# SENECA HEALTHCARE DISTRICT

# Medical Staff Rules

## 2023

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| **Medical Chief of Staff** | | |
| **Governing Board** | | |
| | *Signature* | *Date* |

**POLICY NUMBER REFERENCE: MDSTF-00C.2016**

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# SENECA HEALTHCARE DISTRICT

## MEDICAL STAFF RULES

## 2016

### PREAMBLE/DEFINITIONS

**A.** These Rules are intended to provide for the operation and governance of the Medical Staff in accordance with the guidance and structure set forth in the Medical Staff Bylaws ("Bylaws"). Inthe event of any conflict between the Bylaws and the Rules, the Medical Staff Bylaws shall prevail.

**B.** All Rules contained herein have been recommended by the voting members of the Medical Executive Committee of the Whole of the Hospital and approved by the Governing Body in accordance with Section 14.01 of the Medical Staff Bylaws. These Rules are incorporated by reference and are a part of those Bylaws, carrying with them the Bylaws' force and effect.

C. These Rules are organized in general to correspond to the parallel article of the Medical Staff Bylawsthat addresses the same issue (however, the section numbers may not be identical).

**D.** All definitions contained in the Bylaws are incorporated in these Rules.

## Rule I SENECA HEALTHCARE DISTRICT

(Reserved)1

1 Rules relating to this Article of the Bylaws may be adopted and inserted as needed, in accordance with the provisions for adoption of Medical Staff Rules.

## Rule II MEDICAL STAFF MEMBERSHIP

## STANDARDS OF CONDUCT

### RULE II-1 Purpose

The purpose of this Rule is to clarify the provisions of Section 2.05 of the Medical Staff Bylaws, regarding expectations of all Practitioners during any and all interactions with persons at the Hospital, whether such persons are colleagues, other health care professionals, Hospital employees, patients and/or other individuals. This Rule is intended to address conduct, which does not meet the professional standards expected of Medical Staff members. In dealing with incidents of inappropriate conduct, the protection of patients, employees, Practitioners and other persons at the hospital is the primary concern. In addition, the well-being of a Practitioner whose conduct is in question is also of concern, as is the orderly operation of the hospital.

### RULE II-2 Examples of Inappropriate Conduct

Examples of common inappropriate conduct include, but are not limited to, the following:

Rule II-2.1 Verbal abuse: Verbal abuse is usually in the form of vulgar, profane or demeaning language, screaming, sarcasm or criticism directed at an individual, having the intent or effect of lowering the recipient's reputation or self-esteem. Itis often intimidating to the recipient, and often causes the recipient or others around him or her to become ineffective in performing their responsibilities (e.g., the individuals become afraid or unwilling question or to communicate concerns, or to notify or involve either the involved Practitioner or others when problems occur).·This kind of conduct becomes disruptive at the point where it reaches beyond the bounds of fair professional comment or where it seriously impinges on staff morale.

Rule II-2.2 Non-communication: Refusal to communicate with responsible persons can be extremely disruptive in the patient care setting. This kind of behavior often results from individual fighting or feuding, or lack of trust. It becomes disruptive at the point where important information should be communicated, but is not. Closely related are incomplete or ambiguous communications. This becomes disruptive when it diverts patient care resources into having to devote substantial and unnecessary time obtaining follow-up clarification.

Rule II-2.3 Refusal to return calls: Refusing to return telephone calls from the Hospital staff can be another form of the problem. Often this type of behavior is a result of what a Practitioner feels are repeated, inappropriate phone calls from the Hospital's staff. However, unless a phone call is returned, the Practitioner cannot know the urgency of the matter. The problem becomes disruptive at the point where patient care is placed in unnecessary jeopardy, or when matters that were not initially urgent, and needn't have become urgent, become so as a result of a refusal to return calls.

Rule II-2.4 Inappropriate communication: It is inappropriate to criticize the Hospital, its staff, or professional peers outside of official problem-solving and peer review channels. This includes written or verbal derogatory statements to an inappropriate audience, such as patients and families, or statements placed in the medical records of patients. These kinds of communications indiscriminately undermine morale and reputation of the Hospital and its staff, and contribute to inaccurate perceptions of Hospital quality.

Rule II-2.5 Failure to comply: Failure to comply with the Bylaws, policies and procedures of the Medical Staff and the Hospital can be inadvertent, or it can be willful. Willful failure to comply -i.e., refusal to comply -with rules becomes disruptive at the point it places the Medical Staff or the Hospital in jeopardy with respect to licensing or accreditation requirements, complying with other applicable laws, or meeting other specific obligations to patients, potential patients and Hospital staff. Specific examples include:

a. Refusing to provide information or otherwise cooperate in the peer review process (e.g., refusing to meet with responsible committee members, refusing to answer reasonable questions relevant to the evaluation of patient care rendered in the Hospital, especially when coupled with an attitude that the responsible committee has no right to be questioning or examining the matter at hand).

b. Refusing to provide information necessary to process the Hospital's or a patient's paperwork. The Hospital, its patients and their families have a right to expect timely and thorough compliance with all requirements of the Hospital, third party payors, regulators, etc., as necessary to assure smooth functioning of the Hospital and that patients receive the benefits to which they are entitled.

c. Violating confidentiality rules -e.g., disclosing confidential peer review information outside the confines of the formal peer review process. This has the effect of undermining the peer review process, and jeopardizing important protections that often serve as inducements to assuring ongoing willingness to participate in peer review activities.

d. Refusing to comply with established protocols and standards, including but not limited to utilization review standards. Here, it is recognized that from time to time established protocols and standards may not adequately address a particular circumstance, and deviation is necessary in the best interests of patient care. However, in such circumstances, the member will be expected to account for the deviation, and in appropriate circumstances, to work cooperatively and constructively toward any necessary refinements of protocol or standards so as to avoid unnecessary problems in the future.

e. Refusing to participate in or meet Medical Staff obligations can be disruptive when it reaches the point the individual's refusal obstructs or significantly impairs the ability of the Medical Staff to perform its delegated responsibilities -all of which, in the final analysis, are aimed at facilitating quality patient care.

f. Repeatedly abusing or ignoring scheduling policies, or reporting late for scheduled appointments, surgeries, and treatments, resulting in unnecessary delays in or hurrying of patient care services being rendered to any patient of the facility.

g. Sexual harassment -unwelcome comments or contacts of a sexual nature or characterized by sexual overtones, whether overt or covert, are both illegal and disruptive.

Rule II-2.6 Physical abuse: Offensive or nonconsensual physical contact would generally be deemed disruptive, as would intentional damage to Hospital premises or equipment.

Rule II-2.7 Threatening behavior: Threats to another's employment or position, or otherwise designed to intimidate a person from performing his or her designated responsibilities or interfering with his or her well-being are generally disruptive. Examples include threats of litigation against peer review participants or against persons who report concerns in accordance with established reporting channels, and threats to another's physical or emotional safety or property.

Rule II-2.8 Combative behavior: Combative behavior refers to that which is constantly challenging, verbally or physically, legitimate and generally recognized authority or generally recognized lines of professional interaction and communication. It becomes disruptive at the point it results in an inability to acknowledge or to deliver constructive comments and criticism.

Rule II-3 Procedures

Rule II-3.1 Reporting: Any person may report potentially disruptive conduct in accordance with the Hospital's usual reporting procedures. The Medical Staff office or other appropriate recipient of a disruptive conduct complaint shall submit each report to the Chief of Staff and Chief Executive Officer for investigation. The Chief of Staff and Chief Executive Officer may agree to delegate the investigation and any action to an appropriate committee. The Chief of Staff and Chief Executive Officer may agree to consult with the Hospital's Human Resources department or other consultant as appropriate.

Rule II-3.2 Investigation

a. The Chief of Staff and Chief Executive Officer, or designated committee, shall ensure appropriate documentation of each incident of disruptive conduct is acquired in order to facilitate the investigation process. Such documentation should include:

1. Date and time of the reported disruptive behavior.

2. A statement by the reporting individual of whether the behavior involved a patient in any way, and, if so, information identifying the patient involved.

3. The reporter's account of the circumstances that precipitated the situation.

4. A factual and objective description of the reported disruptive behavior.

5. To the extent known to the reporter, the consequences, if any, of the disruptive behavior as it relates to patient care or Hospital operations.

6. A record of any action taken to address the situation, prior to the Medical Staff's investigation as required by the Code of Conduct, including the date, time, place, action and name(s) of those taking such an action.

b. The Chief of Staff and Chief Executive Officer, or designated committee, shall conduct an appropriate investigation for each matter reported.

c. If the report of inappropriate conduct is anonymous, then, the Chief of Staff and Chief Executive Officer, or designated committee, shall exercise discretion as to whether or not to investigate the matter.

d. The investigation shall take place within 14calendar days from receipt of a report of inappropriate conduct.

Rule II-3.3 Action

a. Unfounded Report: Based on the investigation, the Chief of Staff, Chief Executive Officer, or designee shall dismiss any unfounded report by providing a written explanation of the evidence supporting this conclusion. The report shall be maintained in the Medical Staff member's file with the original complaint. The individual who initiated the report of the decision shall be notified of the decision.

b. Confirmed Report:A confirmed report will be addressed as follows: The Chief of Staff and Chief Executive Officer, or designee, shall consider a number of variables to determine how best to address each incident of disruptive behavior. These variable shall include, but not be limited to:

1. Degree of disruptiveness

2. Number of incidents (i.e., pattern of disruptive behavior over time)

3. Length of time between incidents of disruptive behavior, if multiple incidents have occurred.

c. Plan for Addressing Disruptive Behavior: Relying on the variables described above as well as the overall intent of Section 2.05 of the Medical Staff Bylaws, the Chief of Staff, and Chief Executive Officer, or the designated committee, shall document a plan for addressing the disruptive behavior. The copy of the plan shall be included in the individual's file. The plan shall include item (1) below and may include any portion or all of items (2) and (3) below;

1. The Chief Executive Officer, or designee, shall send a letter to the offending individual that describes the inappropriate conduct, explains the behavior is in violation of Section 2.05 of the Medical Staff Bylaws, notes any patient care or Hospital operations implications, explains why the behavior in question is inappropriate , encourages the individual to be more thoughtful or careful in the future, invites the individual to respond , and makes clear that attempts to confront, intimidate, or otherwise retaliate against the individuals who reported the behavior in question is a violation of this Rule and grounds for further disciplinary action. A copy of Section 2.05 of the Bylaws and this Rule should be included with the letter. Documentation of both the letter and the individual's response should be included in the individual's file.

2. The Chief of Staff, Chief Executive Officer or the designated committee, and any other number of appropriate participants from the Medical Staff and Board, shall initiate a discussion with the offending individual to discuss the inappropriateness of their behavior and require such behavior cease. A copy of Section 2.05 of the Medical Staff Bylaws and this Rule may be hand delivered to the offending individual and he or she should be advised the Medical Staff requires compliance with the Bylaws . Each individual or a designated member of a group, (if the group meets with the offending individual), shall send a follow-up letter

documenting the content of the discussion and any specific actions the offending individual has agreed to perform. The offending individual should be invited to respond. This letter and any response will be included in the individual's file.

