

PMC Medical Staff Bylaws, Rules and Regulations

- (a) detrimental to patient safety or to the delivery of quality patient care within the Hospital;
- (b) unethical;
- (c) contrary to bylaws, rules and regulations of the Medical Staff; or
- (d) below applicable professional standards,

A request for an investigation or action against such Member may be initiated by the Chief of Staff, the Executive Committee, Administrator, or Board of Directors.

8.1.2 Initiation

A request for an investigation shall be in writing, submitted to the Executive Committee, and supported by reference to specific activities or alleged conduct. If the Practitioner is a member of the Pomerado Hospital medical staff, or the Surgery Center medical staff, the request for corrective action shall also be forwarded to the chief of staff of the hospital and/or to the Medical Director of the Surgery Center, for informational purposes. The chief of staff may also forward the request for corrective action, and such other information regarding the investigation as he deems appropriate, to the medical staffs of any other District Facilities if such information has a bearing on the Member's fitness to exercise privileges at such facilities. If the Executive Committee initiates the request, it shall make an appropriate record of the reasons.

8.1.3 Investigation

(a) Single Membership

If the Executive Committee concludes an investigation is warranted, it shall direct an investigation to be undertaken. The Executive Committee may conduct the investigation itself, or may assign the task to an appropriate officer of the Medical Staff, department, or committee of the Medical Staff, standing or ad hoc. If the investigation is delegated to an officer or committee, other than the Executive Committee, such officer or committee shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the Executive Committee as soon as practicable. The individual initiating the complaint shall not serve on the committee investigating the complaint. The report may include recommendations for appropriate corrective action.

(b) The Member shall be notified by certified, return receipt requested mail that an investigation is being conducted and be advised of the nature of the allegations. The Member shall be given an opportunity to provide information in a manner, and upon such terms, as the investigating body deems appropriate. The individual or body investigating the matter may, but is not obligated to, conduct interviews with persons involved; however, such investigation shall not constitute a 'hearing' as that term is used in Article IX, nor shall the procedural rules with respect to hearings or appeals apply.

(c) Despite the status of any investigation the Executive Committee, at all times, shall retain authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension, termination of the investigative process, or other action.

8.1.4 Executive Committee Action

71

PMC Medical Staff Bylaws, Rules and Regulations

As soon as practicable, after the conclusion of the investigation, the Executive Committee shall take action which may include, without limitation:

- (a) determining no corrective action be taken and, if it is determined that there was no credible evidence for the complaint in the first instance, removing any adverse information from the Member's file.
- (b) deferring action for a reasonable time where circumstances warrant.
- (c) issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude department chairmen from issuing informal written or verbal warnings outside of the mechanism for corrective action. In the event such letters are issued, the affected Member may make a written response which shall be placed in the Member's file.
- (d) recommending the imposition of terms of probation or special limitation upon continued membership or exercise of clinical privileges, including, without limitation, requirements for co-admissions, or mandatory consultation.
- (e) recommending reduction, modification, suspension, or revocation of clinical privileges.
- (f) recommending limitations of membership of any prerogatives directly related to the Member's delivery of patient care.
- (g) recommending suspension, revocation, or probation of membership.
- (h) taking other actions deemed appropriate under the circumstances. In all cases involving an investigation of a member of the Surgery Center medical staff, the Executive Committee shall promptly notify the Medical Director of the Surgery Center of any action taken or recommendations made pursuant to this section.

8.1.5 Subsequent Action

The recommendation of the Executive Committee, and the subsequent actions taken on such recommendation, shall be processed in the same manner as applications for membership and request for clinical privileges as described in 5.3.7 through 5.3.14. Notwithstanding the foregoing, should the Board of Directors determine that the Executive committee's failure to investigate, or initiate disciplinary action, is contrary to the weight of the evidence, the Board may direct the Executive Committee to initiate an investigation or a disciplinary action, but only after consultation with the Executive Committee. In the event the Executive Committee fails to take action in response to a directive from the Board of Directors, the Board, after notifying the Executive Committee, in writing, may taken action on its own initiative.

8.2 SUMMARY RESTRICTION OR SUSPENSION

8.2.1 Criteria for Initiation

Whenever a Member's conduct appears to require that immediate action be taken to protect the life or well-being of patients or to reduce a substantial and imminent likelihood of significant impairment of the life, health, safety of any patient, prospective patient, or other person, the Chief of Staff, Executive Committee, Administrator, or Board of Directors may summarily restrict or suspend the membership of clinical privileges of such Member.

Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition, and the person or body responsible for the action shall promptly

PMC Medical Staff Bylaws, Rules and Regulations

give written notice to the Member, the Board of Directors, the Executive Committee, and the Administrator, and where applicable, the Medical Director of the Surgery Center.

The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. A suspension by the Board of Directors or Administrator, which has not been ratified by the Executive Committee within two (2) working days, excluding weekends and holidays, after the suspension, shall automatically terminate. Such summary restriction or suspension by the Board of Directors or Administrator will occur only if the Chief of Staff and members of the Executive Committee are not available to summarily restrict or suspend the member's membership or clinical privileges and then only after the Board of Directors or Administrator has made reasonable attempts to contact the Executive Committee before the suspension.

Unless otherwise indicated by the terms of the summary restriction or suspension, the Member's patients shall be promptly assigned to another Member by the department chairman or by the Chief of Staff, considering, where feasible, the wishes of the patients in the choice of a substitute Member.

8.2.2 Executive Committee Action

As soon as practicable after such summary restriction or suspension has been imposed, a meeting of the Executive Committee shall be convened to review and consider the action. Upon his request, the Member may attend and make a statement concerning the issues under investigation, on such terms and conditions as the Executive Committee may impose although in no event shall any meeting of the Executive Committee, with or without the Member, constitute a 'hearing' as that term is defined in Article IX, nor shall the procedural rules with respect to hearings or appeals apply. The Executive Committee may modify, continue, or terminate the summary restriction or suspension, and recommend any additional corrective action but, in any event, it shall furnish the Member with notice of its decision.

8.2.3 Procedural Rights

Unless the Executive Committee promptly terminates the summary restriction or suspension, the Member shall be entitled to the procedural rights afforded by Article IX.

8.2.4 Notification Procedure

8.2.4.1 Upon receipt of notice that a summary suspension has been imposed at Pomerado Hospital on a Practitioner with membership on this Medical Staff, the Chief of Staff (or, in his absence, the Administrator) shall impose a summary suspension which shall become effective immediately. Summary suspensions may also be imposed upon receipt of notice of summary suspension at another District Facility. Thereupon, the procedure to be followed shall be set forth in 8.2.2

8.2.4.2 If the Practitioner is a member of the medical staff of Pomerado Hospital or any other District Facility, the chief of staff at such facilities shall be notified immediately of the suspension.

8.3 AUTOMATIC SUSPENSION OR LIMITATION

In the following instances, the Member's membership or admitting and clinical privileges may be suspended or limited as described, which action shall be final without a right to hearing or further review, except as provided in Section 8.3.5(a) or where the Executive Committee determines in its sole discretion that a bona fide dispute exists as to whether the circumstances have occurred. To the extent provided in Sections 8.3.1 and 8.3.5(d) and (f), the Member's membership shall also be revoked.

8.3.1 Licensure

73

PMC Medical Staff Bylaws, Rules and Regulations

Revocation and Suspension: Whenever a Member's license or other legal credential authorizing practice in California is revoked, suspended, or expired, membership and clinical privileges shall be automatically revoked as of the date such action becomes effective.

Restriction: Whenever a Member's license or other legal credential authorizing practice in California is limited or restricted by the applicable licensing or certifying authority, any clinical privileges which the Member has been granted at the Hospital, which are within the scope of said limitation or restriction, shall be automatically limited or restricted in a similar manner as of the date such action becomes effective and throughout its term.

Probation: Whenever a Member is placed on probation by the applicable licensing or certifying authority, his membership and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

Neither the provision regarding restriction nor probation shall preclude the commencement of additional corrective action.

8.3.2 Controlled Substances

Whenever a member's DEA certificate is revoked, limited, suspended, or expired, the Member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.

Probation: Whenever a Member's DEA certificate is subject to probation, the Member's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

8.3.3 Failure to Satisfy Special Appearance Requirement

A Member who fails, without good cause, to attend any meeting scheduled to discuss the Member's practice or conduct, shall automatically be suspended from exercising all admitting and clinical privileges, except such clinical privileges as may be deemed necessary by the Executive Committee to maintain continuity of care for patients already admitted by the Member.

8.3.4 Conviction of Felony

A Member convicted of a felony, whether or not appealed, may be a cause for a summary suspension.

8.3.5 Bylaws, Rules and Regulations Violations

Suspension of all admitting and clinical privileges, except such clinical privileges as may be deemed necessary by the Executive Committee to maintain continuity of care for patients already admitted by the Member, shall be imposed by the Chief of Staff, Executive Committee, or Board of Directors for the following bylaws, rules and regulations violations:

- (a) **Record Deficiencies:** Temporary suspension of a Member's admitting and clinical privileges, except as provided above, will be imposed automatically for failure to complete deficient or delinquent medical records within fourteen (14) days after a patient's discharge, unless the Chief of Staff intercedes on his behalf. The Director of Medical Records will notify the Member when a medical record has been found to be incomplete after a patient's discharge. Upon such notice, the Member is permitted seven (7) days in which to complete the delinquent record after which he receives a letter from the Chief of Staff. If delinquent records are not completed within an additional seven (7) days, the Member's admitting and clinical privileges shall, except as provided above, be

PMC Medical Staff Bylaws, Rules and Regulations

suspended by a letter from the Chief of Staff or Executive Committee at the end of the fourteen (14) day period and until the delinquent record is completed by the Member. A copy, for information, will be forwarded to the Administrator and the Director of Medical Records who will call the office of suspended physicians to notify them that the suspension is in effect.

Only in the event there has been a suspension of a Practitioner's privileges pursuant to this Section that requires the filing of a report pursuant to Business and Professions Code Section 805 is the Practitioner entitled to hearing rights as set forth in Article IX. In all other instances, no procedural rights are available for Practitioners whose privileges are suspended due to incomplete medical records.

- (b) Meeting Attendance: Failure to attend required meetings of the Medical Staff, department, and committees shall be grounds for corrective action as described in 15.7.1.
- (c) Failure to Provide Emergency Department Consultation: A Member who refuses to provide required Emergency Department consultative services shall have his admitting and clinical privileges suspended, except as provided above. Emergency Department consultative services shall not apply or encompass the participation by any Member on a separate trauma services consultation panel, which in all events shall be voluntary; provided, however, a Member may be disciplined for failure to respond, treat, consult, or follow designated trauma patients, if the Member has volunteered for the trauma services consultation panel.
- (d) Professional Liability Coverage: The admitting and clinical privileges of any Member who fails to provide documentation of professional liability coverage shall be automatically suspended. A failure to provide such documentation within three (3) months after the date this suspension becomes effective shall be deemed to be a voluntary resignation of membership.
- (e) Tuberculin Testing Documentation: The admitting and clinical privileges of any Member who fails to provide documentation of Tuberculin Testing in accordance with the Medical Staff Policy entitled "Procedure for Tuberculin Testing for Medical Staff Members" shall be automatically suspended. Failure to provide such documentation within three (3) months after the date this suspension becomes effective shall be deemed to be a voluntary resignation of membership.
- (f) Dues: Any Member required to pay dues, who fails to pay such dues as required by Article XV or XVII, after written warning of delinquency, shall have his admitting and clinical privileges, except as provided above, suspended and shall remain so suspended until Member pays the delinquent dues. A failure to pay such dues in three (3) months after the date this suspension becomes effective shall be deemed to be a voluntary resignation of membership.

8.3.6

Exclusion from Federal Healthcare Programs

Whenever a Member is excluded from participation in federal healthcare programs by the Office of the Inspector General (OIG) or the Government Services Administration (GSA), membership and clinical privileges shall be automatically suspended as of the date such exclusion becomes effective. The Member's membership and clinical privileges may be reinstated within the same reappointment period upon proof that the exclusion has ended.

8.3.7

Notification Procedure

75

PMC Medical Staff Bylaws, Rules and Regulations

8.3.7.1 An automatic suspension, in place for seven (7) days or more, imposed at Pomerado Hospital or at the Surgery Center for a medical records deficiency on a Practitioner with membership on this Medical Staff may result in an automatic suspension which shall become effective immediately upon notification to the Chief of Staff of Pomerado Hospital's or the Surgery Center's action. Thereupon, the procedure to be followed shall be as set forth in these bylaws as if the medical records deficiency occurred at the Hospital.

8.3.7.2 If the Practitioner is a member of Pomerado Hospital's medical staff, the chief of staff at that hospital shall be notified, on the seventh day after the suspension has been imposed, of the suspension.

8.3.8 Continuity of Care

In the event the terms of any of the occurrences specified in Sections 8.3.1 and 8.3.2 preclude a Member from continuing to provide necessary care to a patient already admitted, or if the Chief of Staff or Executive Committee determines it is appropriate to transfer the care of patients already admitted by the Member to another Member, such patients shall be promptly assigned to another Member by the department chairman or Chief of Staff, considering, where feasible, the wishes of the patient in the choice of a substitute Member.

**Article IX
Hearing and Appellate Review**

9.1 DEFINITIONS

In addition to those definitions herein above set forth, the following definitions shall apply under this article:

DAYS refers to calendar Days for purposes of determining periods of time.

NOTICE refers to a written communication sent by certified, return receipt requested mail. Personal service shall also constitute Notice.

PERSON WHO REQUESTED THE HEARING refers to the applicant or Member, as the case may be, who has requested a hearing pursuant to 9.2.

MEDICAL DISCIPLINARY CAUSE OR REASON means that aspect of a Practitioner's competence or conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care.

9.2 REQUEST FOR HEARING

9.2.1 Notice of Decision

In all cases in which the Executive Committee has taken any of the actions constituting grounds for hearing as hereinafter set forth in 9.2.2, the applicant or Member, as the case may be, shall promptly be given Notice, including Notice that the action, if adopted by the Board of Directors shall be taken and reported pursuant to Business and Professions Code Section 805, if applicable, and Notice of his right to request a hearing pursuant to this Section.

Such applicant or Member shall have fifteen (15) Days following the date of receipt of such Notice within which to request a hearing by the Judicial Review Committee hereinafter referenced. The request shall be by written Notice to the Executive Committee via the Chief of Staff. In the event the applicant or Member does not request a hearing within the time and in the manner hereinabove set forth, he shall be deemed to have accepted the action involved and to have waived his rights to a hearing or appeal. If the applicant or Member does not request a hearing, the recommendation of

76

PMC Medical Staff Bylaws, Rules and Regulations

the Executive Committee shall be forwarded to the Board of Directors.

