
MEDICAL STAFF BYLAWS

OF

LOS ALAMOS MEDICAL CENTER

PREAMBLE

WHEREAS, Los Alamos Medical Center, hereinafter referred to as "Hospital", is operated by PHC-Los Alamos, Inc., a private corporation organized under the laws of the State of New Mexico and is lawfully doing business in New Mexico, and is not an agency or instrument of any state, county or federal government; and

WHEREAS, the purpose of this Hospital is to serve as a general short-term, acute care hospital, providing patient care and education; and

WHEREAS, the Hospital must ensure that such services are delivered efficiently and meet the evolving regulatory requirements applicable to functions within the Hospital; and

WHEREAS, it is recognized that the Medical Staff has the initial responsibility for the quality of medical care in the Hospital and must accept and discharge this responsibility subject to the ultimate authority of the Governing Board and that the cooperative efforts of the Medical Staff, Chief Executive Officer and the Governing Board are necessary to fulfill these goals.

NOW, THEREFORE, the Physicians, Podiatrists and Dentists practicing in Los Alamos Medical Center hereby organize themselves into a Medical Staff conforming to these Bylaws.

DEFINITIONS

1. "Active Staff" shall be those Physicians, Podiatrists and Dentists that have the privilege of admitting patients, holding office and voting.
2. "Allied Health Professional" or "AHP" refers to any person other than a Physician, Podiatrist or Dentist who is granted Privileges to practice in the Hospital.
3. "Board" means the Governing Board of Los Alamos Medical Center.
4. "Chief Executive Officer" or "CEO" means the individual appointed by the Corporation to provide for the overall management of the Hospital; and may also refer to an individual appointed by the CEO to fulfill the responsibilities of his position in his absence.
5. "Chief of Staff" means the member of the Active Staff who is duly elected in accordance with these Bylaws to serve as chief officer of the Medical Staff of this Hospital, and may also refer to an individual appointed by the Chief of Staff to fulfill the responsibilities of his position in his absence.
6. "Clinical Privileges" or "Privileges" means the permission granted to a Staff Member or Allied Health Practitioner to render specific diagnostic, therapeutic, medical, dental, podiatric or surgical services.
7. "Corporation" means Province Health Care-Los Alamos, Inc. (PHC-Los Alamos, Inc.)
8. "Data Bank" means the National Practitioner Data Bank established pursuant to the Health Care Quality Improvement Act of 1986 for the purposes of reporting of adverse actions and malpractice information.
9. "Dentist" means an individual who has been awarded a doctorate degree in Dentistry from a dental school approved by the American Dental Association's Commission on Dental Accreditation.
10. "Designee" means one selected by the CEO, Chief of Staff or other officer to act on his behalf with regard to a particular responsibility or activity.
11. "Ex-Officio" means service as a member of a body by virtue of an office or position held, and unless otherwise expressly provided, means without voting rights.
12. "Good Standing" means the Staff Member, at the time the issue is raised, has met the attendance requirements during the previous Medical Staff Year, is not in arrears in dues payment and has not received a suspension of his appointment or admitting Privileges in the previous twelve (12) months. The prerogatives provided by these Bylaws to Members to vote, to hold office or serve as a member of the Medical Executive Committee, a Service Chair or committee chair shall be limited to Active Staff Members in Good Standing.
13. "Hospital" means Los Alamos Medical Center. The term "Hospital" shall not be construed to include private practitioners' offices in the Los Alamos Medical Center building.
14. "Hospital Representative" or "Representative" means the Corporation, the Hospital and any of the following individuals who have any responsibility for obtaining or evaluating credentials, or acting upon an application or conduct in the Hospital:
 - the Board, its members and committees;
 - the CEO, other Hospital employees and consultants to the Hospital;
 - all appointees to the Medical Staff, its services and committees; and
 - any authorized representative of any of the foregoing .

15. "Malice" means the intent, without just cause or reason, to commit an act that will result in injury to another.
16. "Medical Executive Committee" or "MEC" means the Executive Committee of the Medical Staff.
17. "Medical Staff" or "Staff" means the formal organization of Physicians, Podiatrists and Dentists who are appointed by the Board as Members of the Medical Staff of Los Alamos Medical Center.
18. "Medical Staff Bylaws" or "Bylaws" means the Bylaws, the Fair Hearing Plan and the accompanying Staff Rules & Regulations.
19. "Medical Staff Year" means the period from January 1 to December 31.
20. "Member" means a Practitioner who has been granted Medical Staff membership and Clinical Privileges pursuant to these Bylaws.
21. "Physician" means an individual who has been awarded either a:
 - (1) Doctorate of Medicine (MD) from a school approved by the Liaison Committee on Medical Education or the Canadian Medical Association, or who, if the MD was awarded by a foreign medical school, must have passed the FLEX examination or have a permanent certificate of the Educational Council for Foreign Medical Graduates; or
 - (2) Doctorate of Osteopathic Medicine (DO) from a college of osteopathic medicine approved by the American Osteopathic Association.
22. "Practitioner" as used in these Bylaws, refers to a Physician, Podiatrist or Dentist who either has been granted or is applying for Staff Membership or Clinical Privileges at the Hospital.
23. "Prerogative" means a participatory right granted by the Board and exercised subject to the conditions imposed in these Bylaws.
24. "Special Notice" means a written notice sent by certified mail with a return receipt requested or delivered by hand with a written acknowledgment of receipt.
25. "Telemedicine" means the use of electronic communication or other communication technologies to support clinical care at this Hospital by accessing a provider or service at a location remote from Hospital.
26. "Third Parties" means all individuals, including appointees to this Medical Staff or to the medical staffs of other hospitals; other physicians, health practitioners or nurses; and/or government agencies, organizations, associations, partnerships and corporations, whether hospitals/health care facilities or not; from whom information has been requested by Hospital Representatives or who have requested such information from Hospital Representatives.

ARTICLE I
NAME

The name of this organization shall be the Medical Staff of Los Alamos Medical Center.

ARTICLE II
PURPOSES & RESPONSIBILITIES

2.1 PURPOSE

The purposes of the Medical Staff are:

- 2.1(a) to be the organization through which the benefits of membership on the Medical Staff may be obtained and the obligations of Staff membership may be fulfilled;
- 2.1(b) to foster cooperation with the CEO and the Board;
- 2.1(c) to ensure that all patients of the Hospital shall receive quality care commensurate with community resources by accounting regularly to the Board on patient care, including monitoring and other quality improvement activities in accordance with the Hospital's quality assurance and performance improvement programs;
- 2.1(d) to serve as the primary means for accountability to the Board for the quality and appropriateness of the professional performance and ethical conduct of all Members and AHPs authorized to practice in the Hospital through delineation of Clinical Privileges, on-going review and evaluation of each Member's performance in the Hospital, and supervision, review, and evaluation of each AHP's performance in the Hospital;
- 2.1(e) to work with the Board and CEO to meet regulatory requirements;
- 2.1(f) to support educational activities in the interest of providing quality patient care and promoting the general health of the community served by the Hospital;
- 2.1(g) to develop, maintain and enforce Bylaws for the proper functioning of the Medical Staff;
- 2.1(h) to provide a means by which issues concerning the Medical Staff and the Hospital may be discussed with the Board or the CEO;
- 2.1(i) to participate in educational activities and research subject to approval by an Institutional Review Board as may be justified by the facilities, personnel, funds or equipment available;
- 2.1(j) to provide a means through which the Staff may participate in the Hospital's policy-making and planning process; and
- 2.1(k) to accomplish its goals through appropriate officers, services and committees.

2.2 RESPONSIBILITIES

The responsibilities of the Medical Staff include:

- 2.2(a) ensuring that Members cooperate with each other in caring for patients in the Hospital;

- 2.2(b)** accounting for the quality and appropriateness of patient care rendered by all Members and AHPs authorized to practice in the Hospital by taking action to:
- (1) assist the Hospital in data compilation, adequate medical record documentation, review and evaluation of cost effectiveness and other such functions as necessary to meet accreditation and licensure standards, as well as federal and state law requirements;
 - (2) implement credentialing procedures, including a Hospital-specific mechanism for appointment and reappointment and the matching of Clinical Privileges to be granted with the verified credentials and current demonstrated performance of the Staff Member or AHP;
 - (3) provide a continuing medical education program fashioned at least in part on the type of care provided at the Hospital and the findings from Performance Improvement activities. Participation in such programs by all Members and AHPs will be documented;
 - (4) implement a utilization review program;
 - (5) develop an organizational structure that allows continuous monitoring and evaluation of patient care practices and appropriate supervision of AHPs;
 - (6) initiate and pursue corrective action with respect to Staff Members and AHPs, when warranted;
 - (7) develop, administer and seek compliance with these Bylaws;
 - (8) review and evaluate the quality of patient care through monitoring procedures, including identification and resolution of important problems in patient care and treatment;
 - (9) ensure that the functions of Staff committees delineated in these Bylaws are performed; and
 - (10) implement a process to identify and manage matters of individual Member health that is separate from the Medical Staff disciplinary function.
- 2.2(c)** recommending to the Board action with respect to appointments, reappointments, Staff category and service assignments, Clinical Privileges and corrective action.
- 2.2(d)** participating in the implementation of federal and state regulatory policy, including the requirements of the Data Bank; and
- 2.2(e)** maintaining confidentiality with respect to the records and affairs of the Hospital, except as disclosure is required by law.
- 2.2(f)** working with the various organizations in Northern New Mexico to identify community health needs and implement programs to meet those needs.

ARTICLE III
MEDICAL STAFF MEMBERSHIP

3.1 NATURE OF MEDICAL STAFF MEMBERSHIP

Medical Staff membership is granted by the Board and shall be extended only to professionally competent Physicians, Podiatrists and Dentists who continuously meet the qualifications, standards and requirements set forth in these Bylaws. Membership on the Medical Staff shall confer on the Member only such Clinical Privileges and prerogatives as have been granted by the Board in accordance with these Bylaws. No person shall admit patients to, or provide services to patients in the Hospital, unless he is a Member of the Medical Staff with appropriate Privileges, or has been granted Temporary Privileges as provided herein. Those Physicians, Podiatrists or Dentists holding administrative positions who desire Staff membership or Privileges shall be subject to the same procedures as all other applicants for Staff Membership or Clinical Privileges.

3.2 BASIC QUALIFICATIONS FOR STAFF MEMBERSHIP

3.2(a) Basic Qualifications

Only Physicians, Podiatrists, and Dentists legally licensed to practice in the State of New Mexico shall be qualified for membership on the Staff. They shall also:

- (1) document their professional experience, background, training, demonstrated ability, and physical and mental health status with sufficient adequacy to demonstrate to the Staff and the Board that any patient treated by them will receive quality care taking into account patient needs, the available Hospital facilities and utilization standards in effect at the Hospital;
- (2) adhere strictly to the ethics of their respective professions, work cooperatively with others and demonstrate their willingness to participate in the discharge of Staff responsibilities;
- (3) provide evidence of professional liability insurance that meets the requirements of Section 14.2;
- (4) be graduates of an approved college holding appropriate degrees as set forth under Definitions.
- (5) show evidence of fifty (50) continuing medical education (CME) credits every two (2) years of which fifty percent (50%) must be in a specialty in which the Practitioner has Privileges.
- (6) have board certification or postgraduate training sufficient for board eligibility by a board recognized by the American Board of Medical Specialties, the American Board of Podiatric Surgery or the American Dental Association. This requirement shall not apply to anyone already a Member of the Medical Staff as of 9/8/03.

3.2(b) Effects of Other Affiliations

No Practitioner shall be automatically entitled to membership on the Medical Staff or to particular Clinical Privileges merely because he is licensed to practice in this or any other state, or because he is a member of any professional organization, or because he is certified by any specialty or professional board, or because he had, or presently has, staff membership or privileges at another health care facility.

3.2(c) Non-Discrimination

Medical Staff membership or particular Clinical Privileges shall not be denied on the basis of:

- (1) gender, sexual orientation, race, age, creed, color or national origin;
- (2) disability (except as such may impair the Practitioner's ability to provide quality patient care or fulfill his duties under these Bylaws); or
- (3) any other criteria unrelated to the efficient delivery of patient care at the generally recognized professional level of quality in the Hospital.

3.3 BASIC RESPONSIBILITIES OF STAFF MEMBERSHIP

Each Member of the Medical Staff shall:

- 3.3(a)** provide his patients with care at the generally recognized professional level of quality;
- 3.3(b)** adhere to the Hospital's Utilization Review policies;
- 3.3(c)** abide by the Medical Staff Bylaws and Rules and Regulations and by all other established standards and policies (including the Impaired and Disruptive Physician policies) of the Medical Staff;
- 3.3(d)** discharge such Staff, service, committee and Hospital functions for which he is responsible by appointment, election or otherwise;
- 3.3(e)** cooperate with other members of the Medical Staff, the CEO, the Board and employees of the Hospital in the interest of quality patient care;
- 3.3(f)** adequately prepare and complete in a timely and legible fashion the medical and other required records for all patients he admits or in any way provides care to in the Hospital;
- 3.3(g)** be encouraged to participate in the continuing medical educational programs conducted by the Staff;
- 3.3(h)** agree to a health screening, including drug testing, at the request of the Medical Executive Committee. Such a request will comply with Section 6.4(b)(3) or the Impaired Physician Policy;
- 3.3(i)** abide by the principles of Medical Ethics of the American Osteopathic Association, the American Medical Association or other applicable codes of ethics;
- 3.3(j)** notify the CEO within seven (7) days if:
 - (1) his professional liability insurance is modified or terminated;
 - (2) he is named as a defendant, or is subject to a final judgment or settlement, in any court proceeding alleging that he committed professional negligence or fraud;
 - (3) he is subject to a formal investigation or filing of charges by any federal or state law enforcement or health regulatory agency; or
 - (4) he is the subject of a successful or current pending challenges to, or the voluntary relinquishment of, any of the following:

- (i) specialty board certifications;
- (ii) professional licenses in any jurisdiction;
- (iii) Drug Enforcement Agency (DEA) number/controlled substance license;
- (iv) medical staff membership or voluntary or involuntary limitation, reduction or loss of clinical privileges at any hospital or other health care institution;
- (v) participation in any private, federal or state health insurance program, including Medicare or Medicaid.