3. The plan may incorporate additional components, including, but not limited to:

    i. Warning the offending individual that failure to abide by the terms of the Standards of Conduct shall be grounds for disciplinary action, including but not limited to suspension and/or actual termination of Medical Staff membership.

    ii. Notifying one or all of the following individuals of the member's disruptive behavior and any relevant history relating to the member: Chief of Staff, Medical Executive Officers Committee and Chief Executive Officer.

    iii. Requiring the offending individual to agree to specific corrective actions aimed at eliminating that individual's disruptive behavior. Suggested actions are counseling, leave of absence, written apologies, courses or programs specific to the behavior trait (i.e., anger management), or requiring the offending individual to sign a behavior modification contract. The Chief of Staff, Chief Executive Officer or designated committee shall document any corrective action and require the offending individual to sign his or her acceptance of this plan. The plan may clearly delineate the consequences for the offending individual not successfully completing the agreed upon corrective action.

    iv. In appropriate circumstances, the plan may provide for immediate suspension and/or action to terminate Medical Staff membership without need of further warning or counseling.

Rule II-3.4 Final Warning: If the Chief of Staff, Chief Executive Officer, or designated committee determines the plan has been unsuccessful, the Medical Executive Officers Committee shall be informed in writing of the offending individual's disruptive behavior, including any relevant history regarding this behavior, and advise the Medical Executive Officers Committee to proceed with a final warning. If the Medical Executive Officers Committee determines the offending individual deserves a final warning, the Medical Executive Officers Committee Chair/designee (or the Chief of Staff/designee or CEO/designee) shall meet with and advise the offending individual that the disruptive behavior in question is intolerable and must stop. The Chief of Staff/designee or CEO/designee will inform the individual that a single recurrence of disruptive behavior shall be sufficient cause to result in his/her suspension and/or termination of Medical Staff membership.
This meeting shall not be a discussion, but rather will constitute the offending individual's final warning. The offender will also receive a follow-up letter that reiterates the final warning and the consequence of suspension and possible termination of Medical Staff membership and privileges.

Rule II-3.5 Suspension: If after the final warning the offending individual engages in disruptive behavior that is deemed to require intervention, the individual's Medical Staff membership and privileges shall be subject to suspension consistent with the terms of the Medical Staff Bylaws and policies and procedures. Additional action may also be taken at this time. Action may be taken to revoke the individual's membership and privileges. The individual may also be found ineligible to reapply to the Medical Staff for a period of at least two years.

Rule II-3.6 Consequences of a Member's Failure to Comply with the Standards of Conduct: Members who do not act in accordance with the Standards of Conduct shall be subject to corrective action and/or disciplinary action, up to and including termination of membership and privileges, pursuant to the Bylaws. Any recommendation to restrict, or restriction of Member's membership or privileges shall entitle the member to hearing procedures set forth in the Bylaws.

## Rule III CATEGORIES OF MEDICAL STAFF MEMBERSHIP

### Rule III-1 Provisional Staff

a. The Provisional Staff shall consist of Practitioners who are newly appointed to the Medical Staff and who intend to admit/attend at least 6 in-patients per year. Except for Consulting and Telemedicine Consulting Staff appointments, or as otherwise determined by the Governing Body, all initial appointments to the Staff shall be to the Provisional category. Provisional members are expected to attend Staff meetings as required under Rule VIIl-2.1, and they may serve on Staff committees but may not vote. They may not vote at any general or special meeting of the Staff. A Provisional member may not serve as a general Staff officer or a committee chairperson. Provisional Staff members need not pay dues during their initial term of appointment but they must pay the Medical Staff application fee and they must pay dues (as applicable), as set by Rule XIV-2, upon reappointment to the Provisional Staff for a second one-year term.

b. Each Provisional member shall be proctored in accordance with proctoring requirements established by the Credentials Committee in accordance with the provisions of Rule V-4. A member remains in Provisional status until he/she meets all the qualifications and has successfully completed his/her proctoring program. Provisional appointments are for not less than three months, and a member may serve no more than two consecutive one-year terms as a Provisional Staff member. The Credentials Committee shall certify satisfactory completion of the Provisional period to the Medical Executive Committee of the Whole and the Chief Executive Officer.

### Rule III-2 Active Staff

The Active Staff shall be composed of Practitioners who utilize the Hospital on a regular basis, intend to admit I attend at least 6 in-patients per year, and who have completed their Provisional Staff term(s) satisfactorily. Active Staff members may vote on all matters presented at general and special Staff meetings, are expected to attend meetings as required under Rule Vill-2.1, and may hold office in the Staff organization and committees, except that limited license members shall only have the right to hold office or vote on matters within the scope of their licensure. In the event of a dispute over a limited license member's right to vote or hold office, the issue shall be determined by the chairperson of the meeting, subject to final decision by the Medical Executive Committee of the Whole. Active Staff members must pay dues as set by Rule XIV-2.

### Rule III-3 Consulting Staff

The Consulting Staff shall consist of Practitioners who possess ability and knowledge so as to constitute an important adjunct in the care of difficult cases. Consulting Staff members shall be members of the Active or Provisional Medical Staff of another licensed hospital (in or out of state), although exceptions to this requirement may be made by the Medical Executive Committee of the Whole for good cause. Consulting Staff members may not admit patients to the Hospital. A Consulting Staff member may (but is not required to) attend general Staff meetings or committee meetings. Consulting Staff members are not eligible to vote or hold office in the Medical Staff organization, but may chair or serve on committees and are required to pay dues.

### Rule III-4 Courtesy Staff

The Courtesy Staff shall consist of Practitioners who intend to admit/attend fewer than 6 in-patients per year, and who are members of the Medical Staff of or physicians-in-training at another accredited hospital where such physician is subject to a patient care audit program and other quality maintenance activities similar to those required by this Hospital. A Courtesy Staff member may (but is not required to) attend general Staff meetings or committee meetings. Courtesy Staff members are not eligible to vote or to hold office in the Medical Staff organization or the committees, but Courtesy members must pay dues as set by Rule XIV-2.

### Rule III-5 Clinic Staff

The Clinic Staff shall be composed of Practitioners who primarily utilize the Clinic, but may admit/attend a limited number of inpatients and skilled nursing residents. Clinic Staff members may vote on all matters

presented at general and specific meetings, are expected to attend meetings as required by Rule VIII-2.1, and may hold office in the Staff organization and committees. Clinic Staff members must pay dues as set by Rule XIV-2.

Rule III-6 Telemedicine Consulting Staff

Rule III-6.1 Definitions

a. Distant Site is the location at which the telemedicine equipment is located and from which the Telemedicine Consulting Staff member delivers his/her patient care.

b. Originating Site is the location at which the patient is located.

c. Telemedicine Consulting Staff member is the individual provider who uses the telemedicine equipment at the Distant Site to render services to patients who are located at the Originating Site. The Telemedicine Consulting Staff member is generally a physician, but other health professionals may also be involved as telemedicine providers. The telemedicine provider would generally contract with (or in the case of nonphysicians, be employed by) the entity that serves as the Distant Site.

Rule III-6.2 Prerogatives and Limitations

The Telemedicine Consulting Staff shall consist of Practitioners who are not otherwise members of the Medical Staff but who participate in telemedicine interactions involving Hospital patients. Generally, telemedicine interactions are defined as interactive (involving real time [synchronous] or near real time [asynchronous] two-way transfer of medical data and information) audio, video, or data communications, and may include consultations, diagnosis, treatment, transfer of medical data and medical education. Telemedicine interactions exclude interactions in which the patient is not directly involved, such as informal consultations between Practitioners, as well as telephone or electronic mail communications between Practitioner and patient Telemedicine Consulting Staff members may not give orders, and may not admit patients to the Hospital or have ultimate authority over the care or primary diagnosis of a Hospital patient. Telemedicine Consulting Staff members may serve upon committees with or without vote and the discretion of the Medical Executive Committee of the Whole, and they may attend Medical Staff meetings, including open committee meetings and educational programs. Telemedicine Affiliate members must pay dues as set by Rule XIV-2.

Rule III-6.3 Responsibilities

a. There is a need for clear delineation of reporting responsibilities respecting telemedicine providers' performance. At very least, the Medical Staff officials at the Hospital must be informed of any Practitioner-specific problems that arise in the delivery of services to the Hospital's patients.

b. Additionally, the Hospital should communicate to the Medical Staff officials at the Distant Site, through peer review channels, any problems that may arise in the delivery of care by the Telemedicine Consulting Staff member to patients and the Hospital.

c. Similarly, when a member of the Hospital's Medical Staff is providing telemedicine services to patients at another facility, the Hospital's Medical Staff should communicate to the medical staff officials at the Originating Site, through peer review channels, any problems that may arise in the delivery of telemedicine services by members of this Hospital's Medical Staff.

d. The Chief of Staff may enter into appropriate information sharing agreements and/or develop and implement appropriate protocols to effectuate these provisions.

Rule III-6.4 Responsibility to Review Practitioner Specific Performance

a. Special proctoring arrangements may be made for qualified Practitioners at the Distant Site to proctor cases performed by new members of the Telemedicine Consulting Staff.

b. Primary responsibility to assess what, if any, Practitioner-specific performance improvement and/or remedial action may be warranted rests with the Originating Site. Ifsuch action gives rise to procedural rights at the Hospital, the provisions of Article XII of the Bylaws will apply.

c. However, the Medical Staff of this Hospital is authorized to develop integrated peer review policies and procedures with other hospitals whereby representatives of both the Originating and the Distant Sites' Medical Staff engage in integrated review and recommendation.

Rule III-7 Inactive Staff

a. Any Active or Courtesy Staff member having to discontinue practice at this Hospital for a stated period of time of one year or more, and for a stated purpose, may apply for Inactive Staff status. There shall, however, be no right to Inactive Staff status; any such decision shall be solely within the discretion of the Medical Executive Committee of the Whole and the Governing Body, and there are no procedural rights associated with a denial of a request for Inactive Staff status. During Inactive Staff status, the member may not admit patients, exercise Clinical Privileges, or exercise other prerogatives of Medical Staff membership. Inactive status is not intended as a mechanism for averting Medical Staff peer review action. Inactive Staff members are not required to pay dues.

b. Upon return of an Inactive Staff member to active practice in this area, he/she may be eligible for reinstatement to the same Staff category he/she held immediately prior to his/her Inactive status; however, he/she shall then complete an application for reappointment and his/her application will be processed in the same manner as described in Rule IV-2.3. Pending processing of the reappointment application, the member may request Temporary Privileges in accordance with Rule V-1.

Rule III.8 Medical Director Administrator

The Medical Director Administrator staff member shall have clinical privileges for roles and responsibilities designated through the Medical.Executive Committee. These may include clinical privileges, voting, holding office, serving on committees, Committee chair, Medical Staff Functions, attending meetinga, paying dues, any application fees and Malpractice Insurance.

a.

Rule IV APPOINTMENT AND REAPPOINTMENT

Rule IV-1 Appointment

Rule IV-1.1 Application Form

The application shall include a statement of agreement to abide by the Medical Staff Bylaws and Rules, and such lawful and reasonable requirements imposed by the Hospital. The application shall also include statements regarding the applicant's involvement in any professional liability actions (including but not limited to all final judgments or settlements involving the applicant), previously successful or currently pending challenges to any licensure or registration or the voluntary relinquishment of such licensure or registration, voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary limitation, reduction, or loss of Clinical Privileges while under investigation or disciplinary action at another hospital, health facility, or healthcare entity, and information detailing any prior (within the preceding five years) or pending government agency or third party payer investigation, proceeding, or litigation challenging or sanctioning the Practitioner's patient admission, treatment, discharge, charging, collection, or utilization practices, including but not limited to Medicare or Medi-Cal fraud and abuse proceedings or convictions. The application form shall also contain a confidential inquiry regarding the applicant's health sufficient to enable the Hospital to determine whether the Practitioner is able to perform all of the responsibilities of Medical Staff membership, or whether reasonable accommodation will be needed to facilitate such performance (together with a general description of the nature of the accommodation that may be needed). The application shall also release all persons and entities from any liability that might arise from their investigating and/or acting on the application. Additionally, the Practitioner shall provide the names and addresses of professional peers who are able to attest to the Practitioner's relevant qualifications.

