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**MEDICAL STAFF BYLAWS**

### OF

### ODESSA REGIONAL MEDICAL CENTER

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# Adopted 11/03

# Amendments:

**06/04 Article III, Section 3.6, Added Resignation from the Medical Staff**

**06/05 Article VII, Section 7.4 Temporary Privileges amended to include Allied Health Professionals**

**05/06 Article IV, Section 4.3 Courtesy Staff amended to include minimum number of patients**

**02/07 Article XII, Section 12.2 Amend Composition of MEC to include Physician Adviser to Corporate as member.**

**09/07 Article VI, Section 6.2 (0) edited to add a government issued ID must be submitted with initial application.**

**Article VII, Section 7.6 edited to reflect language required by Joint Commission Standards.**

**10/07 Article VI and Article VII edited to include that DEA & DPS will not be required of practitioners who solely practice Teleradiology.**

**01/08 Article XI, Clinical Sections & Services; eliminated Radiology Section, added Radiology members to Medicine Section**

**Edited Article VI, 6.2 Photograph to include language required by TJC**

**Edited Article VII, 7.6 to include language required by The Joint Commission.**

**01/09 Added Definitions for Executive Session and Peer**

**Amended Article VII, 7.6 Emergency Disaster Privileges (Added language to meet TJC Standards)**

**Amended Article X, 10.1 (h) Duties of Elected Officers (Vice Chief of Staff to serve as Bylaws Committee Chair)**

**Amended Article XI, 11.4 Section Chiefs (Added language to Section Chief’s responsibilities to meet TJC Standards)**

**Amended Article XIV, 14.7 Practitioner Health (Added Paragraph 14.7 (g) Practitioner’s Failure to Complete Rehabilitation Program**

**08/09 Amended Definition for Peer (to allow for peer review by a practitioner with privileges to perform the same service or procedures(s) as that under review)**

**Amended Article VI, 6.2 Content of Application for Initial Appointment / Clinical Privileging (Added language to specify that electronic primary source verification of state licenses, DEA registration/controlled substance certificate, and state controlled substance certificate (DPS) meets documentation requirements in lieu of the requirement that copies of the documents be furnished and maintained in the Practitioner’s credentials file)**

**Amended Article VII, 7.4 Temporary Privileges, Locum Tenens Temporary Privileges and Case by Case Temporary Privileges (Amended language to meet CMS Standards and DNV Accreditation Standards)**

**Amended Article XI, 11.4(b) (3), Section Chiefs (Added language to the responsibilities of the Section Chief to meet accreditation standards)**

**Amended Article XII, 12.2(a), Medical Executive Committee Composition (Deleted language to remove Chairperson of the Special Care Committee)**

**Amended Article XII, 12.2(b), Medical Executive Committee Functions (Added language to meet accreditation standards)**

**09/10 Amended Article VI, 6.6(b) Requirements for Service (deleted reference to a specific accrediting body, the Joint Commission, and in lieu thereof that contractual services provided meet accreditation requirements.**

**Amended Article VII, 7.7 Privileges for Telemedicine (added language for telemedicine scope of service and to allow reliance upon a telemedicine practitioner’s credentialing information from and/or privileging decision of an accredited distant site under a contract service with all telemedicine practitioners continuing to be credentialed and privileged through the ORMC Medical Staff)**

**04/13 Amend Article IV, Categories of the Medical Staff, Section 4.3(a) Qualifications, to add subparagraph (4) to the Courtesy category for the delineation of approved Courtesy Staff Out-of-Area**

**04/13 Amend Article VI, Procedures for Appointment, Reappointment and Clinical Privilege Delineation, Section 6.2, Content of Application for Initial Appointment / Clinical Privileging to include other facility-specific forms for complete application packet, adding approved discretionary application fee; and adding ECFMG certification verification, if applicable, to subparagraph (g) Education**

**04/13 Amend Article VI, Procedures for Appointment, Reappointment and Clinical Privilege Delineation, Section 6.4, subparagraph 6.4(a), Information Form for Reappointment and Reprivileging, and 6.4(e), Basis for Recommendations, to include approved discretionary reappointment application fee and use of peer references to establish current competency**

**04/13 Amend Article VII, Determination of Clinical Privileges, Section 7.4, Temporary Privileges, Locum Tenens Temporary privileges and Case By Case Temporary Privileges, 7.4(a) (1), Pendency of New Applications; 7.4(a) (3) Locum Tenens; and Section 7.7, Privileges for Telemedicine, Telemedicine Physicians, to be in accordance with current NIAHO-DNV accreditation standards**

**04/13 Amend Article XI, Clinical Sections & Services, to add provision 11.1(b) for inclusion of clinical section ad hoc committees**

**04/13 Amend Article XII, Committees and Functions, Medical Executive Committee, Paragraph 12.2(b) (11), Functions, to delete reference to Joint Commission**

**04/13 Amend Article XIII, Meetings, subparagraph 13.4, Quorum, 13.4(c) Section Meeting**

**06/14 Amend Article III, Medical Staff Membership and Clinical Privileges, 3.3, Basic Responsibilities of Medical**

**Staff Members and AHPs adding Section 3.3(m) for required disclosure of ownership and/or investment**

**interest in the Hospital to patients.**

**06/14 Amend Article VIII, Peer Review and Corrective Action, 8.4, Automatic Suspension to insert language for**

**automatic suspension for failure to disclose ownership and/or investment interest in the Hospital to patients**

**as required by Section 3.3(m) referenced in Article III, 3.3.**

**06/17 Amend Definitions, “Telemedicine” to** add definition for telemedicine.

**06/17 Amend Article II, Purposes & Responsibilities, 2.2, Responsibilities, 2.2(a)** to revise text to conform with accreditation standards insofar as responsibilities of the Medical Staff.

**06/17 Amend Article II, Purposes & Responsibilities, 2.2, Responsibilities, 2.2(b) to** add AHPs to cooperate with each other.

**06/17 Amend Article II, Purposes & Responsibilities, 2.2, Responsibilities, 2.2(c) (4) to** add participation in a utilization management program.

**06/17 Amend Article III, Medical Staff Membership and Clinical Privileges, 3.2, Basic Qualifications/Conditions for Staff Membership and Clinical Privilege Delineation, 3.2(a) Basic Qualifications (8)** to conform with accreditation standards that all individuals with delineated privileges participate in continuing education that is at least in part related to their clinical privileges.

**06/17 Amend Article III, Medical Staff Membership and Clinical Privileges, 3.3, Basic Responsibilities of Medical Staff Members and AHPs, 3.3(l), 3.3(m) and 3.3(n)** to add provisions from corporate legal template with regard to required notification and compliance with maintaining confidentiality of patient identifying information and hospital policies and applicable legal standards related to hospital reimbursement, billing, third party payors, and federal health care programs.

**06/17 Amend Article III, Medical Staff Membership and Clinical Privileges, 3.3, Basic Responsibilities of Medical Staff Members and AHPs, 3.3(q) and 3.3(r)** to add admission history and consultations to Bylaws in accordance with accreditation standards and to specify that a consultant must see patient within 24 hours of consult and dictate a note.

**06/17 Amend Article III, Medical Staff Membership and Clinical Privileges, 3.5, Leave of Absence, 3.5(a) to** add text to avoid confusion when appointment ends while member is on leave of absence.

**06/17 Amend Article IV, Categories of the Medical Staff, 4.2, Active Staff, 4.2(a) Qualifications, (4) to** add text to more clearly define “regularly involved” in care of patient.

**06/17 Amend Article IV, Categories of the Medical Staff, 4.3, Courtesy Staff, 4.3(a) Qualifications, (3)** for consistency with “regularly involved” definition in 4.2(a)(4) for the Active Category.

**06/17 Amend Article IV, Categories of the Medical Staff, 4.4, Consulting Staff, 4.4(b) Prerogatives, (1) i, ii, and iii** to add new i to consult on patients within his/her own specialty and renumber subparagraphs thereafter.

**06/17 Amend Article V, Allied Health Professionals (AHP), 5.2, Independent Allied Health Professionals, 5.2(a) Qualifications, (1) and (2)** to delete certain qualifications already stated in Section 3.2 of these Bylaws, to renumber and to add provision (2) and new (1) under (2).

**06/17 Amend Article V, Allied Health Professionals (AHP), 5.3, Dependent Allied Health Professionals, 5.3(a) Qualifications, (1) and (2)** to delete certain qualifications already stated in Section 3.2 of these Bylaws, to renumber and to add provision (2).

**06/17 Amend Article V, Allied Health Professionals (AHP), 5.4, Conditions for Granting Clinical Privileges, 5.4(c)** to reference Article V instead of subparagraph 5.4(b).

**06/17 Amend Article VI, Procedures for Appointment, Reappointment and Clinical Privilege Delineation, General Procedures, 6.1(a), 6.1(b)** to add subsection numbering and add text to 6.1(b) to address negative decision by committee results in return to MEC for further recommendation prior to final action by Board.

**06/17 Amend Article VI, Procedures for Appointment, Reappointment and Clinical Privilege Delineation, 6.3, Processing the Application, 6.3(b) Applicant’s Burden, (4) and (5)** to add text from corporate legal template to acknowledge provision of false or misleading information, or omission of information whether intentional or not, may be grounds for rejection of application without fair hearing rights and that appointment and/or clinical privileges may be revoked without fair hearing rights due to misstatements, misrepresentation, or omission.

**06/17 Amend Article VI, Procedures for Appointment, Reappointment and Clinical Privilege Delineation, 6.3, Processing the Application, 6.3(c) Statement of Release & Immunity from Liability** to add text from corporate legal template as stated in 6.3(b) (4) (5).

**06/17 Amend Article VI, Procedures for Appointment, Reappointment and Clinical Privilege Delineation, 6.3, Processing the Application, 6.3(c) Statement of Release & Immunity from Liability, (2)** to add criminal history to authorization.

**06/17 Amend Article VI, Procedures for Appointment, Reappointment and Clinical Privilege Delineation, 6.3, Processing the Application, 6.3(c) Statement of Release & Immunity from Liability** to add if granted clinical privileges to the last paragraph.

**06/17 Amend Article VI, Procedures for Appointment, Reappointment and Clinical Privilege Delineation, 6.3, Processing the Application, 6.3(d) Submission of Application & Verification of Information, (2) Membership or Clinical Privileges Denied or Terminated** to add text for an application rejected at this hospital as a result of fraudulent conduct, misrepresentations in the application process, or other basis involving dishonesty.

**06/17 Amend Article VI, Procedures for Appointment, Reappointment and Clinical Privilege Delineation, 6.3, Processing the Application, 6.3(d) Submission of Application & Verification of Information, (8) Application Incomplete** to add text for providing false or misleading information on the application.

**06/17 Amend Article VI, Procedures for Appointment, Reappointment and Clinical Privilege Delineation, 6.3, Processing the Application, 6.3(d) Submission of Application & Verification of Information** to add AHP to the first paragraph below (8).

**06/17 Amend Article VI, Procedures for Appointment, Reappointment and Clinical Privilege Delineation, 6.3, Processing the Application, 6.3(d) Submission of Application & Verification of Information** to amend the last paragraph in accordance with accreditation standards.

**06/17 Amend Article VI, Procedures for Appointment, Reappointment and Clinical Privilege Delineation, 6.3, Processing the Application, 6.3(i) Effect of Medical Executive Committee Action** to correct numbering and to amend to specify appeal process for AHPs in Article V.

**06/17 Amend Article VI, Procedures for Appointment, Reappointment and Clinical Privilege Delineation, 6.3, Processing the Application, 6.3(j) Board Action, (3) Adverse Action** amend to specifyprocedural rights for AHPs found in Article V.

**06/17 Amend Article VI, Procedures for Appointment, Reappointment and Clinical Privilege Delineation, 6.3, Processing the Application, 6.3(o) Appointment Considerations** to add evidenced-based assessment areas.

**06/17 Amend Article VI, Procedures for Appointment, Reappointment and Clinical Privilege Delineation, 6.4, Reappointment and Reprivileging Process, 6.4(b) Content of Reapplication Form to** add numbering for individual items and add requirement for DEA in accordance with accreditation standards.

**06/17 Amend Article VI, Procedures for Appointment, Reappointment and Clinical Privilege Delineation, 6.4, Reappointment and Reprivileging Process, 6.4(c) Verification of Information** amend items required for verification in accordance with accreditation standards.

**06/17 Amend Article VI, Procedures for Appointment, Reappointment and Clinical Privilege Delineation, 6.6, Practitioners Providing Contractual Professional Services, 6.6(b) Requirements for Service** to specify *if any*.

**06/17 Amend Article VI, Procedures for Appointment, Reappointment and Clinical Privilege Delineation, 6.6, Practitioners Providing Contractual Professional Services, 6.6(c) Termination** to specify Article V in the case of AHPs.

**06/17 Amend Article VII, Determination of Clinical Privileges, 7.2, Delineation of Privileges in General, 7.2(e) Initial and Additional Grants of Privileges** to add provision for period for focused evaluation for initial or new or additional privileges to be consistent with our FPPE Assignment and Evaluation forms.

**06/17 Amend Article VII, Determination of Clinical Privileges, 7.4, Temporary Privileges, Locum Tenens Temporary Privileges and Case By Case Temporary Privileges** amend heading to *Clinical Privileges Held by Non-Medical Staff Members or Non-Allied Health Professional Staff Members* to conform with corporate legal template.

**06/17 Amend Article VII, Determination of Clinical Privileges, 7.4, Clinical Privileges Held by Non-Medical Staff Members or Non-Allied Health Professional Staff Members, 7.4(a) Circumstances** in accordance with accreditation standards.

**06/17 Amend Article VII, Determination of Clinical Privileges, 7.4, Clinical Privileges Held by Non-Medical Staff Members or Non-Allied Health Professional Staff Members, 7.4(a) Circumstances (1) Pendency of New Applications, (2) One Case Basis, and (3) Locum Tenens** to include text from corporate legal template, add AHP to (3) and *Exception* paragraphs below (2) and (3) respectively to delete DPS no longer required.

**06/17 Amend Article VII, Determination of Clinical Privileges, 7.4, Clinical Privileges Held by Non-Medical Staff Members or Non-Allied Health Professional Staff Members, 7.4(b) Conditions** to add *one-case and locum tenens* to temporary privileges.

**06/17 Amend Article VII, Determination of Clinical Privileges, 7.4, Clinical Privileges Held by Non-Medical Staff Members or Non-Allied Health Professional Staff Members, 7.4(c) Termination** to add *one-case or locum tenens* to temporary privileges.

**06/17 Amend Article VII, Determination of Clinical Privileges, 7.4, Clinical Privileges Held by Non-Medical Staff Members or Non-Allied Health Professional Staff Members, 7.4(d) Rights of the Practitioner or Allied Health Professional t**o add *one-case or locum tenens* to temporary privileges.

**06/17 Amend Article VII, Determination of Clinical Privileges, 7.5, Emergency & Disaster Privileges** to combine emergency and disaster privileges as modified from corporate legal template.

**06/17 Amend Article VII, Determination of Clinical Privileges, 7.6, Privileges for Telemedicine, 7.6(a) and 7.6(b)** to delete DPS requirement in first paragraph and amend 7.6(a) to include numbered subsection, delete existing subsection 7.6(b) and amend provisions in accordance with accreditation standards.

**06/17 Amend Article VIII, Peer Review, 8.1, Peer Review and Corrective or Rehabilitative Action, 8.1(a) Criteria for Initiation of Peer Review and/or Corrective or Rehabilitative Action** to add *Rehabilitative* and *any officer of the Board* in accordance with accreditation standards.

**06/17 Amend Article VIII, Peer Review, 8.1, Peer Review and Corrective or Rehabilitative Action, 8.1(b) Request & Notices** first paragraph of subsectionin accordance with accreditation standards.

**06/17 Amend Article VIII, Peer Review, 8.1, Peer Review and Corrective or Rehabilitative Action, 8.1(c) Investigation by the Medical Executive Committee** subsection as taken from corporate legal template.

**06/17 Amend Article VIII, Peer Review, 8.1, Peer Review and Corrective or Rehabilitative Action, 8.1(e) Procedural Rights** o correct subparagraph numbering.

**06/17 Amend Article VIII, Peer Review, 8.1, Peer Review and Corrective or Rehabilitative Action, 8.1(f) Other Action** to specify correct subparagraph numbering.

**06/17 Amend Article VIII, Peer Review, 8.3, Administrative Corrective Action, 8.3(h) Other Action** to specify correct subparagraph numbering.

**06/17 Amend Article VIII, Peer Review, 8.4, Automatic Suspension, 8.4(a) License** to add *restricted* and add *or AHP Staff* in accordance with accreditation standards.

**06/17 Amend Article VIII, Peer Review, 8.4, Automatic Suspension, 8.4(b) Drug Enforcement Administration (DEA) Registration Number** to add automatic suspension of clinical privileges for revocation/suspension/probation of DEA in accordance with accreditation standards.

**06/17 Amend Article VIII, Peer Review, 8.4, Automatic Suspension, 8.4(e) Exclusions/Suspension from Medicare** to add Medicaid in accordance with accreditation standards.

**06/17 Amend Article VIII, Peer Review, 8.4, Automatic Suspension, 8.4(f) Automatic Suspension – Failure to Disclose Interest in Hospital to Patient** to correct subparagraph numbering.

**06/17 Amend Article VIII, Peer Review, 8.5, Confidentiality** to delete “discipline” and add “corrective action” instead.

**06/17 Amend Article VIII, Peer Review, 8.9, False Information on Application** to add subsection 8.9 from corporate legal template.

**06/17 Amend Article X, Officers, 10.1, Officers of the Staff, 10.1(h) Duties of Elected Officers** to add required responsibility in accordance with accreditation standards.

**06/17 Amend Article X, Officers, 10.1, Officers of the Staff, 10.1(h) Duties of Elected Officers, (viii) and (ix)** to add additional responsibilities in accordance with accreditation standards.

**06/17 Amend Article XI, Clinical Sections & Services, 11.2, Department Scope of Service** to add subsection 11.2 for required scope of service in accordance with accreditation standards.

**06/17 Amend Article XI, Clinical Sections & Services, 11.3, Section Functions, 11.3(j)** subsection as taken from corporate legal template for data to be collected and evaluated to conduct an evidence-based analysis of quality.

**06/17 Amend Article XII, Committees & Functions, 12.2, Medical Executive Committee, 12.2(a) Composition** subsection in accordance with accreditation standards and to specify composition.

**06/17 Amend Article XII, Committees & Functions, 12.2, Medical Executive Committee, 12.2(b) Functions** to add text as taken from corporate legal template.

**06/17 Amend Article XII, Committees & Functions, 12.2, Medical Executive Committee, 12.2(c) Meetings** subsection in accordance with accreditation standards.

**06/17 Amend Article XII, Committees & Functions, 12.5, Medical Staff Functions, 12.5(b) Functions, (3)** to add word “review” to utilization management activities.

**06/17 Amend Article XII, Committees & Functions, 12.5, Medical Staff Functions, 12.5(b) Functions, (4)** to add assist hospital in providing continuing education opportunities responsive to services provided within the Hospital.

**06/17 Amend Article XII, Committees & Functions, 12.5, Medical Staff Functions, 12.5(b) Functions, (10), (11), (12), (13), (14), (15), (16), (17), (18), (19) (20) (21) (22)** to add subsections 10 thru 22 for the addition of functions of the Medical Staff in accordance with accreditation standards.

**06/17 Amend Article XIII, Meetings, 13.2, Regular Meetings, 13.2(d) Required Meetings** to add subsection in accreditation standard for periodic meetings to review and analyze medical records for adequacy and quality of care.

**06/17 Amend Article XV, Adoption & Amendment of Bylaws, 15.1, Development,** text in accordance with accreditation standards as taken from corporate legal template.

**06/17 Amend Article XV, Adoption & Amendment of Bylaws, 15.2(a), Medical Staff,** to add subparagraph title paragraph.

**06/17 Amend Article XV, Adoption & Amendment of Bylaws, 15.2(b), Board,** to renumber and add text for amendment of the Bylaws when necessary to provide for protection of patient welfare or when necessary to comply with accreditation standards or applicable law.

**10/17 Amend Article VI, Procedures for Appointment, Reappointment, and Clinical Privilege Delineation, 6.5, Request for Modification of Appointment,** to add paragraph to provide for granting temporary additional privileges requested.

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**MEDICAL STAFF BYLAWS**

### OF

### ODESSA REGIONAL MEDICAL CENTER

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***P R E A M B L E***

***WHEREAS****,* Odessa Regional Medical Center, hereinafter referred to as "Hospital", is operated by IASIS Healthcare, a private corporation organized under the laws of the state of Texas and is lawfully doing business in Texas, and is not an agency or instrumentality of any state, county or federal government; and

***WHEREAS****,* no Practitioner is entitled to Medical Staff membership and privileges at this Hospital solely by reason of education or licensure, or membership on the Medical Staff of another hospital; and

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

***WHEREAS****,* the Hospital must ensure that such services are delivered efficiently and with concern for keeping medical costs within reasonable bounds and meeting the evolving regulatory requirements applicable to functions within the Hospital; and

***WHEREAS***, the Medical Staff must cooperate with and is subject to the ultimate authority and direction of the Governing Board; and

***WHEREAS***, the cooperative efforts of the Medical Staff, management and the Governing Board are necessary to fulfill these goals.

***NOW, THEREFORE***, the Practitionerspracticing in Odessa Regional Medical Center hereby organize themselves into a Medical Staff conforming to these Bylaws.

**D E F I N I T I O N S**

1. "Active Staff" shall be those Practitioners (D.O.s, M.D.s, dentists, oral/maxillofacial surgeons, and podiatrists) licensed in the state of Texas that are both clinically privileged to admit and treat patients, and are Members of the Medical Staff who may hold office and vote in Medical Staff elections.

1. "Allied Health Professional" or “AHP” means an individual, other than a Practitioner, who is qualified to render direct or indirect medical or surgical care under the supervision of a Practitioner, or who is licensed by the State of Texas to perform such duties apart from a supervising physician, and who has been afforded privileges to provide such care in the Hospital. Those AHPs who render care under the supervision of a Practitioner are considered Dependent Allied Health Professionals. Such AHPs shall include, without limitation Anesthesia Tech, Audiologist, Certified Ophthalmology Assistant, First Assistant, Nurse Practitioner, Perfusionist, Physician Assistant, Physician’s Nurse, Surgical Tech and such other categories of health care professionals as shall from time to time be determined by the Governing Board. Those AHPs who are licensed by the State of Texas to perform duties apart from a supervising physician are considered Independent Allied Health Professionals. Such AHPs shall include, without limitation, Certified Registered Nurse Anesthetist (CRNA), Licensed Professional Counselor, Licensed Medical Social Worker, Orthotist/Prosthetist, and such other categories of licensed independent health care professionals as shall from time to time be determined by the Governing Board. The authority of an AHP to provide specified patient care services is established by the Medical Staff based on the professional's qualifications.

3. "Board" means the Governing Board of Odessa Regional Medical Center.

4. "Board Certification" shall mean certification in a member board of the American Board of Medical Specialties, the American Board of Osteopathic Specialists, or other appropriate specialty boards.

5. "Chief Executive Officer" or “CEO” means the individual appointed by the Corporation to provide for the overall management of the Hospital; and may also refer to an individual appointed by the CEO to fulfill the responsibilities of his/her position in his/her absence.