9.2.2 Grounds for Hearing

Any one or more of the following actions shall constitute grounds for a hearing, if taken for a medical disciplinary cause or reason:

- (a) denial of membership
- (b) denial of requested advancement in membership
- (c) denial of reappointment
- (d) demotion to lower category
- (e) suspension of membership
- (f) expulsion from membership
- (g) denial of requested privileges
- (h) reduction in privileges
- (i) suspension of privileges
- (j) termination of privileges
- (k) requirement of consultation or co-admitting.

9.2.3 Time and Place for Hearing

Upon receipt of a written request for hearing, the Judicial Review Committee, or its chairman, shall schedule and arrange for a hearing. The Judicial Review Committee shall give Notice to the applicant or Member of the time, place and date of the hearing. The date of the commencement of the hearing shall be not less than fifteen (15) Days, nor more than forty-five (45) Days from the date of receipt of the request by the Chief of Staff for a hearing; provided, however, that when the request is received from a Member who is under suspension which is then in effect, the hearing shall be held as soon as the arrangements may reasonably be made, but not to exceed fifteen (15) Days from the date of receipt of the request for hearing by the Chief of Staff.

9.2.4 Notice of Charges

- (a) The Executive Committee shall state in writing, in concise language, the acts or omissions with which the Member is charged, a list of charts under question, by chart number, or the reasons for the denial of the request of the applicant or Member. The Notice, where applicable, shall specify the acts or omissions and charts pertaining to the Surgery Center, as well as the reasons for any denial of a request pertaining to the Surgery Center. The Notice of charges shall accompany the Notice of hearing and, where applicable, shall be promptly provided to the Medical Director of the Surgery Center. If either party, by Notice, requests a list of witnesses, then each party, within a reasonable time of such request, shall furnish to the other a list, in writing, of the names and addresses of the individuals, so far as is then reasonably known, who will give testimony in support of that party at the hearing. Additionally, at the request of either party, the other party shall provide copies of all documents expected to be produced by that party. Failure to disclose the identity of a witness or produce copies of all documents expected to be introduced at least ten (10) days before the commencement of the hearing shall constitute good cause for a continuance.

The Person Who Requested the Hearing shall have the right to inspect and copy at his expense any documentary information relevant to the charges which the Executive Committee has in its possession or under its control, as soon as practicable after the receipt of the request for a hearing. The Executive Committee shall have the right to inspect and copy at its expense any documentary information relevant to the charges

PMC Medical Staff Bylaws, Rules and Regulations

which the Person Who Requested the Hearing has in his possession or control as soon as practicable after receipt of the Executive Committee's request. The failure by either party to provide access to this information at least 30 days before the hearing shall constitute good cause for a continuance. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable members or applicants, other than the person requesting the hearing. In order to ensure a fair and expeditious hearing, all requests for discovery of this information shall be received no later than forty (40) days before the hearing, except in the case of a summary suspension or when determined impracticable by the hearing officer. The hearing officer shall consider and rule upon any request for access to information, and may impose any safeguards the protection of the peer review process and justice requires.

- (b) When ruling upon a request for access to information and determining the relevancy thereof, the hearing officer shall, among other factors, consider the following:
- (1) Whether the information sought may be introduced to support or defend the charges.
 - (2) The exculpatory or inculpatory nature of the information sought, if any.
 - (3) The burden imposed on the party in possession of the information sought, if access is granted.
 - (4) Any previous request for access to information submitted or resisted by the parties to the same proceeding.

9.2.5 Judicial Review Committee

9.2.5.1 Single Hearing:

When a hearing is requested, the Chief of Staff shall appoint a Judicial Review Committee which shall be composed of not less than five (5) Members of the staff.

The Judicial Review Committee shall be composed of individuals who shall gain no direct benefit from the outcome of the hearing, who have not acted as accusers, investigators, fact finders or initial decision makers in the matter at any previous level, and shall include, where feasible, an individual practicing the same specialty as the Person Who Requested the Hearing. Such appointment shall include designation of the chairman. Knowledge of the matter involved shall not preclude a Member from serving as a member of the Judicial Review Committee. The Chief of Staff may appoint qualified persons from any of the membership divisions or categories, or from outside the staff, if necessary.

9.2.5.2 Joint Hearing:

- (a) If the hearing results from similar recommendations of the Executive Committee and executive committee of Pomerado Hospital, the hearing will be conducted as set forth in this paragraph.
- (b) The joint Judicial Review Committee shall consist of an equal number of Members from Pomerado Hospital and Palomar Medical Center except when it is necessary to appoint individual(s) from outside the staff as provided in section 9.2.5.1. However, an additional Practitioner, who shall serve as Chairman of the Judicial Review Committee, shall be

PMC Medical Staff Bylaws, Rules and Regulations

appointed by the initiating medical staff.

- (c) The decision of the Judicial Review Committee shall be delivered in accordance with 9.2.8 provided, however, each executive committee shall be furnished with a copy of the recommendation and report including, without disclosing the representatives identifies, how the representatives from this Hospital voted.

9.2.6 Failure to Appear or Proceed

Failure without good cause of the Person Requesting the Hearing to appear personally and proceed at such a hearing in an efficient, orderly and expeditious manner, shall be deemed to constitute voluntary acceptance of the recommendations or actions involved and a waiver of the right to appeal.

9.2.7 Continuances

Continuances shall be granted upon agreement of the parties or by the hearing officer on a showing of good cause.

9.2.8 Decision of the Judicial Review Committee

Within fifteen (15) Days after the hearing is closed (provided that in the event the Member is currently under suspension, this time shall be seven (7) Days) the Judicial Review Committee shall render a decision which shall be accompanied by a report in writing which shall be forwarded to the Executive Committee and to the Medical Director of the Surgery Center. The report shall contain a concise statement of the reasons justifying the decision made and, where applicable, shall include a specific statement of decision and the reasons justifying it as to the applicant's or member's application or actions at the Surgery Center. At the same time, a copy of the report and decision, and an explanation of the procedure for appealing the decision, shall be delivered to the Person Who Requested the Hearing by certified, return receipt requested mail and to the Medical Director of the Surgery Center.

9.2.9 Board of Directors' Decision

If neither the Person Who Requested the Hearing nor the Executive Committee appeals the decision of the Judicial Review Committee in the manner specified in section 9.5, the Board of Directors shall render a decision after receiving the decision of the Judicial Review Committee. The Board of Directors shall make its decision within fifteen (15) Days after the time to appeal expires unless the Board of Directors refers the matter back to the Judicial Review Committee for further review and recommendation in accordance with instructions given by the Board of Directors. This further review process and report back to the Board of Directors shall, in no event, exceed thirty (30) Days after the time to appeal expired. The Board of Directors shall deliver copies of the decision to the Person Who Requested the Hearing and to the Executive Committee and, when applicable, to the Medical Director of the Surgery Center in person or by certified or registered, return receipt mail. The Board of Directors may affirm, modify, or reverse the decision of the Judicial Review Committee. The decision of the Board of Directors shall be final and effective immediately.

9.3 HEARING PROCEDURES

9.3.1 Personal Presence Mandatory

Under no circumstances shall the Judicial Review Committee hearing be conducted without the personal presence of the Person Requesting the Hearing unless he has waived such appearance or has failed without good cause to appear after appropriate Notice.

9.3.2 Representation

The Judicial Review Committee hearing is for the purpose of interprofessional resolution of

PMC Medical Staff Bylaws, Rules and Regulations

matters bearing on conduct or professional competency. Accordingly, neither the Person Requesting the Judicial Review Committee hearing nor the Executive Committee shall be represented at the hearing by an attorney unless the Judicial Review Committee in its discretion, permits both sides to be represented by legal counsel. The Person Requesting the Hearing shall be entitled to be accompanied by and represented at the hearing by a Physician or a Practitioner in the same profession as the Person Requesting the Hearing, licensed to practice in the State of California, who is not a lawyer and who, preferably, is a Member in good standing. The Executive Committee shall appoint a representative from the medical staff to present its recommendation in support thereof and to examine witnesses.

9.3.3 Presiding Officer

The presiding officer at the hearing shall be the hearing officer. The presiding officer shall act to ensure that all participants in the hearing have a reasonable opportunity to be heard, to present all oral testimony and documentary evidence, and that decorum is maintained. He shall be entitled to determine the order of procedure during the hearing. He shall have the authority and discretion, in accordance with these bylaws, to make all rulings on questions which pertain to matters of law and to admissibility of evidence.

9.3.4 Hearing Officer

At the request of the Executive Committee or the Judicial Review Committee, the Board of Directors, the Administrator or his designee may appoint a hearing officer who may be an attorney to preside at the hearing. An attorney regularly utilized by the Hospital or the District for legal advice regarding its affairs and activities shall not be eligible to serve as hearing officer. The hearing officer shall gain no direct financial benefit from the outcome of the hearing. The hearing officer may not participate in the deliberation of such body, but may be a legal advisor if requested by the Judicial Review Committee as to procedural and evidentiary matters, but he shall not be entitled to vote.

9.3.5 Record of Hearing

A record of the Judicial Review Committee hearing shall be made by shorthand reporter or recording device. One-half (1/2) the cost of the reporter and original transcript shall be borne by the Person Requesting the Hearing and one-half (1/2) such cost shall be borne by the Hospital. All witnesses at the hearing shall be sworn by the reporter. The hearing shall be held in closed session. The hearing is an official proceeding within the meaning of Civil Code Section 46(2).

9.3.6 Rights of Both Sides

At a hearing, both sides shall have the following rights:

- (a) to ask the Judicial Review Committee members and the hearing officer questions which are directly related to determining whether they are impermissibly biased and to challenge their impartiality.
- (b) to call and examine witnesses, to introduce exhibits,
- (c) to cross-examine any witness on any matter relevant to the issues,
- (d) to impeach any witness.
- (e) to rebut any evidence.
- (f) to be provided with all information made available to the Judicial Review Committee, and
- (g) to submit a written statement at the close of the hearing.

PMC Medical Staff Bylaws, Rules and Regulations

If the Person Requesting the Hearing does not testify in his own behalf, he may be called and examined as if under cross-examination. Any challenge directed at one or more members of the Committee or hearing officer shall be ruled on by the hearing officer prior to continuation of the hearing.

9.3.7

Admissibility of Evidence

The hearing shall not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant evidence shall be admitted by the presiding officer if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Each party shall have the right to submit a memorandum of points and authorities and the Judicial Review Committee may request such a memorandum to be filed following the close of the hearing.

The Judicial Review Committee may interrogate witnesses or call additional witnesses if it deems it appropriate.

9.3.8

Judicial Notice

The Judicial Review Committee shall have the discretion to take judicial notice of any matters either technical or scientific, relating to the issues under consideration which could have been judicially noticed by the courts of California. Participants in the hearing shall be informed of the matters to be judicially noticed and they shall be noted in the record of the hearing. The Person Requesting the Hearing shall have the opportunity to request that a matter be judicially noticed or to refute the noticed matters by evidence or by written or oral presentation of authority. Reasonable or additional time shall be granted, if requested, to present written rebuttal of any evidence admitted on judicial notice.

9.3.9

Basis of Decision

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

- (a) oral testimony of witnesses;
- (b) briefs, or memorandum of points and authorities presented in connection with the hearings;
- (c) any material contained in the credential file of the Person Who Requested the Hearing;
- (d) any and all applications, references and accompanying documents;
- (e) all judicially noticed matters;
- (f) any other evidence deemed admissible under 9.3.7.

9.3.10

Burden of Proof

The Executive Committee shall have the initial duty to present evidence which supports the charge or recommended action.

When the hearing involves an initial applicant and his medical staff membership, the applicant shall bear the burden of persuading the Judicial Review Committee by preponderance of the evidence of his qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning his current qualifications for staff privileges, membership or employment. Initial applicants shall not be permitted to introduce information not

PMC Medical Staff Bylaws, Rules and Regulations

produced upon request of the Executive Committee during the application process, unless the initial applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

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

9.3.11 Adjournment and Conclusion

The presiding officer may adjourn the hearing and reconvene the same at the convenience of the participants without special Notice. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Judicial Review Committee shall thereupon, within the time specified in 9.2.7, outside of the presence of any other person, conduct its deliberations and render a decision and accompanying report as provided in 9.2.7.

9.4 SPECIFIC DETERMINATION

The Judicial Review Committee shall have the right to make an express finding that a Member's conduct poses an immediate risk to patients and/or staff and with respect to any Member whose appeal is based on any ground other than the suspension or termination of privileges. It shall have the right to recommend the suspension or termination of the Member's privileges, which suspension or termination shall be and remain in full force and effect irrespective of such Member's election to pursue the right of appeal as described in 9.5.

9.5 APPEAL TO BOARD OF DIRECTORS

9.5.1 Time for Appeal

The Judicial Review Committee's decision shall be final, subject to the right of appeal by either the Person Who Requested the Hearing or the Executive Committee. Such appeal should be made in writing within ten (10) days after receipt of the recommendation of the Judicial Review Committee. A request for appellate review to the Board of Directors shall be made in writing either in person or by certified mail, return receipt requested, to the Chief of Staff, Hospital Administrator and the other party to the hearing. Where the Practitioner is a member of the Surgery Center medical staff, the Chief of Staff shall provide a copy of the request to the Medical Director of the Surgery Center. If appellate review is not requested within such period, both parties shall be deemed to have accepted the action involved and to have waived their right to appeal. The written request for appeal shall also include a brief statement as to the reasons for appeal, which shall include one of the grounds for appeal specified in section 9.5.2.

9.5.2 Grounds for Appeal

The grounds for appeal shall be:

- (a) substantial failure of the Judicial Review Committee, Executive Committee, or Board of Directors to comply with the procedures required by this article in the conduct of the hearing so as to deny due process and a fair hearing;
- (b) action taken arbitrarily, capriciously or without substantial evidence of support.

9.5.3 Time, Place and Notice

In the event of any appeal to the Board of Directors as set forth in the preceding subsection, the Board of Directors shall schedule and arrange for an appellate review. The Board of Directors shall cause the applicant or Member to be given Notice of the time, place and date of the appellate review. The date of the appellate review shall not be less than fifteen (15) Days nor more than

PMC Medical Staff Bylaws, Rules and Regulations

forty-five (45) Days from the date of receipt of the request for appellate review; provided, however, that when a request for appellate review is from a Member who is under suspension which is then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made and not to exceed twenty (20) Days from the date of receipt of the request for appellate review. The time for appellate review may be extended by the Chairman of the Board of Directors or the hearing officer for good cause.