Rule IV-1.2 Processing the Application

a. Applicant's Burden: The applicant shall have the burden of producing adequate information for a proper evaluation of his/her experience, background, training, demonstrated ability, and, upon request of the Medical Executive Committee of the Whole or of the Governing Body, physical and mental health status (as evidenced by the results of a physical or mental examination conducted by a Practitioner acceptable to the Medical Executive Committee), and ofresolving any doubts about these or any of the other qualifications specified in these Bylaws. The provision of information containing significant misrepresentations or omissions and/or a failure to sustain the burden of producing information shall be grounds for denying an application or request.

b. Complete Applications: The applicant shall fill out and deliver an application form to the Medical Staff Secretary. The application will not be deemed complete until all necessary information has been provided and verifications have been obtained, including current license, specialty board certification status, licensing board disciplinary records, National Practitioner Data Bank information, DEA certificate (if appropriate), verification of all practice from professional school through the present, as well as verification of board certification/qualification status, current malpractice liability insurance, reference letters and proof of continuing education.

    1. Board certification may be confirmed by the listings in the Official ABMS Directory of Board Certified Medical Specialists, published by the American Board of Medical Specialists, or through such other means as the Medical Executive Committee of the Whole determines to be a reasonably reliable source of current information as to Board status. Ifthe applicant uses the phrase "board qualified" or "board eligible" (or other comparable phrasing to indicate the applicant has completed the prerequisites to taking his/her board certification examination), such status shall be confirmed by a letter or diploma from the relevant ABMS specialty board.

    2. Efforts shall be made to obtain letters addressing the following specific aspects of current competence:

        i. For applicants in fields doing operative or other invasive procedures, the number and types of operative procedures performed as the surgeon of record, the handling of complicated deliveries, or the skill demonstrated in performing invasive procedures, including information on appropriateness and outcomes. In the case of applicants in non- surgical fields, the types and outcomes of medical conditions managed by the applicant as responsible physician should be addressed.

        ii. The applicant's clinical judgment and technical skills.

c. Obtaining Information

    1. The application shall request information pertaining to the condition of the applicant's physical and mental health on a separate page of the form, which can be removed from the remaining application and processed separately. Upon receipt of the application, the page addressing physical and mental disabilities shall be removed and referred to the Physician Well-Being Committee.

    2. When the Medical Staff office verifies information and obtains references, it shall ask for any information concerning physical or mental disabilities to be reported on a confidential form, which can be processed separately from the other information obtained regarding the applicant. This information will also be referred to the Physician Well-Being Committee.

    3. The Physician Well-Being Committee shall be responsible for investigating any Practitioner who has or may have a physical or mental disability that might affect the Practitioner's ability to exercise his or her requested privileges in a manner that meets the Hospital and Medical Staff's quality of care standards. This may include one or all of the following:

i. Medical Examination : To ascertain whether the Practitioner has a physical or mental disability that might interfere with his or her ability to provide care, which meets the Hospital and Medical Staff's quality of care standards.

ii. Interview: To ascertain the condition of the Practitioner and to assess if and how reasonable accommodations can be made.

4. Any Practitioner who feels limited or challenged in any way by a qualified mental or physical disability in exercising his or her Clinical Privileges and in meeting quality of care standards should make such limitation immediately known to the Physician Well-Being Committee. Any such disclosure will be treated with the high degree of confidentiality that attaches to the Medical Staffs peer review activities.

d. Review and Reasonable Accommodations

1. Any Practitioner who discloses or manifests a qualified physical or mental disability will have his or her application processed in the usual manner without reference to the condition.

2. The Physician Well-Being Committee shall not disclose any information regarding any Practitioner's qualified physical or mental disability until the Medical Executive Committee of the Whole (or, in the case of Temporary Privileges, the Medical Staff representatives who review Temporary privilege requests) have determined the Practitioner is otherwise qualified for membership and/or to exercise the privileges requested. Once the determination is made that the Practitioner is otherwise qualified, the Physician Well-Being Committee may disclose information it has regarding any physical or mental disabilities and the effect of those on the Practitioner's application for membership and privileges. Any such disclosure shall be limited as necessary to protect the Practitioner's right to confidentiality of health information, while at the same time communicating sufficient information to permit the Medical Executive Committee of the Whole to evaluate what, if any, accommodations may be necessary and feasible. The Physician Well-Being Committee and any other appropriate committees may meet with the Practitioner to discuss if and how reasonable accommodations can be made.

3. As required by law, the Medical Staff and Hospital will attempt to provide reasonable accommodations to a Practitioner with known physical or mental disabilities, if the Practitioner is otherwise qualified and can perform the essential functions of the staff appointment and privileges in a manner, which meets the Hospital and, Medical Staff quality of care standards. If reasonable accommodations are not possible under the standards set forth herein, it may be necessary to withdraw or modify a Practitioner's privileges and the Practitioner shall have the hearing and appellate review rights described in Article XII of the Bylaws.

4. Once it is deemed complete, the application and all supporting materials (when applicable) shall be transmitted to the Credentials Committee.

e. Incomplete Application:

1. An application shall be deemed incomplete if:

i. The applicant is unable to document satisfaction of the general requirements set forth at Section 2.02-1 of the Bylaws. In this case, the application need not be further processed.

ii. All of the information has not been verified, or if all necessary references have not been received, or ifthe application is otherwise incomplete in any material respect. In this case, transmission of the application to appropriate committees may be delayed, or only the available information may be transmitted with an indication that further information will be forwarded upon receipt. (Transmitting an incomplete application shall not be deemed a waiver of any requirements for a complete application.)

2. If processing of the application is delayed for more than 60 days due to incompleteness, and if the missing information is reasonably deemed significant to a fair determination of the applicant's qualifications, the applicant shall be so informed. He/She shall then be given the opportunity to withdraw his/her application, or to request the continued processing of his/her application, as follows:

    i. The applicant may affirmatively request, inwriting, that his/her application be withdrawn. Additionally, if the applicant does not respond within 30 days, he/she shall be deemed to have voluntarily withdrawn his/her application.

    ii. The applicant may request, in writing, that he/she be given additional time (up to 45 days) to provide or arrange the provision of the needed information, or that the application be processed without that information.

    iii. If the applicant requests additional time, but then fails to provide or arrange for the provision (within 45 days or any other mutually agreed upon date) of the necessary information the applicant could have provided or caused to be provided using reasonable diligence, the applicant shall be deemed to havevoluntarily withdrawn his/her application.

    iv. An applicant who requests the information be processed without the complete information, or who is otherwise unable to provide or arrange for the provision of all required information, is nonetheless subject to the general provisions of Bylaws Section 2.02-1, and to all other requirements of these Bylaws.

3. Any procedural rights shall be limited to those specified in Article XIl of the Bylaws; there shall be no Article XII procedural rights associated with an incomplete application.

f. Credentials Committee Action: The Credentials committee shall review the application, the supporting documentation and such other information available to it that may be relevant. The Credentials Committee may choose to conduct a personal interview with each applicant. It shall then provide to the Medical Executive Committee of the Whole a written report and recommendations, as well as any minority report, as to Staff appointment and Clinical Privileges.

g. Medical Executive Committee of the Whole Action: At its next regular meeting after receipt of the Credentials Committee report and recommendations, the Medical Executive Committee of the Whole shall consider all relevant information available to it. The Medical Executive Committee of the Whole shall then formulate a preliminary recommendation . Ifthe preliminary recommendation is favorable, the Medical Executive Committee of the Whole shall then assess the applicant's health status, determine whether the applicant is able to perform, with or without reasonable accommodation, the necessary functions of a member of the Medical Staff, and forward to the Governing Body, through the Chief Executive Officer or his/her designee, a written report and recommendations as to Staff appointment, Clinical Privileges to be granted, and any special conditions to be attached to the appointment.

    1. Favorable Recommendation: When the recommendation is favorable, the Chief Executive Officer shall promptly forward it to the Governing Body together with the application form and its accompanying information and the reports (including any minority reports) and recommendations of the Medical Executive Committee of the Whole as to Staff appointment, Clinical Privileges to be granted, and any special conditions to be attached to the appointment.

    2. Adverse Recommendation: When the recommendation is adverse, the Chief Executive Officer shall immediately inform the Practitioner by Special Notice, and he/she shall be entitled to the procedural rights as provided in Article XII of the Bylaws. The Governing Body shall be generally informed of, but shall not receive detailed information and shall not take action on the pending recommendation, until the applicant has exhausted or waived his/her procedural rights.

For the purposes of this Rule, an "adverse recommendation" by the Medical Executive Committee of the Whole is as defined in Section 12.04-2 of the Bylaws. A "minority report" is a dissenting opinion on the recommendation, together with the reasons for the dissent.

h. Deferral: The Credentials Committee or the Medical Executive Committee of the Whole may defer its recommendation in order to obtain or clarify information, or in other special circumstances. A deferral must be followed up within 60 days of receipt of information with a subsequent recommendation for appointment and Privileges, or for rejection for Staff membership.

i. Governing Body Action:

1. On Favorable Medical Executive Committee of the Whole Recommendation : The Governing Body shall adopt, reject, or modify a favorable recommendation of the Medical Executive Committee of the Whole, or shall refer the recommendation back to the Medical Executive Committee of the Whole for further consideration, stating the reasons for the referral and setting a time limit within which the Medical Executive Committee of the Whole shall respond. If the Governing Body's action is adverse to the applicant, the conflict resolution procedures described in Rule IV-1.2 (j), below, shall be implemented . Thereafter, if the Governing Body's recommendation remains adverse, the Chief Executive Officer shall promptly inform the applicant by Special Notice, and be/she shall be entitled to the procedural rights as provided in Article XII of the Bylaws.

2. Without Benefit of Medical Executive Committee of the Whole Recommendation: Ifthe Governing Body does not receive a Medical Executive Committee of the Whole recommendation within the time period specified in Rule IV-1.2 (1), the Governing Body may take action or tentative action as follows: Ifsuch action is favorable, it shall become effective as the final decision of the Governing Body. Ifsuch action would be adverse, the conflict resolution procedures described in Rule IV-1.2 (j), below, shall be implemented. Thereafter, if the Governing Body's recommendation remains adverse, the Chief Executive Officer shall promptly inform the applicant by Special Notice, and he/she shall be entitled to the procedural rights as provided in Article XII of the Bylaws.

3. After Procedural Rights: In the case of an adverse Medical Executive Committee of the Whole recommendation pursuant to Rule IV-1.2 (g) (2) or an adverse Governing Body decision pursuant to Section Rule IV-1.2 (i) (1) or (2), the Governing Body shall take final action inthe matter only after the applicant has exhausted or has waived his/her procedural rights as provided in Article XII of the Bylaws. Action thus taken shall be the conclusive decision of the Governing Body, or the Governing Body may defer final determination by referring the matter back for further reconsideration. Any such referral shall state the reasons therefore, shall set a reasonable time limit within which reply to the Governing Body shall be made, and may include a directive that additional hearings be conducted to clarify issues that are in doubl After receipt of such reply and of any new evidence in the matter, the Governing Body shall make a final decision either to appoint or reject the applicanl

4. The Governing Body may delegate any of the above-described decision-making authority to a committee of the Governing Body;however, any final decision of the Governing Body committee must be subject to ratification by the full Governing Body at its next regularly scheduled meeting. Expedited processing is generally not available if:

i. The Practitioner or Member submits an incomplete application;

ii. The Medical Executive Committee of the Whale's final recommendation is adverse in any respect or has any limitations;

iii. There is a current challenge or a previously successful challenge to the Practitioner's licensure or registration;

iv. The Practitioner has received an involuntary termination of Medical Staff membership or some or all privileges at another organization;

v. There has been a finaljudgment adverse to the Practitioner in a professional liability action.