6. "Chief of Staff" means the Member of the Active Medical Staff who is duly elected in accordance with these Bylaws to serve as chief officer of the Medical Staff of this Hospital.

7. "Clinical Privileges" means the Board's recognition of the Practitioners' or AHPs’ competence and qualifications to render specific diagnostic, therapeutic, medical, dental, podiatric, or surgical services.

1. “Corporation” means IASIS Healthcare.

9. "Data Bank" means the National Practitioner Data Bank, (or any state designee thereof), established pursuant to the Health Care Quality Improvement Act of 1986, for the purposes of reporting of adverse actions and Medical Staff malpractice information.

10. “Designee” means one selected by the CEO, Chief of Staff or other corporate or Medical Staff officer to act on his/her behalf with regard to a particular responsibility or activity as permitted by these Bylaws.

11. “Executive Session: A closed session of any medical staff meeting. Attendance shall be limited to appropriate members of the medical staff, administration, and others at the discretion of the Chair and or CEO, as may be required for the issue(s) to be reviewed and/or discussed.

12. "Ex-Officio" means service as a member of a body by virtue of an office or position held, and unless otherwise expressly provided, means without voting rights.

13. "Fair Hearing Plan" means the procedure adopted by the Medical Staff with the approval of the Board to provide for an evidentiary hearing and appeals procedure when a Practitioner's Clinical Privileges are adversely affected by a determination based on the Practitioner's professional conduct or competence.

14. “Hospital” means Odessa Regional Medical Center.

15. “Medical Executive Committee” or "MEC" means the Executive Committee of the Medical Staff.

16. "Medical Staff" means the formal organization of Practitioners who are Members of the Medical Staff by virtue of appointment or reappointment to the Medical Staff and who have been granted Clinical Privileges by the Board.

17. "Medical Staff Bylaws" means the Bylaws and the accompanying Policies & Procedures and Rules & Regulations, Fair Hearing Plan, and such other departmental Rules and Regulations as may be adopted by the Medical Staff subject to the approval of the Board.

18. "Medical Staff Year" means calendar year.

19. "Member" means a Practitioner who has been granted Medical Staff membership and Clinical Privileges pursuant to these Bylaws.

20. “Peer” means a Practitioner from the same discipline with equal qualifications as the individual under review (for example, physician and physician, dentist and dentist, etc.) or a Practitioner with privileges to perform the same service or procedure(s) as that under review.

21. "Physician" means an individual with a D.O. or M.D. degree who is properly licensed to practice medicine in Texas.

22. "Practitioner" means a physician, dentist, oral/maxillofacial surgeon, or podiatrist who has been granted Clinical Privileges at the Hospital.

23. "Prerogative" means a participatory right granted by the Governing Board and exercised subject to the conditions imposed in these Bylaws and in other Hospital and Medical Staff policies.

24. "Special Notice" means a written notice sent by mail with a return receipt requested or delivered by hand with a written acknowledgment of receipt.

25. “Telemedicine” means the use of electronic communication or other communication technologies to provide or support clinical care at a location remote to the Hospital.

# ARTICLE I

**NAME**

The name of this organization shall be the Medical Staff of Odessa Regional Medical Center.

**ARTICLE II**

**PURPOSES & RESPONSIBILITIES**

**2.1 PURPOSE**

The purposes of the Medical Staff are:

2.1(a) To be the organization through which the benefits of membership on the Medical Staff (mutual education, consultation and professional support) may be obtained and the obligations of Medical Staff membership may be fulfilled;

2.1(b) To foster cooperation with administration and the Board while allowing Medical Staff Members to function with relative freedom in the care and treatment of their patients.

2.1(c) To ensure that all patients admitted to or treated in any of the facilities or services of the Hospital shall receive the same level of quality care, by accounting for and reporting regularly to the Board on patient care evaluation, including monitoring and other Performance Improvement activities in accordance with the Hospital's Performance Improvement Program;

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2.1(d) To serve as a primary means for accountability to the Board to ensure high quality professional performance of all Practitioners and AHPs authorized to practice in the Hospital through delineation of Clinical Privileges, on-going review and evaluation of each Practitioner's performance in the Hospital, and supervision, review, evaluation and delineation of duties and Prerogative of AHPs;

2.1(e) To work with the Board and management to develop a strategy to maintain medical costs within reasonable bounds and meet evolving regulatory requirements;

2.1(f) To provide an appropriate educational setting that will promote continuous advancement in professional knowledge and skill;

2.1(g) To promulgate, maintain and enforce Bylaws, Policies &Procedures, and Rules and Regulations for the proper functioning of the Medical Staff;

2.1(h) To provide a means by which issues concerning the Medical Staff and the Hospital may be discussed with the Board or the CEO;

2.1(i) To participate in educational activities and scientific research with approved colleges of medicine and dentistry as may be justified by the facilities, personnel, funds or other equipment that are or can be made available;

2.1(j) To assist the Board in identifying changing community health needs and preferences and implement programs to meet those needs and preferences; and

2.1(k) To accomplish its goals through appropriate committees and departments.

**2.2 RESPONSIBILITIES**

The responsibilities of the Medical Staff include:

2.2(a) Ensuring that all patients are under the care of a member of the Medical Staff or under the care of a practitioner who is directly under the supervision of a member of the Medical Staff, and ensure that all patient care is provided by or in accordance with the orders of a practitioner who meets the Medical Staff criteria and procedures for the privileging granted, who has been granted privileges in accordance with those criteria by the Board, and who is working within the scope of those granted privileges.[[1]](#footnote-1)

2.2(b) Ensuring that Practitioners and AHPs cooperate with each other in caring for patients in the Hospital.

2.2(c) Accounting for the quality, appropriateness and cost effectiveness of patient care rendered by all Practitioners and AHPs authorized to practice in the Hospital, by taking action to:

(1) Assist the Board, the CEO and their designees in data compilation, medical record administration, review and evaluation of cost effectiveness and other such functions necessary to meet accreditation and licensure standards, as well as federal and state law requirements;

(2) Implement credentialing procedures, including a mechanism for appointment and reappointment and the delineation of Clinical Privileges and assurance that all individuals with Clinical Privileges provide services within the scope of individual Clinical Privileges granted;

(3) Provide a continuing medical education program addressing issues of Performance Improvement and including the types of care offered by the Hospital; and document individual participation in such programs;

(4) Implement and participate in a utilization management program, based on the requirements of the Hospital's Utilization Management Plan;

1. Develop an organizational structure that provides continuous monitoring of patient care

practices and appropriate supervision of AHPs;

(6) Initiate and pursue corrective action with respect to Practitioners and AHPs, when warranted;

(7) Develop, administer and enforce these Bylaws, the Policies & Procedures**,** andthe Rules and Regulations of the Medical Staff and other Hospital policies related to medical care; and

(8) Review and evaluate the quality of patient care through a valid and reliable patient care monitoring procedure, including identification and resolution of important problems in patient care and treatment.

2.2(d) Assisting the Board in maintaining the accreditation status of the Hospital;

2.2(e) Participating and cooperating in implementation of the policies of federal and state regulatory agencies, including the requirements of the Data Bank; and

2.2(f) Maintaining confidentiality with respect to the records and affairs of the Hospital, except as disclosure is authorized by the Board or required by law.

**ARTICLE III**

**MEDICAL STAFF MEMBERSHIP AND CLINICAL PRIVILEGES**

**3.1 NATURE OF MEDICAL STAFF MEMBERSHIP AND CLINICAL PRIVILEGES**

Medical Staff membership is a privilege extended by the Hospital, and is not a right of any person. Membership on the Medical Staff shall be extended only to professionally competent Practitioners who continuously meet the qualifications, standards and requirements set forth in these Bylaws, Policies and Procedures, and Rules and Regulations. Membership on the Medical Staff shall confer on the Practitioner only those Prerogatives and responsibilities as have been granted by the Board in accordance with these Bylaws such as participation in Medical section activities, meetings and Medical Staff elections. Granting of Clinical Privileges is also a privilege extended by the Hospital, and is not a right of any person. Practitioners and AHP’s granted Clinical Privileges shall continuously meet the qualifications, standards and requirements set forth in these Bylaws, Policies and Procedures, andRules and Regulations. The Board shall confer on Practitioners and AHP’s such Clinical Privileges for treatment of Hospital patients as appropriate, based on qualifications as stated in these Bylaws. Medical Staff membership and Clinical Privilege delineation are separate and distinct privileges extended by the Governing Board. No person shall admit patients to, or provide services to patients in the Hospital, unless such person has had appropriate Clinical Privileges granted.

**3.2 BASIC QUALIFICATIONS/CONDITIONS FOR STAFF MEMBERSHIP AND CLINICAL PRIVILEGE DELINEATION**

**3.2(a) Basic Qualifications**

The only people who shall qualify for membership on the Medical Staff or for Clinical Privilege delineation are those Practitioners or AHPs legally licensed in Texas, who:

(1) Document their professional experience, background, education, training, demonstrated ability, current competence, and physical and mental health status with sufficient adequacy to demonstrate to the Medical Staff and the Board that any patient treated by them will receive quality care and that they are qualified to provide needed services within the Hospital;

(2) Are determined, on the basis of documented references, to adhere strictly to the ethics of their respective professions, to work cooperatively with others and to be willing to participate in the discharge of Medical Staff responsibilities;

(3) Comply and have complied with federal, state and local requirements, if any, for their medical practice, are not and have not been subject to challenges to licensure, or loss of Medical Staff membership or privileges which will adversely affect their services to the Hospital;

1. Have professional liability insurance that meets the requirements of Section 14.2;
2. Are graduates of an approved college and/or professional school holding appropriate degrees for their Medical Staff membership or Clinical Privilege delineation;

(6) Have successfully completed approved graduate medical education or the equivalent where applicable;

(7) Maintain a good reputation in his/her professional community; have the ability to work successfully with other professionals and have the physical and mental health to adequately practice his/her profession and to perform any Clinical Privileges granted;

(8)Show evidence every two years of continuing education credits as required by Texas. The education should be related at least in parttothe provision of quality patient care to Hospital patients; Practitioner or AHP’s clinical privileges[[2]](#footnote-2);

(9) Meet one (1) of the following requirements, in addition to those listed above:

(i) Board certification; or

(ii) adequate progress toward Board certification. The determination of adequacy shall be recommended by the MEC and must be approved by the Governing Board; or

(iii) demonstration to the satisfaction of the MEC and the Governing Board, competency and training equal or equivalent to that required for Board certification.

The above requirements shall not apply to any Practitioner already a Member of the Medical Staff as of the date these Bylaws are approved by the Governing Board.

(10) Have skills and training to fulfill a patient care need existing within the Hospital, and be able to adequately provide those services with the facilities and support services available at the Hospital; and

(11) Practice in such a manner as not to interfere with orderly and efficient rendering of services by the Hospital or by other Practitioners within the Hospital.

**3.2(b) Effects of Other Affiliations**

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

**3.2(c) Non-Discrimination**

No aspect of Medical Staff membership or particular Clinical Privileges shall be denied on the basis of sex, race, age, creed, color, national origin, disability (except as such may impair the Practitioner's ability to provide quality patient care or fulfill his/her duties under these Bylaws), or on the basis of any other criteria unrelated to the delivery of quality patient care in the Hospital, to professional ability and judgment, or to community need.

**3.2(d) Ethics**

The burden shall be on the applicant to establish that he/she is professionally competent and worthy in character, professional ethics and conduct. Acceptance of membership on the Medical Staff shall constitute the Member's certification that he/she has in the past, and agrees that he/she will, in the future, abide by the lawful principles of Medical Ethics of the American Osteopathic Association, or the American Medical Association, or other applicable codes of ethics.

**3.3 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERS AND AHPS**

Each Practitioner/ Medical Staff Member and AHP shall:

3.3(a) Provide his/her patients with continuous care at the generally recognized professional level of quality;

3.3(b) Consistent with generally recognized quality standards, deliver patient care in an efficient and financially prudent manner, and adhere to local medical review policies with regard to utilization;

3.3(c) Abide by the Medical Staff Bylaws and other lawful standards, Policies & Procedures, and Rules & Regulations of the Medical Staff;

3.3(d) Discharge the Medical Staff, department, committee and Hospital functions for which he/she is responsible by Medical Staff category assignment, appointment, election or otherwise;

3.3(e) Cooperate with other Members of the Medical Staff, management, the Governing Board, and employees of the Hospital in the interest of quality patient care;

3.3(f) Adequately prepare and complete in a timely fashion the medical and other required records for all patients he/she admits or, in any way provides care to, in the Hospital;

3.3(g) Be encouraged to be a member in good standing of respective professional societies and to participate in educational programs as contemplated by these Bylaws;

3.3(h) If, at any time, the Hospital does not have arrangements for the provision of Emergency Services, any physician on the Active or Provisional Staff clinically treating patients shall take emergency call on a rotating basis with the other Active and Provisional Staff Members;

3.3(i) Participate in a health screening prior to initial exercise of privileges;

3.3(j) Participate in the Hospital drug testing program;

3.3(k) Abide by the ethical principles of his/her profession and specialty;

3.3(l) Notify the CEO and Chief of Staff immediately if:

i. His/Her professional licensure in any state is suspended or revoked;

ii. His/Her professional liability insurance is modified or terminated;

iii. He/She is named as a defendant, or is subject to a final judgment or settlement, in any court proceeding alleging that he/she committed professional negligence or fraud;

iv. He/She has been excluded from any federal or state health program, including Medicare and Medicaid; or

v. He/She has any change in status or privileges at another facility.

3.3(m) Comply with all state and federal requirements for maintaining confidentiality of patient identifying medical information, including the Health Insurance Portability and Accountability Act of 1996, as amended, and its associated regulations, and execute a health information confidentiality agreement with the Hospital.

3.3(n) Comply with all hospital policies and applicable legal standards related to Hospital reimbursement, billing, third party payors, and federal health care programs. Each member of the Medical Staff shall further cooperate with the Hospital in order to facilitate Hospital billing and reimbursement efforts.

3.3(o) Refuse to engage in improper inducements for patient referral; and

3.3(p) If the physician is a referring physician owner, he/she must disclose to the patient, in writing,

his/her ownership and/or investment interest in the Hospital. Such disclosure is a condition of continued medical staff membership or admitting privileges. In the event that a referring physician owner fails to comply with such condition, the matter shall be subject to automatic suspension in accordance with Section 8.4(f) of these Bylaws. For the purposes of this provision, a “referring physician owner” is a physician who has any ownership and/or investment interest in the Hospital. The written disclosure must, at a minimum, indicate the following: "Dr. [insert name] is one of the proud owners of Odessa Regional Medical Center, a physician-owned hospital under 42 U.S.C. §1395nn. At the time of a referral for any necessary hospital services, each of our patients may choose Odessa Regional Medical Center or any other facility, center or hospital for the purpose of having such services performed as determined by the patient to be in the patient's best interest."

3.3(q) **Admission History**

Each patient admitted for inpatient care shall have complete admission history and physical examination recorded by a qualified doctor of medicine or osteopathy, or an oral maxillofacial surgeon (If the patient is admitted only for oral or maxillofacial surgery, the history and physical may be performed by an oral and maxillofacial surgeon who has been granted such privileges by the medical staff, in accordance with State law). Alternatively, a physician’s assistant or advanced practice nurse may perform a history and physical if permitted by State law and scope of practice and is privileged to do so by the medical staff. The responsible physician must review and approve the history and physical as specified by the medical staff. The medical history and physical examination for each patient shall be done no more than 30 days before or twenty-four (24) hours after an admission or registration, but prior to surgery or other procedure requiring anesthesia services and placed in the patient’s medical record within twenty-four (24) hours after admission. The history and physical must be in the medical record prior to any high-risk procedure, surgery or other procedure requiring anesthesia services and within 24 hours of admission or registration.[[3]](#footnote-3)

The Medical Staff shall determine the content and applicability of the medical history and physical examination.[[4]](#footnote-4) The content of the history and physical examination will be determined by an assessment of the patient’s condition and any co-morbidity in relation to the reason for admission or surgery.[[5]](#footnote-5)

Except in emergencies, there must be a complete history and physical in the medical record of every patient prior to surgery or procedure requiring anesthesia services.[[6]](#footnote-6)  If the history and physical has been dictated but not yet present in the patient’s medical record, the practitioner who admitted the patient shall write a statement to that effect as well as an admission note in the medical record. Such circumstance is acceptable only in a medical emergency and is not applicable for a scheduled surgery.[[7]](#footnote-7)

Where the history and physical is completed within 30 days prior to admission (or procedure or service that requires a history and physical), the hospital will ensure that this history and physical is updated by a qualified individual to document any changes in the patient’s condition. If there are no changes to the history and physical as written, the physician can document an update note stating that the history and physical has been reviewed, that the patient has been examined, and that the physician concurs with the findings of the history and physical completed on the specified date or that “no change” has occurred in the patient’s condition since the history and physical was completed. This examination and update of the patient’s current medical condition shall be completed and placed in the medical record within twenty-four (24) hours after admission or registration, but prior to surgery or other procedure requiring anesthesia services.[[8]](#footnote-8)

The practitioner completing the update is responsible for ensuring that the history and physical is documented in the medical record and is complete and accurate. The completed history and physical must be authenticated by the practitioner who conducted the history and physical, and as applicable, the physician who delegated the performance of the history and physical. Authentication includes dating and timing of this medical record entry. Therefore, it is not necessary to document the time the history and physical was physically placed in the medical record. For the purposes of this requirement, the term “admission” applies to any admission regardless of whether care is being provided in an inpatient or outpatient basis.[[9]](#footnote-9)

If a short form history and physical is used, the minimal content and applicability will be determined by the medical staff. This short form history and physical may be used for non-patients and be completed by the individuals as described above. Without exception, the history and physical must be in the medical record prior to any high-risk procedure.

3.3(r) **Consultations**

It will be the responsibility of the Attending Physician or surgeon to obtain consultation in those circumstances outlined in the mandatory consultation policy of this hospital. Consultations shall be obtained through written order of the Attending Physician. The consultation report shall include evidence of a review of the patient’s record by the consultant, pertinent findings on examination of the patient, the consultant’s opinion and recommendations. The report shall be made a part of the patient’s record. A limited statement, such as “I concur” does not constitute an acceptable report of consultation. When operative procedures are involved, the consultation note shall be recorded prior to the operation, except in emergency situations so verified on the record.[[10]](#footnote-10) Providers who are consulting are to visit the patient within 24 hours of the consult and dictate a consult note.

**3.4 DURATION OF APPOINTMENT**

**3.4(a) Duration of Initial Appointments**

(1) All initial appointments to the Active or Courtesy Staff and initial Clinical Privilege delineation shall be Provisional and shall be for a period of one (1) year. In no case shall the Board take action on an application, refuse to renew an appointment, or cancel an appointment, except as provided for herein. Appointment to the Medical Staff and/or Clinical Privilege delineation shall confer to the appointee only such privileges as may hereinafter be provided.

(2) Provisional status may not be renewed for a period that would extend the provisional status beyond eighteen (18) months from the date provisional status began. If the provisional appointee fails within that period to meet the requirements for advancement, such provisional appointee’s Medical Staff membership and/or particular Clinical Privileges, as applicable, shall terminate. The appointee so affected shall be given Special Notice of such termination and shall be entitled to the procedural rights afforded in the Fair Hearing Plan.

**3.4(b) Declaration of Moratorium**

The Board may from time to time declare moratoriums in the granting of Medical Staff membership and/or Clinical Privilege determination when the Board, in its discretion, deems such a moratorium to be in the best interest of this Hospital and in the best interest of the health and patient care capable of being provided by the Hospital and its staff. The aforementioned moratoriums may apply to individual medical specialty groups, or any combination thereof.

**3.4(c) Reappointments**

Reappointment to the Medical Staff and re-granting of Clinical Privileges shall be for a period of not more than two (2) years.

**3.4(d) Modification in Staff Category and Clinical Privileges**

The MEC may recommend to the Board that a change in Medical Staff category of a current Medical Staff Member or the granting of additional privileges to a current Medical Staff Member be made provisional in accordance with the procedures for initial appointment as outlined herein.

**3.5 LEAVE OF ABSENCE**

**3.5(a) Leave Status**

A Medical Staff Member may obtain a voluntary leave of absence from the Medical Staff by submitting a written request to the MEC stating the reason for the leave and the time period of the leave, which may not exceed one (1) year. If the leave request is granted, all rights and privileges of Medical Staff membership and any Clinical Privileges granted shall be suspended from the beginning of the leave period until reinstatement. If the staff member’s period of appointment ends while the member is on leave, he/she must reapply for Medical Staff membership and clinical privileges. Any such application must be submitted and shall be processed in the manner specified in these Bylaws for applications for initial appointment.

**3.5(b) Termination of Leave**

(1) Prior to the termination of leave, the Medical Staff Member may request reinstatement of his/her privileges and Medical Staff membership by submitting a written notice to that effect to the CEO or the CEO’s designee for transmittal to the MEC. The Medical Staff Member shall submit a written summary of the Member’s relevant activities during the leave. The MEC shall make a recommendation to the Board concerning the reinstatement of the Member's Medical Staff membership and Clinical Privileges after the MEC has satisfied itself as to the continuing competency of the returning Medical Staff Member. Such action will take place within sixty (60) days of receipt of request for termination of leave. Failure to request reinstatement in a timely manner shall result in automatic termination of Medical Staff membership, privileges and Prerogatives without right of hearing or appellate review. Termination of Medical Staff membership, privileges and Prerogatives pursuant to this section shall not be considered an adverse action, and shall not be reported to the Data Bank. A request for Medical Staff membership subsequently received from an individual so terminated shall be submitted and processed in the manner specified for application for initial appointments.

(2) If a Member requests leave of absence for the purpose of obtaining further medical training, reinstatement will ordinarily become automatic upon request for same, but only after the MEC has satisfied itself as to the continuing competency of the returning Medical Staff Member.

Any new privileges requested will be acted upon and monitored in similar fashion as if the Member were a new applicant and may include provisional status.

1. Reinstatement will ordinarily be automatic if a leave of absence is an armed services commitment. However, if such a leave of absence occurs with no medical activity for twelve (12) or more months, the MEC may require proof of competency by further education, such as a refresher course, or appropriate monitoring for a period of time, or both, to insure continuing competence.
2. If a Member requests leave of absence for reasons other than further medical training or

an armed services commitment, the MEC and/or the Board may, prior to reinstatement, require proof of competency by further education, such as a refresher course, or appropriate monitoring for a period of time, or both, to insure continuing competence. Evidence of current health status may be required.

* 1. **Resignation from the Medical Staff**

If a practitioner wishes to resign from the Medical Staff at any time other than in connection with the reappointment he/she must submit a written resignation to the Chief Executive Officer. Such resignation shall be effective as of the date set forth in the resignation unless there are incomplete medical records, corrective action has been initiated against such practitioner under Article VIII of the Medical Staff Bylaws, or his appointment or reappointment to the Medical Staff is being reviewed in which case the resignation shall not be effective until the medical records have been completed, or corrective action procedures have been terminated, or the review process has been completed, or the Executive Committee recommends to the Board that such resignation be accepted. Such resignation shall be effective when approved by the Board.