3.4 DURATION OF APPOINTMENT

3.4(a) Duration of Initial Appointments

All initial appointments to Medical Staff shall be provisional for a period of up to one (1) year as outlined in Section 4.6.

3.4(b) Reappointments

Reappointment to the Medical Staff shall be for a period of two (2) years.

3.4(c) Modification in Staff Category and Clinical Privileges

Any modification of appointment or Privileges shall remain in effect until the expiration of the current term. The MEC may recommend to the Board that a change in Staff category or the granting of additional Privileges to a current Member be made provisional in accordance with the procedures for initial appointment as outlined herein.

3.5 LEAVE OF ABSENCE

3.5(a) Leave Status

A Staff Member may request a voluntary leave of absence from the Medical Staff by submitting a written request to the Credentials Committee stating the reason for and the time period of the leave, which may not exceed the remainder of the current Staff appointment. A leave of absence may be granted by the MEC, subject to such conditions or limitations as the MEC shall determine to be appropriate. All rights and Privileges of Medical Staff membership shall be suspended from the beginning of the leave period until reinstatement.

3.5(b) Termination of Leave

- (1) Unless the leave of absence is covered under Section 3.5(b)(3), the Staff Member must request reinstatement of his Privileges and prerogatives at least fifteen (15) days prior to the termination of leave by submitting a written notice to that effect to the Credentials Committee. The Member shall submit a written summary of his relevant activities during the leave. When the leave has been granted for treatment of any physical or mental disorder, the Member shall submit evidence of recovery from the disorder sufficient to permit him to provide quality patient care. Failure, without good cause, to request reinstatement by the above deadline shall result in automatic

termination of Staff membership, Privileges and prerogatives without right of hearing or appellate review as such action shall not be considered adverse and shall not be reported to the Data Bank. A request for Staff membership subsequently received from a Member so terminated shall be submitted and processed in the manner specified for application for initial appointments.

- (2) The Credentials Committee shall forward a recommendation to the MEC. The MEC shall then submit a recommendation to the Board concerning the reinstatement of the Staff Member's Privileges and prerogatives at the termination of the leave.
- (3) If a Member requests leave of absence for obtaining further medical training or for an armed services commitment, reinstatement will ordinarily become automatic upon written request to the Chief of Staff for same. However, if such leave occurs with no medical activity for more than twelve (12) months, the request will go through the process noted in 3.5(b)(1) and (2). Credentials Committee may require proof of competency by further education and/or monitoring to insure continuing competence.

ARTICLE IV
CATEGORIES OF THE MEDICAL STAFF

4.1 CATEGORIES

The Staff shall include be divided into Active, Consulting, Courtesy, Honorary and Provisional categories.

4.2 ACTIVE STAFF

4.2(a) Qualifications

The Active Staff shall consist of those Members who:

- (1) meet the Basic Qualifications set forth in Section 3.2(a);
- (2) are professionally based in the community served by the Hospital; and
- (3) regularly admit or are otherwise involved in the care of at least twelve (12) patients during a twelve (12) month period.

4.2(b) Prerogatives

The prerogatives of an Active Staff Member shall be:

- (1) to have admitting Privileges;
- (2) to exercise such Privileges as are granted to him pursuant to Article VII;
- (3) to vote at meetings of the Medical Staff and at meetings of services and committees of which he is a member; and
- (4) to serve as an officer of the Staff or service and committees to which he is appointed.

4.2(c) Responsibilities

Each Active Staff Member shall:

- (1) meet the Basic Responsibilities set forth in Section 3.3;
- (2) within his area of professional competence, retain responsibility for the continuous care and supervision of each patient in the Hospital for whom he is providing services, or arrange a suitable alternative for such care. This shall include an initial assessment of all patients within twenty-four (24) hours of admission, and for patients in the intensive care unit, no later than six (6) hours after admission.
- (3) actively participate in:
 - (i) the performance improvement/utilization management activities required of the Staff;
 - (ii) monitoring of Provisional Members of the same service;

(iii) the Emergency Department on-call rotation, except as exempted by his service or the Medical Executive Committee. This includes a personal appearance to assess patients in the Emergency Room when deemed appropriate by the Emergency Department Physician. Such participation requires services to all patients including Medicaid/Medicare patients, indigent patients and those whose personal physician is not a Staff Member of this Hospital; and

(iv) take an active role in Medical Staff affairs by accepting and fulfilling committee assignments, serving as Staff officers and otherwise contributing to the accomplishment of Medical Staff purposes.

(4) accept appointment to and serve on committees;

(5) satisfy the requirements set forth in these Bylaws for attendance at Medical Staff and his assigned service(s) and committees; and

(6) pay dues and assessments as determined by the Staff.

4.2(d) Failure to Fulfill Responsibilities

Failure to carry out the responsibilities or meet the qualifications as enumerated shall be grounds for corrective action, including, but not limited to, termination of Staff membership.

4.3 COURTESY STAFF

4.3(a) Qualifications

The Courtesy Staff shall consist of those Members who:

(1) meet the Basic Qualifications set forth in Section 3.2(a);

(2) are professionally based in the community served by the Hospital; and

(3) do not admit more than eighteen (18) patients in a calendar year.

For the purposes of this Section 4.3(a), "admit" refers to a patient whose Hospital stay exceeds twenty-three (23) hours. If a Courtesy Staff member exceeds eighteen (18) admissions, his Staff category will be reviewed for appropriateness by the Credentials Committee.

4.3(b) Prerogatives

Courtesy Staff shall not be permitted to vote for officers. The prerogatives of a Courtesy Staff Member shall be to:

(1) have admitting Privileges to the Hospital;

(2) exercise such Privileges as are granted to him pursuant to Article VII;

(3) attend any meetings of the Staff and assigned service he may wish to attend as a non-voting member and any Staff or Hospital education programs; and

- (4) serve on any committee as a voting member and by accepting such committee assignment, he agrees to satisfy the attendance requirements of these Bylaws for committee meetings.

4.3(c) Responsibilities

Each member of the Courtesy Staff shall:

- (1) meet the Basic Responsibilities specified in Section 3.3;
- (2) retain responsibility within his area of professional competence for the care and supervision of each patient in the Hospital for whom he is providing service; and
- (3) pay dues and assessments as determined by the Staff.

4.4 CONSULTING STAFF

4.4(a) Qualifications

Consulting Staff must meet the Basic Qualifications set forth in Section 3.2(a). Consulting Staff Members shall not have admitting Privileges and can act only as consultants.

4.4(b) Prerogatives

Consulting Staff shall not hold office nor be eligible to vote in the Medical Staff organization. The prerogatives of a Consulting Staff Member shall be to:

- (1) consult only in their specialties on patients only by request of an Active, Courtesy or Provisional Staff Member; and
- (2) attend all meetings of the Staff and his assigned service that he may wish to attend as a non-voting visitor.

4.4(c) Responsibilities

The responsibilities of the Consulting Staff shall be to:

- (1) assume responsibility for the consultation and appropriate documentation thereof;
- (2) meet the Basic Responsibilities of Section 3.3; and
- (3) pay dues as determined by the Staff.

4.5 HONORARY STAFF

4.5(a) Qualifications:

The Honorary Staff shall consist of Members who are not active in Hospital practice but who, because of outstanding reputation, service or recognition, may be appointed to this category. Honorary Staff members' term shall be indefinite. Honorary Staff are not required to meet the Basic Qualifications set forth in Section 3.2.

4.5(b) Prerogatives

- (1) Honorary Staff prerogatives shall be:
 - (i) attending by invitation any such meetings that he may wish to attend as a non-voting visitor;
 - (ii) serving as a non-voting member of standing committees; and
 - (iii) serving as a voting member of an ad hoc committee.
- (2) Honorary Staff Members shall not in any circumstances admit patients or hold office.

4.6 PROVISIONAL STAFF

4.6(a) Nature of Provisional Staff Appointment

- (1) All initial appointments to the Medical Staff shall be provisional for a period of up to one (1) year. Conditions of appointment, including monitoring or proctoring, may be imposed as specified by Credentials Committee. The Monitoring Protocol is delineated in Appendix A of these Bylaws. Monitoring/Proctoring of a Provisional Staff Member will be terminated when:
 - (i) the Provisional Member has participated in the care of at least twelve (12) patients or the minimum number of patients stipulated by the Credentials Committee, if otherwise specified;
 - (ii) the Service Chair has reviewed the care provided for these patients and recommends that supervision be terminated;
 - (iii) Credentials Committee recommends termination of supervision and advancement of Staff category; and
 - (iv) the MEC has ratified the Credentials Committee recommendation.
- (2) If not sooner, at the end of the one (1) year provisional period, the Member will be evaluated as delineated in Section 4.6(a)(1).
- (3) The MEC, after receipt of Credentials Committee's recommendation, shall make one of the following recommendations to the Board:
 - (i) extension of provisional status for an additional period up to twelve (12) months;
 - (ii) advancement to the appropriate Staff category; or
 - (iii) to not reappoint the Provisional Member to the Staff.

The decision of the MEC shall be based on the Provisional Member's demonstrated competence, appropriate utilization, meeting attendance and Bylaws compliance, as well as all other factors considered in the reappointment process as outlined in these Bylaws. Upon Board approval, the Practitioner will be advanced to the appropriate Medical Staff category. If the MEC recommends that the Board not reappoint a Provisional Staff Member, said Member shall have the procedural rights accorded by these Bylaws and the Fair Hearing Plan.

(4) A Staff Member whose appointment remains provisional for two (2) years shall be scheduled for a personal interview with Credentials Committee to discuss his continued interest in maintaining an appointment to the Medical Staff. After such interview, the Credentials Committee shall report to the MEC, which shall make one of the following recommendations to the Board:

- (i) to advance Staff status; or
- (ii) to not reappoint the Provisional Member to the Staff.

4.6(b) Qualifications

The Provisional Staff shall consist of newly appointed Members who meet the Basic Qualifications of Section 3.2(a) and are seeking advancement to another Staff category, but have not yet completed the period of provisional appointment established in these Bylaws. The qualifications of a Provisional Staff Member shall be the same as those required for the category to which he seeks advancement.

4.6(c) Prerogatives

The prerogatives of a Provisional Staff Member shall be:

- (1) to serve on committees (except the MEC) and services of the Medical Staff as a voting member if seeking advancement to Active Staff and as a non-voting member if seeking advancement to another category;
- (2) to attend Medical Staff meetings as a non-voting member; and
- (3) to admit and treat patients subject to the limitations of the category to which he seeks advancement.

4.6(d) Responsibilities

The responsibilities of a Provisional Staff Member shall be the same as those of the category to which he seeks advancement, including Medical Staff meeting requirements. A Provisional Staff Member is responsible for notifying his monitor/proctor of admissions and/or procedures as required by the Credentials Committee.

4.7 TELEMEDICINE

4.7(a) Scope of Privileges

The Medical Staff shall make recommendations to the Board regarding which clinical services are appropriately delivered through the medium of telemedicine, and the scope of such services.

4.7(b) Telemedicine Physicians

Any Physician who prescribes, renders a diagnosis, or otherwise provides clinical treatment to a patient at the Hospital through a telemedicine procedure (the “telemedicine physician”), must be credentialed and privileged pursuant to the procedures described in these Medical Staff Bylaws.

4.8 LIMITATIONS OF PREROGATIVES

The prerogatives set forth under each Staff category are general in nature and may be subject to limitation by special conditions attached to a Member's appointment, by other sections of the Bylaws or by Hospital policies.

ARTICLE V
ALLIED HEALTH PROFESSIONALS (AHPs)

5.1 CATEGORIES

Allied Health Professional (“AHP”) refers to any person other than a Physician, Podiatrist or Dentist who is granted Privileges to practice in the Hospital. AHPs are not granted Medical Staff membership at this Hospital. Such AHPs shall include Nurse Practitioners, Physician’s Assistants, Clinical Psychologists, Certified Registered Nurse Anesthetists, Certified Nurse Midwives, Optometrists, and Ophthalmic Assistants. Such persons must be under the supervision of a Staff Member unless independent practice is permitted by state law and the Hospital.

5.1(a) AHPs Granted Supervised Privileges

It is not the policy of this Hospital to grant independent Privileges to Nurse Practitioners, Physician’s Assistants, Certified Registered Nurse Anesthetists, Certified Nurse Midwives, Optometrists or Ophthalmic Assistants. A Staff Member may request an application from the CEO for an AHP in one of the above categories to assist him with direct patient care. Such AHPs must be under the direct supervision and direction of the Staff Member. The application for the AHP must include the following:

If the supervising Staff Member employs or directly contracts with the AHP for services, the Staff Member shall indemnify the Hospital and hold the Hospital harmless from and against all actions, claims, damages, costs and expenses, including reasonable attorney fees, resulting from, caused by or arising from improper or inadequate supervision of the AHP, negligence of such AHP, the failure of such AHP to satisfy the standards of proper care of patients, or any action by such AHP beyond the scope of his license or Clinical Privileges.

5.1(b) AHPs Granted Independent Privileges

The Staff may recommend to the Board that the Hospital allow certain categories of AHPs independent Privileges, as allowable under state law, when this is necessary to provide a needed service for the Hospital.

- (1) Clinical Psychologists: may be allowed to apply for independent Consulting Privileges. The psychologist shall be responsible for documentation of adequate consultation reports. The psychologist shall not have Privileges to admit or discharge or to assume sole responsibility for a patient’s care. All such psychologists will be assigned to the Adult Medicine Service for the purposes of performance improvement and utilization review.
- (2) Certified Registered Nurse Anesthetists may be allowed to apply for independent anesthesia and conscious sedation privileges. The CRNA will be responsible for the required medical record documentation. The CRNA shall not have privileges to admit or discharge or to assume sole responsibility for a patient’s care. All CRNAs will be assigned to the Surgery Service.