5. As used inthis section, adverse actions are as defined in Section 12.04-2 of the Bylaws.

j. Conflict Resolution: The Governing Body shall give great weight to the actions and recommendations of the Medical Executive Committee of the Whole, and inno event shall act in an arbitrary and capricious manner. Ifthe Governing Body's proposed decision differs from the recommendation of the Medical Executive Committee of the Whole, or if the Medical Executive Committee of the Whole has not yet rendered its recommendation, the Governing Body or its designated representative shall consult with the Medical Executive Committee of the Whole, and thereafter may issue a directive to the Medical Executive Committee of the Whole to investigate or initiate a recommendation. If the Medical Executive Committee of the Whole shall fail to render a recommendation within a reasonable time (as determined by the Governing Body), the Governing Body may, after written notice to the Medical Executive Committee of the Whole, render its recommendation with respect to the application. The provisions of this Rule IV-1.2 do not apply where the applicant has received or waived a hearing inaccordance with Article XII of the Bylaws.

k. Notice of Final Decision: The Chief Executive Officer shall give notice of the Governing Body's final decision to the Medical Executive Committee of the Whole and (by Special Notice, if adverse) to the applicant. A decision and notice to appoint shall include: (i) the Staff category to which the applicant is appointed; (ii) the Clinical Privileges he/she may exercise; and (iii) any special conditions attached to the appointment

l. 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 and Rules to act thereon and, except for good cause, shall be processed within the time periods specified in these Bylaws and Rules, and summarized in this Rule IV-1.2 (1). The Medical Staff Office personnel shall transmit an application to the Credentials Committee upon completing the information collection and verification tasks. The Credentials Committee shall act within 30 days ofreceipt of the information. The Medical Executive Committee shall review the application and make its recommendation to the Governing Body within 30 days after receiving the Credentials Committee report. The Governing Body shall then take action on the application at its next regular meeting. These time periods are provided to assist in the processing of the application and not to create rights for applicants to have their applications processed within these specific periods.

m. In the event the Governing Body should delegate some or all of its responsibilities described in this Rule to one of its committees, the Governing Body shall nonetheless retain ultimate authority to accept, reject, modify, or return for further action or hearing, the recommendations of its committee.

Rule IV-2 Reappointment

Rule IV-2.1 Information Form for Reappointment

At least 150 days prior to the expiration date of each Staff member's term of appointment, the Medical Staff Secretary shall provide the member with a reappointment packet. The completed reappointment form shall be returned to the Chief of Staff or Medical Staff Office within 60 days. Failure, without good cause, to return the form shall be deemed a voluntary resignation effective at the expiration of the member's current term.

Rule IV-2.2 Content of Reappointment Form

The reappointment form shall be a prescribed form and shall seek at least the following information necessary to update the Medical Staff file on the Staff member's healthcare related activities other than as a member of this Staff: a statement of agreement to abide by Hospital and Medical Staff Bylaws and Rules; a statement detailing the amounts of malpractice insurance carried; and a renewed request for Clinical Privileges. It shall also include signature blocks for each committee responsible for reappointment, stipulating that the file of the Staff member has been reviewed. This form shall be developed by the Credentials Committee and be approved by the Medical Executive Committee of the Whole. In addition to completing the information requested on the reappointment form, the Staff member shall submit his/her

dues (if applicable), and shall be responsible to provide any physical or mental health evaluations requested. The application for reappointment shall also include statements regarding the applicant's involvement in any professional liability actions; previously successful or currently pending challenges to any required licensure or registration or the voluntary relinquishment of such licensure or registration in this or any other state; voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary limitation, reduction, or loss of Clinical Privileges at another hospital, health facility, or healthcare entity; and information detailing any prior (within the preceding five years) or pending government agency or third party payer investigation, proceeding, or litigation challenging or sanctioning the Practitioner's patient admission, treatment, discharge, charging, collection, or utilization practices, including but not limited to Medicare or Medi-Cal fraud and abuse proceedings or convictions. The reappointment form shall also contain a confidential inquiry regarding the applicant's health sufficient to enable the Hospital to determine whether the Practitioner remains able to perform all of the responsibilities of Medical Staff membership, or whether reasonable accommodation will be needed to facilitate such performance (together with a general description of the nature of the accommodation that may be needed).

Rule IV-2.3 Processing the Application for Reappointment

a. The reappointment application shall be processed in substantially the same manner and subject to the same conditions described in Rule IV-1.2. Personal interviews may, but need not, be conducted. For purposes of reappointment, the terms "applicant" and "appointment" as used in that section shall be read, respectively, as "Staff member" and "reappointment."

b. The Credentials Committee and Medical Executive Committee of the Whole shall appraise the Staff member's performance over the previous two years and shall consider his/her physical and mental health status. The foregoing appraisal shall be documented, together with the appraiser’s recommendations for reappointment.

c. Except as provided at Section 4.03 (c) of the Bylaws, if the reappointment application has not been fully processed before the member's appointment expires, the Staff member shall refrain from exercising his or her current membership status and Clinical Privileges until the reappointment review is complete.

## Rule V PRIVILEGES

### Rule V-1 Temporary Privileges for Locum Tenens

### Rule V-1.1 Temporary Privileges

Upon the written concurrence of both the Chief of Staff and the Chief Executive Officer (or his/her designee), Temporary Privileges may be granted in the following circumstances:

a. Pendency of Application: After (i) receipt of an application for Staff appointment, including a request for specific Temporary Privileges, (ii) written verification of satisfaction of the insurance requirements set forth at Rule XIV-1, and (iii) verification of the application in accordance with Rule V-1.2 allowing one to form a preliminary judgment as to the applicant's qualifications, an appropriately licensed applicant may be granted Temporary Privileges for an initial period of 60 days, with subsequent renewal not to exceed 60 days. In exercising such Privileges, the applicant shall act under the supervision of the Chief of Staff, and in accordance with the conditions specified in Rule V-1.2.

b. Locum Tenens: A Practitioner applying for Temporary Privileges in a locum tenens capacity shall follow the same procedure required for appointments and reappointments, as specified in Rule IV. After (i) receipt of an application for locum tenens appointment, including a request for specific Temporary Privileges, (ii) written verification of satisfaction of the insurance requirements set forth at Rule XIV-1, and (iii) verification of the application in accordance with Rule V-1.2 allowing one to form a preliminary judgment as to the applicant's qualifications, an appropriately licensed Practitioner of documented competence, who is serving as a locum tenens for a member of the Medical Staff, may be granted Temporary Privileges for a period not to exceed 90 days with subsequent renewal not to exceed 90 days.

c. Care of Specific Patients as Necessary to Fulfill an Important Patient Care Need: Upon receipt of a written application for specific Temporary Privileges, written verification of satisfaction of the insurance requirements set forth at Rule XIV-1, and verification of the application in accordance with Rule V-1.2 allowing one to form a preliminary judgment as to the applicant's qualifications, a Practitioner who is not an applicant for membership, but whose services are deemed necessary to fulfill an important patient care need, may be granted Temporary Privileges for the care of one or more specific patients. Such Privileges shall be restricted to the treatment of not more than four patients in any one-year by any Practitioner, except that out-of-state Practitioners granted temporary consulting Privileges within the limitations of California Business and Professions Code section 2060 are not subject to this limitation. Except as provided for out- of-state Practitioners, Practitioners requesting permission to attend more than four patients in any one year shall be required to apply for Medical Staff membership before being granted the requested Privileges.

### Rule V-1.2 Application and Review

a. Temporary Privileges may be granted after the applicant completes the application procedure and the Medical Staff office completes the application review process. The following conditions apply:

    1. There must first be verification of:

        i. Current licensure;

        ii. Relevant training or experience;

        iii. Current competence;

        iv. Ability to perform the Privileges requested.

    2. The results of the National Practitioner Data Bank and Medical Board of California queries have been obtained and evaluated.

    3. The applicant has:

i. Filed a complete application with the Medical Staff office;

ii. No current or previously successful challenge to licensure or registration;

iii. Not been subject to involuntary termination of medical staff membership at another organization; and

iv. Not been subject to involuntary limitation, reduction, denial, or loss of Clinical Privileges.

b. There is no right to Temporary Privileges. Accordingly, Temporary Privileges should not be granted unless the available information supports, with reasonable certainty, a favorable determination regarding the requesting applicant's or AHP's qualifications, ability and judgment to exercise the Privileges requested. If the available information is inconsistent or casts any reasonable doubts on the 1pplicant's qualifications, action on the request for Temporary Privileges may be deferred until the doubts have been satisfactorily resolved. Temporary Privileges may be granted by the Chief Executive Officer (or his or her designee) on the recommendation of the Chief of Staff where the Privileges will be exercise, or either's designee. A determination to grant Temporary Privileges shall not be binding or conclusive, with respect to an applicant's pending request for appointment to the Medical Staff.

Rule V-1.3 General Conditions and Termination

a. Members granted Temporary Privileges shall be subject to the proctoring and supervision specified in these Rules.

b. Temporary Privileges shall automatically terminate at the end of the designated period or earlier terminated as provided at Rule V-1.3(c).

c. Temporary Privileges may be terminated with or without cause at any time by e Chief of Staff or the Chief Executive Officer after conferring with the Chief of Staff. A person shall be entitled to the procedural rights afforded by Article XII of the Medical Staff Bylaws, only if a request for Temporary Privileges is refused based upon, or if all or any portion of Temporary Privileges are terminated or suspended for, a medical disciplinary cause or reason. In all other cases (including a deferral in acting on a request for Temporary Privileges), the affected Practitioner shall not be entitled to any procedural rights based upon any adverse action involving Temporary Privileges.

d. Whenever Temporary Privileges are terminated, the Chief of Staff shall assign a member to assume responsibility for the care of the affected Practitioner's patient(s). The wishes of the patient and affected Practitioner shall be considered in the choice of a replacement member.

e. All persons requesting or receiving Temporary Privileges shall be bound by the Medical Staff Bylaws and Rules.

Rule V-2 Disaster or Emergency Privileges

Disaster Privileges may be granted when the Hospital's emergency management plan has been activated and the organization is unable to handle the immediate patient needs. The following provisions apply:

a. Disaster Privileges may be granted by the Chief Executive Officer, based upon recommendation of the Chief of Staff, upon presentation of any of the following:

1. A current picture Hospital identification card;

2. A current license to practice and a valid picture ID issued by a state, federal or regulatory agency;

3. Identification indicating the Practitioner is a member of a Disaster Medical Assistance Team (DMAT);

4. Identification indicating the Practitioner has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state, or municipal entity;

5. Presentation by current Hospital or Medical Staff member(s) with personal knowledge regarding the Practitioner's identity.

b. Persons granted Disaster Privileges shall wear identification badges denoting their status as a DMAT member.

c. The Medical Staff office shall begin the process of verification of credentials and Privileges as soon as the immediate situation is under control, using a process identical to that described as Rule V-1.2 (except the individual is permitted to begin rendering services immediately, as needed).

d. The Chief of Staff shall arrange for appropriate concurrent or retrospective monitoring of the activities of Practitioners granted Disaster Privileges.