# ARTICLE IV

**CATEGORIES OF THE MEDICAL STAFF**

**4.1 CATEGORIES**

The Medical Staff shall include Physicians, Oral/Maxillofacial Surgeons, Dentists, and Podiatrists.

**4.2 ACTIVE STAFF**

**4.2(a) Qualifications**

The Active Staff shall consist of Practitioners who:

(1) Meet the basic qualifications for Medical Staff membership set forth in these Bylaws;

(2) Meet the qualifications for Clinical Privilege delineation in Practitioner’s specialty area;

(3) Have an office and/or residence located within 25 miles of the Hospital in order to be continuously available within 30 minutesfor provision of care to his/her patients, as determined by the Board; and

(4) Regularly admit to, or are otherwise regularly involved in the care of at least twenty (20) patients annually in the Hospital during an appointment period. For purposes of determining whether a practitioner is "regularly involved" in the care of the requisite number of patients, a patient encounter or contact shall be deemed to include any of the following: admission; consultation with active participation in the patient's care; provision of direct patient care or intervention in the hospital setting; performance of any outpatient or inpatient surgical or diagnostic procedure; interpretation of any inpatient or outpatient diagnostic procedure or test; or admission or referral of a patient for inpatient care by a Hospitalist. When a patient has more than one procedure or diagnostic test performed or interpreted by the same practitioner during a single hospital stay, the multiple tests for that patient shall count as one patient contact.

**4.2(b) Prerogatives**

The Prerogatives of an Active Staff Member shall be:

(1) To admit patients without limitation, unless otherwise provided in the Medical Staff Bylaws, Policies & Procedures or Rules & Regulations;

(2) To exercise such Clinical Privileges as are granted to him/her pursuant to Article VII;

(3) To vote on all matters presented at general and special meetings of the Medical Staff;

(4) To vote and hold office in the Medical Staff organization and departments and on committees to which he/she is appointed; and

1. To vote in all Medical Staff elections.

**4.2(c) Responsibilities**

Each Member of the Active Staff shall:

(1) Meet the basic responsibilities set forth in Section 3.3;

(2) Within his/her area of professional competence, retain responsibility for the continuous care and supervision of each patient in the Hospital for whom he/she is providing services, as evidenced by the ability to provide care within thirty (30) minutes, or arrange a suitable alternative for such care and supervision. An initial assessment of all patients must be performed within twenty-four (24) hours of admission and an initial assessment of all patients in a critical care unit must be performed within eight (8) hours after admission into the critical care unit, recognizing the physician is responsible to respond within thirty (30) minutes if warranted by the patient’s condition.

(3) Actively participate:

(i) in the performance improvement program and other patient care evaluation and monitoring activities required of the Medical Staff;

(ii) in supervision of provisional appointees where appropriate;

(iii) in the emergency on-call rotation, including personal appearance to assess patients in the emergency department when deemed appropriate by the emergency department physician;

(iv) in promoting effective utilization of resources consistent with delivery of quality patient care; and

(v) in discharging such other Medical Staff functions as may be required from time-to-time.

(4) Serve on at least one (1) Medical Staff committee, if appointed by the Chief of Staff; and

(5) Satisfy the requirements set forth in these Bylaws for attendance at meetings of the Medical Staff and of section and committees of which he/she is a Member.

**4.2(d) Failure**

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

**4.3 COURTESY STAFF**

**4.3(a) Qualifications**

The Courtesy Staff shall consist of Practitioners, who:

(1) Meet the basic qualifications set forth in Section 3.2(a);

(2) Have an office and/or residence located within 25 miles of the Hospital, in order to be continuously available within thirty (30) minutes for provision of care to his/her patients, or arrange to have continuous coverage of these patients by another Member of the Medical Staff with privileges appropriate to the treatment provided;

(3) Regularly admit to, or are otherwise regularly involved in the care of at least six (6) patients annually in the Hospital during an appointment period, but may not admit more than twenty (20) patients in a calendar year~~s~~.

Care of patients is defined as the following:

For purposes of determining whether a practitioner is "regularly involved" in the care of the requisite number of patients, a patient encounter or contact shall be deemed to include any of the following: admission; consultation with active participation in the patient's care; provision of direct patient care or intervention in the hospital setting; performance of any outpatient or inpatient surgical or diagnostic procedure; interpretation of any inpatient or outpatient diagnostic procedure or test; or admission or referral of a patient for inpatient care by a Hospitalist. When a patient has more than one procedure or diagnostic test performed or interpreted by the same practitioner during a single hospital stay, the multiple tests for that patient shall count as one patient contact.

(4) Courtesy Staff Out-of-Area

* Meet the basic qualifications set forth in Section 3.2(a); and
* Have fewer than 20 encounters in which they manage direct patient care or must have their primary practice outside the community, which shall be defined as a greater than 25 mile radius of the Hospital. For Courtesy Staff members who have their primary practice outside the community, such members may provide or manage direct patient care, within the scope of their granted clinical privileges, in an unlimited number of cases, where there is, as determined by the Board of Trustees in consultation with and on the recommendation of the Medical Executive Committee, an otherwise unfulfilled community need for the services to be provided by the particular Courtesy Staff member. A determination by the Medical Executive Committee and/or Board of Trustees that there is not an unfulfilled community need for the services of a particular Courtesy Staff member shall not be subject to appeal nor entitle the member to any of the procedural rights under these Bylaws. Courtesy Staff members whose primary practice is located in the community must transfer to Active Staff if they exceed the accepted number of encounters referenced above.

**4.3(b) Prerogatives**

The Prerogatives of a Courtesy Staff Member shall be to:

(1) Admit patients to the Hospital within the limitations provided in Section 4.3(a);

(2) Exercise such Clinical Privileges as are granted to him/her pursuant to Article VII;

(3) Attend meetings of the Medical Staff and any Medical Staff or Hospital education programs; and

(4) Serve on any of the standing committees as a voting Member on matters of policies and procedure, except that he/she shall not be entitled to vote for Chief of any Section, any officer of the Medical Staff and shall not vote as a Member of the MEC or at a general Medical Staff meeting.

**4.3(c) Responsibilities**

Each Member of the Courtesy Staff shall:

(1) Discharge the basic responsibilities specified in Section 3.3;

(2) Within his/her area of professional competence, retain responsibility for the continuous care and supervision of each patient in the Hospital for whom he/she is providing services, as evidenced by the ability to provide care within thirty (30) minutes, or arrange a suitable alternative for such care and supervision. An initial assessment of all patients must be performed within twenty-four (24) hours of admission and an initial assessment of all patients in a critical care unit must be performed within eight (8) hours after admission into the critical care unit, recognizing the physician is responsible to respond within thirty (30) minutes if warranted by the patient’s condition.

(3) Satisfy the requirements set forth in these Bylaws for attendance at meetings of the Medical Staff and of the committees of which he/she is a member.

**4.4 CONSULTING STAFF**

**4.4(a) Qualifications**

Consulting Staff shall consist of a special category of Physicians each of whom is, because of board certification, training and experience, recognized by the medical community as an authority within his/her specialty.

**4.4(b) Prerogatives**

(1) Prerogatives of a Consulting Staff Member shall be to:

* + 1. Consult on patients within his/her own specialty;
    2. Consult on patients only by request of an Active, Courtesy or Provisional Staff Member, and
    3. Attend all meetings of the Medical Staff and the applicable department that he/she may wish to attend as a non-voting visitor.

(2) Consulting Staff Members shall not in any circumstance admit patients to the Hospital or transfer patients from the Hospital or be the physician of primary care or responsibility for any patient within the Hospital. Consulting Staff Members shall not hold office nor be eligible to vote in the Medical Staff organization.

**4.4(c) Responsibilities**

Each Member of the Consulting Staff shall assume responsibility, as requested by an Active, Courtesy or Provisional Staff Member, for consultation and appropriate documentation thereof with regard to particular patients.

**4.5 HONORARY STAFF**

**4.5(a) Qualifications**

The Honorary and Retired Staff shall consist of physicians who are not active in the Hospital and who are honored by emeritus positions. These may be:

(1) Physicians who have retired from active Hospital services, but continue to demonstrate a genuine concern for the Hospital; or

(2) Physicians of outstanding reputation in a particular specialty, whether or not a resident in the community.

Honorary Staff Members shall not be required to meet the qualifications set forth in Section 3.2(a) of these Bylaws.

**4.5(b) Prerogatives**

(1) Prerogatives of an Honorary Staff Member shall be:

(i) attending by invitation any such meetings that he/she may wish to attend as a non-voting visitor.

(2) Honorary Staff Members shall not in any circumstances admit patients to the Hospital or be the physician of primary care or responsibility for any patient within the Hospital. Honorary Staff Members shall not hold office nor be eligible to vote in the Medical Staff organization.

**4.6 PROVISIONAL STAFF**

**4.6(a) Nature of Provisional Staff Appointment**

(1) Initial appointments to the Medical Staff shall be provisional for a period of one (1) year. Each newly appointed Member shall be assigned to a section where his/her performance and competence shall be observed by the Section Chief. Conditions of appointment, such as proctorship requirements, may be imposed as deemed appropriate by the MEC.

(2) At the end of the one (1) year provisional status, the Member will be evaluated by the Chief of the Section for the removal or extension of the provisional status. Information and findings from the Hospital’s performance improvement program shall be considered as part of the evaluation process.

(3) Provisional status may be extended for one (1) additional six (6) month period. If at the end of this period the Practitioner has not met the requirements for advancement to another Medical Staff category, he/she will be removed from the Medical Staff.

(4) At the end of the provisional period, the Practitioner may request advancement to another Medical Staff category. The MEC shall consider the recommendation of the department, and shall recommend to the Board that the Practitioner be advanced to the appropriate category, or that he/she be removed from the Medical Staff. The decision of the MEC shall be based on the Practitioner's demonstrated competence, appropriate utilization, meeting attendance and Bylaws compliance, as well as all factors considered in the reappointment process as outlined in these Bylaws. Upon Board approval, the Practitioner will be advanced to the appropriate Medical Staff category.

**4.6(b) Qualifications**

The Provisional Staff shall consist of Practitioners who meet the basic requirements of Medical Staff membership and specialty specific Clinical Privilege criteria and are seeking advancement to another Medical Staff category, but have not completed the period of provisional appointment established in these Bylaws. The qualifications of a Provisional Staff Member shall be the same as those required for the category to which he/she seeks advancement.

**4.6(c) Prerogatives**

The Prerogatives of a Provisional Staff Member shall be:

(1) To serve on committees (except the MEC and Credentials) and sections of the Medical Staff as a voting Member if seeking advancement to Active Staff and as a non-voting Member if seeking advancement to another Medical Staff category;

(2) To attend Medical Staff meetings as a non-voting Member; and

(3) To admit and treat patients subject to the limitations of the category to which he/she seeks advancement.

**4.6(d) Responsibilities**

The Responsibilities of a Provisional Staff Member shall be the same as those of Practitioners in the category to which he/she seeks advancement.

* 1. **RESIDENTS**

**4.7 (a) Qualifications**

The terms “residents” and interns” (hereinafter referred to collectively as “residents”) as used in these Bylaws, refer to practitioners who are currently enrolled in a graduate medical education program approved by the Medical Staff Executive Committee and the Governing Board, and who, as part of their educational program, will provide health care services at the hospital. Residents shall not be considered independent practitioners, shall not be eligible for clinical privileges or medical staff membership, and shall not be entitled to any of the rights, privileges, or to the hearing or appeal rights under these Bylaws. In compliance with federal laws, it shall not be necessary to submit a query to the National Practitioner Data Bank prior to permitting a resident to provide services at this hospital. Residents may render patient care services at the hospital only pursuant to and limited by the following:

1. Applicable provisions of the hospital licensing laws of this state;

(ii) the written affiliation agreement between Odessa Regional Medical Center and Texas Tech University Health Sciences Center. Such agreement shall identify the individual or entity responsible for providing professional liability insurance coverage for Residents in amounts of not less than $100,000/300,000 per occurrence, and with a carrier approved by the governing body of this hospital; and

(iii) the protocols established by the Medical Staff Executive Committee, in conjunction with the sponsoring school or training program, regarding the scope of the Resident’s authority, direction and supervision of the Resident, and other conditions imposed upon the Resident by Odessa Regional Medical Center or its Medical Staff. Assignment of the Resident to a member of the Medical Staff shall be the sole responsibility of Texas Tech University Health Sciences Center in cooperation with the Medical Staff Member. The Medical Staff Member may decline this assignment at his/her sole discretion.

**4.7 (b) Responsibilities**

While functioning at this hospital, Residents shall abide by all provisions of the Medical Staff Bylaws, Rules and Regulations, and Hospital and Medical Staff Policies and Procedures, and shall be subject to limitation or termination of their ability to function at the hospital at any time at the discretion of the Chief Executive Officer or the Chief of Staff. Residents may perform only those services set forth in the training protocols developed by the applicable training program to the extent that such services do not exceed or conflict with the Rules and Regulations of the Medical Staff or Hospital policies and to the extent approved by the Governing Board. Residents shall be responsible and accountable at all times to a member of the Medical Staff and shall be under the supervision and direction of a member of the Medical Staff of this Hospital. Residents shall not attend Medical Staff Meetings except when invited or as required.

Complete an Information Form which contains basic information about the Resident and the program of which he/she is a part.

Provide a letter from the program director of which the Resident is a part, indicating that the individual is in an accredited training program, and the assignment of the individual to a rotation at ORMC is a part of that training.

Provide a copy of the Texas Medical License.

Provide evidence of Professional Liability Insurance with minimum limits of $100,000 per occurrence and $300,000 in the aggregate with a carrier reasonably acceptable to the Hospital.

**4.7(c) Prerogatives**

Practitioners who are currently enrolled in a graduate medical education program, and who are independently licensed by the Texas Board of Medical Examiners may provide patient care services independently at the hospital (e.g., moonlighting in the Express Care or locum tenens) and not as part of their educational program. Such practitioners who provide independent services must meet the qualifications for medical staff membership and privileges as provided in the Medical Staff Bylaws, Article III, and shall be credentialed in the same manner as a practitioner seeking initial appointment to the Medical Staff.

**ARTICLE V**

**ALLIED HEALTH PROFESSIONALS (AHP)**

**5.1 CATEGORIES**

Allied Health Professionals (“AHPs”) shall be identified as any person(s), other than Practitioners, who are granted privileges to practice in the Hospital and are directly involved in patient care. If such persons areDependent AHPs, they may be employed by Physicians on the Medical Staff, but whether or not so employed, must be under the direct supervision and direction of a Medical Staff Practitioner. The Allied Health Staff shall include Independent and Dependent Allied Health Professionals.

**5.2 INDEPENDENT ALLIED HEALTH PROFESSIONALS**

The Independent Allied Health Staff shall consist only of those individuals licensed by the State of Texas to perform their duties apart from a supervising physician, e.g., Certified Registered Nurse Anesthetists (CRNAs), Licensed Medical Social Workers, Licensed Counselors, etc. Each Independent AHP shall function within a section of the Medical Staff.

* 1. **(a) Qualifications**

1. Only Independent AHPs holding a license, certificate or other official credentials as provided under state law, shall be eligible to provide specified services in the Hospital as recommended by the MEC and approved by the Board.
2. In addition to the qualifications as required of AHPs in Section 3.2 of these Bylaws, AHPs must:
3. Provide a needed service within the Hospital.

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**5.2 (b)** **Responsibilities**

Each member of the Independent Allied Health Staff shall:

1. Meet the basic responsibilities set forth in Section 3.3
2. Actively participate in the performance improvement program and other patient care evaluation and monitoring activities as required of the Medical Staff.
3. Promote effective utilization of resources consistent with delivery of quality patient care;
4. Discharge such other functions as may be required from time-to-time; and
5. Comply with Medical Staff and Hospital Policies & Procedures and Rules & Regulations.

**5.2(c)** **Prerogatives**

Upon establishing experience, training, and current competency, Independent AHPs, as identified in Section 5.2, may:

(i) Provide patient care services within the limits of their professional skills, abilities, and their license. The degree of participation in patient care shall be determined according to privileges recommended and approved by the Governing Board;

1. Exercise independent judgment in their areas of competence, provided that an Active or Provisional member of the Medical Staff shall have the ultimate responsibility for patient care. Certified Registered Nurse Anesthetists may exercise independent judgment in their area of competence with a physician’s order for anesthesia. Such order does not require the order to be drug, dosage, or administration technique specific;
2. Participate directly in the management and care of patients under the general supervision or direction of an Active or Provisional member of the Medical Staff;
3. Record reports and progress notes on the patients’ records and write orders for treatment to the extent established in the Rules and Regulations of the Medical Staff, provided such orders are within the scope of his/her license;
4. Participate as appropriate in patient care evaluation and other performance improvement activities required of the Medical Staff, and to discharge such other Medical Staff functions as may be required from time-to-time.
5. **NOT** admit or discharge patients at the Hospital.
   1. **DEPENDENT ALLIED HEALTH PROFESSIONALS**

Dependent Allied Health Staff shall consist of individuals who are employed by members of the Medical Staff or are contracted by the Hospital, and must be under the direct supervision and direction of a member of the Medical Staff. Each Dependent AHP shall function within a section of the Medical Staff. The Dependent AHP will be assigned to the same Section as his/her supervising member of the Medical Staff.

**5.3 (a)** **Qualifications**

1. Only AHPs holding a license, certificate or other official credentials as provided under state law, shall be eligible to provide specified services in the Hospital as recommended by the MEC and approved by the Board. ~~and must:~~
2. In addition to the qualifications as required of AHPs in Section 3.2 of these Bylaws, AHPs must:
3. Provide a needed service within the Hospital; and
4. Provide written documentation that a Medical Staff appointee has assumed responsibility for the acts and omissions of the AHP and responsibility for directing and supervising the AHP.

**5.3 (b)** **Responsibilities**

Each member of the Dependent Allied Health Staff shall:

1. Meet the basic responsibilities set forth in Section 3.3;
2. Actively participate in the performance improvement program and other patient care evaluation and monitoring activities as may be required.
3. Discharge such other functions as may be required from time-to-time; and
4. Comply with Medical Staff and Hospital Policies & Procedures and Rules &

Regulations.

**5.3 (c)** **Prerogatives**

Upon establishing experience, training, and current competency, Dependent AHPs, as identified in Section 5.3, may:

1. Exercise judgment within the AHPs area of competence, providing that a member of the Medical Staff has the ultimate responsibility for patient care;
2. Participate directly, including writing orders, to the extent permitted by law and within the limits of their professional skills, abilities, and their license/certificate. The degree of participation by the Dependent AHP in patient care shall be determined according to privileges requested and approved by the Supervising Member of the Medical Staff and ultimately approved by the Governing Board; and
3. Participate as appropriate in patient care evaluation and other performance improvement activities required of the Medical Staff, and to discharge such other Medical Staff functions as may be required from time-to-time.

**5.4 CONDITIONS FOR GRANTING CLINICAL PRIVILEGES**

5.4(a) AHPs shall be credentialed in the same manner as outlined in Article VI of the Medical Staff Bylaws for credentialing of Practitioners. Each AHP shall be assigned to one (1) of the clinical sections and shall be granted Clinical Privileges relevant to the care provided in that department. The Board in consultation with the MEC shall determine the scope of the activities which each AHP may undertake. Such determinations shall be furnished in writing to the AHP and shall be final and non-appealable, except as specifically and expressly provided in these Bylaws.

AHPs are not members of the Medical Staff and, are not subject or entitled to the rights and obligation of Medical Staff members.

5.4(b) Clinical Privilege delineation of AHPs must be approved by the Board and may be terminated at will by the Board or the CEO. AHP privileges and their reduction or termination (“Adverse Decisions”) shall not be covered by the provisions of the Fair Hearing Plan, but rather are provided for by the following:

The appointee so affected shall be given Special Notice of such termination and the reason(s) for the Adverse Decision. The AHP may request an appearance before the Medical Staff Executive Committee in order to present evidence on behalf of him/her self and appeal the decision to suspend, modify, or terminate privileges prior to final action by the Board. Should the MEC recommend an Adverse Decision to the Board, the AHP shall then be permitted to submit a written statement of appeal to the MEC for consideration prior to an Adverse Decision becoming permanent.

5.4(c) AHP privileges shall automatically terminate upon revocation of the privileges of the AHP's supervising Practitioner Member, unless another qualified Practitioner indicates his/her willingness to supervise the AHP and complies with all requirements hereunder for undertaking such supervision. In the event that an AHP's supervising Practitioner Member's privileges are significantly reduced or restricted, the AHP's privileges shall be reviewed and modified by the Board upon recommendation of the MEC. Such actions shall not be covered by the provisions of the Fair Hearing Plan or Article V in the case of AHPs.

5.4(d) If the supervising Practitioner employs or directly contracts with the AHP for services, the Practitioner shall indemnify the Hospital and hold the Hospital harmless from and against all actions, cause of actions, claims, damages, costs and expenses, including reasonable attorney fees, resulting from, caused by or arising from improper or inadequate supervision of the AHP, patients, or any action by such AHP beyond the scope of his/her license or Clinical Privileges. If the supervising Practitioner does not employ or directly contract with the AHP, the Practitioner shall indemnify the Hospital and hold the Hospital harmless from and against all actions, causes of action, claims, damages, costs and expenses, including reasonable attorney fees, resulting from, caused by or arising from improper or inadequate supervision of the AHP by the Practitioner in question.

**5.5 RESPONSIBILITIES**

Each AHP shall:

5.5(a) Provide his/her patients with continuous care at the AHP’s generally recognized professional level of quality;

5.5(b) Abide by the Medical Staff Bylaws and other lawful standards, Policies & Procedures, and Rules & Regulations of the Medical Staff, and personnel policies of the Hospital, if applicable;

5.5(c) Discharge any committee functions for which he/she is responsible;

5.5(d) Cooperate with Members of the Medical Staff, administration, the Governing Board, and employees of the Hospital;

5.5(e) Adequately prepare and complete in a timely fashion the medical and other required records for which he/she is responsible;

5.5(f) Participate in performance improvement activities and in continuing professional education;

5.5(g) Abide by the ethical principles of his/her profession and specialty; and

5.5(h) Notify the CEO and the Chief of Staff immediately if:

(1) His/Her professional license in any state is suspended or revoked;

(2) His/Her professional liability insurance is modified or terminated;

1. He/She is named as a defendant, or is subject to a final judgment or settlement, in any

court proceeding alleging that he/she committed professional negligence; or

(4) He/She ceases to meet any of the standards or requirements set forth herein

for continued enjoyment of AHP Clinical Privileges.

**ARTICLE VI**

**PROCEDURES FOR APPOINTMENT, REAPPOINTMENT AND CLINICAL PRIVILEGE DELINEATION**

**6.1 GENERAL PROCEDURES**

**6.1 (a)** The Medical Staff through its designated committees and sections shall investigate and consider each application for appointment or reappointment to the Medical Staff and Clinical Privilege delineation and each request for modification of Medical Staff membership and/or Clinical Privilege delineation status and shall adopt and transmit recommendations thereon to the Board which shall be the final authority on granting, extending, terminating or reducing Medical Staff membership and Clinical Privileges. The Board shall be responsible for the final decision as to Medical Staff appointments, reappointments and Clinical Privilege delineation. A separate, confidential record shall be maintained for each individual requesting Medical Staff membership or Clinical Privileges.

