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DEFINITIONS

Chief Executive Officer means the individual appointed by the Board as CEO, or his designee, to act on its behalf in the overall administrative management of the Hospital.

Adverse Action/Recommendation (as used in Article X and Article XI) means a professional review action as used in the "Health Care Quality Improvement Act of 1986."

Allied Health Professional or AHP means an individual other than a licensed Physician or Other Licensed Individual who exercises independent judgment within the areas of his professional competence and who is qualified to render medical or surgical care under the supervision of a Sponsor who has been accorded privileges to provide such care in the Hospital or who has been accorded privileges to provide care without supervision in accordance with a license granted by the State Board of Nursing. The following may be deemed Allied Health Professionals: clinical psychologists, advanced practice registered nurses, physician assistants, and doctoral scientists (Ph.D.) and others as specified by the MEC and approved by the Board.

Ancillary Staff Professional or ASP means an individual who is qualified to render medical or surgical care under the direct supervision of a Sponsor/Supervisor who has been accorded privileges to provide such care in the Hospital. The following may be deemed Ancillary Staff Professionals: certified surgical assistant certified first assistant, registered nurse first assistant, dental assistant, surgical technologist, certified clinical perfusionist and others as specified by the MEC and approved by the Board.

Board means the SMRMC Hospital Governing Board.

Clinical Privileges or Privileges means the rights granted to a Practitioner to provide those diagnostic, therapeutic, medical, surgical, dental or podiatric services specifically delineated to him/her.

Credentials Policy Manual means the Credentials Policy Manual approved by the MEC and the Board and containing credentialing policies and procedures to be followed in connection with Medical Staff appointments, reappointments and delineations of privileges.

Division refers to one or more of the clinical Divisions set forth in Article VII of these Bylaws to which a Practitioner is assigned.

Division Chairman refers to the member of the Medical Staff elected by Division members to manage the professional and administrative responsibilities of a Division.

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.

Fair Hearing Plan means the plan adopted by the MEC and the Board describing due process rights and procedures applicable to corrective actions relating to a Practitioner's Staff status or privileges, set forth in Article XI of these Bylaws.
Focused Professional Practice Evaluation, or “FPPE”, refers to the time-limited evaluation of practitioner competence in performing a specific privilege. This process is implemented for all initially-requested privileges and whenever a question arises regarding a Practitioner’s ability to provide safe, high quality patient care.

Hospital means Saint Mary’s Regional Medical Center (SMRMC), Reno, NV

Information means a record of proceedings, minutes, interviews, records, reports, forms, memoranda, statements, recommendations, findings, evaluations, opinions, conclusions, actions, data and other disclosures or communications whatever in written or oral form.

Medical Executive Committee or MEC means that group of active Members of the Medical Staff elected to represent and coordinate all activities and policies of the Medical Staff and its Divisions.

Organized Medical Staff or Staff means the formal organization created by the Board composed of Physicians and Podiatrists who have been appointed by the Board to assist the Hospital in carrying out certain assigned functions.

Medical Staff Year means the Period from October 1 to September 29.

Medico-Administrative Officer means a Physician or Other Licensed Individual holding a formal administrative position with the institution while also maintaining Clinical Privileges.

Members or Appointees means those Practitioners who have been appointed to the Medical Staff pursuant to the provisions of these Bylaws.

Oral Surgeon means a licensed dentist with advanced training qualifying him for Board Certification by the American Board of Oral and Maxillofacial Surgery.

Other Licensed Individual refers to any individual, including those holding a D.P.M. degree, which is permitted by the State of Nevada and the Hospital to provide patient care services in the Hospital without direction or supervision, within the scope of said individual's license and in accordance with individually granted Clinical Privileges.

Physician means an individual with a M.D. or D.O. degree and possessing a valid and subsisting license to practice as such.

Practitioner means, unless otherwise expressly provided, any Physician or Other Licensed Individual applying for or exercising Clinical Privileges or providing other diagnostic, therapeutic teaching, or research services in the Hospital; or any Allied Health Professional or Ancillary Staff Professional applying for or providing specific patient care services under the supervision of a sponsoring physician or providing other diagnostic, therapeutic, teaching or research services in the Hospital.

Prerogative means a participatory right granted, by virtue of Staff category or otherwise, to a Member or Allied Health Professional or Ancillary Staff Professional, and exercisable subject to
the conditions and limitations imposed in these Bylaws and in other Hospital and Medical Staff policies.

Representatives means a Board of Directors of a Hospital and any director, trustee or committee thereof; the Hospital Chief Executive Officer or his designee; any employee of other organizations; a Medical Staff organization and any Member, officer, clinical unit, or committee thereof; and any individual authorized by any of the foregoing to perform specific information gathering, analysis, use or disseminating functions.

Special Notice means written notification sent by certified or registered mail, return receipt requested.

Sponsor or Supervisor means a Physician or Other Licensed Individual, as defined above, who is a member of the Medical Staff in good standing and has agreed to sponsor (to supervise, periodically evaluate, and assume responsibility for the activities within the Hospital of an independent or dependent AHP or ASP) a dependent or an independent Allied Health Professional or dependent Ancillary Staff Professional. He must hold at least the clinical privileges of the AHP or ASP he is sponsoring/supervising.

Therapeutic Intervention means the exercising of any privilege that requires specific credentialing by the Medical Staff and Hospital, beyond those privileges automatically granted to all members of the applicable Division. Examples of therapeutic intervention would be performing or assisting on surgical or special procedures, or daily progress notes. Events that would not qualify as therapeutic intervention include ordering of tests, admission and discharge from the hospital.

Third Parties mean both individuals and organizations providing information and representatives.

Unrestricted License means there are no restrictions on the Practitioner’s license and ability to practice medicine as the result of a disciplinary action taken by a state licensing board.

Unrestricted DEA Certificate means there are no restrictions on the Practitioner’s ability to prescribe medications as the result of a disciplinary action taken by a state licensing board or any other state or Federal regulatory body.

The terms “he”, “him” and “his” are used in these Bylaws to designate both male and female for purposes of brevity.
BYLAWS OF THE MEDICAL STAFF
OF
SAINT MARY’S REGIONAL MEDICAL CENTER

PREAMBLE

These Bylaws provide a structure to permit the Medical Staff to discharge its responsibilities in matters involving the quality of medical care. These Bylaws describe the activities of the Medical Staff and relations between applicants and members of the Medical Staff. These bylaws, along with the Bylaws of the Governing Board, describe a policy of the Hospital governing the Medical Staff, which is a constituent part of the Hospital and not a separate entity. The Medical Staff acts on behalf of the Hospital in peer review, quality assurance, credentialing, and other matters hereunder.

These Bylaws are not intended to operate as a contract between the Hospital and the Medical Staff. Medical Staff membership is a privilege, and not a right.

ARTICLE I.

NAME

1.1 Name. The name of this organization shall be the Medical Staff of Saint Mary’s Regional Medical Center (SMRMC).

ARTICLE II.

PURPOSES, RESPONSIBILITIES AND NATURE OF THE MEDICAL STAFF

2.1 Purposes. The purposes of the Medical Staff are:

2.1.1 Professional Body. To constitute a self-governing professional body that is accountable to the Governing Board, providing mutual educational, consultative and professional support;

2.1.2 Organizational Structure. To provide a structure through these Bylaws, Rules and Regulations, and related manuals which define the responsibility, authority, and accountability of each organizational component and individual Member of the Medical Staff;

2.1.3 Clinical Privileges and Peer Review. To provide a mechanism for appropriate delineation of Clinical Privileges and a means for the ongoing evaluation of performance of all Practitioners authorized to practice in the Hospital; and
2.1.4 **Policy Communication.** To provide a means by which the Medical Staff can participate in the Hospital's policy making and planning processes and through which such policies and plans are communicated to Members.

2.2 **Responsibilities.** The primary function of the organized medical staff is to provide oversight for the quality of care, treatment and services provided by Practitioners with privileges. To accomplish the above purposes, it is the obligation and responsibility of the Medical Staff:

2.2.1 **Quality Management.** To participate in the quality management program by:

2.2.1.1 Providing leadership for the process measurement, assessment and improvement of patient care processes, patient safety, and evaluating Practitioner and institutional performance through sound measurement systems in the hospital and its off-site facilities;

2.2.1.2 Monitoring patient care practices and enforcement of Medical Staff and Hospital policies;

2.2.1.3 Assisting in the evaluation of Practitioners' credentials for initial and continuing Medical Staff appointment and for the delineation of Clinical Privileges in a manner that is thorough, effective and timely;

2.2.1.4 Assisting in the development of a sound system of utilization management;

2.2.1.5 Providing leadership in activities relating to patient safety;

2.2.1.6 Providing oversight in analyzing and improving patient satisfaction;

2.2.1.7 Aiding in any Medical Staff-approved educational program, for staff physicians, nurses, resident house staff and other personnel.

2.2.2 **Staff Recommendations.** To make recommendations to the Governing Board regarding appointments, reappointments to the Medical Staff, including Staff category, Division assignments and Clinical Privileges of all Practitioners;

2.2.3 **Community Needs.** To participate in the Governing Board's planning activities, to assist in identifying community health needs and to suggest to the Governing Board appropriate policies and programs to meet those needs; and

2.2.4 **Bylaws Administration.** To develop, administer, recommend amendments to and enforce compliance with these Bylaws, its supporting manuals and the Rules and Regulations of the Staff, and with the Hospital Bylaws and policies. These documents shall be consistent with the Governing Board Bylaws.
2.3 **Nature of Medical Staff Membership**

2.3.1 Appointment to the Medical Staff may be granted to fully licensed Physicians and Other Licensed Individuals who are permitted by law and the Hospital to provide patient care services independently in the Hospital. Membership on the Medical Staff may not be granted to Allied Health Professionals or Ancillary Staff Professionals.

2.3.2 Medical Staff membership is recommended by the Medical Executive Committee and granted by the Governing Board and is a privilege extended only to those professionally competent Practitioners who continuously meet the qualifications standards and requirements set forth in these Bylaws.

2.3.3 All Medical Staff Members must have delineated Clinical Privileges that allow them to provide patient care services independently, with the exception of those Non-Admitting Practitioners who hold staff appointment only.

2.3.4 Medical Staff membership does not automatically confer Clinical Privileges to Practitioners.

2.3.5 Members of the Medical Staff, Allied Health Professionals and Ancillary Staff Professionals are subject to Medical Staff Bylaws, Rules and Regulations, and Divisional Rules & Regulations and are subject to review as part of the Hospital quality management program.

**ARTICLE III.**

**APPOINTMENT AND REAPPOINTMENT**

3.1 **General Qualifications.** Every Physician or Other Licensed Individual who seeks or enjoys Staff appointment must continuously demonstrate to the satisfaction of the Medical Staff and of the Board at least the following qualifications: (Refer to Credentialing Policy & Procedure)

3.1.1 **Licensure.** A valid unrestricted license issued by the State of Nevada to practice as a Physician or Other Licensed Individual, and a valid unrestricted Drug Enforcement Administration ("DEA") Certificate, unless specifically excused by the MEC in circumstances where a DEA is not needed to practice the privileges requested (e.g. Pathologists, Teleradiologists). Except as otherwise provided, each Member of the Medical Staff is strongly encouraged to maintain a DEA certificate that includes all drug schedules (2, 2N, 3, 3N, 4 and 5). Any exceptions to the full schedule DEA will be addressed on a case-by-case basis by the Credentials Committee and MEC.

3.1.2 **Education/Post-Graduate Training**

3.1.2.1 Successfully graduated from an approved school of medicine, osteopathy, podiatry, or dentistry.
3.1.2.2 Successful completion of one of the following:

3.1.2.2.1 For physicians, an allopathic or osteopathic residency program that is approved by the ACGME or the AOA.

3.1.2.2.2 For podiatrists, a two-year Podiatric Medicine and Surgery residency program (at least one year must be a podiatric surgical residency) approved by the Council on Podiatric Medical Education (CPME).

3.1.2.2.3 For Oral/Maxillofacial surgeons, an American Dental Association-approved residency program.

3.1.2.3 Physicians who are still in a training program (residency or fellowship) may not be granted privileges or begin practicing at the hospital in that particular specialty until completion of the training program (i.e. physicians may not provide patient care services at the Hospital in the specialty for which they are still in training).

3.1.3 Board Certification

3.1.3.1 Be board certified, or be eligible to enter the certification examination system in accordance with the training and/or experience requirements defined by the applicable certifying board. The certifying board must be one of the following: 1) member board of the American Board of Medical Specialties (ABMS), 2) member board of the American Osteopathic Association (AOA), 3) the American Board of Podiatric Surgery (ABPS), 4) the American Board of Oral & Maxillofacial Surgery (ABOMS); 5) certification by the Royal College of Physicians and Surgeons of Canada will be accepted in the following circumstances: (a) the applicable ABMS specialty board recognizes the Canadian post-graduate training as equivalent to the ACGME post-graduate training (i.e. the ABMS specialty board accepts Canadian trained physicians for entrance into the ABMS certification exam process) and, relying on that, (b) the Medical Staff Division has approved acceptance of Canadian Boards for Division members. Such board status (eligible or certified) must be in the primary specialty for which privileges are sought (subspecialty certification requirements will be determined at the Division level). The applicant must achieve Board Certification within seven (7) years of completion of residency/fellowship training. Physicians who do not complete their board certification within seven years will be voluntarily resigned from the medical staff. However, a Division chairman, the Credentials Committee and/or Medical Executive Committee may, in certain situations, recommend that a Practitioner be granted privileges in a specialty other than the specialty in which he is certified if the Practitioner otherwise meets the criteria for staff appointment and the training and/or experience criteria for the privileges requested; (Refer to Division Rules and Regulations)
3.1.3.2 Physicians appointed to the Medical Staff **August 1, 2011** and thereafter are required to continuously maintain Board Certification in the specialty for which privileges have been granted.

3.1.3.3 Physicians who were members of the medical staff during the period from January 1, 1960 to August 1, 2011 and who are now members of the medical staff are considered grandfathered. The Medical Staff who are members at the time these Bylaws are approved will continue their membership and eligibility for reappointment regardless of their board certification status as long as they continuously qualify for membership as otherwise specified in these Bylaws.

3.1.4 **Performance.**

3.1.4.1 Education, training, and experience demonstrating current clinical competence.

3.1.4.2 Actively engaged in a clinical practice at least six of the last twelve months (residency/fellowship or private practice); exception may be made by the Credentials Committee.

3.1.4.3 Actively practiced in a hospital deemed acceptable by the Credentials Committee for at least two of the past five years (exception may be made by the Credentials Committee, e.g. physician is requesting affiliate status with no clinical privileges, or physicians who limit their practice to urgent care). Twelve months of recent experience in a full-time clinical residency/fellowship will be considered equivalent.

3.1.5 **Attitude.** A willingness and capability based on current attitude and documented performance, to:

3.1.5.1 Work with and relate to other Practitioners, Hospital management and other Staff, visitors and the community in a cooperative, professional manner;  
(Refer to Unprofessional and Disruptive Conduct Policy)

3.1.5.2 Discharge Medical Staff obligations appropriate to Staff category;

3.1.5.3 Adhere to high standards of professional ethics.

3.1.6 **Professional Liability Insurance.** Provide evidence of current and continuous professional liability insurance in the amount of at least $1 million per occurrence and $3 million aggregate in the form required by the Board and MEC. Physicians in the affiliate (non-admit) category (except urgent care providers) are exempt from this requirement.

3.1.7 **TB/PPD.** Proof of negative Tuberculosis status by one of the following: (refer to TB/PPD Policy and Guidelines)
3.1.7.1 Negative tuberculin skin test within the preceding 12 months or,

3.1.7.2 A negative Quantiferon-TB result within the preceding 12 months or, in the event of a positive Quantiferon-TB test, a negative chest x-ray or,

3.1.7.3 Tuberculosis screening questionnaire is required.

3.1.7.4 For failure to maintain annual and current TB/PPD as may be required under the Bylaws and TB/PPD Policy and Guidelines, a Practitioner's Medical Staff appointment and Clinical Privileges are immediately suspended. The procedure for further action is set forth in the Fair Hearing Plan, Article XI.

3.1.8 Disability. Freedom from a physical or behavioral impairment that interferes with the qualifications required in 3.1.4 above, such that the Practitioner poses a significant risk to the health or safety of others that cannot be eliminated with a reasonable modification of policies, practices or procedures or by the provision of auxiliary aids or services.

3.2 Basic Responsibilities of Individual Staff Appointment. Each Practitioner, regardless of assigned staff category, exercising any privileges under these Bylaws shall:

3.2.1 Provide his patients with continuous care and supervision at the generally recognized professional level of quality and efficiency.

3.2.2 Abide by the Medical Staff Bylaws, Rules & Regulations, Division rules and regulations, and all other standards and policies of the Medical Staff and Hospital.

3.2.3 Discharge such Staff functions for which he is responsible by appointment, election or otherwise.

3.2.4 Prepare and complete in a timely fashion the medical and other required records for all patients he admits or in any way provides care to in the Hospital.

3.2.4.1 History and Physical Examination. A medical history and physical examination must be completed no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. When the history and physical examination are completed within thirty (30) days prior to admission or registration, and updated examination of the patient that includes any changes in the patient’s condition must be completed and documented within twenty-four (24) hours after admission or registration, but prior to any surgery or procedures requiring anesthesia services. The history and physical examination and any updates must be completed and documented by a physician, an oral maxillofacial surgeon, or other qualified licensed individual in accordance with State law and who has been granted such privileges. The content of the history and physical and additional requirements are detailed in the Medical Staff Rules & Regulations.
3.2.5 Promptly inform the hospital of any of the following: 1) revocation or cancellation or reduction of professional liability insurance below the minimum limits required by the Board; 2) health status change which would affect his ability to practice his specialty; 3) voluntary or involuntary termination of staff membership or voluntary or involuntary reduction or loss of privileges at other health care facilities; 4) change in licensing status, including disciplinary actions by a state licensing board; and 5) Medicare/Medicaid sanctions;

3.2.6 Strictly abide by the principles adopted by said Practitioner's profession;

3.2.7 Comply with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and regulations promulgated there under by the U.S. Division of Health and Human Services (“HIPAA”) and other laws which protect the privacy, security and confidentiality of a patient’s PHI; and

3.2.8 Maintain the qualifications and standards set forth in these Bylaws for Medical Staff membership.

3.3 Term of Appointment. (Refer to Credentialing Policy & Procedure)

3.3.1 Appointment. All initial appointments will be for a provisional period of not less than one year.

3.3.2 Reappointment. Reappointments to any category of the Medical Staff may not exceed two years in duration.

3.3.3 Procedures for Appointment and Reappointment. The detailed procedures for appointment and reappointment of the Medical Staff are outlined in the Credentials Manual.

3.3.3.1 The basic steps of the initial appointment/credentialing process include:

3.3.3.1.1 Obtaining a complete application from the applicant in a format approved by the MEC and the Governing Board.

3.3.3.1.2 Verifying the information provided in the application (and/or determining that certain information cannot be verified).

3.3.3.1.3 Obtaining a passport photo, Curriculum Vitae, evidence of current and previous malpractice coverage, statement of 5 years claims history, medical school, internship, residency, and fellowship certificates, state medical license, other state licenses, DEA, Nevada State Board of Pharmacy certificate, ECFMG certificate, government issued ID, PPD or TB or Chest x-ray or TB questionnaire, processing fee, board certificates, explanation of time gaps, signed hospital policies, delineation of privilege form, two (2) year case list or post grad case logs from internship, residency or fellowship training, CME transcripts (if applicable), ACLS, BCLS, PALS, etc if applicable and post moderate sedation test and requesting additional information from the applicant as needed.
3.3.3.1.4 Determining whether the application is complete and the applicant meets minimum qualifications to be considered for appointment, and whether the application can continue through the process.

3.3.3.1.5 Submitting the application, if complete and minimum qualifications are met, to the relevant Division chairman and Credentials Committee for evaluation and recommendation.