5.2 QUALIFICATIONS

AHPs must:

- (1) hold a license, certificate or other official credential as provided under state law;
- (2) meet the basic qualifications stated in the Rules and Regulations for their respective professions;
- (3) have professional liability insurance in the amount required by these Bylaws;
- (4) provide a needed service within the Hospital; and

- (5) unless permitted by state law and the Hospital to practice independently, provide written documentation that a Medical Staff Member has assumed responsibility for directing and supervising the AHP.

5.3 PREROGATIVES

AHPs shall have the right to participate directly in the management of patients according to the specific Privileges granted them.

5.4 CONDITIONS OF APPOINTMENT

- 5.4(a)** AHPs shall be credentialed in the same manner as outlined in Section 6.3 of the Medical Staff Bylaws for credentialing of Staff Members. Credentials Committee shall determine the specific Privileges each AHP may undertake, subject to the allowable scope of patient care services listed in the Rules and Regulations for a specific category of AHP. These recommended Privileges will be submitted for approval to the MEC and the Board.
- 5.4(b)** Although not granted Staff membership, AHPs must agree to abide by the Basic Responsibilities of Section 3.3 of the Bylaws. Each AHP shall be assigned to a service and be subject to patient care evaluation and other monitoring activities.
- 5.4(c)** Supervised AHP Privileges shall automatically terminate upon revocation of the Privileges of the AHP's supervising Staff Member, unless another qualified Member indicates his willingness to supervise the AHP and complies with all requirements listed in these Bylaws for undertaking such supervision. In the event that an AHP's supervising Staff Member's Privileges are significantly reduced or restricted, the AHP's Privileges shall be reviewed and modified by the Board upon recommendation of the MEC. Such action shall not be covered by the provisions of the Fair Hearing Plan, but instead follow the process set forth in Section 5.5.

5.5 PROCEDURAL RIGHTS

5.5(a) Adverse Action

“Adverse Action” means the following:

- (1) a recommendation by Credentials Committee, the MEC or the Board to deny a request for Privileges within the allowable scope of practice to an AHP applicant; or
- (2) a decision by the CEO, the MEC or the Board to reduce, suspend, revoke, limit or terminate such Privileges.

Any such adverse action shall not give rise to the procedural rights set forth in the Fair Hearing Plan or the Hospital employee grievance policy, but instead follow the process outlined herein.

5.5(b) Review

The AHP, the Hospital and the Staff are not entitled to be represented by counsel at the review or appeal.

- (1) The AHP shall be given Special Notice within fifteen (15) days after such an adverse action is taken of the specific reasons for the actions and of the AHP's rights under these Bylaws. If the AHP does not deliver a written request for a review to the CEO within ten (10) days following receipt of the notice of adverse action, such action shall be final and cannot be appealed.
- (2) or more Staff Members to a Review Committee. These individuals may not have been involved previously in the recommendation to take adverse action against the AHP.
- (3) The AHP shall be given ten (10) days prior written notice of the time, place and date of the review and a list of witnesses who will be called to support the adverse action. The Hospital, MEC and the AHP are entitled to submit a written statement to the Review Committee, if so submitted at least five (5) days prior to the review.
- (4) The AHP shall be given a review before the Review Committee. The AHP, Chief of Staff and the CEO are entitled to be present at the review, to call witnesses and to testify. A written record of the review shall be made.
- (5) Within fourteen (14) days after completion of the review, the Review Committee shall submit a written report to the MEC. The CEO shall forward a copy of the report via Special Notice to the AHP.

5.5(c) Appeal

- (1) "Grounds for Appeal" are:
 - i. the review failed to comply with this procedure or applicable law and such noncompliance created demonstrable prejudice; or
 - ii. the Review Committee's recommendation was not supported by substantial evidence based upon the review minutes.
- (2) The AHP has ten (10) days following receipt of the Review Committee's report to submit a written request for an appeal to the CEO. The request must identify the Grounds for Appeal and include a clear and concise statement of the facts in support of the request. If appellate review is not so requested, the Review Committee's recommendation shall become final and cannot be appealed.
- (3) Appellate Officers: two (2) or more individuals designated by the CEO and Chief of Staff. These individuals may not have been involved previously in this adverse action.
- (4) The CEO shall give the AHP prompt notice of the time, place and date of the appellate review, which shall be scheduled not less than fifteen (15) days or more than ninety (90) days from the date of the CEO's receipt of the request for appeal.
- (5) The Appellate Officers shall make their final determination on the adverse action within fourteen (14) days after completion of the appellate review. This decision shall not be subject to further appeal and will be submitted to the MEC and the Board for approval.

ARTICLE VI
PROCEDURES FOR APPOINTMENT & REAPPOINTMENT

6.1 GENERAL PROCEDURES

The Medical Staff through its designated services and committees shall review each application for appointment or reappointment to the Staff, each request for modification of Staff membership category and each request for Clinical Privileges and shall transmit recommendations thereon to the Board. The Board shall be the final authority on granting, extending, terminating or reducing Medical Staff appointments and Clinical Privileges. The four (4) core criteria essential to establishing and maintaining a qualified and competent Staff are current licensure, relevant training and experience, current competence and the physical and mental ability to perform the Privileges requested.

A separate, confidential record shall be maintained for each individual requesting Medical Staff membership or Clinical Privileges. The CEO shall collect a reasonable fee for processing the application.

6.2 CONTENT OF APPLICATION FOR INITIAL APPOINTMENT

Each application for appointment to the Medical Staff shall be in writing and signed by the applicant. The standard New Mexico Medical Society application form will be used whenever possible. The application form shall include, at a minimum, the following:

- 6.2(a) Acknowledgment & Agreement:** A statement that the applicant has received and had an opportunity to read the Bylaws, Rules & Regulations and Fair Hearing Plan and that he agrees:
- (i) to be bound by the terms thereof if he is granted membership and/or Clinical Privileges; and
 - (ii) to be bound by the terms thereof in all matters relating to consideration of his application, without regard to whether or not he is granted membership and/or Clinical Privileges.
- 6.2(b) Administrative Remedies:** A statement indicating that the applicant agrees that he will exhaust the administrative remedies afforded by these Bylaws before resorting to formal legal action should an adverse ruling be made with respect to his Staff membership and/or Clinical Privileges;
- 6.2(c) Felony Charges:** Any current criminal charges pending against the applicant and any past convictions or pleas. A criminal background check will be done as part of the verification process;
- 6.2(d) Fraud:** Any current or past allegations of civil or criminal fraud against the applicant including their resolution and any investigation concerning participation in a health insurance program, including Medicare or Medicaid;
- 6.2(e) Health Status:** a statement of current physical and mental health status only to the extent necessary to demonstrate that the applicant is capable of performing the functions of Staff membership and exercising the Privileges requested. If doubt is raised about the applicant's ability to perform the Privileges requested, an evaluation of the applicant by an examiner designated by the MEC shall be requested by the MEC.

Regardless of any physical or mental health condition which could affect an applicant's ability to exercise the Privileges requested, the application will be processed in the usual manner. If such an applicant is otherwise found to be professionally qualified for Staff appointment/Privileges, the applicant will be given an interview with Credentials Committee to determine what accommodations may be

necessary or feasible to allow the applicant to practice safely and competently. These accommodations would then be included in the committee's report to the MEC and the Board.

- 6.2(f) Information on Malpractice Experience:** full disclosure of all claims made against the applicant involving allegations of professional negligence or malpractice whether filed, pending, settled, or pursued to final judgment;
- 6.2(g) Education and Training:** full disclosure of all the institutions of higher learning and training programs attended by the applicant including dates of attendance, areas of study and degrees awarded.
- 6.2(h) Insurance:** A certificate of insurance from a reliable insurance carrier indicating that the applicant has currently in force professional liability coverage meeting the requirements of Section 14.2 of these Bylaws;
- 6.2(i) Notification of Release & Immunity Provisions:** a signed Statement of Release and Immunity from Liability as stated in Section 6.3(c).
- 6.2(j) Professional Sanctions:** full disclosure of previously successful or currently pending challenges to, or the voluntary relinquishment of, any of the following:
- (i) specialty board certifications;
 - (ii) professional licenses in any jurisdiction;
 - (iii) Drug Enforcement Agency (DEA) number/controlled substance license;
 - (iv) medical staff membership or clinical privileges: This shall require full disclosure by the applicant of any voluntary or involuntary denial, loss, revocation, restriction, reduction, suspension or termination of privileges or staff appointment at any health facility. The applicant must also disclose peer review information related to any disciplinary or corrective action taken against the applicant.

If any such actions were taken, the particulars thereof shall be obtained before the application is considered complete. The applicant shall have a continuing duty to notify the CEO within seven (7) days of receiving notice of initiation of any of the above actions against him.

- 6.2(k) Professional Qualifications:** Detailed information concerning the applicant's satisfaction of the Basic Qualifications for Staff membership specified in Section 3.2(a), including:
- (i) **Specialty Board status:** the applicant shall identify all acceptable specialty boards for which he is Board Certified and dates of certification. Acceptable boards are those recognized by the American Board of Medical Specialties, the American Dental Association or the American Board of Podiatric Surgery. If an applicant is not so certified, he must demonstrate adequate progress towards certification. That effort must be to the satisfaction of Credentials Committee.
 - (ii) **Continuing Medical Education (CME):** documentation of fifty (50) CME credits every two (2) years of which at least fifty percent (50%) must apply to the specialty in which the applicant is applying for Privileges.
 - (iii) **Licensing Experience:** full disclosure of the applicant's experience with any government licensing agency related to the practice of any health care profession. Copies of all currently

active state licenses, DEA registration, and Controlled Substance certificates may be requested with the application.

- 6.2(l) References:** The names of at least three (3) Physicians, Podiatrists or Dentists (as appropriate for the applicant's profession) who are personally acquainted with the applicant. At least two (2) of these references must have, within the past year, personally observed his professional performance and be able to provide adequate references as to the applicant's professional competence, clinical judgment, ethical character and technical skills. The determination of adequacy of such references shall be made by Credentials Committee.
- 6.2(m) Requested Privileges:** a request stating the Staff category and specific Clinical Privileges for which the applicant wishes to be considered;
- 6.2(n) Practice Affiliations:** The name and address of all other hospitals, health care organizations or practice settings with whom the applicant is or has previously been affiliated;
- 6.2(o) Citizenship Status:** Attestation of United States citizenship or legal residency. Proof of United States citizenship or legal residency may be requested.

6.3 PROCESSING OF INITIAL APPLICATIONS

6.3(a) Request for Application

Written requests for application forms from Physicians, Dentists, or Podiatrists shall be filled promptly by the CEO. However, if a moratorium has been imposed by the Board upon acceptance of applications within the Practitioner's specialty, the CEO will so inform the applicant and an application form will not be sent. Such refusal to send an application form shall not be deemed adverse and shall not entitle the individual to any procedural rights under these Bylaws.

6.3(b) Time Periods for Processing

Applications for Staff appointments shall be considered in a timely and good faith manner by all individuals and groups required by these Bylaws to act thereon and, except on good cause, shall be processed within the time periods specified in this Article.

6.3(c) Statement of Release & Immunity from Liability

The following are express conditions applicable to anyone having or seeking Medical Staff membership or anyone having or seeking Privileges to practice his profession in the Hospital during his term of appointment or reappointment. These statements shall be included on the application form and, By applying for appointment, reappointment or Clinical Privileges the applicant expressly accepts the conditions listed on the Release during the processing and consideration of his application, and at all times thereafter, regardless of whether or not he is granted appointment or Clinical Privileges.

STATEMENT OF RELEASE & IMMUNITY FROM LIABILITY

I hereby apply for Medical Staff appointment and/or Privileges as requested in this application and, whether or not my application is accepted, I acknowledge, consent and agree as follows:

APPLICANT'S BURDEN

As an applicant for appointment or reappointment, I have the burden of producing adequate information for proper evaluation of my qualifications.

During the processing of my application, I agree to inform the CEO of any change in the areas of inquiry contained herein no later than seven (7) days after any such changes. I agree to provide any additional information as may be requested by the Hospital or its authorized Representatives. Failure to produce any such information will prevent my application from being evaluated and acted upon.

I hereby signify my willingness to appear for an interview, if requested, in regard to my application.

Information given in or attached to this application is accurate and complete to the best of my knowledge. I fully understand and agree that as a condition to making this application, any misrepresentations or misstatement in, or omission from it, whether intentional or not, shall constitute cause for automatic and immediate rejection of this application, resulting in denial of appointment and/or Clinical Privileges.

RELEASE & IMMUNITY FROM LIABILITY

I accept the following conditions:

- (1) I extend immunity to, and release from any and all liability, the Hospital, its authorized Representatives and any Third Parties, for any acts, communications, recommendations or disclosures performed without intentional fraud or malice involving me; made, requested or received by this Hospital and its authorized Representatives from any Third Party, including otherwise privileged or confidential information, relating, but not limited to, the following:
 - (i) applications for appointment or Clinical Privileges, including Temporary Privileges;
 - (ii) periodic reappraisals;
 - (iii) proceedings for suspension or reduction of Privileges or for denial or revocation of appointment, or any other disciplinary action;
 - (iv) summary suspension;
 - (v) hearings and appellate reviews;
 - (vi) proctoring or monitoring evaluations;
 - (vii) utilization reviews;
 - (viii) any other Hospital, Medical Staff, service or committee activities;

- (ix) inquiries concerning my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics or behavior; and
 - (x) any other matter that might directly or indirectly affect or reflect on my competence, on patient care or on the orderly operation of this Hospital.
- (2) I specifically authorize the Hospital and its authorized Representatives to consult with any Third Party who may have information, including otherwise privileged or confidential information, bearing on my professional qualifications, clinical competence, mental or emotional stability, physical condition, ethics, or behavior bearing on my satisfaction of the criteria for continued appointment to the Medical Staff, as well as to inspect or obtain any communications, reports, records, statements, documents, recommendations and/or disclosure of Third Parties relating to such questions. I also specifically authorize said Third Parties to release said information to the Hospital and its authorized Representatives upon request.
- (3) The applicant agrees that any lawsuit brought by the applicant against a Hospital Representative or against a Third Party providing information to a Hospital Representative shall be brought in a court, federal or state, in the state in which the defendant resides or is located.