**6.1 (b)** In its discretion, the Board may delegate authority for Medical Staff appointments, reappointments and Clinical Privilege delineation to a committee of the Board consisting of at least two Board members, (the “Expedited Process”). A positive decision by the committee and ratified by the full Board, results in the status or privileges requested by the applicant. If the committee returns a negative decision concerning the application, the application shall be returned to the MEC for further recommendation prior to final action by the Board. The following criteria must be met in order for the full Board to delegate the Expedited Process to a Board committee:

(a) The applicant’s application is complete;

(b) The Medical Executive Committee makes a final recommendation that is in favor of the Applicant and that is without limitation;

(c) There are no current challenges or previously successful challenges to the applicant’s licensure or registration;

(d) The applicant has not received an involuntary termination of medical staff membership at another organization;

(e) The applicant has not received involuntary limitation, reduction, denial, or loss of Clinical Privileges; and

(f) There have been no final judgments adverse to the applicant in a professional liability action.

**6.2 CONTENT OF APPLICATION FOR INITIAL APPOINTMENT/ CLINICAL PRIVILEGING**

Each application for appointment or reappointment to the Medical Staff and each application for delineation of Clinical Privileges shall be in writing, submitted on the prescribed form approved by the Board, and signed by the applicant. A copy of all active state licenses, current DEA registration/controlled substance certificate (as applicable), a signed Medicare penalty statement, information on participation in required continuing education[[11]](#footnote-11), a certificate of insurance, and other facility-specific forms must be submitted with the application . An application fee may be assessed and collected at the time application is made. Applicants shall supply the Hospital with all information requested on the application. In lieu of copies of these documents, Practitioners shall furnish along with their application, information sufficient for electronic online primary source verification of all state licenses and DEA registration/controlled substance certificate. **EXCEPTION:** DEA registration/controlled substance certificate shall not be required for pathologists, teleradiologists, or AHPs.

The application form shall include, at a minimum, the following:

(a) Acknowledgment and Agreement: A statement that the applicant has received and read the

Bylaws, Policies & Procedures, Rules & Regulations and Fair Hearing Plan of the Medical Staff, and that he/she agrees:

(i) to be bound by the terms thereof if he/she is granted membership and/or Clinical Privileges; and

(ii) to be bound by the terms thereof in all matters relating to consideration of his/her application, without regard to whether he/she is granted membership and/or Clinical Privileges.

(b) Administrative Remedies: A statement indicating that the applicant agrees that he/she will exhaust the administrative remedies afforded by these Bylaws before resorting to formal legal action, should an adverse ruling be made with respect to his/her Medical Staff membership, Medical Staff status, and/or Clinical Privileges;

(c) Felony Charges: Any current criminal charges pending against the applicant and any past convictions or pleas. The applicant shall notify the CEO and the Chief of Staff within seven (7) days of receiving notice of the initiation of any felony charges;

(d) Fraud: Any allegations of civil or criminal fraud pending against any applicant and any past allegations including their resolution and any investigations by any private, federal or state agency concerning participation in any health insurance program, including Medicare or Medicaid;

(e) Health Status: Evidence of current physical and mental health status only to the extent necessary to demonstrate that the applicant is capable of performing the functions of Medical Staff membership and exercising the privileges requested;

(f) Information on Malpractice Experience: All information concerning malpractice cases against the applicant either filed, pending, settled, or pursued to final judgment. It shall be the continuing duty of the applicant to notify the MEC of the initiation of any professional liability action against him/her. The applicant shall have a continuing duty to notify the MEC through the CEO or his/her designee within seven (7) days of receiving notice of the initiation of a professional liability action against him/her. The CEO or his/her designee shall be responsible for notifying the MEC of all such actions;

(g) Education: Detailed information concerning the applicant’s education and training, including ECFMG certification (if applicable);

(h) Insurance: Information as to whether the applicant has currently in force professional liability coverage meeting the requirements of these Bylaws together with a letter from the insurer stating that the Hospital will be notified should the applicant's coverage change at any time. Each applicant must, at all times, keep the CEO informed of changes in his/her professional liability coverage;

(i) Notification of Release and Immunity Provisions: Statements notifying the applicant of the scope and extent of authorization, confidentiality, immunity and release provisions of Section 6.3(b) and (c).

(j) Professional Sanctions: Information as to previously successful or currently pending challenges to, or the voluntary relinquishment of, any of the following:

(i) membership/fellowship in local, state or national professional organizations;

(ii) specialty board certifications;

(iii) license to practice any profession in any jurisdiction;

(iv) Drug Enforcement Agency (DEA) number/controlled substance license; or

(v) Medical Staff membership or voluntary or involuntary limitation, reduction or loss of Clinical Privileges; or

(vi) the Practitioner's or AHP’s management of patients which may have given rise to investigation by the state medical board or state professional board; or

(vii) participation in any private, federal or state health insurance program, including Medicare or Medicaid.

If any such actions were taken, the particulars thereof shall be obtained before the application is considered complete. The Practitioner shall have a continuing duty to notify the MEC through the CEO or his/her designee within seven (7) days of receiving notice of the initiation of any of the above actions against him/her. The CEO or the CEO’s designee shall be responsible for notifying the MEC of all such actions;

(k) Qualifications: Detailed information concerning the applicant's experience and qualifications for the requested Medical Staff category, including information in satisfaction of the basic qualifications specified in Section 3.2(a), and any and all of the applicant's current professional license(s) and federal and state drug registration numbers;

(l) References: The names of at least three (3) Practitioners, (excluding partners, associates in practice, employers, employees or relatives), who have worked with the applicant within the past three (3) years and personally observed his/her professional performance and who are able to provide knowledgeable peer recommendations as to the applicant's education, experience and clinical ability, ethical character and ability to work with others;

(m) Request: Specific requests stating the Medical Staff category and specific Clinical Privileges for which the applicant wishes to be considered;

(n) Practice Affiliations: The name and address of all other hospitals, health care organizations or practice settings with whom the applicant is or has previously been affiliated;

(o) Photograph: A valid picture ID issued by a state or federal agency (e.g., driver’s license or passport) and a recent, wallet sized photograph of the applicant; and

(p) Managed Care Affiliations: The names of all HMO’s, PPO’s and other managed care organizations in which the applicant has participated in the past three (3) years.

**6.3 PROCESSING THE APPLICATION**

**6.3(a) Request for Application**

A Practitioner or AHP wishing to be considered for Medical Staff appointment or reappointment and/or Clinical Privileges may obtain an application form therefore by submitting his/her written request for an application form to the CEO or his/her designee.

**6.3(b) Applicant's Burden**

By submitting the application, the applicant:

(1) Signifies his/her willingness to appear for interviews and acknowledges that he/she shall have the burden of producing adequate information for a proper evaluation of his/her qualifications for Medical Staff membership and Clinical Privileges;

(2) Authorizes Hospital representatives to consult with others who have been associated with him/her and/or who may have information bearing on his/her current competence and qualifications;

(3) Consents to the inspection by Hospital representatives of all records and documents that may be material to an evaluation of his/her licensure, specific training, experience, current competence, health status and ability to carry out the Clinical Privileges he/she requests as well as of his/her professional ethical qualifications for Medical Staff membership;

1. Represents and warrants that all information provided by him/her is true, correct and complete in all material respects, agrees to notify the Hospital of any change in any of the information furnished in the application, and acknowledges that provision of false or misleading information, or omission of information, whether intentional or not, may be grounds for immediate rejection of his/her application without fair hearing rights;
2. Acknowledges that, if he/she is determined to have made a misstatement, misrepresentation, or omission in connection with an application and such misstatement, misrepresentation, or omission is discovered after appointment and/or the granting of clinical privileges, his/her appointment and clinical privileges may be revoked without fair hearing rights;

(6) Pledges to provide continuous care for his/her patients who are treated in the Hospital;

(7) Agrees to be bound by the statements described in Section 6.3(c).

**6.3(c) Statement of Release & Immunity from Liability**

The following are express conditions applicable to any applicant and to any person appointed to the Medical Staff and to anyone having or seeking privileges to practice his/her profession in the Hospital during his/her term of appointment or reappointment. In addition, these statements shall be included on the application form, and by applying for appointment, reappointment or Clinical Privileges (“Appointment” in this Section 6.3(c) of these Medical Staff Bylaws) the applicant expressly accepts these conditions during the processing and consideration of his/her application, and at all times thereafter, regardless of whether or not he/she is granted appointment, reappointment or Clinical Privileges.

I hereby apply for Appointment as requested in this application and, whether or not my application is accepted, I acknowledge, consent and agree as follows:

As an applicant for Appointment, I have the burden for producing adequate information for proper evaluation of my qualifications. I also agree to update the Hospital with current information regarding all questions contained in this application as such information becomes available and any additional information as may be requested by the Hospital or its authorized representatives. Failure to produce any such information will prevent my application for Appointment from being evaluated and acted upon. I hereby signify my willingness to appear for the interview, if requested, in regard to my application.

Information given in or attached to this application is accurate and complete to the best of my knowledge. I fully understand and agree that as a condition to making this application, any misrepresentations or misstatement in, or omission from it, whether intentional or not, shall constitute cause for automatic and immediate rejection of this application, resulting in denial of appointment, reappointment and/ or Clinical Privileges without fair hearing rights. I further acknowledge that if I am reasonably determined to have made a misstatement, misrepresentation, or omission in connection with an application that is discovered after appointment and/or the granting of clinical privileges, my appointment and clinical privileges, may be revoked without fair hearing rights.

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If granted appointment, reappointment or Clinical Privileges, I accept the following conditions:

(1) I extend immunity to, and release from any and all liability, the Hospital, its authorized representatives and any third parties, as defined in subsection (3) below, for any acts, communications, recommendations or disclosures performed without intentional fraud or malice involving me; performed, made, requested or received by this Hospital and its authorized representatives to, from or by any third party, including otherwise privileged or confidential information, relating, but not limited to, the following:

(i) applications for appointment, reappointment and/ or Clinical Privileges, including temporary privileges;

(ii) periodic reappraisals;

(iii) proceedings for suspension or reduction of Clinical Privileges or for denial or revocation of appointment, or any other disciplinary action;

(iv) summary suspension;

(v) hearings and appellate reviews;

(vi) medical care evaluations;

(vii) utilization reviews;

(viii) any other hospital, Medical Staff, department, service or committee activities;

(ix) inquiries concerning my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics or behavior; and

(x) any other matter that might directly or indirectly impact or reflect on my competence, on patient care or on the orderly operation of this Hospital.

1. I specifically authorize the Hospital and its authorized representatives to consult with any third party who may have information, including otherwise privileged or confidential information, bearing on my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, criminal history, ethics, behavior or other matter bearing on my satisfaction of the criteria for continued Appointment, as well as to inspect or obtain any and all communications, reports, records, statements, documents, recommendations and/or disclosure of said third parties relating to such questions. I also specifically authorize said third parties to release said information to the Hospital and its authorized representatives upon request.
2. The term “Hospital” and “its authorized representatives” means IASIS Healthcare, Odessa Regional Medical Center to which I am applying and any of the following individuals who have any responsibility for obtaining or evaluating my credentials, or acting upon my application or conduct in the Hospital: the members of the Board and their appointed representatives, the CEO or his/her designees, other Hospital employees, consultants to the Hospital, the Hospital’s attorney and his/her partners, associates or designees, and all appointees to the Medical Staff. The term “third parties” means all individuals, including appointees to the Medical Staff, and appointees to the Medical Staffs of other Hospitals or other physicians or health practitioners, nurses or other government agencies, organizations, associations, partnerships and corporations, whether hospitals, health care facilities or not, from whom information has been requested by the Hospital or its authorized representatives or who have requested such information from the Hospital and its authorized representatives.

I acknowledge that: (1) Appointments at this Hospital are not a right; (2) my request will be evaluated in accordance with prescribed procedures defined in these Bylaws, Policies & Procedures, and Rules & Regulations; (3) all Medical Staff recommendations relative to my application are subject to the ultimate action of the Board whose decision shall be final; (4) if Appointed, my appointment, reappointment and/or Clinical Privileges shall be provisional; (5) I have the responsibility to keep this application current by informing the Hospital through the CEO, of any change in the areas of inquiry contained herein; and (6) appointment, reappointment and continued Clinical Privileges remain contingent upon my continued demonstration of professional competence and cooperation, my general support of the acceptable performance of all responsibilities related thereto, as well as other factors that are relevant to the effective and efficient operation of the Hospital. Appointment shall be granted only on formal application, according to the Hospital and these Bylaws, Policies & Procedures, and Rules & Regulations, and upon final approval of the Board.

I understand that before this application will be processed that: (1) I will be provided a copy of the Medical Staff Bylaws and such Hospital policies and directives as are applicable to appointees to the Medical Staff, and/ or to those granted Clinical Privileges including these Bylaws, Policies & Procedures, and Rules & Regulations of the Medical Staff currently in force; and (2) I must sign a statement acknowledging receipt and an opportunity to read the copies and agreement to abide by all such Bylaws, Policies & Procedures, directives and Rules and Regulations as are in force, and as they may thereafter be amended, during the time I am appointed to the Medical Staff or exercise Clinical Privileges at the Hospital.

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

**6.3(d) Submission of Application & Verification of Information**

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

(1) Not Licensed. The Practitioner or AHP is not licensed in this state to practice in a field of health care eligible for appointment to the Medical Staff or Clinical Privilege delineation; or

(2) Membership or Clinical Privileges Denied or Terminated. Within one (1) year immediately preceding the request, the Practitioner or AHP has had his/her application for Medical Staff appointment and/ or Clinical Privilege delineation at this Hospital denied, has resigned his/her Medical Staff appointment and/ or Clinical Privileges at this Hospital during the pendency of an active investigation which could have led to revocation of his/her appointment or Clinical Privilege delineation, or has had his/her appointment or Clinical Privileges revoked or terminated at this Hospital; or had an application rejected at this hospital as a result of fraudulent conduct, misrepresentations in the application process, or other basis involving dishonesty; or

(3) Exclusive Contract or Moratorium. The Practitioner or AHP practices a specialty which is the subject of a current written exclusive contract for coverage with the Hospital or a moratorium has been imposed by the Board within the Practitioner’s or AHP’s specialty; or

(4) Inadequate Insurance. The Practitioner or AHP does not meet the liability insurance coverage requirements of these Bylaws; or

(5) Ineligible for Medicare Provider Status. The Practitioner or AHP if applicable, is not a participating provider in the Medicare and Medicaid programs and is currently ineligible to be a participating provider; or

(6) No DEA number. The Practitioner’s (or AHP’s if applicable) DEA number/controlled substance license has been revoked or voluntarily relinquished (this shall not apply to pathologists); or

(7) Continuous Care Requirement. For applicants who will be seeking advancement to Active or Courtesy Staff, failure to maintain an office or residence within 25 miles of the Hospital; or

(8) Application Incomplete. The Practitioner or AHP has failed to provide any information required by these Bylaws or requested on the application, has provided false or misleading information on the application, or has failed to execute an acknowledgment, agreement or release required by these Bylaws or included in the application.

The refusal to further process an application form for any of the above reasons shall not entitle the Practitioner or AHP to any further procedural rights under these Bylaws.

In the event that none of the above applies to the application, the CEO or his/her designee shall promptly seek to collect or verify licensure, education, specific training, experience, and current competence.[[12]](#footnote-12) The CEO or his/her designee shall promptly notify the applicant, via Special Notice, of any problems in obtaining the information required and it shall then be the applicant's obligation to ensure that the required information is provided within two (2) weeks of receipt of such notification. Verification shall be obtained from primary sources, with the AMA Master Profile being acceptable.[[13]](#footnote-13) As applicable, the CEO or his/her designee must also verify the ECFMG.[[14]](#footnote-14) When collection and verification are accomplished, the application and all supporting materials shall be transmitted to the Chief of the applicable section. An application shall not be deemed complete nor shall final action on the application be taken until verification of all information, including query of the Data Bank and OIG Medicare/Medicaid Exclusions[[15]](#footnote-15), is complete. Licensure is also verified at the time of expiration of the applicant’s licensure expiration regardless of whether the applicant is in the process of applying for medical staff membership or Clinical Privilege delineation.

**6.3(e) Description of Initial Clinical Privileges**

Medical Staff appointments or reappointments shall not confer any Clinical Privileges or rights to practice in the Hospital. Each Practitioner who is appointed to the Medical Staff of the Hospital shall be entitled to exercise only those Clinical Privileges specifically granted by the Board. The Clinical Privileges recommended to the Board shall be based upon the applicant's education, training, experience, past performance, demonstrated competence and judgment, references and other relevant information required, including meeting any and all specialty specific criteria for Clinical Privileges. The applicant shall have the burden of establishing his/her qualifications for, and competence to exercise the Clinical Privileges he/she requests.

**6.3(f) Recommendation of Section Chief**

The Chief of the appropriate section shall review the application, the supporting documentation, reports and recommendations, and such other relevant information available to him/her, and shall transmit to the Credentials Committee on the prescribed form a written report and recommendation as to Medical Staff appointment and, and/or Clinical Privileges to be granted and any specific conditions to be attached to the appointment. The reason for each recommendation shall be stated and supported by references to the completed application and all other information considered. Documentation shall be transmitted with the report.

**6.3(g) Credentials Committee Action**

Within thirty (30) days of receiving the completed application, the members of the Credentials Committee shall review the application, the supporting documentation, the recommendation of the Section Chief, and such other information available as may be relevant to consideration of the applicant’s qualifications for the Medical Staff category and Clinical Privileges requested. The Credentials Committee shall transmit to the MEC on the prescribed form a written report and recommendation as to Medical Staff appointment and, if appointment is recommended, Clinical Privileges to be granted and any special conditions to be attached to the appointment. For AHPs the Credentials Committee shall transmit to the MEC on the prescribed form a written report and recommendation as to the delineation of Clinical Privileges and any special conditions to be attached to such delineation. The Credentials Committee also may recommend that the MEC defer action on the application. The reason for each recommendation shall be stated and supported by references to the completed application and all other information considered by the committee. Documentation shall be transmitted with the report. Any minority views shall also be in writing, supported by explanation, references and documents, and transmitted with the majority report.

**6.3(h) Medical Executive Committee Action**

At its next regular meeting after receipt of the Credentials Committee recommendation, the MEC shall consider the recommendation and other relevant information available to it. The MEC shall then forward to the Board a written report on the prescribed form concerning Medical Staff recommendations and, if appointment is recommended, Medical Staff category and Clinical Privileges to be granted and any special conditions to be attached to the appointment. The MEC also may defer action on the application. The reasons for each recommendation shall be stated and supported by reference to the completed application and other information considered by the committee. Documentation shall be transmitted with the report. Any minority views shall also be reduced to writing, supported by reasons, references and documents, and transmitted with the majority report.

**6.3(i) Effect of Medical Executive Committee Action**

(1) Deferral: Action by the MEC to defer the application for further consideration must be followed up within ninety (90) days with a recommendation for either provisional appointment with specified Clinical Privileges or for rejection for Medical Staff membership. An MEC decision to defer an application shall include specific reference to the reasons therefore and shall describe any additional information needed. If additional information is required from the applicant, he/she shall be so notified, and he/she shall then bear the burden of providing same.

In no event shall the MEC defer action on a completed and verified application for more than ninety (90) days beyond receipt of same.

(2) Favorable Recommendation: When the recommendation of the MEC is favorable to the applicant, the CEO or his/her designee shall promptly forward it, together with all supporting documentation, to the Board. For purposes of this section, "all supporting documentation" generally shall include the application form and its accompanying information and the report and recommendation of the Section Chief. The Board shall act upon the recommendation at its next scheduled meeting, or may defer action if additional information or clarification of existing information is needed, or if verification is not yet complete.

1. Adverse Recommendation: When the recommendation of the MEC is adverse to the applicant, the CEO or his/her designee shall immediately inform the Practitioner by Special Notice which shall specify the reason or reasons for the recommendation of denial and the Practitioner then shall be entitled to the procedural rights as provided in the Fair Hearing Plan. The applicant shall have an opportunity to exercise his/her procedural rights prior to submission of the adverse recommendation to the Board. For the purpose of this section, an "adverse recommendation" by the MEC is defined as the recommendation of denial of appointment, or recommendation of denial or restriction of requested Clinical Privileges. Upon completion of the Fair Hearing process, the Board shall act in the matter as provided in the Fair Hearing Plan. When the recommendation of the MEC is adverse to the AHP applicant, provisions of Article V shall be followed.

**6.3(j) Board Action**

(1) Decision; Deadline. The Governing Board may accept, reject or modify the MEC recommendation. The Secretary of the Board shall reduce the decision to writing and shall set forth therein the reasons for the decision. The written decision shall not disclose any information which is or may be protected from disclosure to the applicant under applicable laws. The Governing Board shall make every reasonable effort to render its decision within sixty (60) days following receipt of the MEC’s recommendation.

(2) Favorable Action. In the event that the Governing Board’s decision is favorable to the applicant, such decision shall constitute final action on the application. The CEO or his/her designee shall inform the applicant within twenty (20) days that his/her application has been approved and that Medical Staff membership and/or Clinical Privileges are granted. The decision to grant Medical Staff appointment or reappointment, together with all requested Clinical Privileges, shall constitute a favorable action even if the exercise of Clinical Privileges is made contingent upon monitoring, proctoring, periodic drug testing, additional education concurrent with the exercise of Clinical Privileges, or any similar form of Performance Improvement that does not materially restrict the applicant’s ability to exercise the requested Clinical Privileges.

(3) Adverse Action. In the event that the MEC’s recommendation was favorable to the applicant, but the Governing Board’s action is adverse, Practitioners shall be entitled to the procedural rights specified in the Fair Hearing Plan. The CEO or his/her designee shall immediately deliver to the applicant by Special Notice a letter enclosing the Governing Board’s written decision and containing a summary of the applicant’s rights as specified in the Fair Hearing Plan. AHP’s shall be entitled to procedural rights as described in Article V of these Bylaws.

1. Under no circumstances shall any applicant be entitled to more than one (1) evidentiary hearing under the Fair Hearing Plan based upon an adverse action.

**6.3(k) Interview**

An interview may be scheduled with the applicant during any of the steps set out in Section 6.3(f) - 6.3(j). Failure to appear for a requested interview without good cause may be grounds for denial of the application.

**6.3(l) Reapplication After Adverse Appointment Decision**

An applicant who has received a final adverse decision regarding appointment and/or initial Clinical Privilege delineation shall not be considered for appointment or initial Clinical Privilege delineation for a period of one (1) year after notice of such decision is sent, or until the defect constituting the grounds for the adverse decision is corrected, whichever is later. An applicant who has received a final adverse decision as a result of fraudulent conduct, misrepresentations in the application process, or other basis involving dishonesty shall not be permitted to reapply for a period of five (5) years after notice of the final adverse decision is sent. Any reapplication shall be processed as an initial application and the applicant shall submit such additional information as the Medical Staff or the Board may require.

**6.3(m) Time Periods for Processing**

Applications for Medical Staff appointments shall be considered in a timely and good faith manner by all individuals and groups required by these Bylaws to act thereon and, except for good cause, shall be processed within the time periods specified in this section. The CEO or his/her designee shall transmit a completed application to the Section Chief upon completing the CEO’s verification tasks, but in any event within ninety (90) days after receiving the completed application, unless the Practitioner or AHP has failed to provide requested information needed to complete the verification process.

