Routine pre-operative testing will be done within one week of the procedure and will include any test and/or examination as specifically ordered by the patient's physician, surgeon, and/or anesthesiologist which are determined to be appropriate to the patient's individual needs.

If the anesthesiologist feels that there is an abnormality in the preoperative EKG or other preoperative test that is hazardous to the patient, he may cancel the case after discussing this with the surgeon.

8.2 All patients receiving local anesthesia by the surgeon shall have preoperative laboratory work done at the discretion of the surgeon.

9. **Documentation and Records Requirements**

9.1 The medical record should document or contain a current history and physical examination, and preoperative diagnosis prior to the performance of surgery, except in cases of life threatening emergencies. In the cases of life threatening emergencies, a brief note, including the preoperative diagnosis is recorded before surgery.

9.2 A brief preoperative history and physical form shall be provided by the hospital to all Medical Staff members performing outpatient surgery. This form or the dictated or written history and physical shall be completed prior to outpatient surgery.

10. **General Surgery Laparoscopic Privileges:**

10.1 Basic Laparoscopic privileges, including Laparoscopic Cholecystectomy, Laparoscopic Appendectomy, Laparoscopic Simple Biopsy, Laparoscopic Liver Biopsy, Laparoscopic Lysis of Adhesions, Laparoscopic Directed Percutaneous Liver Biopsy, and Diagnostic Laparoscopy must be requested in writing through the Department of Surgery.

a) Physician must have the privilege to do the open procedure in this Hospital.

b) Qualifications for Basic Laparoscopic privileges are:

i) Completion of an approved residency training program in General Surgery with a letter from the program director indicating that the practitioner is qualified to do basic Laparoscopic procedures, or

ii) Completion of a minimum of two (2) days or twelve (12) hours of continuing medical education accredited by the California Medical Association or the American Medical Association to include didactic and hands-on experience on live animals for basic Laparoscopic procedures.

c) Proctoring will consist of retrospective chart review of the first three (3) cases per surgeon.

10.2 Requirements for basic laparoscopy assisting privileges include:

a) Physicians who have general, gynecological and urological laparoscopic operative privileges in this Hospital are automatically granted privileges to assist at general, gynecological and urological laparoscopic procedures.

b) Family Practitioners and Internal Medicine physicians must have assisting at surgery privileges and must comply with the following for assisting privileges:

i) Participation as the cameraman or assistant in a total of three (3) laparoscopic/thoracoscopic cases; or

ii) A practitioner who has basic laparoscopic assisting privileges in another hospital or other accredited surgical facility needs to provide documentation of three (3) cases from the hospital where he has assisted. Assisting in the three (3) cases need not be with two different surgeons.

10.3 Advanced Laparoscopy Privileges, including Laparoscopic Common Bile Duct Exploration, Laparoscopic Hernia Repair, Laparoscopic Bowel Resection, Laparoscopic Retroperitoneal Node Dissection, Laparoscopic Vagotomy, Laparoscopic Pyloroplasty, Laparoscopic Pyloromyotomy, laparoscopic Gastromyotomy, Laparoscopic Gastrostomy and Laparoscopic Lymphadenectomy must be requested in writing through the Department of Surgery.

Requirements for Advanced Laparoscopy privileges include:

a) Surgeon requesting Advanced Laparoscopy Privilege must have the privilege to do the open procedure in this Hospital.

b) Surgeons on Staff requesting Advanced Laparoscopy Privileges must have completed training and experience in the basic laparoscopy procedures and will need to demonstrate competency in basic laparoscopy procedures. Evidence of training must be submitted for evaluation and recommendation.

Qualifications for Advanced Laparoscopy Privileges are:

a) Completion of an approved residency training program in general surgery with a letter from the program director indicating that the practitioner is qualified to do advanced laparoscopic procedures, or

b) Completion of a minimum of two (2) days or twelve (12) hours of Continuing Medical Education accredited by the California Medical Association or the American Medical Association to include didactic and hands-on experience on live animals for advanced laparoscopic procedures.

c) Proctoring shall consist of retrospective chart review of first three (3) cases, which must be of different advanced laparoscopy procedures per surgeon.

10.4 Requirements for advanced laparoscopic assisting privileges include:

a) Physicians who have general, gynecological and urological Laparoscopic operative privileges in this Hospital are automatically granted privileges to assist at general, gynecological and urological laparoscopic procedures.

10.5 Basic Laparoscopic Urology privileges including Diagnostic Laparoscopy, Laparoscopic Varicocelectomy, Laparoscopic Pelvic Lymphadenectomy, Laparoscopic Orchidopexy (Fowler-Stephen's) and Laparoscopic Orchidectomy must be requested in writing through the Department of Surgery.

a) Physician must have privileges to do the open procedure in this Hospital.

b) Qualifications for Basic Laparoscopic Urology privileges are:

i) Completion of an approved residency training program in Urology with a letter from the Program Director indicating that the practitioner is qualified to do basic laparoscopic urology procedures, or

ii) Completion of a minimum of two (2) days or seven (7) hours of Continuing Medical Education accredited by the California Medical Association or the American Medical Association to include didactic and hands-on experience on live animals for basic laparoscopic procedures.

c) Proctoring will consist of retrospective chart review of the first three (3) cases per surgeon.

10.6 Requirements for basic laparoscopic urology assisting privileges include:

a) Physicians who have general, gynecological and urological laparoscopic operative privileges in this Hospital are automatically granted privileges to assist at general, gynecological and urological laparoscopic procedures.

b) Family Practitioners and Internal Medicine physicians must have assisting at surgery privilege and must comply with the following for assisting in basic laparoscopic urology privileges:

i) Participation as the cameraman or second assistant in a total of three (3) laparoscopic cases, two (2) of which should be laparoscopic cholecystectomy cases and one (1) other basic laparoscopy case, or

ii) A practitioner who has basic urology laparoscopic assisting privileges in another hospital or other accredited surgical facility needs to provide documentation of five (5) cases from the hospital where he has assisted. Assisting in the five cases need not be with two different surgeons.

10.7 Advanced Laparoscopic Urology Privileges including Laparoscopic Retroperitoneal Node Dissection, Laparoscopic Nephrectomy, and Laparoscopic Bladder Neck Suspension must be requested in writing through the Department of Surgery.

a) Surgeon requesting advanced laparoscopic urology privilege must have the privilege to do the open procedure in this hospital.

b) Surgeons on Staff requesting advanced laparoscopic urology privileges must have completed training and have experience in the basic laparoscopic urology procedures and will need to demonstrate competency in basic laparoscopic urology procedures. Evidence of training must be submitted for evaluation and recommendation.

Qualifications for Advanced Laparoscopic Urology privileges are:

i) Completion of an approved residency training program in urology with a letter from the program director indicating that the practitioner is qualified to do advanced Laparoscopic urology procedures, or

ii) Completion of a minimum of seven (7) hours of Continuing Medical Education by the California Medical Association or the American Medical Association to include didactic and hands-on experience on live animals for advanced Laparoscopic procedures.

c) Proctoring shall consist of retrospective chart review of first three (3) cases, which must be of different advanced laparoscopic urology procedures, per surgeon.

10.8 Requirements for advanced laparoscopic urologic assisting privileges include:

a) Physicians who have general, gynecological and urological laparoscopic operative privileges in this Hospital are automatically granted privileges to assist at general, gynecological and urological laparoscopic procedures.

## 11. Laser Privileges

11.1 Laser privileges must be requested through the practitioner's clinical department. Requests will be laser class-specific.

Basic requirements for laser privileges include:

a) Completion of an approved residency training program with a letter from the program director indicating that the practitioner is qualified to use the specific class of laser requested or

b) Completion of a minimum of six (6) hours of continuing medical education accredited by the California Medical Association or the American Medical Association to include laser fundamentals, tissue biophysics and hands-on laboratory training.

c) Any new class of laser to be reviewed by Department of Surgery Peer Review Committee to determine if additional training is warranted due to new regulations.

11.2 The above qualifications for laser privileges shall be applied to all new applicants and to current Medical Staff members as they apply for privileges at the time of their reappointment.