ACKNOWLEDGEMENT & AGREEMENT

I acknowledge that:

- (1) Medical Staff appointments and Privileges at this Hospital are not a right;
- (2) my request will be evaluated in accordance with the procedures defined in these Bylaws;
- (3) all Medical Staff recommendations relative to my application are subject to the ultimate action of the Board whose decision shall be final;
- (4) if appointed, my appointment and Clinical Privileges shall be provisional;
- (5) I have the responsibility, as noted in Section 3.3(j), to notify the CEO of changes to the information provided in this application regarding malpractice actions, liability insurance, felony or fraud charges or professional sanctions no later than seven (7) days after I am notified of any such changes;
- (6) appointment and continued Clinical Privileges remain contingent upon my continued demonstration of professional competence and satisfaction of the Basic Responsibilities listed in Section 3.3; and
- (7) reappointment and continued Clinical Privileges shall be granted only on formal application according to these Bylaws and subject to final approval by the Board.

ADMINISTRATIVE REMEDIES

I understand that before this application will be processed that:

- (1) I will be provided a copy of the Medical Staff Bylaws including the Rules and Regulations along with a list of all Hospital policies. Copies of such policies are available on request from the CEO.
- (2) I must sign a statement acknowledging receipt and an opportunity to read and agreement to abide by all such Bylaws, policies, and Rules and Regulations as are in force, and as they may thereafter be amended, during the time I am appointed to the Medical Staff or exercise Clinical Privileges at the Hospital.

ETHICS PLEDGE

If appointed or granted Clinical Privileges, I specifically agree to:

- (1) refrain from fee-splitting or other inducements relating to patient referral;
- (2) refrain from delegating responsibility for care of hospitalized patients to any other Practitioner or AHP who is not qualified to undertake this responsibility or who is not adequately supervised;
- (3) refrain from deceiving patients as to the identity of any individual providing treatment or services;
- (4) seek consultation whenever necessary;
- (5) abide by generally recognized ethical principles applicable to my profession;
- (6) provide or arrange suitable coverage for, continuous care and supervision to all patients in the Hospital for whom I have responsibility; and
- (7) accept committee assignments and such other duties and responsibilities as shall be assigned to me by the Board or Chief of Staff.

6.3(d) Grounds for the CEO to Reject an Application

Upon completion of the application form and attachment of all required information, the applicant shall submit the form to the CEO. The application shall be returned to the applicant and shall not be processed further if one (1) or more of the following applies:

- (1) **Not Licensed:** The applicant is not licensed in this state to practice in a field of health care eligible for appointment to the Medical Staff or for Clinical Privileges;
- (2) **Prior Privileges Denied or Terminated at this Hospital:**
 - (i) Within one (1) year immediately preceding the request, the applicant has had his application for initial appointment at this Hospital denied, except as noted below in Section 6.3(d)(2)(ii) or has resigned his appointment at this Hospital during an active investigation that could have led to revocation of his appointment.
 - (ii) Within five (5) years immediately preceding the request, the applicant has, at this Hospital, had an application for reappointment denied, had an initial application denied

as a result of fraudulent conduct, misrepresentations in the application, or other basis involving dishonesty, or had his Staff appointment or Privileges revoked;

- (3) **Inadequate Liability Insurance:** The applicant does not meet the liability insurance coverage requirements of Section 14.2;
- (4) **Ineligible for Medicare Provider Status.**
- (5) **Application Incomplete:** Failure to adequately complete the application form, withholding of requested information, providing false or misleading information or failure to execute a required acknowledgement or release required by these Bylaws shall be grounds to reject an application.

The refusal to further process an application form for any of the above reasons shall not be deemed adverse and shall not entitle the applicant to any procedural rights under these Bylaws.

6.3(e) CEO ACTION ON ACCEPTED APPLICATIONS

In the event that none of the criteria in Section 6.3(d) apply to the application, the CEO shall promptly seek to verify the references, licensure and other evidence submitted. Verification shall be obtained from primary sources whenever feasible. The CEO shall promptly notify the applicant of any problems in obtaining the information required and it shall then be the applicant's obligation to ensure that the required information is provided.

The CEO will forward the completed application and all supporting materials to the Credentials Committee within thirty (30) days after receipt of all necessary documentation from the applicant. An application shall not be deemed complete until verification of all information, including query of the Data Bank, is complete.

6.3(f) Interview

An interview may be scheduled with the applicant during any of the steps set out in Sections 6.3(g) - 6.3(i). Failure to appear for a requested interview without good cause may be grounds for denial of the application. Such denial shall not entitle the applicant to any procedural rights under these Bylaws.

6.3(g) CREDENTIALS COMMITTEE ACTION

The Credentials Committee shall review the application and such other information available as may be relevant to consideration of the applicant's qualifications for the Staff category, service assignment and Clinical Privileges requested. If the committee feels that the requested Privileges need to be modified, the applicant will be notified and will have an opportunity to agree to any such modification before the Credentials Committee forwards a recommendation to the MEC.

In special situations where there are no members on the Credentials Committee with the appropriate qualifications to review the application, the Chair of Credentials Committee may request that the Chief of Staff appoint one or more individuals from the Medical Staff, if possible, or from outside the Staff, to serve on the committee for the specified purpose of helping the committee make a recommendation on the applicant.

Within thirty (30) days of receipt of the application and completion of an interview, if so requested by the committee, the Credentials Committee shall forward to the MEC a recommendation as to Staff appointment and Clinical Privileges to be granted. Minority views may also be transmitted with the report. The Credentials Committee also may recommend that the MEC defer action on the application. A recommendation to grant Staff membership and/or Privileges shall include:

- (1) the Staff category, if applicable;
- (2) the assigned service;
- (3) the Clinical Privileges he may exercise; and
- (4) the specific monitoring or proctoring conditions attached to the provisional appointment.

6.3(h) MEDICAL EXECUTIVE COMMITTEE ACTION

Within thirty (30) days after receipt of the Credentials Committee recommendation, the MEC shall consider the recommendation and other relevant information available to it. The MEC shall then forward to the Board a written report. The reasons for each recommendation shall be stated and supported by reference to the completed application and other information considered by the committee. Any minority views shall also be reduced to writing, supported by reasons, references and documents, and transmitted with the majority report. The MEC may take the following actions:

(1) Referral back to Credentials Committee

This MEC action shall include specific reasons therefore and describe any additional information needed. Such action must, within thirty (30) days, be followed by a subsequent report from Credentials Committee. If additional information is required from the applicant, he shall be so notified and he shall then bear the burden of providing such information in a timely manner.

(2) Favorable Recommendation to the Board

A decision to grant Medical Staff appointment or reappointment, together with all requested Clinical Privileges, shall constitute a favorable action even if the exercise of Clinical Privileges is made contingent upon monitoring, proctoring, periodic drug testing, additional education or any similar form of quality improvement that does not materially restrict the applicant's ability to exercise the requested Clinical Privileges.

The MEC can ratify a favorable recommendation by Credentials Committee. However, the MEC may not make a favorable recommendation to the Board given an adverse recommendation by Credentials Committee until the application has been referred back to Credentials Committee for reevaluation at least once as described in Section 6.3(h)(1). The CEO shall forward the MEC's recommendation and any minority views, including the Credentials Committee recommendation if it was unfavorable, to the Board. The CEO shall notify the applicant of such action.

(3) Adverse Recommendation to the Board

For the purposes of this Section, an "adverse recommendation" is defined as denial of appointment or denial or restriction of requested Privileges (in those cases where the applicant does not voluntarily agree to changes the Credentials Committee made to his requested Privileges). An adverse recommendation can occur by the MEC:

- (i) ratifying an adverse recommendation from Credentials Committee; or
- (ii) rejecting or modifying a favorable recommendation from Credentials Committee, provided that the application has been referred back to Credentials Committee for reconsideration at least once per Section 6.3(h)(1).

Minority views, including the Credentials Committee report if it was favorable to the applicant, will be transmitted to the Board. The CEO will provide the applicant within fourteen (14) days by ~~Special Notice~~ with a copy of the MEC's written decision and a summary of the applicant's procedural rights as specified in these Bylaws. The Chief of Staff shall have the responsibility to report to the Board on the status of the application for informational purposes only. The recommendation will not be submitted to the Board until the applicant has either waived his right to a hearing or completed the hearing and appeal process. To maintain confidentiality, all participants in the appointment process shall limit their discussion of the matters involved to the formal avenues provided in these Bylaws.

6.3(i) BOARD ACTION

Applications with the MEC recommendation will be forwarded to the Board for review at the next Board meeting.

6.3(i)(1) On Favorable Recommendation by the MEC

(i) Referral Back to the MEC

Action by the Board to refer the application back for further consideration shall include specific reference to the reasons therefore and describe any additional information needed. A subsequent recommendation shall be submitted to the Board within thirty (30) days. The MEC may, at its discretion, refer the matter back to Credentials Committee. The CEO shall inform the applicant by Special Notice of the Board's action.

(ii) Favorable Action

In the event that the Board of Trustees' decision is favorable to the applicant, such decision shall constitute final action on the application. The CEO shall promptly inform the Chief of Staff, appropriate Service Chair and the applicant that the application has been granted.

(iii) Adverse Action

The Board may reject, but not modify, a favorable recommendation by the MEC. In the event that the MEC's recommendation was favorable to the applicant, but the Board's action is adverse [as defined in Section 6.3(h)(3)], the applicant shall be entitled to the procedural rights specified in these Bylaws. The CEO shall deliver within fourteen (14) days by Special Notice to the applicant the Board's written decision and a summary of the applicant's rights. If a Practitioner does not request a hearing within thirty (30) days or an AHP does not request a review within ten (10) days of receipt of this notice, the adverse action will become the final action of the Board and the matter will be closed.

(iv) Expedited Review

The Board shall make every reasonable effort to act upon the MEC's recommendation within thirty (30) days following receipt of the MEC's recommendation or the conclusion of the hearing and appeal process. The Board may approve applications for appointment, reappointment and Clinical Privileges through an expedited process when the following requirements are met:

- A complete application is submitted by the applicant;
- Credentials Committee and MEC have made favorable recommendations with no limitations;

- There are no previous or current challenges to professional licensure;
- There is no involuntary termination of Medical staff membership at another organization; and
- There is no involuntary termination, limitation, reduction, denial or loss of clinical privileges

6.3(i)(2) On Adverse Recommendation by the MEC

The applicant shall have an opportunity to exercise his procedural rights under these Bylaws prior to submission of the adverse recommendation to the Board. Under no circumstances shall any Practitioner be entitled to more than one (1) evidentiary hearing based upon an adverse action..

6.3(j) Written Notification

The CEO will send the applicant written notification of Medical Staff appointment, including the date of the appointment, the assigned service, the types of Clinical Privileges granted, any limitations that may have been imposed and the name of the monitor, if applicable.

6.4 REAPPOINTMENT PROCESS

6.4(a) Time Periods for Processing

At least ninety (90) days prior to the expiration date of a current Member's appointment or an AHP's term of Privileges, the CEO shall provide the individual with instructions for application for reappointment. Each individual who desires reappointment shall, at least sixty (60) days prior to the expiration date, return his completed application form. Failure, without good cause, to return a completed application form shall result in automatic termination of membership at the expiration of the individual's current term. A Member whose rights are so terminated shall be entitled to procedural rights for the sole purpose of resolving the issue of good cause. If the individual is under suspension or restriction of Privileges, such suspension or restriction shall continue in effect until processing has been completed and a final decision made by the Board.

6.4(b) Content of Reapplication Form

The reappointment form shall include updated information from the preceding two (2) years on the following:

- (1) **Education**: documentation of fifty (50) CME credits earned during the last two (2) years of which at least fifty percent (50%) must apply to the specialty in which the applicant is applying for Privileges.
- (2) **License**: Current licensure;
- (3) **Health Status**: The health statement from an applicant for reappointment should stipulate whether there are any physical or mental health conditions that would preclude him from performing the Privileges he has requested. When doubt is raised about the applicant's ability, an evaluation of the applicant by an examiner approved by the MEC may be requested by the MEC;
- (4) **Other Affiliations**: The name and address of any other hospital, health care organization or practice setting where the applicant provided clinical services during the preceding appointment period;

- (5) **Professional Sanctions**: as listed in Section 6.2(i);
- (6) **Malpractice Experience**: as listed in Section 6.2(h);
- (7) **Felony or Fraud Charges**: as listed in Sections 6.2(c) and (d);
- (8) **Insurance**: as listed in Section 6.2(g);
- (9) **Current Competency**: Objective evidence of the individual's clinical performance, competence, ethics and judgment, based on performance improvement and utilization review data, his Service Chair's evaluation and a letter of reference from one (1) other Staff Member; and
- (10) **A Signed Notification of Release & Immunity From Liability**: as set forth in Section 6.3(c).

6.4(c) Verification of Information

The CEO shall, in timely fashion, verify the information on the reappointment form and collect any other materials or information deemed pertinent, including information on professional conduct and performance in the Hospital and a query of the Data Bank. An application shall not be deemed complete nor shall final action on the application be taken until verification of all information, including query of the Data Bank, is complete.