**6.3(n) Denial for Hospital's Inability to Accommodate Applicant**

A decision by the Board to deny Medical Staff membership, Medical Staff category assignment or particular Clinical Privileges based on any of the following criteria shall not be deemed to be adverse and shall not entitle the applicant to the procedural rights provided in the Fair Hearing Plan:

(1) On the basis of the Hospital's present inability to provide adequate facilities or supportive services for the applicant and his/her patients as supported by documented evidence; or

(2) On the basis of inconsistency with the Hospital's current management plan including the mix of patient care services to be provided; or

(3) On the basis of professional contracts the Hospital has entered into for the rendition of services within various specialties.

However, upon written request of the applicant, the application shall be kept in a pending status for the next succeeding two (2) years. If during this period, the Hospital finds it possible to accept applications for Medical Staff positions for which the applicant is eligible, and the Hospital has no obligation to applicants with prior pending status, the CEO or his/her designee shall promptly so inform the applicant of the opportunity by Special Notice.

Within thirty (30) days of receipt of such notice, the applicant shall provide, in writing on the prescribed form, such supplemental information as is required to update all elements of his/her original application. Thereafter, the procedure provided in Section 6.2 for initial appointment shall apply.

**6.3(o) Appointment Considerations**

Each recommendation concerning the appointment of a staff member and/or for clinical privileges to be granted shall be based upon an evidence-based assessment of the applicant’s experience, ability, and current competence by the Credentials Committee, MEC and Board, including assessment of the applicant’s proficiency in areas such as the following:

1. **Patient Care** with the expectation that applicants provide patient care that is compassionate, appropriate and effective;
2. **Medical/Clinical Knowledge** of established and evolving biomedical clinical and social sciences, and the application of the same to patient care and educating others;
3. **Practice-Based Learning and Improvement** through demonstrated use and reliance on scientific evidence, adherence to practice guidelines, and evolving use of science, evidence and experience to improve patient care practices;
4. **Interpersonal and Communication Skills** that enable establishment and maintenance of professional working relationships with patients, patients’ families, members of the Medical Staff, Hospital Administration and employees, and others;
5. **Professional** behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude to patients, the medical profession and society; and
6. **Systems-Based Practice** reflecting an understanding of the context and systems in which health care is provided.

**6.4 REAPPOINTMENT AND REPRIVILEGING PROCESS**

**6.4(a) Information Form for Reappointment and Reprivileging**

At least ninety days prior to the expiration date of a Practitioner’s or AHP’s present Medical Staff appointment and/or Clinical Privileges delineation, the CEO or his/her designee shall provide the Practitioner or AHP a reapplication form for use in considering reappointment and reprivileging. The Medical Staff Member or AHP who desires reappointment and/ or reprivileging shall, at least sixty (60) days prior to such expiration date, complete the reapplication form by providing updated information with regard to his/her practice during the previous appointment period, and shall forward his/her reapplication form to the CEO or his/her designee. A reappointment application fee may be assessed and collected at the time application is made. Failure to return a completed application form shall result in automatic termination of membership at the expiration of the Member's current term.

**6.4(b) Content of Reapplication Form**

The Reapplication Form shall include, at a minimum, updated information regarding the following:

1. Education: Continuing training, education, and experience during the preceding appointment period that qualifies the Practitioner or AHP for the privileges sought on reappointment;
2. License: Current licensure;
3. Federal Narcotics Registration (DEA) number (if required)[[16]](#footnote-16);
4. Health Status: Current physical and mental health status only to the extent necessary to determine the Practitioner’s or AHP’s ability to perform the functions of Medical Staff membership or to exercise the privileges requested;

(5) Previous Affiliations: The name and address of any other hospital, health care organization or practice setting where the Practitioner or AHP provided clinical services during the preceding appointment period;

(6) Professional Recognition: Memberships, awards or other recognitions conferred or granted by any professional health care societies, institutions or organizations during the preceding appointment period;

(7) Professional Sanctions: Information as to previously successful or currently pending challenges to, or the voluntary relinquishment of, any of the following during the preceding appointment period:

(i) membership/fellowship in local, state or national professional organizations; or

(ii) specialty board certification; or

(iii) license to practice any profession in any jurisdiction; or

(iv) Drug Enforcement Agency (DEA) number/controlled substance license (except for pathologists); or

(v) voluntary or involuntary limitation, reduction or loss of Medical Staff membership or Clinical Privileges; or

(vi) the Practitioner’s or AHP’s management of patients which may have given rise to investigation by the state medical board or other professional state boards; or

(vii) participation in any private, federal or state health insurance program, including Medicare or Medicaid.

(8) Information on Malpractice Experience: Details about filed, pending, settled, or litigated malpractice claims and suits during the preceding appointment period;

(9) Felony Charges: Any current criminal charges pending against the applicant and any convictions or pleas during the preceding appointment period. The Practitioner or AHP shall notify the CEO and the Chief of Staff within seven (7) days of receiving notice of the initiation of any felony charges;

(10) Fraud: Any allegations of civil or criminal fraud pending against any applicant, and any past allegations resolved during the previous appointment period; as well as any investigations during the preceding appointment period by any private, federal or state agency concerning participation in any health insurance program;

(11) Managed Care Affiliations: The names of all HMO’s, PPO’s and other managed care organizations in which the applicant has participated in the past three (3) years during the preceding appointment period;

(12) Insurance: Information as to whether the applicant has currently in force professional liability coverage meeting the requirements of these Bylaws, together with a letter from the insurer stating that the Hospital will be notified should the applicant’s coverage change at any time. Each Practitioner or AHP must, at all times, keep the CEO informed of changes in his/her professional liability coverage;

(13) Current Competency: Objective evidence of the individual's clinical performance, competence, and judgment, based on the findings of departmental evaluations of care, including an evaluation by the Section Chief. and by one (1) other Medical Staff Member who is not a partner, employer, employee or relative of the Practitioner;

(14) Notification of Release & Immunity Provisions: The acknowledgments and statement of release set forth in Sections 6.3(b) and (c); and

(15) Information on Ethics/Qualifications: Such other specific information about the Medical Staff Member's professional ethics and qualifications that may bear on his/her ability to provide patient care in the Hospital.

**6.4(c) Verification of Information**

The CEO or his/her designee shall, in timely fashion, verify the additional information made available on each Reapplication Form (primary source verification of licensure and current competence is required (AMA Master Profile is acceptable))[[17]](#footnote-17) and collect any other materials or information deemed pertinent, including information regarding the Medical Staff Member’s or AHP’s professional activities, performance and conduct in the Hospital, information on participation in required continuing education,[[18]](#footnote-18) and query of the Data Bank and OIG Medicare/Medicaid Exclusions[[19]](#footnote-19) as applicable. Peer recommendations will be collected and considered in the reappointment and reprivileging process. Additionally, performance data must be reviewed for variation from benchmark. Variation shall go to Peer Review for determination of validity, written explanation of findings and, if appropriate, an action plan to include improvement strategies.[[20]](#footnote-20) When collection and verification are accomplished, the CEO or his/her designee shall transmit the Reapplication Form and supporting materials to the Chief of the appropriate section. An application shall not be deemed complete nor shall final action on the application be taken until verification of all information, including query of the Data Bank, and OIG Medicare/Medicaid Exclusions, is complete.

**6.4(d) Action on Application**

The application for reappointment or reprivileging shall thereafter be processed as set forth as described in Section 6.3(f) - 6.3(m) for initial appointment and initial privileging; except that an individual whose application for reappointment and/ or reprivileging is denied shall not be permitted to reapply for a period of five (5) years or until the defect constituting the basis for the adverse action is corrected, whichever is later. Any reapplication shall be processed as an initial application and the applicant shall submit such additional information as the Medical Staff or the Board may require.

**6.4(e) Basis for Recommendations**

Each recommendation concerning the reappointment of a Medical Staff Member and/ or Clinical Privileges to be granted shall be based upon such Member's or AHP’s professional performance, ability and clinical judgment in the treatment of patients, his/her discharge of Medical Staff obligations, his/her compliance with the Medical Staff Bylaws, Policies & Procedures, Rules & Regulations, his/her cooperation with other Practitioners, AHP’s and with patients. Other information upon which each recommendation will be based includes any matters bearing on his/her ability and willingness to contribute to quality patient care in the Hospital and the results of the Hospital monitoring and evaluation process, including performance improvement activities. Such Performance Improvement activities shall include relevant applicant specific information that is considered and compared to aggregate information when appropriate. In circumstances where there is insufficient practitioner-specific/AHP-specific data available when evaluating a practitioner or AHP for reappointment, peer references may be used as a basis for recommending the reapproval of clinical privileges.

**6.5 REQUEST FOR MODIFICATION OF APPOINTMENT**

A Medical Staff Member or AHP may, either in connection with reappointment and/ or reprivileging or at any other time, request modification of his/her Medical Staff category or Clinical Privileges, by submitting a written application to Administration on the prescribed form. Such application shall be processed in substantially the same manner as provided in Section 6.4 for reappointment and reprivileging. No Medical Staff Member or AHP may seek modification of privileges or Medical Staff category previously denied on initial appointment, reappointment and/ or reprivileging unless supported by documentation of additional training and experience. Modifications of Medical Staff category or Clinical Privileges shall remain in effect until the next regularly scheduled reappointment/ reprivileging period.

Temporary privileges may be granted to a Medical Staff member or Allied Health Staff member after receipt of a completed application for additional privileges, including a request for specific temporary privileges, for a period not to exceed the pendency of the application for additional privileges, which said application for additional privileges is waiting for review and recommendation by the Medical Executive Committee and approval of the Board. Should an immediate patient care need be demonstrated, temporary additional privileges may be granted with approval of the Chief Executive Officer, Section Chief of the department, and the Chief of Staff prior to approval of Credentials with subsequent approval through the committee approval process to follow. Temporary privileges may be granted for a limited period of time, not to exceed 120 days. Temporary privileges may be granted only after receipt of database profiles from NPDB and OIG Medicare/Medicaid Exclusions, demonstration of current competence and ability to perform the additional Clinical Privileges requested, primary source verification of current licensure, and receipt of at least one professional reference (including current competence)..

**6.6 PRACTITIONERS PROVIDING CONTRACTUAL PROFESSIONAL SERVICES**

**6.6(a) Qualifications & Processing**

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

**6.6(b) Requirements for Service**

In recommending approval of any such Practitioners or AHP’s, the Medical Staff must require that the services provided meet accreditation requirements, if any, are subject to appropriate quality controls, and are evaluated as part of the overall Hospital performance improvement program.

**6.6(c) Termination**

Unless otherwise provided in the contract for services, expiration or termination of any contract for services pursuant to this Section 6.6 shall automatically result in concurrent termination of Medical Staff membership and Clinical Privileges. The Fair Hearing Plan and Article V in the case of AHPs shall not apply in this case.

**ARTICLE VII**

**DETERMINATION OF CLINICAL PRIVILEGES**

**7.1 EXERCISE OF PRIVILEGES**

Every Practitioner or AHP providing direct clinical services at this Hospital shall, in connection with such practice and except as provided in Section 7.5, be entitled to exercise only those Clinical Privileges or services specifically granted to him/her by the Board. Said privileges must be within the scope of the license authorizing the Practitioner or AHP to practice in this state and consistent with any restrictions thereon.

**7.2 DELINEATION OF PRIVILEGES IN GENERAL**

**7.2(a) Requests**

Each application for appointment and reappointment to the Medical Staff and/ or each application for Clinical Privileges must contain a request for the specific Clinical Privileges desired by the applicant. The request for specific privileges must be supported by documentation demonstrating the Practitioner’s or AHP’s qualifications to exercise the privileges requested. A request by a Medical Staff Member or AHP for a modification of privileges must be supported by documentation supportive of the request, including at least one (1) peer reference.

**7.2(b) Basis for Privileges Determination**

Granting of Clinical Privileges shall be Hospital specific and shall be based on the Practitioner's or AHP’s education, training, current competence, including documented experience, treatment areas or procedures; the results of treatment; and the conclusions drawn from performance improvement activities, when available. When privilege delineation is based primarily on experience, the individual's credentials record should reflect the specific experience and successful results that form the basis for granting of privileges, including information pertinent to judgment, professional performance and clinical or technical skills. Clinical Privileges granted or modified on pertinent information concerning clinical performance obtained from other health care institutions shall be added to and maintained in the Medical Staff file established for a Medical Staff Member or AHP.

**7.2(c) Procedure**

All requests for Clinical Privileges shall be evaluated and granted, modified or denied pursuant to the procedures outlined in Article VI. The Data Bank shall be queried each time new privileges are requested.

**7.2(d) Limitations on Privileges**

The delineation of an individual's Clinical Privileges includes the limitations, if any, on an individual's Prerogatives to admit and treat patients or direct the course of treatment for the conditions for which the patients were admitted.

**7.2(e) Initial and Additional Grants of Privileges**

All initial appointments and grants of new or additional privileges to existing members of the Medical Staff shall be subject to a focused professional practice evaluation during the Provisional Staff Membership period (twelve (12) months) as assigned by the Credentials Committee to the Section Chief or his/her designee. Results of the focused professional practice evaluation conducted during the Provisional Staff Membership period shall be incorporated into the practitioner or AHP’s evaluation for reappointment.

**7.3 SPECIAL CONDITIONS FOR DENTAL AND PODIATRIC PRIVILEGES**

Requests for Clinical Privileges from dentists and podiatristsshall be processed, evaluated and granted in the manner specified in Article VI. Surgical procedures performed by dentists and podiatrists shall be under the overall supervision of the Chief of Surgery, however, other dentists and podiatrists as appropriate shall participate in the review of the dentist or podiatrist through performance improvement process. All dental and podiatric patients shall receive the same basic medical appraisal as patients admitted for other surgical services. A Physician Member of the Medical Staff or appropriately credentialed AHP shall be responsible for admission evaluation, history and physical, and for the care of any medical problem that may be present at the time of admission or that may be discovered during hospitalization, and shall determine the risk and effect of the proposed surgical procedure on the total health status of the patient. Dentists and podiatrists are responsible for that part of their patients’ histories and physicals that relate to dentistry or podiatric surgery.

**7.4 CLINICAL PRIVILEGES HELD BY NON-MEDICAL STAFF MEMBERS OR NON-ALLIED HEALTH PROFESSIONAL STAFF MEMBERS**

**7.4(a) Circumstances**

When dictated by urgent patient care need or when an application is complete without any negative or adverse information before action by the Medical Staff or Board, the CEO or his/her designee, upon recommendation of a member of the Medical Executive Committee, president of the Medical Staff (Chief of Staff) or Medical Director (as defined by the Medical Staff), if such person exists at the facility, and upon proof of current licensure, current competence, appropriate malpractice insurance, and completion of the required Data Bank query and upon any further proof as designated below, may grant temporary privileges in the circumstances described below. Prior to the granting of any temporary privileges, the applicant must sign the consent and release required by these Bylaws.

(1) Pendency of New Applications: After receipt of a completed application for staff appointment, including a request for specific temporary privileges, for a period not to exceed the pendency of the application. Temporary privileges may be granted when a new applicant for Medical Staff membership and Clinical Privileges or an applicant for clinical privileges as an Allied Health Professional (AHP), whose application is as described below in this Section 7.4(a) (1) is waiting for review and recommendation by the Medical Executive Committee and approval of the Board. Temporary privileges may be granted for a limited period of time, not to exceed 120 days. Temporary privileges may be granted to an applicant who has a completed application, has no current or previously successful challenges to licensure or registration, has not been subject to involuntary termination of Medical Staff membership at another organization and has not been subject to involuntary limitation, reduction, denial or loss of clinical privileges. Temporary privileges may be granted only after receipt of database profiles from AMA, AOA, NPDB, OIG Medicare/Medicaid Exclusions, primary source verification of relevant training or experience, education (AMA/AOA Profile is acceptable), demonstration of current competence and ability to perform the Clinical Privileges requested, primary source verification of current licensure, receipt of professional references (including current competence) and all other criteria as required in a completed application as specified in these Bylaws.

(2) One Case Basis: Upon receipt of a written request, an appropriately licensed person who is not an applicant for membership may be granted temporary privileges for the care of one (1) patient. Such privileges are intended for isolated instances in which extension of such privileges are shown to be in an individual patient’s best interest and no Practitioner shall be granted temporary privileges on more than five (5) occasions in any given year. If a given Practitioner exceeds the five (5) case requirement, such person shall be required to apply for membership on the Medical Staff before being allowed to attend additional patients. Prior to any award of one case privileges pursuant to this Section, the applicant must submit, in addition to the completed application, a photograph, the consent and release required by these Bylaws, copies of the Practitioner’s license to practice medicine, DEA certificate, and the CEO or his/her designee must obtain telephone verification of the physician’s privileges at his/her primary hospital. In exercising temporary privileges, the applicant shall act under the supervision of the Chief of the applicable section.

EXCEPTION: In lieu of copies of state license to practice medicine and DEA certificate, applicant may submit information sufficient for electronic on-line verification to be conducted, with the results obtained prior to consideration and granting of privileges. Additionally, the verification results are to be maintained with the applicant’s credentials file.

(3) Locum Tenens: Upon receipt of a written request, an appropriately licensed person who is serving as locum tenens for a Member of the Medical Staff or Allied Health Professional Staff may, without applying for membership on the Medical Staff or Allied Health Staff, be granted temporary privileges for an initial period not to exceed thirty (30) days. Such privileges may be renewed for successive periods not to exceed thirty (30) days, and in no event to exceed one hundred and twenty (120) days of service as locum tenens within a calendar year. All physicians or AHPs providing coverage through such locum tenens services must ensure that all legal requirements, including billing and reimbursement regulations, are met. Prior to any award of locum tenens privileges pursuant to this section, the applicant must submit, in addition to a completed application, a form of photographic identification, proof of appropriate malpractice insurance, the consent and release required by these Bylaws, copies of the Practitioner’s license to practice medicine, or the AHP’s license for their particular specialty, the practitioner’s DEA certificate, and telephone verification of privileges at the Practitioner’s or AHP’s primary hospital.

EX EXCEPTION: In lieu of copies of practitioner’s state license to practice medicine or AHP’s license for their particular specialty, and practitioner’s DEA certificate, and state controlled substance certificate (DPS), applicant may submit information sufficient for electronic on-line verification to be conducted, with the results obtained prior to consideration and granting of privileges. Additionally, the verification results are to be maintained with the applicant’s credentials file.

Members of the Medical Staff or Allied Health ProfessionalStaff seeking to provide coverage through locum tenens,physicians or AHPs shall, where possible, advise the Hospital at least thirty days in advance of the identity of the locum tenens and the dates during which the locum tenens services will be utilized in order to allow adequate time for appropriate verification to be completed. Failure to do so without good cause shall be grounds for corrective action.

**7.4(b) Conditions**

Temporary, one-case and locum tenens privileges shall be granted only when the information available reasonably supports a favorable determination regarding the requesting Practitioner's or AHP’s qualifications, ability and judgment to exercise the privileges granted. Special requirements of consultation and reporting may be imposed by the Chief of Staff, including a requirement that the patients of such Practitioner be admitted upon dual admission with a Member of the Active Staff. Before temporary privileges are granted, the Practitioner or Allied Health Professional must acknowledge in writing that he/she has received and read the Medical Staff Bylaws, Policies & Procedures, and Rules & Regulations, and that he/she agrees to be bound by the terms thereof in all matters relating to his/her temporary privileges.

**7.4(c) Termination**

On the discovery of any information or the occurrence of any event of a professionally questionable nature concerning a Practitioner's qualifications or those of an AHP, or ability to exercise any or all of the temporary privileges granted, the CEO may, after consultation with the Chief of Staff and/or the Chief of the section, terminate any or all of such Practitioner's or AHP’s temporary, one-case, or locum tenens privileges. Where the life or well-being of a patient is endangered by continued treatment by the Practitioner or AHP, the termination may be effected by any person entitled to impose summary suspensions under Article VIII, Section 8.2(a). In the event of any such termination, the Practitioner's patients then in the Hospital shall be assigned to another Practitioner by the Chief of Staff or by the Chief of the Section. The wishes of the patient shall be considered, if feasible, in choosing a substitute Practitioner.

**7.4(d) Rights of the Practitioner or Allied Health Professional**

A Practitioner or Allied Health Professional shall not be entitled to the procedural rights afforded by Article IX because of his/her inability to obtain temporary, one-case, or locum tenens privileges or because of any termination or suspension of temporary, one-case, or locum tenens privileges

**7.4(e) Term of Temporary Privileges**

For purposes of this subparagraph 7.4(e), the applicant may be granted temporary privileges for the time periods as specified in 7.4(a) (1) (2) and (3) above as delineated in the respective subparagraph. Any temporary privileges granted shall expire automatically at the end of the time period for which they were granted.

**7.5 EMERGENCY & DISASTER PRIVILEGES**

For the purpose of this section, an "emergency" is defined as a condition in which serious or permanent harm to a patient is likely to occur, or in which the life of a patient is in immediate danger, and delay in administering treatment would add to that danger. A “disaster” for purposes of this section as a community-wide disaster or mass injury situation in which the number of existing, available medical staff members is not adequate, or as determined by the CEO based on other pertinent considerations, to provide all clinical services required by the citizens served by this facility. In the case of an emergency or disaster, as defined herein, any Practitioner, to the degree permitted by his/her license and regardless of Medical Staff status or Clinical Privileges, shall, as approved by the CEO or his/her designee or the Chief of Staff, Vice-Chief of Staff, or Section Chief, be permitted to do, and be assisted by Hospital personnel in doing everything to save the life of a patient or to save the patient from serious harm.

Disaster privileges may be granted by the CEO or his/her designee, Chief of Staff, Vice-Chief of Staff, or Section Chief when, and for so long as, the emergency management plan has been activated and the hospital is unable to handle the immediate patient needs. Prior to granting any disaster privileges, the volunteer practitioner shall be required to present a valid photo ID issued by a state, federal or regulatory agency, and **at least one** of the following:

* A current picture hospital ID card that clearly identifies the professional designation;
* A current licensure, certification or registration;
* Primary source verification of licensure, certification or registration (if required by law to practice a profession);
* Identification indicating that the individual is a member of a Disaster Medical

Assistance Team (DMAT), or the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or groups;

* Identification indicating that the individual has been granted authority to render

patient care, treatment, and services in a disaster; or

* Identification by current hospital or medical staff member(s) who possesses personal

knowledge regarding the volunteer practitioner’s qualifications.

No individual, or group of individuals who are granted authority to grant disaster privileges, is required to grant such privileges to any individual and shall make such decisions only on a case-by-case basis.

As soon as possible after disaster privileges are granted, but not later than seventy-two (72) hours thereafter, the practitioner shall undergo the same verification process outlined in Section 7.4(a) for temporary privileges when required to address an emergency patient care need. In extraordinary circumstances in which primary source verification of licensure, certification or registration cannot be completed within 72 hours (e.g., no means of communication or a lack of resources), it shall be done as soon as possible, and the Hospital shall document in the emergency/disaster volunteer’s credentialing file why primary source verification cannot be performed in the required time frame, the efforts of the practitioner to continue to provide adequate care, and all attempts to rectify the situation and obtain primary source verification as soon as possible. In all cases, whether or not primary source verification could be obtained within seventy-two (72) hours following the grant of disaster privileges, the Chief of Staff, or his or her designee, shall review the decision to grant the practitioner disaster privileges, and shall, based on information obtained regarding the professional practice of the practitioner, make a decision concerning the continuation of the practitioner’s disaster privileges. The disaster privileges will cease automatically at the end of the disaster.