Rule V-2.2 Emergency

In the event of an emergency, any member of the Medical Staff or credentialed AHP shall be permitted to do everything reasonably possible, within the scope of their licensure, to save the life of a patient or to save a patient from serious harm. The member or AHP shall promptly yield such care to a qualified member when one becomes available. [If additional Practitioners are needed and available, the emergency credentialing procedure described in the Rules shall be used to grant credentials to the Practitioner.]

Rule V-3 Transport and Organ Harvest Teams

Properly licensed Practitioners who individually, or as members of a group or entity, have contracted with the Hospital to participate in transplant and/or organ harvesting activities may exercise Clinical Privileges within the scope of their agreement with the Hospital.

Rule V-4 Proctoring

Rule V-4.1 When Proctoring May Be Imposed

All initial appointees to the Medical Staff and all members granted new Clinical Privileges shall be subject to a period of proctoring as determined by the Credentials Committee. Members who are seeking reappointment may also be subject to a period of proctoring to demonstrate current competence as determined by the Credentials Committee. (For example, when a member requests renewal of a privilege that has been performed with such infrequency as to make assessment of current competence difficult or unreliable.) Finally, proctoring may be implemented whenever the Medical Executive Committee of the Whole determines additional information is needed to enable assessment of a Practitioner's performance. Proctoring is not viewed as a disciplinary measure, but rather is an information-gathering measure. Therefore, it should be imposed only for such period (or number of cases) as is reasonably necessary to enable such assessment, and its imposition does not give rise to the procedural rights described in Article XII of the Bylaws, unless the proctoring becomes a restriction of Privileges because procedures cannot be done unless a proctor is present and proctors are not available after reasonable attempts to secure a proctor.

Rule V-4.2 Role of Credentials Committee

Proctoring shall be conducted under the auspices of the Credentials Committee. The Chief of Staff shall appoint proctors, and the persons appointed shall be deemed members of the Credentials Committee while serving as proctors.

Rule V-4.3 Proctoring Guidelines

The Credentials Committee shall develop rules (subject to approval by the Medical Executive Committee of the Whole and the Governing Body) to implement the following guidelines relative to proctoring:

a. The number and types of cases to be proctored, as well as the time frame wihin which proctoring must be completed, shall be determined by the Rules. The Chief of Staff is authorized to supplement basic proctoring requirements as deemed reasonably necessary for particular circumstances; however, additional proctoring requirements shall not be arbitrarily imposed.

b. For all procedures subject to proctoring, proctoring shall commence with the first case scheduled, and shall continue in effect for each subsequent case involving the proctored procedure(s) until the proctoring requirement for each proctored procedure has been completed. Proctoring shall be deemed successfully completed when the Practitioner completes the required number of proctored cases within the time frame established in the Bylaws and the Rules, and the Practitioner's professional performance in the cases meet the standard of care of the Hospital.

c. Privileges subject to proctoring shall be appropriately documented in the member's credentials file, and shall be communicated to hospital administration as necessary to help assure compliance.

d. The proctored cases are assigned randomly among the primary care staff, and surgery staff proctoring is done by other surgeon.

e. If possible, proctors should have unrestricted Privileges to perform the procedures that will be proctored. If possible, given the resources available within the Medical Staff, each member shall be proctored by least two different Practitioners during the period of proctorship.

f. The duty of the proctor is not to participate in patient care, but to review and report on the care reviewed. Generally, if the proctor and the proctored Practitioner disagree on the appropriate treatment of a patient, the dispute shall be resolved by the Chief of Staff: In an emergency, proctors hre authorized to participate in or assume responsibility for patient care as determined by the proctor to be reasonably necessary for patient safety.

g. A proctor may or may not act as the assistant during a surgical procedure.

h. The proctor is expected to evaluate the proctored Practitioner's performance rr1om admission to discharge of the case proctored. Proctors shall submit written reports on appropriate evaluation forms promptly following each case evaluated. The proctoring forms shall be designed to help assure the proctor evaluates indications for admission, discharge, diagnostic work-up, and therapeutic management; and if invasive procedures are involved, the evaluation shall also include indications for the procedure, as well as preoperative, operative, and postoperative care and technique.

i. The activities of a proctor constitute an integral part of the peer review system! of the Medical Staff, and as such, all records, reports, documents, and any other information regarding the ,proctorship shall be subject to all confidentiality requirements within the Medical Staff Bylaws and Rules, and the proctors are subject to all immunities accorded Medical Staff peer review activities by these Bylaws and Rules, and any applicable regulations, statutes or legal decisions.

j. When, in the reasonable judgment of the Medical Executive Committee of the Whole, the results from the initial period of proctoring are inconclusive, proctoring may be extended for a specified number of cases or period of time approved by the Medical Executive Committee of the Whole.

k. Failure to satisfactorily complete proctoring shall have the consequences set forth in Rule V-4 .6.

Rule V-4.4 Reciprocal Proctoring

a. Reciprocal proctoring may be accepted to supplement actual observation on the premises.

b. As a general rule, reciprocal proctoring is acceptable only if all of the following conditions are met:

1. The proctor is a member of the Medical Staff at both hospitals, and is eligible to serve as a proctor in both hospitals.

2. The Practitioner has requested the same range and level of Privileges at both institutions.

3. Copies of the actual proctoring reports or a written summary of cases are provided and available upon request to the Credentials Committee and the Medical Executive Committee of the Whole.

c. The Medical Executive Committee of the Whole may authorize other proctoring arrangements in unusual circumstances where it is determined to be in the best interests of the Hospital. However, there shall be no right to alternative proctoring arrangements, and the Medical Executive Committee of the Whole shall have discretion to recommend denial of Privileges (or other remedial action) where appropriate proctoring cannot be reasonably accomplished within the existing resources of the Medical Staff

Rule V-4.5 Completion of Proctoring

Proctoring shall be deemed successfully completed when the Practitioner completes the required number of proctored cases within the time frame established by the Credentials Committee and the Practitioner's professional performance during the proctoring period is sufficient to enable the Medical Executive Committee of the Whole to determine the Practitioner can be expected to consistently meet the standard of care of the Hospital and perform in accordance with all applicable Rules, policies, and procedures of the Medical Staff and the Hospital.

Rule V-4.6 Effect of Failure to Complete Proctoring

a. Failure to Complete Necessary Volume: If the initial appointee or member fails to complete the required number of proctored cases within the time frame established, he/she shall be deemed to have voluntarily withdrawn his/her request for membership or Privileges, and he/she shall not be afforded the procedural rights provided in Article XII of the Bylaws. However, the Credentials Committee has the discretion to extend the time for completion of proctoring in appropriate cases, to be ratified by the Medical Executive Committee of the Whole. The inability to obtain such an extension shall not give rise to procedural rights described in Article XII of the Bylaws.

b. Failure to Obtain Certification: If a Practitioner completes the necessary volume of proctored cases but fails to obtain the necessary certification of satisfactory completion of such cases, he/she may be terminated (or the relevant Privileges may be revoked) but he/she shall be afforded the procedural rights as provided in Article XII of the Bylaws, subject to the following:

1. If the Practitioner is an initial appointee or a member who has been granted new Clinical Privileges, his/her procedural rights shall be those of an applicant.

2. If the Practitioner is a member of the Medical Staff who has been subjected to proctoring due to reasons related to insufficient use or to investigate potential problems, his/her procedural rights shall be those of a Staff member.

3. Effect on Advancement: The failure to complete proctoring for any specific privilege shall not, by itself, preclude advancement from Provisional Staff. If advancement is approved prior to completion of proctoring, the proctoring will continue for the specified privileges. The specific privileges may be voluntarily relinquished or terminated if proctoring is not completed thereafter within a reasonable time.

Rule V-5 Credentialing of Allied Health Professionals

Rule V-5.1 Qualifications of Allied Health Professionals

Allied Health Professionals (AHPs) are not eligible for Medical Staff membership. They may be granted Practice Privileges if they hold a license, certificate, or other credentials ina category of AHP that the Governing Body (after securing comments from the Medical Executive Committee of the Whole) bas identified as eligible to apply for Practice Privileges and only if the AHPs are professionally competent and continuously meet the qualifications, standards, and requirements set forth in the Medical Staff Bylaws and Rules.

Rule V-5.2 Categories

a. The Governing Body shall determine, based upon recommendation of the Medical Executive Committee of the Whole and such other information as it bas before it, those categories of AHPs that shall be eligible to exercise Clinical Privileges in the Hospital. Such AHPs shall be subject to the supervision requirements developed by the Medical Executive Committee of the Whole, and the Governing Body.

b. The procedural rights described in Rule V-5.6 shall not apply to any decision regarding whether a category of AHP shall or shall not be eligible for Clinical Privileges and the terms, prerogatives, or conditions of . such decision. Those questions shall be submitted for consideration to the Governing Body, which has the discretion to decline to review the request, or to review it using any procedure the Governing Body deems appropriate.

Rule V-5.3 Credentialing Procedure

Except as provided in Rule V-5.6, applications for ARP Privileges will be processed in substantially the same manner as specified in Rule IV-1; however, the following special procedures apply as well:

a. The applicant will obtain and complete an application form that has been developed by the Credential Committee and approved by the Medical Executive Committee of the Whole and the Governing Body.

b. The application information will be submitted to the Credential Committee who will forward its recommendation to the Medical Executive Committee of the Whole.

c. The Medical Executive Committee of the Whole shall make a recommendation to the Governing Body.

d. Applications shall be processed in timely fashion appropriate to the circumstances of the case; strict compliance with Rule IV-1.2(1) is waived.

Rule V-5.4 Frequency of Credentialing

The Credential Committee shall develop policies and procedures (which shall become effective upon approval by the Governing Body) to implement the following:

a. All new AHPs shall be subject to a six-month period of formal proctoring.

b. Proctoring requirements shall be determined by the Credential Committee

c. Upon successful completion of the proctoring period, the credentials of each AHP practicing in the

Rule V-5.5 Privileges and Responsibilities

a. AHPs may exercise only those Privileges specifically granted them by the Governing Body. The range of Privileges for which each AHP may apply, and any special limitations or conditions to the exercise of such Privileges, shall be based on recommendations of the Medical Executive Committee of the Whole, subject to approval by the Governing Body.

b. Each AHP shall be required to comply with all applicable rules established by the Credential Committee, and to participate in and cooperate with patient care audit and other quality review, evaluation, and monitoring activities required of AHPs, in supervising initial appointees of his/her same occupation or profession or of a lesser included occupation or profession, and in discharging such other functions as may be required from time to time.

Rule V-5.6 Adverse Actions/Procedural Rights

Denial, revocation, or modification of AHPs' Privileges shall be the prerogative of the Medical Executive Committee of the Whole and the Governing Body. The following procedural rights shall apply:

a. Clinical psychologists (whether applicant or holding Clinical Privileges) shall have the hearing and appeal rights described at Article XII of the Bylaws.

b. Applicants (other than clinical psychologists) shall have the following procedural rights. Prior to denying Privileges for any disciplinary reason, the affected AHP shall be given notice of the proposed action and an opportunity to present written or verbal response to the Medical Executive Committee of the Whole. This section shall not be deemed to afford an AHP a right to an adversarial hearing as described in Article XII of the Bylaws.

c. AHPs (other than clinical psychologists) holding Clinical Privileges shall have the following rights.

    1. Written notice of the Medical Executive Committee of the Whole's recommended action and the general reasons therefore.

    2. 10 days to request a Medical Executive Committee of the Whole review hearing of the action.