11.3 A practitioner requesting laser privileges must have a minimum of his first three (3) laser procedures proctored.

## 12. Thoracoscopy

12.1 Thoracoscopy privileges, including Diagnostic Thoracoscopy, Thoracoscopic Biopsies, Thoracoscopic Pericardial Window, Thoracoscopic Sympathectomy, Thoracoscopic Lobectomy, Thoracoscopic Pneumonectomy, Thoracoscopic Wedge Resection of Lung, Thoracoscopic Pleurectomy, and Thoracoscopic Phlebectomy must be requested in writing through the Department of Surgery. Requirements for Thoracoscopy privileges include:

a) Physician must have the privilege to do open thoracic procedure in this Hospital.

b) Must have completed a residency program in thoracic surgery approved by the American Board of Thoracic Surgery.

c) Must have completed an approved training program or 12 hour course in thoracoscopy or provide documentation of training on thoracoscopic procedures in his or her residency program.

d) Proctoring shall consist of a retrospective chart review of three thoracoscopic surgeries.

e) Assistant surgeon must have assisting in surgery privilege and one of the following: surgery laparoscopy privileges or assisting in laparoscopy privileges or thoracoscopy privileges.

13. **Abdominal Aortic Aneurysm Endograft Privileges**

13.1 Requirements for privilege include:

a) Must have completed an approved endovascular AAA training program for the application of the Endograft System for abdominal aortic aneurysm repair.

b) Experience in Peripheral Vascular Intervention

c) Proctoring shall consist of a minimum of 5 cases by a general surgeon with representative vendor present.

d) Assistant must have general surgery privileges.

14. **Dental Services**

a) All Dental Services shall be under the direct supervision of the Department of Surgery.

b) Dentists applying for privileges shall do so in accordance with the established Bylaws of the Medical Staff, and those accepted shall adhere to these Bylaws, Rules and Regulations.

c) The dental applicants for Staff membership must be legally licensed to practice in the State of California and must conform to general standards established by the Medical Staff including ethical and moral codes.

d) An adequate medical history, physical examination and indicated laboratory work by a physician member of the Medical Staff shall be required before dental surgery and/or within 24 hours of admission. This information shall be on the patient's chart, or dictated before the patient is allowed to enter surgery.

e) Indicated consultations with Medical Staff shall be required in all complicated cases.

f) An appropriate dental history and examination by the dentist shall be done and included in the patient's chart within 24 hours of admission and/or prior to surgery.

g) Progress notes shall be written by the dentist in accordance with the Rules and Regulations of the Medical Staff. The attending physician may write progress notes if the patient's condition or treatment dictates.

h) Patients may be discharged by either the dentist or physician, and either may dictate the discharge summary.

i) By order of the Los Angeles County Department of Licensure and against the advice of the Medical Staff, a physician and surgeon M.D. is no longer required to admit the patient or required to be present in the operating room during surgery.

15. **Podiatry Services**

a) All Podiatry Services shall be under the direct supervision of the Department of Surgery.

b) Podiatrists applying for privileges shall do so in accordance with the established Bylaws of the Medical Staff, and those accepted shall adhere to these Bylaws, Rules and Regulations.

c) The podiatric applicants for Staff membership must be legally licensed to practice in the State of California and must conform to general standards established by the Medical Staff including ethical and moral codes.

d) An adequate medical history, physical examination and indicated laboratory work by a physician member of the Medical Staff shall be required before any podiatry surgery and/or within 24 hours of admission. This information shall be on the patient's chart, or dictated before the patient is allowed to enter surgery.

e) Indicated consultations with Medical Staff shall be required in all complicated cases.

f) An appropriate podiatric history and examination by the podiatrist shall be done and included in the patient's chart within 24 hours of admission.

g) Progress notes shall be written by the podiatrist in accordance with the Rules and Regulations of the Medical Staff. The attending physician may write progress notes if the patient's condition or treatment dictates.

h) Patients may be discharged by either the podiatrist or physician and either may dictate the discharge summary.

i) By order of the Los Angeles County Department of Licensure and against the advice of the Medical Staff, a physician and surgeon M.D. is no longer required to admit the patient or required to be present in the operating room during surgery.

## II. DEPARTMENTAL RULES AND REGULATIONS

## C. Department of Primary Care

### 1. Privileges

1.1 Requests for privileges in the Department of Primary Care shall be completed on the appropriate privilege delineation form and processed by the Department of Primary Care. Privileges shall be granted in accordance with the Medical Staff Bylaws.

a) Privileges shall be reviewed by the Department of Primary Care and recommended to the Executive Committee on the basis of training, experience and demonstrated ability. Such privileges shall be granted by the Board of Directors after review of the practitioner's credentials by the Executive Committee.

1.2 The determination of privileges shall be based upon an applicant's documented training, experience and/or demonstrated ability.

1.3 Applicants must submit, along with the request for specific privileges requested, a resume of medical training and experience, and letters from any other accredited institution delineating the applicant's specific medical privileges at that facility.

1.4 A resume of the number of specific cases treated in other accredited hospitals by the applicant during the immediate preceding three years may be required in support of an application for privileges.

1.5 The Department may recommend to grant or deny all or part of the privileges requested, or may place such restrictions on the applicant as appropriate and as approved by the Executive Committee.

1.6 The Department may recommend observation of certain procedures to be performed in the case of an applicant or new member. Privileges shall be granted for a provisional period until such time as appropriate proctoring reports are available for review prior to recommendation for advancement from the Provisional category of membership. This period shall be at least six (6) months but no longer than two (2) years.

1.7 Requests for increase in privileges are made in writing to the Department stating the following:

a) Details of experience and further training;

b) References;

c) List of pertinent cases and any other pertinent factors such as certificates of completion of courses, as requested by the Department.

1.8 The Department may recommend to reject the request or may recommend to grant temporary privileges pending observation. The final decision may then be to recommend to reject, accept, or defer for a further period of observation as may be defined. Either the applicant or the Department Chairman may request the applicant's personal appearance before a Departmental meeting.

1.9 In the case of Medical Staff members with established privileges requesting additional privileges, if any observation is recommended by the Department, only those additional privileges requested shall be considered provisional until the observation requirement has been satisfied.

1.10 An applicant for privileges may appeal any decision to the Executive Committee.

1.11 Family practice, pediatric and emergency services privileges for all members of the Department will be reviewed by the Department of Primary Care prior to their reappointment to the Medical Staff. Any modifications recommended will be forwarded to the Executive Committee with the reasons for such modifications given. Said review will be completed two months before the termination of the practitioner's reappointment period.

1.12 Copies of the Primary Care privilege cards will be kept in the practitioner's credential file and in the operating room office, under the supervision of the Department Director of the Surgery Department, along with surgical privileges, to ensure availability and confidentiality.

1.13 All physicians with privileges to attend newborn deliveries must be certified in neonatal resuscitation every two (2) years.

1.14 The privilege to assist at surgery may be recommended by the Department of Primary Care using the guidelines in Section II,B,2 of the Department of Surgery Rules and Regulations.

## 2. Proctoring

2.1 Department of Primary Care members or applicants shall be proctored by direct observation of five (5) cases with the total number of cases to be divided between the two assigned proctors.

2.2. Evidence of proctoring from a reliable accredited hospital may be accepted in place of actual observation on the premises if the proctoring is approved by the appropriate Department Chairman and the Executive Committee.

a) The proctor must be a member of the Medical Staff of both hospitals.

b) The proctor must be eligible to serve as proctor at this Hospital.

c) The same range and level of privileges or lesser privileges must have been requested by the applicant at both hospitals.

## 3. Covering Physicians

A member of the Department of Primary Care shall arrange for coverage of his practice only by a practitioner with approved privileges at this Hospital and who is willing and available to provide service to patients at this Hospital.

## 4. Laser Privileges

4.1 Laser privileges must be requested through the practitioner's clinical department. Requests will be laser class specific.

Basic requirements for laser privileges include:

a) Completion of an approved residency training program with a letter from the program director indicating that the practitioner is qualified to use the specific class of laser requested or

b) Completion of a minimum of six (6) hours of continuing medical education accredited by the California Medical Association or the American Medical Association, to include laser fundamentals, tissue biophysics, and hand-on laboratory training.

c) The practitioner must have completed a minimum of two (2) hours of training for each additional class of laser.

4.2. The above qualifications for laser privileges shall be applied to all new applicants and to current Medical Staff members as they apply for privileges at the time of their reappointment.