In addition, each practitioner granted disaster privileges shall be issued a Hospital ID (or if not practicable by time or other circumstances to issue official Hospital ID, then another form of identification) that clearly indicates the identity of the practitioner, and the scope of the practitioner’s disaster responsibilities and/or privileges. A member of the medical staff shall be assigned to each disaster ~~the~~ volunteer practitioner for purposes of overseeing the professional performance of the volunteer practitioner through such mechanisms as direct observation of care, concurrent or retrospective clinical record review, mentoring, or as otherwise provided in the grant of privileges.

**7.6 Privileges for Telemedicine**

Telemedicine involves the use of electronic equipment and communication systems to provide or to support clinical patient care at a distance. Those Practitioners and AHPs who diagnose or treat patients via Telemedicine systems are subject to the credentialing process, including appointment, reappointment and privileging, of the health care organization where the patient receives the Telemedicine services. DEA registration/controlled substance certificate shall not be required of those individuals whose sole activity at the hospital is that of teleradiology. Appropriate use of telemedicine equipment by Physicians or AHPs is considered as part of the appointment, reappointment and Clinical Privilege delineation processes. Clinical services provided through this means shall be so provided consistent with commonly accepted quality standards.

7.6(a) Scope of Telemedicine Privileges. The Medical Staff shall make recommendations to the Board of Trustees regarding which clinical services are appropriately delivered through the medium of telemedicine, and the scope of such services. Clinical services offered through this means shall be provided consistent with commonly accepted quality standards. The Medical Staff will define and apply criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges. For distant-site physicians and practitioners requesting privileges to furnish telemedicine services under an agreement with the hospital, the criteria for determining privileges and the procedure for applying the criteria are also subject to these requirements.[[21]](#footnote-21)

7.6(b) When telemedicine services are furnished to the hospital’s patient’s through an agreement with a distant-site telemedicine entity or a distant-site hospital, the Board may choose to have its Medical Staff rely upon the credentialing and privileging decisions made by the distant-site telemedicine entity or distant-site hospital when making recommendations on privileges for the individual distant-site physicians and practitioners providing such services, if the Board ensures, through its written agreement with the distant-site telemedicine entity, that the distant-site telemedicine entity furnishes services that, in accordance with requirements in these Bylaws, permit the hospital to comply with all applicable conditions of participation for the contracted services. The Board must also ensure, though its written agreement with the distant-site telemedicine entity or distant-site hospital, that all of the following provisions are met:[[22]](#footnote-22)

(1) The distant-site telemedicine entity’s medical staff credentialing and privileging process and standards at least meet the standards stated in this section,[[23]](#footnote-23) or the distant-site hospital providing the telemedicine services is a Medicare-participating hospital[[24]](#footnote-24);

1. The individual distant-site physician or practitioner is privileged at the distant-site telemedicine entity or distant-site hospital providing the telemedicine services, which provides the hospital with a current list of the distant-site physician’s or practitioner’s privileges at the distant-site telemedicine entity[[25]](#footnote-25) or distant-site hospital[[26]](#footnote-26);
2. The individual distant-site physician or practitioner holds a license issued or recognized by the State in which the hospital whose patients are receiving such telemedicine services is located;[[27]](#footnote-27)
3. With respect to a distant-site physician or practitioner, who holds current privileges at the hospital whose patients are receiving telemedicine services, the hospital has evidence of an internal review of the distant-site physician’s or practitioner’s performance of these privileges and sends the distant-site telemedicine entity or the distant-site hospital such performance information for use in the periodic appraisal of the distant-site physician or practitioner. At a minimum, this information must include all adverse events that result from the telemedicine services provided by the distant-site physician or practitioner to the hospital’s patients, and all complaints the hospital has received about the distant-site physician or practitioner.[[28]](#footnote-28)

iv.However, this Hospital will remain responsible for primary source verification of licensure, professional liability insurance, Medicare/Medicaid eligibility and for the query of the Data Bank. Additionally, the hospital’s governing body is still legally responsible for all privileging decisions.[[29]](#footnote-29)

# ARTICLE VIII

**PEER REVIEW AND CORRECTIVE ACTION**

**8.1 PEER REVIEW AND CORRECTIVE OR REHABILITATIVE ACTION**

**8.1(a) Criteria for Initiation of Peer Review and/or Corrective or Rehabilitative Action**

Whenever activities, omissions, or any professional conduct of a Practitioner or AHP with Clinical Privileges are detrimental to patient safety, to the delivery of quality patient care, are disruptive to Hospital operations, or violate the provisions of these Bylaws, Policies & Procedures, the Medical Staff Rules and Regulations, or duly adopted policies and procedures, peer review and/or corrective or rehabilitative action may be initiated. Such peer review and/or any corrective or rehabilitative action necessary to be taken regarding a Practitioner or AHP may be initiated by any officer of the Medical Staff, by the CEO or the CEO’s designee, or any officer of the Board. Procedural guidelines from this Section 8.1 of the Bylaws, the Fair Hearing Plan and from the Health Care Quality Improvement Act as applicable shall be followed for all Practitioners and any and all peer review and / or corrective action shall be taken in good faith in the interest of quality patient care. Procedural guidelines from this Section 8.1 of the Bylaws and the Allied Health Professional Appeal Process as applicable shall be followed for all AHP’s and all corrective action shall be taken in good faith in the interest of quality patient care. Professional conduct that suggests Impairment of a Practitioner or AHP is referenced in Section 14.7, Practitioner and AHP Health.

**8.1(b) Request & Notices**

All hospital staff should be instructed in the process to follow when a practitioner is conducting him/herself in an unprofessional manner or present signs of impairment that would jeopardize the safety and quality of patient care.[[30]](#footnote-30)

All requests for peer review and/or corrective action under this Section 8.1 shall be submitted in writing to the MEC, and supported by reference to the specific activities or conduct which constitutes the grounds for the request. The Chief of Staff shall promptly notify the CEO or his/her designee in writing of all requests for peer review and/or corrective action received by the committee and shall continue to keep the CEO or his/her designee fully informed of all action taken in conjunction therewith.

**8.1(c) Investigation by the Medical Executive Committee**

The MEC begin to investigate the matter within forty-five (45) days or at its next regular meeting whichever is sooner, or shall on its own, or may, at its option, appoint an Ad Hoc Committee at the MEC’s next regular meeting to investigate and/or perform peer review of the Practitioner or AHP. Such Ad Hoc Committee shall be composed of at least three members of the Medical Staff. The Committee shall not include any partners, associates or relatives of the individual for whom an investigation or peer review is requested. Within thirty (30) days for peer review or investigations conducted internally, or ninety (90) days for peer review or investigations conducted external to the Hospital and within thirty (30) days for corrective action after the investigation begins, a written report of the investigation shall be completed. When the investigation involves an issue of physician impairment, the MEC shall assign the matter to an ad hoc committee of three (3) members who shall operate apart from this corrective action process, pursuant to the provisions of the Hospital’s impaired practitionerpolicy.

**8.1(d) Medical Executive Committee Action**

Within sixty (60) days following receipt of the report, the MEC shall take action upon the request. Its action shall be reported in writing and may include, but shall not be limited to:

(1) Recommending rejection of the request for corrective action;

(2) Recusing itself from the matter and referring same to the Board without recommendation, together with a statement of its reasons for recusing itself from the matter, which reasons may include but are not limited to a conflict of interest due to direct economic competition or economic interdependence with the affected physician;

(3) Recommending the issuing of a warning or a reprimand to which the Practitioner may write a rebuttal, if he/she so desires;

(4) Recommending terms of probation, education or required consultation;

(5) Recommending reduction, suspension or revocation of Clinical Privileges;

(6) Recommending reduction of Medical Staff category or limitation of any Medical Staff Prerogatives; or

(7) Recommending suspension or revocation of Medical Staff membership.

**8.1(e) Procedural Rights**

Any action by the MEC pursuant to Section 8.1(d)(5), (6) or (7), or (d)(4) (where such action materially restricts a Practitioner's exercise of privileges) or any combination of such actions, shall entitle the Practitioner to the procedural rights as specified in the provisions of Article IX and the Fair Hearing Plan. Any action by the MEC pursuant to Section 8.1(d)(5), (6) or (7), or (d)(4) (where such action materially restricts an AHPs exercise of privileges) or any combination of such actions, shall entitle the AHP to the procedural rights as specified in the provisions of Article IX and the AHP Appeal Process set forth in Section 5.4(b). Further, participation of Practitioners or AHPs undergoing investigation or peer review shall be governed by the Fair Hearing Plan or the AHP Appeal Process set forth in Section 5.4(b) respectively. The Board may be informed of the recommendation, but shall take no action until the Member has either waived his/her right to a hearing and/or appearance or completed the hearing and/or the appearance.

**8.1(f) Other Action**

If the MEC's recommended action is as provided in Section 8.1(d)(1) (2), and (3) or (d)(4) (where such action does not materially restrict a Practitioner's or AHP’s exercise of privileges), such recommendation, together with all supporting documentation, shall be transmitted to the Board. The Fair Hearing Plan or the AHP Appeal Process shall not apply to such actions.

**8.1(g) Board Action**

When corrective action is initiated by the Board pursuant to Section 1.2(2) or (3) of the Fair Hearing Plan, the functions assigned to the MEC under this Section 8.1 shall be performed by the Board, and shall entitle the Practitioner to the procedural rights as specified in the Fair Hearing Plan.

**8.2 SUMMARY SUSPENSION**

**8.2(a) Criteria & Initiation**

Notwithstanding the provisions of Section 8.1 above, whenever a Practitioner willfully disregards these Bylaws or other Hospital policies, or his/her conduct may require that immediate action be taken to protect the life, well-being, health or safety of any patient, employee or other person, then the Chief of Staff, the CEO, or a member of the MEC shall have the authority to summarily suspend the Medical Staff membership status or all or any portion of the Clinical Privileges immediately upon imposition. Subsequently, the CEO or his/her designee shall, on behalf of the imposer of such suspension, promptly give Special Notice of the suspension to the Practitioner.

Immediately upon the imposition of summary suspension, the Chief of Staff shall designate a physician with appropriate Clinical Privileges to provide continued medical care for the suspended Practitioner's patients still in the Hospital. The wishes of the patient shall be considered, if feasible, in the selection of the assigned physician.

It shall be the duty of all Medical Staff Members to cooperate with the Chief of Staff and the CEO in enforcing all suspensions and in caring for the suspended Practitioner's patients.

**8.2(b) Medical Executive Committee Action**

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

**8.2(c) Procedural Rights**

If the summary suspension is terminated or modified such that the Practitioner's privileges are not materially restricted, the matter shall be closed and no further action shall be required.

If the summary suspension is continued for purposes of further investigation the MEC shall reconvene within fourteen (14) days of the original imposition of the summary suspension and shall modify, ratify or terminate the summary suspension.

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

**8.3 ADMINISTRATIVE CORRECTIVE ACTION**

**8.3(a) Criteria for Initiation**

Whenever a Practitioner violates Hospital policies, rules or regulations, or acts in a manner disruptive to Hospital operations, or in such a manner as to endanger the assets of the Hospital because of financially imprudent actions not justified by patient care considerations, administrative corrective action may be initiated by the Hospital CEO, by the Chairman of the Governing Board, or by the Board. Such action shall be taken pursuant to this section, rather than Section 8.1 or 8.2, only in those instances in which disruptive or inappropriate conduct, rather than clinical competency is in question. Such instances may include, but are not limited to, abusive treatment of Hospital employees, refusal to discharge Medical Staff duties unrelated to patient care, violation of policies, rules or regulations, or harassment. Disruptive behavior on the part of AHPs shall be managed as per Human Resources policies and procedures.

**8.3(b) Documentation of Behavior**

Physicians and Hospital employees who observe disruptive behavior by a Practitioner shall document the behavior, and shall submit such written documentation to the CEO. In performing all functions hereunder, the CEO and all designees acting on his/her behalf shall be deemed authorized agents of the Board and shall enjoy all immunity and confidentiality protection afforded under state and federal law.

**8.3(c) Administrative Action**

The CEO shall meet with the Practitioner and if the CEO determines that the complaint has merit, he/she will emphasize during the meeting that such conduct is inappropriate, and that further such conduct will result in formal action. A follow-up letter shall be sent to the Practitioner memorializing the discussion of the incident.

If the Practitioner’s disruptive behavior continues, or if the CEO deems it appropriate, the Board Chairperson shall meet with and advise the Practitioner that such conduct is intolerable and must stop. The Practitioner will be informed that the meeting constitutes the final warning prior to formal action. The meeting will be followed with a letter reiterating the warning, which shall become a part of the Practitioner’s permanent file.

Nothing herein shall be deemed to require the occurrence of the above two (2) meetings prior to institution of formal corrective action in the event that the action is sufficiently serious to justify.

**8.3(d) Request & Notices**

Upon occurrence of an additional incident after the above process, the CEO shall submit a formal request for corrective action to the Governing Board. The request shall be submitted in writing and supported by reference to the specific activities or conduct which constitutes the grounds for the request.

**8.3(e) Investigation by the Board**

The CEO shall be responsible for presenting the history of conduct to the Board. The Board shall be fully apprized of the previous meetings and warnings, if any, so that it may pursue whatever action is necessary to terminate the unacceptable conduct. Should the Board determine that further investigation is necessary, the Board Chairperson shall appoint an individual or an ad hoc committee to investigate and report back to the Board at its next regular meeting. Within thirty (30) days after the investigation begins, a written report of the investigation shall be completed.

**8.3(f) Board Action**

Within sixty (60) days following receipt of the report, the Board shall take action upon the request. Its action shall be reported in writing and may include, but is not limited to:

(1) Rejecting the request for corrective action;

(2) Issuing a warning or a reprimand to which the Practitioner may write a rebuttal, if he/she so desires;

(3) Requiring terms of probation or required consultation;

(4) Reducing, suspending or revoking Clinical Privileges;

(5) Reducing Medical Staff category or limiting Prerogatives; or

(6) Suspending or revoking Medical Staff membership.

**8.3(g) Procedural Rights**

Any action by the Board pursuant to Section 8.3(f)(4), (5) or (6), or (f)(3) (where such action materially restricts a Practitioner's exercise of privileges) or any combination of such actions, shall entitle the Practitioner to the procedural rights as specified in the provisions of Article IX and the Fair Hearing Plan. The action will not become final until the Practitioner has either waived his/her right to a hearing or completed the hearing.

**8.3(h) Other Action**

If the Board’s action is as provided in Section 8.3(f)(1) and (2), or (f)(3) (where such action does not materially restrict a Practitioner's exercise of privileges), such action shall become the final action of the Board, and the Practitioner shall not be entitled to the rights enumerated in the Fair Hearing Plan.

**8.4 AUTOMATIC SUSPENSION**

**8.4(a) License**

A Medical Staff Member or AHP whose license, certificate, or other legal credential authorizing him/her to practice in Texas is revoked/restricted[[31]](#footnote-31) or suspended shall immediately and automatically be suspended from the Medical Staff or AHP Staff and practicing in the Hospital. The Medical Staff Member or AHP will not have the right of hearing, appearance or appeal as provided under Article IX of these Bylaws. The Chief of Staff shall designate a physician to provide continued medical care for the suspended Practitioner's patients.

**8.4(b) Drug Enforcement Administration (DEA) Registration Number**

A Practitioner (except a pathologist) or AHP if applicable, whose DEA registration number is on probation or is revoked, suspended, or relinquished[[32]](#footnote-32) shall immediately and automatically be suspended from the staff and practicing in the Hospital, until such time as the registration/certificate is reinstated.

**8.4(c) Medical Records**

(1) Automatic suspension of a Practitioner's admitting privileges shall be imposed for failure to complete medical records as required by the Medical Staff Bylaws, Policies & Procedures,and Rules & Regulations. The suspension shall continue until such records are completed unless the Practitioner satisfies the Chief of Staff that he/she has a justifiable excuse for such omissions.

(2) Medical Records- Expulsion: Notwithstanding the provision of Section 8.4(c)(1), any Medical Staff Member who accumulates forty-five (45) or more CONSECUTIVE days of automatic suspension under said subsection 8.4(c) shall automatically be expelled from the Medical Staff. Such expulsion shall be effective as of the first day after the forty-fifth (45th) consecutive day of such automatic suspension.

**8.4(d) Malpractice Insurance Coverage**

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

**8.4(e) Exclusions/Suspension from Medicare**

Any physician whose Medicare or Medicaid (or any state government payor program) status is terminated or revoked will be automatically suspended.[[33]](#footnote-33)

**8.4(f) Automatic Suspension – Failure to Disclose Interest in Hospital to Patient**

A referring physician owner who has failed to disclose to a patient of his/her ownership and/or investment interest in the Hospital, as required in Section 3.3(p) shall be automatically suspended. The suspension shall continue until the referring physician owner has signed an attestation that he/she has formally implemented a process to make such disclosures to patients.

**8.4(g) Automatic Suspension - Fair Hearing Plan Not Applicable**

No Medical Staff Member, whose privileges are automatically suspended under this Section 8.4, shall have the right of hearing or appeal as provided under Article IX of these Bylaws. The Chief of Staff shall designate a physician to provide continued medical care for any suspended Practitioner's patients. No AHP, whose privileges are automatically suspended under this Section 8.4, shall have the right of appearance or appeal as may be provided under the Allied Health Professional Appeal Process.

**8.4(h) Chief of Staff**

It shall be the duty of the Chief of Staff to cooperate with the CEO in enforcing all automatic suspensions and expulsions and in making necessary reports of same. The CEO or his/her designee shall periodically keep the Chief of Staff informed of the names of Medical Staff Members who have been suspended or expelled under Section 8.4.

**8.5 CONFIDENTIALITY**

To maintain confidentiality, participants in the corrective action process shall limit their discussion of the matters involved to the formal avenues provided in these Bylaws for peer review and corrective action.

**8.6 SUMMARY SUPERVISION**

Whenever criteria exist for initiating corrective action pursuant to this Article, the Practitioner or AHP may be summarily placed under supervision concurrently with the initiation of professional review activities until such time as a final determination is made regarding the Practitioner’s or AHP’s privileges. Any of the following shall have the right to impose supervision: Chief of Staff, applicable Section Chief, the Board and/or CEO.

**8.7 PROTECTION FROM LIABILITY**

All members of the Board, the Medical Staff and Hospital personnel assisting in Medical Staff peer review shall have immunity from any civil liability to the fullest extent permitted by state and federal law when participating in the peer review activities described in these Bylaws.

**8.8 REAPPLICATION AFTER ADVERSE ACTION**

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

## 8.9 FALSE INFORMATION ON APPLICATION

Any practitioner or AHP who, after being granted appointment and/or clinical privileges, is determined to have made a misstatement, misrepresentation, or omission in connection with an application shall be deemed to have immediately relinquished his/her appointment and clinical privileges. No practitioner or AHP who is deemed to have relinquished his/her appointment and clinical privileges pursuant to this Section 8.9 shall be entitled to the procedural rights under these Bylaws, except that the MEC may, upon written request from the practitioner or AHP, permit the practitioner or AHP to appear before it and present information solely as to the issue of whether the practitioner or AHP made a misstatement, misrepresentation, or omission in connection with his/her application. If such appearance is permitted by the MEC, the MEC shall review the material presented by the practitioner or AHP and render a decision as to whether the findings that he/she made a misstatement, misrepresentation, or omission was reasonable, which MEC decision shall be subject to the approval of the Board.

**ARTICLE IX**

**INTERVIEWS & HEARINGS**

**9.1 INTERVIEWS**

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

**9.2 HEARINGS**

**9.2(a) Procedure**

Whenever a Practitioner requests a hearing based upon or concerning a specific adverse action as defined in Section 2 of the Fair Hearing Plan, the hearing shall be conducted in accordance with the procedures set forth in the Fair Hearing Plan and the Health Care Quality Improvement Act.

**9.2(b) Exceptions**

Neither the issuance of a warning, a request to appear before a committee, a letter of admonition, a letter of reprimand, a recommendation for concurrent monitoring, a denial, termination or reduction of temporary privileges, terms of probation, nor any other actions which do not materially restrict the Practitioner’s exercise of Clinical Privileges, shall give rise to any right to a hearing.

**9.2(c)** **Fair Hearing Plan**

The Fair Hearing Plan is contained in its entirely in Medical Staff Policies and Procedures.

**9.3 ADVERSE ACTION AFFECTING AHPS**

Any adverse actions affecting AHPs may be accomplished in accordance with the appeal process set forth in Section 5.4(b). The Fair Hearing Plan shall not apply.

# ARTICLE X

**OFFICERS**

**10.1 OFFICERS OF THE STAFF**

**10.1(a) Identification**

The officers of the Medical Staff shall be:

(1) Chief of Staff;

(2) Vice-Chief of Staff;

(3) Secretary/Treasurer; and

(4) Immediate Past Chief of Staff.

**10.1(b) Qualifications**

Officers must be Members of the Active Staff at the time of nomination and election and must remain Members in good standing during their term of office. Medical Staff Members shall not be eligible to become Officers if such Members are employed by or have investment interests in a health care organization that is a competitor of IASIS Hospital. Failure of an officer to maintain such status shall immediately create a vacancy in the office.

**10.1(c) Nominations**

(1) The Nominating Committee shall consist of the Chief of Staff, the Past-Chief of Staff of the Medical Staff and the CEO. This committee shall offer one (1) or more nominees for each office (with the exception of the office of Immediate Past Chief of Staff) to the Medical Staff thirty (30) days before the annual meeting.

(2) Nominations may also be made from the floor at the time of the annual meeting or by petition filed prior to the annual meeting signed by at least ten percent (10%) of the appointees of the Active Staff, with a signed statement of willingness to serve by the nominee, filed with the Chief of Staff at least thirty (30) days before the annual meeting.

**10.1(d) Election**

Officers shall be elected at the annual meeting of the Medical Staff and when otherwise necessary to fill vacancies. Only Members of the Active Staff who are present at the annual meeting shall be eligible to vote. Voting may be open or by secret written ballot, as determined by the Members present and voting at the meeting. Voting by proxy shall not be permitted. A nominee shall be elected upon receiving a majority of all the valid ballots cast.

As an alternative, officers may be elected by balloting by mail. Only members of the Active Staff shall be eligible to receive a ballot for voting.

**10.1(e) Removal**

Whenever the activities, professional conduct or leadership abilities of a Medical Staff officer are believed to be below the standards established by the Medical Staff or to be disruptive to the operations of the Hospital, the officer may be removed by a two-thirds (2/3) majority of the Active Medical Staff Members present at a called meeting where a quorum exists. Such removal shall not affect the officer’s Medical Staff membership or Clinical Privileges, and shall not be considered an adverse action.

**10.1(f) Term of Elected Officers**

Each officer shall serve a two (2) year term, commencing on the first day of the Medical Staff year following his/her election. Each officer shall serve until the end of his/her term and until a successor is elected, unless he/she shall sooner resign or be removed from office.