    3. At least 14 calendar days notice of the date, time, and place of the Medical Executive Committee of the Whole review hearing. Additional information about the reasons for the recommended action may be provided at this time.

    4. Both "parties" (i.e., the affected AHP and the Medical Executive Committee of the Whole) may submit written argument and documents in support of their positions. These must be received by the Medical Staff Office and the other party at least 4 calendar days prior to the date scheduled for the review hearing.

    5. Both parties may appear at the Medical Executive Committee of the Whole review hearing to present and hear evidence. Neither party may be represented by legal counsel in the review hearing (although either may, at their own expense, have assistance of counsel in preparing for the review hearing).

    6. The Medical Executive Committee of the Whole will deliberate and decide the matter as soon as possible thereafter, outside the presence of the parties. The Medical Executive Committee of the Whole shall issue a written decision stating the reasons for and factual findings in support of its conclusions.

    7. The Medical Executive Committee of the Whole's decision shall be effective immediately

    8. Either party shall have 10 days to request an appeal of the decision by the Governing Body (or in the discretion of the chair of the Governing Body, by an Appeal Board appointed by the Governing Body); however the filing of an appeal shall not stay the effective date of the Medical Executive Committee of the Whole's decision. The request for appeal must state, with specificity, the basis for the appeal.

    9. An appeal hearing shall be conducted within 30 days. The parties to the appeal shall be the Medical Executive Committee of the Whole (which shall be represented by a member of the Medical Staff who may, but need not. be a member of the Medical Executive Committee of the Whole and the affected AHP.

    10. The parties may submit written statements insupport of their positions. The chair of the Governing Body (or Appeal Board) may, in his/her discretion, establish a schedule that sets reasonable time frames for the appellant to submit a written statement and for the respondent to respond. Inthe absence of an articulated schedule, written statements must be received by the Governing Body (or Appeal Board) and the other party at least 5 calendar days prior to the date scheduled for the appeal.

    11. Each party may appear and make oral argument; however, neither party may be represented by legal counsel in the appeal hearing (although either may, at their own expense, have assistance of counsel in preparing for the review hearing).

12. The Governing Body (or Appeal Board) will deliberate and decide the matter as soon as possible thereafter, outside the presence of the parties. The Governing Body (or Appeal Board) shall issue a written decision stating the reasons for and factual findings insupport of its conclusions.

d. Automatic Termination: Notwithstanding the provisions of Rule V.4.6, above, an AHP'sprivileges shall automatically terminate, without review, in the event:

1. The Medical Staff membership of the supervising Practitioner is terminated, whether such termination is voluntary or involuntary;

2. The supervising Practitioner no longer agrees to act as the supervising Practitioner for any reason, or the relationship between the AHP and the supervising Practitioner is otherwise terminated, regardless of the reason therefore; or

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

Rule V-5.7 Loss of Sponsor

The Certified Registered Nurse Anesthetists (CRNAs), First Assistants and medical students in a surgical setting shall be supervised by the surgical Medical Staff, and the Nurse Practitioners (NPs), Physician Assistants (PAs), and medical students ina medical setting shall be supervised by the primary care Medical Staff. The loss of a sponsoring, supervising Practitioner shall trigger the automatic termination clause at Rule V-5.6(d) above.

Rule V-5.8 Credentialing of Medical Students

Hospital Clerkships for medical students, nurse practitioner or physician assistant students will be credentialed as follows.

Requirements:

a. The student must be in good standing at his/her educational institution.

b. The student must provide written proof of liability insurance.

c. The student must submit Hospital's application for student privileges, including a signed patient confidentiality statement.

d. The student must show proof of TB screening and Hepatitis B immunization.

These documents must be received by the Hospital no less than 60 days prior to their arrival to ensure adequate review by the Credential committee, the Medical Staff and the Governing Board. Additionally, a letter of recommendation from the course chair must accompany the student's application paperwork such that any questions from the Medical Staff or the Governing Board shall be directed to the faculty member. The Governing Board shall consider at the request from the Medical Staff, approval of Temporary Clinical Privileges for each student to last the duration of the clerkship. Clerkships are usually done in Family Medicine and any of the Primary Care staff may serve as preceptor. At the discretion of the preceptor students may rotate through other departments at the Hospital including, but not limited to, Surgery, Physical Therapy, Podiatry, Hospice, Radiology, and the Emergency Department. One Family Physician shall be designated to provide grading and performance review. Clerkships are generally one month in duration but occasionally, student's stay for longer periods of time in these clerkships. It is not the Hospital's responsibility to provide housing for students.

## Rule VI MEDICAL STAFF OFFICES

(Reserved)2

2 Rules relating to this Article of the Bylaws may be adopted and inserted as needed, in accordance with the provisions for adoption of Medical Staff Rules.

## Rule VII COMMITTEES

### Rule VII-1 Credentials Committee

#### Rule VII-1.1 Composition

The Credentials Committee shall be comprised of at least two members of the Active Medical Staff, one of whom shall be the chairperson, and both of whom shall be voting members.

#### Rule VII-1.2 Purpose

The purpose of the Credentials Committee is to evaluate the qualifications of all applicants for Medical Staff appointment, reappointment, promotion, or change in Staff categories. The Committee shall maintain records used in evaluation of applicants, and shall develop recommendations based on its evaluations of each applicant as well as (with respect to reappointment, to the results of any Medical Staff quality assessment and improvement activities.

#### Rule VII-1.3 Accountability and Relationships

a. The Credentials Committee shall be accountable to its chairperson.

b. The chairperson of the Credentials Committee shall be accountable to the Medical Executive Committee of the Whole and the Chief of Staff.

c. The Credentials Committee chairperson shall report the business of the Committee to the Medical Executive Committee of the Whole on a "as needed" basis, but at least twice a year.

d. The Credentials Committee will meet on an "as needed" basis, but at least twice a year.

#### Rule VII-1.4 Other

A confidential file on each applicant, Staff member, and AHP shall be maintained by the Medical Staff Office. The application and all information obtained in conjunction with processing the application shall be Credentials Committee records.

### Rule VII-2 Emergency Services and Trauma Committee

#### Rule VII-2.1 Composition

The Emergency Services and Trauma Committee shall be comprised of at least one member of the Active Medical Staff with Emergency Medicine Privileges and one R.N. Other attendees may include a representative of Administration, one paramedic, and one RN/MICN.

#### Rule VII-2.2 Purpose

The purpose of the Emergency Services and Trauma Committee is to develop, implement, and maintain a well- defined plan for emergency care based on community needs and the capabilities of the Hospital so as to assure adequate appraisal, advice, or initial treatment shall be rendered to all ill or injured persons who present themselves at the Hospital.

#### Rule VII-2.3 Accountability and Relationships

a. The Emergency Services and Trauma Committee shall be accountable to its chairperson.

b. The chairperson of the Emergency Services and Trauma Committee shall be accountable to the Medical Executive Committee of the Whole and the Chief of Staff.

c. The Emergency Services and Trauma Committee chairperson shall regularly report the business of the Committee to the Medical Executive Committee of the Whole.

d. The Emergency Services and Trauma Committee will meet at least quarterly.

Rule VII-3 Health Information Management Committee

Rule VII-3.1 Composition

The Health Information Management Committee shall be comprised of one member of the Active Medical Staff, who shall be chairperson, and the Health Information Manager, both of whom shall be voting members of the Committee. Other non-voting attendees shall include the Director of Acute Nursing, the Director of Quality/Performance Improvement and one (or more) Health Information Management staff member(s).

Rule VII-3.2 Purpose

The purpose of the Health Information Management Committee is to assure all patient records are complete, accurate, legible, contain sufficient information to justify the diagnosis and treatment, and they are completed within the time period required by state law. The Committee will also address all HIPAA rules, regulations and related compliance issues.

Rule VII-3.3 Accountability and Relationships

a. The Health Information Management Committee shall be accountable to its chairperson.

b. The chairperson of the Health Information Management Committee shall be accountable to the Medical Executive Committee of the Whole and the Chief of Staff.

c. The Health Information Management Committee chairperson shall regularly report the business of the Committee to the Medical Executive Committee of the Whole.

d. The Health Information Management Committee will meet at least quarterly.

Rule VII-3.4 Other

The Health Information Management Committee chairperson may require Staff members' correction of medical record deficiencies, and may recommend discipline of any Staff member in accordance with Article XII of the Bylaws.

Rule VII-4 Infection Control Committee

Rule VII-4.1 Composition

The Infection Control Committee shall be comprised of one member of the Medical Staff: who shall be chairperson, and the Infection Control Coordinator, both of whom shall be voting members of the Committee. Other attendees may include the Director of Quality/Performance Improvement, the Director of Acute Nursing, the Director of Skilled Nursing, the Director of Staff Development, the OR Manager, the Laboratory Services Manager, the Outpatient Services Manager, the Respiratory Therapist, and representatives of Administration, Housekeeping, and Laundry.

Rule VII-4.2 Purpose

The purpose of the Infection Control Committee is to develop and monitor the Hospital's infection control program, and the Staff's treatment of infectious disease, including review of the clinical use of antimicrobials. The Committee shall approve action to prevent or control infections and the infection potential among patients and Hospital personnel. The Committee shall ensure the Hospital's infection control plan links with external support systems and with communitywide agencies as they relate to reduction of risk from the environment. The Committee shall ensure appropriate resources are available for infection control activities. The Committee shall also assure the results of infection control studies and reviews are incorporated into the Hospital's educational programs and into the Hospital's quality assessment and improvement activities. At least every two years, the Committee shall review and approve all policies

relating to the infection control program. The chair or his or her designee shall be available for on-the-spot interpretation of applicable rules.

Rule VII-4.3 Accountability and Relationships

a. The Infection Control Committee shall be accountable to its chairperson.

b. The chairperson of the Infection Control Committee shall be accountable to the Medical Executive Committee of the Whole and the Chief of Staff.

c. The Infection Control Committee chairperson shall regularly report the business of the Committee to the Medical Executive Committee of the Whole.

d. The Infection Control Committee will meet at least quarterly.

Rule VII-5 Joint Conference Committee

Rule VII-5.1 Composition

The Joint Conference Committee shall be composed of seven members: the Chief of Staff, the Vice Chief of Staff, the immediate-past Chief of Staff, the Secretary-Treasurer, two members of the Hospital's Governing Body, and the Chief Executive Officer. All members are voting members. The person serving as the Joint Conference Committee chair shall alternate annually between the Chief of Staff and one of the Governing Body representatives.

Rule VII-5.2 Duties and Meeting Frequency

a. This Committee shall serve as a focal point for furthering an understanding of the roles, relationships, and responsibilities of the Governing Body, administration, and the Medical Staff. It may also serve as a forum for discussing any Hospital matters regarding the provision of patient care. It shall meet at least quarterly or as often as necessary to fulfill its responsibilities. Any member of the Committee shall have the authority to place matters on the agenda for consideration by the Committee.

b. The Committee may also serve as the initial forum for exercise of the meet and confer provisions contemplated by Section 12.14 of these Bylaws; provided, however, upon request of at least four committee members (which four must be comprised of at least one Governing Body representative and one Medical Staff representative), a neutral mediator, acceptable to both contingents, shall be engaged to assist in dispute resolution.

Rule VII-5.3 Accountability

The Joint Conference Committee is accountable to the Medical Executive Committee of the Whole and to the Governing Body.

Rule VII-6 Patient Safety Committee

Rule VII-6.1 Composition

The Patient Safety Committee shall be comprised of at least one member of the Active Medical Staff, who shall be chairperson, and one member of the nursing staff, both of whom shall be voting members of the Committee. Other attendees shall include a representative of Administration and the Director of Acute Nursing.