6.4(d) Action on Applications for Reappointment

The application for reappointment shall thereafter be processed as set forth in Sections 6.3(g) - 6.3(i) for initial appointment. In cases where a reappointment is subject to newly instated proctoring, the Staff member may be entitled to procedural rights if such proctoring materially affects his Privileges. No reappointment may be denied on the basis of a Board declared moratorium. An individual who has been denied reappointment at this Hospital shall not be permitted to reapply for a period of five (5) years. Any such reapplication shall be processed as an initial application.

6.4(e) Basis for Recommendations

Each recommendation concerning the reappointment and Privileges of a Staff Member or AHP shall be based upon such person's professional performance, ability and clinical judgment in the treatment of patients, his discharge of Staff obligations, including participation in continuing medical education, his compliance with the Medical Staff Bylaws and Rules & Regulations, his cooperation with other Members, AHPs and patients, results of the Hospital performance improvement activities and other matters bearing on his ability and willingness to contribute to quality patient care in the Hospital.

6.5 REQUEST FOR MODIFICATION OF APPOINTMENT

A Staff member or AHP may, either in connection with reappointment or at any other time, request modification of his Staff category, service assignment or Clinical Privileges by submitting a written application to the Credentials Committee. Such application shall be processed in the same manner as provided in Section 6.4 for reappointment. The MEC may recommend to the Board that an advance in Staff category or the granting of additional Privileges be made provisional in accordance with the procedures for initial appointment as outlined in Section 4.6(a). Any modifications shall remain in effect until the next regularly scheduled reappointment period.

6.6 CONTRACT PRACTITIONERS

6.6(a) Qualifications & Processing

A Practitioner who is providing contract services to the Hospital must meet the same qualifications for membership; must be processed for appointment, reappointment, and Clinical Privileges in the same manner; must abide by the Medical Staff Bylaws and must fulfill all of the obligations for his membership category as any other applicant or Member.

6.6(b) Termination

The contract Practitioner is required to send notice to Credentials Committee when a contract arrangement is ending, however, expiration or termination of a contract for services shall not affect Staff membership or Privileges.

ARTICLE VII

DETERMINATION OF CLINICAL PRIVILEGES

7.1 EXERCISE OF PRIVILEGES

Every Practitioner or AHP providing direct clinical services at this Hospital shall, except as provided in Sections 7.3, 7.4, and 7.5, be entitled to exercise only those Clinical Privileges specifically granted to him by the Board pursuant to the provisions of these Bylaws. Said Privileges must be within the scope of the license authorizing the individual to practice in this state and consistent with any restrictions thereon. Medical Staff appointment alone shall not confer any Privileges. No Physician, Podiatrist or Dentist is entitled to exercise particular Privileges solely because he is licensed to practice in this or any other state, or because he is a member of any professional organization, is certified by any specialty board or because he presently or formerly held privileges at another health care facility.

7.2 DELINEATION OF PRIVILEGES IN GENERAL

7.2(a) Requests

Each application for Staff appointment and reappointment or for the granting or modification of Privileges must contain a written request for the specific Clinical Privileges desired by the applicant. The applicant shall have the burden of establishing his qualifications for the Privileges he requests.

7.2(b) Basis for Privileges Determination

Granting of Clinical Privileges shall be hospital specific and shall be evaluated on the basis of the applicant's education, training, current competence, experience, observed clinical performance, ongoing monitoring of the applicant's clinical and technical skills and other criteria directly related to quality of care, including but not limited to, information related to:

- (1) voluntary or involuntary relinquishment of licensure or registration;
- (2) voluntary or involuntary limitation, reduction or loss of clinical privileges or voluntary or involuntary termination of Medical Staff membership at another hospital;
- (3) involvement in professional liability actions;
- (4) whether the frequency of exercise of Privileges is sufficient to indicate current proficiency; and
- (5) the documented results of the performance improvement and utilization management activities conducted at the Hospital.
- (6) Consideration of the types of procedures and services that can be provided at this Hospital.

Clinical Privileges granted or modified on pertinent information concerning clinical performance obtained from other health care institutions shall be added to and maintained in the Medical Staff file established for the Practitioner or AHP.

7.2(c) Procedure

All requests for Clinical Privileges shall be evaluated and granted, modified or denied pursuant to the procedures outlined in Sections 6.3(g) – 6.3(i). The Data Bank shall be queried each time Privileges are requested.

7.2(d) Limitations on Privileges

The delineation of an individual's Clinical Privileges may include limitations, if any, on an individual's prerogatives to admit and treat patients.

7.3 TEMPORARY PRIVILEGES

Applicants for Temporary Privileges must meet the Basic Qualifications for Staff Membership listed in Section 3.2. Temporary Privileges will be subject to the conditions listed in Section 7.3(b). Under no conditions will the term of such Privileges exceed a total of one hundred and twenty (120) days.

7.3(a) Circumstances

(1) **Pendency of Application:** Only applicants who meet the following criteria will be eligible for Temporary Privileges while awaiting final approval of their application:

- (i) The applicant must have no current or previously successful challenge to licensure or registration.
- (ii) The applicant must not have been subject to involuntary termination of medical staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges at another institution.
- (iii) The applicant has submitted the Hospital's Staff application including three (3) letters of reference, proof of current New Mexico licensure, proof of adequate malpractice insurance and a signed Statement of Release & Immunity from Liability.
- (iv) A Data Bank query must be completed.

The following information must be verified before the applicant may be granted Temporary Privileges based on a pending application: current licensure, relevant training or experience and current competence. Temporary Privileges may be granted upon the written concurrence of the CEO, Chief of Staff and the Credentials Committee Chair, or, when the Chair is not available, a member of the Credentials Committee.

The duration of these Temporary Privileges will not exceed the pendency of the application, but in no case shall exceed the time limit established by Section 7.3. In exercising Temporary Privileges, the applicant shall be subject to the same terms of monitoring or proctoring as will be in effect when his Provisional Staff status is approved.

(2) **One Case Privileges**: Such Privileges are intended for isolated instances in which extension of such are shown to be in an individual patient's best interest. Prior to any award of One Case Privileges:

- (i) the Practitioner must submit proof of current New Mexico licensure;
- (ii) the Practitioner must submit proof of adequate malpractice insurance;
- (iii) confirmation, as necessary, of the Practitioner's Privileges at his primary hospital must be obtained; and
- (iv) a Data Bank query must be completed, if feasible.

A Practitioner may be granted One Case Privileges upon the written concurrence of the CEO and Chief of Staff or Service Chair for the care of one or more designated patients. The CEO will notify the Credentials Committee whenever such Privileges are awarded. No Practitioner shall be granted One Case Privileges on more than two (2) occasions in any calendar year. If a given Practitioner exceeds this restriction, he shall be required to apply for membership on the Medical Staff before being allowed to attend additional patients at this Hospital.

(3) **Locum Tenens**: A Practitioner who is serving as locum tenens for a Staff Member may, without applying for Staff membership, be granted Temporary Privileges for an initial period of sixty (60) days if he meets the following criteria:

- (i) The Practitioner has submitted a complete hospital staff application including three (3) letters of reference, proof of current New Mexico licensure and proof of adequate malpractice insurance. A copy of an application used at another hospital is acceptable;
- (ii) The Practitioner must have no current or previously successful challenge to licensure or registration;
- (iii) The Practitioner must not have been subject to involuntary termination of medical staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges at another institution; and
- (iv) A Data Bank query has been completed.

Temporary Privileges for locum tenens may be granted upon the written concurrence of the CEO, Chief of Staff and Chair of Credentials Committee, or when the Chair is not available, a member of Credentials Committee. Such Privileges may be renewed for a period not to exceed his services as a locum tenens, but only upon the individual establishing his qualifications to the satisfaction of Credentials Committee and the MEC and in no event to exceed one hundred and twenty (120) days in a calendar year. Members of the Medical Staff seeking to provide coverage through locum tenens shall, where possible, advise the Hospital at least thirty (30) days in advance of the identity of the locum tenens and the dates during which his services will be utilized in order to allow adequate time for appropriate verification to be completed. Failure to do so without good cause may constitute grounds for corrective action.

7.3(b) Conditions

- (1) Temporary Privileges shall be granted only when the information available reasonably supports a favorable determination regarding the requesting Practitioner's qualifications, ability and judgment to exercise the Privileges requested.
- (2) Requirements of monitoring or proctoring may be imposed by the Chief of Staff, including requiring that the patients of the Practitioner be admitted as a dual admission with an Active Staff Member.
- (3) Before Temporary Privileges are granted, the Practitioner must acknowledge in writing that he has received and had an opportunity to read the Medical Staff Bylaws and Rules & Regulations, and that he agrees to be bound by the terms thereof in all matters relating to his Temporary Privileges.
- (4) Temporary Privileges will not be granted if a Practitioner fails to provide all information necessary for the processing of his application in a timely manner.

7.3(c) Termination

On the discovery of any information pertinent to the Practitioner's qualifications or the occurrence of any event of a professionally questionable nature concerning his ability to exercise any of the Temporary Privileges granted, the CEO and the Chief of Staff or the responsible Service Chair may terminate any or all of such Practitioner's Privileges. Where the life or well-being of a patient is endangered by continued treatment by the Practitioner, the termination may be effected by any person entitled to impose a summary suspension under Section 8.2(a). In the event of any such termination, the terminated Practitioner's patients remaining in the Hospital will be assigned a substitute Staff Member by the Chief of Staff or by the Service Chair. The wishes of the patient shall be considered, if feasible, in choosing this substitute Practitioner. The terminated Practitioner shall confer with the substitute Practitioner to the extent necessary for the safety of the patient.

7.3(d) Rights of the Applicant for Temporary Privileges

A Practitioner shall not be entitled to the procedural rights afforded by these Bylaws because of inability to obtain Temporary Privileges or because of any termination or suspension of Temporary Privileges.

7.4 DISASTER PRIVILEGES

A "disaster" for the purposes of this section is defined as a mass injury situation in which the number of available Staff Members is not adequate to provide all clinical services required by the citizens served by this facility. Under the Emergency Management Plan, the CEO or the Chief of Staff may grant Disaster Privileges to appropriately licensed Physicians, Podiatrists, or Dentists who do not currently have Privileges at this Hospital. Such a decision will be made on a case-by-case basis and is dependent on Hospital needs during the disaster.

7.4(a) Conditions

- (1) Those wishing to be granted Disaster Privileges must provide an identification document as listed in the "Granting of Disaster Privileges" policy.

- (2) As soon as possible, a hospital employee will begin the verification process. A separate confidential file will be retained for all Practitioners granted Disaster Privileges.

7.4(b) Termination

Disaster Privileges will be terminated by the CEO or Chief of Staff at the end of needed services or when information received through the verification process or the occurrence of any event of a professionally questionable nature suggests the Practitioner is not capable of rendering such services.

7.4(c) Rights of the Applicant for Disaster Privileges

A Practitioner shall not be entitled to the procedural rights afforded by these Bylaws because of inability to obtain or because of any termination of Disaster Privileges.

7.5 EMERGENCY PRIVILEGES

For the purpose of this section, an "emergency" is defined as a condition in which serious or permanent harm to a patient is likely to occur, or in which the life of a patient is in immediate danger, and delay in administering treatment would add to that danger. In the case of an emergency, any Practitioner or AHP, to the degree permitted by his license, regardless of Staff status or Clinical Privileges, shall be permitted to do and be assisted by Hospital personnel in doing everything possible to save the life of a patient or to save the patient from serious harm.

ARTICLE VIII
CORRECTIVE ACTION

8.1 ROUTINE CORRECTIVE ACTION

8.1(a) Criteria for Initiation

Whenever the activities, omissions, or professional conduct of a Member are detrimental to patient safety or to the delivery of quality patient care, are disruptive to Hospital operations, or violate the provisions of these Bylaws, the Medical Staff Rules and Regulations, or duly adopted policies and procedures; corrective action against such Member may be initiated by any officer of the Medical Staff, the Member's Service Chair, the CEO, or the Board. Initiation of corrective action does not preclude summary suspension nor does it require the prior imposition of such a suspension. Procedural guidelines from the Health Care Quality Improvement Act shall be followed and all corrective action shall be taken in good faith in the interest of quality patient care.

8.1(b) Request for Corrective Action

All requests for corrective action under this Section 8.1 shall be submitted in writing to the MEC and supported by reference to the specific activities or conduct which constitute the grounds for the request.

8.1(c) Consideration of the Request by the Medical Executive Committee

The MEC shall consider the request for corrective action at its next regular meeting or within forty-five (45) days, whichever is sooner. When the request involves an issue of Practitioner impairment, the Hospital's Impaired Physician Policy will be initiated instead of the Staff discipline procedures. The MEC may:

- (1) reject the request if it decides it has no merit. The matter shall be closed unless the CEO, within fourteen (14) days, exercises his option to further investigate under Section 8.3(a). The Board will not be informed of requests for corrective action that are so rejected;
- (2) begin an investigation of the matter itself; or
- (3) assign the matter to a special committee for further investigation.

The investigation may consist of a review of the facts of the case, review of pertinent records and informal questioning of persons involved. Such questioning may include an interview, as described in Section 9.1, with the Member under investigation. Within thirty (30) days after the investigation begins, a written report of the investigation shall be completed.

8.1(d) Medical Executive Committee Action After Investigation

At the completion of its investigation or within thirty (30) days following receipt of the special committee's report, the MEC shall take action upon the request. Its action shall be reported in writing and may include, but shall not be limited to:

- (1) Rejecting the request for corrective action;

- (2) Recuse itself from the matter and referring it to the Board without recommendation, together with a statement of its reasons for recusing itself, which reasons may include but are not limited to, a conflict of interest due to direct economic competition or economic interdependence with the affected Member;
- (3) Issuing a warning or a reprimand to which the Member may write a rebuttal, if he so desires or recommending terms of education, counseling or probation that do not materially restrict the Member's Privileges. The MEC may also impose fines if the offending behavior persists or recurs despite the above actions;
- (4) Recommending terms of supervision or probation that do materially restrict the Member's Privileges;
- (5) Recommending reduction, suspension or revocation of Clinical Privileges;
- (6) Recommending reduction of Staff category or limitation of any Staff prerogatives; or
- (7) Recommending suspension or revocation of Staff membership.