3.3.3.1.6 Submitting the application along with the Division chairman and Credentials Committee recommendations to the MEC for review and recommendation.

3.3.3.1.7 Submitting the application along with the MEC’s recommendation to the Governing Board.

3.3.3.1.8 Obtaining a final decision from the Governing Board.

3.3.3.1.9 Notifying the applicant of the Governing Board’s decision and, if applicable, any procedural rights.

3.3.3.2 The basic steps of the reappointment/re-credentialing process include:

3.3.3.2.1 Obtaining a reappointment application from each applicant in a format approved by the MEC and Governing Board.

3.3.3.2.2 Verifying the information provided in the application (and/or determining that certain information cannot be verified).

3.3.3.2.3 Gathering ongoing professional practice evaluation data regarding the applicant, and focused professional practice evaluation data, if any, from the expiring appointment term.

3.3.3.2.4 Requesting additional information from the applicant as needed.

3.3.3.2.5 Determining whether the application is complete and can continue through the process.

3.3.3.2.6 Submitting the application, if complete, to the relevant Division chairman and Credentials Committee for evaluation and recommendation.

3.3.3.2.7 Submitting the application along with the Division chairman and Credentials Committee recommendations to the MEC for its review and recommendation.
3.3.3.2.8 Submitting the application along with the MEC’s recommendation to the Governing Board.

3.3.3.2.9 Obtaining a final decision from the Governing Board

3.3.3.2.10 Notifying the applicant of the Governing Board’s decision and, if applicable, any procedural rights.

3.3.3.3 Applications for initial appointment will be processed by the Credentials Committee within 90 days after the Applicant submits a completed application. The application shall not be considered complete until (1) all blanks on the application form are filled in and all necessary additional explanations are received, (2) verification of all information is complete and (3) responsive letters of reference and information from past hospitals, other affiliations and references have been received. Applications received incomplete will not be submitted to the Credentials Committee. The Governing Board shall act on the Application within 120 days after receiving the Credentials Committee’s recommendation. These periods are deemed guidelines and do not create any right for the Practitioner to have an application processed on this schedule.

3.4 Practitioners Providing Contractual Services

3.4.1 Exclusive Contracts. The Hospital may contract exclusively with a Practitioner or group for clinical or other services. Examples are, but are not limited to, Emergency Medicine, Anesthesiology, Radiology, Pathology, and Clinical Laboratory/Pathology. A Practitioner providing services under such an exclusive contract with the Hospital must meet the same membership qualifications, must be processed for appointment, reappointment, and privilege delineation in the same manner, and must fulfill all of the obligations for his membership category and privileges as any other applicant or member.

The Governing Board may determine that the Hospital’s mission, community service or business interests may be best implemented by closing the membership in a Division or Section. Only those Practitioners who are either employed by or contracted with the Hospital may continue to exercise privileges or provide clinical or non-clinical services in a Division or service with a closed membership. The decision to close membership in a Division or Section may be undertaken by the Governing Board after consultation with the MEC.

Clinical Privileges in such a closed Division or service may be contingent upon continued employment by or contract with the Hospital. If a Practitioner ceases to be contracted with or employed by the Hospital in a closed Division or service, that Practitioner’s privileges to practice in the closed Division shall automatically terminate, and such termination shall not give rise to the fair hearing procedures or other appeal procedures set forth in the Bylaws or Fair Hearing Plan, as long as the Hospital service/Division remains closed. Unless a Division or service has been closed by the Hospital, Practitioners may apply for and exercise clinical privileges they have been granted.
3.4.2 **Telemedicine.** Practitioners who provide patient care services via a telemedicine link must meet the same criteria and their applications will be processed in the same manner and with the same requirements as any other applicant or Member.

3.4.2.1 Telemedicine Practitioners are not required to have an annual TB test.

3.4.2.2 Telemedicine practitioners are not voting members of the medical staff, and are not required to attend meetings in order to advance to senior active status.

3.4.2.3 Telemedicine practitioners are not eligible to hold office or sit on or be chairman of any committee.

3.4.2.4 Telemedicine practitioners are not required to serve as a member of a fair hearing panel, but may be required to testify as a witness in any investigation of a physician or at any formal hearing conducted pursuant to these bylaws.

3.4.3 **Effect of Staff Appointment Termination.** A contracted or employed Practitioner's right to use Hospital facilities is automatically terminated when his Staff appointment expires or is terminated.

3.4.4 **Effect of Agreement Expiration or Termination.** The effect of expiration or other termination of an exclusive agreement upon a Practitioner's Staff appointment and Privileges will be governed solely by the terms of the Practitioner's agreement with the Hospital. Unless the agreement expressly provides that the termination of the agreement, or the Practitioner’s separation from the group that has contracted with the Hospital, does not affect Staff appointment or Clinical Privileges, then the expiration of the agreement or Practitioner’s separation from the group shall be deemed a voluntary resignation of medical staff membership, giving no right to the fair hearing procedures or other appeal procedures set forth in the Bylaws or Fair Hearing Plan.

3.4.5 **Conflict.** Any conflict between these bylaws and an employment or provider contract shall be resolved in favor of the contract.

3.5 **Bylaws.**

3.5.1 **Orientation.** The Medical Staff shall provide to its Members and individuals holding Clinical Privileges a complete copy of or electronic access to the Medical Staff Bylaws and of the Rules and Regulations of the Medical Staff.

3.5.2 **Revisions.** To insure a continued awareness of approved Medical Staff policy and procedure is maintained, the Medical Staff shall provide to its members and individuals holding Clinical Privileges the written text of all significant revisions of the Medical Staff Bylaws, Rules and Regulations and supplemental documents.
ARTICLE IV.

MEDICAL STAFF CATEGORIES & ALLIED HEALTH PROFESSIONALS/ANCILLARY STAFF PROFESSIONALS

4.1 Categories. There are six categories within the Medical Staff: active, senior active, affiliate, resident, emeritus and leave of absence. Allied Health Professionals shall not be members of the Medical Staff but may participate in the Staff organization as provided for in Section 4.9.

4.2 Active Category.

4.2.1 Qualifications.

4.2.1.1 Regularly admit, consult, and perform diagnostic studies or therapeutic intervention.

4.2.1.2 Appointment to the Medical Staff by the Governing Board, meeting both the general requirements of membership outlined in the Bylaws, Rules and Regulations, and Policies as well as the requirements of membership for the specific section or division to which the physician is assigned.

4.2.2 Prerogatives. Members to this category may:

4.2.2.1 Admit patients without limitation, except as otherwise provided in the Medical Staff rules and regulations, or by specific Privilege delineation;

4.2.2.2 Vote on all matters presented at general and special meetings of the Medical Staff, or presented via mail ballot, and of the Division and committees to which they are appointed;

4.2.2.3 Hold office and sit on or be the chairman of any committee, unless otherwise specified elsewhere in these Bylaws; and

4.2.2.4 Exercise such Clinical Privileges as are granted to them.

4.2.2.5 FPPE/OPPE Activity – please refer to Division Rules and Regulations for specific activity by specialty and Professional Practice Evaluation Policy (Peer Review, FPPE,OPPE, and Proctoring)

4.2.3 Responsibilities. Members to this category must:

4.2.3.1 Contribute to the organizational and administrative affairs of the Medical Staff;

4.2.3.2 Actively participate in recognized functions of Staff appointment including quality improvement and other monitoring activities, and in discharging other Staff functions as may be required from time to time. This includes the obligation to testify as a witness in any investigation of a physician or at any formal hearing conducted pursuant to those Bylaws and to serve as a member of the fair hearing panel when so appointed pursuant to Article XI of these Bylaws;
4.2.3.3 Supervise/proctor initial members during their provisional period, as requested by initial members or by the Division chairman or Chief of Staff;

4.2.3.4 Participate in the Emergency Division specialty coverage program as determined by their respective Divisions in accordance with Rules and Regulations and Policies.

4.2.3.5 Provide continuous appropriate coverage for patients and able to respond to the hospital within 30 minutes in an emergency.

4.2.3.6 Fulfill these obligations. Failure to do so is grounds for discipline or termination of medical staff appointment.

4.3 Senior Active Category.

4.3.1 Qualifications.

4.3.1.1 Appointment to the Medical Staff by the Governing Board, meeting both the general requirements of membership outlined in the Bylaws, Rules and Regulations, and Policies as well as the requirements of membership for the specific section or division to which the physician is assigned.

4.3.1.2 Physicians requesting this category, who have reached age 55 and have been members of the Active Staff for the 10 most recent, consecutive years.

4.3.2 Prerogatives. Members to this category may:

4.3.2.1 Admit and attend patients within the scope of granted privileges and proctoring requirements:

4.3.2.2 Vote on matters presented at meetings of committees of which they are members, and vote on amendments, revisions or additions to the Medical Staff Bylaws, Policies and Procedures, and Rules and Regulations.

4.3.2.3 Hold office and sit on or be the chairperson of any committee, unless otherwise specified in these Bylaws:

4.3.2.4 Exercise such Clinical Privileges as are granted to them.

4.3.3 Responsibilities. Members to this category must:

4.3.3.1 Participate in Medical Staff affairs as requested on a voluntary basis:

4.3.3.2 Provide continuous appropriate coverage for patients and able to respond to the hospital within 30 minutes in an emergency:
4.3.3.3 Provide Emergency Room coverage as assigned by their specialty and as required in accordance with Rules and Regulations and Policies:

4.4 Affiliate Category

4.4.1 Qualifications.

4.4.1.1 The affiliate staff shall consist of Practitioners who share the same common interests of the Medical Staff and Governing Board for community health, quality patient care, and other aims and goals of the professionals in other staff categories, but do not intend to practice within the Hospital and are therefore not able to fulfill the criteria to be on staff in any other categories of the Medical Staff and the Hospital. The Affiliate Staff wish to have an association with the Medical Staff and the Hospital. These Practitioners may or may not have practices and must maintain good professional standings but do not wish to have clinical privileges to manage patients in the Hospital setting. Board Certification is not required.

4.4.2 Prerogatives.

4.4.2.1 May utilize outpatient facilities consistent with their medical practice;

4.4.2.2 May refer patients for outpatient diagnostic testing and specialty services provided by the Hospital

4.4.2.3 May refer patients for treatment by a member of the Medical Staff, who has admitting privileges

4.4.2.4 May visit inpatients at the request of the attending physician or the patient and may verbally confer with the attending physician, but may not write orders, and may not substitute for daily attendance of the patients for the attending or consulting physicians.

4.4.3 Obligations. Members of the Affiliate Staff

4.4.3.1 May accept committee assignments and in doing so, must carry out such assignments in the same manner as required of the other categories of the Medical Staff;

4.4.3.2 Be appointed to committees unless otherwise provided by these Bylaws; vote on matters presented at committees to which he or she has been appointed and at Division meetings unless otherwise limited by these Bylaws or by Division Rules and Regulations;

4.4.3.3 Must reapply to the Medical Staff every two years, however, requirements will not include documentation associated with clinical privileges, i.e., delineation of clinical privileges, current competency to perform privileges, CME, OPPE/FPPE etc;

4.4.3.4 Is welcome to attend meetings of the full Medical Staff, and the Divisions to which they are assigned, and are urged to attend Continuing Medical Education programs;
4.4.3.5 Shall not have clinical privileges in the Hospital. Members of the Affiliate Staff who wish to advance to active category may do so by completing the required reappointment application and process as defined in these Bylaws. Physicians who currently hold other Staff Categories and then at a later date wish to return to original Staff category may do so at the discretion of the Division chair and must be approved by appropriate committees;

4.4.3.6 Shall be subject to application fees and any reappointment fees as specified in the Initial and Reappointment Applications.

4.4.4 Limitations of Prerogatives.

4.4.4.1 The prerogatives set forth under each staff category are general in nature, and may be subject to limitation by special conditions attached to a Practitioner’s staff appointment, by other Sections of these Bylaws, by Division Rules and Regulations, and by other policies of the Medical Staff or Hospital.

4.5 Emeritus Category.

4.5.1 Qualifications. Practitioners who have been Members of the Active Staff or Senior Active Staff for no less than ten years, who have retired from active hospital practice and who have demonstrated many years of quality, leadership and caring which exemplify the best aspects of the medical profession.

4.5.2 Appointed by the Governing Board on the recommendation of the Medical Executive Committee.

4.5.3 Prerogatives. Emeritus Members are not eligible to admit patients to the Hospital, or to exercise Clinical Privileges in the Hospital. They may, however, attend, as non-voting members, Medical Staff and Division meetings and serve on Medical Staff Committees.

4.5.4 Responsibilities. Abide by the general medical staff responsibilities as outlined in Article III, Section 3.

4.5.5 Prerogatives. Visit patients in the hospital.

4.5.6 Change in status. Except as provided in Section 4.9, Emeritus staff members may change categories of Membership only through the application and credentialing process established in these Bylaws.

4.6 Resident Category.

4.6.1 Qualifications. The Resident Staff shall consist of individuals who:

4.6.1.1 Are post-doctoral trainees (interns and residents) enrolled in accredited residency training programs of teaching institutions approved by the MEC and the Governing Board, who are not eligible for another Staff category; and

4.6.1.2 Who are either licensed or registered with the appropriate State of Nevada licensing board. Resident Staff must obtain a license to practice
medicine within the State of Nevada when eligible. Resident Staff shall not be considered licensed independent Practitioners and shall not be eligible for Medical Staff membership or clinical privileges.

4.6.2 Prerogatives. The Resident Staff shall be entitled to render patient services at the hospital only pursuant to and limited by the following:

4.6.2.1 Applicable provisions of the professional licensure requirements of the State;

4.6.2.2 Resident Staff shall be credentialed by the sponsoring medical school or training program in accordance with a written affiliation agreement between the Hospital and that sponsoring medical school or training program. The school or program shall provide a written description of the role, responsibilities and patient care activities of participants in the program, and shall make credentialing information available to the hospital upon request.

4.6.2.2.1 The affiliation agreement shall identify the individual or entity responsible for providing professional liability insurance coverage for Resident Staff members, in amounts established by the Governing Board.

4.6.2.3 Policies, procedures and protocols established by the Hospital and Medical Staff shall define Residents Staff’s authority, mechanism for direction and supervision and other conditions imposed.

4.6.2.4 Resident Staff shall abide by all applicable provisions of the Medical Staff Bylaws, Rules and Regulations, and administrative policies and procedures.

4.6.2.5 Resident Staff may perform only those services set forth in their scope of practice, training protocol, job description and/or policies, which shall be established by the Medical Executive Committee, in conjunction with the sponsoring medical school or training program.

4.6.2.6 Resident Staff shall be responsible and accountable at all times to a member of the Active medical staff and shall be under the supervision and direction of a member of the Active medical staff. The supervising physician accepts continuing responsibility to follow the progress of the professional activities of house staff and the patient.

4.6.2.7 Resident Staff may give orders to Hospital personnel, as long as such orders are co-signed by the supervising Medical Staff Member; and

4.6.2.8 Resident Staff may participate in the activities of the Medical Staff through membership on the Education Committee or associated education function, with the right to vote within that committee only if
specified at time of appointment, and non-voting attendance at Medical Staff meetings.

4.6.2.9 The applicable Division shall be responsible for overseeing, Resident Staff and shall communicate to the Medical Executive Committee and the Governing Board about the patient care provided by, and the educational and supervisory needs of the participants in the professional graduate education program.

4.6.3 Medical Staff Dues. Resident Staff Members shall not be required to pay Medical Staff dues or Medical Staff application fees.

4.6.4 Limitation of Prerogatives.

4.6.4.1 Resident Staff are not members of the Medical Staff.

4.6.4.2 The training period may not be considered as the observational period required to be completed by Active Medical Staff Members; and

4.6.4.3 Any Resident Staff member may be terminated at any time for good cause by unanimous decision of the Chief Medical Officer and Chief of Staff, and in such case, the resident is not entitled to the hearing rights set forth in Article XI.

4.7 Leave of Absence.

4.7.1 Policy. Any medical staff member who plans to suspend his hospital privileges for a period not less than three months and not more than one year may request a leave of absence. Requests for leaves of absence in compliance with these criteria and requests for leaves of absence for periods of time outside these criteria will be considered on a case-by-case basis by the Medical Executive Committee and the Governing Board.

4.7.2 All requests for leaves of absence must be in writing and submitted to the Medical Staff Office and include the following:

4.7.2.1 A brief description of the reason for the leave;

4.7.2.2 Type of leave requested, including Professional, Educational, Personal, Medical or Military;

4.7.2.3 Date that the leave will begin and estimated length of the leave;

4.7.2.4 Contact information during the leave period; and,

4.7.2.5 Signature and date on the request letter.

4.7.3 All written requests will be reviewed by the Credentials Committee whose recommendations will be forwarded to Medical Executive Committee and to the Governing Board for final approval and action. A recommendation by the MEC
or a decision by the Governing board to deny a request for leave shall not trigger rights pursuant to the Fair Hearing Plan, Article XI of these Bylaws.

4.7.4 Prior to the approved leave, the member is required to fulfill all responsibilities of staff membership, including but not limited to completion of medical records and coverage of scheduled E.R. call assignments, unless those requirements are waived by the member’s section, division or the Medical Executive Committee due to the extenuating circumstances.

4.7.5 **During the leave of absence.**

4.7.5.1 The member will maintain membership on the medical staff

4.7.5.2 Emergency Division backup responsibilities will be waived.

4.7.5.3 The member will hold NO clinical privileges.

4.7.5.4 The member is not required to maintain malpractice insurance (unless practicing in the community).

4.7.5.5 A leave shall NOT suspend the disciplinary process.

4.7.5.6 The member may not supervise or sponsor any Allied Health Professional.

4.7.6 **Returning from Leave of Absence.**

4.7.6.1 At least 30 days prior to termination of the leave of absence, the member must request reinstatement of his privileges, prerogatives and obligations by submitting a written request to the Credentials Committee via the Medical Staff Office. The request for reinstatement of clinical privileges will be processed and must be approved before the member resumes work in the hospital. Temporary privileges may be considered (see Temporary Privileges Policy).

4.7.6.2 The request for reinstatement shall include the following:

4.7.6.2.1 Written summary of activities during the leave of absence;

4.7.6.2.2 Documentation of current DEA;

4.7.6.2.3 Documentation of professional liability insurance;

4.7.6.2.4 Documentation of Nevada State Licensure;

4.7.6.2.5 Members returning from leave of absence following a medical leave of absence must submit a written release from their physician that they are fit for duty/able to perform their requested privileges, and which must specify
any applicable medical restrictions. The Credentials Committee reserves the right to request further documentation of fitness to perform the privileges requested.

4.7.6.3 The Credentials Committee will review the request for reinstatement and forward its recommendations to the Medical Executive Committee and Governing Board for final approval. In acting upon the request for reinstatement the Governing Board may approve reinstatement either to the same or a different staff category, and may limit or modify the clinical privileges to be extended to the member. The Governing Board will notify the Practitioner in writing of the final decision and recommendations as determined by the Governing Board and Medical Executive Committee.

4.7.6.4 Proctoring may be required after an absence longer than 6 months. Requirements for proctoring are in the Medical Staff Proctoring Policy.

4.7.7 If the duration of the absence extends beyond the member’s current full appointment expiration date, he/she must complete the full reappointment application and meet all requirements, requesting a conditional reappointment (membership only) and submit the package to the medical staff office according the reappointment schedule.

4.7.8 If the member does not apply for a conditional reappointment and his appointment and privileges lapse during the leave of absence, he/she will be required to submit an application for initial appointment, including the initial application fee. This application must be processed and approved before the member returns to exercise privileges.

4.7.9 Appropriate documentation of reasons for a request to extend a leave of absence must be submitted to the Credentials Committee. Requests for extension of leave must be submitted in writing at least 30 days prior to termination of the initial leave of absence and will be processed as described above. Total leave of absence shall not exceed two (2) years. If no notice of return or request for extension of leave is timely received, the member will be removed from staff and must submit an application for initial appointment, including the initial application fee. This application must be processed and approved before the member returns to exercise privileges. Any absence for greater than six (6) months without an approved leave of absence shall be cause for administrative termination of staff privileges.