4.3 A practitioner requesting laser privileges must have a minimum of his first three (3) laser procedures proctored.

5. **Evaluation of Suicide Ideation**

5.1 The privileges of Evaluation of Suicidal Ideation must be requested through the Department of Primary Care. Basic requirements for this privilege include:

a) For new applicants to the Medical Staff:

i) Board certification in Family Practice or Pediatrics, or

ii) Completion of an approved residency training program with a letter from the program director indicating that the practitioner is qualified for this privilege.

b) For members of the Medical Staff as of 6/11/98:

i) Board certification in Family Practice or Pediatrics, or

ii) If not board certified, an interview with an ad hoc committee of board certified family practitioners or pediatricians to verify training and experience.

5.2 A new applicant to the Medical Staff must have a minimum of his first three (3) potential suicide patients proctored on a retrospective basis.

# SERVICE RULES & REGULATIONS

## III. SERVICES RULES AND REGULATIONS

### A. Emergency Services

### 1. Emergency Service Coverage

1.1 Physicians covering the emergency service must be members of the Hospital's Medical Staff and must be approved for membership on the staff as stated in the Medical Staff and Hospital Bylaws.

1.2 Physicians who are regularly employed in the Emergency Department (ED) shall not have admitting or consulting privileges in the hospital.

1.3 Physicians covering the emergency service will provide coverage for all patients seeking care through the Emergency Department.

1.4 Emergency Medicine physicians will provide back-up coverage and 24-hour availability for all of the following in-house emergencies as permitted by ED patient volume and responsibilities. Primary coverage will be the responsibility of the following specialists: Intensivists will respond to "Code Blue", "Code STEMI" and "Code Neuro" patients. Neonatologists will respond to "Code White" patients. OB Laborists will respond to obstetrical emergencies.

1.5 Will render initial evaluation of industrial injuries of Hospital personnel.

1.6 Will coordinate and assist in the medical aspects of the base station, paramedic program, trauma program, and other related projects.

1.7 Backup coverage of the Emergency Department will be provided by other members of the Medical Staff.

### 2. Patient-Private Physician Relationships

2.1 Every effort will be made to protect any pre-existing relationship between patients and their private practitioner.

2.2 Following treatment in the Emergency Department, patients will be referred to their own practitioner.

2.3 If patients require immediate hospitalization and the private practitioner cannot be reached within a reasonable amount of time, then the patient will be admitted to a physician serving on the ED Backup Panel.

2.4 If a consultation is required, it will be arranged whenever possible with a practitioner requested by the patient in conjunction with his primary physician or his prepaid health plan, or a member of the Backup Panel.

2.5 Patients who do not have a private practitioner will be evaluated and treated by the emergency service physician and if admission to the Hospital is needed, the emergency service physician will call any practitioner specifically requested by the patient, or if unavailable, assigned to the HMNH Hospitalist.

2.6 Patients not requiring hospitalization will be provided a referral physicians name. The referral physician will be the physician of the day from the ED Backup Panel. In addition, for specialties not included on the ED Backup Panel, a specialist who is on the HMNH medical staff will be provided.

3. **Privileges**

3.1 Requests for privileges in the emergency service shall be completed on the appropriate privileges delineation form and processed by the Chairman of the Department of Primary Care. Privileges granted shall be in accordance with the Medical Staff Bylaws.

3.2 The Chairman of the Department of Primary Care will evaluate the qualifications of Staff members or applicants to Staff who wish to be granted emergency privileges. This evaluation shall be based on the applicant or member's documented training, experience, and/or demonstrated ability as evidenced board certification in emergency medicine or verification by the director of an approved emergency medicine residency program that the practitioner is qualified for the requested privileges. All emergency service physicians shall be board certified in emergency medicine or become board certified within three (3) years of joining the Emergency Department.

4. **Proctoring**

4.1 The proctoring for new emergency services physicians shall occur before or during the Provisional Staff status period. The Provisional Staff status period shall be at least six (6) months but no longer than two (2) years.

4.2 The performance of each emergency services physician shall be observed on at least six (6) different occasions by at least two (2) other emergency service physicians or staff physicians. The six (6) proctored cases shall include at least two (2) medical cases, two (2) surgical cases, and two (2) obstetrics or pediatric cases.

5. **Patient Records**

5.1 All patients, when leaving the Emergency Department, will be provided with a follow up instruction sheet.

5.2 Records accessed through EMR.

5.3 History and physical examinations should be sufficiently complete to evaluate the given problem.

6. **General Rules of Conduct**

6.1 All clinical studies necessary to evaluate the patient's presenting problem and any other emergent conditions which may be discovered should be performed.

6.2 It is the emergency service physician's responsibility to see that good relations are maintained between the several parties providing care to the patient.

6.3 It is the emergency service physician's responsibility to see that good public relations are maintained with the community, patient, family, law enforcement agencies, and paramedics.

6.4 Emergency service physicians shall refer to the appropriate specialty or facility the following list of medical problems:

a) Complicated reductions and fractures;
b) Extensive lacerations requiring surgery;
c) Lacerations that may cause cosmetic problems.

6.5 After the patient is evaluated and the patient's emergent condition is stabilized, the ED case manager will assist to determine the appropriateness of admission at our facility versus transfer to HMO contracted facility. The Rules established by EMTALA will be followed.

6.6 Transfer to higher level of care for unstable patients is acceptable provided the transferring physician and the accepting physician are in agreement. Transfer of all other patients will be at the discretion of the patient. All transfers will comply with the rules of EMTALA.

## 7. Backup Panels

Only members of the Medical Staff shall be allowed to provide backup coverage for the emergency service. Backup panels or referral panels will be arranged between the emergency service and interested Medical Staff members in at least the following specialties, as available, with additional specialty categories added at the discretion of the Emergency Services Committee:

- Cardiothoracic Surgery
- ENT (Otolaryngology)
- General Surgery
- General Practice/Internal Medicine – HMNH Hospitalist
- Neurosurgery
- OB/GYN – HMNH OB Hospitalist
- Ophthalmology
- Oral Maxillofacial Surgery
- Orthopedic Surgery
- Pediatrics
- Psychiatry
- Plastic Surgery
- STEMI
- Stroke
- Trauma
- Urology
- Critical Care Intensivist
- Vascular Surgery

## 8. Service on the Back-up Panels

8.1 Service shall be limited to Medical Staff members interested in rendering such service.

8.2 Applicants to these panels should contact the Medical Staff Office and complete the required forms.

8.3 The Emergency Services Committee will review the applicant's eligibility and notify him of the recommendation of the Committee within 60 days of receipt of the completed application and all other required backup material by the Emergency Services Committee. Such recommendation shall be forwarded to the Medical Executive Committee for review and recommendation and to the Board of Directors for approval or denial.

8.4 All members of the Emergency Backup Panels, in accepting this position, will be expected to abide by the rules and regulations of the service, as well as all other Bylaws, Rules and Regulations.

8.5 Members will be reappointed bi-annually to the backup panels.

8.6 An Emergency Department Backup Panel member wishing to resign from the Backup Panel shall

provide written notice to the Medical Director of Emergency Services, the Chairman of the Emergency Services Committee and the Medical Staff Office at least thirty (30) days prior to the effective day.

9. **Qualifications for Appointment to the Backup Panel**

Qualifications shall include but are not limited to:

9.1 Demonstrated competence to render the services required of a physician providing emergency care.

9.2 Demonstrated commitment to the community through a practice in the community, an office in the Santa Clarita Valley, and follow-up care provided in this community.

9.3 Completion of proctoring requirements as established by the Medical Staff.

9.4 Qualifications for service on the Trauma Panels in General Surgery, Orthopedics, Neurosurgery, and Emergency Medicine Panel include:

a) Board certified in their specialty, board eligible or demonstration of compliance with the American College of Surgeons Committee on Trauma alternative pathway as follows:

1. Physician demonstrate and the Hospital documents that the physician has met requirements which are equivalent to those of the Accreditation council for Graduate Medical Education or the Royal College of Physicians and Surgeons of Canada, or

2. Physician clearly demonstrates that he/she has substantial education, training and experience in treating and managing major trauma patients which shall be tracked by the Trauma quality improvement program and the physician has completed a residency program.