Rule VII-6.2 Purpose

The purpose of the Patient Safety Committee isto oversee, in accordance with state regulations, the promotion of the safety of all patients, visitors, volunteers, healthcare workers, and trainees. This committee is charged with reducing medical/health system errors and hazardous conditions by utilizing continuous improvement to support an organization culture of safety.

Rule VII-6.3 Accountability and Relationships

a. Patient Safety Committee shall be accountable to its chairperson.

b. The chairperson of the Patient Safety shall be accountable to the Medical Executive Committee of the Whole and the Chief of Staff

c. The Patient Safety Committee chairperson shall regularly report the business of the Committee to the Medical Executive Committee of the Whole.

d. The Patient Safety Committee will meet at least twice per year.

Rule VII-7 Physician Well-Being Committee

Rule VII-7.1 Composition

The Physician Well-Being Committee shall be comprised of one member of the Active Medical Staff, who shall be chairperson and the Director of Quality/Performance Improvement, both of whom shall be voting members of the Committee. A representative of Administration shall also attend the meetings.

Rule VII-7.2 Purpose

a. The purpose of the Physician Well-Being Committee shall be to improve the quality of care and promote the competence of the Medical Staff by attempting to resolve matters relating to Medical Staff members' health, well-being, or impairment prior to their evolving into significant patient care problems.

b. The Physician Well-Being Committee shall develop a process that provides education about physician health, addresses prevention of physical, psychiatric, or emotional illness, and facilitates confidential diagnosis, treatment, and rehabilitation of Practitioners who suffer from a potentially impairing condition.

Rule VII-7.3 Accountability and Relationships

a. The Physician Well-Being Committee shall be accountable to its chairperson.

b. The chairperson of the Physician Well-Being Committee shall be accountable to the Medical Executive Committee of the Whole and the Chief of Staff.

c. The Physician Well-Being Committee chairperson shall regularly report the business of the Committee to the Medical Executive Committee of the Whole.

d. The Physician Well-Being Committee will meet on an "as needed" basis.

Rule VII-7.4 Other

The Physician Well-Being Committee shall maintain only such records of its proceedings, as it deems advisable, and shall provide general reports on its activities on a routine basis to the Medical Executive Committee of the Whole. More specific reporting guidelines shall be adopted by the Committee and approved by the Medical Executive Committee.

## Rule VIII MEETINGS

### Rule VIII-1 Quarum

#### Rule VIII-1.1 General Staff Meetings

Any voting members present, but not less than two members, shall constitute a quorum for the transaction of business.

#### Rule VIII-1.2 Medical Executive of the Whole, Medical Executive Officers Committee and other Committee Meetings

Any voting members present, but not less than two members, shall constitute a quorum for the transaction of business.

#### Rule VIII-1.3 Manner of Action

Except as otherwise specified, 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. Valid action may be taken without a committee meeting if at least 10 days' notice of the proposed action has been given to all members entitled to vote, and it is subsequently approved by a writing setting forth the action so taken and which is signed by each voting member. The meeting chairperson shall refrain from voting, except as necessary to break a tie vote.

#### Rule VIII-1.4 Minutes

Minutes of all meetings shall be prepared and shall include a record of attendance and the vote taken on each action item. Copies of minutes shall be signed by the Committee chairperson, approved by the attendees, and filed with the Committee's records. Summaries of the minutes shall be regularly reported to the Medical Executive Committee of the Whole. Upon request, the complete minutes shall be made available to the Medical Executive Committee of the Whole or the Chief of Staff

### Rule VIII-2 Attendance Requirements

#### Rule VIII-2.1 Regular Attendance

Each member of a Staff category required to attend meetings under Rule III and who are committee members shall be required to attend six Medical Staff committee meeting per year. Each Medical Staff member of a committee shall be required to attend at least one-half of the committee meetings held in any given calendar year.

#### Rule VIII-2.2 Failure to Meet Attendance Requirements

Staff members will be notified semi-annually if they have not yet met the full attendance requirements. Physicians who have not met meeting attendance requirements before the end of the appointment/reappointment period will be reappointed for a two-year period on probationary status. If the physician does not meet the meeting attendance requirements during the next two-year period, he/she will not be reappointed. Exceptions can be made at the discretion of the Chief of Staff and the Medical Executive Committee of the Whole.

#### Rule VIII-2.3 Special Appearance

A committee, at its discretion, may require the appearance of a Practitioner during a review of the clinical course of treatment regarding a patient. If possible, the chairperson of the meeting should give the Practitioner at least 10 days advance written notice of the time and place of the meeting. In addition, whenever an appearance is requested because of an apparent or suspected deviation from standard clinical practice, special notice shall be given and shall include a statement of the issue involved and that the Practitioner's appearance is mandatory. Failure of a Practitioner to appear at any meeting with respect to which he/she was given special notice shall (unless excused by the Medical Executive Officers Committee upon a showing of good cause) result in possible suspension (as delineated in Article 11-06.6) imposed by the Medical Executive Officers Committee. The Practitioner shall be entitled to the procedural rights described in Article XII of the Bylaws; provided, however, if the suspension is limited to an administrative

suspension, any hearing shall be limited to a review of whether or not good cause existed, and was promptly made !mown to the Medical Executive Officers Committee, for the Practitioner's failure to appear.

## Rule IX CONFIDENTIAL RECORDS AND INFORMATION

(Reserved)3

3 Rules relating to this Article of the Bylaws may be adopted and inserted as needed, in accordance with the provisions for adoption of Medical Staff Rules.

## Rule X IMMUNITY AND RELEASES

(Reserved)*

## Rule XI CORRECTIVE ACTION

(Reserved)*

## Rule XII INTERVIEWS, HEARINGS AND APPELLATE REVIEW

(Reserved)*

## Rule XIII REVIEW OF BYLAWS, RULES, AND MEDICAL STAFF POLICIES

(Reserved)*

## Rule XIV GENERAL PROVISIONS

### Rule XIV-1 Professional Liability Insurance

Each Practitioner granted Clinical Privileges in the Hospital shall maintain inforce professional liability insurance from a company authorized to sell insurance in the State of California or from an insurance trust incorporated under the laws of one of the United States of America in no less than the minimum amounts of $1,000,000 each claim and $3,000,000 Aggregate Limit per Policy Period, if any, as from time to time may be jointly determined by the Governing Body and Medical Executive Committee of the Whole. In lieu thereof, the member may participate in a trust agreement entered into pursuant to California statute or may demonstrate to the Medical Executive Committee of the Whole and the Governing Body, in the exercise of their sole discretion, that the member has obtained insurance or made other provision satisfying the intent of this paragraph by affording equivalent financial security for the payment of any judgment or award, in no less than the minimum amounts established of $1,000,000 each claim and $3,000,000 Aggregate Limit per Policy Period. Subject to the approval of the Governing Body, upon written request, the Medical Executive Committee of the Whole, for good cause shown, may waive this requirement with regard to such member as long as such waiver is not granted or withheld on an arbitrary, discriminatory, or capricious basis. In determining whether an individual exception is appropriate, the following factors may be considered.

a. Whether the Practitioner has applied for the requisite insurance;

b. Whether the Practitioner has been refused insurance, and if so, the reasons for such refusal;

c. Whether insurance is reasonably available to the Practitioner, and ifnot, the reasons for its unavailability; and

d. The Practitioner's ability to demonstrate alternative means of satisfying financial responsibilities in the event of professional negligence.

### Rule XIV-2 Dues

Medical Staff members shall pay dues as follows:

| | |
|---|---|
| Provisional | $100.00 |
| Active | $100.00 |
| Consulting | $100.00 |
| Courtesy | $100.00 |
| Telemedicine Consulting | $100.00 |
| Inactive | None |
| Medical Director Adminisstrator | $100.00 |

## Rule XV OTHER

### Rule XV-1 EMTALA

#### Rule XV-1.1 Examination or Treatment

a. Seneca Healthcare District must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists.

b. Any patient who presents at Seneca Healthcare District's dedicated emergency department, and requests examination or treatment for a medical condition, or has such a request made on his or her behalf will receive a medical screening examination. In the absence of such a request by or on behalf of the individual, a request on behalf of the individual will be considered to exist if a prudent layperson observer would believe, based on the individual' s appearance or behavior, the individual needs examination or treatment for a medical condition.

c. Any patient presented on hospital property, other than the dedicated emergency department, and requests examination or treatment for what may be an emergency medical condition, or has such a request made on his or her behalf will receive a medical screening examination. In the absence of such a request by or on behalf of the individual, a request on behalf of the individual will be considered to exist if a prudent layperson observer would believe, based on the individual's appearance or behavior, the individual needs emergency examination or treatment.

#### Rule XV-1.2 The medical screening examination will include the following:

a. Log entry with disposition performed by Nurse.

b. Triage record (performed by Nurse).

c. Ongoing recording of vital signs performed by Nurse.

d. Oral History performed by Nurse, mid-level practitioner and Physician.

e. Physical Examination performed by Physician or mid-level practitioner.

f. Use of all necessary testing resources to check for an emergency medical condition performed by Physician or mid-level practitioner.

g. Use of on-call physician as needed performed by Nurse, mid-level practitioner and Physician.

h. Discharge or transfer vital signs performed by Nurse, mid-level practitioner or Physician and must be reviewed by Physician.

i. Adequate documentation of all the above.

j. Availability of Emergency Room Physician and mid-level practitioner supervised by the MD on call that day.

#### Rule XV-1.3 Training

All Seneca Employees will receive EMTALA training. All nurses working at Seneca Healthcare Districts' Emergency Department will receive MSE training and triage training in addition to EMTALA training.

#### Rule XV-1.4 Availability of Emergency Room Physician

The covering emergency room physician must be immediately available by pager, telephone or radio, and available on site within 30 minutes of verbal communication with the physician.

### Rule XV-2 Admission and Discharge of Paitents

a. Upon physician orders the Hospital shall accept all patients for care and treatment.

b. A patient may be admitted to the Hospital only by a physician member of the Medical Staff. All Practitioners shall be governed by the official admitting policy of the Hospital. All dental and podiatry patients will be admitted with the concurrence of a physician with admitting privileges at the Hospital who will assume responsibility for the overall aspects of patient care.

c. A member of the Medical Staff shall be responsible for the medical care and treatment of patients in the Hospital, for the prompt and complete accuracy of the medical record, for necessary instructions and for transmitting reports on the condition of the patient to the referring Practitioner, patient or patient representative, and/or family of the patient. Whenever these responsibilities are transferred to another Staff member, an order covering the transfer of responsibility shall be entered on the order sheet of the medical record.

d. Except in an emergency, a patient will not be admitted to the Hospital without a provisional diagnosis. In the event of an emergency, a provisional diagnosis shall be recorded as soon as possible.

e. When a patient requires emergency admission, the physician or podiatrist shall, when possible, first contact the nursing staff to ascertain the availability of an appropriate bed

f. Members of the Medical Staff who do not reside in the immediate vicinity shall name a member of the Medical Staff who resides in the area who may be called to attend their patients in an emergency or until they arrive. In cases of failure to name such associate, the Chief of the service concerned, or staff registered nurse in charge at the time of need, shall have the authority to call any member of the Medical Staff as needed.

g. The admitting physician shall be responsible for giving information necessary to assure the protection of others, whenever the patient might be a source of danger from any cause whatsoever.

h. Patients shall be discharged only on the order of the attending Practitioner. Should a patient leave the Hospital Against Medical Advice (AMA), a notation shall be made in the patient's record and the patient will be requested to sign a Leaving the Hospital Against Medical Advice form.

i. In the event of a Hospital death the patient shall be pronounced dead by the attending physician or physician designee or qualified R.N. within a reasonable time. The body shall be released upon the written order of a physician.