4.8 Reassignment to Active Staff:

4.8.1 If a member of the Active Staff, or Senior Active Staff category changes, for less than two (2) years, to the Affiliate Staff, Emeritus Staff, or Leave-of-Absence, the
Medical Executive Committee may recommend appointment of the individual back to the Active Staff based on:

- Assessment of his current clinical competency;
- A favorable recommendation by the physician’s specialty and the Credentials-Privileges Committee;
- Documentation of at least having met current CME requirements of the Nevada State Board of Medical Examiners or the Nevada State Board of Osteopathic Medicine.

4.9 Allied Health Professionals and Ancillary Staff Professionals.

4.9.1 General.

4.9.1.1 The term "Allied Health Professional" refers to an individual, other than a Physician or Other Licensed Individual and not a Hospital Employee, who exercises independent judgment within the areas of said individual's professional competence and the limits established by the Governing Board, the Medical Staff and the State of Nevada, and who is qualified to render direct or indirect patient care independently or under the sponsorship/supervision of a Medical Staff member possessing privileges to provide such care in the Hospital. A sponsoring/supervising physician must be an active or senior active member of the Medical Staff. An Allied Health Professional is not eligible for Medical Staff Membership.

4.9.1.2 The term “Ancillary Staff Professional” refers to an individual who is qualified to render medical or surgical care under the direct supervision of a Sponsor/Supervisor who has been granted such privileges to provide such care in the hospital. A sponsoring/supervising physician must be an active or senior active member of the Medical Staff. An Ancillary Staff Professional is not eligible for Medical Staff membership.

4.9.1.3 Based upon the recommendations of the Medical Executive Committee the Governing Board shall delineate: (1) the Allied Health categories eligible to apply for Clinical Privileges; (2) the mode of practice in each category (whether dependent or independent); and (3) the scope of practice or Clinical Privileges, Prerogatives, terms and conditions attended to each category; (4) the Ancillary Staff Professional categories and their scope of practice.

4.9.1.4 The activities of Allied Health Professionals and Ancillary Staff Professionals will be governed by the applicable section of the Credentials Manual.
4.9.1.5 Sponsors/supervisors shall be responsible for overseeing and evaluating the work performance of dependent Allied Health Professionals and Ancillary Staff Professionals at the Hospital and for providing a written evaluation of their performance and competence annually and at reappointment.

4.9.2 Removal Procedures and Status.

4.9.2.1 Allied Health Professionals and Ancillary Staff Professionals are not Members of the Medical Staff and accordingly, have none of the duties and Prerogatives of Members; and

4.9.2.2 The Hospital has the right, either through the administration or upon recommendation of the Medical Executive Committee, to suspend, terminate, revoke or modify any or all of the clinical activities/scope of practice or privileges or functions of any one, or an entire classification of Allied Health Professionals or Ancillary Staff Professional without recourse on the part of such person(s) or others to the review and appeal procedures for Medical Staff Members as set forth in the Fair Hearing Plan, Article XI.

4.9.2.2.1 An Allied Health Professional or Ancillary Staff Professional whose clinical privileges are suspended, terminated, revoked or modified shall be entitled only to the procedural rights set forth in Article J of the Allied Health Professionals Policy.

4.10 Credentialing Requirements and Guidelines.

The credentialing requirements and guidelines for participation in patient care are described in the Credentialing and Clinical Guidelines established and adopted by the Medical Staff and the Board.

**ARTICLE V.**

**CLINICAL PRIVILEGES**

5.1 Exercise of Privilege. A Practitioner providing clinical services at the Hospital or outpatient facility may exercise only those privileges granted to him by the Governing Board or specified in Section 5.6 of these Bylaws. The Governing Board has final authority on granting, renewing, revising, reinstating or denying privileges. The Privileges granted to each Practitioner shall be kept on file in the office of Medical Staff Services and on file or accessible electronically in other appropriate locations in the Hospital.

5.2 Delineation of Clinical Privileges. *(Refer to Credential Policy Manual)*

5.2.1 Requests. Each application for appointment or reappointment to the Medical Staff must include a request for the specific Clinical Privileges desired by the
applicant. Specific requests must also be submitted, in writing, for locum tenens privileges. The National Practitioner Data Bank will be queried at the time of initial granting of privileges, biennial renewal, and when new or additional privileges are requested.

5.2.2 Basis for Privileges Determinations. Requests for Clinical Privileges will be evaluated on the basis of education, training, experience, demonstrated competence, ability and judgment. The basis for privileges determination to be made in connection with periodic reappointment or a requested change in privileges must include observed clinical performance and documented results of the Staff's quality management program activities. Privileges determinations will also be based on pertinent information from other sources, especially other institutions and health care settings where a professional exercises Clinical Privileges. The information will be added to and maintained in the Medical Staff file established for the member.

5.2.3 Basis for “Grandfathering”. From time to time, a Division may decide that optimizing patient safety requires it to revise the credentials required for a medical staff member to exercise particular privileges within a Division. Such revision may prospectively render previously qualified medical staff members no longer qualified to exercise the privilege. In such cases, a decision must be made whether to “grandfather” those Practitioners. It is the responsibility of each Division, at the time a decision is made to revise the credentials required to exercise a privilege, to make a determination whether medical staff members currently holding the privilege will be granted an exemption from the new requirement(s). Any decision to disallow grandfathering of medical staff members currently holding a privilege should be made based on objective, verifiable data supported by relevant literature and practice in the community, reflecting an underlying desire to maximize patient safety. In no case should subjective factors be used to make the determination. In every case, the criteria for the decision must be consistently applied to every affected member of the Division.

5.2.4 System and Procedure for Delineating Privileges. The procedure by which requests for Clinical Privileges are processed and the specific qualifications for the exercise of privileges are set forth in the Credentials Manual and are incorporated herein by reference.

5.2.5 Focused and Ongoing Evaluations. All Practitioners who are granted clinical privileges are subject to the focused and ongoing practice evaluations described in the Peer Review-OPPE-FPPE Policy.

5.3 Special Conditions for Podiatric Privileges. Requests for Clinical Privileges for podiatrists are processed in the manner specified in this Article. Surgical procedures performed by podiatrists will be under the overall supervision of the chairman of the Division of Surgery. All podiatric patients will receive a basic medical appraisal by a member of the Medical Staff who must determine the risk and effect of any proposed
surgical or special procedure. This basic medical appraisal form (history and physical) issued by the hospital must be completed by the podiatrist prior to the procedure and updated 24 hours prior to the procedure. For patients with any pre-existing medical conditions (ASA II or higher), there must be a history and physical or consultation report from an appropriate specialist, in addition to the basic medical appraisal that indicates the patient is medically stable and optimized for surgery. It is the responsibility of the podiatrist to make arrangements with a qualified M.D. or D.O. to assume responsibility for medical management of the patient in the event of a complication during the surgical procedure that necessitates further medical intervention or admission.

5.4 Special Conditions for Allied Health Professionals (AHP) & Ancillary Staff Professionals (ASP). Requests to perform specified patient care services from AHPs and ASPs are processed in the manner specified in Section 4.9 and in the applicable section of the Credentials Manual. An AHP or ASP may, subject to any licensure requirements or other limitations, exercise independent judgment within the areas of his professional competence and participate directly in the medical management of patients under the supervision of a Physician (Sponsor/Supervisor) who has active staff privileges to provide such care.

5.5 Temporary Privileges/Locum Tenens.

5.5.1 Conditions. Temporary privileges may be granted as described in Section 5.5.2, only for a specified period, not to exceed 120 days, to an appropriately licensed Practitioner, when available information reasonably supports a favorable determination regarding the requesting Practitioner's qualifications, ability, and judgment to exercise the Privileges requested, and only after the Practitioner has satisfied the professional liability insurance requirement of these Bylaws, if required. Special requirements of consultation and reporting may be imposed by the Division chairman responsible for supervision. Except in unusual circumstances, temporary privileges will not be granted unless the Practitioner has agreed in writing to abide by the Bylaws, Rules and Regulations and policies of the Staff and the Hospital in all matters relating to his temporary privileges. Whether or not such written agreement is obtained, these Bylaws, Rules, Regulations and policies control all matters relating to the exercise of Clinical Privileges, including temporary privileges.

5.5.2 Circumstances. Upon written concurrence of the Chief of Staff or the Chairman of the Division where the privileges will be exercised, the Chief Executive Officer, or authorized designee, may grant temporary privileges in the following circumstances:

5.5.2.1 For Care of Specific Patients. Upon receipt of a written request, or via telephone in unusual circumstances, temporary privileges may be granted for an important patient care need for the care of one or more specific patients to a Practitioner who is not an applicant for Staff appointment if there is verification of current unrestricted licensure, current professional liability insurance, current unrestricted and valid
DEA certificate, and current competence. Such requests for temporary privileges shall be limited to nine (9) patients in any twelve (12) month period.

5.5.2.2 **Pending Application.** After receipt of an application for medical staff appointment, an appropriately licensed applicant may be granted temporary privileges, for an initial period of sixty (60) days, with subsequent renewal not to exceed the pendency of the application (the temporary privileges in such case cannot exceed the regular privileges applied for by the applicant). In exercising such privileges, the applicant shall act under the supervision of the Chair of the service to which he is assigned or is appointed.

5.5.2.3 **Locum Tenens.** Locum tenens privileges may be granted to a Practitioner to provide coverage for a current medical staff member. Locum tenens privileges may not exceed one hundred twenty (120) days and will be granted no more than one (1) time in a 12-month period. Practitioners seeking locum tenens privileges shall provide the items listed below, and any additional information requested by the Chief Executive Officer or Chief of Staff. All information provided by the applicant will be verified prior to locum tenens privileges being granted. The applicant must establish that he is a medical staff appointee at another healthcare facility in a category and with a practice which indicates regular opportunity for review and evaluation of the applicant’s work, and that he holds clinical privileges encompassing the procedures and responsibilities for which he is making a request at the hospital, or that he can supply a list of healthcare entity affiliations so that enough data may be obtained for review and evaluation of the applicant’s work by the Chief of Staff or Chief Executive Officer.

5.5.2.3.1 A completed Locum Tenens application

5.5.2.3.2 A completed privileges request form

5.5.2.3.3 Copy of Medical School diploma, if applicable

5.5.2.3.4 Copy of internship/residency/fellowship certifications, if applicable

5.5.2.3.5 Three letters of recommendation from peers who are familiar with the applicant’s current clinical skills and abilities

5.5.2.3.6 Evidence of current Board status (eligibility or certification)

5.5.2.3.7 Evidence of current professional liability insurance in the form and amounts prescribed in these bylaws and by the Board for all Practitioners
5.5.2.3.8 Copy of current Nevada license and/or certification Current (annual) TB/PPD

5.5.2.3.9 Copy of DEA certificate, if applicable

5.5.2.3.10 An application fee in the amount determined by the MEC

5.5.3 **Designation.** An applicant for temporary privileges must designate an alternate member of Medical Staff with appropriate privileges to provide coverage during times where the Practitioner exercising temporary privileges is not available.

5.5.4 **Termination of Temporary Privileges.** Temporary Privileges shall automatically expire at the end of the specified period, without recourse by the Practitioner to the procedural rights under these Bylaws or the Fair Hearing Plan. The Chief Executive Officer, after consultation with the appropriate Division chairman (or his designee), must on the discovery of any information or the occurrence of any event of a nature which raises questions about a Practitioner's professional qualifications or ability to exercise any or all of the temporary privileges granted, and **may** at any other time, terminate any or all of a Practitioner's temporary Privileges; provided, however, that where the life or well-being of a patient is determined to be endangered, the termination may be effected by any person entitled to impose summary suspension under these Bylaws. In the event of any such termination, the Practitioner's patients then in the Hospital will be assigned to another Practitioner by the chairman responsible for supervision. The wishes of the patient shall be considered, where feasible, in choosing a substitute Practitioner.

5.5.5 **Rights of the Practitioner with Temporary Privileges.** A Practitioner shall not be entitled to the procedural rights afforded by these Bylaws and the Fair Hearing Plan because his request for temporary privileges is refused or because all or any part of his temporary privileges expire.

5.6 **Disaster Privileges.** Disaster privileges may be granted by the Chief Executive Officer, Chief Medical Officer, or Chief Executive Officer, or his designee, when the disaster plan has been activated and if the organization is unable to handle the immediate patient needs. The decision to grant disaster privilege shall be made by the responsible individual on a case-by-case basis at his discretion. (Refer to Disaster Credentialing Policy)

5.6.1 Disaster privileges may be granted to a Practitioner on presentation of a valid government-issued photo identification issued by a state or federal agency, and any or some combination of the following items:

5.6.1.1 A current photo hospital ID card

5.6.1.2 A current license to practice
5.6.1.3 Presentation by a current hospital staff member with personal knowledge regarding Practitioner’s identity.

5.6.2 A photo ID badge will be issued by the hospital and must be worn by the Practitioner and visible at all times to allow staff to readily identify these individuals.

5.6.3 Oversight of individuals granted disaster privileges shall be accomplished either by direct observation by a member of the medical staff or a review of the records, to the extent possible, based on the nature of the disaster.

5.6.4 As soon as the immediate disaster situation is under control, the process of verifying the credentials and privileges of the individuals granted disaster privileges shall be instituted and completed within 72 hours from the time the volunteer Practitioner presents to the organization; this process shall include the following:

5.6.4.1 Current unrestricted licensure;

5.6.4.2 Current unrestricted DEA;

5.6.4.3 Current professional liability insurance as required by these Bylaws;

5.6.4.4 Relevant training/experience;

5.6.4.5 Current competence;

5.6.4.6 Health status/ability to perform privileges;

5.6.4.7 Board status;

5.6.4.8 National Practitioner Data Bank query;

5.6.4.9 No current or previously successful licensure challenges;

5.6.4.10 No involuntary termination of medical staff membership at another institution;

5.6.4.11 No involuntary limitation, reduction, denial or loss of clinical privileges;

5.6.4.12 No OIG sanctions.

5.6.5 The organization will make a decision, based on the information listed in Section 5.6.4 above, regarding continuation of the disaster privileges initially granted within 72 hours.

5.7 **Emergency Privileges.** In the case of emergency, any Practitioner will be permitted to use any Hospital facility and take any action necessary, within the scope of said Practitioner's license, to save a patient's life or to save a patient from serious harm,
regardless of the individual's Staff status or Clinical Privileges. When the emergency ceases to exist, such a Practitioner must request, pursuant to the terms of this Article 5, temporary or additional privileges necessary to continue to attend the patient. In the event such temporary privileges are denied or are not requested, the patient shall be assigned to an appropriate member of the Medical Staff. For purposes of this Section, emergency is defined as a condition in which the patient is in immediate danger of a loss of life or serious permanent harm, and any delay in administering treatment would add to such a danger.

5.8 Provisional Period.

5.8.1 Duration. All new Members to the Medical Staff and all new grants of Clinical Privileges shall be monitored for a minimum period of one year.

5.8.2 Purpose. During that provisional period, a Practitioner's performance will be evaluated and documented as specified in the Professional Practice Evaluation Policy.

5.8.3 Procedure for Concluding or Extending the Provisional Period. The mechanism for extending and concluding the provisional period is outlined in the Credentials Manual and incorporated herein by reference.

ARTICLE VI.

OFFICERS, DIVISION CHAIRMEN, AND MEC MEMBER-AT-LARGE

6.1 Officers of the Staff.

6.1.1 Designation. The officers shall be the:

6.1.1.1 Chief of Staff

6.1.1.2 Vice Chief of Staff

6.1.1.3 Immediate Past Chief of Staff

6.1.1.4 Secretary of Staff

6.1.2 Qualifications.

6.1.2.1 General Officers must be Members of the active category for a minimum of one year and election and must remain Members in good standing of the active category during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

6.1.2.2 The Chief of Staff and the Vice Chief of Staff must be Practitioners with demonstrated competence in their fields of practice and demonstrated qualifications on the basis of training, experience, and ability to direct
the medico-administrative aspects of Hospital and Staff activities. Medical Staff Officers must have active board certification in their declared specialty at the time of nomination and for the duration of their term of office.

6.1.2.3 In addition to the above qualifications, to be eligible for nomination to a Medical Staff Officer position the Practitioner must have attended at least twenty-five percent (25%) of Division or committee meetings during the preceding 12 months to demonstrate active participation in Medical Staff related functions and activities.

6.2 Nominations and Elections.

6.2.1 Nominations by Nominating Committee. The Nominating Committee comprised of the Division Chairmen with the Chief Executive Officer serving as Chairman without vote, shall convene before July 1st to nominate candidates for the Secretary of Staff and the at-large members of the MEC. The Nominating Committee shall submit to the Staff before July 15th, one or more qualified members for each office (if applicable in that year) and Members-At-Large positions. The Nominating Committee may also be convened by its Chairman as necessary to nominate candidates to fill unexpired terms when they arise. The process and time frames for such nominations and subsequent special elections shall be similar to those specified in Sections 6.3.2 and 6.3.3 below.

6.2.2 Nominations by Petition. Nominations may also be made by petition signed by at least fifteen percent (15%) of the Members of the active category and filed with the Chief of Staff at least fifteen days prior to the annual Staff mail ballot. As soon thereafter as reasonably possible, the names of these additional nominees shall be reported to the Staff.

6.2.3 Nominations by Other Means. If, before the election, any of the individuals nominated for an office pursuant to Section 6.2.1 and 6.2.2 shall refuse, be disqualified from, or otherwise be unable to accept nominations, then the Nominating Committee shall submit one or more substitute nominees at least 15 days prior to the annual Staff mail ballot.

6.2.4 Election. Except as set forth in Section 6.2.5 with respect to the Chief of Staff, officers and at-large MEC members shall be elected by written ballot. The ballots will be sent either by regular mail, fax or electronically to all voting members of the Medical Staff on or before August 1st and returned on or before August 15th of the Medical Staff Year in which the respective incumbent officer’s term ends. Only Members to the active category of the Medical Staff shall be eligible to vote. Voting will be by secret mail or electronic ballot procedurally administered by the Medical Staff Office on behalf of the Medical Executive Committee. The nominee receiving the highest number of valid votes cast shall be elected to the position.

6.2.5 Chief of Staff. Sections 6.2.1 through 6.2.4 shall not apply to the office of Chief of Staff. The Vice-Chief of Staff shall, upon the completion of his term of office
in that position, or upon the resignation or removal from office of the Chief of Staff, immediately succeed to the office of Chief of Staff.

### 6.2.6 Term of Elected Office
Each officer shall serve a two (2) year term, commencing on the first day of October the Medical Staff Year following his election or succession to office. Each officer shall serve until the end of his term and until a successor is elected, unless he shall sooner resign or be removed from office. No officer shall serve in two offices, Division Chairman or Member-At-Large positions simultaneously. The Vice-Chief shall succeed the Chief of Staff and the Secretary shall succeed the Vice-Chief upon a vote of confidence of the Active and Senior Active Staff.