8.1(e) MEC Actions that Qualify for Procedural Rights

Any action by the MEC pursuant to Section 8.1(d)(4), (5), (6) or (7) shall entitle the Member to the procedural rights specified in the Fair Hearing Plan. The Chief of Staff may notify the Board for informational purposes only of the MEC's decision. The Board will not be given specifics at this stage of the proceedings because of the confidentiality of peer review. The Board shall take no action on this matter until the Member has either waived or exhausted his procedural rights under the Fair Hearing Plan. Subsequent Board action will be pursuant to the Fair Hearing Plan.

8.1(f) MEC Actions that do not Qualify for Procedural Rights

- (1) If the MEC rejects a request for corrective action as provided in Section 8.1(d)(1), the matter shall be closed unless the CEO exercises his option under Section 8.3(a).
- (2) If the MEC's action is as in 8.1(d)(3), the Board will not be informed as Privileges are not affected.

8.1(g) Board Action

If the MEC recuses itself, the functions assigned to the MEC under Section 8.1 shall be performed by the Board. When the MEC takes any action that qualifies for procedural rights, the matter will go before the Board only after the affected Member has either waived or exhausted his procedural rights under the Fair Hearing Plan.

8.2 SUMMARY SUSPENSION

8.2(a) Criteria & Initiation

Notwithstanding the provisions of Section 8.1 above, whenever a Member willfully disregards these Bylaws or other Hospital policies, or his conduct requires that immediate action be taken to protect the life, well-being, health or safety of any patient, employee or other person in the Hospital, then the CEO or any Staff Member of MEC shall have the authority to summarily suspend the Medical Staff

membership status or all or any portion of the Clinical Privileges immediately upon imposition. Subsequently, the CEO shall promptly give Special Notice of the suspension to the Member.

Immediately upon the imposition of summary suspension, the Chief of Staff shall designate another Staff Member with appropriate Clinical Privileges to provide continued medical care for the suspended Member's patients remaining in the Hospital. The wishes of the patient shall be considered, if feasible, in the selection of the substitute Member. The suspended Member shall confer with the substitute Member to the extent necessary for the safety of the patient. It shall be the duty of all Staff Members to cooperate with the Chief of Staff and the CEO in enforcing suspension and in caring for the suspended Member's patients.

8.2(b) Medical Executive Committee Action

Within seventy-two (72) hours after such summary suspension, a meeting of the MEC shall be convened to review and consider the suspension. The MEC may recommend modification, ratification, continuation with further investigation or termination of the summary suspension.

8.2(c) Procedural Rights

If the summary suspension is terminated or modified such that the affected Member's Privileges are not materially restricted, the matter shall be closed unless the CEO exercises his right, under Section 8.3(a), to further investigate the matter.

If the summary suspension is continued for purposes of further investigation, the MEC shall reconvene within fourteen (14) days of the original imposition of the suspension and shall modify, ratify or terminate the summary suspension. If the summary suspension is then terminated or modified such that the affected Member's Privileges are not materially restricted, the matter shall be closed unless the CEO exercises his right to further investigate the matter.

Upon ratification of the suspension or a modification which materially restricts the Member's Clinical Privileges, the Member shall be entitled to the procedural rights provided in the Fair Hearing Plan prior to submission of the MEC's recommendation to the Board. The terms of the summary suspension as sustained or as modified by the MEC shall remain in effect pending a final decision by the Board.

8.3 ADMINISTRATIVE OPTION

8.3(a) When the CEO Disagrees with a MEC Action

When the CEO disagrees with the action of the MEC on a request for corrective action or a summary suspension, he may, within fourteen (14) days, exercise his option to further investigate the matter by appointing a special committee composed of at least three (3) Staff Members. This committee will submit a written report to the MEC within thirty (30) days. The MEC will take final action on the report as listed in Section 8.1(d).

8.3(b) Disruptive Behavior

Whenever a Member violates Hospital policies, Staff Bylaws or Rules and Regulations or acts in a manner disruptive to Hospital operations, the CEO may act according to the Disruptive Physician Policy. If the Chief of Staff does not concur with the CEO's recommendation to pursue this policy,

the CEO may take the matter to the MEC. The MEC will act on the CEO's request as outlined in Section 8.1.

8.4 AUTOMATIC SUSPENSION

8.4(a) License

A Member or AHP whose license, certificate or other legal credential authorizing him to practice in New Mexico is revoked or suspended shall immediately and automatically be suspended from the Staff and practicing in the Hospital.

8.4(b) Failure to Satisfy a Special Appearance Request

Failure of a Member to appear at any meeting to which he was given Special Notice pursuant to Section 13.7(c) shall, unless excused by the MEC for good cause, result in an automatic suspension of all or such portion of the Member's Clinical Privileges as the MEC may direct.

8.4(c) Malpractice Insurance Coverage

Any Member or AHP unable to provide proof of current medical malpractice coverage in the amounts prescribed in these Bylaws will be automatically suspended until proof of such coverage is provided to the MEC and CEO.

8.4(d) Suspension from Medicare

Any Member who is excluded from participating in the Medicare program or any state government payor program will be automatically suspended.

8.4 (e) Delinquent Medical Records

An automatic suspension of clinical privileges may be imposed by the Chief of Staff per hospital policy for failure to complete medical records within thirty (30) days after patient discharge. Such suspension shall remain in effect until the incomplete medical records are completed.

8.4(f) Automatic Suspension - Fair Hearing Plan Not Applicable

No Member who is automatically suspended under this Section 8.4 shall have the right of hearing or appeal as provided under these Bylaws.

8.4(g) Chief of Staff

The Chief of Staff shall designate a substitute Member to provide continued medical care for a suspended Member's patients. The wishes of the patient shall be considered, if feasible, in the selection of the substitute Member. The suspended Member shall confer with the substitute Member to the extent necessary for the safety of the patient. It shall be the duty of the Staff to cooperate with the CEO in enforcing all automatic suspensions.

8.5 CONFIDENTIALITY

All participants, including Staff Members, Hospital employees and the Board, shall limit their discussion of the matters involved to the formal avenues provided in these Bylaws for peer review and discipline. Violation of the intent of this Section 8.5 shall be grounds for exclusion from any further participation in the process.

8.6 SUMMARY SUPERVISION

Whenever criteria exist for initiating corrective action pursuant to this Article, a Member may be summarily placed under supervision concurrently with the initiation of peer review activities until such time as a final determination is made regarding his Privileges. The following shall have the right to impose supervision: Chief of Staff, the Member's Service Chair or the CEO.

8.7 PROTECTION FROM LIABILITY

All members of the Board, the Medical Staff and Hospital personnel assisting in Medical Staff peer review shall have immunity from any civil liability to the fullest extent permitted by state and federal law when participating in any activity described in the Release and Immunity from Liability subsection of Section 6.3(c) of these Bylaws.

8.8 REAPPLICATION AFTER ADVERSE ACTION

A Staff Member who has received a final adverse decision pursuant to Section 8.1, 8.2 or 8.3 shall not be considered for appointment to the Medical Staff for a period of five (5) years after notice of such decision is sent. Any reapplication shall be processed as an initial application.

ARTICLE IX
INTERVIEWS & HEARINGS

9.1 INTERVIEWS

When the MEC or Board is considering initiating an adverse action concerning a Practitioner, it may, in its discretion, request an interview. The interview shall not constitute a hearing, shall be preliminary in nature and shall not be conducted according to the procedural rules provided with respect to hearings. The Practitioner shall be informed of the general nature of the proposed action and may present information relevant thereto. A summary record of such interview shall be made. No legal or other outside representative shall be permitted to participate for either party.

9.2 HEARINGS

9.2(a) Procedure

Whenever a Practitioner requests a hearing based upon an adverse action as defined in Article I of the Fair Hearing Plan, the hearing shall be conducted in accordance with the procedures set forth in the Fair Hearing Plan and the Health Care Quality Improvement Act.

9.2(b) Exceptions

The issuance of a warning, a request to appear before a committee, a letter of admonition, a letter of reprimand, a recommendation for concurrent monitoring, a denial, termination or reduction of Temporary or Disaster Privileges, or terms of probation which do not materially restrict the Practitioner's exercise of Clinical Privileges shall not give rise to any right to a hearing.

9.3 ADVERSE ACTION AFFECTING AHPs

Any adverse actions affecting AHPs shall be addressed in accordance with Section 5.5 of these Bylaws.

ARTICLE X
OFFICERS

10.1 OFFICERS OF THE STAFF

10.1(a) Identification

The officers of the Staff shall be:

- (1) Chief of Staff;
- (2) Vice-Chief of Staff;
- (3) Secretary; and
- (4) Immediate Past Chief of Staff.

10.1(b) Qualifications

Officers must be Active Staff Members in Good Standing at the time of nomination and election and must remain so during their term of office. Failure of an officer to maintain such status shall immediately create a vacancy in the office. Officers shall serve no more than two (2) consecutive terms.

10.1(c) Nominations

- (1) The Nominating Committee shall consist of the members of the Credentials Committee.
- (2) Nominations may be made in three (3) ways:
 - i. By Nominating Committee: This committee shall meet at least ninety (90) days prior to the annual Staff meeting and shall submit to the Secretary of the Staff a list of two qualified nominees for Vice-Chief of Staff and Secretary, and if deemed necessary, an additional nomination for Chief of Staff. The names of such nominees shall be reported to the Staff at the September Staff meeting.
 - ii. By Petition: Nominations may also be made by petition signed by at least ten percent (10%) of the Active Staff and with a signed statement of willingness to serve by the nominee, filed with the Secretary of the Staff at least thirty (30) days before the annual Staff meeting.
 - iii. By Other Means: If, before the election, all of the nominees pursuant to Sections 10.1(c)(2)(i) and (ii) are disqualified or otherwise unable to accept the nomination, then the Nominating Committee shall submit one or more substitute nominees to the Staff.

10.1(d) Election

- (1) Election of officers so nominated shall be completed by secret ballot seven (7) days prior to the annual Staff meeting. The MEC shall conduct all elections and shall have charge of all matters pertaining thereto.
- (2) If more than two (2) nominees appear on the ballot and no nominee receives a majority of the votes cast on the first ballot, all of the nominees except the two receiving the most votes shall be

10.1(e) Removal of Officers

Whenever the activities, professional conduct or leadership abilities of a Medical Staff officer are believed to be below the standards established by the Medical Staff or to be disruptive to the operations of the Hospital, the officer may be removed by a two-thirds (2/3) majority of the Active Staff. Reasons for removal may include, but shall not be limited to, violation of these Bylaws, breaches of confidentiality, mental or physical impairment, inability or unwillingness to perform the duties of the office or unethical behavior. Such removal shall not affect the officer's Medical Staff membership or Clinical Privileges and shall not be considered an adverse action. Removal may be initiated by submission of a petition to the MEC signed by not less than one-third of the Active Staff. A special Staff meeting shall be held within thirty (30) days of receipt of the petition. The notice of said special meeting must state that the purpose of the meeting is to vote on removal of one or more designated officers.

10.1(f) Term of Elected Officers

Each officer shall serve a one (1) year term, commencing on the first day of the Medical Staff Year following his election. Each officer shall serve until the end of his term and until a successor is elected unless he shall sooner resign or be removed from office.

10.1(g) Vacancies in Elected Office

Vacancies in office, other than Chief of Staff, shall be filled by the MEC. If there is a vacancy in the office of Chief of Staff, the Vice-Chief of Staff shall serve out the remaining term.

10.1(h) Duties of Elected Officers

- (1) **Chief of Staff:** The Chief of Staff shall serve as the chief medical officer and principal elected official of the Staff. As such he shall:
 - (i) appoint Staff Members to Staff and Hospital committees, unless otherwise expressly provided by these Bylaws or Hospital policies;
 - (ii) aid in coordinating the activities of the Hospital administration, nursing and other non-physician patient care services with those of the Medical Staff;
 - (iii) report to the Board on the quality and efficiency of clinical services and professional performance within the Hospital and on the effectiveness of the performance improvement and utilization review programs;
 - (iv) develop and implement, in concert with the service and committee chairmen, methods for credentials review and delineation of privileges; continuing medical education programs, utilization review, monitoring functions and patient care evaluations;
 - (v) communicate to the Board and the CEO the opinions, policies, needs and grievances of the Medical Staff;

- (vi) work with the MEC, services and committees to enforce these Bylaws and Rules & Regulations, to implement sanctions where indicated, and ensure the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a Practitioner or AHP;
 - (vii) call, preside at and be responsible for the agenda of all general Staff meetings;
 - (viii) serve as the chairman of the MEC and as an ex-officio member of all other Staff committees;
 - (ix) serve as a member of the Board; and
 - (x) be available to serve as spokesperson for the Medical Staff in its external professional and public relations.
- (2) **Vice-Chief of Staff:** The Vice-Chief of Staff shall be a member of the MEC. In the absence of the Chief of Staff, he shall assume all the duties and have all the authority of the Chief of Staff. He shall perform such additional duties as may be assigned to him by the Chief of Staff, the MEC or the Board. The Vice-Chief of Staff will assume the position of Chief of Staff at the end of the current Chief of Staff's term.
- (3) **Secretary:** The duties of the Secretary shall be to:
- (i) give proper notice of all Staff meetings on order of the appropriate authority;
 - (ii) supervise the preparation of accurate and complete minutes for MEC and Medical Staff meetings;
 - (iii) assure that an answer is rendered to all official Medical Staff correspondence;
 - (iv) serve as member of the MEC; and
 - (v) perform such other duties as ordinarily pertain to his office.
- (4) **Immediate Past Chief of Staff:** when available, shall be a member of the MEC and shall perform such additional duties as may be assigned to him by the Chief of Staff.