Rule XV-3 Medical Records

a. Within 24 hours after admission every inpatient shall have a complete History and Physical examination performed providing the condition of the patient permits. Within 72 hours after admission or 5 days prior to admission every skilled nursing/longterm care resident shall have a complete History and Physicial examination performed. The attending physician shall be responsible for preparation of a complete and legible medical record for each patient. Content shall be pertinent and current. The record shall include identifying data:

1. Chief Complaint;
2. History of Chief Complaint;
3. Known Allergies;
4. Present Medications;
5. Social History;
6. Family History; and
7. Review of Systems.

A complete examination shall include all pertinent findings resulting from an assessment of all systems of the body, provisional diagnosis and plan of treatment.

b. When a History and Physical examination is not recorded before surgery or any potentially dangerous procedure, the procedure shall be cancelled unless the attending Practitioner states in writing that such delay would be detrimental to the patient's health.

c. Pertinent progress notes shall be recorded at the time of observation sufficient to permit continuity of care and transferability. Whenever possible the patient's clinical problems shall be clearly identified in the progress notes as well as results of tests and treatment. Progress notes shall be written to include date and time at least daily on all patients.

d. Operation reports shall include:

1. Preoperative diagnosis;

2. Postoperative diagnosis;

3. Details of surgical procedure;

4. Detailed account of findings and patient's immediate postoperative condition.

Operation reports will be documented in the patient's medical record as soon after surgery as possible but within 24 hours for inpatients and outpatients. The report shall be signed as soon after completion as possible.

e. Consultations shall document evidence of a review of the patient's record, pertinent findings on examination of the patient, diagnosis, and recommendations. Consultations shall be documented and made part of the patient's permanent medical record. When operative procedure(s) are performed, consultation shall, when applicable, be completed and recorded in the medical record prior to surgery.

f. All clinical entries in the patient's medical record shall be accurately entered and authenticated to include the date and time. Medical records may be authenticated by a signature stamp in lieu of a physician's signature only when the physician has placed a signed statement in the Hospital administrative offices to the effect that he/she is the only person who has possession of the stamp and will be the only person using the stamp.

g. Symbols and abbreviations may be used only when they have been approved by the Medical Staff. A record of approved abbreviations shall be kept on file in the medical record department.

h. Final diagnosis shall be recorded in full without the use of symbols or abbreviations, dated and signed by the Practitioner as soon after discharge as possible. Some final diagnosis may be pending results of outside laboratory tests.

i. All inpatient and skilled nursing/longterm care charts are to include a discharge summary.

j. Written consent of the patientshall be obtained prior to providing services unless the service needed is emergent and the patient is unable to sign and no representative is available.

k. Records may be removed from the Hospital District’s jurisdiction and safekeeping only in accordance with court order, subpoena or statue. All records are the property of the Hospital District and shall not be removed without permission of the Chief Executive Officer. In case of readmission of a patient all previous records shall be available to the attending Practitioner. This shall apply whether the patient is attended by the same Practitioner or another.

l. Free access to all medical records of all patients shall be afforded to members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning individual patients in the Hospital.

m. A medical record shall not be permanently filed until it is completed by the responsible Practitioner or is ordered filed by the Medical Staff

n. Practitioner's routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's record, dated, timed and signed by the Practitioner.

o. The patient's medical record shall be completed at the time of discharge including progress notes, final diagnosis, discharge summary and signatures. When this is not possible because final laboratory or other essential reports have not been received at the time of discharge, the patient's chart shall be available in a stated location in the medical records department for fourteen (14) days after discharge. If the record still remains incomplete eleven (11) days after discharge, the medical records supervisor shall notify the Practitioner that his/her privileges to treat patients in the Hospital may be suspended until the record(s) have been completed. SNF/LT charts shall be completed within 30 days after discharge. Medical records will notify the Practitioner of incomplete charts by a Memo to Physician – Incomplete Charts day seven (7) and twenty-one (21) days post discharge. Clinic charts shall be completed within 30 days after discharge. Medical records will notify the Practitioner of incomplete charts by a Memo to Physician – Incomplete Charts day seven (7) and twenty-one (21) days post discharge. The Chief of Staff, Administration,, Chief Nursing Officer, Emergency Room Supervisor, Operating Room Supervior, Skilled Nursing Facility Director of Nursing, Medical Staff Secretary and Lake Almanor Clinic Manager shall be notified of such action. Suspension totaling thirty (30) days in any twelve (12) month period shall be reported to the Medical Board of California. In the event a summary suspension remains in effect in excess of fourteen days (14) days, a report to the Medical Board of California shall be filed within thirty (30) days following imposition of a summary suspension.

Rule XV-4 General Conduct of Care

a. A general consent form signed by the patient, patient/representative shall be obtained for all patients. It is the responsibility of the Practitioner to document informed consent in the medical record for all procedures. The above requirements do not preclude rendering emergency medical or surgical care to a patient in dire circumstances.

b. All orders for treatment shall be in writing. A verbal order, including telephone orders shall be considered in writing if dictated to a licensed person functioning within the scope of that license and signed by the responsible Practitioner. All orders dictated over the telephone shall be signed by the appropriate authorized person to whom dictated with name and title of the Practitioner. The responsible Practitioner shall sign such orders for inpatients within 48 hours, for SNF/LT within five (5) days and for clinic within ten (10) days. Failure to do so shall be brought to the attention of the Medical Staff for appropriate action through the Quality Assurance/Performance Improvement Committee.

c. The Practitioner's orders must be written legibly and completely. Orders, which are illegible or improperly written, will not be carried out until rewritten or understood by the nurse. The use of "Renew" or "Continue" are not acceptable. The laboratory shall accept laboratory orders from any licensed Practitioner. It will be the laboratory's responsibility to check on these Practitioners.

d. All previous orders are cancelled when patients go to surgery.

e. All drug and medications administered to patients shall be those listed in the latest edition of United States Pharmacopedia, National Formulary, American Hospital Formulary Service, Physician Drag Reference (PDR) or American Medical Association (AMA) and Drug Evaluations. New drugs not contained in these publications may be used if written clearance from the Federal Drug Administration (FDA) is on file in the Hospital. All drugs in these categories listed below, ordered for inpatients in the Hospital without specific limitation as to the dosage and time, shall be called to the attention of the attending physician upon expiration of 5 days by the nursing staff. All drugs in these categories listed below, ordered for SNF/long term care residents in the hospital without specific limitation as to the dosage and time, shall be called to the attention of the attending physician upon expiration of 45 days by the nursing staff. The attending physician will reorder the drug, change the order or cancel it. If the expiration of the order occurs after the Practitioner's regular office hours, the request for change in order may be accomplished the following morning. The 3 categories of drugs are:

1. Narcotics;

2. Sedatives, hypnotics, soporifics, and tranquilizers; and

3. Antibiotics and cortisone products.

Antibiotics and ergot, because of their extreme danger and toxicity shall be ordered specifically as to the dosage and time. Self-medication by patients shall not be allowed. The nurse shall ask the patient if they have any medication with them and request they give them to nursing until discharge of the patient. If they are prescribed in written order, they may utilize.

f. Any qualified Practitioner with Clinical Privileges in the Hospital can be called for consultation within their area of expertise.

g. Except in an emergency, consultation is required in the following situations:

1. All high-risk surgical patients.

Rule XV-5 General Rules for Surgical Care

a. Scheduling Operations :

1. Elective surgical procedures will be scheduled by the Practitioner with the nursing staff on the day shift at least one (1) day prior to surgery.

2. Such operations will be scheduled in order of reservation made.

3. Operations will be scheduled in order of reservations made. Infected cases will be done last on any scheduled surgery day.

4. Information required to make reservations:

i. Name of Patient;

ii. Sex;

iii. Age;

iv. Surgeon;

v. Assistant Surgeon (when Applicable);

vi. Category of Service: Inpatient, Outpatient;

vii. Operation starting time;

viii. Procedure(s) to be performed and type of anesthesia planned.

b. Change of Schedule.

If possible, the surgeon is to give at least 24-hour notice.

c. Emergency Operations.

The Hospital staff will make every effort to aid the surgeon in performing emergency procedures.

d. Requirements prior to anesthesia and surgery:

1. Patient's Name, Age, and Sex listed;

2. Pre-Op tests will be performed in a certified laboratory prior to surgery. Pre-Op labs will be ordered at the discretion of the attending physician in each individual case with the following exceptions:

   An early pregnancy test (EPT serum) will be done of all females between ages 10 and 55 scheduled for any surgery with the following exceptions:

   i. When the status of pregnancy is definitely known; or

   ii. The results of the pregnancy test would not alter the medical management of the case.

3. Informed consent signed by the patient, patient/representative.

4. Preoperative diagnosis, History & Physical examination performed in manner consistent with Seneca Bylaws, section 2.03 (q). If completed within 30 days prior to the procedure, a Interval History and Physical by the surgeon prior to surgery shall confirm the History & Physical remains the same or any additions and subsequent changes are recorded in the patient's medical chart. Signed informed consent must be recorded in the patient's chart prior to induction of anesthesia and start of surgery. If not recorded, the operation shall be cancelled with the exception of emergency surgery. The Practitioner, in the event of emergency, shall confirm the History & Physical remains the same or any additions and subsequent changes are recorded in the patient's medical chart. If not recorded, the operation shall be cancelled with the exception of emergency surgery. The Practitioner, in the event of emergency, shall document in the patient's chart a comprehensive note regarding the patient's condition.

e. A patient admitted for dental care is under the dual responsibility of the dentist and a physician member of the medical staff.

   Dentist's Responsibilities:

   1. A detailed dental history justifying Hospital admission.

   2. A detailed description of the examination of the oral cavity and a preoperative diagnosis.

   3. A complete operative report describing the findings and technique. Incases of abstraction of teeth, the dentist shall clearly state the number of teeth and fragments removed.

   4. Progress notes pertinent to the oral condition.

   5. Summary statement.

   Physician's Responsibilities:

   1. Medical History & Physical

   2. Supervision of the patient's general health status while hospitalized and documentation of any related problems.

   The discharge of the patient may be on the written order of the dentist after consulting with the physician.

f. A patient admitted for podiatry care is under the dual responsibility of the podiatrist and a physician member of the medical staff.

   Podiatrist's Responsibilities:

   1. A detailed podiatry history justifying Hospital admission.

2. A detailed description of the podiatric examination and a preoperative diagnosis.

3. Designate in orders, name of physician sharing responsibility .

4. A complete operative report describing findings and the surgical technique used.

5. Progress notes as pertain to the podiatry condition.

6. Discharge summary.

Physician's Responsibilities:

1. Medical History & Physical.

2. Supervision of the patient's general health status while hospitalized and documentation of any related problems.

The discharge of the patient shall be on the written order of the podiatrist after consulting with the physician.

g. The anesthetist shall maintain a complete anesthesia record to include evidence of the pre-anesthesia evaluation and post anesthesia follow-up of patients' condition. He/She shall be responsible for follow up of surgical patient's to determine they have fully recovered from the administration of anesthetics. Findings shall include blood pressure, recovery of swallowing reflux, whether cyanosis is present, pulse and general condition of the patient. The evaluation shall be documented in the Anesthesia Record.

h. In any surgical procedure with unusual hazard to life, there must be a qualified physician serving as assistant surgeon, present and scrubbed.