9.5 Trauma Panel members, including trauma surgeons, general surgeons, orthopedists and neurosurgeons, shall document trauma-related continuing medical education by staying current with board certification continuing medical education requirements.

a) General (Trauma) surgeon: Current certification in Advanced Trauma Life Support is required for physicians who have completed their residency.

b) Orthopedists and neurosurgeons: Current certification in Advanced Trauma Life Support is recommended for physicians who have completed their residency and have not yet attained board certification.

c) Emergency Medicine physician: Current continuing medical education must be consistent with board certification requirements. Current certification in Advanced Trauma Life Support is required for physicians who have completed their residency and have not yet attained board certification.

d) General surgeons on the Trauma Panel must attend at least fifty percent (50%) of the Trauma Committee meetings.

9.6. The Trauma Committee documents that the physicians on the Trauma Panel continuously meet the clinical function standards as set forth by the American College of Surgeons Committee on Trauma Optimal Resources document, Title 22, and the Los Angeles County Department of Health

Services/Emergency Medical Services Agency's Trauma Contract.

9.7 At the discretion of the Emergency Services Committee, and after consultation with the appropriate department or service, physicians who do not otherwise qualify may serve where there is a demonstrated need in that particular specialty. All such exceptions shall be forwarded to the Executive Committee for review and recommendation and to the Board of Directors for approval or denial.

a) Any physician who is appointed to the ED Backup Panel based on a demonstrated need shall be appointed to the ED Backup Panel for a period of one year. At the conclusion of the one year period, the physician shall be reappointed to the ED Backup Panel, if the demonstrated need continues to exist or the physician has fulfilled all requirements for membership in the ED Backup Panel, as determined by the Emergency Services Committee.

## 10. Backup Panel Rules

Members of the Backup Panel shall:

10.1 Serve on the Emergency Services Committee when nominated.

10.2 Be entitled to an equal number of shifts as any other member of the ED Backup Panel in their specialty and is obligated to cover his proportionate number of shifts. There may be flexibility in the number of shifts covered by an ED Backup Panel member if the members of that specialty panel agree.

10.3 Function as an advisor to the Service.

10.4 Arrange his own alternate (must be another qualified panelist) when unable to able to cover his assigned time of backup coverage and must notify the Emergency Department of the change. Notification must occur prior to the scheduled day of coverage. Failure to notify the ED timely will result in a sequence of administration actions (See 11.2 below).

10.5 Respond promptly when requested by the Emergency Department personnel.

10.6 Agree to see all patients who are present in the Emergency Department at the request of the Emergency Department physician on the days on which he is scheduled on call.

10.7 ED Backup Panel shift change time is 0700.

## 11. Loss of Appointment to the Backup Panel

11.1 Failure to comply with the qualifications in Section III-A-9.

a) When it becomes apparent that there is non-compliance with Section III-A-9., the practitioner will be given a 90 day notice to comply, resign, or be dropped from the Backup Panel.

b) In the event of non-compliance with Section III-A-9 the practitioner may be removed from the Backup Panel as deemed necessary by the Emergency Services Committee, with the approval of the Medical Executive Committee.

11.2 Failure to abide by rules, Section III-A-10. Sequence of administrative action in case of failure to abide by rules will be as follows:

a) A written notification of violation and request for information of circumstances will be sent to the practitioner by the Emergency Services Committee via certified or registered mail.

b) The practitioner in question must respond in writing within fifteen (15) days.

c) At the next meeting of the Emergency Services Committee, the circumstances will be reviewed by the Committee and by a simple majority, a decision will be made on the matter. If the Committee feels the practitioner was in violation of the rules, an official warning will be issued.

d) If the practitioner in question again fails to abide by the rules in Section III-A-11, steps (a) through (c) above will be reinstituted. If the Committee issues a second official warning to the practitioner, he will be recommended to the Medical Executive Committee, via the Chairman of the Department of Primary Care, for suspension from the Backup Panel.

e) At this time, the suspended practitioner has the right of appeal to the Medical Executive Committee of the Medical Staff.

f) If the practitioner is suspended by the Medical Executive Committee, the period of suspension is to be determined by the Medical Executive Committee.

B. **Obstetrics and Gynecology Service**

1. **Privileges**

1.1 Obstetrics and Gynecology privileges may be considered upon written application. Privilege requests will be forwarded to the Chairman of the Department of Surgery for evaluation and recommendation, to the Executive Committee and Board of Directors.

1.2 When additional training has been received, following the submission of case records and/or upon written recommendation by other staff members, existing members of the staff holding privileges may request consideration of an increase in privileges.

1.3 In cases where additional information is required prior to a decision being made, service members shall provide said documentation prior to a recommendation being forwarded to the Department of Surgery.

1.4 The Department of Surgery will exercise ultimate authority in deciding precise procedures recommended to the Executive Committee for approval on an individual's surgery privilege card as related to obstetrical and gynecological privileges.

1.5 Final action on application for OB/GYN privileges will be taken by the Board of Directors upon the recommendation of the Department of Surgery and Executive Committee.

1.6 Gynecological Operative Laparoscopy Privileges at HMNH would include the following:

Laparoscopic salpingectomy
Laparoscopic ovarian cystectomy
Laparoscopic oophorectomy
Laparoscopic myomectomy
Laparoscopic hysterectomy/Laparoscopic assisted vaginal hysterectomy
Diagnostic laparoscopy (with or without biopsy)
Laparoscopic simple biopsy
Laparoscopic lysis of adhesions
Laparoscopic tubal sterilization
Other laparoscopic procedures (please specify)_____.

In order to be approved for gynecological operative laparoscopy privileges, the practitioner must demonstrate the following:

a) Evidence of residency training in operative laparoscopy or completion of a minimum of two (2) days or twelve (12) hours of continuing medical education accredited by the California Medical Association or the American Medical Association to include didactic and hands-on experience for laparoscopic gynecology privileges.

b) The practitioner must have privileges for simple laparoscopy and also for the open operative procedure in question (such as salpingectomy, ovarian cystectomy, etc.)

c) See section 7.2 for proctoring requirements for gynecological operative laparoscopy privileges.

1.7 Privileges for assisting at gynecological operative laparoscopy (laparoscopic salpingectomy, laparoscopic ovarian cystectomy, laparoscopic oophorectomy, and laparoscopic myomectomy):

a) Privileges in gynecological operative laparoscopy or,

b) Evidence of satisfactory completion of a training course in operative laparoscopy or,

c) Sufficient skill or experience in assisting at operative laparoscopy procedures as determined by the primary surgeon.

## 2. Anesthesia

2.1 Requests for anesthesia privileges in the OB/GYN Service shall be completed on the appropriate privilege delineation form(s), and processed through the Chairman of the department of Surgery and the Executive Committee for final determination by the Board of Directors.

2.2 Privileges shall be evaluated by the Chairman of the Department of Surgery on the basis of training, experience, and demonstrated ability. General guidelines for qualifications are as follows:

a) Pudendal block or local infiltration anesthesia: Training and experience in OB/GYN.

b) Caudal, epidural, or saddle block anesthesia: Board Certified or Board Qualified in OB/GYN.

2.3 The attending obstetrician or anesthesiologist should be present during the initial induction f epidural anesthesia to obstetrical patients for anesthesia and pain management and remain on the hospital campus.

2.4 Caudal, epidural or continuous caudal or epidural anesthesia may be administered in the Labor Room by a Board Certified or Board Qualified obstetrician or anesthesiologist approved for said privileges. The patient must be continuously attended by the appropriate physician immediately available from within the hospital building. Caudal, epidural or continuous caudal or epidural anesthesia will not be provided in the outpatient Birthing Center.

## 3. Patient Records

3.1 Copies of prenatal records shall be forwarded to the hospital or Outpatient Birthing Center, according to where the patient is scheduled for delivery, prior to the expected date of confinement on all obstetrical patients.

3.2 Obstetrics Interval Progress Note Supplement form may be used for minor cases for patients staying less than 48 hours.

3.3 Dictated history and physical examinations in the prescribed hospital format are required on major surgical cases prior to surgery.

3.4 In cases of emergency, exceptions to 3.3 above will be made, however, the report is to be dictated within 24 hours of admission.

3.5 For documentation of anemia, Hgb 10 gm or less or Hct 30% or less will be the approved criteria.

3.6 Puerperal morbidity criteria will be a fever over 38 C (100.40 F) for any 24 hour postpartum period, excluding the first 24 hours.