ARTICLE XI
CLINICAL SERVICES

11.1 ORGANIZATION OF STAFF SERVICES

Each service shall be organized as a separate part of the Medical Staff and shall have a Chair who is selected and has the authority, duties and responsibilities specified in Section 11.3. Further departmentalization of Staff specialities may be added by amendment as described in Article XV of these Bylaws.

There shall be clinical services of:

11.1(a) Adult Medicine: including all Members from dermatology, internal medicine, family medicine, neurology, radiology, and psychiatry. The Adult Medicine service, in addition to the general service responsibilities listed in Section 11.2, shall:

- (i) provide consultation and function as an Ambulatory Treatment Unit advisory committee to enhance the effective performance of the unit and to consider the needs of the unit both current and future

11.1(b) Pediatrics/Obstetrics: including all Members from obstetrics, gynecology and pediatrics. The Pediatric/Obstetrics service, in addition to the responsibilities listed in Section 11.2, shall:

- (i) develop and implement plans for the delivery room, cesarean section deliveries, birthing rooms, nursery and pediatric inpatients;
- (ii) provide consultation and serve as an advisory board to enhance the effective performance of the Labor and Delivery ward and Nursery and to consider the needs of these units, both current and future;

11.1(c) Surgery: including all Members from anesthesia; dentistry; ears, nose and throat; general surgery; gynecology; ophthalmology; orthopedics; pathology; plastic surgery; podiatry; urology and other related specialties. The Surgery service, in addition to the responsibilities of Section 11.2, shall:

- (i) function as an advisory board to develop and implement plans for the operating room and the recovery room to enhance their effectiveness and to consider their needs, both current and future; and
- (ii) review invasive procedures, both inpatient and outpatient.

11.1(d) Emergency Medicine: including all Members serving in the Emergency Room and two (2) other Medical Staff Members. The duties of the Emergency Medicine service shall include:

- (i) establishing rules of conduct, treatment, and care in the Emergency Room; and
- (ii) developing a mass casualty disaster plan.

11.2 SERVICE ASSIGNMENT

Each Staff Member will be assigned to at least one service, but may be granted membership and/or Privileges in one or more of the other services. The exercise of Privileges within each service shall be subject to the rules and regulations therein and to the authority of the Service Chair. The CEO or his designee and a member of the

nursing service appointed by the CEO may serve as Ex-Officio members of each of the services. AHPs will be assigned to their supervising Member's service as Ex-Officio members. Clinical Psychologists will be assigned to the Medicine service.

11.3 MEETINGS

Each of the services shall meet at least quarterly and shall conform in its proceedings and actions to the relevant provisions of Article XIII.

11.4 SERVICE RESPONSIBILITIES

The primary function of each service is to implement specific review and evaluation activities to contribute to the preservation and improvement of the quality and efficiency of patient care provided in the service. To carry out this overall function, each service shall:

11.4(a) require that patient care evaluations be performed and that service members be reviewed on an ongoing basis and upon application for reappointment. Each service shall choose two (2) aspects of patient care to monitor in the coming year at the last service meeting of the year;

11.4(b) participate in and make recommendations regarding the need for continuing education programs pertinent to changes in current professional practices and standards;

11.4(c) monitor on an ongoing basis the compliance of its service members with these Bylaws, the Rules and Regulations, policies, procedures and other standards of the Hospital;

11.4(d) monitor on an ongoing basis the compliance of its service members with applicable professional standards;

11.4(e) coordinate the patient care provided by the service's members with nursing, administrative, and other non-Medical Staff services;

11.4(f) review all deaths and all unexpected patient care events occurring in the service and report findings to the MEC; and

11.4(g) submit written minutes of service meetings to the MEC on a regular basis concerning:

- (i) findings of the service's review and evaluation activities, actions taken thereon, and the results thereof;
- (ii) recommendations for maintaining and improving the quality of care provided in the service and in the Hospital; and
- (iii) such other matters as may be requested from time to time by the MEC.

11.5 SERVICE CHAIRS

11.5(a) Qualifications: A service member must be certified by an appropriate specialty board [as described in Section 3.2(a)(9)] in at least one of the clinical areas covered by the service or have established comparable competence through the credentialing process to be eligible for serving as Service Chair. Service Chairs shall be and remain Active Staff members in Good Standing and be willing and able to discharge the functions of the office.

11.5(b) Appointment: The Service Chair shall be appointed at the beginning of the Medical Staff Year by the incoming Chief of Staff, subject to the approval of the MEC. A Service Chair shall serve a term of one (1) year and shall be eligible to succeed himself. A Service Chair may be removed from office by an affirmative vote of two-thirds of the service's Active Staff members.

11.5(c) Responsibilities: The responsibilities of the Service Chair include:

- (1) accounting to the MEC for all professional and Medical Staff administrative activities within the service unless otherwise provided for by the Hospital;
- (2) continuing review of the professional performance, qualifications and competence of the Members and AHPs who exercise Privileges in the service. This includes submitting to the Credentials Committee a written evaluation, including approving the requested Privileges, for all service members including AHPs as part of the reappointment process. Should a Member exercise Privileges in more than one (1) service, each Service Chair shall submit such an evaluation to the Credentials Committee.
- (3) All clinically related activities of the service including assuring that a formal process for monitoring and evaluating the quality and appropriateness of the care and treatment of patients served by the service is carried out;
- (4) Orientation of new members and encouraging the participation of service members in continuing education programs and required meetings;
- (5) assuring that required quality improvement and control functions are performed within the service, and that findings from such activities are properly integrated with the primary functions of the Hospital;
- (6) appointing such committees as necessary to conduct the functions of the service;
- (7) implementing within the service any actions or programs designated by the MEC;
- (8) assisting in the preparation of reports as may be required by the MEC, the CEO or the Board;
- (9) implementing and enforcing the Medical Staff Bylaws and Rules & Regulations, and developing and implementing policies within his service including initiating corrective action, investigating clinical performance and ordering required consultations;
- (10) participating in every phase of administration of his service, in cooperation with nursing, Hospital administration, the Board and other Staff services and committees;
- (11) assessing and recommending to the CEO any off-site sources for needed patient care services not provided by the service or Hospital;
- (12) making recommendations for a sufficient number of qualified and competent health care providers to provide care within the service; and(13) calling and presiding at service meetings.
- 13) Recommendation to the Medical Staff of criteria for Privileges that are relevant to the care provided by the service.

ARTICLE XII
COMMITTEES AND FUNCTIONS

12.1 GENERAL PROVISIONS

- 12.1(a)** The standing committees and their functions are set forth below. The Chief of Staff shall appoint special committees to perform functions that are not within the stated functions of one of the standing committees.
- 12.1(b)** All committee meeting attendance and proceedings shall be recorded in minutes which shall be submitted to the MEC for approval. The CEO shall keep a permanent record of all committee minutes.
- 12.1(c)** All information pertaining to activities performed by the Medical Staff or its committees and services shall be privileged and confidential to the full extent provided by law.
- 12.1(d)** The CEO or his appointee shall serve as an Ex-Officio member of each standing and special Medical Staff committee.
- 12.1(e)** Sturgis' Standard Code of Parliamentary Procedure shall be used to conduct committee meetings.
- 12.1(f)** The Chief of Staff shall appoint the Staff members of standing and special Medical Staff committees and to any Hospital committees as needed. Committee appointments are for the Medical Staff Year.
- 12.1(g)** The Chief of Staff shall appoint one of each Committee's Staff Members to serve as Chair.
- 12.1(h)** Committee functions shall be performed as required by state and federal regulatory requirements and accrediting bodies and as deemed appropriate by the MEC and the Board.

12.2 MEDICAL EXECUTIVE COMMITTEE (MEC)

12.2(a) Composition: Members of the MEC shall include the following:

- (i) Chief of Staff, who shall serve as Chairperson;
- (ii) Vice-Chief of Staff;
- (iii) Secretary of the Staff;
- (iv) immediate past Chief of Staff;
- (v) two (2) At-Large Active Staff Members; and
- (vi) CEO, Ex-Officio, or his designee.

12.2(b) Functions: The MEC shall be responsible for governance of the Medical Staff and shall serve as a liaison between the Staff and the Hospital administration and Board. The MEC is empowered to act for the Medical Staff in the intervals between Medical Staff meetings. The functions and responsibilities of the MEC shall include at least the following:

- (1) approving and acting upon service and committee reports;

- (2) implementing and coordinating the approved policies of the Medical Staff, its services and committees;
- (3) making recommendations to the Board on all matters relating to Staff appointments, reappointments and the granting of Clinical Privileges, including the mechanism used to review credentials and delineate individual Privileges;
- (4) fulfilling the Medical Staff's accountability to the Board for the quality of the professional care rendered to the patients in the Hospital;
- (5) recommending action to the CEO on matters of a medico-administrative nature;
- (6) appointing a Staff Member to develop and implement programs for continuing medical education that relate, at least in part, to the type and nature of care provided at the Hospital and coordinate with the quality assurance and performance improvement programs.
- (7) developing and implementing an Impaired Physician Policy and addressing prevention of physical, emotional and psychological illness in Members and AHPs;
- (8) establishing a mechanism to conduct, evaluate and revise performance improvement and quality assurance activities, including review of the annual evaluations of the Hospital's Quality Assessment and Performance Improvement Program and regular reporting of the results of these activities, along with recommendations, if any, to the Board;
- (9) evaluating areas of risk in the clinical aspects of patient care and safety and proposing plans and recommendations for reducing these risks;
- (10) informing the Medical Staff of JCAHO and other accreditation programs and the accreditation status of the Hospital;
- (11) initiating an investigation of any incident, conduct, or allegation indicating that a Staff Member or AHP may not be complying with the Bylaws, may be rendering care below the standards established for the Hospital, or may otherwise not be qualified for continued Medical Staff appointment or Clinical Privileges without supervision, further training, or other safeguards;
- (12) participating in identifying community health needs and in setting Hospital goals and implementing programs to meet those needs;
- (13) developing and monitoring compliance with these Bylaws and the Rules and Regulations, policies and other Hospital standards; and
- (14) making recommendations to the Board regarding the Medical Staff structure, the mechanism for corrective action and fair hearing procedures and the mechanism by which Medical Staff membership may be granted and terminated.

12.2(c) Meetings

The MEC shall meet as needed, but at least six (6) times a year. The Chief of Staff shall present a summary of the MEC's activities at each general Staff meeting.

12.2(d) Special Meeting of the Medical Executive Committee

Special meetings of the MEC may be called as necessary by the Chief of Staff whenever a quorum can convene.

12.3 CREDENTIALS/NOMINATING COMMITTEE

12.3(a) Composition

The Credentials Committee shall consist of at least four (4) Active Staff members, including at least one member from the Adult Medicine service, the Pediatrics/Obstetrics Service and the Surgery Service. The CEO or his designee may serve as an Ex-Officio member.

12.3(b) Functions

The functions of the Credentials Committee shall be to:

- (1) review and evaluate the qualifications, competence and performance of each applicant for Hospital Privileges, including locum tenens, Temporary Privileges and Allied Health Professionals;
- (2) make a recommendation to the MEC on each applicant for Medical Staff membership and/or Clinical Privileges, including terms of monitoring or proctoring for provisional appointments;
- (3) review every two (2) years applications for Staff and AHP reappointment; and make recommendations to the MEC on such applications; and
- (4) serve as the Nominating Committee and recommend a slate of nominees for the officers of the Medical Staff according to the provisions of Section 10.1(c).

12.3(c) Meetings

This committee shall meet at least quarterly or as required to perform its functions.

12.4 BYLAWS COMMITTEE

12.4(a) Composition: The Bylaws Committee shall consist of at least three (3) members of the Medical Staff, including one member each from the Adult Medicine, Pediatric/Obstetrics and Surgery services.

12.4(b) Functions:

- (i) Review the Bylaws and Rules and Regulations at least every two (2) years and, when necessary, propose revisions to reflect current practices.
- (ii) Act upon any proposals for revisions or amendments that may originate from the MEC, the Board, a service or committee or an Active Staff Member.

12.4(c) Meetings: This committee shall meet as required to perform its functions.

12.5 UTILIZATION REVIEW COMMITTEE

12.5(a) Composition: The Utilization Review Committee shall consist of members of the Staff representing the Adult Medicine, Pediatrics/Obstetrics and Surgery services of which at least two (2) must be Physicians. The Physician Advisor, as appointed by the CEO, shall serve as a voting member of the UR committee and may serve as its chair. The utilization review coordinator and representatives from administration, nursing and discharge planning as appointed by the CEO will serve as Ex-Officio members.

12.5(b) Functions:

- (i) Monitor and evaluate the appropriateness of admissions, lengths of stay, discharge practices, use of Hospital services and other related factors which may contribute to the effective use of the Hospital.
- (ii) Formulate a written utilization review plan for the Hospital, subject to approval by the MEC and the Board.

12.5(c) Meetings: This committee shall meet at least four (4) times a year and as required to perform its functions.

12.6 PUBLIC RELATIONS AND GRIEVANCE COMMITTEE

12.6(a) Composition: This committee shall consist of three (3) Staff Members.

12.6(b) Functions:

- (i) Receive, review and make recommendations to the MEC on all patient or public complaints filed with the committee against the Staff or any individual Member of the Staff; and
- (ii) Be responsible for publicity given to the news media regarding Medical Staff activities in areas of public interest.

12.6(c) Meetings: This committee shall meet as required to perform its functions.

12.7 PHARMACY AND THERAPEUTICS/ INFECTION CONTROL COMMITTEE

12.7(a) Composition: This committee shall consist of at least four (4) Staff members including one member from the Adult Medicine, Pediatrics/Obstetrics and Surgery services. The CEO shall appoint a pharmacist as an Ex-Officio member. The Infection Control Coordinator shall also serve as an Ex-Officio member, and in this case will be granted voting rights but on infection control issues only.