### 6.2.7 Removal of Elected Officers
Except as otherwise provided, removal of an elected Medical Staff officer or Member-At-Large may be initiated by the MEC, by the Board, or by a petition signed by at least 25% of Members of the Staff eligible to vote for Staff officers. The grounds for removal shall be presented in writing to the Officer or Member-At-Large whose removal has been proposed. The Officer or Member-At-Large shall be given the opportunity to present a written statement regarding the asserted grounds for removal prior to a vote. Voting shall be by secret ballot marked “for removal” or “against removal”. Any removal shall be effective only with the concurrence of the Board and MEC, and a 66% majority of votes cast by Members of the Staff eligible to vote for Staff officers. Conditions under which removal of an officer may be considered shall include but not be limited to:

1. **Failure to perform the duties of the position held;**
2. **Failure to satisfy the position qualifications;**
3. **Malfeasance in office (illegal activities);**
4. **Drug, alcohol, or other substance abuse;**
5. **A pattern of substantiated code of conduct reports;**
6. **Adverse action taken by state licensing board.**

### 6.2.8 Vacancies
If an officer of the staff is removed or resigns during the Medical Staff year, their position will be filled as follows:

1. **The Chief of Staff's position will be assumed by the Vice Chief of Staff for the remainder of the term;**
2. **The Vice Chief of Staff's position will be assumed by the Secretary of Staff for the remainder of the term;**
6.2.8.3 A vacancy in the position of Secretary of Staff will be filled by a selection chosen by the Chief of Staff and endorsed by the Medical Executive Committee for the remainder of the term.

6.2.8.4 If a vacancy is created by removal or resignation of the Chief of Staff or the Vice Chief of Staff, the Vice Chief of Staff or the Secretary of Staff may decline to advance pursuant to the terms of this Section, without affecting the remainder of his existing term or his eligibility to succeed to higher medical staff office following that term. Should an officer decline to advance in the event of a vacancy, that vacancy will be filled by a selection chosen by vote of the Medical Executive Committee for the remainder of the term.

6.3 **Duties of General Officers.**

6.3.1 **Chief of Staff.** If a Chief Medical Officer has not been appointed by the Hospital, the Chief of Staff serves as the Chief Medical Officer of the Hospital. When serving as Chief Medical Officer, the Chief of Staff shall fulfill the duties of the Chief Medical Officer as set forth in Section 6.5.1 as well as those enumerated for the office of Chief of Staff. As the principal elected official of the Staff, the Chief of Staff shall:

6.3.1.1 Aid in coordinating the activities and concerns of the Hospital administration and of the nursing and other patient care services with those of the Medical Staff;

6.3.1.2 Communicate and represent the opinions, policies, concerns, needs and grievances of the Medical Staff to the Governing Board, the Chief Executive Officer, and other officials of the Staff;

6.3.1.3 Be responsible for the enforcement of Medical Staff Bylaws, Rules and Regulations, for implementation of sanctions where these are indicated, and for the Medical Staff’s compliance with procedural safeguards in all instances where corrective action has been requested against a Practitioner;

6.3.1.4 Call, preside, and be responsible for the agenda of all general meetings of the Medical Staff;

6.3.1.5 Consult with the Chief Medical Officer (if any) on matters of special concern to Members and maintain liaison with the Chief Medical Officer to assist in settling grievances and problems of the Staff;

6.3.1.6 Foster collaboration with the Chief Executive Officer and Medical Staff in accordance with the Governing Board’s Information Sharing Policy and applicable law and regulation.

6.3.2 **Vice-Chief of Staff.** The Vice-Chief of Staff shall be a member of the Medical Executive Committee. In the absence -- temporary or permanent -- of the Chief of Staff, he shall assume all the duties and have the authority of the Chief of Staff. He shall perform such
additional duties as may be assigned to him by the Chief of Staff, the Medical Executive Committee, or the Governing Board. He shall also:

6.3.2.1 Perform such other duties as ordinarily pertain to his office.

6.3.2.2 Serve as Chairman of the Credentials Committee and Professional Practice Evaluation Committee.

6.3.2.3 The Vice-Chief of Staff, in the absence of the Chief of Staff, shall assume all of his duties and have all of his authority. He will also be expected to perform other duties of supervision as may be assigned by the Chief of Staff. The Vice-Chief of Staff will Chair the Credentials & Privileges Committee, barring any extenuating circumstances that make such service unacceptable. The Vice-Chief of Staff will automatically succeed the Chief of Staff upon a vote of confidence by the active staff.

6.3.3 Immediate Past Chief of Staff. The Immediate Past Chief of Staff shall be a member of the Medical Executive Committee. He shall perform such additional duties as may be assigned to him by the Chief of Staff, the Medical Executive Committee, or the Governing Board. He shall also:

6.3.3.1 Serve as Chairman of the Bylaws Committee.

6.3.3.2 Perform such other duties as ordinarily pertain to his office.

6.4 Division Chairmen.

6.4.1 Qualifications.

6.4.1.1 Each Chairman shall be a Member of the active category and currently regularly practicing at the Hospital at the time of nomination and election and must remain a Member in good standing of the active category during the term of office, and shall be willing and able to discharge the functions of his office.

6.4.1.2 Each Chairman shall be board certified in a specialty represented by his Division, or demonstrate comparable competence affirmatively established through the credentialing process.

6.4.1.3 In addition, to be eligible for nomination to a Division Chairman position the Practitioner must have attended at least twenty-five percent (25%) of Division or committee meetings during the preceding twelve (12) months to demonstrate active participation in Medical Staff related functions and activities.

6.4.2 Nominations and Elections. Nominations for each Chairman shall be made by mail or electronic mail by active staff members of the Division prior to July 15th of the year in which the respective incumbent Chairman's term ends. A mail ballot or electronic voting should be sent out by August 1st and returned completed prior to August 15th of that year. The nominee receiving the highest number of valid votes cast by Active Staff members of the Division shall be elected to the position.
6.4.3 **Term of Office.** A Division Chairman shall serve a two (2) year term commencing on the first day of the Medical Staff year following his election. No Division Chairman shall serve in a Division Chairman, Member-At-Large, or Officer position simultaneously.

6.4.4 **Removal of Division Chairman.** Removal of an elected Division Chairman from office may be initiated by the MEC, by the Governing Board, or by petition signed by 50% of the Division Members eligible to vote for Division chairmen. The grounds for removal shall be presented in writing to the Chairman whose removal has been proposed. The Chairman shall be given the opportunity to present a written statement regarding the asserted grounds for removal prior to a vote. Voting shall be by secret ballot marked “for removal” or “against removal”. Any removal shall be effective only with the concurrence of the Governing Board and MEC, and a 66% vote of the Division members eligible to vote on Divisional matters. Conditions under which a Division Chairman may be removed include, but are not limited to:

6.4.4.1 Failure to perform the duties of the position;
6.4.4.2 Failure to satisfy the position qualifications;
6.4.4.3 Malfeasance in office (illegal activities);
6.4.4.4 Drug, alcohol, or other substance abuse;
6.4.4.5 A pattern of substantiated code of conduct reports;
6.4.4.6 Adverse action taken by the state licensing board.

6.4.5 **Interim Appointment.** If a Division Chairman should resign from his position, or lose his eligibility to serve as a Division Chairman pursuant to this Section, or be removed as a Division Chairman pursuant to this Section, his position shall be filled by a selection chosen by the Chief of Staff and endorsed by the MEC for the remainder of that Chairman’s term.

6.4.6 **Duties.** Each Chairman shall:

6.4.6.1 Be accountable to the Medical Executive Committee and to the Chief Executive Officer for all clinical and administrative activities within his Division, and particularly for the quality of patient care rendered by Members of the Division and for the effective conduct of the patient care evaluation and monitoring functions delegated to his Division;

6.4.6.2 Submit reports to the MEC concerning findings of the Division’s review, evaluation and monitoring activities, actions taken thereon, and the results of such action; recommendations for maintaining and improving the quality of care provided in the Division and the Hospital and recommendations to medical staff as to the criteria for clinical privileges.
relevant to care provided in the Division; and such other matters as may be required from time to time by the MEC;

6.4.6.3 Develop and implement Divisional programs and policies and procedures in cooperation with the Chief of Staff and consistent with the provisions of Article VII, for evaluation of patient care, on-going monitoring of practice, recommend criteria for privileges applicable to the Division, credentials review and privileges delineation, medical education and utilization management;

6.4.6.4 Promote and oversee the coordination of interDivisional and intraDivisional services, and the integration of the Division into the overall functions of the organization;

6.4.6.5 Provide oversight, as appropriate, of applicable quality control programs and processes;

6.4.6.6 Be a member of the Medical Executive Committee and attend regularly scheduled meetings (unless excused for good cause by the Chief of Staff), give guidance on the medical policies of the Hospital, and make specific recommendations and suggestions regarding his own Division;

6.4.6.7 Maintain continuing review of the professional performance of all Practitioners with Clinical Privileges and of all Allied Health Professionals with specified services in his Division and report regularly thereon to the Chief of Staff and to the Medical Executive Committee;

6.4.6.8 Transmit to the appropriate authorities as required by these Bylaws, his recommendations concerning appointment and staff category, reappointment, delineation of Clinical Privileges or specified services, and corrective action with respect to Practitioners in his Division;

6.4.6.9 Appoint such committees as are necessary to conduct the functions of the Division as specified in Article VII and designate chairmen thereof;

6.4.6.10 Enforce the Hospital and Medical Staff Bylaws, Rules, Regulations and Policies within his Division, including initiating corrective action and investigation of clinical performance and ordering consultations to be provided or to be sought when necessary;

6.4.6.11 Implement within his Division actions taken by the Medical Executive Committee and by the Governing Board;

6.4.6.12 Conduct or participate in, and make recommendations regarding the need for continuing education programs pertinent to change in the state-of-the-art and to findings of review, evaluation and monitoring activities;

6.4.6.13 Participate in every phase of administration of the Division through cooperation with the nursing service and the Hospital administration in
matters affecting patient care, including personnel, supplies, space and other resources, special regulations, standing orders and techniques, and assessing and recommending off-site sources for needed patient care services not provided by the Division or organization;

6.4.6.14 Assist in the preparation of such annual reports, including budgetary planning, pertaining to his Division as may be required by the Medical Executive Committee, the Chief Executive Officer or the Governing Board;

6.4.6.15 Perform such other duties commensurate with his office as may from time to time be reasonably requested of him by the Chief of Staff, the Medical Executive Committee or the Governing Board;

6.4.6.16 Appoint a Vice Chairman with the concurrence of the Division, and

6.4.6.17 Foster collaboration with Division Chairmen and Divisions in accordance with applicable law and regulation.

6.5 Other Officials of the Staff.

6.5.1 Chief Medical Officer.

6.5.1.1 Qualifications. The Chief Medical Officer must be a Physician who is qualified on the basis of his experience and training to administer all the medically related professional and administrative aspects of the Hospital.

6.5.1.2 Selection and Appointment. The Chief Medical Officer shall be appointed by the Hospital after feedback/input from the MEC.

6.5.1.3 Term of Office. The Chief Medical Officer’s term of office shall be as provided in his contract, employment agreement or other arrangement.

6.5.1.4 Duties. The Chief Medical Officer’s duties shall be set forth in his hospital job description.

ARTICLE VII.

STAFF CLINICAL DIVISIONS

7.1 Structure of the Medical Staff. Each Division shall be organized as a separate part of the Medical Staff and shall have a Chairman who is selected and has the authority, duties and responsibilities specified in Article VI. The Medical Staff is divided into the following clinical divisions and sections:

7.1.1 MEDICAL SERVICES DIVISION:
Cardiology Section
Dermatology Section
Emergency Medicine Section
Family Practice Section
Gastroenterology Section
Medicine Section
Neurology Section
Radiology Section
Radiation Therapy Section

7.1.2 SURGICAL SERVICES DIVISION:
    Anesthesiology Section
    Cardiac Surgery Section
    General Surgery Section
    Neurosurgery Section
    Ophthalmology Section
    Oral & Maxillofacial Surgery Section
    Orthopedics Section
    Otolaryngology, Head & Neck Surgery Section
    Pathology Section
    Plastic Surgery Section
    Urology Section

7.1.3 MATERNAL/CHILD SERVICES DIVISION:
    Ob-Gyn Section
    Pediatrics Section
    NICU Section

7.2 Designation.

7.2.1 Current Divisions. An up-to-date list of the Division Chairs of each Section of the Hospital's Medical Staff will be kept in the Medical Staff office.

7.2.2 Future Divisions. When deemed appropriate and consistent with the provisions of Section 7.5, the Medical Executive Committee and the Governing Board, by their joint action, may create a new Division, or eliminate, subdivide, further subdivide or combine Divisions.

7.3 Assignment to Divisions. Each Member of the Staff and each Allied Health Professional shall be assigned to one Division, but may be granted Clinical Privileges or specified services in one or more of the other Divisions. The exercise of Clinical Privileges or the performance of specified services within any Division shall be subject to the Rules and Regulations of that Division and the authority of the Division Chairman.

7.4 Functions of Divisions. The primary responsibility delegated to each Division is to monitor and assess the performance of individuals granted privileges in the Division and use the results of such assessments to improve the quality of care. The Professional Practice Evaluation Committee (PPEC) is the body designated to conduct the initial peer review, but the Division is ultimately responsible for ensuring that the process is clearly defined, fair, timely, and useful. (Refer to Medical Staff Policies and Procedures)
To carry out this responsibility, each Division shall:

7.4.1 Assess results of special studies of care and specified monitoring activities, including mortality and surgical case review, for the purpose of evaluating clinical work performed under its jurisdiction;

7.4.2 Recommend criteria for the granting of Clinical Privileges and the performance of specified services within the Division and submit the recommendations required under Articles III and V regarding the specific privileges each Member or applicant may exercise and the specified services each Allied Health Professional may provide;

7.4.3 Monitor, on a continuing and concurrent basis, adherence to: (1) Staff and Hospital policies and procedures; (2) requirements for alternate coverage and for consultations; and (3) sound principles of clinical practice;

7.4.4 Coordinate the patient care provided by the Division's Members with nursing and ancillary patient care services and with administrative support services;

7.4.5 Meet at least quarterly as a Committee (if applicable) and/or as a Division for the purpose of receiving, reviewing and considering patient care review findings and the results of the Division's other review, evaluation and monitoring activities and of performing or receiving reports on other Division and Staff functions;

7.4.6 Establish such committees or other mechanisms as are necessary and desirable to properly perform the functions assigned to it;

7.5 Modifications in Clinical Organization Unit. In creating, eliminating, subdividing or combining Divisions, Sections or any other clinical organization units that may exist or be contemplated, the following guidelines shall be followed:

7.5.1 Creation or Subdivision. A sufficient number of Practitioners are available for appointment to and will be appointed to and/or actively participate in the new organizational component to enable accomplishment of the functions generally assigned to such components in these Bylaws and the Rules and Regulations, and the patient or service activity to be associated with the new component is substantial enough to warrant imposition of the responsibility to accomplish those functions;

7.5.2 Eliminations. The number of Practitioners is no longer adequate and will not be so in the foreseeable future to accomplish assigned functions, or the patient or service activity associated with the component to be dissolved is no longer substantial enough to warrant imposition of the responsibility to accomplish those assigned functions or failure to meet as required by these Bylaws; or

7.5.3 Combination. The union of two or more organizational components will result in more effective and efficient accomplishment of assigned functions and the patient or service activity to be associated with the combination is substantial enough,
without being unwieldy, to warrant imposition of the responsibility to accomplish those assigned functions.

ARTICLE VIII.

COMMITTEES AND FUNCTIONS

8.1 Designation and Substitution. There shall be a Medical Executive Committee (MEC) and such other standing and special committees of the Staff responsible to the MEC as may from time to time be necessary and desirable to perform the Staff functions listed in Section 8.3 and elsewhere in these Bylaws. The MEC may, by resolution and upon approval by the Governing Board, establish a Staff committee to perform one or more of the required Staff functions. Those functions requiring participation of, rather than direct oversight by, the Staff may be discharged by the Medical Staff representation on such Hospital committees as are established to perform such functions.

Whenever these Bylaws require that a function be performed by, or that a report or recommendation be submitted to:

8.1.1 A named Medical Staff committee but no such committee shall exist, the MEC shall perform such function or receive such report or recommendation or shall assign the functions to a new or existing committee of the Staff or to the Staff as a whole; and

8.1.2 The MEC, but if a standing or special committee has been formed to perform the function, the committee so formed shall act in accordance with the authority delegated to it.

8.2 Staff Functions. Provision shall be made in these Bylaws or by resolution of the MEC approved by the Board, either through assignment to the Divisions, to Staff committees, to Staff officers or officials, for the effective performance of the Staff functions specified in this Section and of such other Staff functions as the MEC or the Governing Board shall reasonably require. These are to:

8.2.1 Monitor and evaluate care provided in and develop clinical policy for all patient care areas, including special care areas, such as intensive or coronary care units; ancillary support services, such as respiratory therapy, diagnostic imaging, and all outpatient or ambulatory care services.;

8.2.2 Oversee and evaluate patient care reviews of quality and appropriateness and monitoring activities, including patient safety, tissue, blood usage, antibiotic and drug usage reviews, medical record completion including accuracy, timeliness and legibility, and surgical/invasive procedure case reviews;

8.2.3 Oversee and evaluate utilization management activities;

8.2.4 Coordinate and review credentials investigations and recommendations regarding Staff membership and grants of Clinical Privileges and specified services;
8.2.5 Provide continuing education opportunities responsive to quality activity findings, new state-of-the-art developments and other perceived needs;

8.2.6 Develop and maintain surveillance over drug utilization policies and practices;

8.2.7 Prevent, investigate and control nosocomial infections and monitor the Hospital's infection control program;

8.2.8 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;

8.2.9 Direct Staff organizational activities, including Staff Bylaws review and revision, Staff officer and committee nominations and elections, liaison with the Governing Board and Hospital administration, and review and maintenance of Hospital accreditation; and

8.2.10 Coordinate the care provided by Practitioners with the care provided by the nursing service and with the activities of other hospital patient care and administrative activities.

8.3 Medical Executive Committee.

8.3.1 Composition. The Medical Executive Committee shall consist of the Chief of Staff, the Vice Chief of Staff, the Secretary of Staff, the Immediate Past Chief of Staff, the Chairman of each Division and five (5) Members elected at-large by the Medical Staff (Members elected at-large from the Medical Staff shall be Members of the Active or Senior Active Staff). Each of the committee members is entitled to vote. The Medical Executive Committee includes physicians, and the majority of voting MEC Members shall be physicians actively practicing in the Hospital, but may include other Practitioners or individuals as determined by the organized Medical Staff. No Medical Staff Member shall be ineligible for Medical Executive Committee membership solely because of his professional discipline or specialty. Ex-Officio members without vote shall include Administrative representatives from SMRMC, including the Chief Executive Officer. The Chief Executive Officer, or his designee, shall sit with the MEC at all times. The Chief of Staff shall serve as chairman of the committee. The MEC has the authority to act on behalf of the Medical Staff between or in lieu of general staff meetings.

8.3.1.1 Members of the MEC who are not elected at-large shall be removed from the Committee automatically upon ceasing to hold the position supporting their inclusion in the committee in Section 8.3.1. Otherwise, MEC members may be removed from the committee only upon a two-thirds affirmative vote of MEC members. When a member who was elected at-large is removed or resigns, the MEC will arrange for an at-large election for a replacement to serve the remainder of the term, following procedures established by the MEC.
8.3.2 **Delegation of Authority.** By adopting these Bylaws, the Medical Staff has delegated to the MEC the authority to perform on behalf of the Medical Staff all of the functions described in Sections 8.3.3 and Article XV. The authority delegated herein may be removed by amending Sections 8.3.3 and Article XV of these Bylaws as provided herein.