9.5.4 Hearing Officer

The appellate review may be conducted by a committee of the Board of Directors, the Board of Directors or by a hearing officer designated by the Board of Directors. Any hearing officer designated by the Board of Directors shall be an attorney admitted to practice law in California for at least ten (10) years prior to the hearing. Such attorney shall not be an attorney who regularly provides services to the District, the Hospital or the Medical Staff.

9.5.5 Nature of Appellate Review

The proceedings shall be in the nature of an appellate hearing based upon the record of hearing before the Judicial Review Committee, provided that the Board of Directors, committee of the Board of Directors, or hearing officer may, in its or his discretion, accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Judicial Review Committee hearing. Each party shall have the right to present a written statement in support of his position on appeal, the right to personally appear and make oral argument and respond, and the right to be represented by an attorney or other representative designated by the party. The Board of Directors may limit any such oral argument as to time and issue. At the conclusion of oral argument, the Board of Directors or committee of the Board of Directors may thereupon, at the time convenient to itself, conduct deliberations in closed session outside the presence of the appellant and respondent and their representatives. If a committee or hearing officer was appointed, it or he shall conduct the appellate review hearing and shall make recommended findings, conclusions and a decision which may be adopted, modified or rejected by the Board of Directors. The Board of Directors may affirm, modify, or reverse the decision of the Judicial Review Committee, or, in its discretion, refer the matter for further review and recommendation.

9.5.6 Decision

If the appellate review hearing is conducted by a committee or hearing officer, it or his recommended findings, conclusions, and decision shall be rendered within fifteen (15) Days after the conclusion of the appellate review hearing. Within fifteen (15) Days after receipt of the hearing officer's recommendation, or within fifteen (15) Days after the conclusion of the appellate review hearing by the Board of Directors, the Board of Directors shall render a decision in writing and shall deliver copies thereof to the applicant or Member and to the Executive Committee and, where appropriate, to the Medical Director of the Surgery Center in person or by certified or registered, return receipt requested mail. Where applicable, the recommended findings, conclusions, and decision shall be set forth separately as to Palomar Medical Center and the Surgery Center.

9.5.7 Further Review

Except where the matter is referred for further review and recommendation, the decision of the Board of Directors, following the appeal procedure, shall be final and effective immediately. Provided, however, if the matter is referred back to the Judicial Review Committee for further review and recommendation, the committee shall promptly conduct its review and make its recommendations to the Board of Directors in accordance with the instructions given by the Board of Directors. This further review process and the report back to the Board of Directors shall, in no event, exceed thirty (30) Days duration except as the parties may otherwise stipulate.

PMC Medical Staff Bylaws, Rules and Regulations

9.5.8 Right to One Hearing Only

Except as otherwise provided in this article, no applicant or member shall be entitled as a matter of right to more than one appellate review hearing on any single matter which may be the subject of an appeal without regard to whether such subject is the result of action by the Executive Committee or the Board of Directors, or a combination of acts of such bodies.

9.5.9 Contract Physician

Physicians, dentists and podiatrists under contract with the Hospital in a medical-administrative capacity or in closed departments shall be subject to the procedural rights specified in Article IX only:

- (a) to the extent that any contract modifications, or termination or restrictions of staff status or clinical privileges proposed by the Hospital, are expressly based on a recommendation by the Executive Committee resulting from that aspect of a Practitioner's competence or conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care, or
- (b) to the extent that the Physician, dentist or podiatrist's medical staff membership or clinical privileges, which would otherwise exist independent of the contract, are to be limited or terminated because of that aspect of Practitioner's competence or conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care.

Except as provided above, termination or alteration of a contract held between the Hospital or District and Physician will be considered an administrative matter and termination or alteration of a contract will not be grounds for any of the procedures in Article IX.

9.5.10 Exhaustion of Remedies

If adverse action, as described herein, is taken or recommended, the applicant or Member must exhaust the remedies afforded by the terms of these bylaws before resorting to legal action.

**Article X
Officers**

10.1 OFFICERS OF THE MEDICAL STAFF

10.1.1 Identification

The officers of the Medical Staff shall be the Chief of Staff, Chief of Staff Elect, Immediate Past Chief of Staff, Secretary-Treasurer, and the Hospital Medical Staff Section Representative.

10.1.2 Qualifications

Officers shall be of the active category of the Medical Staff at the time of their nominations and election and shall remain Members in good standing during their term of office. Failure to maintain such status shall create a vacancy in the office involved.

10.1.3 Nominations

Elections shall be held every third Medical Staff Year. The Nominating Committee shall fulfill its obligations specified in 11.6.

Further nominations may be made for any office by any voting Member, provided that the name of the candidate is submitted in writing to the chairman of the Nominating Committee, is endorsed by the signature of at least ten (10) other voting Members, and bears the candidate's written consent. These nominations shall be delivered to the chairman of the Nominating Committee as soon as

PMC Medical Staff Bylaws, Rules and Regulations

reasonably practicable, but at least twenty (20) days prior to the date of election. If any nominations are made in this manner, the voting Members shall be advised by notice, delivered or mailed, at least ten (10) days prior to the meeting.

10.1.4 Elections

The Chief of Staff Elect, Secretary-Treasurer, and Hospital Medical Staff Section Representative, shall be elected at the annual meeting of the Medical Staff every third Medical Staff Year. Voting shall be by acclamation if there is only one (1) candidate for each position. If more than one (1) candidate is running for a position, written mail ballot shall be undertaken. Written ballot shall include handwritten signatures on the envelope for comparison with signatures on file when necessary. A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate for the office receives a majority vote on the first ballot, a runoff election shall be held promptly between the two (2) candidates receiving the highest number of votes. In the case of a tie on the second ballot, the majority vote of the Executive Committee shall decide the election by secret written ballot at its next meeting or a special meeting called for that purpose.

10.1.5 Terms of Elected Office

Each officer shall serve a three (3) year term, commencing on the first day of the staff year following his election. Each officer shall serve in each office until the end of his term, or until a successor is elected, unless he shall sooner resign or be removed from office.

At the end of his term, the Chief of Staff shall automatically assume the office of Immediate Past Chief of Staff and the Chief of Staff-Elect shall automatically assume the office of Chief of Staff.

10.1.6 Recall of Officers

Any medical staff officer may be removed from office for valid cause, including, but not limited to, gross neglect or misfeasance in office, or serious acts of moral turpitude. Except as otherwise provided, recall of an officer may be initiated by the Executive Committee or shall be initiated by a petition signed by at least one-fourth (1/4) of the eligible voting Members. Recall shall be considered at a special meeting called for that purpose. Recall shall require a fifty-one percent (51%) vote of the voting Members who actually cast votes at the special meeting in person or by mail ballot.

10.1.7 Vacancies in Elected Office

Vacancies in office occur upon the death or disability, resignation, or removal of the officer or such officer's loss of membership. Vacancies, other than that of Chief of Staff, shall be filled by appointment by the Executive Committee until the next regular election. If there is a vacancy in the office of Chief of Staff, the Chief of Staff Elect serves out the remaining term and shall immediately request a meeting of the Nominating Committee to decide promptly upon nominees for the office of Chief of Staff Elect. Such nominees shall be reported to the Executive Committee and to the Medical Staff. A special election to fill the position shall occur at the next regular staff meeting. If there is a vacancy in the office of Chief of Staff Elect, that office need not be filled by election, but the Executive Committee shall appoint an interim officer to fill this office until the next regular election, at which time the election shall also include the office of Chief of Staff.

10.2 DUTIES OF OFFICERS

10.2.1 Chief of Staff

The Chief of Staff shall serve as the chief officer of the Medical Staff. The duties of the Chief of Staff shall include, but not be limited to:

- (a) enforcing the bylaws, rules and regulations of the Medical Staff implementing sanctions where indicated, and promoting compliance with procedural safeguards

PMC Medical Staff Bylaws, Rules and Regulations

where corrective action has been requested or initiated.

- (b) calling, presiding at, and being responsible for the agenda of all meetings of the Medical Staff.
- (c) serving as chairman of the Executive Committee and serving as a member of the Joint Conference Committee.
- (d) serving as a nonvoting member of all other committees of the Medical Staff unless his membership in a particular committee is required by these bylaws.
- (e) interacting with the Administrator and Board of Directors in all matters of mutual concern within the Hospital.
- (f) appointing members for all standing and special liaison, multidisciplinary, or Medical Staff committees, except where otherwise provided by these bylaws and, except where otherwise indicated, designating the chairmen of these committees.
- (g) representing the views and policies of the Medical Staff to the Board of Directors and to the Administrator.
- (h) being a spokesman for the Medical Staff in external professional and public relations.
- (i) serving on liaison committees with the Board of Directors and administration as well as outside licensing or accreditation agencies.
- (j) certifying to the Board that applicants recommended by the Executive Committee for appointment, advancement or reappointment to the Medical Staff, or to receive authorization to provide patient care services as specified professional personnel, have satisfied all requirements specified by the Medical Staff and the Board.
- (k) performing such other functions as may be assigned to him by these bylaws, the Medical Staff or by the Executive Committee.

10.2.2. Chief of Staff Elect

The Chief of Staff Elect shall assume all duties and authority of the Chief of Staff in the absence of the Chief of Staff. The Chief of Staff Elect shall be a member of the Executive Committee, the Joint Conference Committee, Credentials Committee and Nominating Committee. He shall chair the Bylaws Committee, shall be a non-voting member of the Quality Management Committee and shall perform such other duties as the Chief of Staff may assign, or as may be delegated by these bylaws or by the Executive Committee.

10.2.3 Immediate Past Chief of Staff

The Immediate Past Chief of Staff's role shall be advisory in nature. He shall be a member of the Executive Committee, the Bylaws Committee, the Credentials Committee and the Nominating Committee and shall perform such other duties as may be assigned by the Chief of Staff or delegated by these bylaws or by the Executive Committee.

10.2.4 Secretary-Treasurer

The Secretary-Treasurer shall be a member of the Executive Committee and shall:

PMC Medical Staff Bylaws, Rules and Regulations

- (a) attend meetings of the Medical Staff and Executive Committee and cause minutes to be maintained.
- (b) be custodian of all records and papers belonging to the Medical Staff.
- (c) supervise the addition of any amendments to the bylaws, rules and regulations.
- (d) cause to be collected all dues and assessments, make payments, and generally manage the fiscal affairs of the Medical Staff.

10.2.5 Hospital Medical Staff Section Representative
The Hospital Medical Staff Section Representative shall:

- (a) be a member of the American Medical Association, the California Medical Association, and San Diego County Medical Association.
- (b) attend meetings of the Executive Committee.
- (c) serve as the representative to the Medical Staff section of the American Medical Association, California Medical Association and San Diego County Medical Association.
- (d) make a report to the Executive Committee after attending meetings of the hospital medical staff sections of the American Medical Association, California Medical Association and San Diego County Medical Association.

10.2.6 Chain of Command

- (a) Chief of Staff
- (b) Chief of Staff Elect
- (c) Immediate Past Chief of Staff
- (d) chairman, department of Surgery
- (e) chairman, department of Medicine
- (f) chairman, department of OB/GYN
- (g) chairman, department of Pediatrics

**Article XI
Committees**

11.1 DESIGNATION

The committees described in this article shall be the standing committees of the Medical Staff. Special or ad hoc committees may be created by the Executive Committee to perform specified tasks. Unless otherwise specified, the chairman and members of all committees shall be appointed by and may be removed by the Chief of Staff, subject to consultation with and approval by the Executive Committee. Committees of the Medical Staff shall be responsible to the Executive Committee.

11.2 GENERAL PROVISIONS

11.2.1 Terms

Unless otherwise specified, committee members shall be appointed for a term of one (1) year and shall serve until the end of this period or until the member's successor is appointed, unless the

87

PMC Medical Staff Bylaws, Rules and Regulations

member shall be removed from the committee. Service on a committee to which a Member is appointed is mandatory for fifty percent (50%) of the meetings if so specified and can only be excused by either the Executive Committee or Chief of Staff: Executive Committee, Credentials Committee, Quality Assessment & Improvement Committee, Critical Care Committee, and Investigational Review Committee.

11.2.2 Removal

If a member of a committee ceases to be a Member in good standing, or loses a contract relationship with the Hospital, suffers a loss or significant limitation of practice privileges, or if any other good cause exists, that member may be removed by the Executive Committee.

11.2.3 Vacancies

Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to such a committee is made; provided however, that if an individual who obtains membership by virtue of these bylaws is removed for cause, a successor may be selected by the Chief of Staff.

11.3 EXECUTIVE COMMITTEE

11.3.1 Composition

The Executive Committee shall consist of the following individuals:

- (a) officers of the Medical Staff.
- (b) department chairmen.
- (c) quality management chairman.
- (d) credentials committee chairman
- (e) representatives of administration which may include the Chief Executive Officer of the District, the Administrator/Chief Operating Officer, the Assistant Administrator(s) for Nursing Services, and the Vice President for Medical Affairs. These members shall serve as nonvoting members and may not attend executive sessions of this committee, unless requested by the Chief of Staff with approval of the Executive Committee.
- (f) the Medical Director of the Surgery Center.
- (g) the Medical Director of the Trauma Program as a non-voting member.

11.3.2 Duties

The duties of the Executive Committee shall include, but not be limited to:

- (a) representing and acting on behalf of the Medical Staff in the intervals between meetings of the Medical Staff, subject to such limitations as may be imposed by these bylaws.
- (b) coordinating and implementing the professional and organizational activities and policies of the Medical Staff.
- (c) receiving and acting upon reports and recommendations from departments, committees and assigned activity groups of the Medical Staff.