## 4. Attendance at Routine C-sections

4.1 The Neonatal Resuscitation Team, consisting of a neonatal respiratory therapist and a RN trained in neonatal resuscitation, will attend all routine c-sections and any vaginal deliveries with meconium present to assist with intubation and respirator care.

## 5. Consultations - High Risk Protocol

The following categories are for determining high risk factors for a mother and infant. The course of action would be one of the following:

5.1 Mandatory transfer to another facility while the infant is in utero. Patients meeting the following criteria require mandatory transfer to Level II or III facility while infant is in utero.

a) Gestational age less than 34 weeks unless the patient is in labor and cannot be transferred.

b) Rh sensitization.

c) Maternal history of substance abuse (maternal history of use of alcohol or drugs which would put the infant at risk of withdrawal or other conditions or known risk, e.g. fetal alcohol syndrome).

5.2 Mandatory consultation to determine appropriateness of delivery at HMNH. Patients meeting the following criteria require mandatory consultation upon identification of high risk factor with documentation of consultation attached to the prenatal record. Attending physician and consultant must be in agreement to deliver at HMNH. If attending physician and the consultant are not in agreement, final determination will be made by the Chairman of the OB/GYN Committee.

a) Gestational age of 34-36 weeks - individual MD discretion with consultation with Board Certified pediatrician.

b) Heart disease of Class II or above. Consult should be with a Cardiologist.

c) Collagen vascular disease. Consult with an Internist.

5.3 Mandatory that OB/GYN be attending physician. Insulin dependent diabetic patients may deliver at HMNH if:

a) Patient is within 14 days of well-documented due date.

b) Patient has had a "level III" ultrasound for congenital anomalies.

c) Patient is currently in good diabetic control.

d) Patient's attending physician is OB/GYN.

5.4 Mandatory consult with a Board Certified OB/GYN by a non-Board Certified OB/GYN or non-OB/GYN to determine appropriateness of delivery at HMNH.

Risk factors requiring mandatory consultation with Board Certified OB/GYN by a non-Board Certified OB/GYN or non-OB/GYN upon identification of high risk factor with documentation of consultation attached

to the prenatal record. Attending physician and consultant must be in agreement to deliver patient at HMNH. If attending physician and consultant are not in agreement, final determination will be made by the Chairman of the OB/GYN Committee.

a) Previous perinatal death, including stillborn and neonatal.

b) Previous major congenital malformations.

c) Habitual abortions (meaning 3 or more).

d) Class A diabetes - normal FBS, not on insulin.

e) Chronic hypertension that is stable and controlled.

f) Chronic renal disease that is stable and controlled.

g) Thyroid disease.

h) Acute pulmonary disease

I) Seizure disorder.

j) Any patient admitted for tocolysis.

k) Vaginal bleeding over 20 weeks during this pregnancy.

l) Pregnancy induced hypertension (Toxemia)

m) Estimated fetal weight of less than 2500 grams (5 lbs. 8 oz.) and greater than 4000 grams (8 lbs. 14 oz.). (small for gestational age (SGA) or large for gestational age (LGA) infant.)

n) Elective medical induction.

o) Multiple Gestation

p) Vaginal Birth After Cesarean Section (VBAC), consult should be obtained prior to 32 weeks gestation.

q) Intrauterine grown retardation. Consult with Board Certified Obstetrician.

5.5 Delivery consultation - A consultation by a Board Certified or Board Qualified pediatrician or Board Qualified family practitioner who has been granted this privilege is mandatory at all multiple births. In high risk cases, as defined by Obstetrician, a Board Certified or Board Qualified pediatrician is required to be in attendance. The only exception to this: If immediate delivery is necessary and in the opinion of the delivering physician, it would be more hazardous to await the arrival of the approved consultant pediatrician to accomplish delivery.

## 6. Orders, Therapies, and Tests

6.1 Maternal patients shall have one plain tube of cord blood secured on every delivery. These specimens will be sent to the Laboratory and held for one week at no charge to the patient.

6.2 A specimen of urine for analysis will be obtained on al inpatient admissions to the labor suite and sent to the laboratory. Patients admitted to the Outpatient Birthing Center shall have their urine tested by dipstick onsite at the Outpatient Birthing Center.

6.3 Rh Negative and/or Type 0 mothers will have routine cord blood studies performed on the clotted specimen.

6.4 If a patient is a candidate for Rh Immune Globulin (RhIG), the physician must sign the order on the proper form, and the procedure for the ordering and administration of Rh Immune Globulin (RhIG) will be as contained in the Nursing Service Procedure Manual. If Rh Immune Globulin (RhIG) administration is indicated and the patient declines to accept the medication, the patient must sign the appropriate form for the refusal to permit Rh Immune Globulin (RhIG) administration.

6.5 Every abortion or tubal pregnancy patient admitted should have an Rh determination on admission. The attending physician will be advised of the laboratory data and he will then order the administration of Rh Immune Globulin (RhIG) if indicated unless previously done. All Rh Negative patients discharged after the termination of a pregnancy must have a nursing note on the chart stating that the Rh type was checked, reported to the physician, and Rh Immune Globulin (RhIG) was administered, if indicated. This procedure applies to all spontaneous, therapeutic and tubal abortions. Minidose is acceptable for gestation less than 12 weeks.

6.6 All Rh Negative patients delivered will have a specimen of cord blood sent to the laboratory for a "stat" Rh type for possible RH Immune Globulin (RhIG) Administration. The results of the test will be phoned to the unit. The Maternity staff will notify the Nursery staff of the report. Written lab reports will be sent to both units.

6.7 All Rh negative patients who have delivered an RH positive infant will have a Rosette test performed post-partum to screen for a large fetomaternal hemorrhage that would require more than a single dose of RhIG. If the Rosette test is positive a Kleihauer-Betke test will be sent out Astat@ to quantitate how much a fetal bleed occurred and how much RhIG is required. Results of the K-B will be phoned stat to the Women's Unit.

## 7. Documentation and Records Requirements

7.1 All maternity patients must have a complete blood type and Rh factor recorded on the chart. This information must be included on the newborn record sheet and forwarded to the Nursery Unit.

7.2 Every newborn infant shall have an apgar rating score determined by the OB nurse or pediatrician at C-Section at one and five minutes after birth. This information will be recorded on the Apgar rating sheet.

7.3 A high-risk identification sheet will be provided for all patients identified with complicated obstetrical problems. The nursing staff on the labor and delivery unit will assist in alerting the respective departments to any impending problems.

## 8. Proctoring

8.1 At least two (2) different Proctors shall be responsible to observe three (3) different major actual surgical cases (C-section, hysterectomy and laparoscopic procedure) and four (4) different cases for chart review related to completeness and adequacy of documentation of care and care rendered.

8.2 The practitioner will have his first five (5) gynecological operative laparoscopy procedures proctored

in a retrospective fashion by a gynecologist on staff at HMNH.

## 9. Labor and Delivery

9.1 A patient may be observed in a labor suite in the Hospital building for a period of two (2) hours. The observation period in the Outpatient Birthing Center may be extended at the discretion of the physician. Vital signs, fetal heart tones and contraction patterns will be followed during this period. There will be no charge for this observation.

a) No preparation, enema or medications will be given during this period unless it is determined that the patient requires admission.

9.2 A cardiac emergency cart will be provided in the Labor and Delivery Suite.

9.3 Patients whose deliveries have occurred outside the hospital may be admitted to the obstetrical unit of the Hospital for examination and repair of lacerations.

## 10. Labor Coaches in Labor and Delivery

10.1 Those persons having completed childbirth classes of certified Lamaze or Bradley instructors or classes approved by the Ob/Gyn Committee will be qualified as "coaches." Upon the request of the patient and with the permission of the attending obstetrician, persons not having completed the certified or approved classes may qualify as a coach.

10.2 A coach must have permission of the physician to be present in labor and delivery and must agree to abide by the rules and regulations established for those areas.

10.3 Coaches may accompany patients anywhere in the labor and delivery suites unless requested by the physician or nurse to leave. In such cases, the coach will wait wherever designated by the physician or nurse.

10.4 The coach's position in the delivery room will be as directed by the physician.

10.5 Photographs and tape recordings will be taken only with permission of the physician.

10.6 Any visitors other than qualified coaches will be admitted to the labor and delivery room only on the request of the patient and with the permission of the physician and at the discretion of the delivery nurse.