8.3.3 **Duties.** The duties of the MEC shall be to:

8.3.3.1 Make recommendations to the Governing Board on the organized medical staff’s structure;

8.3.3.2 Receive and act upon reports and recommendations from the Divisions, committees and officers of the Staff concerning patient care quality and appropriateness reviews, evaluation and monitoring functions and the discharge of their delegated administrative responsibilities and recommend to the Board specific programs and systems to implement these functions;

8.3.3.3 Coordinate the activities of and policies adopted by the Staff, Divisions and committees;

8.3.3.4 Relay recommendations to the Governing Board on all matters relating to appointments, reappointments, Staff category, Division assignments, Clinical Privileges and corrective action;

8.3.3.5 Provide leadership for the performance improvement activities of the Medical Staff organization and establish mechanisms for the process measurement, assessment and improvement of patient care;

8.3.3.6 Account to the Governing Board and to the Staff for the overall quality and efficiency of patient care in the Hospital;

8.3.3.7 Take reasonable steps to promote professionally ethical conduct and competent clinical performance on the part of Members including initiating investigations and initiating and pursuing corrective action, when warranted;

8.3.3.8 Make recommendations on medico-administrative and Hospital management matters, including the credentialing and privileging process;

8.3.3.9 Inform the Medical Staff of the accreditation program and accreditation status of the Hospital;

8.3.3.10 Participate in identifying community health needs and in setting Hospital goals and implementing programs to meet those needs;
8.3.3.11 Represent and act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws;

8.3.3.12 Initiate, approve, and recommend to the Board corrections to the Medical Staff Bylaws, Rules and Regulations, and initiate, approve and recommend to the Governing Board related documents and policies in accordance with Article XV of these Bylaws;

8.3.3.13 Other functions as appropriate.

8.3.4 Meetings. The MEC shall meet at least nine (9) times per year and maintain a permanent record of its proceedings and actions.

8.4 Other Committees of the Staff.

8.4.1 Composition and Appointment. A Staff committee established to perform one or more of the Staff functions required by these Bylaws shall be composed of Members of the active and affiliate staff, and may include, where appropriate, Allied Health Professionals, and representation from Hospital administration, nursing services, medical records service, pharmaceutical service, social services, and such other Divisions as are appropriate to the function(s) to be discharged as non-voting members. Unless otherwise specifically provided, the Medical Staff Members shall be appointed in the following manner. The Chief of Staff will appoint a committee chairman and the individual members of the committee shall be appointed by the Chairman. The Chief Medical Officer shall be Ex-Officio non-voting member of all Staff committees. The Medical Executive Committee will maintain the right of final approval of all members. Medical Staff committees established under this Bylaws provision shall be composed of a minimum of three Physicians. The Chief Executive Officer or his respective designees shall serve as Ex-Officio member without vote on all committees, unless otherwise expressly provided.

8.4.2 Term and Prior Removal. Unless otherwise specifically provided, a Medical Staff committee member (other than one serving Ex-Officio) shall continue as such for at least two years or until his successor is elected or appointed, unless he shall sooner resign or be removed from the committee. A Medical Staff committee member, other than one serving Ex-Officio, may be removed by a majority vote of the MEC. An administrative Staff committee member shall serve for a term equivalent to that of a Medical Staff committee member and until his successor is elected or appointed, unless he shall sooner resign or be removed from the committee. An administrative Staff committee member may be removed by action of the Chief Executive Officer.

8.4.3 Vacancies. Unless otherwise specifically provided, vacancies on any Staff committee shall be filled in the same manner in which original appointment to such committee is made.
8.5 **Cancer Committee:**

8.5.1 **Composition.** The Cancer Committee will consist of members of the medical staff appointed by the Chief of Staff representing at least one (1) physician member from the required specialties: diagnostic radiology, pathology, general surgery, medical oncology, radiation oncology and palliative care. The Cancer Committee includes at least one (1) physician member representing the five major cancer sites (breast, prostate, lung, colon/rectum, and bladder).

The committee shall consist of at least one (1) non-physician member from: cancer program administration, oncology nursing, cancer registry, social services, quality improvement and other members as needed.

Additional physician or non-physician members can include: hospice, clinical research, nutrition, pharmacy, pastoral care, mental health, American Cancer Society, and public member of Governing served.

The Cancer Committee Chair is a physician who may also fulfill the role of one of the required physician specialties.

8.5.2 **Responsibilities**

8.5.2.1 Responsible and accountable for all cancer program activities Saint Mary’s Regional Medical Center.

8.5.2.2 Designates one coordinator for each of the four areas of Cancer Committee activity: cancer conference, quality control of cancer registry data, quality improvement, and Governing outreach coordinator.

8.5.2.3 Develops annual goals and objectives for clinical Governing outreach, quality improvement, and programmatic endeavors related to cancer care.

8.5.2.4 Evaluates annual goals and objectives for clinical, Governing outreach, quality improvement, and programmatic endeavors on an annual basis.

8.5.2.5 Establishes the cancer conference frequency, format, and multidisciplinary attendance requirements for cancer conferences on an annual basis.

8.5.2.6 Ensures that the required numbers of cases are discussed at cancer conference and that at least 75 percent of the cases discussed at cancer conferences are presented prospectively.

8.5.2.7 Monitors and evaluates the cancer conference frequency, multidisciplinary attendance, total case presentation, and prospective case presentation on an annual basis.
8.5.2.8 Establishes and implements a plan to evaluate the quality of cancer registry data and activity on an annual basis.

8.5.2.9 Completes site-specific analysis that includes comparison and outcome data and disseminates the results of the analysis to the medical staff.

8.5.2.10 Reviews and monitors report of 10 percent of the analytic caseload to ensure that AJCC staging is assigned by the managing physician and recorded on a staging form in the medical record on at least 90 percent of eligible analytic cases.

8.5.2.11 Reviews and monitors report of 10 percent of the analytic caseload to ensure that 90 percent of cancer pathology reports include the scientifically validated data elements outlined in the CAP protocols.

8.5.2.12 Provides a formal mechanism to educate patients about cancer-related clinical trials.

8.5.2.13 Reviews the percentage of cases accrued to cancer-related clinical trials each year.

8.5.2.14 Monitors Governing outreach activities on an annual basis.

8.5.2.15 Offers one cancer-related educational activity each year.

8.5.2.16 Completes and documents the required studies that measure quality and outcomes.

8.5.2.17 Implements two improvements that directly affect patient care.

8.5.2.18 Establishes subcommittees or workgroups as needed to fulfill cancer program goals.

8.5.3 Meetings

8.5.3.1 Cancer Committee meets at least quarterly each year.

8.5.3.2 Cancer Accreditation Subcommittee meets on the first Friday of each month.

8.6 Credentials Committee.

8.6.1 Composition. The Credentials Committee shall be a standing Committee comprised of the Chief of Staff, Vice Chief of Staff, Secretary of Staff, Immediate Past Chief of Staff, and Chairs of the Divisions of Medical Services, Surgical Services and Maternal/Child Services. Additional members who are members of the Active Staff may be appointed at the discretion of the Chairman. The Chief Executive Officer, or designee, shall be a non-voting Ex-Officio member. The
Vice Chief of Staff shall serve as Chairman. *(Refer to Credentials Committee Policy)* The appointed members of the Credentials Committee shall be appointed every two years, with terms commencing in October, and may be reappointed for successive terms.

8.6.2 **Duties.** The primary responsibility and function of the Credentials Committee is to investigate, review, consider and make recommendations to the MEC in all matters relating to credentialing for Saint Mary’s Regional Medical Center Medical Staff including:

8.6.2.1 Initial appointments, interviewing applicants as necessary;

8.6.2.2 Reappointments;

8.6.2.3 Requests for clinical privileges;

8.6.2.4 Requests for change in staff status;

8.6.2.5 Leave of absence requests;

8.6.2.6 Resignations;

8.6.2.7 Privilege delineation checklists;

8.6.2.8 Establishment or change in criteria for granting privileges in each service;

8.6.2.9 Any other matters relating to credentialing and privileging.

8.6.3 **Meetings.** The Credentials Committee shall meet at least six (6) times per year and maintain a permanent record of its proceedings and action. The recommendations of the Credentials Committee shall be forwarded to the Medical Executive Committee.

8.6.4 Whenever an Applicant’s or Medical Staff Appointee’s practice is in direct economic competition with the practice of a member of the Credentials Committee, such member of the Credentials Committee who is in direct economic competition with the Applicant or Medical Staff Appointee shall abstain from voting during proceedings involving the Applicant or Medical Staff Appointee. Such abstention shall be recorded in the minutes of the meeting. This provision shall not impair or prevent a Division Chair from recommending for or against approval of an Applicant’s application for privileges within that Division.

8.7 **Professional Practice Evaluation Committee (PPEC).**

8.7.1 **Composition.** The composition of the Professional Practice Evaluation Committee (PPEC) shall be as set forth in the Professional Practice Evaluation Committee Policy. The Committee members will be appointed and approved by
the MEC. The members of the MEC, the Chief Medical Officer and Chief Executive Officer, and appropriate support personnel from the Quality Department are ex-officio members without vote.

8.7.2 **Chairman.** The Chairman of the PPEC shall be the Vice Chief of Staff.

8.7.3 **Functions.** The functions and goals of the PPEC are fully described in the Professional Practice Evaluation Committee Policy. The PPEC is responsible for evaluating and improving physician performance in the following areas:

8.7.3.1 **Technical Quality:** Skill and judgment related to the effectiveness and appropriateness in performing the clinical privileges granted.

8.7.3.2 **Service Quality:** Ability to meet the customer service needs of patients and other caregivers.

8.7.3.3 **Patient Safety/Patient Rights:** Cooperation with patient safety and rights, rules and procedures.

8.7.3.4 **Resource Use:** Effective and efficient use of hospital clinical resources.

8.7.3.5 **Relations:** Interpersonal interactions with colleagues, hospital staff, and patients.

8.7.3.6 **Citizenship:** Participation and cooperation with medical staff responsibilities.

8.7.4 **Meetings/Reporting.** The PPEC will meet and report to the MEC at least four (4) times per year and will maintain a permanent record of its proceedings.

8.8 **Nominating Committee.** The composition, function and meeting frequency are described in Nominating Committee Policy.

8.9 **Pharmacy & Therapeutics Committee.** (Refer to P&T Policy)

8.9.1 **Composition.** The Pharmacy & Therapeutics Committee shall include representatives from each of the three Medical Staff Divisions appointed as voting members by the MEC. Non-voting members will include the Director of Pharmacy, Clinical Pharmacist, Chief Nursing Officer, and other Hospital Staff representatives as appropriate.

8.9.2 **Chairman.** An Active member of the Medical Staff that is appointed by the Chief of Staff will serve as Chairman of the Committee.

8.9.3 **Functions.** The functions of the Pharmacy & Therapeutics Committee will include:
8.9.3.1 Evaluate and review a list of medications or formulary for use in the hospital;

8.9.3.2 In conjunction with the Pharmacy, review, evaluate, advise, and recommend the use of new drugs or preparations;

8.9.3.3 Implement and oversee the ongoing assessment of physician prescribing habits;

8.9.3.4 Address and resolve issues relating to drug usage;

8.9.3.5 Develop medication protocols;

8.9.3.6 Develop/update policies related to drug administration and schedules;

8.9.3.7 Develop/review medication utilization evaluation (MUE) criteria;

8.9.3.8 Coordinate and monitor clinical drug trials;

8.9.3.9 Distribute information on drug usage;

8.9.3.10 Review untoward medication reactions;

8.9.3.11 Review medication error statistics;

8.9.3.12 Report on drug purchasing and provide input regarding the pharmaceutical budget;

8.9.3.13 Evaluate literature regarding medication efficacy and best therapeutic alternatives;

8.9.3.14 Develop plans to deal with extended drug shortages or unavailability;

8.9.4 Meetings. The Pharmacy & Therapeutics Committee shall meet at least 4 times per year and forward its report to the MEC.

8.10 Infection Prevention Committee. (Refer to IC Policy)

8.10.1 Composition. The Infection Prevention Committee shall include an Infectious Disease specialist, and representatives from each of the three Medical Staff Divisions appointed as voting members by the MEC. Non-voting members will include the Chief Medical Officer, Infection Prevention Nurse, Director of Performance Improvement, Chief of Nursing Officer and other Hospital Staff representatives as appropriate.

8.10.2 Chairman. An Active member of the Medical Staff that is appointed by the Chief of Staff will serve as Chairman of the Committee.

8.10.3 Functions. The functions of the Infection Prevention Committee will include:
8.10.3.1 Provide oversight for the infection prevention program;

8.10.3.2 Analyze and report infection surveillance data, recommending interventions and evaluating effectiveness;

8.10.3.3 Identify and implement measures to reduce the risk and prevent nosocomial infections;

8.10.3.4 Establish definitions of nosocomial infections;

8.10.3.5 Determine the method, population, time frame, and focus of surveillance;

8.10.3.6 Develop/update policies relating to infection prevention and control practices;

8.10.3.7 Institute appropriate prevention and control measures and/or studies when there is reason to believe there is a danger to patients, personnel, or the community.

8.10.4 **Meetings.** The Infection Prevention Committee shall meet at least 4 times per year and forward its report to the MEC.

8.11 **Quality/Utilization Committee and Patient Safety Committee.** (Refer to Quality/Utilization Management & Patient Safety Committee Policies).

8.11.1 **Composition.** Each Committee shall be composed of not less than four (4) members of the Medical staff and shall be representative of the various Divisions of the Medical staff, Administration and Performance Improvement, Finance, Nursing, and Professional Services. Other hospital Division leadership and staff ad hoc.

8.11.2 **Quality/Utilization Functions.** The Quality/Utilization Committee will oversee, evaluate, and recommend change in quality and performance related activities for all aspects of services rendered by Saint Mary’s Regional Medical Center, including the following:

8.11.2.1 Performance Improvement (evaluating the effectiveness of quality and performance initiatives, recommending changes in direction of quality and performance initiatives, and sanctioning new performance improvement initiatives).

8.11.2.2 Medication Use

8.11.2.3 Infection Control

8.11.2.4 Blood Utilization
8.11.2.5 Risk Management

8.11.2.6 Utilization Management

8.11.2.7 Medical Records

8.11.2.8 Employee Health

8.11.2.9 Customer/Patient and Employee Satisfaction

8.11.2.10 Joint Commission and other regulatory agency accreditations

8.11.3 **Patient Safety Functions.** The Patient Safety Committee will oversee, evaluate and recommend policies to achieve national patient safety goals.

8.11.4 **Meetings/Reporting.** Each of the Audit/Utilization Committee and the Patient Safety Committee will meet at least six (6) times per year and maintain a permanent record of its proceedings and actions and shall make a regular report thereof to the Medical Executive Committee.

**ARTICLE IX.**

**CONTINUING MEDICAL EDUCATION**

9.1 **Participation.** All Practitioners granted privileges are required to comply with state requirements for continuing medical education.

9.2 **Hospital Sponsored Activities.** Hospital-sponsored educational activities will relate to the types of services offered by the hospital and will be based on findings of the quality review process and performance improvement activities.

**ARTICLE X.**

**PHYSICIAN HEALTH, UNPROFESSIONAL & DISRUPTIVE BEHAVIOR, CORRECTIVE ACTION, SUSPENSION AND VOLUNTARY RESIGNATION**

(Under Nevada State Law, peer review proceedings are protected by NRS 49.119 and NRS 49.121)

10.1 **Physician Health.** The process for identifying and managing suspected or confirmed health issues is described in the Physician/LIP Health and Wellness Guidelines.

10.2 **Unprofessional & Disruptive Behavior.** All Practitioners are expected to conduct themselves in a professional and cooperative manner and treat others with respect, courtesy and dignity. The process for identifying and managing incidents of inappropriate conduct is fully set forth in the Unprofessional and Disruptive Conduct Policy. Upon receipt of a report of unprofessional or inappropriate conduct, the Unprofessional and Disruptive Conduct Policy will govern, unless, at the discretion of the Division chairman, Chief Executive Officer and/or Chief Medical Officer, the incident is so egregious that immediate corrective action is warranted.

(Refer to Unprofessional and Disruptive Conduct Policy)
10.3 **Corrective Action.** Corrective action may be requested whenever a Practitioner with Clinical Privileges engages in, makes or exhibits acts, statements, demeanor or professional conduct either within or outside the Hospital, and the same is, or is reasonably likely to be inconsistent with the standards of the Medical Staff, detrimental to the quality of patient care or safety, disruptive to the Hospital's operations, or an impairment to the community's confidence in the Hospital.

10.3.1 **Requests.** A request for corrective action may be made by the Chief Executive Officer, any Medical Staff Officer, the Chair of any Division or Committee, any Medical Staff Appointee, or any Governing Board Member. All requests for corrective action shall be in writing, made to the MEC, and supported by reference to the specific activities or conduct constituting grounds for the request. The MEC shall promptly notify the Chief Executive Officer and the MEC members in writing of any requests for corrective action received by the Committee.

10.3.2 **Initiation of Corrective Action.** When a request for corrective action is received by the MEC, the Chief of Staff shall consult with the Chief Executive Officer and put to the MEC the question whether the request for corrective action should be investigated. The initiation of an investigation shall not preclude the imposition of summary suspension or precautionary administrative suspension under these Bylaws. Upon receiving notice of a Practitioner’s arrest, indictment, conviction, or plea of guilty or no contest as to any alleged criminal act, other than a misdemeanor traffic citation not involving the use of drugs or alcohol, the MEC shall conduct an immediate investigation into the circumstances of the arrest, indictment, plea or conviction, whether or not a request for corrective action has been made to the MEC. The MEC shall review the circumstances leading to the arrest, indictment, plea or conviction and shall determine if corrective action is warranted prior to or following the resolution of the criminal proceeding.

10.3.2.1 **Collegial Intervention.**

When considering initiating corrective action, and prior to deciding whether to initiate a formal investigation, the MEC may arrange for an informal interview with the requesting individual, the involved Practitioner, or both. In conjunction with this interview, the MEC, or a designee thereof, may discuss with the requestor and/or the Practitioner additional information concerning the circumstances cited in the request for action, to obtain the Practitioner’s response to any allegations. This interview is not a procedural right of the Practitioner, and need not be conducted in accordance with the procedures of the Fair Hearing Plan, and may be waived by the MEC or the Practitioner without triggering rights pursuant to the Fair Hearing Plan. Prior to initiation of any investigation, the MEC shall retain the power to conduct corrective counseling, issue a letter of warning, admonition or reprimand, which letter would become part of the appointee’s quality assurance file, and to recommend to the Chief Executive Officer a
voluntary performance improvement plan be agreed to in advance of or in lieu of a formal investigation.

10.3.2.2 **Appointment of Ad Hoc Investigation Committee.**

If the MEC determines to investigate formally the necessity of corrective action against a Practitioner, the MEC shall appoint an Ad Hoc Investigation Committee and shall promptly provide the Practitioner with special notice that he is under investigation. In addition, an Ad Hoc Investigation Committee shall be appointed to investigate a Practitioner any time the State Medical Board places a restriction or a limitation on such Practitioner’s license or places the Practitioner on probation, unless the action of the State Board has resulted in an automatic termination of the Practitioner’s license. The Ad Hoc Investigation Committee shall consist of the Chief of Staff, or his designee, one Medical Staff Member appointed by the Chief Executive Officer and one Medical Staff Member appointed by the Chief of Staff. The Practitioner’s Division Chair shall serve as a consultant to the Ad Hoc Investigation Committee, and the Chief of Staff, or his designee, shall serve as Chairman. The Investigation Committee shall have no members who are in direct economic competition with the Practitioner. If there are no available Medical Staff members who meet such criteria, the Chief Executive Officer may appoint physicians to the Investigation Committee who are not affiliated with the hospital. The Practitioner shall be advised of the names of the Investigation Committee members within ten (10) days of their appointment. If the Practitioner advises the Chief of Staff that he believes the member of the committee does not meet the above criteria, the Chief of Staff shall consider and if necessary appoint a substitute to serve on the committee. An investigation by the committee is an administrative matter and not an adversarial proceeding. The Practitioner is not entitled to have legal counsel present during meetings or discussions between the Practitioner and the committee members, and evidence taken informally at the investigation state must be verified under oath at any later fair hearing.

10.3.2.2.1 **Examinations**

The investigation committee may require the Practitioner to undergo a physical and/or mental examination and may access the results of those exams.

10.3.2.3 **Preliminary Report of Ad Hoc Investigation Committee.**

Upon conclusion of its investigation, the Ad Hoc Investigation Committee shall submit a preliminary report to the MEC, the Chief Executive Officer, and the Practitioner. The report shall contain a
statement detailing the preliminary findings, conclusions and recommendations of the committee. Upon receipt of the report, the Chief Executive Officer, the officers of the Medical Staff and the Practitioner shall each be given the opportunity to submit comments on the report within fifteen (15) days following receipt of the report.