PMC Medical Staff Bylaws, Rules and Regulations

- (d) recommending action to the Board of Directors on matters of a medical-administrative nature.
- (e) establishing the structure of the Medical Staff, the mechanism to review credentials and delineate individual clinical privileges, the organization of quality assurance activities and mechanisms of the Medical Staff, termination of membership and fair hearing procedures, as well as other matters relevant to the operation of an organized Medical Staff, including a cooperative working relationship with other District Facilities, as to each of these obligations.
- (f) evaluating the medical care rendered to patients in the Hospital.
- (g) participating in the development of policies, practices, and planning of the Medical Staff and Hospital.
- (h) reviewing the qualifications, credentials, performance and professional competence and character of applicants and Members.
- (i) taking reasonable steps to promote ethical conduct and competent clinical performance on the part of the Members including the initiation of and participation in corrective or review measures when warranted.
- (j) designating such committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the Medical Staff and approving or rejecting appointments to those committees by the Chief of Staff.
- (k) reporting to the Medical Staff at meetings of the Medical Staff.
- (l) assisting in the obtaining and maintaining of accreditation.
- (m) developing and maintaining methods for the protection and care of patients and others in the event of internal or external disaster.
- (n) appointing such special or ad hoc committees as may seem necessary or appropriate to assist the Executive Committee in carrying out its functions and those of the Medical Staff.
- (o) reviewing the quality and appropriateness of services provided by contract Physicians.
- (p) making Medical Staff recommendations to the Board of Directors for its approval, pertaining to at least the following:
 - (1) the Medical Staff's structure
 - (2) the mechanism used to review credentials and to delineate individual clinical privileges.
 - (3) appointment and reappointment of Medical Staff members, and restricting, reducing, suspending, terminating and revoking Medical Staff membership.
 - (4) granting, modifying, restricting, reducing, suspending, terminating and revoking clinical privileges, and assignments to departments.
 - (5) the participation of the Medical Staff in organization performance improvement activities.

PMC Medical Staff Bylaws, Rules and Regulations

- (6) the mechanism by which Medical Staff membership may be terminated.
- (7) the mechanism for fair hearing procedures.

11.3.3 Meetings

The Executive Committee shall meet as often as necessary (usually monthly) and shall maintain a record of its proceedings and actions.

11.4 CREDENTIALS COMMITTEE

11.4.1 Composition

The Credentials Committee shall consist of a chairman appointed by the Chief of Staff, the Immediate Past Chief of Staff, the Chief of Staff-Elect, the Chief of Staff, the Chief Medical Quality Officer as a non-voting member and a representative from the Medical Advisory Committee of the Surgery Center. Department chairmen, if they so desire, may be invited and may participate as members of the Credentials Committee from time to time.

11.4.2 Duties

The Credentials Committee shall:

- (a) review and evaluate the credentials of all applicants to the Medical Staff and Allied Health Professional staff after receiving applications.
- (b) submit timely recommendations to the Executive Committee and/or departments.
- (c) investigate, review, and report on matters referred by the Chief of Staff, the Executive Committee, or departments regarding conduct, professional character, or competence of any applicant.
- (d) charge the creation of an Interdisciplinary Practice Committee, when necessary, to perform functions consistent with the requirements of law and regulation and to receive reports from same.

11.4.3 Meetings

The Credentials Committee shall meet as often as necessary (usually quarterly). It shall maintain a record of its proceedings and report its activities and recommendations to the Executive Committee.

11.5 NOMINATING COMMITTEE

11.5.1 Composition

Every third Medical Staff Year, the Nominating Committee shall consist of the Chief of Staff, Chief of Staff-Elect, and one (1) representative from the departments of surgery, medicine, pediatrics, OB/GYN, anesthesia, emergency medicine, radiology, pathology, family practice, orthopaedics/rehab and trauma. The Chief of Staff shall be the chairman of the committee.

11.5.2 Duties

The Nominating Committee shall meet at the direction of the Chief of Staff to select nominees for consideration of the Medical Staff as its officers for the next year. The Nominating Committee shall nominate one or more nominees for each office except for Chief of Staff who automatically succeeds to that office (10.1.5).

11.5.3 Meetings

The Nominating Committee shall meet and report to the Executive Committee at least forty-five (45) days prior to the annual meeting, and notice of its nominees shall be delivered or mailed to the

PMC Medical Staff Bylaws, Rules and Regulations

voting Members at least thirty (30) days prior to the election.

11.6 QUALITY MANAGEMENT COMMITTEE

The composition, responsibilities, and functions (blood usage, drug usage, pharmacy and therapeutics, nutrition, medical records timeliness and clinical pertinence, surgical case review, special care unit review, utilization review, Palomar Continuing Care Center, and infection control) are specified in the Palomar Pomerado Health System Performance Improvement/Utilization Review Plan, the pertinent provisions of which are incorporated herein by this reference.

11.7 CRITICAL CARE COMMITTEE

The composition, responsibilities, meeting requirements and reporting requirements of this committee are as specified in the PPHS Performance Improvement Plan, pertinent provisions of which are incorporated herein by this reference.

11.8 CANCER COMMITTEE

11.8.1 Composition

The Cancer Committee shall function as a multidisciplinary committee with representatives from the departments of surgery (general), medicine (oncology), diagnostic radiology, radiation oncology, pathology, ACOS Liaison Physician and as nonvoting members, a representative of administration, nursing (oncology), pharmacy, dietary, social services, cancer registry and quality assurance. Additional members may be appointed by the Chief of Staff.

11.8.2 Duties

The duties of the Cancer Committee shall include:

- (a) develop and evaluate annual goals and objectives for the clinical, educational, and programmatic endeavors related to cancer care.
- (b) promote a coordinated multidisciplinary approach to patient management.
- (c) ensure that educational and consultative cancer conferences are available to the medical staff and allied health professionals, and that all major sites and related issues are covered.
- (d) ensure an active supportive care system for patients, families and staff.
- (e) monitoring quality through measures and selected quality improvement projects, identified and selected by the committee and aimed at improving patient care. The committee shall recommend corrective actions when necessary.
- (f) promote clinical research.
- (g) supervise the cancer registry and ensure accurate and timely abstracting, staging, and follow-up by performing quality control of registry data.

11.8.3 Meetings

The Cancer Committee shall meet every other month. It shall maintain a record of its proceedings and shall report its activities and recommendations to the Executive Committee.

11.9 INVESTIGATIONAL REVIEW COMMITTEE

PMC Medical Staff Bylaws, Rules and Regulations

The composition and responsibilities of the Investigational Review Committee are specified in the Policies and Procedures of the Investigational Review Committee of Palomar Medical Center and Pomerado Hospital, the pertinent provisions of which are incorporated herein by this reference.

11.10 BYLAWS COMMITTEE

11.10.1 Composition

The Bylaws Committee shall consist of five (5) Members and shall include the immediate past Chief of Staff and Chief of Staff-Elect. The Chief of Staff-Elect shall serve as chairman.

11.10.2 Duties

The duties of the Bylaws Committee shall include:

- (a) conducting an annual review of the bylaws, rules and regulations and forms promulgated by the Medical Staff.
- (b) submitting recommendations to the Executive Committee for changes in these documents as necessary to reflect current practices of the Medical Staff.
- (c) receiving and evaluating for recommendation to the Executive Committees suggestions for modifications of the items specified in (a).

11.10.3 Meetings

The Bylaws Committee shall meet as often as necessary at the call of its chairman, but at least annually. It shall maintain a record of its proceedings and shall report its activities and recommendations to the Executive Committee.

11.11 WELL BEING COMMITTEE

11.11.1 Composition

In order to improve the quality of care and promote the competence of the medical staffs, the executive committees shall establish a joint committee of the medical staffs of Palomar Medical Center and Pomerado Hospital comprised of five (5) active category Members from each medical staff. A subcommittee of this committee shall be formed at each hospital composed of the five (5) representatives from the respective hospital. Except for initial appointments, each member shall serve a term of two (2) years and the terms shall be staggered as deemed appropriate by the executive committees to achieve continuity. Insofar as possible, members of the committee will be expected to excuse themselves from any peer review being conducted in other committees if there is the potential for conflict with their role as a member of the Well Being Committee. The chairman shall be appointed by the chiefs of staff in alternate years.

11.11.2 Duties

The Well Being Committee may receive reports, including self referral by a member, related to the health, well being, or impairment of Members and, as it deems appropriate may investigate, or cause the subcommittee to investigate, such reports. With respect to matters involving individual Members, the committee, or subcommittee(s), may, on a voluntary basis, provide such advice, counseling or referrals to both internal and external sources as may seem appropriate. Such activities shall be confidential; however, in the event information received by the committee clearly demonstrates that the health or known impairment of a Member poses a substantial risk of harm to hospitalized patients, that information may be referred for corrective action to the chiefs of staff. The committee shall also consider general matters related to the health and well being of the medical staffs and, with the approval of the executive committees, develop educational programs

PMC Medical Staff Bylaws, Rules and Regulations

on related activities. The committee shall provide education as appropriate, to medical staff and other hospital staff about illness and impairment recognition issues specific to medical staff.

11.11.3 Meetings

The subcommittees may meet as often as necessary, and the Well Being Committee shall meet as often as necessary, but at least twice a year. It shall maintain a record of proceedings as it deems advisable, but shall report on its activities on at least a quarterly basis to the executive committees.

11.12 BIOMEDICAL ETHICS COMMITTEE

11.12.1 Composition

The Biomedical Ethics Committee shall be a joint committee of the medical staffs of Palomar Medical Center and Pomerado Hospital consisting of three (3) Physicians and other members as the executive committees may deem appropriate. It may include lay representatives, social services, clergy, ethicists, attorneys, nursing staff, Administrator (or his designee), and representatives from the Board of Directors as nonvoting members. Practitioner members will be appointed by the chiefs of staff, including a chairman for each hospital. The chairman of the joint committee will alternate yearly. A subcommittee of the committee shall be formed at each hospital composed of the three (3) representatives from the respective hospital.

11.12.2 Duties

The Biomedical Ethics Committee shall participate in development of guidelines for consideration of cases having bio-ethical implications; development and implementation of procedures for the review of such cases; development and/or review of institutional policies regarding care and treatment of such cases; retrospective review of cases for the evaluation of bio-ethical policies; consultation with concerned parties to facilitate communication and aid to conflict resolution; and education of the hospital staffs on bio-ethical matters.

11.12.3 Meetings

The Biomedical Ethics Committee shall meet as often as necessary at the call of the chairman who shall maintain a record of its activities and report to the executive committees.

11.13 OPERATING ROOM COMMITTEE

11.13.1 Composition

The Operating Room Committee shall be composed of two (2) members from the Department of Anesthesia, one (1) member from each of the following departments: OB/GYN, surgery, orthopaedic surgery/rehabilitation and trauma. The Nurse Manager of the Operating Room, or his designee, the Medical Director of the Operating Room or his designee, and the Assistant Administrator for Nursing Services/Outpatient, or his designee shall serve as voting members of this committee. Voting rights are defined as follows: 1/3 anesthesia, 1/3 surgery departments, 1/3 administration. The Chairmanship will be selected from the membership by majority vote for a two (2) year period.

11.13.2 Duties

The duty of the Operating Room Committee is to coordinate the functioning of the operating room suite and recovery room, including scheduling, equipment, purchases and operating policies.

11.13.3 Meetings

The Operating Room Committee shall meet at least monthly. It shall maintain a record of its proceedings and report to the Executive Committee.

PMC Medical Staff Bylaws, Rules and Regulations

11.14 EDUCATION/LIBRARY COMMITTEE

11.14.1 Composition

The Education/Library Committee shall be composed of broad physician representation. The following ancillary representatives shall serve as non-voting members: the Director of Clinical Education, the Tumor Registrar and the Medical Librarian, all of which are district positions.

11.14.2 Duties

The Education/Library Committee shall include:

- (a) coordinating all continuing medical education activities including recording of attendance at educational meetings;
- (b) assuring that any deficiencies in patient care as revealed by peer review and disease audits are made subjects of educational sessions;
- (c) prioritizing hospital-sponsored continuing education;
- (d) reviewing library policies and procedures, establishing priorities in the selection of new texts and selecting or reviewing journal subscriptions; and
- (e) evaluating effectiveness of the library in meeting the informational and educational needs of users.

11.14.3 Meetings

The Education/Library Committee shall meet as often as necessary (usually quarterly). It shall maintain a record of its proceedings and report to the Executive Committee.

11.15 INFECTION SURVEILLANCE COMMITTEE

The composition, responsibilities, meeting requirements and reporting requirements of this committee are as specified in the Infection Surveillance Plan, pertinent provisions of which are incorporated herein by this reference.

11.16 HEALTHCARE RESOURCE COMMITTEE

The composition, responsibilities, meeting requirements and reporting requirements of this committee are as specified in the PPHS Performance Improvement Plan, pertinent provisions of which are incorporated herein by this reference.

11.17 PHARMACY AND THERAPEUTICS COMMITTEE

The composition, responsibilities, meeting requirements and reporting requirements of this committee are as specified in the PPHS Performance Improvement Plan, pertinent provisions of which are incorporated herein by this reference.

11.18 SPINE COMMITTEE

11.18.1 Composition

The Spine Committee shall be composed of Members of the active and provisional category who perform spinal procedures. The Committee shall select a chair who will be responsible for arranging and conducting meetings. The Chair shall be elected by a majority vote and shall serve

PMC Medical Staff Bylaws, Rules and Regulations
for a two-year term.

- 11.18.2 Duties
The Spine Committee shall primarily provide subspecialty peer review, as indicated.
- 11.18.3 Meetings
The Spine Committee shall meet at least quarterly. Members must attend at least fifty (50%) of all meetings.

11.19 JOINT CONFERENCE COMMITTEE

- 11.19.1 Purpose
The purpose of the Joint Conference Committee is two-fold: (1) to facilitate communication between the Board, administrations of Palomar Medical Center and Pomerado Hospital, and the medical staffs of both hospitals involving medical staff issues such as credentialing, quality improvement, corrective action and bylaws amendment; and (2) to address and confer in good faith to resolve medical staff disputes including but not limited to those set forth in Section 2282.5 of the Business and Professions Code.
- 11.19.2 Composition
The Joint Conference Committee shall be a joint committee of the medical staffs of Palomar Medical Center and Pomerado Hospital consisting of the following: Three Board members selected by the Board; the Chief Executive Officer of Palomar Pomerado Health; Chief of Staff and Chief of Staff Elect of Palomar Medical Center; Chief of Staff and Chief of Staff Elect of Pomerado Hospital; an At-Large member of one of the medical staffs selected by members of the Joint Conference Committee to represent both medical staffs. The chairman shall alternate annually between the Chiefs of Staff.
- 11.19.3 Meetings
The Joint Conference Committee shall meet as often as necessary (usually quarterly.) It shall maintain a record of its proceedings as it deems advisable and report to the executive committees of both medical staffs.

Article XII
Clinical Departments

- 12.1 ORGANIZATION
The Medical Staff shall be divided into clinical departments. Each department shall be organized as a separate component and shall have a chairman selected and entrusted with the authority, duties and responsibilities specified in 12.4. When appropriate, the Executive Committee may recommend to the Medical Staff the creation, elimination, modification or combination of departments.
- 12.2 CURRENT DEPARTMENTS
The current departments are:
 - (a) anesthesiology
 - (b) emergency medicine
 - (c) family medicine
 - (d) medicine
 - (e) obstetrics/gynecology
 - (f) orthopaedic surgery and rehabilitation

PMC Medical Staff Bylaws, Rules and Regulations

- (g) pathology
- (h) pediatrics
- (i) radiology
- (j) surgery
- (k) trauma

12.3 MEMBERSHIP

The Executive Committee, following the recommendation of the clinical department(s), shall recommend initial department assignments for all Members. Representatives from the Hospital may be invited to attend departmental meetings and, when so present, shall not be entitled to vote.