## 11. Induction or Stimulation of Labor

11.1 Initiation of Oxytocin for Labor Induction Physicians must be present during initiation of oxytocic administration and until regular contractions have started. At that time, the physician may leave the labor and delivery area and hospital campus. After the physician has left the labor and delivery area and hospital campus, he shall be immediately and continuously available by phone, and he shall be available to attend in labor and delivery within twenty (20) minutes of the request of his presence.

11.2 Labor Augmentation with Oxytocin Use of the oxytocin to augment labor with failure to progress may be ordered and administered without requirement of physician's presence. However, the physician shall be immediately and continuously available by phone, and he shall be available to attend in labor and delivery within twenty (20) minutes of the request of his presence.

11.3 Should the physician be unavailable or not respond in any instance regarding a nurse's request for

attendance at an initiation of oxytocin for labor induction or labor augmentation with oxytocin, the case shall be reviewed by the OB Committee. In reviewing the case, the OB Committee will consider whether there existed a patient care problem or if the physician had been unavailable or did not respond on other occasions. Upon recommendation of the Obstetrics Committee, the Chairman of the Obstetrics Committee may submit a request for corrective action to the Executive Committee in accordance with Article V, Corrective Action, of the Medical Staff Bylaws. After investigation by the chairman of the department to the Medical Staff Bylaws, the Executive Committee may determine appropriate action including:

a) Physician will not be allowed to conduct oxytocic administration for one (1) month unless physically in the main hospital building;

b) Physician will not be allowed to conduct oxytocic administration for a period of six (6) months unless physically in the main hospital building;

c) Physician will not be allowed to conduct oxytocic administration indefinitely unless physically in the main hospital building.

d) Corrective action as described in Article V of the Medical Staff Bylaws.

11.4 Elective medical induction of labor may be undertaken by any practitioner with obstetrical privileges including elective cesarean sections.

11.5 Pitocin for induction and augmentation may only be administered per IV protocol route.

## 12. Recovery Room

12.1 All patients admitted to the labor and delivery unit will be observed for a minimum period of one (1) hour after delivery in labor and delivery.

12.2 In the presence of complications, the observation period shall be extended until the patient's condition is stable and she can be cared for safely on a regular nursing unit.

12.3 Visitors to the patient during this recovery period will be limited to the immediate family or close friends. No more than two (2) visitors per patient may enter the area at one time.

12.4 Patients who require a C-section shall be recovered in the Surgery Recovery Room until they meet the recovery room discharge criteria.

12.5 There shall be no visitors to the Surgery Recovery Room unless approved by the physician and the Department Director of Surgery or his designee.

## 13. Women's Unit

13.1 Post-partum patients in the Hospital building will be cared for on the Women's Unit.

13.2 In the case of adoption or fetal death, post-partum patients may be cared for on another unit in the Hospital.

## 14. Newborn Nursery

The attending obstetrician will be responsible for the infant from birth until the pediatrician or general practitioner arrives and assumes charge of the infant.

## 15. **Abortions**

15.1 Incomplete Abortions

a) The signature of the patient or legal guardian is the only signature required on the consent form.

b) A pregnancy test is not required.

15.2 Therapeutic Abortions

a) The signature of the patient or her legal guardian must be obtained.

b) If the patient is an unmarried adult or an emancipated minor, her written consent is the only signature required.

c) A blood Rh factor must be done on the patient at the time of admission unless the physician has provided this information and it is available on the chart.

d) Any patient with a pregnancy of 16 weeks or over gestation who is undergoing an Amnio Infusion abortion must be attended by a Board Certified or Board Qualified OB/GYN or be seen in consultation by a Board Certified or Board Qualified OB/GYN to determine the length of gestation.

e) Any patient with a pregnancy of 18 weeks or over gestation must have gestation age confirmed by ultrasound.

According to an opinion of the California Attorney General, the Therapeutic Abortion Act should be interpreted as prohibiting abortions after the 20th week of pregnancy, with the exception of non-viable fetuses and abortions necessary to preserve the life or health of the mother.

f) Any fetus under 500 grams weight or 20 weeks gestation or crown-to-heel 28 cm., shall be classified as an abortion. The Pathology Department will assist in determination of fetal weight. Any State or Federal Law shall have precedence over these requirements.

## 16. **Sterilization**

16.1 Federal and State Regulations regarding sterilization have precedence over any of the following rules and regulations.

16.2 Any pregnant patient who is 18 years of age or older, of sound mind, not under the influence of drugs, married or single, and with or without the consent of her spouse, may sign the sterilization permit for postpartum sterilization. MediCal or federally funded patients must be 21 years or older.

16.3 In accordance with California Law, any pregnant minor is an emancipated minor. She may sign a consent to Hospital and medical care, anesthesia, dental or x-ray diagnosis or treatment related to her pregnancy to be rendered by a practitioner on Staff.

16.4 Postpartum sterilization may be done following vaginal delivery by tubal legation or partial salpingectomy. It may be done in conjunction with Cesarean Section by either tubal surgery or hysterectomy, at the discretion of the surgeon, if the appropriate consent is signed before the procedure

is undertaken.

## 17. Infection Control

17.1 Patients with known infectious illnesses should not be admitted to the Women's Unit Obstetrics Service if there is any reasonable alternative.

17.2 When labor is in progress or if a known infectious patient comes to the Hospital in labor, she may be cared for in a private labor room. Delivery should be accomplished under isolation technique. Clean up procedures should be followed as determined by the Infection Control Committee.

17.3 Obstetrics patients suspected of transmissible infection (undiagnosed fever, discharging skin lesions, purulent vaginal discharge, etc.) should be managed by room separation where isolation techniques will be instituted. This should be done according to Hospital policies and procedures relating to infection control. By itself, urinary tract infection does not require isolation regardless of temperature elevation.

17.4 Any mother developing an elevated temperature above 100.6 degrees F in an eight (8) hour period will be kept by herself or moved to an isolation room if the temperature does not respond to therapy and is not below 100.6 degrees F for two (2) consecutive times in an eight (8) hour period.

17.5 Proper attire to ensure infection control will be worn in certain Hospital areas as follows:

a) Nursery: gown over street clothes for infant examination or circumcision.

17.6 All open wound infections will be cultured by the nursing personnel according to Hospital policy and notification of the attending physician will occur.

## 18. Radio Frequency Bladder Neck Suspension

18.1 Requirements for privilege include:

a) Attendance at FDA approved course arranged by vendor

b) Experience in Anterior Colporrhapy

c) Proctoring shall consist of a minimum of three (3) cases by a physician with the privilege of radio frequency bladder neck suspension with the product vendor in attendance.

## C. Orthopedic Service

### 1. Privileges

1.1 The Chairman of the Department of Surgery will evaluate qualification of Staff members or applicants to Staff who wish to perform orthopedic procedures. Such evaluation along with recommendations for approval, denial or further study will be forwarded to the Executive Committee. Final action on orthopedic privileges will be taken by the Board of Directors upon the recommendation of the Executive Committee.

1.2 Orthopedic privileges will be considered upon receipt of written application to the Chairman of Department of Surgery on the appropriate privilege form with documentation of training and/or case records and/or written recommendation of other Staff members to substantiate the request.

1.3 Increase in privileges will be considered upon receipt of written application to the Chairman of Department of Surgery supported by documentation of additional training obtained.

### 2. Proctoring

2.1 Procedures selected for observation shall not be scheduled unless the proctor can be present. Exceptions are emergencies or procedures scheduled with prior approval of the Chairman of the Department.

2.2 The applicant shall be responsible to be proctored on a minimum number of cases, as determined by the Service as outlined below.

a) Direct observation of at least three (3) different major cases by two different proctors;

b) Review of at least four (4) different cases for chart review related to completeness and adequacy of documentation of care rendered.

2.3. Qualifications of the proctors are as follows:

a) Status as an Active, Associate, or Consulting member;

b) Sufficient experience to judge the quality of work being performed;

c) The proctor needs to have privileges for the procedure he is proctoring. In situations where a proctor cannot be found in the sub-specialty, a waiver of this rule may be granted by the Department Chairman;

2.4 Evidence of proctoring from a reliable accredited hospital may be accepted in place of actual observation on the premises if the proctoring is approved by the Department Chairman and the Medical Executive Committee.

a) The proctor must be a member of the Medical Staff of both hospitals.

b) The proctor must be eligible to serve as proctor at this hospital.

c) The same range and level of privileges must have been requested by the applicant at both hospitals.