10.3.2.4 Procedure After Receipt of Report.

The report of the Ad Hoc Investigation Committee shall be forwarded to the Governing Board (1) at such time as a hearing, if requested, is completed and the Hearing Committee’s recommendation is forwarded to the Governing Board, (2) if the Fair Hearing right is waived by the Practitioner, or (3) upon its issuance if no hearing right is triggered. After considering the Ad Hoc Investigation Committee’s Report, the MEC shall issue its recommendation to the Governing Board. If the MEC recommends an action for which a hearing right is required, then the Practitioner shall be entitled to the Fair Hearing Rights set forth in these Bylaws before final action is taken by the Governing body. If a hearing is requested and the Fair Hearing Committee (or upon appeal, an authorized committee of the Governing Board) recommends a decision in accordance with the MEC’s recommendation, then the proposed recommendation shall be deemed made, and the Governing Board shall make its final decision in accordance with the Fair Hearing Plan. If the right to hearing is waived by the Practitioner, the Governing Board shall be notified that the recommendation of the MEC is final, and the Governing Board shall take final action after reviewing the Investigative Committee’s Report. If the MEC does not recommend any action that triggers a hearing right, then the Investigation Committee’s report shall be forwarded to the Governing Board for final action.

10.4 Automatic Relinquishment. Automatic relinquishment of some or all of a Practitioner’s prerogatives and/or privileges shall occur whenever there is revocation, suspension, or restriction of the Practitioner’s state license or DEA; whenever a Practitioner has been excluded from participation in the Medicare and/or Medicaid program; whenever the Practitioner fails to maintain malpractice insurance, if any, required by these Bylaws. An automatic relinquishment may be imposed by the CEO, the Chief of Staff, or the designee of either of them. The Practitioner will promptly be notified via certified mail, return receipt requested, of such automatic relinquishment. An automatic relinquishment shall terminate automatically upon resolution or correction of the triggering cause under this section, except for relinquishment pursuant to sections 10.4.1, 10.4.2, and 10.4.3. Practitioners seeking reinstatement of privileges following relinquishment under those sections must reapply for privileges pursuant to Article V. of these bylaws.
10.4.1 State of Nevada License.

10.4.1.1 Revocation. Whenever a Practitioner's license to practice in the State of Nevada is revoked, the Practitioner's staff appointment and clinical privileges are immediately and automatically relinquished.

10.4.1.2 Restriction. Whenever a Practitioner's license is partially limited or restricted in any way, those Clinical Privileges that he has been granted that are within the scope of the limitation or restriction are similarly and automatically relinquished.

10.4.1.3 Suspension. If a Practitioner’s license is suspended, the Practitioner's Staff appointment and Clinical Privileges are automatically relinquished effective upon and for at least the term of the suspension.

10.4.1.4 Probation. If a Practitioner is placed on probation by his licensing authority, his voting and office holding Prerogatives are automatically relinquished effective upon and for at least the term of the probation.

10.4.2 Drug Enforcement/Nevada Pharmacy Certificates. If a Practitioner's right to prescribe controlled substances is revoked, restricted, suspended, or placed on probation, by a proper licensing authority, his privileges to prescribe such substances in the Hospital will also be relinquished automatically and to the same degree. This will be effective upon and for at least the term of the imposed restriction.

10.4.3 Medicare/Medicaid Sanction. Whenever a Practitioner has been excluded from participation in the Medicare and/or Medicaid program, including without limitation the Nevada Division of Health all of his hospital privileges and the medical staff membership of the Practitioner shall be automatically relinquished.

10.4.4 Professional Liability Insurance. For failure to maintain a policy of professional liability insurance as may be required under these Bylaws and accompanying manuals, a Practitioner's Medical Staff appointment and Clinical Privileges are immediately and automatically relinquished.

10.4.5 Timely Completion of Medical Records. The failure to prepare and/or complete a patient's medical records in a timely fashion as outlined in the Rules and Regulations shall result in discipline, which may include suspension of a Practitioner's Prerogatives and Clinical Privileges, or automatic relinquishment of a Practitioner's Prerogatives and Clinical Privileges after special notice is provided by the MEC of such action. Practitioners who fail timely to complete medical records may be referred to the Professional Practice Evaluation Committee or directly to the MEC.

10.4.6 Tuberculosis. For failure to maintain annual and current Tuberculosis tests as required under these Bylaws and accompanying manuals, a Practitioner's
Medical Staff appointment and Clinical Privileges are immediately and automatically relinquished.

10.5 Voluntary Relinquishment/Demotion.

10.5.1 Prolonged Medical Record Suspension. More than 60 consecutive days of medical record suspension in a 12-month period shall be deemed a demotion of staff category.

10.5.2 Failure to Reapply. Failure to apply for reappointment in a timely manner, as set forth in the Credentials Manual shall be deemed a voluntary relinquishment of staff membership and privileges.

10.6 Summary Suspension. Summary suspension shall be initiated whenever a Practitioner's conduct requires that immediate action be taken to prevent imminent danger to the life, health or safety of any individual, including patients, employees, or other persons present in the Hospital. Summary suspension may be initiated by the Chief of Staff, the Chief Executive Officer or the Executive Committee of either the Medical Staff or the Governing Board. Each has the authority to summarily suspend the Medical Staff status or any portion of the Clinical Privileges of such Practitioner. A summary suspension is effective immediately and the person imposing the suspension shall give written special notice within 72 hours of the suspension to the Practitioner. The special notice shall state the general reasons for the summary suspension. Summary suspension shall be effective, however, notwithstanding failure to serve special notice due to lack of availability of the affected Practitioner. A suspended Practitioner's patients then in the Hospital shall be assigned to another Practitioner by the appropriate Division Chairman or his designee. This assignment should consider the wishes of the patient in choosing a substitute Practitioner when feasible. Immediately upon imposition of a summary suspension, the Chief Executive Officer will be notified.

10.7 Precautionary Administrative Suspension. The Chief Executive Officer (or his designee) may administratively suspend all or any portion of a Practitioner's clinical privileges or impose a mandatory consultation, proctoring or supervision requirement, effective immediately, in order to allow for an immediate investigation to determine if there is a basis for emergency corrective action or summary suspension. This precautionary suspension may not exceed 14 days and does not entitle the Practitioner to any procedural rights or review. The precautionary administrative suspension shall be imposed on behalf of the board in the course of its professional review activity responsibilities, but is not considered corrective action. Imposition of a precautionary administrative suspension is not required prior to imposition of summary suspension or other emergency corrective action. The Chief Executive Officer (or his designee) will immediately notify the Practitioner of the precautionary administrative suspension verbally and by special written notice. The Chief Executive Officer (or his designee), may lift the precautionary administrative suspension at any time.

ARTICLE XI.
PROCEDURAL RIGHTS AND FAIR HEARING PLAN

11.1 Exhaustion of Remedies.

If adverse action triggering hearing rights as described in this article is taken or recommended, the individual agrees to follow and complete the procedures set forth in these Bylaws, including all appellate procedures, before attempting to obtain judicial relief related to any issue or decision that may be subject to a hearing or appeal under these Bylaws.

11.2 Grounds for Hearing

11.2.1 Subject to the exceptions stated in these Bylaws, an individual is entitled to request a hearing whenever the Medical Executive Committee makes one of the following recommendations regarding that individual:

11.2.1.1 Denial of initial appointment to the Medical Staff;

11.2.1.2 Denial of reappointment to the Medical Staff;

11.2.1.3 Revocation of appointment to the Medical Staff, except where continued appointment to Medical Staff was contingent upon continuance of a contract;

11.2.1.4 Denial of requested clinical privileges, change in Medical Staff Category, unless denial is due to failure to meet objective criteria for the requested category;

11.2.1.5 Revocation or restriction of clinical privileges;

11.2.1.6 Suspension of clinical privileges for more than 14 days;

11.2.1.7 Mandatory concurring consultation requirement (i.e., the consultant must approve the course of treatment in advance); or

11.2.1.8 Denial of reinstatement from a leave of absence if the reasons relate to professional competence or conduct.

11.2.1.9 No other recommendations made by the Medical Executive Committee shall entitle the individual to a hearing.

11.2.1.10 If the Board makes any of these recommendations without an adverse recommendation by the Medical Executive Committee, an individual is also entitled to request a hearing. For ease of use, this Article refers to adverse recommendations of the Medical Executive Committee. When a hearing is triggered by an adverse recommendation of the Governing Board, any reference in this Article to "the Medical Executive Committee" shall be interpreted as a reference to "Governing Board."

11.3 Actions Not Grounds For Hearing.
The following actions involving an individual shall not constitute grounds for a hearing, and such actions shall take effect without hearing or any right to appeal:

11.3.1 The issuance of a letter of guidance, counsel, warning, or reprimand;

11.3.2 The imposition of conditions, monitoring, or a general consultation requirement (i.e., the individual must obtain a consult but need not get prior approval for the treatment);

11.3.3 Expiration of temporary privileges or voluntary relinquishment of privileges;

11.3.4 The imposition of a requirement for additional training or continuing education;

11.3.5 A precautionary suspension;

11.3.6 A denial of a request for a leave of absence, for an extension of a leave of absence, or for reinstatement from a leave of absence if the reasons do not relate to professional competence or conduct;

11.3.7 A determination that an application is incomplete;

11.3.8 A determination that an application will not be processed due to a misstatement or omission;

11.3.9 A determination of ineligibility for Membership on the Medical Staff based on a failure to meet the basic qualifications or denial of privileges because of an exclusive contract;

11.3.10 Appointment of an Ad Hoc Investigation Committee, or conduct of an investigation.

11.3.11 A denial or termination of privileges due to a determination that the requested privileges are not able to be supported with available resources or facilities within the hospital, or due to the hospital closing or discontinuing a service, or entering an exclusive contract.

11.4 Notice of Recommendation.

The Chief of Staff shall promptly give special notice of a recommendation which entitles an individual to request a hearing. This notice shall contain:

11.4.1 A statement of the recommendation and the general reasons for it;

11.4.2 A statement that the individual has the right to request a hearing on the recommendation within thirty (30) days of receipt of such notice; and

11.4.3 A copy of this Article.

11.5 Request for Hearing.
Upon receipt of the Notice of Recommendation, an individual has thirty (30) days to request a hearing. The request shall be made in writing to the Chief of Staff and shall include the name, address, and telephone number of the individual's counsel, if any. Failure to request a hearing within such time period and manner shall constitute a waiver of the right to a hearing, and the recommendation shall be transmitted to the Governing Board for final action.

11.6 Notice of Hearing and Statement of Reasons.

11.6.1 The Chief Executive Officer, in consultation with the Chief of Staff, shall schedule the hearing and provide, by special notice, the following:

11.6.1.1 The time, place, and date of the hearing;

11.6.1.2 A proposed list of witnesses who will give testimony at the hearing and a brief summary of the anticipated testimony;

11.6.1.3 The names of the Hearing Panel members and Presiding Officer (or Hearing Officer) if known; and

11.6.1.4 A statement of the specific reasons for the recommendation, including a list of patient records (if applicable), and information supporting the recommendation. This statement may be revised or amended at any time, even during the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications and the individual has had a reasonable opportunity of up to thirty (30) days to review and rebut the additional information.

11.6.2 The hearing shall be held as soon as practicable, but not sooner than thirty (30) days after the notice of the hearing, unless the parties have agreed in writing to hold the hearing at an earlier date.

11.7 Witness List.

11.7.1 At least fifteen (15) days before the pre-hearing conference, the individual requesting the hearing and the Medical Executive Committee each shall provide the other with a written list of the names of all witnesses expected to offer testimony at the hearing, and each shall provide a copy of that list to the Presiding Officer or Hearing Officer.

11.7.2 The witness lists shall include a brief summary of the anticipated testimony of each witness.

11.7.3 The witness list of either party may, in the discretion of the Presiding Officer, be amended to include additional witnesses at any time during the course of the hearing, provided that notice of the change is given to the other party and that allowing such additional witnesses to testify is not unduly prejudicial to the other party.

11.8 Hearing Panel, Presiding Officer, and Hearing Officer.
11.8.1 **Hearing Panel.**

11.8.1.1 The Chief of Staff shall appoint a Hearing Panel composed of not less than three members. The Hearing Panel shall be composed of Members of the Medical Staff who did not actively participate in the administrative process in the matter at any previous level; physicians not currently connected with the Hospital; or layperson; or a combination thereof, as long as the majority of the Hearing Panel members are physicians. Knowledge of the subject matter of the hearing shall not preclude any individual from serving as a member of the Hearing Panel. Employment by, or a contract with, the Hospital or an affiliate shall not preclude any individual from serving on the Hearing Panel.

11.8.1.2 The Hearing Panel shall not include anyone who has a personal interest in the outcome of the hearing, including but not limited to direct economic competitors to the individual requesting the hearing or anyone who is personally or contractually associated with or related to the individual requesting the hearing.

11.8.2 **Presiding Officer.**

11.8.2.1 The Chief of Staff shall appoint a Presiding Officer, who may be an attorney. The Presiding Officer shall not act as an advocate for either side at the hearing.

11.8.2.2 The Presiding Officer shall not vote.

11.8.2.3 The Presiding Officer shall:

11.8.2.3.1 Allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination;

11.8.2.3.2 Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant or abusive or that causes undue delay;

11.8.2.3.3 Maintain decorum throughout the hearing;

11.8.2.3.4 Determine the order of procedure;

11.8.2.3.5 Rule on all matters of procedure and the admissibility of evidence;

11.8.2.3.6 Conduct argument by counsel on procedural points outside the presence of the Hearing Panel unless the Panel wishes to be present.

11.8.2.4 The Presiding Officer may be advised by legal counsel to the Hospital with regard to the hearing procedure.
11.8.2.5 The Presiding Officer shall not participate in the private deliberations of the Hearing Panel, but may be present during those deliberations, and serve as a legal advisor to the panel, but shall not be entitled to vote on its recommendations.

11.8.2.6 The Presiding Officer may serve as scrivener to the Panel and assist the panel in drafting written findings of fact and recommendations of the Panel.

11.8.3 Hearing Officer.

11.8.3.1 If a Hearing Panel reasonably cannot be selected, the Chief of Staff may appoint a Hearing Officer, preferably an attorney, to perform the functions of a Hearing Panel. The Hearing Officer may not be, nor represent clients who are, in direct economic competition with the individual requesting the hearing. The Hearing Officer may not be an employee of or in a contractual relationship with the Hospital.

11.8.3.2 If a Hearing Officer is appointed instead of a Hearing Panel, all references in this Article to the "Hearing Panel" or "Presiding Officer" shall be deemed to refer to the Hearing Officer.

11.8.3.3 A Hearing Officer may be appointed instead of a Hearing Panel if the subject individual’s objections to Panel Members render the composition of a full impartial panel impractical.

11.8.4 Objections.

Any objection to any member of the Hearing Panel, or the Hearing Officer or Presiding Officer, shall be made in writing to the Chief of Staff within 10 days of receipt of notice of their appointment or selection. The Chief of Staff, shall rule on the objection and give notice to the parties. The Chief of Staff may request that the Presiding Officer make a recommendation as to the validity of the objection.

11.9 Counsel.

The Presiding Officer, Hearing Officer, and counsel for either party may be an attorney at law who is licensed to practice, in good standing, in any state in the United States of America.

11.10 Pre-Hearing Procedures.

11.10.1 General Procedures.

The pre-hearing and hearing processes shall be conducted in an informal manner. Formal Rules of evidence and procedure shall not apply.

11.10.2 Provision of Relevant Information.
11.10.2.1 Prior to receiving any confidential documents, the individual requesting the hearing must agree to maintain the confidentiality of all documents and information and not disclose or use those documents for any purpose outside of the hearing. The individual must also provide a written representation that his counsel and any expert(s) being utilized by the individual have executed appropriate Business Associate agreements acceptable to Hospital in connection with the use and disclosure of any patient’s Protected Health Information contained in any documents provided.

11.10.2.2 Upon receipt of the above agreement and representation, the individual requesting the hearing will be provided with a copy of, or reasonable access for purposes of review to, each of the following:

11.10.2.2.1 All patient medical records referred to in the statement of reasons, at the individual's expense;

11.10.2.2.2 Reports of any experts relied upon by the Medical Executive Committee;

11.10.2.2.3 Relevant minutes of Medical Staff meetings (with portions regarding other physicians and unrelated matters deleted); and

11.10.2.2.4 Any other documents relied upon by the Medical Executive Committee in making its recommendation.

11.10.3 The provision of this information is not intended to waive any applicable privileges protecting the confidentiality of peer review information under federal and state law, the Medical Staff or Hospital Bylaws. The individual shall have no right to discovery beyond the above information. No information shall be provided regarding other Practitioners.

11.10.4 Prior to the pre-hearing conference, on dates set by the Presiding Officer or agreed upon by both sides, each party shall provide the other party with its proposed exhibits. All objections to documents or witnesses, to the extent then reasonably known, shall be submitted in writing in advance of the pre-hearing conference. The Presiding Officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.

11.10.5 Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges shall be excluded. Evidence is not limited to those materials considered by the MEC or other committees that considered the matter prior to the MEC’s recommendation.

11.10.6 Neither the individual, his or her attorney, nor any other person acting on behalf of the individual, shall contact Hospital employees appearing on the
Medical Executive Committee's witness list concerning the subject matter of the hearing, unless specifically agreed upon by counsel.

11.11 **Pre-Hearing Conference.**

The Presiding Officer shall require a representative (who may be counsel) for the individual and for the Medical Executive Committee to participate in a pre-hearing conference. At the pre-hearing conference, the Presiding Officer shall resolve all procedural questions, including any objections to exhibits or witnesses, and any requests for proposed questions to be posed to panel members in advance of the hearing regarding any potential bias. The Presiding Officer shall establish the time to be allotted to each witness' testimony and cross-examination. It is expected that the hearing will last no more than 15 hours, with each side being afforded approximately seven and a half hours to present its case, in terms of both direct and cross-examination of witnesses. Both parties are required to prepare their case so that a hearing shall be concluded after a maximum of 15 hours. The Presiding Officer may, after considering any objections, grant limited extensions upon a demonstration of good cause and to the extent compelled by fundamental fairness.

11.12 **Stipulations.**

The parties and counsel, if applicable, shall use their best efforts to agree and stipulate to those evidentiary matters that are not in controversy so as to provide for a more orderly and efficient hearing by narrowing the issues on which live testimony is reasonably required.

11.13 **Provision of Information to The Hearing Panel.**

The following documents will be provided to the Hearing Panel in advance of the hearing:

11.13.1 A pre-hearing statement that either party may choose to submit;

11.13.2 All exhibits offered by the parties and allowed by the Presiding Officer following the pre-hearing conference (without the need for authentication); and

11.13.3 Any stipulations of the parties regarding evidentiary matters.

11.14 **The Hearing.**

11.14.1 **Failure To Appear.**

11.14.1.1 Failure, without good cause, by an individual requesting a hearing to appear and proceed at the hearing shall constitute a waiver of the right to a hearing and the matter shall be transmitted to the Governing Board for final action.

11.14.2 **Record of Hearing.**
A stenographic reporter shall be present to make a record of the hearing. The cost of the reporter shall be borne by the Hospital. A copy of the transcript shall be made available to the individual. Oral evidence shall be taken only on oath or affirmation administered by any person entitled to notarize documents in this state.