Each Member will be assigned to one clinical department and will have voting rights only in that department, with the exception of the Department of Trauma. The assigned department will be that department in which he does the majority of his work. He may exercise clinical privileges in other departments (except contract departments unless approved by those departments) at the Member's request and with approval of the other department(s). Each Member, active and provisional, must attend at least twenty-five percent (25%) of the business meetings held each staff year by each department of which he is a member. Each Member must also comply with all requirements of departmental membership, including Emergency Department consultation panel service pursuant to applicable rules and regulations, for each department of which he is a member. Only department members shall be entitled to vote on departmental matters and hold departmental office.

Members may be granted privileges in other departments, without membership, but shall not be required to attend departmental meetings or serve on the Emergency Department consultation panel of those departments. Members with privileges in other departments shall be subject to all the applicable rules of such department and to the jurisdiction of the departmental chairman. The chairman of any department may require the attendance of any Member with privileges in the department at a specific department meeting for review of particular cases or for the purpose of continuing medical education.

12.4 CHAIRMAN

The department chairman shall be an active staff Member and shall have served as chairman-elect for the previous one (1) or two (2) years, as determined by department rules and regulations, except in departments which do not provide for a chairman-elect in their rules and regulations. The chairman or director of each department shall be certified by the appropriate specialty board or it shall be affirmatively established through the privilege delineation process, that the chairman/director possesses comparable competence. The department chairman-elect or chairman, as applicable, shall be elected by the voting members of each department at least thirty (30) days prior to the annual staff meeting. Terms of office shall be for one (1) or two (2) years as determined by department rules and regulations. Chairmen may be removed with a simple majority vote by the department with approval of the Executive Committee. Duties of the department chairman shall include but not be limited to

- (a) supervising the professional, medical and administrative activities within the clinical areas of the department such as participating in the development of policies, procedures, practices and planning of the Medical Staff and Hospital.
- (b) serving on the Executive Committee in accordance with 11.3.1.
- (c) maintaining continuing assessment and improvement of the quality of care, treatment and services, review of the professional performance of all Members with privileges in the department and assure preparation of biennial assessment of all Members for consideration by the Credentials Committee, Executive Committee and Board of Directors.
- (d) enforcing the bylaws, rules and regulations and department rules and regulations.

PMC Medical Staff Bylaws, Rules and Regulations

- (e) transmitting to the Executive Committee the department's recommendations concerning the granting of privileges to Members and the results of any disciplinary measure or changes in privileges.
- (f) responsibility for implementation of any actions taken by the Executive Committee.
- (g) supervising, by means of appropriate committees
 - (1) peer review of individual Members holding privileges in the department including an ongoing program of non-disciplinary Practitioner observation;
 - (2) audit of disease entities and morbidity and mortality;
 - (3) the presentation of educational programs using any deficiencies or suboptimal patterns of care detected by review as subjects; and
 - (4) subsequent review to assure that improved performance has occurred.
- (h) participating in every phase of administration of his department through cooperation with nursing and administration in matters affecting patient care, including personnel, supplies, special regulations, standing orders, and techniques.
- (i) providing emergency room backup list.
- (j) assisting in the preparation of such annual reports, including budgetary planning, pertaining to his department as may be required by the Executive Committee and Administrator.
- (k) requesting consultant representatives from other departments. Such representatives shall have the approval of their own department chairman. This process shall continue until mutually satisfactory representatives are chosen.
- (l) acting as presiding officer at department meetings.
- (m) Assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment and services not provided by the department or the organization.
- (n) Coordinating and integrating interdepartmental and intradepartmental services.

12.5 DEPARTMENT FUNCTIONS

Departments shall

- (a) establish criteria relevant to the care provided in the department, consistent with the policies of the Medical Staff and the Board of Directors for granting clinical privileges and monitoring as described in the department rules and regulations.
- (b) participate in medical care evaluation including reviewing the results of the Hospital generic screening program and conducting retrospective review of completed patient records. Such reviews shall be conducted monthly and should include a consideration of selected deaths, unimproved patients, patients with infections, complications, drug usage, errors in diagnosis and treatment, and such other instances as are believed to be important, such as patients currently in the Hospital with unsolved clinical problems. A summary of these medical care evaluation activities will be sent to the Quality Management Committee to be included in the Hospital wide quality assurance program.
- (c) review minutes and requests of department committees and forward recommendations to the

PMC Medical Staff Bylaws, Rules and Regulations
Executive Committee.

- (d) review department rules and regulations along with the Bylaws Committee annually. Changes must be approved by the Executive Committee and Board of Directors.
- (e) provide education.
- (f) provide the emergency department with a panel of Physicians to do consultations, admit patients to the Hospital, and to see outpatient referrals. Failure to participate according to these bylaws may result in suspension in the case of a Physician failing to provide emergency department consultation service or corrective action in the case of a Physician failing to provide requested outpatient follow up.
- (g) Provide the department of trauma services with a panel of Physicians to do consultations and provide continuing care of designated trauma patients (trauma services consultation panel) meeting the criteria of the County of San Diego; provided, however, participation on such panel shall be voluntary for any provisional or active category Member and, therefore, no department shall be compelled to provide a trauma services consultation panel.
- (h) recommend when appropriate, annual exemptions from the departmental attendance requirements.

12.6 COMMITTEES/SUBSECTIONS

Committees and/or subsections may be created by departments when necessary to accomplish the goals of the department.

12.7 CREATION OF NEW DEPARTMENTS

When there are sufficient Members of a specialty to allow the effective operating of a new department, the Executive Committee shall review a petition signed by at least seventy-five percent (75%) of the prospective Members of the department. If approved, the request shall be drafted as a bylaws amendment and acted upon in accordance with Article XVIII.

Article XIII
Immunity From Liability

13.1 The following shall be express conditions to any application for membership and/or privileges or for exercise of any Member's clinical privileges at the Hospital.

13.1.1 That any act, communication, report, recommendation or disclosure, with respect to any such applicant or Member, performed or made in good faith and without malice and at the request of an authorized representative of this or any other health care facility, for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged to the fullest extent permitted by law.

13.1.2 That there shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure, even where the information involved would otherwise be deemed privileged.

13.1.3 The Health System shall provide insurance covering Practitioners providing services to the

PMC Medical Staff Bylaws, Rules and Regulations

Medical Staff as officers, committee members, or department chairmen against any liability asserted as or incurred by such Practitioner in such capacity or arising out of the Practitioner's status as such.

- 13.1.4 That by accepting membership on the Medical Staff, all Members agree to respect and maintain the confidentiality of all discussions, deliberations, proceedings and activities of the Medical Staff committees and departments which have the responsibility for evaluating and improving the quality of care in the Hospital. Such information shall not be disclosed voluntarily to anyone except for persons authorized to receive it in the conduct of such Medical Staff affairs or as directed by the Executive Committee or the Board of Directors. Any questions regarding whether information is confidential shall be resolved by the Chief of Staff and the Administrator. Any violation of this provision may subject the Member to corrective action, including summary suspension, as provided in Article VIII.

**Article XIV
Medical Staff Meetings**

14.1 REGULAR MEETINGS

- 14.1.1 Regular meetings shall be held annually. Active and provisional Members are encouraged to attend all meetings and shall be required to attend any meetings designated by the Executive Committee as mandatory. Representatives from the Hospital may be invited to attend and, when so present, shall not be entitled to vote.
- 14.1.2 The annual meeting shall be held within thirty (30) days before the end of the Medical Staff Year.

14.2 SPECIAL MEETINGS

- 14.2.1 The Chief of Staff may call a special meeting at any time. In addition, the Chief of Staff shall call a special meeting within thirty (30) days after receipt by him of a written request for same signed by not less than one-fourth (1/4) of the voting Members and stating the purpose for such a meeting. The Chief of Staff shall designate the time and place of any special meeting.
- 14.2.2 Written or oral notice stating the place, day and hour of any special meeting shall be given, either personally or by mail, to each active and provisional Member not less than seven (7) nor more than thirty (30) days before the date of such meeting, by or at the direction of the Chief of Staff. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.
- 14.2.3 Active and provisional Members are encouraged to attend all special meetings and shall be required to attend any meetings designated by the Executive Committee or Chief of Staff as mandatory. Representatives from the Hospital may be invited to attend and, when so present, shall not be entitled to vote.
- 14.2.4 A Member of the Medical Staff may arrange for a proxy vote at special meetings if the Member is unable to attend. In order for the proxy to be valid, the Member must so inform the Chief of Staff at least one (1) week in advance of the meeting in writing as to why he is unable to attend and to designate the individual who will hold his proxy vote.

14.3 ATTENDANCE REQUIREMENTS

Each active category Member and each provisional category Member, except those intending to become consulting, associate or courtesy surgery assist categories, shall be required to attend all meetings of the Medical Staff which are designated as mandatory by the Executive Committee, provided that the Executive Committee shall have given notice to any such meeting at least thirty (30) days in advance. A Member, who is compelled to

PMC Medical Staff Bylaws, Rules and Regulations

be absent from any such meeting, shall, preferably in advance, submit to the Chief of Staff, in writing, his reason for such absence. An unexcused failure to attend such meetings may result in sanctions as described in section 15.7.1 of these bylaws.

14.4 AGENDA

14.4.1 The agenda of the annual meeting shall include such items as call to order, introduction of guests, approval of minutes of previous meeting and of any special meetings, unfinished business, communications, reports of standing special committees, new business, approval of granting, renewing or terminating contracts held between Members and the District, and election of officers.

14.4.2 The agenda of special meetings shall be reading of the notice calling the meeting, transaction of business for which the meeting was called, and adjournment.

14.4.3 No formal action may be taken at any general or special meeting on any item which has not been specifically described in a notice of the meeting provided at least thirty (30) days before the meeting.

Article XV

Committee and Department Meetings

15.1 REGULAR MEETINGS

Committees may, by resolution, provide the time for holding regular meetings without notice other than such resolution. Departments shall hold regular to facilitate fulfillment of the department functions as specified within these bylaws.

15.2 SPECIAL MEETINGS

A special meeting of any committee or department may be called by or at the request of the chairman, by the Chief of Staff, or by one-third (1/3) of the committee or department's voting Members, but not less than two (2) Members.

15.3 NOTICE OF MEETINGS

Written or oral notice stating the place, day and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be given to each committee or department Member not less than three (3) days before the time of such meeting by the person or persons calling the meeting.

15.4 MANNER OF ACTION

The action of the majority of the Members present shall be the action of a committee or department. Action may be taken without a meeting by unanimous consent in writing signed by each voting Member.

15.5 RIGHTS OF NONVOTING MEMBERS

Practitioners serving under these bylaws as nonvoting members of a committee/department shall have all rights and privileges of regular members, except that they shall not be counted in determining the existence of a Quorum or allowed to vote.

15.6 MINUTES

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

15.7 ATTENDANCE REQUIREMENTS

15.7.1 Except as provided in Section 4.1 of these bylaws, each active or provisional Member shall be

PMC Medical Staff Bylaws, Rules and Regulations

required to attend twenty-five percent (25%) of department meetings, and fifty percent (50%) of any specified medical staff committee of which he may be a member in each year. Departments may, with the approval of the Executive Committee, increase meeting attendance requirements up to fifty percent (50%) of department meetings. The failure to meet the foregoing attendance requirement during the medical staff year shall be grounds for sanctions as stated below to the same effect as provided in 8.3.5 of these bylaws. Committee and department chairmen shall report all such failures to the Executive Committee for action. The Departments may, with the approval of the Executive Committee, exempt members of the Department from attendance for reasons which exist sufficient to justify such exemption. These exemptions would need to be reappraised annually if appropriate. Nothing herein shall be deemed to restrict the discretion of the Executive Committee to impose such greater or lesser corrective action as it deems appropriate under the circumstances, in its discretion.

Failure to satisfy meeting attendance requirements for one (1) year shall, at a minimum, double the amount of dues required from the Member of the next medical staff year. If the Member fails to satisfy attendance requirements a second time within three (3) years of the first violation, the Member's dues shall be tripled; if he fails to satisfy attendance requirements a third time within the following three (3) years the Member's dues shall quadruple; and each subsequent violation within a three (3) year period of the most recent violation shall result in a similar increase in the amount charged following such violation.

Article XVI Staff Year

- 16.1 The staff year shall commence the first (1st) day of January.

Article XVII Dues

- 17.1 Annual dues shall be assessed to Members in an amount to be determined by the Executive Committee and approved at the annual meeting. Designated use of dues is to be reflected via the budget submitted at the annual General Medical Staff meeting and shall include stipends for officers of the Medical Staff including department chairmen. Such dues shall be due and payable no later than May 1 of the year assessed. Any Member not paying dues on or before May 1 shall receive, by certified mail, a letter of delinquency advising the Member of his obligation to pay dues. Any Member who does not pay the delinquent dues shall have his clinical privileges suspended, and shall remain so suspended until the Member pays the delinquent dues or until the parameters in 8.3.5(f) are met. A member may petition for a waiver of dues by submitting reasons for the request to the Chief of Staff, who, with the concurrence of the Executive Committee, may waive payment.

Article XVIII Amendments

- 18.1 **BYLAWS**
Amendments to the bylaws of this Medical Staff may be made at either a regular or special meeting, or by mail ballot. A two-thirds (2/3) majority of returned votes of voting Members shall be required for adoption. Proposed amendments shall be distributed to each voting Member at least thirty (30) days before a vote. A copy of any proposed amendments to the following sections: 5.2.3(g); 5.3.2; 5.3.8; 6.2.3; 8.1.2; 8.1.3(b) (c) (d); 8.2.4.1; 8.2.4.2; 8.3.6.1; 8.3.6.2; 9.2.5.2 and 18.1 will be forwarded to the chief of staff of Pomerado Hospital thirty (30) days prior to the amendment being distributed to the Members. Members of the active Medical Staff shall be offered the opportunity to include in the distribution a pro or con statement. Such amendments shall become effective when approved by the Board of Directors. Such approval shall not be unreasonably withheld.

Amendments are usually recommended by the Bylaws Committee via the Executive Committee; however,

PMC Medical Staff Bylaws, Rules and Regulations

amendments may also be submitted in writing by Members of the Medical Staff, provided they have the endorsing signature of three (3) voting Members. Such proposals shall be referred to the Bylaws Committee and Executive Committee for their recommendation. Endorsing signatures of 10% of voting members is required for an amendment to be automatically sent out for vote.