D. **Behavioral Health Service**

1. **Privileges**

1.1 For the purpose of privileging,

a) Psychiatric patients are those patients with a psychiatric principal diagnosis and no chemical dependency secondary diagnosis.

b) Dual diagnosis patients are those patients with a psychiatric principal diagnosis and a chemical dependency secondary diagnosis.

1.2 Behavioral Health privileges may be considered upon written application. Privilege requests will be forwarded to the Chairman of the Department of Medicine for evaluation and recommendation, to the Executive Committee and the Board of Directors. Requests for new or additional privileges shall be reviewed by the Behavioral Health Committee prior to submission to the Chairman of the Department of Medicine.

1.3 Existing members of the Staff may request consideration of an increase in privileges following the submission of documentation of successful completion of additional training and/or case records.

1.4 In cases where additional information is required prior to a decision being made, applicants shall provide said documentation prior to a recommendation being forwarded to the Department of Medicine.

1.5 The Department of Medicine will exercise ultimate authority in deciding precise privileges recommended to the Executive Committee for approval.

1.6 Final action on application for Behavioral Health privileges will be taken by the Board of Directors upon the recommendation of the Department of Medicine and Executive Committee.

1.7 Minimum qualifications for Behavioral Health privileges are:

a) Psychiatrist: Successful completion of a psychiatry residency program approved by the American Board of Psychiatry and Neurology and licensure in the State of California.

Psychiatrists may be granted privileges as follows:

1.00 Admission of psychiatric patient to Behavioral Health Program.
3.00 Individual psychotherapy
4.00 Group psychotherapy
5.00 Family therapy
6.00 Psychological testing
7.00 Neuropsychiatric testing
9.00 Sleep disorders evaluation
10.00 Pharmaceutical pain management therapy/evaluation
10.01 Non-pharmaceutical pain management therapy/evaluation
10.02 5150 Involuntary detention

b) Psychologist: Successful completion of a psychology doctoral program and licensure in the State of California as a psychologist. Minimum of three years post-licensure experience treating psychiatric patients in an inpatient setting, and who has been designated by HMNH Behavioral Health Medical Director and authorized by the Department of Mental Health for involuntary detention.

Psychologists may be granted privileges as follows:

2.00 Co-admission to Behavioral Health Program
3.00 Individual psychotherapy
4.00 Group psychotherapy
5.00 Family therapy
6.00 Psychological testing
7.00 Neuropsychiatric testing
10.01 Non-pharmaceutical pain management therapy/evaluation
10.02 5150 Involuntary detention

c) Licensed Clinical Social Worker (LCSW): Successful completion of at least two years of post-graduate hospital training and licensure in the State of California. Minimum of three years post-licensure experience treating psychiatric patients in an inpatient setting, and who has been designated by HMNH Behavioral Health Medical Director and authorized by the Department of Mental Health for involuntary detention.

LCSWs may be granted privileges as follows:

3.00 Individual psychotherapy
4.00 Group psychotherapy
5.00 Family therapy
10.01 Non-pharmaceutical pain management therapy/evaluation
10.02 5150 Involuntary Detention

d) Marriage Family Child Counselor (MFCC): Successful completion of a course of study leading to licensure and maintenance of current license in the State of California. Minimum of three years post-licensure experience treating psychiatric patients in an inpatient setting, and who has been designated by HMNH Behavioral Health Medical Director and authorized by Department of Mental Health for involuntary detention.

MFCCs may be granted privileges as follows:

3.00 Individual psychotherapy
4.00 Group psychotherapy
5.00 Family therapy
10.01 Non-pharmaceutical pain management therapy/evaluation
10.02 5150 involuntary detention

e) Registered Nurses (RN): Current license in the State of California. Minimum of three years post-licensure experience treating psychiatric patients in an inpatient setting, and who has been designated by HMNH Behavioral Health Medical Director and authorized by Department of Mental Health for involuntary detention.

1.00 5150 involuntary detention

1.8 The specific privileges which the above practitioners may request are delineated on the Behavioral Health privilege request form.

1.9 The credentials of Allied Health Professionals (AHP), ie. Psychologists, licensed clinical social workers, and marriage family child counselors authorized for 5150 detention, and registered nurses

authorized for 5150 detention, shall be reviewed by the Medical Staff Credentials Committee for a recommendation for appointment to the AHP Staff. These recommendations shall be forwarded to the Executive Committee and the Board of Directors. AHP are not considered members of the Medical Staff.

1.10 AHP with valid and current contracts with the Hospital which assure that the contracting body is responsible for assuring that appropriate credentialing is done are exempt from the review process of the Medical Staff Credentials Committee, the Behavioral Health Service, the Department of Medicine, and the Executive Committee, as long as the Medical Staff Credentials and Executive Committees have approved the language in the contract which outlines the AHPs credentialing process.

1.10 Requirements for 5150 Involuntary detention to Behavioral Health Program privileges include documented authorization by the Los Angeles Mental Health Director.

## 2. Proctoring

2.1 Proctoring requirements are as outlined in the Department of Medicine Rules and Regulations. AHP must also comply with the proctoring requirements.

2.2 Proctors shall have the same healing arts licensure as the practitioner being proctored, except that psychiatrists are qualified to serve as proctors for psychologists, licensed clinical social workers, and marriage family child counselors. All other requirements for proctoring are as outlined in the General Medical Staff Rules and Regulations.

## 3. Documentation and Records Requirements

3.1 Any physician who is a member of the Medical Staff or who has been granted temporary privileges may admit dual diagnosis or chemical dependency patients to the Behavioral Health Program. Psychiatrists who have been granted admitting privileges may admit psychiatry patients to the Behavioral Health Program.

3.2 Psychologists who have been granted admitting privileges may co-admit patients to the Behavioral Health Program.

3.3 For all patients admitted to the Behavioral Health Unit, there shall be an admitting note by the admitting practitioner within 24 hours of patient admission to the Behavioral Health Program, followed by a dictated psychiatric history within 48 hours of admission.

3.4 An initial medical evaluation, or history and physical, shall be completed within 24 hours of admission by the patient's physician. A history and physical performed in an acute hospital up to five (5) days prior to the patient's admission to the Behavioral Health Unit is acceptable if a signed and dated copy thereof is provided for the Unit by the physician. When a 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.

3.5 The attending physician, psychologist, licensed clinical social worker, and marriage family child counselor will participate in the formulation of the patient's treatment plan and will participate in the regular review and updating of this plan.

3.6 The psychiatrist shall be responsible for completing a psychiatric discharge summary at the time of the patient's discharge from the Hospital.

4. **Involuntary Detention**

4.1 Henry Mayo Newhall Hospital has been designated by Los Angeles County and approved by the State Department of Mental Health as a facility for 72-hour evaluation and treatment of persons who, as a result of mental disorder, are a danger to themselves or others or gravely disabled.

4.2 The following persons may, upon probable cause, take a person who, as a result of mental disorder, is a danger to self or others or is gravely disabled, into custody or cause the person to be taken into custody and place the person at Henry Mayo Newhall Memorial Hospital:

a) A peace officer (including park peace officers and regional park peace officers);

b) A physician with approved privileges who has been designated by the HMNH Behavioral Health Medical Director and authorized by the L.A. County – Department of Mental Health;

c) Allied health professional with approved privileges who has been designated by the HMNH Behavioral Health Medical Director and authorized by the L.A. County – Department of Mental Health.

Psychologists with successful completion of a psychology doctoral program and licensure in the State of California as a psychologist. Minimum of three years post-licensure experience treating psychiatric patients in an inpatient setting, and who has been designated by HMNH Behavioral Health Medical Director and authorized by the Department of Mental Health for involuntary detention.

Marriage Family Therapist or Licensed Clinical Social Worker with successful completion of a course of study leading to licensure and maintenance of current license in the State of California. A minimum of three years post-licensure experience treating psychiatric patients in an inpatient setting, designation by HMNH Behavioral Health Medical Director and authorization by the Department of Mental Health for involuntary detention.