**10.1(g) Vacancies in Elected Office**

Vacancies in office, other than Chief of Staff, shall be filled by the MEC. If there is a vacancy in the office of Chief of Staff, the Vice-Chief of Staff shall serve out the remaining term. If the Vice Chief of Staff is unable or unwilling to assume the office of Chief of Staff, the MEC will fill the vacancy.

**10.1(h) Duties of Elected Officers**

(1) Chief of Staff. The Chief of Staff shall serve as the Chief Medical Officer and principal official of the Medical Staff. The Chief of Staff is assigned responsibility for organization and conduct of the Medical Staff.[[34]](#footnote-34) As such he/she will:

(i) appoint multi-disciplinary Medical Staff committees;

(ii) aid in coordinating the activities of the Hospital administration and of the nursing and other non-physician patient care services with those of the Medical Staff;

(iii) be responsible to the Board, in conjunction with the MEC, for the quality and efficiency of clinical services and professional performance within the Hospital and for the effectiveness of patient care evaluations and maintenance functions delegated to the Medical Staff; work with the Board in implementation of the Board's quality, performance, efficiency and other standards;

(iv) in concert with the MEC and clinical departments, develop and implement methods for credentials review and for delineation of privileges; along with the continuing medical education programs, utilization management, monitoring functions and patient care evaluation studies;

(v) participate in the selection (or appointment) of Medical Staff representatives to Medical Staff and Hospital management committees;

(vi) report to the Board and the CEO concerning the opinions, policies, needs and grievances of the Medical Staff;

(vii) be responsible for enforcement and clarification of Medical Staff Bylaws, Policies & Procedures, and Rules & Regulations, for the implementation of sanctions where indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a Practitioner or AHP;

(viii) confer with the CEO and/or, CFO, and/or CNO and/or Service Chief, if necessary, on a least a quarterly basis as to whether there exists sufficient space, equipment, staffing and financial resources or that the same will be available within a reasonable time to support each privilege requested by applicants to the Medical Staff; and report on the same to the MEC and to the Board;

1. assist the Service Chief as to the types and amounts of data to be collected and compared in determining and informing the Medical Staff of the professional practice of its members;

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

(xi) serve as a member of the MEC and as an ex-officio member of all other Medical Staff committees or functions;

(xii) assist in coordinating the educational activities of the Medical Staff; and

(xi) serve as liaison for the Medical Staff in its external professional and public relations.

(2) Vice-Chief of Staff: The Vice-Chief of Staff shall be a member of the MEC. In the absence of the Chief of Staff, he/she shall assume all the duties and have all the authority of the Chief of Staff. He/She shall serve as the Chair of the Bylaws Committee. He/She shall perform such additional duties as may be assigned to him/her by the Chief of Staff, the MEC or the Board.

(3) Secretary/Treasurer: The duties of the Secretary/Treasurer shall be to:

(i) give proper notice of all Medical Staff meetings on order of the appropriate authority;

(ii) prepare accurate and complete minutes for MEC and Medical Staff meetings;

(iii) assure that an answer is rendered to all official Medical Staff correspondence;

(iv) be responsible for the preparation of financial statements and report status of Medical Staff funds, if any; and

(v) perform such other duties as ordinarily pertain to his/her office.

(4) The Immediate Past Chief of Staff shall be a member of the MEC and shall perform such additional duties as may be assigned to him/her by the Chief of Staff, the MEC or the Board.

# ARTICLE XI

**CLINICAL SECTIONS & SERVICES**

**11.1 SECTIONS & SERVICES**

11.1(a) There shall be clinical sections of:

(1) Medicine, including internal medicine and all subspecialties thereof, family medicine, general practice, psychiatry and all subspecialties thereof including outpatient and ambulatory care physicians, and radiologists and all subspecialties thereof including Teleradiology;

(2) Surgery, including general surgery and all subspecialties thereof, pathology, OB/GYN, anesthesia, perinatology, urology, dentistry, podiatry, and outpatient services;

1. Pediatrics and all subspecialties thereof; and

1. Emergency Medicine, including other specialties that are provided through the contracted emergency room provider.

11.1(b) Ad hoc committees of the clinical sections may be formed for various subspecialties as determined by the respective clinical section and such ad hoc committees shall be reportable to their respective clinical section.

11.1(c) Recommendation for further sectionalization of specialties may be made by unanimous vote of the MEC to the Governing Board or added by amendment as described in Article XV of these Bylaws.

## 11.2 DEPARTMENT SCOPE OF SERVICE

11.2(a) Each department, whether clinical or supportive, and each patient unit shall have a written scope of service that includes at least:[[35]](#footnote-35)

(1) The hours of operation;

(2) Patient populations served;

(3) Skill mix;

(4) Core staffing and methods for determining and modifying staffing to meet patient or process needs; and

(5) Description of assessment and reassessment practices, including timeframes.

(6) Hospital policies will identify how often and under what circumstances each department’s scope of service must be reviewed and updated. (i.e., if new service is added or discontinued, change of population served, etc.) The hospital will also describe and illustrate the sequence and interaction of these processes (services).

**11.3 SECTION FUNCTIONS**

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

11.3(a) Require that patient care evaluations be performed and that appointees exercising privileges within the section be reviewed on an ongoing basis and upon application for reappointment;

11.3 (b) Establish guidelines for the granting of Clinical Privileges within the section and submit the recommendations as required under these Bylaws regarding the specific Clinical Privileges for applicants and reapplicants for Clinical Privileges;

11.3 (c) Conduct, participate in, and make recommendations regarding the need for continuing education programs pertinent to changes in current professional practices and standards;

11.3(d) Monitor on an ongoing basis the compliance of its section Members with these Bylaws, Policies and Procedures, and the Rules and Regulations and policies, procedures and other standards of the Hospital;

11.3(e) Monitor on an ongoing basis the compliance of its Members with applicable professional standards;

11.3(f) Coordinate the patient care provided by the section’s Members with nursing, administrative, and other non-Medical Staff services;

11.3(g) Foster an atmosphere of professional decorum within the section;

11.3(h) Review all deaths occurring in the Section and all unexpected patient care events and report findings to the MEC;

11.3(i) Submit written reports or minutes of section meetings to the MEC on a regular basis concerning:

(1) Findings of the section’s review and evaluation activities, actions taken thereon, and the results thereof;

(2) Recommendations for maintaining and improving the quality of care provided in the section and in the Hospital; and

(3) Such other matters as may be requested from time to time by the MEC;

11.3(j) Recommend to the MEC, subject to the Board approval of the kinds, types and amounts of data to be collected and evaluated to allow the Medical Staff to conduct an evidence-based analysis of the quality of professional practice of its members; and receive regular reports from department subcommittees regarding all pertinent recommendations and actions by the subcommittees.

**11.4 SERVICES**

In addition to the sections of the Medical Staff, there shall be services within the Medical Staff. The various services within the Medical Staff (e.g., anesthesiology service, pathology service, etc.) shall not constitute sections as that term is used herein without the express designation by the MEC and the Governing Board. Each service shall be headed by a chief selected in the manner and having the authority and responsibilities set forth in these Bylaws. The purpose of the services shall be to provide specialized care within the Hospital and to monitor and evaluate the quality of care rendered in the service and to be accountable to the section to which such service is assigned for the discharge of these functions.

**11.5 SECTION CHIEFS**

11.5(a) Each section shall have a Chief, who shall be approved by the Board after election by the section Members and shall be a Member of the Active Staff, qualified by training, certification by an appropriate specialty board or equivalent, (as described in Section 3.2(a)(9)), experience and administrative ability for the position. Section Chiefs may be removed by affirmative vote of two-thirds (2/3) of the section Members as provided for removal of officers in Section 10.1(e).

11.5(b) The responsibilities of the Section Chief include:

(1) Accountability to the MEC for all professional/ clinical and Medical Staff administrative activities within the section;

(2) Continuing review of the professional performance, qualifications, and competence of the Medical Staff Members and AHPs who exercise privileges in the section;

(3) Assuring that a formal process for monitoring and evaluating the quality and appropriateness of the care and treatment of patients served by the section is carried out and ensuring that such performance improvement activities and findings are communicated to the section;

(4) Assuring the participation of section Members in section orientation, continuing education programs and required meetings;

(5) Assuring participation in risk management activities related to the clinical aspects of patient care and safety;

(6) Assuring that required performance improvement occurs, including but not limited to: use of operative and other procedures, use of blood and blood components, use of medications, medical record review, medical assessment and treatment of patients and other patient care processes, efficiency of clinical practice patterns, risk management, safety, infection control and utilization management, are performed within the section and that findings from such activities are properly integrated with the primary functions of the section level;

(7) Recommending criteria for Clinical Privileges and specific Clinical Privileges for each Member of the section;

(8) Implementing within the section any actions or programs designated by the MEC;

(9) Assisting in the preparation of reports as may be required by the MEC, the CEO or the Board;

(10) Developing, implementing and enforcing the Medical Staff Bylaws, Policies & Procedures, and Rules & Regulations that guide and support the provision of services;

1. Participating in every phase of administration of the section, in cooperation with

nursing and Hospital administration, other sections and the Board;

(12) Assessing and recommending to the CEO any off-site sources for needed patient care services not provided by the section or organization; and,

1. Making recommendations for a sufficient number of qualified and competent persons to provide care or services within the section.

(14) Recommending space and other resources needed by the section;

1. The integration of the Section into the primary functions of the hospital and the coordination and integration of interdepartmental and intradepartmental services; and,
2. Assist in determining the qualifications and competence of Section personnel who are

not licensed independent practitioners and who provide patient care, treatment, and

services.

11.5(c) Section Chiefs shall be elected biennially and serve for a term of two (2) years.

**11.6 ORGANIZATION OF SECTION**

11.5(a) All organized sections shall have written Rules and Regulations, which govern the activity of the section. These Rules and Regulations shall be approved by the Board. The exercise of Clinical Privileges within any section is subject to the section Rules and Regulations and to the authority of the Section Chief.

11.5(b) Each section shall meet separately but such meetings shall not release the Members from their obligations to attend the general meetings of the Medical Staff as provided in Article XIII of these Bylaws. Additionally, each section shall meet at least quarterly to present educational programs and conduct clinical review of practice within their section. Written minutes must be maintained and furnished to the MEC.

11.5(c) Each Medical Staff Member, at the time of initial appointment, shall designate his/her primary section and he/she may only vote for the Chief of that section. The Practitioner’s designation of section shall be approved by the MEC and shall be the section in which the Practitioner’s practice is concentrated. Should the Practitioner exercise privileges relevant to the care in more than one (1) section, each section shall make a recommendation to the MEC regarding the granting of such privileges.

**11.7 SERVICE CHIEF**

11.6(a) Chiefs of Service, when determined to be needed, shall be selected by the Board in consultation with the Chief of Staff. The chief of each service shall have the following duties with respect to his/her service:

(1) Account to the appropriate Section Chief and to the MEC for all professional activities within the service;

(2) Develop and implement service programs in cooperation with the Section Chief;

(3) Maintain continuing review of the professional performance of all Medical Staff and AHP Staff appointees having Clinical Privileges in the service and report regularly thereon to the Section Chief;

(4) Implement within his/her service any actions or programs designated by the MEC;

(5) Participate in every phase of administration of his/her service in cooperation with the Section Chief, the nursing service, other sections, administration and the Board;

(6) Assist in the preparation of such annual reports regarding the service as may be required by the MEC, the CEO or the Governing Board;

(7) As applicable, establish a system for adequate professional coverage within the service, including an on-call system, which systems shall be fair and non-discriminatory; and

(8) Perform such other duties as may reasonably be requested by the Chief of Staff, the MEC, the Section Chief or Governing Board.

**ARTICLE XII**

**COMMITTEES & FUNCTIONS**

**12.1 GENERAL PROVISIONS**

12.1(a) The Standing Committees and the functions of the Medical Staff are set forth below. The MEC shall appoint special committees to perform the functions that are not within the stated functions of one (1) of the standing committees.

12.1(b) Each committee shall keep a permanent record of its proceedings and actions. All committee actions shall be reported to the MEC.

12.1(c) All information pertaining to activities performed by the Medical Staff, its committees and sections shall be privileged and confidential to the full extent provided by law.

12.1(d) The CEO or his/her designee shall serve as an ex-officio member, without vote, of each standing and special Medical Staff committee.

**12.2** **MEDICAL EXECUTIVE COMMITTEE**

**12.2(a) Composition**

Members of the committee, the majority of whom must be doctors of medicine or osteopathy[[36]](#footnote-36), shall include the following:

(1) The Chief of Staff, who shall act as Chairperson;

(2) The Vice Chief of Staff;

(3) The Immediate Past Chief of Staff / Chairperson of Credentials Committee;

(4) The Secretary/Treasurer of the Medical Staff;

(5) The Chiefs of sections;

(6) One at large member from each of the following Sections: Medicine, Pediatrics, and

Surgery;

(7) One at large member appointed by the Executive Committee to represent the Hospital-based physicians;

(8) Chairperson of the Pharmacy & Therapeutics Committee

(9) Chairperson of the Quality Council;

(10) Physician Adviser to Corporate;

(11) The CEO, ex-officio, or his/her designee,

(12) The Nurse Executive, ex-officio, or his/her designee.

The CEO and the nurse executive of the organization or designee shall each attend each executive meeting on an ex-officio basis, with or without vote.[[37]](#footnote-37)

**12.2(b) Functions**

The committee shall be responsible for governance of the Medical Staff, shall serve as a liaison mechanism between the Medical Staff, Hospital administration and the Board and shall be empowered to act for the Medical Staff in the intervals between Medical Staff meetings, within the scope of its responsibilities as defined below. When approval of procedural details related to credentialing, corrective action, or selection and duties of department leadership are delegated to the MEC, it shall represent to the Board the organized Medical Staff’s views on issues of patient safety and quality of care. All Active Medical Staff Members shall be eligible to serve on the MEC. The functions and responsibilities of the MEC shall include~~,~~ at least the following:

1. Receiving and acting upon section, committee, and other assigned activity groups

reports;

(2) Implementing the approved policies of the Medical Staff;

(3) Recommending to the Board on all matters relating to appointments and reappointments, the delineation of Clinical Privileges, Medical Staff category and corrective action;

(4) Fulfilling the Medical Staff’s accountability to the Board for the quality of the overall medical care rendered to the patients in the Hospital;

(5) Initiating and pursuing corrective action when warranted, in accordance with Medical Staff Bylaws provision;

(6) Recommending action to the CEO on matters of a medico-administrative nature;

(7) Developing and implementing programs for continuing medical education for the Medical Staff;

(8) Assuring regular reporting of performance improvement and other Medical Staff issues to the MEC and to the Governing Board and making recommendations to the Board regarding Performance Improvement processes and activities;

(9) Evaluating areas of risk in the clinical aspects of patient care and safety and proposing plans and recommendations for reducing these risks;

(10) Assuring an annual evaluation of the effectiveness of the Hospital’s performance improvement program is conducted;

(11) Informing the Medical Staff of accreditation programs and the accreditation status of the Hospital;

(12) Requesting evaluation of practitioners in instances where there is doubt about an applicant’s or practitioner’s ability to perform the privileges requested or previously granted. Initiating an investigation of any incident, course of conduct, or allegation indicating that an appointee to the Medical Staff may not be complying with the Bylaws, may be rendering care below the standards established for appointees to the Medical Staff, or may otherwise not be qualified for continued enjoyment of Medical Staff membership or Clinical Privileges without limitation, further training, or other safeguards;

(13) Participating in identifying community health needs and in setting Hospital goals and implementing programs to meet those needs;

(14) Developing and monitoring compliance with these Bylaws, Policies and Procedures, and the Rules and Regulations, and policies and other Hospital standards; and

(15) Making recommendations to the Board regarding the Medical Staff structure, the mechanism for fair hearing procedures and the mechanism by which Medical Staff membership may be granted and terminated.

**12.2(c) Meetings**

The MEC shall meet at regular intervals[[38]](#footnote-38) as needed, but at least monthly and maintain a permanent record of its proceedings and actions, which reflects the participation of the Medical Staff and the CEO and nurse executive (or designees) at the meetings.[[39]](#footnote-39)

**12.2(d) Special Meeting of the Medical Executive Committee**

The Chief of the Medical Staff or the Chief’s designee may call a special meeting of the MEC, when at least five (5) members of the MEC can be convened.

**12.3 CREDENTIALS COMMITTEE**

**12.3(a) Composition**

The Credentials Committee shall be appointed by the Chief of Staff and shallconsist of a minimum of five (5) active Medical Staff Members, one of whom shall be the Immediate Past Chief of Staff, who shall serve as Chairperson. The Chief Executive Officer or his designee shall serve as a non-voting, ex-officio member.

**12.3(b) Functions**

The functions of the Credentials Committee shall be to:

(1) Review and evaluate the qualifications, competence and performance of each applicant and make recommendations for Medical Staff membership and delineation of Clinical Privileges;

(2) Make a report to the MEC on each applicant for Medical Staff membership and Clinical Privileges;

(3) Review, on a periodic basis, applications for reappointment including information regarding the competence of Medical Staff Members; and as a result of such reviews make recommendations for the granting of privileges and reappointments; and

(4) Investigate any breach of ethics that is reported to it.

**12.3(c) Meetings**

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

**12.4 NOMINATING COMMITTEE**

**12.4(a) Composition**

The Nominating Committee shall consist of the Chief of Staff, the Past Chief of Staff and the CEO. All Members shall have voting privileges.

**12.4(b) Functions**

To prepare and recommend a slate of nominees for the officers of the Medical Staff.

**12.4(c) Meetings**

The Nominating Committee shall meet biennially at least sixty (60) days prior to the annual meeting, maintain a permanent record of its proceedings and actions and report its recommendations to the Medical Staff at least thirty (30) days prior to the slated election.

**12.5 MEDICAL STAFF FUNCTIONS**

**12.5(a) Composition of Committees**

The MEC shall designate appropriate Medical Staff committees to perform the functions of the Medical Staff.

**12.5(b) Functions**

The functions of the Medical Staff are to:

(1) Monitor, evaluate and improve care provided in and develop clinical policy for special care areas, such as intensive or coronary care unit; patient care support services, such as respiratory therapy, physical medicine and anesthesia; and emergency, outpatient, home care and other ambulatory care services;

(2) Conduct or coordinate quality, appropriateness and improvement activities, including operative and other procedures, use of blood and blood components, use of medications, medical record and other reviews;

(3) Conduct or coordinate utilization review/management activities;

(4) Assist the Hospital in providing continuing education opportunities responsive to performance improvement activities, new state-of-the-art developments, services provided within the Hospital, and other perceived needs;

(5) Develop and maintain surveillance over use of medications policies and practices;

(6) Investigate and control nosocomial infections and monitor the Hospital’s infection control program;

(7) Plan for response to fire and other disasters, for Hospital growth and development, and for the provision of services required to meet the needs of the community;

(8) Direct Medical Staff organizational activities, including Medical Staff Bylaws, review and recommendations for revision, Medical Staff officer and committee nominations, liaison with the Board and Hospital administration, and review and maintenance of Hospital accreditation;

(9) Coordinate the care provided by Members of the Medical Staff with the care provided by the nursing service and with the activities of other Hospital patient care and administrative services; and

(10) Provide as part of the Hospital and Medical Staff’s obligation to protect patients and others in the organization from harm, a mechanism for addressing the health of all licensed individual practitioners. The purpose of this mechanism is to provide education about practitioner health, address prevention of physical, psychiatric, or emotional illness, and facilitate confidential diagnosis, treatment, and rehabilitation of practitioners who suffer from a potentially impairing condition. The Impaired Practitioner Policy affords resources separate from the corrective action process to address physician health. The policy provides a confidential mechanism for addressing impairment of Medical Staff members and providing appropriate advice, counseling or referrals;

(11) Provide leadership in activities related to patient safety;

1. Ensure that the Medical Staff provides leadership for process measurement, assessment and improvement for the following processes which are dependent on the activities of individuals with clinical privileges:
2. medical assessment and treatment of patients;
3. use of medications, use of blood and blood components;
4. use of operative and other procedure(s);
5. efficiency of clinical practice patterns; and
6. significant departure from established patterns of clinical practice.
7. Ensure that the Medical Staff participates in the measurement, assessment and improvement of other patient care processes, including, but not limited to, those related to:
8. education of patients and families;
9. coordination of care, treatment and services with other practitioners and hospital personnel, as relevant to the care of an individual patient;
10. accurate, timely and legible completion of patients’ medical records including history and physicals;
11. Patient satisfaction;
12. Sentinel events; and
13. Patient safety.
14. Participate in at least the following organization activities:[[40]](#footnote-40)

i. Medication management oversight;

ii. Infection prevention and control oversight;

iii. Tissue review;

iv. Utilization review;

v. Medical record review;

vi. Quality Management System; and

vii. Reports and recommendations from these activities shall be prepared and shared with the Medical Executive Committee and the Board. Actions taken by the Medical Staff and Board will be evaluated to ensure implementation and effectiveness.

1. Ensure that when the findings of assessment processes are relevant to an individual’s performance, the Medical Staff determines their use in peer review or the ongoing evaluation of a practitioner’s competence;
2. Recommend to the Board policies and procedures which define the circumstances requiring a focused review of a practitioner’s performance and evaluation of a practitioner’s performance by peers;
3. Make recommendations to the Board regarding the Medical Staff Bylaws, Rules & Regulations, and review same on a regular basis;
4. Review and evaluate the qualifications, competence and performance of each applicant and make recommendations for membership and delineation of clinical privileges;
5. Review, on a periodic basis, applications for reappointment including information regarding the competence of staff members; and as a result of such reviews make recommendations for the granting of privileges and reappointments;
6. Investigate any breach of ethics that is reported to it;
7. Review AHP appeals of adverse privilege determinations as provided in Article V of these Bylaws; and
8. To prepare and recommend a slate of nominees for the officers of the Medical Staff.

(23) Engage in other functions reasonably requested by the MEC and Board or those that are outlined in the Medical Staff Policies & Procedures and Rules & Regulations, or other policies of the Medical Staff.

**12.5(c) Meetings**

These functions shall be performed as required by state and federal regulatory requirements, accrediting bodies, and as deemed appropriate by the MEC and the Board.

# ARTICLE XIII

**MEETINGS**

**13.1 ANNUAL STAFF MEETING**

**13.1(a) Meeting Time**

The annual Medical Staff meeting shall be held in October, at a date, time and place determined by the MEC.

**13.1(b) Order of Business & Agenda**

The order of business at an annual meeting shall be determined by the Chief of Staff. The agenda shall include:

(1) Reading and accepting the minutes of the last regular and of all special meetings held since the last regular meeting;

(2) Administrative reports from the CEO or his/her designee, the Chief of Staff and appropriate Section Chiefs;

(3) The election of officers and other officials of the Medical Staff when required by these Bylaws;

(4) Recommendations for maintenance and improvement of patient care; and

(5) Other old or new business.

**13.2 REGULAR STAFF MEETINGS**

**13.2(a) Meeting Frequency & Time**

The Medical Staff shall meet annually. Other meetings, as needed, may be called at the discretion of the Medical Staff Executive Committee or the Governing Board as is deemed necessary for the purpose of discussing information or presenting/discussing new issues.

**13.2(b) Order of Business & Agenda**

The order of business at a regular meeting shall be determined by the Chief of Staff.