18.2 RULES AND REGULATIONS

18.2.1 Amendments to the rules and regulations shall require only a simple majority of returned votes.

18.2.2 Amendments to department rules and regulations shall be distributed to all voting Members thirty (30) days prior to a scheduled department meeting. Adoption of an amendment shall require a two-thirds (2/3) vote of voting Members of the department present. Amendments shall become effective after recommendation by the Executive Committee and approval by the Board of Directors.

18.3 MANDATED AMENDMENTS

In the event any amendment to the bylaws or the rules and regulations is required based on any provision of state or federal statute or regulation, or any interpretation of any such law or regulation by duly authorized regulatory body or court of competent jurisdiction, such amendment may be approved by the Executive Committee and presented to the Board of Directors. Notwithstanding any other provision of this article, such amendments shall become effective upon approval by the Board, and shall be distributed to active category members as soon as reasonably possible.

Article XIX
Contract Physicians

19.1 All contract Physicians shall have applied for membership and privileges and shall undergo the same individual evaluation and appointment process as the other Members. Upon termination of a contract, membership shall continue unaltered, unless otherwise provided for in the contract or if the termination is for medical disciplinary cause or reason at which time Article VIII may apply.

19.2 The Board of Directors shall make an annual determination with respect to the quality and availability of contract Physician services to the patients at the Hospital in such areas as emergency medicine, pathology, radiology, respiratory therapy and any other Physician services for which the Hospital may choose to contract. Evaluation shall include use of a Medical Staff questionnaire, criteria for which will be developed and revised annually by respiratory therapy and the departments of emergency medicine, pathology and radiology, approved by the Executive Committee and Medical Staffs/Board Liaison Committee. The questionnaire shall be distributed by, returned directly to and evaluated by the Board of Directors or its designee. The Board may rely upon such consultants as it deems appropriate in evaluating the quality of contract Physicians.

RULES AND REGULATIONS

1. **ADMISSION OF PATIENTS**

- 1.1 The Hospital shall accept patients for care and treatment except for those patients with critical burns. Patients for alcohol and/or drug detoxification, if appropriate, may be admitted to the Behavioral Medicine Center at Pomerado Hospital, or to the Mental Health Unit at Palomar Medical Center if a particular plan requires treatment at PMC, or if Pomerado Hospital's Behavioral Medicine Center is full.
- 1.2 No patient shall be admitted to the Hospital without a provisional diagnosis. In the case of an emergency, the provisional diagnosis shall be recorded as soon as possible.
- 1.3 A patient may be admitted to the Hospital only by Members as per these bylaws.
- 1.4 A Member, designated as the attending Physician, or his qualified call coverage, shall be responsible for the medical care, the accuracy of medical records, necessary special instructions, and transmitting reports of the condition of the patient to relatives of the patient. Whenever consultations are requested or required, physician to physician contact is encouraged. Physicians are required to record the reason for the consult, the consultant to be contacted and the urgency of the consult. Consultants shall write their findings and recommendations on the appropriate consultation sheets or progress notes. All orders shall continue to be by the attending Physician (unless otherwise specifically requested by the attending Physician). Nurses shall contact the attending Physician for additional orders. Whenever a patient undergoes a major interventional procedure (e.g. surgery, angioplasty), the attending physician designation shall automatically change to the physician who performed the interventional procedure. The attending physician designation may also change pursuant to a specific written chart order transferring care to an accepting physician. Referral or transfer of patient responsibility to another attending Physician or surgeon shall be with the consent of the referral Physician and the patient. This may be either temporary for a specific procedure, a period of time, or for the remainder of the hospitalization. Orders on the charts must clearly reflect this transfer of responsibility. For trauma patients, the Trauma Surgeon or Trauma Neurosurgeon will remain the attending physician until the patient is transferred out of the ICU with specific written orders transferring care to an accepting physician as appropriate. The consultant shall be responsible for transmitting reports of the condition of the patient to the referring Physician and/or family as may be appropriate. It is the responsibility of all caregivers involved in a patient's care to communicate regarding treatment and services.
- 1.5 A complete history and physical examination shall be prepared within twenty-four (24) hours of admission of all patients, unless a history and physical examination have been performed and documented as set forth in Rules and Regulations Section 3.5. A 'short admission' form may be employed in the case of patients with problems of a minor nature who require less than a twenty-four (24) hour period of hospitalization, and in the case of normal newborn infants and uncomplicated obstetric deliveries. The 'short admission' form shall not be used for patients undergoing procedures requiring anesthesia or conscious sedation with American Society of Anesthesia (ASA) scores of greater than two (2), patients admitted to the Mental Health Unit, or patients undergoing cardiac catheterization. History shall include a description of the patient, the presenting clinical problem, family history, social history, past medical history, system review, plus a list of current medications and allergies. Each Department will determine those non-inpatient procedures for which a history and physical examination is not required.
- 1.6 In any emergency case in which it appears the patient will have to be admitted to the Hospital, the Member shall, when possible, first contact the admitting department to ascertain whether there is an available bed.

PMC Medical Staff Bylaws, Rules and Regulations

- 1.7 Members admitting emergency cases shall be prepared to justify to the Quality Assessment and Improvement Committee and the administration that said emergency admission was a bona fide emergency. A history and physical examination shall clearly justify the patient being admitted on an emergency basis and these findings shall be recorded in the patient's chart as soon as possible after admission.
- 1.8 A patient to be admitted on an emergency basis, who does not have a Physician, may select any Member (with his concurrence) in the applicable department or service to attend him. Where no such selection is made, an active or a provisional Member on duty in the department shall be assigned to the patient on a rotational basis from the emergency room roster.
- 1.9 In the care of hospitalized patients, each Member who does not reside within thirty (30) minutes of the Hospital shall name a Member, who is a resident in the area, who may be called to attend his patients in an emergency, or until he arrives. In case of failure to name such associate, the Chief of Staff or the appropriate department chairman shall have authority to call any Member in such an event. Each Member must assure timely adequate professional care of his patients in the Hospital by being available, or having available through his office, an eligible alternative Member with whom prior arrangements have been made and who has at least equivalent clinical privileges at the Hospital. Failure of an attending Member to provide these requirements may result in loss of clinical privileges.
- 1.10 The admitting Member shall be held responsible for giving such information as may be necessary to assure the protection of the patient from self harm and to assure the protection of others whenever his patient might be a source of danger from any cause whatever.
- 1.10.1 Patients will be placed in restraints only when necessary to prevent them from harming themselves or others, and only when less restrictive methods of assisting the patient have failed or would pose immediate danger.
- 1.10.2 Restraints may be used only with a physician's order, or with the authorization of a registered nurse in case of emergency. The physician is to be notified that restraints have become necessary and that an order for their use is needed.
- 1.10.3 A physician's time-limited order, written or verbal, will be obtained for each use of restraint, or seclusion, per hospital policy. All orders shall include the type of restraint and reason. An order shall be in effect for not longer than 24 hours but may be renewed if necessary. PRN ("as needed") orders for initiating restraints are not permitted.
- 1.10.4 Hospital policy addresses: the periodic observation of the patient, maximum time between observations and documentation that the needs of the patient are attended to.
- 1.10.5 Any patient known or suspected to be suicidal shall have consultation with a member of the psychiatric staff.
- 1.11 All orders shall be dated and timed in writing. Relevant verbal orders can be accepted by a licensed nurse, registered pharmacist, registered physical, occupational, or speech therapist, registered dietitian, and qualified respiratory therapy personnel and other specialists allowed by law if such specialist has been approved for same by the Executive Committee and the Board of Directors. All verbal orders must be signed by the Physician, at his next visit and in no case later than forty-eight (48) hours. Verbal orders shall be signed by the person to whom dictated with the name of the Physician and his own name.

PMC Medical Staff Bylaws, Rules and Regulations

- 1.12 Circumstances where consultation is required are identified in the procedure entitled "Physician Consultation." If a nurse has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, the nurse shall call this to the attention of a superior who may in turn refer the matter to the Assistant Administrator for Nursing Services. If warranted, the Assistant Administrator for Nursing Services may bring the matter to the attention of the appropriate department chairman. Where circumstances are such as to justify any action, the chairman may himself request a consultation. In the absence of the chairman, the chairman elect shall be notified.
- 1.13 Pathology specimens will not be processed or interpreted or radiologic examinations performed unless they are accompanied by the appropriate clinical information.

2. DISCHARGE OF PATIENTS

- 2.1 The patient shall be discharged only on order of the attending physician or his designee.
 - 2.1.1 If a patient is admitted to the Mental Health Unit from the Emergency Department in a medically stable condition and a bed becomes available at County Mental Health within twelve (12) hours of admission, the patient may be transferred to County Mental Health even if not seen by a staff psychiatrist.
- 2.2 A discharge summary must be prepared by the attending physician or his alternate. This summary shall include the reason for admission, pertinent history, physical findings, laboratory abnormalities, a brief description of the patient's course, major diagnosis or diagnoses relevant to the admission, procedures performed, condition on discharge, and instructions given to the patient or his family regarding diet, activity, medications, and follow up date.

All deaths require a full discharge summary.

3. MEDICAL RECORDS AND PROTECTED HEALTH INFORMATION

- 3.1 All medical records shall be completed within fourteen (14) days after discharge as stated in the bylaws (8.3.5(a)).
- 3.2 All records are the property of the Hospital. X-rays and charts, or copies thereof shall be released from the Hospital only as provided by law. In cases of readmission of the patient, all previous records shall be made available to the attending Physician. Unauthorized removal of medical records from the Hospital is grounds for suspension.
- 3.3 Pertinent progress notes shall be recorded at the time of observation sufficient to permit continuing of care and transferability. Wherever possible, each of the patient's clinical problems should be clearly identified in the progress notes, and correlated with specific orders as well as the result of tests and treatment. It is recommended that:
 - (a) Patients be seen and progress notes be written at least daily in the med/surg areas. In lieu of daily physician visits, daily visits may be made and progress notes written by an approved nurse practitioner, certified nurse midwife, or physician assistant with appropriate privileges, subject to any specific requirements set forth in the applicable department's rules and regulations. The department requirements should be based upon any applicable federal or state regulations.
 - (b) Patients be seen and progress notes written in accordance with the level of care in the

PMC Medical Staff Bylaws, Rules and Regulations
extended care unit.

- (c) Patients be seen and progress notes written a minimum of five (5) days a week but a least every other day in the mental health unit. Any patient admitted to the mental health unit must be seen within twenty-four (24) hours of admission.

Timing of progress notes is encouraged.

- 3.4 The Member shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current. This record shall include identification data, complaints, history and physical examination, special reports and other consultations, clinical history and radiology reports, provisional diagnoses, medical or surgical treatment, operative reports, pathological findings, progress notes, final diagnosis, conditions on discharge, summary for discharge note, clinical resume and autopsy report when performed.
- 3.5 If a complete history has been recorded and a physical examination performed prior to the patient's admission to the Hospital, a reasonable, durable, legible copy of these reports may be used in the patient's Hospital medical record in lieu of the admission history and report of physical examination described in Section 1.5 of these Rules and Regulations, provided the history and physical examination were performed by a Member not more than thirty (30) days prior for the same medical condition. In such circumstances, an interval admission note that includes all additions to the history and any subsequent changes in physical findings must always be documented in the medical record within twenty-four (24) hours of admission. These reports may only be done 1) by an M.D. or D.O. for cases other than oromaxillofacial surgery or podiatric surgery, 2) for oromaxillofacial surgery the special case permits oromaxillofacial surgeons to do the H&P provided that they have proper privileges, and 3) for podiatric surgery the special case permits podiatric surgeons to do the H&P provided that they have the proper privileges.
- 3.6 Record of an adequate history and physical examination must be part of the patient's chart before he may be transferred to the operating room. An exception may be made to this rule when the Member states in the medical record that any delay would be detrimental. However, in these rare instances, a late chart note will be placed in the chart and the history and physical examination shall be recorded within twenty-four (24) hours of admission.
- 3.7 Operative reports shall include a detailed account of the findings at surgery, as well as the details of the surgical technique. Operative reports shall be written and dictated immediately following surgery for outpatients as well as inpatients.
- 3.8 Consultation shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, and the consultant's opinion and recommendation. This report shall be made part of the patient's record.
- 3.9 Symbols and abbreviations may be used only when they have been approved by the Medical Staff. There shall be available, in the Medical Staff office, an explanatory legend of those symbols and abbreviations used.
- 3.10 Other than members, only the individuals referenced in PPHS Policy #4710 may initiate entries in physician progress notes.
- 3.11 For purposes of complying with the Health insurance portability and Accountability Act Standards for Individually Identifiable Health Information, 45 C.F.R. Parts 160 and 164 ("Privacy Standards") and Hospital policies and procedures relating to compliance with the Privacy Standards, such medical

PMC Medical Staff Bylaws, Rules and Regulations

records shall be part of the "Designated Record Set."

The Medical Staff and Hospital jointly treat patients in a clinically integrated setting and need to share information relating to their common patient's medical, mental, physical and/or general health condition. Protected health information (as defined below) must be shared between the Hospital its medical Staff for purposes of treatment, payment and the health care operations of the Hospital. Health care operations of the Hospital which require Medical Staff participation, and thus access to patient identifiable health information, include but are not limited to mortality and morbidity board review, other peer review, training of medical students, medical departmental operations, such as developing clinical guidelines, and other activities consistent with the definition of "Health Care Operations" at 45 C.F.R. Section 164.501 and the Hospital's policies and procedures.