11.14.3 Rights of The Parties And The Hearing Panel At The Hearing.

11.14.3.1 At a hearing, both sides shall have the following rights, subject to reasonable limits that may be determined and imposed by the Presiding Officer:

11.14.3.1.1 The right to call and examine witnesses, to the extent they are available and willing to testify;

11.14.3.1.2 The right to introduce exhibits;

11.14.3.1.3 The right to cross-examine any witness on any matter relevant to the issues;

11.14.3.1.4 The right to be represented by counsel who may be present. However, said counsel may not call, examine, or cross-examine witnesses, nor may counsel present or argue the case;

11.14.3.1.5 The right to submit a written statement at the close of the hearing; and

11.14.3.1.6 The right to submit proposed findings, conclusions and recommendations to the Hearing Panel.

11.14.4 If the individual who requested the hearing does not testify on his or her own behalf, he or she may be called and questioned by the Medical Executive Committee, Hearing Panel, or Hearing Officer.

11.14.5 The Hearing Panel may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

11.14.6 Admissibility of Evidence.

The hearing shall not be conducted according to federal or state rules of evidence. Evidence shall not be excluded merely because it is hearsay. Relevant evidence shall be admitted if it is the sort of evidence on which reasonable persons would rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The guiding principle shall be that the record contains information sufficient to allow the Hospital Governing Board to decide whether the individual is qualified for appointment and clinical privileges.

11.14.7 Order of Presentation Of Case.
The Medical Executive Committee shall present evidence in support of its recommendation first. Thereafter, the burden shall shift to the individual who requested the hearing to present evidence.


Each party shall have the right to submit a written statement, and the Hearing Panel may request that statements be filed, following the close of the hearing. All post-hearing statements shall be submitted within fifteen (15) calendar days after the conclusion of the presentation of evidence.

11.14.9 Persons to be Present.

The hearing shall be restricted to those individuals involved in the proceeding. Administrative personnel, including the Chief Executive Officer or his designee, may be present as requested by the Chief of Staff. The Presiding Officer may exclude witnesses, other than the Subject Individual, the Chief of Staff, or other representatives of the MEC, from the proceedings other than during those witnesses’ own testimony.

11.14.10 Postponements and Extensions.

Postponements and extensions of time may be requested by any individual involved in the proceeding, but shall be permitted only by the Presiding Officer on a showing of good cause.


A majority of the Hearing Panel shall be present throughout the hearing. If a Hearing Panel member must be absent from any part of the hearing due to unforeseen circumstances, he or she shall read the transcript for that portion of the hearing from which he or she was absent.

11.15 Hearing Panel Deliberations, Recommendation And Report.

11.15.1 Basis Of Hearing Panel Recommendation.

Consistent with the burden on the individual to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial appointment, reappointment and clinical privileges, the Hearing Panel shall recommend in favor of the Medical Executive Committee unless it finds that the individual who requested the hearing has proved, by a preponderance of the evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.
11.15.2 Deliberations and Recommendation of The Hearing Panel.

Within 20 days after the date on which the Hearing Panel receives the hearing transcript or any post-hearing statements, whichever is later, the Hearing Panel shall conduct its deliberations outside of the presence of any other person except the Presiding Officer. The Hearing Panel shall render a written recommendation that is agreed upon by at least a majority of the Hearing Panel, accompanied by a written report that contains a concise statement of the basis for its recommendation.

11.15.3 Disposition Of Hearing Panel Report.

The Hearing Panel shall deliver its report to the Chief of Staff. The Chief of Staff shall send by special notice a copy of the report to the individual who requested the hearing. The Chief of Staff shall also provide a copy of the report to the Medical Executive Committee.

11.16 Appeal Procedure.

11.16.1 Time For Appeal.

Within 10 days after notice of the Hearing Panel's recommendation, either party may request an appeal. The request shall be in writing, delivered to the Chief of Staff either in person or by certified mail, return receipt requested, and shall include a statement of the reasons for appeal and the specific facts or circumstances which justify further review. If an appeal is not requested within 10 days, all rights to an appeal are deemed to be waived and the Hearing Panel's report and recommendation shall be forwarded to the Governing Board for final action.

11.17 Grounds For Appeal.

11.17.1 The grounds for appeal shall be limited to the following:

11.17.1.1 The party was denied the right to a fair hearing due to a substantial failure on the part of the Medical Executive Committee, Hospital Administration, the Presiding Officer, and/or the Hearing Panel to comply with the Bylaws of the Medical Staff and/or the Hospital prior to or during the hearing; and/or

11.17.1.2 The recommendations of the Hearing Panel were made arbitrarily or capriciously and/or were not supported by credible evidence.

11.18 Time, Place and Notice.

Whenever a party requests an appeal as set forth in this Section the Chairman of the Hospital Governing Board shall schedule and arrange for a hearing of that appeal. The parties shall be given special notice of the time, place, and date of the appeal hearing. The appeal hearing shall be held as soon as arrangements reasonably can be made, taking into account the schedules of parties, but unless agreed to by the parties not more than 30 days after receipt of the request for an appeal.
11.19 **Nature of Appellate Review.**

11.19.1 The Governing Board may act as the Review Panel if it elects to do so and can, as a body, hold the hearing within the time limits detailed above. Alternatively, the Chairman of the Governing Board shall appoint a Review Panel composed of not less than three persons who are members of the Governing Board or reputable persons in the community, and at least one of whom shall be a physician. The Review Panel or Board shall review the grounds for the appeal by considering the record upon which the recommendation was made, any matters raised in the written statements of the parties on appeal or during any oral argument allowed, and any additional evidence that the Review Panel, in its discretion, chooses to accept as stated below. Review Panel members must not have participated in the proceedings at the committee or hearing panel level.

11.19.2 Each party shall have the right to present a written statement in support of its position on appeal, a copy of which it shall provide to the other party. The party requesting the appeal shall submit a statement first and the other party shall then have ten days to respond. In its sole discretion, the Review Panel (or Board) may allow each party or its representative to appear personally and make oral argument not to exceed 30 minutes. This argument may be presented by counsel.

11.19.3 The Review Panel (or Board) may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Hearing Panel proceedings. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence or that any opportunity to admit it at the hearing was improperly denied, and then only at the discretion of the Review Panel (or Governing Board). Any proposed new evidence must be attached to or reasonably described in the written statement in support of that party’s position on appeal.

11.19.4 The Review Panel shall issue a written recommendation that the Board either accepts the Hearing Panel’s recommendation, or that the Governing Board take such different action as may be recommended by the Review Panel.

11.20 **Final Decision of The Board.**

Within 30 days after receipt of the Review Panel's written recommendation, the Governing Board shall render a final written decision that includes specific findings supporting its decision, and shall send special notice thereof to the individual. In its decision, the Governing Board may affirm, modify, or reverse the recommendation of the Review Panel or, in its discretion, may refer the matter for further review and recommendation, or make its own decision based upon the Governing Board's ultimate legal responsibility to grant appointment and clinical privileges. A copy of the final decision also shall be provided to the Medical Executive Committee for its information. Board Members who participated in the proceedings at the committee or hearing panel level shall recuse themselves from discussion and voting on the final decisions of the Board.
11.21 **Further Review.**

Except where the matter is referred for further action and recommendation by the Governing Board, the final decision of the Governing Board following the appeal shall take effect immediately and shall not be subject to further review. If the matter is referred for further action and recommendation, such recommendation shall be made to the Governing Board promptly in accordance with the instructions given by the Governing Board.

11.22 **Right To One Hearing And One Appeal Only.**

No Individual shall be entitled to more than one hearing and one appellate review on any matter. If the Governing Board denies initial appointment or reappointment to the Medical Staff or revokes the appointment and/or clinical privileges of a current Member of the Medical Staff, that individual may not apply for staff appointment or for those clinical privileges for a period of three (3) years unless otherwise provided by the Governing Board.

11.23 **Review Committee Function.**

The Governing Board, whether acting as an appellate body as a committee of the whole or as a Review Panel, or acting as a committee of the whole or as a subcommittee when considering a possible settlement of a matter subject to this Article, is an organized committee of the Hospital having the responsibility for evaluation and improvement of patient care, as defined in N.R.S. 49.117 and N.R.S. 49.265, and its deliberations in such matters are therefore privileged.

**ARTICLE XII.**

**MEETINGS**

12.1 **Medical Staff Year.** The Medical Staff Year will begin on October 1.

12.2 **Medical Staff Meetings.**

12.2.1 **General Medical Staff Meetings.** The MEC may authorize the holding of general Staff meetings on an as needed basis. The resolution authorizing such additional meeting shall require 7 days written notice specifying the place, date and time for the meeting, and that the meeting can transact any business as may come before it.

12.2.2 **Special Meetings.** A special meeting of the Medical Staff may be called by the Chief of Staff, and must be called by the Chief of Staff at the written request of the Governing Board, the MEC or by fifteen percent (15%) of the Members of the active Medical Staff.
12.2.3 Meeting Procedure:

Robert’s Rules of Order shall not be binding at meetings or elections, but may be used for reference in the discretion of the chair or presiding officer for the meeting. Specific provisions of these bylaws or any of the related policies, manuals, and medical staff or committee custom shall prevail at all meetings, and the chair or presiding officer shall have the authority to rule definitively on all matters of procedure.

12.2.3.1 All properly qualified members of committees are entitled to vote, unless recused due to a disqualifying conflict of interest. Ex-officio members of committees shall not vote.

12.2.4 Quorum. The Quorum requirement for the following meetings shall be:

12.2.4.1 Medical Executive Committee: Fifty percent (50%) of the voting members of the committee
12.2.4.2 Division and Committee Meetings: Those present and voting
12.2.4.3 All other Medical Staff Meetings: Those present and voting
12.2.4.4 The action of a majority of its members present at a meeting at which a quorum is present shall be the action of a Committee, Division or Section.

12.3 Division and Committee Meetings.

12.3.1 Regular Meetings. Divisions and committees shall determine the time for holding regular meetings. Divisions (or their appointed committees) must hold meetings at least semiannually.

12.3.2 Special Meetings. A special meeting of any Division or committee may be called by the chairman thereof, and must be called by the chairman at the written request of the Board, the Chief of Staff, or at least fifty percent (50%) of the Division’s or Committee’s current Members who are Members of the active Medical Staff.

12.3.3 Executive Closed Session. All Divisions and committees of the Medical Staff may sit in executive session. During this time, in addition to the physician members, the Chief Executive Officer or designee may remain; during peer review, representatives from Quality Management and other hospital representatives, as requested by the Chairman, may remain.

12.4 Attendance Requirements.

12.4.1 Medical Executive Committee. Active Members on the Medical Executive Committee must attend at least seventy-five percent (75%) of the Medical Executive Committee meetings (unless excused for good cause by the Chief of Staff) or they shall be removed from their office or position.
12.4.2 **Medical Staff, Divisions, and Committees.** Although meeting attendance is strongly encouraged for all Members, there shall be no attendance requirements for Medical Staff, Division, or Committee meetings, other than those established by those Divisions from time to time. Pertinent information shall be communicated in writing to the Members as appropriate.

12.4.3 **Special Appearances or Conferences.**

12.4.3.1 A Practitioner who receives a written request from the Professional Practice Evaluation Committee, a Division, or MEC to provide additional or specific information regarding the care and management of a patient is expected to respond in the manner (written or personal appearance) and in the timeframe specified in the request. Failure to respond and/or provide the requested information after two written requests, unless excused by the chairman of the requesting Committee/Division, may result in Precautionary Administrative suspension of any or all of the Practitioner’s privileges. In the absence of a response from the Practitioner, a final determination on standard of care will be made based on the available information.

12.4.3.2 Whenever a Staff or Division educational program is prompted by findings of quality management program activities, the Practitioner whose performance prompted the program will be notified of the time, date and place of the program, of the subject matter to be covered, and its special applicability to the Practitioner's practice. Except in unusual circumstances, he will be required to be present.

12.4.3.3 Whenever a pattern of suspected deviation from standard clinical practice is identified, the Chief of Staff or the applicable Division Chairman may, but is not obligated to, require the Practitioner to confer with him or with a standing or ad hoc committee that is considering the matter. The Practitioner will be given written special notice of the conference at least ten (10) days prior to the conference, including the date, time and place, and a statement of the issue involved, and that the Practitioner's appearance is mandatory. Failure of the Practitioner to appear at any such conference, unless excused by the MEC upon showing good cause, result in an automatic suspension of all or such portion of the Practitioner's Clinical Privileges as the MEC may direct. A suspension under this Section will remain in effect until the matter is resolved by subsequent action of the MEC and the Board or through corrective action, if necessary. Such resolution shall be made in a timely manner not to exceed ten (10) days.

12.4.3.4 When a Division or committee is engaged in any of the activities listed in this Section at the same time as another Division or committee, joint meetings may be held, in accordance with the Saint Mary’s Regional Medical Center Conflicts of Interest Policy.
12.5 **Meeting Procedures.**

12.5.1 **Order of Business and Agenda at General Staff Meetings.** The order of business at a regular meeting shall be determined by the Chief of Staff. The agenda shall include at least:

12.5.1.1 Reading and acceptance of the minutes of the last regular and all special meetings held since the last regular meeting;

12.5.1.2 Administrative reports from the Chief Executive Officer, the Chief of Staff, Divisions and committees;

12.5.1.3 The election of officers and of representatives to Staff and Hospital committees, when required by these Bylaws;

12.5.1.4 New business.

12.5.2 **Notice of Meetings.** Written notice stating the place, day and hour of any general Staff meeting, of any special meeting, or of any regular committee or Division meeting shall be delivered either by mail, facsimile, or e-mail to each person entitled to be present thereat not less than seven (7) days before the date of such meeting. The same notice shall be provided as to meetings cancelled pursuant to resolution, when feasible.

12.5.3 **Minutes.** Minutes of all meetings shall be prepared and shall include a record of attendance and the vote taken on each matter. Copies of such minutes shall be approved by the attendees, forwarded to the Medical Executive Committee and, except those portions that are confidential, made available to the Staff. A permanent record of the minutes of each meeting shall be maintained.

12.5.4 **Manner of Action.** Except as otherwise provided, 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 by a Division or committee by a document setting forth the action so taken signed by each Member entitled to vote thereat. In an urgent case, action may be taken without a meeting by a Division or committee by a document setting forth the action so taken being sent by e-mail to each Member entitled to vote thereon, and acknowledgments returned by e-mail by a majority of such Division or committee to the proposed action. A record of such e-mail acknowledgments shall be maintained by the secretary of such Division or Committee.

**ARTICLE XIII.**

**CONFIDENTIALITY, IMMUNITY AND RELEASES**

13.1 **Authorizations and Conditions.** By submitting an application for Staff appointment or by applying for or exercising Clinical Privileges or providing specified patient care services in this Hospital, a Practitioner:
13.1.1 Authorizes representatives of the Hospital and the Medical Staff to solicit, provide and act upon any and all information bearing on his or her professional ability and qualifications, training, background, ethics, physical and mental health, emotional stability, and any other matter relevant to said applicant’s application or exercise of privileges; including without limitation soliciting medical peer review records from any other healthcare institution, and agrees any such information need not be disclosed to him if the third party providing such information does so on the condition it be kept confidential.

13.1.2 Consents to the inspection of records and documents pertinent to his or her licensure, specific training, experience, current competence, and ability to perform the privileges requested and, if requested, agrees to appear for an interview.

13.1.3 Agrees to be bound by the provisions of this Article and to waive forever all legal and equitable claims against the Hospital or any Hospital representative who acts in accordance with the provisions of this Article.

13.1.4 Specifically authorizes the Hospital, Medical Staff leaders, and their authorized representatives (1) to consult with any third party who may have information bearing on the individual’s professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on his or her qualifications for initial and/or continued appointment to the Medical Staff, and (2) to obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of third parties that may be relevant to such questions. The Practitioner specifically authorizes third parties to release this information to the Hospital and its authorized representatives upon request.

13.1.5 Specifically authorizes the Hospital, Medical Staff leaders, Divisions, committees and their authorized representatives to disclose to, and obtain from, its Medical Staff leaders, Divisions, committees and their authorized representatives any information bearing on the individual’s professional qualifications, credentials, competence, character, ability to perform safely and competently, ethics, behavior or any other matter reasonably having a bearing on his or her qualifications for Medical Staff membership or privileges.

13.1.6 Agrees to sign any necessary authorizations to permit a consumer reporting agency to conduct a criminal background check and report the results to the Hospital.

13.1.7 Authorizes Hospital to maintain information concerning the Practitioner, including confidential and peer review information, and to release such information to a centralized physician database for the purpose of making aggregate physician information available for use by the Hospital and its affiliates, and for purposes of reducing morbidity and mortality and for the improvement of patient care within the Hospital and among the Hospital and its affiliates.
13.1.8 Consents to the reporting by Hospital of information to the National Practitioner Data Bank established pursuant to the Health Care Quality Improvement Act of 1986, which the Hospital believes in good faith is required by law to be reported.

13.1.9 Releases from any liability Hospital and all Hospital representatives for their acts performed in connection with evaluating his credentials or releasing information to other institutions for the purpose of evaluating his credentials, and all third parties who provide information (including otherwise privileged or confidential information) to Hospital representatives, concerning Practitioner’s credentials, unless such information is false and the party providing it knew it to be false.

13.1.10 Agrees to follow and exhaust the administrative remedies afforded by the Medical Staff Bylaws as a prerequisite to any other action or proceeding, including court actions, and agrees that the Practitioner will have the burden of demonstrating that he meets the standards for appointment or continued appointment to the Medical Staff or for specific clinical privileges.

13.1.11 Agrees that the foregoing provisions are in addition to any agreements, understandings, covenants, waivers, authorizations or releases provided by law or contained in any application or request forms.

13.2 Confidentiality of Information. Information with respect to any Practitioner submitted, collected or prepared by any representatives of this or any other health care facility, organization, or Medical Staff for the purposes of evaluating and improving the quality and efficiency of patient care, reducing morbidity and mortality, contributing to teaching or clinical research and determining that health care services are professionally indicated and performed in compliance with the applicable standards of care shall, to the fullest extent permitted by law, be confidential and shall not be used in any way except as provided herein or except as otherwise provided by law. Such confidentiality shall also extend to information of the kind that may be provided by third parties. This information shall not become a part of any patient's record. Breach of confidentiality by response to legal process apparently valid on its face or exercise of legal rights by or on behalf of or in respect of a patient shall not nullify or void any other provision of this Article 13.

13.3 Immunity from Liability

13.3.1 For Action Taken. By submitting an application for Staff appointment or by applying for or exercising Clinical Privileges or providing patient care services in this Hospital, a Practitioner expressly acknowledges and agrees that neither the Hospital nor any representative of the Hospital or Medical Staff shall be liable to the Practitioner for damages or other relief based on any theory or cause of action whatsoever, whether in tort or otherwise, for any decision, opinion, action, statement or recommendation made within the scope of his duties as a representative of the hospital or the Medical Staff. Regardless of the provisions of state law, and without limiting other defenses, including a defense based on this Section 13.3.1, truth shall be an absolute defense in all circumstances.
13.3.2 **For Providing Information.** By submitting an application for Staff appointment or by applying for or exercising Clinical Privileges or providing patient care services in this Hospital, a Practitioner expressly acknowledges and agrees that neither the Hospital nor any representative of the Hospital or Medical Staff and no third party shall be liable to a Practitioner for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative of the Hospital or Medical Staff or to an appropriate state or federal regulatory agency, or the National Practitioner Data Bank, concerning a Practitioner who is or has been an applicant to or a Member of the Staff or who did or does exercise Clinical Privileges or provide specific patient care services at this Hospital, unless such information is false and the party providing it knew it to be false.