**13.2(c) Special Meetings**

Special meetings of the Medical Staff or any committee may be called at any time by the Chief of Staff or by written request of the Board, the Executive Committee, the Chief Executive Officer, or any five members of the Active Staff. Any such request must specify the purpose for such meeting. The Chief of Staff shall designate the place, date and time of any special Medical Staff Meeting and that information shall be included in the meeting notice. No business shall be transacted at any special meeting unless stated in the meeting notice.

**13.2(d) Required Meetings**

The Medical Staff shall have periodic meetings at regular intervals to review and analyze medical records of the patients for adequacy and quality of care. The scope of these reviews and any subsequent actions taken to address any findings shall be maintained in minutes or other records.[[41]](#footnote-41)

**13.3 NOTICE OF MEETINGS**

The MEC may, by resolution, provide the time for holding regular meetings and no notice other than such resolution shall be required. If a special meeting is called or if the date, hour and place of a regular Medical Staff meeting has not otherwise been announced, the Secretary of the MEC shall give written notice stating the place, day and hour of the meeting, delivered either personally or by mail, to each person entitled to be present there at not less than five (5) days nor more than thirty (30) days before the date of such meeting. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

**13.4 QUORUM**

**13.4(a) General Staff Meeting**

The presence of twenty-five percent (25%) of the voting Members of the Active Staff shall constitute a quorum for the transaction of all business before any action may be taken, but once found, the business of the meeting may continue and all actions taken thereafter shall be binding, even though less than a quorum may be present at a later time during the meeting excepting the amending of Bylaws where a quorum is required at the time of the vote. Written, signed proxies will be permitted in any voting at any meeting.

**13.4(b) Committee Meetings**

The greater of three (3) members or 25% of the committee membership shall constitute a quorum at any meeting of such committee.

**13.4(c) Section Meetings**

The presence of 15% of the voting members of a Section, but in no event less than three (3) voting members, shall constitute a quorum. After a quorum has been established, the subsequent withdrawal of voting members present to fewer than the number required for a quorum shall not affect the validity of any action thereafter taken. A voting member shall be deemed present at meeting if he/she participated by conference telephone, speaker telephone, or other method by which all persons participating in the meeting can hear one another at the same time.

**13.5 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. Action may be taken without a meeting of the committee, if a unanimous consent in writing setting forth the action to be taken is signed by each member entitled to vote.

**13.6 MINUTES**

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

Complete and detailed minutes must be recorded and maintained.

**13.7 ATTENDANCE**

**13.7(a) Regular Attendance**

Members of the Active Staff shall be required to attend a minimum oftwo meetings of their section annually. Members must also attend a minimum of fifty percent (50%) of committee meetings of which they are a member.

**13.7(b) Absence from Meetings**

Any Member who is compelled to be absent from any Medical Staff, section or committee meeting shall promptly provide, in writing to the regular presiding officer thereof, the reason for such absence. Unless excused for a good cause, failure to meet the attendance requirements of these Bylaws may be grounds for corrective action, to be determined by the MEC.

**13.7(c) Special Appearance**

Any committee or section of the Medical Staff may request the appearance of a Medical Staff Member at a meeting when the committee or section is questioning the Practitioner's clinical course of treatment. Such special appearance requirement shall not be considered an adverse action and shall not constitute a hearing under these Bylaws. Whenever apparent suspected deviation from standard clinical practice is involved, seven (7) days advance notice of the time and place of the meeting shall be given to the Practitioner. When such Special Notice is given, it 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 such Special Notice shall, unless excused by the MEC upon a showing of good cause, result in an automatic suspension of all or such portion of the Practitioner's Clinical Privileges as the MEC may direct. Such suspension shall remain in effect until the matter is resolved by the MEC or the Board, or through corrective action, if necessary.

# ARTICLE XIV

##### GENERAL PROVISIONS

**14.1 STAFF POLICIES & PROCEDURES AND RULES & REGULATIONS**

Subject to approval by the Board, the Medical Staff shall adopt Policies and Procedures and Rules and Regulations necessary to implement more specifically the general principles found within these Bylaws. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is required of each Medical Staff Member or affiliate in the Hospital. Such Policies and Procedures andRules and Regulations shall be considered a part of these Bylaws, except that they may be amended or repealed at any regular meeting of the Medical Executive Committee at which a quorum is present and without previous notice, or at any special meeting on notice, by a majority vote of those present and eligible to vote. Such changes shall become effective when approved by the Board. Significant changes that are made in the Policies and Procedures or Rules and Regulations, shall be conveyed to the members of the Medical Staff and the revised documents shall be distributed to Medical Staff members within thirty (30) days of final approval. The Policies and Procedures andthe Rules and Regulations shall be reviewed at least every two (2) years, and shall be revised as necessary to reflect changes in regulatory requirements, corporate and Hospital policies, and current practices with respect to Medical Staff organization and functions. The Board reserves the right to suspend, override, supplement, or replace all or a portion of the Medical Staff Policies and Procedures and/orRules and Regulations in the event of exigent and compelling circumstances affecting the operation of the Hospital, welfare of its employees and staff, or provision of care to patients. However, should the Board so suspend, override, supplement or replace such Rules & Regulations, it shall consult with the Medical Staff at the next regular Medical Staff meeting (or at a specially called meeting as provided in these Bylaws), and shall thereafter proceed as provided herein for adoption and amendment of Policies and Procedures and/or Rules & Regulations.

**14.2 PROFESSIONAL LIABILITY INSURANCE**

Each Practitioner granted Clinical Privileges in the Hospital shall maintain in force professional liability insurance in an amount not less than $100,000 per occurrence and $300,000 in the aggregate with a carrier reasonably acceptable to the Hospital, such insurance to be on an occurrence basis or, if on a claims made basis, the Practitioner agrees to obtain tail coverage covering his/her practice at the Hospital. All AHPs shall be required to carry malpractice coverage in an amount not less than $100,000 per occurrence and $300,000 in the aggregate with a carrier reasonably acceptable to the Hospital, such insurance to be on an occurrence basis or, if on a claims-made basis, the AHP agrees to obtain tail coverage covering his/her practice at the Hospital. Each Practitioner and AHP shall be responsible for advising the MEC and the CEO of any change in such professional liability coverage as soon as reasonably possible, but not longer than fourteen (14) days of such change.

**14.3 FORMS**

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

**14.4 CONSTRUCTION OF TERMS & HEADINGS**

Words used in these Bylaws shall be read as the masculine or feminine gender and as the singular and plural, as the context requires. The captions or headings in these Bylaws are for convenience and are not intended to limit or define the scope or effect of any provision of these Bylaws.

**14.5 TRANSMITTAL OF REPORTS**

Reports and other information which these Bylaws require the Medical Staff to transmit to the Board shall be deemed so transmitted when delivered to the CEO or his/her designee.

**14.6 CONFIDENTIALITY & IMMUNITY STIPULATIONS & RELEASES**

**14.6(a) Reports to be Confidential**

Information with respect to any Practitioner, including applicants, Medical Staff Members or AHPs, submitted, collected or prepared by any representative of the Hospital including its Board or Medical Staff, for purposes related to the achievement of quality care or contribution to clinical research shall, to the fullest extent permitted by the law, be confidential and shall not be disseminated beyond those who need to know nor used in any way except as provided herein. Such confidentiality also shall apply to information of like kind provided by third parties.

**14.6(b) Release from Liability**

No representative of the Hospital, including its Board, CEO, administrative employees, Medical Staff or third party shall be liable to a Practitioner or AHP for damages or other relief by reason of providing information, including otherwise privileged and confidential information, to a representative of the Hospital including its Board, CEO or his/her designee, or Medical Staff or to any other health care facility or organization, concerning a Practitioner who is or has been an applicant to or Member of the Medical Staff, or who has exercised Clinical Privileges or provided specific services for the Hospital, provided such disclosure or representation is in good faith and without malice.

**14.6(c) Action in Good Faith**

The representatives of the Hospital, including its Board, CEO, administrative staff, and Medical Staff shall not be liable to a Practitioner or AHP for damages or other relief for any action taken or statement of recommendation made within the scope of such representative's duties, if such representative acts in good faith and without malice after a reasonable effort to ascertain the facts and in a reasonable belief that the action, statement or recommendation is warranted by such facts. Truth and/ or good faith shall be (a) defense(s) in all circumstances.

**14.7 PRACTITIONER HEALTH**

**14.7(a) Identification of Practitioner Health Matters**

The Medical Staff identifies and manages matters of individual Practitioner health in the interest of protecting patients from harm that may result in the event a Practitioner becomes impaired due to physical, psychiatric, or emotional illness, including but not limited to alcohol and/or substance abuse (“Impaired” or “Impairment”) that interferes with the ability of the Practitioner to engage safely in professional activities. In addition, the Medical Staff manages these matters to assist the rehabilitation of, and to aid the Practitioner in retaining or regaining optimal professional functioning. The reporting procedure, investigation and discipline if necessary, of a Practitioner will be done as appropriate and in accordance with Sections 14.7, 14.8, Article VIII, Peer Review and Corrective Action and as appropriate, Human Resources policies and procedures/ the IASIS Substance Abuse Policy. For AHPs, the reporting procedure, investigation and discipline if necessary will be done as appropriate and in accordance with Human Resources policies and procedures/ IASIS Substance Abuse Policy.

**14.7(b) Corrective Action/ Reporting Requirements as Necessary**

Depending upon the nature and severity of the Impairment, the Hospital may take one or more of the following actions:

(1) Require the Practitioner to undergo a rehabilitation program as a condition of continued Medical Staff Membership and/or Clinical Privileges delineation;

(2) Impose restrictions on Practitioner’s practice as per Article VIII, Peer Review and Corrective Action; or

(3) If necessary, immediately suspend Practitioner’s privileges in the Hospital until rehabilitation has been accomplished, if Practitioner does not voluntarily agree to discontinue practicing under his/her delineated Clinical Privileges.

Corrective actions, as necessary, will be adhered to per Article VIII and Section 14.7(e). Any reporting requirements, legal or ethical will be followed as necessary.

**14.7(c)** **Education and Referral**

The Medical Staff will be periodically educated about illness and impairments that may affect Practitioners as part of Hospital continuing education efforts. The affected Practitioner or other Hospital employee or Medical Staff Member may refer a Practitioner to the MEC, which shall evaluate the credibility of the reported concern. Evaluation shall consist of discussion of the report, research, and consensus of the MEC. If appropriate, the MEC shall commission the Physician Affairs Committee. The Physician Affairs Committee shall consider advice, counseling or referral of the Practitioner designed to remedy the Impairment. Such advice, counseling or referral may use internal or external resources for diagnosis and treatment. Fitness for duty evaluations shall be performed as per the Hospital Substance Abuse Policy/ Drug Free Workplace Policy.

**14.7(d)** **Confidentiality of Information**

An individual who reports or refers a Practitioner to the MEC Physician Affairs Committee, shall be instructed as to the confidentiality of the report, however, such reporting individual shall be notified that follow up action (generally) has occurred or is occurring. Individuals on the MEC and Physician Affairs Committee shall also maintain the report/ referral as confidential except as required by law or ethical obligations or in instances where patient safety is threatened, however, only those individuals or agencies with a need to know will be notified of the report after credibility of the report is determined.

**14.7(e)** **Practitioner Privileges during Diagnosis and Treatment of Impairment**

If patient safety concerns arise as a result of the Practitioner Impairment, the Physician Affairs Committee shall notify the appropriate parties as specified in Section 14.7(b) and Article VIII. If it is determined that the Practitioner may safely undergo diagnosis and treatment and maintain Clinical Privileges and/or Medical Staff Membership, the Impaired Practitioner shall be monitored and/or proctored during the diagnosis, treatment, and/or corrective action process of the Impairment as per Article VIII, Peer Review and Corrective Action. Such monitoring and proctoring will continue until treatment and/or corrective actions are completed. In instances when it is determined that patient safety may be affected and privilege restriction, voluntary or involuntary, or suspension of the Practitioner/ AHP has occurred, the reinstatement process described below must be implemented.

**14.7(f)** **Practitioner Reinstatement after Diagnosis and Treatment of Impairment**

In the event that the affected Practitioner has had corrective action taken such that privileges or Medical Staff Membership have not been continuous, The Physician Affairs Committee shall consider and make recommendation to the MEC as to whether the Practitioner shall be reinstated. In considering such reinstatement, the Physician Affairs Committee shall consider:

(1) Patient care and safety;

(2) Whether the Practitioner has satisfactorily participated in the rehabilitation program;

(3) Whether an aftercare program for rehabilitation has been recommended and whether the Practitioner is in compliance with all aftercare program requirements; and,

(4) Whether the Practitioner’s primary care provider believes the Practitioner is fit to practice per such Practitioner’s Clinical Privileges.

Upon return to work, the Practitioner shall comply with a return-to-work agreement providing for unannounced substance testing, if applicable. Continuing and ongoing primary care provider reports regarding the Impaired Practitioner and his/her ability to continue to practice Clinical Privileges shall be considered by the Physician Affairs Committee and the MEC for a time period found to be appropriate by the Physician Affairs Committee.

**14.7(g)** **Practitioner’s Failure to Complete Rehabilitation Program**

If the practitioner fails to complete the Rehabilitation Program, the individual will be referred to the Medical Staff Executive Committee for disciplinary action, as set forth in Article VIII of the Medical Staff Bylaws. Such referral will include a report of the findings and actions taken by the Physician Affairs Committee, as well as their recommendations that were not completed by the practitioner.

**14.8 medical staff PHYSICIAN AFFAIRS committee**

**14.8 (a)** **Composition**

The Medical Executive Committee shall establish, if appropriate, the Physician Affairs Committee which shall be comprised of no less than five active members of the Medical Staff, a majority of which, including the Chair, shall be Physicians. Insofar as possible, members of this Physician Affairs Committee shall not serve as active participants on other peer review or Performance Improvement committees while serving on the Physician Affairs Committee. Also, members of the Physician Affairs Committee shall, insofar as possible, have expertise or experience in treating individuals with Impairments.

**14.8 (b)** **Duties**

The Physician Affairs Committee may receive referrals from the MEC related to the health, well being or impairment of Medical Staff members and, as it deems appropriate, may investigate such reports as designated by the MEC. For matters involving individual Practitioners, the Physician Affairs Committee may provide such advice, counseling, or referrals for rehabilitation as may seem appropriate. These activities shall be confidential; however, if information received by the Physician Affairs Committee clearly demonstrates that the health or known Impairment of a Medical Staff Member poses an unreasonable risk of harm to hospitalized patients, that information shall be released as per Section 14.7(d) Confidentiality of Information. The Physician Affairs Committee shall also consider general matters related to the health and well being of the Medical Staff and, with the approval of the Medical Executive Committee, develop educational programs or related activities in coordination with the Education Committee.

**14.8(c)** **Meetings**

The Physician Affairs Committee shall meet as often as necessary, once it has been commissioned by the MEC. It shall maintain only such record of its proceedings as it deems advisable, but shall report on its activities to the Medical Executive Committee.

**ARTICLE XV**

**ADOPTION & AMENDMENT OF BYLAWS**

**15.1 DEVELOPMENT**

The Medical Staff shall be appointed by the governing body and operate under the bylaws, rules and regulations adopted and enforced by the Medical Staff and approved by the governing body.[[42]](#footnote-42)  The Medical Staff shall have the initial responsibility to formulate, adopt and recommend to the Board the Medical Staff Bylaws and amendments thereto which shall be effective when approved by the Board. Neither the Medical Staff nor the governing body may unilaterally amend the Bylaws, Rules and Regulations.[[43]](#footnote-43) The Medical Staff shall exercise its responsibility in a reasonable, timely and responsible manner, reflecting the interest of providing patient care of recognized quality and efficiency and of maintaining a harmony of purpose and effort with the Hospital, the Board, and the community.

**15.2 ADOPTION, AMENDMENT & REVIEWS**

The Bylaws shall be reviewed and revised as needed, but at least every two (2) years. When necessary, the Bylaws and Rules and Regulations will be revised to reflect changes in regulatory requirements, corporate and Hospital policies, and current practices with respect to Medical Staff organization and functions. Changes to the Medical Staff Bylaws require approval of the Medical Staff and the Board.[[44]](#footnote-44)

**15.2(a) Medical Staff**

These Bylaws may be amended after submission of the proposed amendment to the Executive Committee for discussion and evaluation. Amendments may be proposed by any Active or Provisional Active member of the Medical Staff or any section or committee of the Medical Staff by submitting in writing any such proposed change to the Executive Committee. To be adopted, the amendment shall require a two-thirds (2/3) vote of the Active Medical Staff voting. Voting may be accomplished at a regularly scheduled meeting of the Medical Staff or the amendment question(s) may be voted upon by mail. Prior to presenting any amendment(s) for balloting, the proposed amendment(s) will be provided to all Active and Provisional Active members of the Medical Staff at least two weeks prior to a scheduled meeting wherein the amendment(s) are schedule to be voted upon, or prior to mailing ballots for voting. Upon approval by the members of the Medical Staff, the amendment(s) will be forwarded to the Governing Board for consideration at its next regularly scheduled meeting and will be effective the date they receive final approval from the Governing Board.

**15.2(b) Board**

The Medical Staff Bylaws may be adopted, amended or repealed by the affirmative vote of two-thirds of the Board. If the Medical Staff fails to act within a reasonable time after notice from the Board to such effect, the Board may resort to its own initiative in formulating or amending Medical Staff Bylaws when necessary to provide for protection of patient welfare or when necessary to comply with accreditation standards or applicable law. In such event, Medical Staff recommendations and views shall be carefully considered by the Board.

**15.3 SUSPENSION, SUPPLEMENTATION OR REPLACEMENT**

The Board reserves the right to suspend, override, supplement, or replace all or a portion of the Medical Staff Bylaws in the event of exigent and compelling circumstances affecting the operation of the Hospital, welfare of its employees and staff, or provision of care to patients. However, should the Board so suspend, override, supplement or replace such Bylaws, it shall consult with the Medical Staff at the next regular Medical Staff meeting (or at a special called meeting as provided in these Bylaws), and shall thereafter proceed as provided in Section 15.2(a) for amendment and adoption of Bylaws provisions.

**15.4 DOCUMENTATION & DISTRIBUTION OF AMENDMENT**

Amendments to these Bylaws, approved as set forth herein, shall be documented by either:

15.4(a) Appending to these Bylaws the approved amendment, which shall be dated and signed by the Chief of Staff, the CEO, the Chairperson of the Governing Board and reviewed by corporate legal counsel as to form; or

15.4(b) Restating the Bylaws, incorporating the approved amendments and all prior approved amendments which have been appended to these Bylaws since their last restatement, which restated Bylaws shall be dated and signed by the Chief of Staff, the CEO and the Chairperson of the Governing Board and approved by corporate legal counsel as to form.

Each Member of the Medical Staff and AHPs shall be given a copy of any amendments to these Bylaws in a timely manner.

1. #### MS.3 Interpretive Guideline.

   [↑](#footnote-ref-1)
2. MS.10 requires that all individuals with delineated clinical privileges participate in continuing education that is at least in part related to their clinical privileges. [↑](#footnote-ref-2)
3. #### MS.17, SR.1 and SR.3.

   [↑](#footnote-ref-3)
4. #### MS.17, SR.3 indicates that the content of the history and physical examination and applicability shall be determined by the medical staff.

   [↑](#footnote-ref-4)
5. MS.17, SR.3. [↑](#footnote-ref-5)
6. SS.4, SR.1 [↑](#footnote-ref-6)
7. SS.4, SR. 2 and 3. [↑](#footnote-ref-7)
8. MS.17, SR.1b. [↑](#footnote-ref-8)
9. MS. 17, Interpretive Guidelines. [↑](#footnote-ref-9)
10. MS.18 provides that the Medical Staff must in its bylaws define the circumstances and criteria under which consultation or management by a physician or other qualified licensed independent practitioner is required. [↑](#footnote-ref-10)
11. Action on an individual’s application for appointment/reappointment or initial or subsequent clinical privileges is withheld until the information regarding required continuing education is available and verified. MS.10, SR.2. [↑](#footnote-ref-11)
12. MS.8, SR.1a requires primary source verification of licensure, education, specific training, experience, and current competence. [↑](#footnote-ref-12)
13. MS.8, SR.1a indicates that primary source verification of licensure, education, specific training, experience, and current competence is required, but that the AMA Master Profile is acceptable. [↑](#footnote-ref-13)
14. MS.8, SR.1a(1). [↑](#footnote-ref-14)
15. MS.8, SR.1e requires receipt of database profiles from NPDB, OIG Medicare/Medicaid Exclusions. [↑](#footnote-ref-15)
16. MS.8, SR.2b. [↑](#footnote-ref-16)
17. MS.8, SR.2a. [↑](#footnote-ref-17)
18. Action on an individual’s application for appointment/reappointment or initial or subsequent clinical privileges will be withheld until information regarding required continuing education is available and verified. MS.10, SR.2. [↑](#footnote-ref-18)
19. MS.8, SR.2e requires receipt of database profiles from NPDB and OIG Medicare/Medicaid Exclusions. [↑](#footnote-ref-19)
20. MS.8, SR.2d. MS.9 deals specifically with what is required of performance data. [↑](#footnote-ref-20)
21. MS.20, SR.3. [↑](#footnote-ref-21)
22. MS.20, SR.1 and MS.20, SR.2. [↑](#footnote-ref-22)
23. MS.20, SR.1a. [↑](#footnote-ref-23)
24. MS.20, SR.2a. [↑](#footnote-ref-24)
25. MS. 20, SR.1b. [↑](#footnote-ref-25)
26. MS.20, SR.2b. [↑](#footnote-ref-26)
27. MS.20, SR.1c and MS.20, SR.2c. [↑](#footnote-ref-27)
28. MS.20, SR.1d and MS.20, SR.2d. [↑](#footnote-ref-28)
29. MS.20 Interpretive Guideline. [↑](#footnote-ref-29)
30. MS.14 Interpretive Guideline. [↑](#footnote-ref-30)
31. MS.12, SR.6a requires that the Bylaws provide a mechanism for consideration of automatic suspension of clinical privileges if a professional license has been revoked/restricted. [↑](#footnote-ref-31)
32. MS.12, SR.6b requires that the Bylaws provide a mechanism for consideration of automatic suspension of clinical privileges for revocation/suspension/probation of Federal Narcotics Registration Certificate (DEA). [↑](#footnote-ref-32)
33. MS.12, SR.7. [↑](#footnote-ref-33)
34. MS.4. [↑](#footnote-ref-34)
35. SM.3 [↑](#footnote-ref-35)
36. MS.5, SR.1 requires that if the Medical Staff has an executive committee, that a majority of the members of the committee are doctors of medicine or osteopathy. [↑](#footnote-ref-36)
37. MS.5, SR.2 requires that the CEO and the nurse executive of the organization or designee attend each executive committee meeting on an ex-officio basis, with or without vote. [↑](#footnote-ref-37)
38. MS.5, SR.1 requires that the Medical Staff meet at regular intervals and that minutes are maintained. [↑](#footnote-ref-38)
39. MS.5. [↑](#footnote-ref-39)
40. MS.6, SR1-SR.7. [↑](#footnote-ref-40)
41. MS.16, SR.2. [↑](#footnote-ref-41)
42. MS.7, SR.1 [↑](#footnote-ref-42)
43. MS.7 Interpretive Guideline. [↑](#footnote-ref-43)
44. MS.7, SR.2. [↑](#footnote-ref-44)