Registered Nurse employed by Henry Mayo Newhall Memorial Hospital who is certified in mental health by the American Nursing Association or who has had (3) years of post graduate experience treating psychiatric patients in an inpatient setting, designation by HMNH Behavioral Health Medical Director and authorization by Department of Mental Health for involuntary detention.

4.3 A patient who has been detained for evaluation and treatment must be released at the end of the 72-hour period unless any of the following applies;

a) The patient is referred for further care and treatment on a voluntary basis;

b) The patient has been certified for detention for fourteen (14) day treatment because, as a result of a mental disorder, he is a danger to self or others or gravely disabled;

c) A conservatory or temporary conservator has been appointed for the patient pursuant to Welfare and Institutions Code Section 5350 et seq.

E. **Pediatric Service**

1. **Privileges**

1.1. Requests for privileges in the Pediatric Service shall be completed on the appropriate privilege delineation form and processed by the Chairman of the Department of Primary Care. Privileges shall be granted in accordance with the Medical Staff Bylaws.

a) Requests for new privileges shall be reviewed by the Pediatric Committee, the Chairman of the Department of Primary Care and recommended to the Executive Committee on the basis of training, experience and demonstrated ability. Requests for existing privileges shall be reviewed by the Chairman of the Department of Primary Care and recommended to the Executive Committee on the basis of training, experience and demonstrated ability. Such privileges shall be granted by the Board of Directors after review of the practitioner's credentials by the Medical Executive Committee.

1.2. The determination of privileges shall be based upon an applicant's documented training, experience and/or demonstrated ability as evidenced by the following:

a) Verification by the director of an approved pediatric residency program that the practitioner is qualified for the requested privileges, or

b) Board certification in pediatrics.

c) If a practitioner requests privileges outside the scope of his residency training program, he shall provide documentation of adequate training, experience, and demonstrated ability.

1.3. The Department may recommend to grant or deny all or part of the privileges requested, or may place such restrictions on the applicant as appropriate and as approved by the Executive Committee and the Board of Directors.

1.4. Requests for increase in privileges are made in writing to the Committee stating the following:

a) Details in experience and further training;

b) References;

c) List of pertinent cases and any other pertinent factors such as certificates of completion of courses, as requested by the Committee.

1.5 The Department may recommend to reject the request or may recommend to grant temporary privileges pending observation. The final decision may then be to recommend to reject, accept or defer for a further period of observation as may be defined. Either the applicant or the Department Chairman may request the applicant's personal appearance before a departmental meeting.

1.6 In the case of Medical Staff members with established privileges who request additional privileges, if any observation is recommended by the Department, only those additional privileges requested shall be considered provisional until the observation requirement has been satisfied.

1.7 An applicant for privileges may appeal any decision to the Executive Committee.

1.8 Pediatric privileges for all members of the Department will be reviewed by the department of

Primary Care prior to their reappointment to the Medical Staff. Any modifications recommended will be forwarded to the Executive Committee with the reasons for such modifications given. Said review will be completed two months before the termination of the practitioner's reappointment period.

1.9 Copies of the pediatric privilege cards will be kept in the practitioner's credential file and in the operating room office and the Intensive Care Unit, under the supervision of the Department Director of Surgery and the Department Director of ICCU, to ensure availability and confidentiality.

## 2. Proctoring

2.1 Proctoring Categories:

a) All new Medical Staff members in the Pediatric Service shall be proctored.

b) Existing Medical Staff members in the Pediatric Service requesting an increase in clinical privileges shall be proctored.

c) All practitioners requesting temporary privileges in the Pediatric Service shall be proctored.

d) Existing members of the Medical Staff shall have their performance monitored whenever deemed necessary by the Chairman of the Department of Primary Care, Executive Committee, the Chief of Staff or the Deputy Chief of Staff.

2.2 Proctoring of Admissions and Consultations:

a) The proctoring for new Medical Staff members in the Pediatric Service shall occur before or during the Provisional Staff status period. This period shall be at least six (6) months but no longer than two (2) years.

b) Two (2) proctors will be appointed to each practitioner requiring proctoring. At least one proctor shall be of the same specialty as the practitioner being proctored. This proctor cannot be an associate or partner of that person being proctored, except for contracted services.

c) Proctoring shall include direct observation, concurrent chart review and the monitoring of diagnostic and treatment techniques. Retrospective evaluation of performance may supplement but not substitute for direct observation. Proctoring involves evaluation of all aspects of the management of any case.

d) A minimum of the FIRST five (5) cases will be reviewed for admissions and/or consultations.

e) It is the responsibility of the practitioner to notify the appointed proctor of the cases to be proctored.

f) A proctoring evaluation form will be completed by the proctor and submitted to the Medical Staff Services Department for review by the Department of Primary Care.

g) Copies of the actual proctoring reports will be maintained in the practitioner's credential file and will be taken into consideration at the time the practitioner is considered for advancement from the Provisional Staff category.

2.3 Proctoring of Procedures:

a) Concurrent proctoring is required for all new Medical Staff members, practitioners requesting temporary privileges, and existing Medical Staff members requesting additional privileges, for all procedures identified by (p) on the privilege delineation card.

b) The first time that a practitioner does one of the procedures marked with a (p), he shall arrange for his proctor to observe him. The proctor may require additional proctoring for the procedure, to a maximum of five (5). If the proctor determines that proctoring needs to be extended for more than five (5) procedures, the proctor shall document the reason(s) on the evaluation form and submit the form to the Department of Primary Care for evaluation and recommendation.

c) A proctoring evaluation form will be completed by the proctor and submitted to the Medical Staff Services Department for review and recommendation of proctoring status by the Department of Primary Care.

d) At the time of scheduling a procedure, it is the responsibility of the practitioner to contact and inform the proctor of the date and time of the procedure. If a proctor is unable to observe the practitioner at the time of the scheduled procedure, the practitioner shall contact the Chairman of the Department of Primary Care or his designee. The Chairman or his designee will determine if the practitioner will be able to do the procedure without a proctor present.

e) Emergency procedures will be excluded from concurrent proctoring. However, retrospective review of the procedure will be conducted to evaluate medical management and ascertain that the procedure was emergent.

2.4. Reciprocal Proctoring:

Evidence of proctoring from an accredited hospital may be accepted in place of actual observation on the premises if the proctoring is approved by the appropriate Department Chairman and the Executive Committee.

a) The proctor must be a member of the Medical Staff at both hospitals.

b) The proctor must be eligible to serve as proctor at this Hospital.

c) The same range and level of privileges or lesser privileges must have been requested by the applicant at both hospitals.

## F. Cardiovascular Surgery Services

Pursuant to Title 22, Cardiovascular Surgery Services is defined to include cardiac catheterization laboratory and cardiovascular operative procedures. A Board Certified or eligible physician shall have overall responsibility and oversight for the Service(s) as follows:

### 1. Cardiovascular Operative Service

A physician certified or eligible for the certification by the Board of Thoracic Surgery or the American Board of Surgery with training and experience in cardiovascular surgery shall have overall responsibility for cardiovascular operative services.

### 2. Cardiovascular Catheterization Laboratory Service

A physician certified or eligible for certification in Cardiology by the Board of Internal Medicine or the American Board of Pediatrics shall have overall responsibility for cardiovascular catheterization services.

### 3. Privileges

Requests for privileges in the cardiovascular surgery service shall be completed on the appropriate privileges delineation form and processed by the Chairman of the Departments of Surgery and/or Medicine. Privileges shall be granted in accordance with the Medical Staff Bylaws.

The Chairman of the Departments of Surgery and/or Medicine will evaluate the qualifications of those who wish to be granted privileges. This evaluation shall be based on the applicant or member's documented training, experience, and/or demonstrated ability as evidenced by board certification or eligibility of board certification. Such evaluation along with recommendation for approval, denial or further study will be forwarded to the Medical Executive Committee. Final action for approval of privileges will be taken for the Board of Directors based upon recommendation of the Medical Executive Committee.

### 4. Proctoring

In addition to the required provisional proctoring for Departments of Medicine and Surgery, additional mandatory proctoring is necessary for the granting of privileges for Cardiovascular Surgery Service.

Applicants shall be responsible to be proctored on a minimum number of cases, as determined by the Department specific criteria and any additional criteria determined by the Service in accordance with State and Federal Regulations, best practice recommendations and governing Medical Staff Bylaws.