- 3.12 Medical Staff obligations with respect to confidentiality of patient Protected Health Information include the following:
- 3.12.1 **Generally.** Medical Staff shall to the best of their ability and consistently with professional standards, respect and maintain the confidentiality of all "Protected Health Information" (which includes any electronic or paper-based Protected Health Information) (as defined below) with respect to all Hospital patients and to comply with the terms and conditions of the the: (i) Confidentiality of Medical Information Act of 1981, California Civil code Section 56 et seq. (General Patient Medical Records); (ii) California Welfare & Institutions Code §5328.6 and §5328.7 (Mental Health Records); and (iii) 42 U.S.C. §§290dd-2; 42 C.F.R., Part 2, §2.31 (Alcohol and Drug Abuse Records); (iv) health Insurance Portability and Accountability Act of 1996 ("HIPPA") and the Regulations promulgated there under (42 U.S.C. Section 1320d-2 and 1320d-4; 45 C.F.R. Subtitle A, Subchapter C, parts 160-164), as amended from time to time, and all Hospital policies and procedures relating to confidentiality and protection of patient information.
- 3.12.2 **Definition of Protected Health Information.** For purposes of these rules and regulations, patient "Protected Health Information" of "PHI" shall include without limitation, all Information regarding a patient's: (1) Medical treatment and condition; (2) Psychiatric and Mental Health; and (3) substance abuse and chemical dependency, which a Medical Staff member may receive in the course of treating Hospital patients consulting with other Medical Staff or as a participant in Health Care Operations of the Hospital, and which is defined as "identifiable pursuant to the Hospital's applicable policies and procedures.
- 3.13 The duties with respect to confidentiality of Protected Health Information are as follows:
- 3.13.1 **General Duty.** Physicians have the duty to keep all information about Hospital patients confidential and to treat such information with the utmost discretion. No Hospital patient Protected Health Information may be accessed by a Medical Staff member, in any manner, including, without limitation; (i) direct medical record access; (ii) access by electronic means; or (iii) access by querying persons involved in a patient's care, unless the member is one of the patient's direct healthcare providers, has been requested to consult on the patient's condition at the request of a patient's direct healthcare provider and requires such Protected Health Information for purposes of diagnosis or treatment of the patient; requires such Protected Health Information for official peer review purposes or to participate in Hospital Health Care Operations; or is otherwise authorized by the patient or appropriate representative, or permitted to be used or disclosed under applicable federal and state laws and regulations, as amended from time to time, and applicable Hospital policies and procedures.
- 3.13.2 **Authorized Use or Purpose; Appropriate Setting for Discussions of PHI.** Discussions of

107

PMC Medical Staff Bylaws, Rules and Regulations

Protected Health Information may be held only in the course of patient care, peer review, Hospital Health Care Operations and/or for any other use or purpose authorized under applicable federal and state laws and regulations. Necessary discussions that include patient PHI must be held in an appropriate setting, and to the best of each Medical Staff's ability, where it cannot be overheard by others (e.g., elevators and lobbies are inappropriate settings for such discussions.)

3.13.3 **Minimum Necessary Requirement.** Except with respect to Protected Health Information necessary for treatment of a Hospital patient (including referrals and consults with other Medical Staff,) access to, discussion of, release of and/or disclosure of Protected Health Information shall be limited to the extent "*minimum necessary*" to achieve the purpose. The definition of minimum necessary for certain standard uses and disclosures of protected health information may, to the extent applicable, be defined by the Hospital policies and procedures.

3.13.4 **Electronic PHI.** Medical Staff members are responsible for any Protected Health Information accessed electronically using their password. All electronic access to patient PHI, including remote access into Hospital information systems, shall be conducted pursuant to Hospital policies and procedures using an approved electronic device or pathway.

3.14 Any violation of this Section 3 or any Hospital policy and procedure regarding the protection of Hospital patient Protected Health Information, shall be considered unprofessional conduct and shall be referred to the appropriate peer review body.

4. MEDICATIONS

4.1 There shall be an automatic stop order for all narcotics, sedatives and hypnotics, antibiotics, and anticoagulants which are ordered without a specific time limitation.

4.2 All limitations for the various drugs are as follows:

4.2.1 All DEA schedule 2, controlled substances, and schedule 3, narcotic controlled substances seven (7) days.

4.2.2 Sedatives, hypnotics and anticoagulants seven (7) days.

4.2.3 Antimicrobials seven (7) days.

4.2.4 Antipsychotic medication should be administered according to applicable law (including Title 9 California Code of Regulations Section 850) and local procedures.

4.2.5 All medications not listed above shall be reviewed and renewed every thirty (30) days by the attending Physician.

4.2.6 Medications acquired by a practitioner from sources other than the pharmacy for patient care within the PPH system that bypass PPH Pharmacy review are prohibited.

4.3 Reminder stickers are generated forty-eight (48) hours before actual stop date and placed on the front of the chart for the prescribing physician to review.

4.4 Members are encouraged to use the full name of all drugs (no abbreviations). Zeros should be used before decimals, but no trailing zeros should be used.

4.5 Blanket Orders are Prohibited.

PMC Medical Staff Bylaws, Rules and Regulations

5. PATIENT DEATH

- 5.1 In the event of a Hospital death, the deceased shall be pronounced dead by the attending Member or his designee and a written note on the medical record shall testify to the death.
- 5.2 The Medical Staff will attempt to secure autopsies in all cases of unusual deaths and of medical-legal and educational interest. Clinical situations in which an autopsy shall be requested will be defined by the Medical Staff in procedure #5716.

6. INFORMED CONSENT

- 6.1 It is the treating Member's responsibility to obtain informed consent for all surgical or other procedures, other than simple, common or routine procedures which do not entail significant risks. Examples of such procedures are venipuncture, arterial blood gas puncture and routine injections of medications. The member's responsibility to obtain informed consent cannot be delegated to personnel of the Hospital.
- 6.2 In order to give informed consent, the patient is to be informed of
 - (a) the nature of the treatment;
 - (b) risks, possible complications and expected benefits or effects from such treatment;
 - (c) likelihood of success;
 - (d) alternatives to the procedures and their risks and benefits, including the possible results of non-treatment;
 - (e) the name of the physician or other practitioner who has primary responsibility for the patient's care.
- 6.3 An informed consent is the verbal exchange of information between Physician and patient, and this shall be documented in the medical record and should include all procedures contemplated other than simple, common or routine procedures as described in section 6.1.
- 6.4 Informed consent shall be obtained prior to any pre-procedure medication which might render the patient incapable of giving consent.
- 6.5 If informed consent is not obtained, the reason shall be documented in the progress note of the medical record. A procedure for which informed consent is required may not be performed unless the consent has been obtained except in an emergency as described in Section 6.6 below.
- 6.6 Consent should be obtained, whenever possible, from a competent "adult". For purposes of this rule, "competency" is defined as the ability to understand the nature and consequences of the medical procedure to which one is asked to consent. For purposes of this rule, an "adult" is:
 - (a) a person who has reached the age of 18, or
 - (b) a minor who has entered into a valid marriage (whether or not the marriage was terminated by dissolution), who was on active duty with the armed forces of the United States, or who has been declared emancipated pursuant to Civil Code Section 64.

PMC Medical Staff Bylaws, Rules and Regulations

6.7 In the event the patient is not a competent adult who is able to give valid informed consent, informed consent must be obtained from an appropriate surrogate decision maker except in an emergency as described in 6.8 below. If the patient is a minor, the surrogate is a court appointed guardian, if one exists, or if none exists, then the parents. If the patient is an incompetent adult, the surrogate is:

- (a) the attorney in fact appointed pursuant to a durable power of attorney for health care, or if none, then;
- (b) a court-appointed guardian or conservator who has been granted power to make medical decisions, or if none, then;
- (c) the patient's closest available relative. Generally, the patient's spouse will be the closest available relative, followed by a child or a parent, and then a brother or sister. However, individual cases may vary depending upon which of these relatives is in the best position to know and articulate the patient's wishes. If no immediate family member can reasonably be located or contacted, other member can reasonably be located or contacted, other relatives may act as surrogate. In unusual circumstances, "significant others" or close friends may be acceptable as surrogate decision makers; however, before relying on such persons, the administrator and chief of staff (or their respective designees) should be contacted for concurrence. If there is no appropriate surrogate, or if there is an unresolvable disagreement between prospective surrogates, the administrator and chief of staff (or their respective designees) shall be consulted to determine whether judicial proceedings should be instigated.

6.8 In the event a patient requiring a surgical or other procedure is incompetent to give informed consent by age or physical or mental status, and no surrogate decision maker as described in Section 6.7 is reasonably available to consent on the patient's behalf, the treating Physician shall make a determination whether an emergency exists. A progress note shall be written documenting

- (a) the need for the procedure,
- (b) the nature and circumstances of the emergency, and
- (c) the unavailability of any surrogate decision maker.

For the purpose of this rule, an emergency is defined as a situation in the hospital, whether or not it occurs in the emergency department, requiring immediate services for alleviation of severe pain, or immediate diagnosis and treatment of unforeseen medical conditions, which, if not immediately diagnosed and treated can reasonably be expected to lead to serious disability or death. If the patient is a minor and the parents are unavailable to give consent, the same documentation is required by the treating physician.

6.9 Informed consent should be obtained by telephone only if the person having legal capacity to consent for the patient is not otherwise available. The Physician must, in so far as possible, provide the patient's legal representative with information regarding risks, benefits, alternatives and consequences of refusing treatment. Hospital personnel will verify that consent for treatment has been given by being a third party on the phone.

6.10 In all cases dealing with informed consent, the Member shall comply with Hospital administrative requirements for documenting consent.

7. POTENTIAL LITIGATION

7.1 Any Member who has a case which he suspects may lead to a malpractice suit which will involve the

PMC Medical Staff Bylaws, Rules and Regulations

Hospital or any Member shall report such a case and give details to the Administrator at the earliest possible moment.

8. AUTHORITY TO ACT

8.1 Any Member who acts in the name of the Medical Staff without proper authority shall be subject to such disciplinary action as the Executive Committee may deem appropriate.

9. DIVISION OF FEES

9.1 Any division of fees, except as allowed by law, by a Member is forbidden and shall be cause for exclusion or expulsion from the Medical Staff.

10. DISCLOSURE OF INTEREST

10.1 All nominees for election or appointment to offices of the Medical Staff, department chairmanships, or the Executive Committee shall at least twenty (20) days prior to the date of election or appointment, disclose in writing to the Executive Committee those personal, professional or financial affiliations or relationships of which they are reasonably aware which could foreseeable result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff.

11. CREDENTIAL FILES

11.1 Insertion of adverse information.

11.1.1 The following applies to actions relating to insertion of adverse information into a Member's credentials file.

11.1.2 Any person may provide information to the Medical Staff about the conduct, performance or competence of it's Members.

11.1.3 When insertion of adverse information into a Member's credentials file is being considered, the appropriate department chairman, the Chief of Staff, and involved Member shall review such information. The Member may write a statement to be placed in his credentials file.

11.1.4 After such a review a decision will be made by the appropriate department chairman and the Chief of Staff to

- (a) not insert the information;
- (b) insert the information along with the notation that no further review is warranted; or
- (c) insert the information along with the notation that a request has been made for an investigation.

11.1.5 This decision, as outlined in 12.1.4, shall be reported to the Executive Committee. The Executive Committee, when so informed, may either ratify or initiate contrary actions to this decision by a majority vote.

11.2 Review of adverse information at the time of reassessment and reappointment.

11.2.1 The following applies to the review of adverse information in the Member's credentials file at the time of reassessment and reappointment.

11.2.2 Following this review, the department shall determine whether documentation in the file warrants further action.

- (a) Prior to recommendation on reappointment, the department, as part of its appraisal

PMC Medical Staff Bylaws, Rules and Regulations

function, shall review any adverse information in the credentials file pertaining to a Member.

- (b) Following this review, the department shall determine whether documentation in the file warrants further action.
- (c) With respect to such adverse information, if it does not appear that an investigation and/or adverse action on reappointment is warranted, the department shall so inform the Executive Committee.
- (d) However, if an investigation and/or adverse action on reappointment is warranted, the department shall so inform the Executive Committee.

11.3 If the Executive committee determines that no corrective action should be taken and this recommendation is concurred with by the Board of Directors and there is no credible evidence for the complaint, any adverse information concerning the complaint shall be removed from the Member's credentials file.

12. CONFIDENTIALITY

12.1 The following applies to records of the Medical Staff and its committees responsible for the evaluation and improvement of patient care.

- 12.1.1 The records of the Medical Staff and its committees responsible for the evaluation and improvement of the quality of patient care rendered in the Hospital shall be maintained as confidential.
- 12.1.2 Access to such records shall be limited to duly appointed officers and committees of the Medical Staff or of any medical staffs of other District Facilities for the sole purpose of discharging Medical Staff responsibilities and subject to the requirement that confidentiality be maintained.
- 12.1.3 Information which is disclosed to the Board of Directors or its appointed representatives, in order that the Board of Directors may discharge its lawful obligations and responsibilities, shall be maintained by the body as confidential.
- 12.1.4 Information contained in the credentials file of any Member may be disclosed with the Member's consent to any medical staff, hospital, professional licensing board, or medical school. However, any disclosure outside of the Medical Staff, except with the Member's consent or to the medical staffs of other District Facilities as authorized in the Medical Staff Bylaws, Rules and Regulations, shall require the authorization of the Chief of Staff.

13. EMERGENCY DEPARTMENT CONSULTATION

13.1 All active category Members and provisional category Members who have completed their respective department requirements, shall participate on the Emergency Department consultation panel in accordance with those requirements.

Participation on a separate trauma services consultation panel will be voluntary. Such panel shall be established and only those Members who volunteer to participate on said panel shall be required to consult and follow designated trauma patients. A separate call schedule for each subspecialty on the trauma services consultation panel may be maintained. Members may volunteer for such participation on the trauma services consultation panel through notification to their respective department.

Participation by members on dedicated call pursuant to the trauma center standards of the Hospital and San Diego County is voluntary and is in addition to the emergency department panel participation. Members shall volunteer for such dedicated call through agreements with the Hospital.

PMC Medical Staff Bylaws, Rules and Regulations

For those Members who volunteer to serve on the trauma services consultation panel, call schedules may be combined with the emergency panel. Nothing contained herein shall prevent any member from receiving compensation for his participation on either a dedicated call schedule or the trauma services consultation panel.

Members may volunteer to serve on the trauma services consultation panel for a period of at least one (1) year, giving at least ninety (90) days notice prior to resignation from the same.

- 13.2 Notwithstanding 13.1, any Member sixty (60) years of age or older shall, upon the Member's request, be excused from participation on the panel.
- 13.3 Unless a shorter period is specified to comply with a departmental rule or trauma designation, or other contractual or legal mandate, the Member shall be able to respond by phone to the Emergency Department approximately fifteen (15) minutes from the initial attempt to contact the Member. The Member shall only be required to come to the Emergency Department if specifically requested, and if so requested, must be present in the Emergency Department within approximately thirty (30) minutes from time of phone contact.
- 13.4 The Member shall respond and evaluate the patient in the Emergency Department and be responsible for the disposition of the patient (i.e. transfer, inpatient care, discharge). Should the Member determine hospitalization is required for the appropriate care of complaints or medical problems within his area of specialty or expertise and a transfer cannot be accomplished within six (6) hours of the time of the request for consultation, the Member shall admit the patient to the appropriate inpatient unit of the hospital, if another appropriate disposition of the patient in accordance with Hospital policy cannot be made.
- 13.5 Failure to respond in the required time or to otherwise comply with the panel requirement may lead to suspension of privileges.
- 13.6 Patients presenting to the Emergency Department who have an established Practitioner-patient relationship will be referred to that Practitioner. Any patient who has no prior existing relationship with a Member and who requires follow up care will be referred to an appropriate facility or to the appropriate primary care or specialty Practitioner who is on call to the Emergency Department when the patient presented. A patient referred for follow-up care shall receive an offer to be seen at least once.
- Clarification: A Practitioner-patient relationship will be assumed to exist by the Emergency Department if (1) the patient identifies a Practitioner as his primary physician; or (2) the patient has been under the care of a Practitioner in the hospital within the previous three (3) months, as indicated in hospital records.