13.3.3 The Immunity protections afforded in these bylaws are in addition to those prescribed by state and federal law.

13.4 **Activities and Information Covered.**

13.4.1 **Activities.** The confidentiality and immunity provided by this Article applies to all acts, communications, proceedings, interviews, reports, records, minutes, forms, memoranda, statements, recommendations, findings, evaluations, opinions, conclusions or disclosures performed or made in connection with this or any other health care facilities or organization's activities concerning but not limited to:

13.4.1.1 Applications for appointment, reappointment, Clinical Privileges or specified services;

13.4.1.2 Periodic reappraisals for reappointment, clinical privileges or specified services;

13.4.1.3 Corrective or disciplinary action;

13.4.1.4 Hearings and appellate reviews;

13.4.1.5 Reports of information to the National Practitioner Data Bank and relevant State and Federal agencies;

13.4.1.6 Performance Improvement program activities;

13.4.1.7 Utilization and claims reviews;

13.4.1.8 Profiles and profile analysis;

13.4.1.9 Malpractice loss prevention; and

13.4.1.10 Other Hospital and Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct.

13.4.2 **Information.** The information referred to in this Article may relate to a Practitioner's professional qualifications, clinical ability, judgment, character, physical or mental health, emotional stability, behavior, professional ethics or any other matter that might directly or indirectly affect patient care.
13.5 **Releases.** Each Practitioner shall, upon request of Hospital, execute general and specific releases in accordance with the tenor and import of this Article, subject to such requirements as may be applicable under the laws of the State of Nevada. Execution of such releases is not a prerequisite to the effectiveness of this Article. Failure to execute such releases that results in information requested or required in conjunction with application for appointment or reappointment shall result in the application being declared incomplete and not processed further.

13.6 **Cumulative Effect.** Provisions in these Bylaws and in application forms relating to authorizations, confidentiality of information and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof.

**ARTICLE XIV.**

**GENERAL PROVISIONS**

14.1 **Medical Staff, Allied Health Staff and Ancillary Staff Credentials Files**

14.1.1 Medical Staff, Allied Health and Ancillary Staff credentials files shall be maintained in a confidential manner. Access is limited to medical staff officers, Division chairman, and committees of the Medical Staff, Hospital Administration, and the Board for the sole purpose of discharging their responsibilities.

14.1.2 Information contained in the credentials file may be disclosed without the Practitioner’s consent or that of the medical staff in accordance with the Saint Mary’s Regional Medical Center Conflict of Interest Policy to any professional licensing board, and as otherwise required by law. Any other disclosure of information outside of the Medical Staff, Administration or the Board shall require the authorization of the Chief Executive Officer or Chief Medical Officer, and notification to the medical staff member.

14.1.3 A Medical Staff member shall be granted access to his own credentials file, subject to the following conditions:

14.1.3.1 Seventy-two (72) hours prior notice for access shall be made to the Chief Executive Officer, or his designee, by the Practitioner;

14.1.3.2 The member may review and receive a copy only of those documents provided by or addressed personally to the member. A summary only of all other letters of reference, supervision reports and complaints shall be prepared and provided to the member within a reasonable period of time, as determined by the Medical Staff. Such summary shall disclose the substance, but not the source, of the information summarized;

14.1.3.3 The review by the member shall take place in the Medical Staff Division during normal working hours; a Medical Staff Officer, or designee, must be present.
14.2 **Conflicts between the Medical Staff and MEC.** To the extent a conflict arises between at least twenty-five percent (25%) of the Active Medical Staff and the Medical Executive Committee on issues including, but not limited to, proposed adoption of or amendments to these Bylaws, Rules, Regulations or Policies, the following dispute resolution process shall be followed as determined by the Chief of Staff and Chief Medical Officer before either the Medical Executive Committee or the Medical Staff takes an action contrary to an action, proposed action or position of the other group:

14.2.1 The Chief of Staff shall appoint at least two Medical Executive Committee members to represent the Medical Executive Committee. The at-large members of the Medical Executive Committee will, in consultation with the Chief Medical Officer, select at least two Active Medical Staff members not on the Medical Executive Committee to represent the Medical Staff in connection with the dispute.

14.2.2 Such appointed representatives shall meet in good faith to attempt to resolve the dispute.

14.2.3 In the event the dispute has not been resolved after at least two meetings of the representatives over at least a thirty (30) day period, the parties agree to submit the dispute to binding arbitration in accordance with the American Health Lawyers Association Alternative Dispute Resolution Service Rules of Procedure for Arbitration; provided, however, that the decision of the arbitrator shall be maintained in confidence by the arbitrator without disclosure to the parties or any other person while the parties engage in mediation in accordance with the American Health Lawyers Association Alternative Dispute Resolution Service Rules of Procedure for Mediation for a period of 45 days. If the dispute is not resolved by mediation at the conclusion of such time period, the arbitrator shall render the award as maintained in confidence since the conclusion of the arbitration proceeding, and such decision shall be final. The same person shall serve both as the mediator and as the arbitrator in such a proceeding.

14.2.4 The conflict management process described in this Section shall be a necessary prerequisite to any proposal to the Board by Medical Staff members for adoption or amendment of Bylaws, Rules and Regulations, or related document or policy provisions not supported by the MEC, including but not limited to a proposed Bylaws amendment intended to remove from the MEC some authority that has been delegated to it by the Medical Staff.

14.2.5 Nothing in this Section is intended to prevent Medical Staff members from communicating with the Governing Board about Medical Staff Bylaws, Rules and Regulations, or related documents or policies in accordance with such procedures as the Board shall specify.

14.2.6 Nothing in this Section shall apply to Peer Review or corrective action proceedings under these Bylaws.
14.3 **Conflict Resolution between MEC and the Governing Board.** If there are concerns or conflicts between the MEC and Governing Board regarding any provisions or amendments to the Bylaws or related documents, a meeting of the Joint Conference Committee of the Governing Board and Medical Staff shall be convened. The ultimate resolution shall be the responsibility of and determined by the Governing Board.

14.4 **Time Constraints.** Any and all time constraints set forth in these Bylaws may be modified or extended according to the terms of these Bylaws or at the agreement of all parties to the hearing or review. Further, the time periods specified herein serve only to assist those named in accomplishing their tasks and shall not be deemed to confer any rights upon any Medical Staff Members or applicants for membership or Clinical Privileges.

**ARTICLE XV.**

**ADOPTION AND AMENDMENT OF MEDICAL STAFF BYLAWS, RULES & REGULATIONS, AND RELATED DOCUMENTS AND POLICIES**

15.1 **Medical Staff Bylaws.** The Medical Staff shall have the responsibility to formulate, approve, and amend Medical Staff Bylaws. Adoption or amendment of Medical Staff Bylaws cannot be delegated. Bylaws become effective only upon approval by the Governing Board. The Medical Staff Bylaws shall be reviewed at least biennially. Proposed amendments to these Bylaws shall be originated by the MEC, or proposed by the Medical Staff (Section 15.2).

15.1.1 **Medical Executive Committee Action.** The Medical Executive Committee will review and approve any proposed changes to Medical Staff Bylaws prior to submission to the voting members of the Medical Staff.

15.1.2 **Medical Staff Action.** A favorable majority of votes cast by Members eligible to vote via mail ballot or by electronic vote is required for approval. Ballots/electronic votes must be received within twenty-one (21) days, unless otherwise specified in the communication to the voting members. Any ballots/votes received after the specified date will not be opened and will not affect the outcome of the vote.

15.1.3 **Governing Board Action.** The affirmative vote of a majority of the Governing Board is required for the adoption of these Bylaws or any amendments thereto. If the Governing Board has concerns regarding any of the provisions of the Bylaws or amendments, the applicable portion of the Conflict Management provisions described in Section 14 will be implemented.

15.2 **Amendments Proposed by Medical Staff.** In addition to the mechanisms set forth above by which the Medical Staff may adopt amendments to the Bylaws proposed by the MEC, the Medical Staff may also propose amendments to the Bylaws (without MEC support) directly to the Governing Board for its approval, but only in accordance with the following procedure:
15.2.1.1 A proposal to amend the Bylaws may be initiated by submitting to the Medical Staff Office a petition signed by at least 25% of voting Active Medical Staff members proposing a specific Bylaw or Rules and Regulations amendment or amendments (which will constitute notice of the proposed amendment(s) to the MEC). Any such petition must identify two Active Medical Staff members who will serve as representatives and act on behalf of the petition signers in the processes described below, as well as any conflict management processes.

15.2.1.2 Upon receipt of such a petition, the MEC will determine whether it supports the proposed amendment(s) and, if so, the Medical Staff Office will arrange for a vote on the proposed amendment(s) by the voting members of the Medical Staff according to the process described above for voting on MEC proposed amendments.

15.2.1.3 If the Medical Staff adopts the MEC supported proposed amendments by virtue of an affirmative majority vote of the voting members of the Medical Staff, the amendments will be submitted to the Governing Board for approval. If the Medical Staff does not adopt the MEC supported proposed amendments by vote, then the MEC supported proposed amendments will be deemed withdrawn.

15.2.1.4 If the MEC does not support the proposed amendment(s) submitted via valid petition, the MEC will notify the designated representatives in writing and they will have 30 days from receipt of the notice to invoke the conflict management process described in Section 14 of these Bylaws. If the conflict management process is not invoked within 30 days, it will be deemed waived and the proposed amendments will be deemed withdrawn.

15.2.1.5 If the conflict is not resolved by withdrawal of the proposed amendment(s) or MEC support of the proposed amendment(s) as modified in the conflict management process, the proposed amendment(s), either in the original form or as modified in the conflict management process, will be submitted to the Medical Staff for a vote. If the voting members of the Medical Staff approve the amendment(s) by a majority of the valid votes cast, the proposed amendment(s) will be submitted to the Board. The MEC’s written statement of its decision and reasons for not supporting or approving the proposed amendments issued at the conclusion of the conflict management process shall be provided to the Governing Board along with the proposed amendments.

15.2.1.6 Such proposed amendments will become effective immediately upon Board approval.

15.2.1.7 If the Governing Board does not approve the proposed amendment(s), the matter will be referred to the conflict management process set forth
in Section 14 for management of conflicts between the Board and MEC.

15.3 Amendment by Governing Board. These Bylaws may be amended by the Governing Board at any regular or special meeting of the Governing Board. A copy of each proposed amendment to these Medical Staff Bylaws shall be distributed to each Medical Staff Member at least thirty (30) days in advance of the meeting at which the Governing Board proposes to take final action thereon. Any amendments approved by the Governing Board also shall require approval by the Medical Staff as provided herein.

15.4 Medical Staff Rules & Regulations and Policies.

15.4.1 To implement the Medical Staff Bylaws, the Medical Staff shall develop administrative procedures, which shall be described in documents that supplement the Bylaws, such as Rules and Regulations and Policies. These Bylaws shall take precedence over any inconsistent provisions of Rules and Regulations, Policies and Procedures. If any administrative procedures contained in supplemental documents relate to credentialing, privileging, appointment, reappointment, corrective actions, fair hearing and appeal, the procedures shall be approved by both the Medical Staff and the Governing Board through the mechanisms described below. Administrative procedures eligible to be in supplemental documents shall meet the following criteria:

15.4.1.1 The administrative procedure is not a step in the process itself;

15.4.1.2 The procedure does not have a major impact on the outcome of the process such as procedures that result in an evaluative conclusion or decision;

15.4.1.3 The procedure is not so material to the appropriateness and fairness of the process that it needs to be in the Bylaws.

15.4.2 Medical Staff Rules and Regulations and Policies: Subject to approval by the Governing Board, the Medical Executive Committee, acting on behalf of the Medical Staff, shall adopt such Rules and Regulations and Policies as may be necessary to implement these Bylaws. The Rules and Regulations and Policies shall relate to the proper conduct of Medical Staff organizational activities and shall embody the level of practice required of each Staff appointee and individuals with clinical privileges. Such Rules and Regulations and Policies shall not conflict with the Governing Board Bylaws or these Bylaws.

15.4.3 Division Rules and Regulations and Policies: Subject to the approval of the Medical Executive Committee, acting on behalf of the Medical Staff, and the Board, each Division shall formulate its own Division Rules and Regulations and Policies for the conduct of its affairs and the discharge of its responsibilities. Such Division Rules and Regulations and Policies shall not be inconsistent with these Bylaws and the Rules and Regulations or Policies of the Medical Staff or other policies of the Hospital and shall not conflict with the Governing Board Bylaws.
15.5 Other Related Documents and Policies. The MEC may adopt or amend other related documents and policies that provide associated details to implement more specifically the general principles established in these Bylaws. The process for amending these related documents and policies shall be as follows:

15.5.1 The MEC shall submit proposed amendments to medical staff policies, rules, and other related documents to the Governing Board. However, except as otherwise provided in this Article, before the MEC submits any proposal for adoption or amendment of rules or policies to the Governing Board for approval, the MEC shall disseminate the proposal to the Medical Staff in a reasonable manner, e.g. posting in a newsletter or any method regularly used by the Medical Staff Office to provide notices to members. Voting members shall be given the opportunity to submit written comments through the Medical Staff Office within 15 days.

15.5.2 After considering any comments that have been received within the allotted period, the MEC may modify the proposal and will disseminate any such modifications to the Medical Staff. After the comment period ends, the MEC may either submit the proposal to the Board for approval in its original form or as modified in light of the comments, or reject the proposal and not submit to the Governing Board.

15.5.3 Proposals for new rules or policies or amendments to existing documents or policies may also be submitted to the MEC by any voting member(s) of the Medical Staff, by the Hospital CEO or designee on behalf of Administration, or proposed by the MEC on its own initiative.

15.5.4 A proposal bearing the signatures of 25% or more of the voting members of the Active Medical Staff (which will constitute notice of the proposal to the MEC) must identify two Active Staff members who will serve as representatives and act on behalf of the proposal signers in the process described below (including any conflict management processes).

15.5.4.1 If the MEC supports the proposal as submitted, the proposal will be disseminated to the Medical Staff for comment before the MEC submits the proposal to the Board for approval.

15.5.4.2 If the MEC does not support the proposal, it will notify the designated representatives in writing and they will have 30 days from receipt of the notice to invoke the conflict management process described in Section 14.4 of these Bylaws. If the conflict management process is not invoked within 30 days, it will be deemed waived and the proposal will be deemed withdrawn.

15.5.4.3 If the conflict is not resolved by withdrawal of the proposal, or by MEC support of the proposal as modified in the conflict management process, the proposal will be submitted, either in original form or as modified in the conflict management process, to the Medical Staff for comment before the proposal is submitted to the Governing Board for approval.
15.5.5 With respect to any proposal that does not bear the signatures of 25% of Active Medical Staff members, the MEC may either disseminate the proposal as submitted to the Medical Staff for comment, modify the proposal and disseminate it as modified to the Medical Staff for comment, or reject the proposal and not disseminate it to the Medical Staff for consideration.

15.5.6 Except as otherwise provided in this Article, before the MEC submits any proposal for adoption or amendment of rules or policies to the Governing Board for approval, the MEC shall disseminate the proposal to the Medical Staff in a reasonable manner, e.g. posting in a newsletter or any method regularly used by the Medical Staff Office to provide notices to members. Voting members shall be given the opportunity to submit written comments through the Medical Staff Office within 21 days.

15.5.7 After considering any comments that have been received within the allotted period, the MEC may modify the proposal and will disseminate any such modifications to the Medical Staff.

15.5.8 After the comment period ends, the MEC may either submit the proposal to the Governing Board for approval in its original form or as modified in light of the comments, or reject the proposal and not submit to the Governing Board.

15.5.9 If a proposal is not approved by the Governing Board, the MEC (or the designated representatives of the group of Medical Staff members who submitted a non-MEC supported proposal that went directly to the Governing Board) may invoke the conflict management process as set forth in Section 14 within 30 days of receiving notice that the proposal was not approved by the Governing Board.

15.6 Division Rules & Regulations. Each Medical Staff Division may establish and amend its own Rules and Regulations by the following process:

15.6.1 Proposals for establishing or amending Division-specific rules and regulations or policies shall be submitted to the MEC by the relevant Division chairman following adoption by a majority of the voting members of the Division.

15.6.2 Division-initiated proposals that are acceptable to the MEC as submitted may be adopted by the MEC and submitted to the Governing Board for approval.

15.6.3 A Division-initiated proposal that the MEC proposes to modify or reject shall be disseminated to the relevant Division members only for comment, along with a statement of the MEC’s reasons, before the MEC submits any such proposal to the Governing Board for approval. The Division will have 30 days to submit responsive comments to the MEC in writing and any such Division comments will be submitted to the Governing Board along with the MEC’s proposal.

15.6.4 If the MEC rejects a Division-initiated proposal, the Division chairman (or Division representative chosen by the Division members if the chairman does not support the proposal), may invoke the conflict management process set forth in
Section 14.4 of these Bylaws within 30 days of receiving the notice of the rejection. If the conflict management process is not invoked timely, it will be deemed waived. If the matter is not resolved in the conflict management process, the proposal will be submitted to the Governing Board for approval along with the written comments of the Division and the MEC.

15.6.5 If the Governing Board does not approve a Division-specific proposal, the MEC, Division chairman and/or designated Division representative may invoke the conflict management process set forth in Section 14.4 within 30 days of receiving notice that the Board did not approve the proposal.

15.7 **Urgent Amendments.** Notwithstanding the foregoing, if there is an urgent need to amend the Medical Staff Bylaws, Rules and Regulations or policies, the MEC may adopt the necessary amendment provisionally and submit it to the Governing Board for provisional approval, without prior notification of the Medical Staff. Immediately following the MEC’s adoption and the Governing Board’s provisional approval of such urgent provisional amendment, the MEC will notify the Medical Staff and offer the opportunity for any Medical Staff member to submit written comments to the MEC within 30 days of the notice. The amendment will become effective at the end of the comment period if there is no substantial conflict regarding the provisional amendment (there is no substantial conflict unless at least 51% of the voting members of the Medical Staff express opposition to the amendment in writing). If the comments indicate a substantial conflict over the provisional amendment, the MEC shall implement the conflict management process as set forth in Section 14.4 of these Bylaws and, if necessary, may submit a revised amendment to the Governing Board for approval.

15.8 **Technical Corrections.** Notwithstanding the foregoing, the Medical Executive Committee shall have the authority to adopt non-substantive changes to the Bylaws, Rules & Regulations, and Related Documents when such correction or change is necessary due to spelling, punctuation, grammar, or context. No prior notice of such change is required. Any such amendments shall be communicated in writing to the Governing Board and shall become effective immediately upon Board approval.

15.9 **Approval and Adoption of Amendments.** Neither the Governing Board nor the Medical Staff may unilaterally amend the Bylaws, Rules and Regulations, Related Documents or Policies.

15.10 **Housekeeping.** Revisions to these Bylaws that are considered “housekeeping” type revisions may be made and approved by the Credentials/Bylaws Committee, MEC and the HCB. “Housekeeping” type revisions are considered: spelling/grammar corrections or process type revisions that do not require medical staff input/review/discussion.

15.11 **Communication of Significant Changes.** All significant changes made to the Medical Staff Bylaws, Rules & Regulations, Related Documents, or policies, shall be communicated to the Medical Staff members in a reasonable manner. Communication in accordance with the procedures set forth in these Bylaws shall be deemed to be communication in a reasonable manner.
15.12 **Compatibility of Documents.** Medical Staff Bylaws, rules and regulations and policies, Board bylaws and hospital policies shall be compatible with each other and compliant with state and federal laws and regulations. In the event of a conflict between these Bylaws and the rules and regulations, related documents or policies, the Bylaws shall prevail.
APPROVAL DATES

1. Bylaws - as originally adopted 8/10/82 and subsequently amended to 01/27/98
2. Reapproved: 09/20/83, 09/10/84, 09/17/85, 09/04/86, 09/15/87, 09/20/88, 09/20/89, 09/18/90, 09/22/93, 09/27/94, 01/28/97, 01/27/98, 01/26/99
3. These Bylaws were approved at the July 24, 2001, meeting of the Saint Mary’s Community of Saint Mary’s Regional Medical Center and replace all other prior Medical Staff Bylaws.
5. Amended to January 27, 2009.
7. Approved & Amended by vote 5/23/11 by the Medical Staff: The Bylaws Committee- 6/8/11, MEC 6/21/11, HCB 7/26/11
8. Approved & Amended by vote by the Medical Staff 8/21/14.
9. Approved & Amended by vote by the Medical Staff & Governing Board 9/23/14.

Chief of Staff

Helen Lidholm, CEO