12.7(b) Functions:

- (i) Investigate and control nosocomial infections and monitor the Hospital's infection control program;
- (ii) Monitor appropriate and effective drug usage as well as quality assessment reports from the pharmacy;
- (iii) Monitor and review drug reactions, medication errors and investigational use of drugs in instances not covered by an Institutional Review Board;
- (iv) Monitor compliance with pharmacy policies and procedures;
- (v) Review blood usage; and
- (vi) Review the Hospital formulary annually.

12.7(c) Meetings: This committee shall meet at least six times per year or as required to perform its functions.

12.8 MEDICAL RECORDS COMMITTEE

12.8(a) Composition: This committee shall consist of three (3) Staff Members and a member of the Health Information Management Department appointed by the CEO as an Ex-Officio member.

12.8(b) Functions:

- (i) Evaluate adequacy and timely entry and completion of medical records;
- (ii) Review and approve forms that are used in the medical records;
- (iii) Supervise the procedure for determination of and notices regarding delinquent records to Members, AHPs and the MEC;

12.8(c) Meetings: This committee shall meet at least quarterly or as required to perform its functions.

12.9 INTENSIVE CARE UNIT (ICU) COMMITTEE

12.9(a) Composition: This committee shall consist of at least three (3) Members who shall be chosen to represent the services that admit patients to the ICU.

12.9(b) Functions: To function as an advisory committee for the ICU to enhance the performance of the unit and consider its needs, both current and future.

12.9(c) Meetings: This committee shall meet at least quarterly or as required to perform its functions.

ARTICLE XIII
MEETINGS

13.1 REGULAR STAFF MEETINGS

13.1(a) Meeting Time

The Medical Staff shall meet quarterly, generally on the second Monday of March, June, September and December. If the date, hour or place of a regular Staff meeting must be changed for any reason, the notice procedure in Section 13.3 shall be followed. The December meeting will be the Annual Medical Staff meeting.

13.1(b) Order of Business & Agenda

The order of business at a regular Staff meeting shall be determined by the Chief of Staff. Sturgis's Standard Code of Parliamentary Procedure shall be used to conduct the meeting. The agenda shall include:

- (1) accepting the minutes of the last regular and all special Staff meetings held since the last regular meeting;
- (2) administrative reports from the CEO, the Chief of Staff and service and committee chairs;
- (3) the announcement of the results of the election for officers of the Medical Staff;
- (4) recommendations for maintenance and improvement of patient care; and
- (5) other old or new business.

13.2 SPECIAL MEETINGS

13.2(a) Staff Meetings: Special meetings of the Medical Staff may be called at any time by the Board, the Chief of Staff, the MEC or shall be called within fourteen (14) days after the Chief of Staff receives a written request by any five (5) members of the Active Staff. Special meetings shall be held at the time and place designated in the meeting notice. No business shall be transacted at any special meeting unless stated in the meeting notice.

13.2(b) Service or Committee Meetings: Special meetings of committees or services may be called at any time by the Board, the Chief of Staff, or the MEC or shall be called within fourteen (14) days after the Chair receives a written request by any five (5) members of a service or two (2) members of a committee. Special meetings shall be held at the time and place designated in the meeting notice. No business shall be transacted at any special meeting unless stated in the meeting notice.

13.3 NOTICE OF MEETINGS

13.3(a) Staff Meetings: Regular Staff meetings will be announced by written notice including the agenda, time, date and hour of the meeting at least seven (7) days prior to the meeting. If a special meeting is called or the Secretary of the Staff shall give written notice stating the place, day and hour of the meeting, delivered either personally or by mail, to each person entitled to be present there not less

than five (5) days before the date of such meeting. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

13.3(b) Service and Committee Meetings: Notice of such meetings may be given orally. Personal attendance at a meeting shall constitute a waiver of such meeting. Whenever possible, seven (7) days advance notice will be given of the meeting.

13.4 QUORUM

13.4(a) General Staff Meeting

The presence of fifty percent (50%) of the members of the Active Staff in Good Standing shall constitute a quorum. A quorum must be present before any action may be taken, but once found, the business of the meeting may continue and all actions taken thereafter shall be binding, even though less than a quorum may be present at a later time during the meeting except for the amending of Bylaws where a quorum is required at the time of the vote. Written, signed proxies will not be permitted in any voting at any meeting.

13.4(b) Service and Committee Meetings

Two (2) Staff members shall constitute a quorum at any such meeting. Ex-Officio members shall not be counted in determining the presence of a quorum.

13.5 MANNER OF ACTION

Except as otherwise specified, (amending the Bylaws, removing an officer) the action of a majority of the Members present and voting at a meeting at which a quorum is present shall be the action of the group. Action may be taken without a meeting of the service or committee, if an unanimous consent in writing setting forth the action to be taken is signed by each member entitled to vote.

13.6 MINUTES

Complete and detailed minutes of all meetings shall be prepared by the secretary of the meeting or his designee and shall include a record of attendance and the vote taken on each matter. Copies of such minutes shall be signed by the presiding officer, approved by the attendees, and forwarded to the MEC. A permanent file of the minutes of each meeting shall be maintained by the CEO.

13.7 ATTENDANCE

13.7(a) Regular Attendance

Members of the Active Staff shall be required to attend at least fifty (50%) percent each of the Medical Staff, assigned service(s) and assigned committee meetings from which they have not been excused as provided in Section 13.7(b). Absence from fifty (50%) percent of these meetings for the year without acceptable excuses may be considered a resignation from the Active Staff.

13.7(b) Absence from Meetings

Any Member who is compelled to be absent from any Medical Staff, service or committee meeting shall promptly provide to the presiding officer thereof the reason for such absence. Unless excused for a good cause, failure to meet the attendance requirements of these Bylaws shall be grounds for

corrective action and removal from such service or committee unless the MEC finds the submitted reasons for the absences are valid and that the Staff Member has attended at least fifty percent (50%) of the meetings other than those for which valid reasons for absence were accepted. Reinstatement of a Staff Member whose membership has been so revoked shall be made only on application, and such application shall be processed in the same manner as an application for initial appointment.

13.7(c) Special Appearance

Any Staff committee or service may request the appearance of a Medical Staff Member or AHP at a meeting when the committee or service is questioning the provider's clinical course of treatment or considering initiating corrective action against the individual. Such special appearance requirement shall not be considered an adverse action and shall not constitute a hearing under these Bylaws. Fourteen (14) days advance Special Notice of the time and place of the meeting shall be given to the provider. Such notice shall include a statement of the issue involved and that the provider's appearance is mandatory. If the provider makes a timely request for postponement supported by an adequate showing of good cause, the presiding officer may grant postponement of the special appearance. Such postponement shall in no case be granted for a period longer than fifteen (15) days. Failure of a provider to appear at any meeting with respect to which he was given such Special Notice shall, unless excused by the MEC upon a showing of good cause, result in an automatic suspension of all or such portion of the provider's Clinical Privileges as the MEC may direct. Such suspension shall remain in effect until the matter is resolved by the MEC or the Board, or through corrective action, if necessary.

ARTICLE XIV
GENERAL PROVISIONS

14.1 RULES & REGULATIONS

14.1(a) Staff Rules and Regulations

Subject to approval by the Board, the Medical Staff shall adopt such Rules and Regulations necessary to implement more specifically the general principles found within these Bylaws. These shall relate to the proper conduct of Medical Staff activities as well as embody the level of practice that is required of each Staff Member or AHP granted Privileges in the Hospital. Such Rules and Regulations shall be considered a part of these Bylaws, except that they may be amended or repealed at any regular Staff meeting at which a quorum present without previous notice, or at any special meeting on notice, by a majority vote of those present and eligible to vote. Such changes shall become effective when approved by the Board. The Rules and Regulations shall be reviewed at least every two (2) years, and shall be revised as necessary to reflect changes in regulatory requirements, corporate and Hospital policies, and current practices with respect to Medical Staff organization and functions.

14.2(b) Service Rules and Regulations

Subject to approval by the MEC and Board, each service may formulate its own rules and regulations. Such rules and regulations shall not be inconsistent with the Bylaws or Hospital policies. The CEO shall maintain a file of current service rules and regulations. Any service rules and regulations must be reviewed by the service at least every two (2) years.

14.2 PROFESSIONAL LIABILITY INSURANCE

Physicians, Podiatrists, Physician Assistants and Nurse Anesthetists granted Clinical Privileges in the Hospital shall maintain in force professional liability insurance in an amount not less than \$200,000 per occurrence and \$600,000 in the aggregate given the certificate of insurance indicates that the provider is covered under the New Mexico Medical Malpractice Act. Dentists, Optometrists, Certified Nurse Midwives, Nurse Practitioners and other health care providers not covered under the Medical Malpractice Act shall be required to carry malpractice coverage no less than \$1,000,000/\$3,000,000. Staff Members and AHPs shall be responsible for advising the MEC and the CEO of any change in such professional liability coverage.

In the event the Medical Malpractice Act is repealed, the Board may raise the required insurance limits by giving the Medical Staff three (3) months written notice of the proposed change. The Staff shall be afforded the opportunity to convey to the Board its comments and suggestions regarding the proposed change. The Board shall, in good faith, consider the input of the Medical Staff prior to implementation of the change.

14.3 FORMS

Application forms and any other prescribed forms required by these Bylaws for use in connection with Staff appointments, reappointments, delineation of clinical privileges, corrective action, notices, recommendations, reports and other matters shall be developed by the CEO, after considering the advice of the MEC, and subject to approval by the Board. Such forms shall meet all applicable legal requirements, including non-discrimination requirements.

14.4 CONSTRUCTION OF TERMS & HEADINGS

The captions or headings in these Bylaws are for convenience and are not intended to limit or define the scope or effect of any provision.

14.5 TRANSMITTAL OF REPORTS

Reports which these Bylaws require the Medical Staff to transmit to the Board shall be deemed so transmitted when delivered to the CEO.

14.6 SUBSTANTIAL COMPLIANCE

Minor deviations from the procedures set forth in these Bylaws shall not be grounds for invalidating the action taken.

14.7 CONFIDENTIALITY & IMMUNITY STIPULATIONS & RELEASES

14.7(a) Reports to be Confidential

Information with respect to any health care provider, whether applicants, Staff Members or AHPs, submitted, collected or prepared by any Hospital Representative for purposes related to the achievement of quality care shall, to the fullest extent permitted by the law, be confidential and shall not be disseminated beyond those who need to know nor used in any way except as provided herein. Such confidentiality also shall apply to information of like kind provided by Third Parties.

14.7(b) Release from Liability

No Hospital Representative shall be liable to an individual for damages or other relief by reason of providing information, including otherwise privileged and confidential information [as delineated in the Release subsection of Section 6.3(c)], to another Hospital Representative or to any other health care facility or organization, concerning a provider who is or has been an applicant to or Member of the Staff, or who has exercised or applied for Clinical Privileges, provided such disclosure or representation is in good faith and without malice.

14.7(c) Action in Good Faith

No Hospital Representative shall be liable to a provider for damages or other relief for any action taken, statement or recommendation made within the scope of such Representative's duties, if such Representative acts in good faith and without malice after a reasonable effort to ascertain the facts and in a reasonable belief that the action, statement or recommendation is warranted by such facts. Truth shall be a defense in all circumstances.

ARTICLE XV
ADOPTION & AMENDMENT OF BYLAWS

15.1 DEVELOPMENT

The Medical Staff shall have the initial responsibility to formulate, adopt and recommend to the Board the Medical Staff Bylaws and amendments thereto which shall become effective when approved by the Board. The Medical Staff shall exercise its responsibility in a reasonable, timely and responsible manner, reflecting the interest of providing patient care of recognized quality and efficiency and of maintaining a harmony of purpose and effort with the Hospital, the Board, and the community. Neither the Medical Staff nor the Board may unilaterally amend the Medical Staff Bylaws or the Rules and Regulations.

15.2 ADOPTION, AMENDMENT & REVIEWS

The Bylaws shall be reviewed and revised as needed, but at least every two (2) years. When necessary, the Bylaws and Rules and Regulations will be revised to reflect changes in regulatory requirements, corporate or Hospital policies, and current practices with respect to Medical Staff organization and functions.

15.2(a) Medical Staff

The Medical Staff Bylaws may be adopted, amended or repealed by approval of at least two-thirds of the voting Active Staff Members who are present at a meeting at which a quorum is present, provided at least five (5) days written notice, accompanied by the proposed Bylaws and/or amendments, has been given of the intention to take such action.

15.2(b) Board

Changes to the Medical Staff Bylaws must be approved by the affirmative vote of two-thirds of the Board.

15.3 DOCUMENTATION & DISTRIBUTION OF AMENDMENTS

Approved amendments to these Bylaws shall be documented by either:

- 15.4(a) appending to these Bylaws the approved amendment, which shall be dated and signed by the Chief of Staff, the CEO, the Board Chair and approved by corporate legal counsel as to form; or
- 15.4(b) restating the Bylaws, incorporating the approved amendments and all prior approved amendments which have been appended to these Bylaws since their last restatement, which shall be dated and signed by the Chief of Staff, the CEO and the Board Chair and approved by corporate legal counsel as to form.

Each Staff Member and Allied Health Practitioner with Hospital Privileges shall be given a copy of all significant amendments (such determination to be made by the Bylaws Committee) to the Bylaws or Rules and Regulations in a timely manner.

**MEDICAL STAFF BYLAWS
ADOPTED & APPROVED:**

MEDICAL STAFF:

By: _____
Chief of Staff

_____ Date

BOARD OF TRUSTEES:

By: _____
Chairperson

_____ Date

LOS ALAMOS MEDICAL CENTER:

By: _____
Chief Executive Officer

_____ Date

APPROVED AS TO FORM:

By: _____
Legal Counsel for PHC-Los Alamos, Inc.

_____ Date