The Emergency Department can assume that a Practitioner-patient relationship does not exist if the patient has been under the care of a specialist whose practice is limited to a specialty and the patient presents with a problem outside the specialty.

The Practitioner-patient relationship can be considered ended if: 1) the Practitioner can document that he/she referred the patient to an alternative physician who has accepted the patient; or 2) the Practitioner has sent a certified letter to discharge the patient and thirty (30) days has elapsed; or 3) the Practitioner indicates that three (3) months has elapsed since the patient was under his care in the hospital and a subsequent Practitioner-patient relationship was never established due to the patient's lack of follow up.

If the Practitioner-patient relationship does exist, the Practitioner is obligated to care for the patient. If a Practitioner-patient relationship does not exist or has been ended, the physician who is on call on the Emergency Department roster is obligated to care for the patient. If a patient, who has been sent a

PMC Medical Staff Bylaws, Rules and Regulations

letter of discharge, presents to the Emergency Department within thirty (30) days of receipt of the letter and alternative Practitioner cannot be found, the original Practitioner is obligated to care for the patient. Failure to carry out a Practitioner's obligation can result in suspension of privileges. (Sending a copy of a certified letter of discharge to the Medical Records Department for inclusion in the patient's chart is encouraged.)

When a Practitioner-patient relationship does not exist and a patient is referred for follow up which required that the patient receive an offer to be seen at least once, the term, "at least once", is interpreted to mean that the practitioner must offer to see the patient in his office one time or, in cases when necessary to prevent serious harm to the patient, an offer to treat the illness, regardless of the patient's ability to pay or the payment source of the patient.

- 13.7 7:00 a.m. shall be the official time for changing the on-call schedule in the Emergency Department. The Member on call for the twenty-four (24) hour period starting at 7:00 a.m., in the specialty required, shall be responsible for a patient referred from the Emergency Department at the time the consult is requested even if the patient arrived prior to 7:00 a.m.

14. COMPLIANCE WITH POLICIES AND PROCEDURES

All Practitioners shall comply with all reasonable policies and procedures which are disseminated to the membership, including but not limited to the Medical Staff Disruptive Conduct Policy/Procedure and the Procedure regarding Compliance with Evidence Based Guidelines.



PALOMAR
POMERADO
HEALTH

POMERADO HOSPITAL MEDICAL STAFF

BYLAWS

RULES AND REGULATIONS

CREDENTIALS MANUAL

MEDICAL STAFF RIGHTS MANUAL

OCTOBER 2007

**POMERADO HOSPITAL
MEDICAL STAFF BYLAWS AND RULES AND REGULATIONS
TABLE OF CONTENTS**

		Page
ARTICLE I	MEMBERSHIP.....	1
	Nature of Membership.....	1
	1.2 Qualifications.....	1
	1.3 Leave of Absence.....	2
	1.4 Termination of Leave of Absence.....	2
	1.5 Non-Eligibility.....	2
	1.6 Quality Assurance.....	2
ARTICLE II	CATEGORIES OF THE MEDICAL STAFF.....	3
	2.1 Provisional.....	3
	2.2 Active.....	3
	2.3 Affiliate.....	3
	2.4 Honorary.....	4
ARTICLE III	CLINICAL PRIVILEGES	4
	3.1 Restricted	5
	3.2 Temporary.....	6
	3.3 Special Conditions.....	7
	3.4 Emergency.....	7
	3.5 Telemedicine Privileges.....	7
ARTICLE IV	ALLIED HEALTH PROFESSIONALS.....	8
	4.1 General Qualifications.....	8
	4.2 Board of Director's Action.....	8
	4.3 Application Procedure.....	8
	4.4 Specification of Services.....	8
	4.5 Qualification Generally.....	10
ARTICLE V	MEDICAL STAFF OFFICERS.....	10
	5.1 Officers of the Medical Staff.....	10
	5.2 Duties of Officers.....	12
ARTICLE VI	COMMITTEES.....	13
	6.1 Designation.....	13
	6.2 General Provisions.....	13
	6.3 Executive Committee.....	17
	6.4 Quality Management Committee.....	19
	6.5 Special Care Unit Committee.....	19
	6.6 Cancer Committee.....	19
	6.7 Investigational Review Committee.....	20
	6.8 Physical Well Being Committee.....	20
	6.9 Biomedical Ethics Committee.....	20

	6.10	Long Term Care Committee.....	21
	6.11	Operating Room Committee.....	21
	6.12	Infection Surveillance Committee.....	22
	6.13	Pharmacy and Therapeutics Committee.....	22
	6.14	Health Care Resource Committee.....	22
	6.15	Interdisciplinary Practice Committee.....	22
	6.16	Joint Conference Committee.....	23
ARTICLE VII		CLINICAL SERVICE DIVISIONS.....	23
	7.1	Organization.....	23
	7.2	Current Clinical Service Divisions.....	23
	7.3	Membership.....	23
	7.4	Clinical Service Director.....	24
	7.5	Clinical Service Division Functions.....	25
	7.6	Committees.....	25
	7.7	Creation of New Clinical Service Divisions.....	25
ARTICLE VIII		SECTIONS	25
	8.1	Sections.....	26
	8.2	Current Sections.....	26
	8.3	Section Chief.....	26
ARTICLE IX		IMMUNITY FROM LIABILITY.....	27
ARTICLE X		MEDICAL STAFF MEETINGS.....	27
	10.1	Regular Meetings.....	27
	10.2	Special Meetings.....	27
	10.3	Quorum.....	28
	10.4	Attendance Requirements.....	28
	10.5	Agenda.....	28
ARTICLE XI		COMMITTEE AND CLINICAL SERVICE DIVISION MEETINGS.....	28
	11.1	Regular Meetings.....	28
	11.2	Special Meetings.....	29
	11.3	Notice of Meeting.....	29
	11.4	Manner of Action.....	29
	11.5	Rights of Nonvoting Members.....	29
	11.6	Minutes.....	29
	11.7	Attendance Requirements.....	29
ARTICLE XII		MEDICAL STAFF YEAR.....	30
ARTICLE XIII		DUES AND FINES.....	30
ARTICLE XIV		AMENDMENTS.....	30
	14.1	Bylaws.....	30
	14.2	Rules and Regulations.....	30
	14.3	Mandated Amendments.....	30
ARTICLE XV		CONTRACT PHYSICIANS.....	31
ARTICLE XVI		INDEPENDENT LEGAL COUNSEL.....	31

RULES AND REGULATIONS.....	31
1. Admission of Patients.....	31
1a. Consultation Policy.....	33
2. Discharge of Patients.....	34
3. Medical Records.....	34
4. Medications.....	37
5. Patient Death.....	38
6. Informed Consent.....	38
7. Potential Litigation.....	39
8. Authority to Act.....	39
9. Division of Fees.....	39
10. Disclosure of Interest.....	39
11. Confidentiality.....	39
12. Emergency Department Consultation.....	40
13. Monitoring.....	40
14. Compliance with Policies and Procedures.....	42
15. Restraint & Seclusion Policy.....	42
CREDENTIALS MANUAL	43
Terms of Appointment.....	43
Application for Appointment.....	43
Appointment Process.....	45
Reappointment Process.....	47
Credentials Files.....	48
Protocol for Credentialing Physicians and Advanced-Level Practitioners in the Event of a Disaster.....	49
MEDICAL STAFF RIGHTS MANUAL.....	50
Collegial Intervention.....	50
Corrective Action.....	50
Summary Restriction or Suspension.....	52
Automatic Suspension or Limitation.....	53
Continuity of Care.....	54
Hearing and Appellate Review.....	54
Request for Hearing.....	55
Hearing Procedures.....	57
Specific Determination.....	59
Appeal to the Board of Directors.....	60

ARTICLE I MEMBERSHIP

1.1 NATURE OF MEMBERSHIP

Membership is a privilege, which shall be extended only to professional competent Practitioners who continuously meet the qualifications, standards, and requirements set forth in these bylaws and such other standards, consistent with these bylaws as shall be specified by the Medical Staff.

1.2 QUALIFICATIONS

- 1.2.1 Only Practitioners licensed to practice medicine, dentistry or podiatry in the State of California, who can document their background, experience, training and demonstrated competence, their adherence to the ethics of their profession, their good reputation, their ability to work with others, and their ability to perform the privileges requested shall be admitted to the Medical Staff.
- 1.2.2 All Practitioners who apply for membership after the effective date (March 11, 1996) of this section shall be certified by a member Board of the American Board of Medical Specialties or by the American Board of Osteopathic Specialties or by the American Board of Podiatric Surgery or by the American Board of Oral and Maxillofacial Surgery, or another board with equivalent requirements, or shall be actively engaged in the Board application and certification process. Every applicant to the Medical Staff who is not board certified shall sign a statement at the time of application attesting that he/she is qualified and shall attain certification within thirty-six (36) months of appointment to the Medical Staff. Any individual who does not attain board certification within thirty-six (36) months may request a waiver. The individual requesting the waiver bears the burden of demonstrating that his or her qualifications are equivalent to board certification. The Board may grant a waiver in exceptional cases after considering the findings of the Executive Committee, the specific qualifications of the individual in question, and the best interests of the Hospital and the community it serves. The granting of a waiver in a particular case is not intended to set a precedent for any other individual. No individual is entitled to a waiver or to a hearing if the Board determines not to grant a waiver. A determination that an individual is not entitled to a waiver is not a "denial" of appointment or clinical privileges.
- 1.2.3 Acceptance of membership shall constitute the Member's agreement that he/she will abide by the Principles of Medical Ethics of the American Medical Association, the Code of Ethics of the American Dental Association, American Podiatric Medical Association Code of Ethics, and the California Medical Association's "Guiding Principles for Physician-Hospital Relations", as appropriate. Specifically, each Member shall:
- (a) Be prohibited from division of fees except as allowed by law.
 - (b) Provide for continuous care of his/her patients.
 - (c) Delegate in their absence the responsibility for diagnosis or care of their patients only to a Member who is qualified to undertake this responsibility.
 - (d) Seek consultation whenever indicated.
- 1.2.4 No person shall be entitled to membership merely because that person holds a certain degree, is licensed to practice in this or in any other state, is a member of any professional organization, is certified by any clinical board, or because such a person had, or presently has, membership or privileges at another health care facility.
- 1.2.5 Every Member, except retired or honorary, shall carry professional liability (malpractice) insurance with a company admitted to practice insurance business in the State of California in limits of not less than \$1 million per occurrence/\$3 million annual aggregate, or have an alternative form of financial security as described below as a condition of obtaining and exercising clinical privileges. Each Member shall cause a current certificate of insurance to be furnished to the Hospital by their insurance company. The certificate shall specify the expiration date of the policy and the amount of insurance. If a Member's insurance is restricted in any manner (such as not covering surgery or

obstetrics), the Member must furnish a copy of the policy restriction to the Hospital, and the Member cannot exercise the privileges excluded from the insurance coverage. The Member shall immediately notify the Hospital if their insurance coverage is reduced below the foregoing limits, or is cancelled or terminated, or it is expired. Alternative forms of financial security shall be in amounts equal to the required amounts of professional liability insurance, shall cover defense costs and liability, and cannot be used as a substitute for insurance without prior individual approval by the Executive Committee and the Board of Directors.

1.2.6 Membership or clinical privileges shall not be denied on the basis of race, creed, sex, age, color, or national origin.

1.2.7 Acceptance of membership shall constitute an agreement that the Member will abide by these bylaws, rules and regulations. When a Member fails to make an appropriate response to a request sent by certified, return receipt requested mail, for reasonable information or action within thirty (30) days, it shall be deemed a voluntary resignation of his/her membership and clinical privileges.

1.3 LEAVE OF ABSENCE

A Member needs to notify the Medical Staff Office at least thirty (30) days prior to the Leave of Absence unless it is due to an emergency circumstance. If the request is submitted less than thirty (30) days in advance to the start of the leave, then it must be approved by the Chief of Staff. A request can be referred to the Executive Committee for review and final approval. Failure to do so could result in suspension of privileges. The request should include the exact period of time and the reason for the leave, which may not exceed two (2) years.

1.4 TERMINATION OF LEAVE OF ABSENCE

At least thirty (30) days prior to termination of the leave, or at any time, the Member may request reinstatement of his/her privileges and prerogatives by submitting a written notice to that effect to the Executive Committee. The Member shall submit a written summary of his/her relevant activities during the entire leave of absence period and materials to update his/her credentials file(s) as if it were a new application. Prior to reinstatement of privileges, these materials and activities will be verified by the Clinical Service Division, which may also request information concerning the current status of the Member's ability to safely perform all of the essential mental and physical functions related to the specific clinical privileges requested. Depending on the length of, and activities performed during the leave of absence, reinstatement might be made provisional for a period of time during which the Member's clinical performance shall be monitored by the appropriate Clinical Service Division(s) granting privileges to determine the Member's abilities. A recommendation shall be made by the Clinical Service Division for reinstatement of full privileges, reinstatement with monitoring, or termination to the Executive Committee who shall, in turn, make a recommendation to the Board of Directors concerning the reinstatement of the Member's privileges and prerogatives. Failure, without good cause, to request reinstatement or to provide the requested summary of activities as above provided, shall result in automatic termination of membership, privileges, and prerogatives. A request for membership and privileges subsequently received from a Member so terminated shall be submitted and processed in the manner specified for application for initial appointment.

1.4.1 Upon reinstatement from leave of absence, medical staff dues shall be assessed on a prorated basis, in the same manner as dues are assessed for provisional staff Members.

1.5 NON-ELIGIBILITY

An applicant who has been denied requested privileges, or had privileges revoked or restricted at Palomar Medical Center, shall not be ineligible for membership, but the facts of such action can constitute evidence of the same action at Pomerado Hospital.

1.6 QUALITY ASSURANCE

The Hospital has an ongoing quality assurance/performance improvement program. Part of the program is to observe a Member's performance both in and outside the Hospital. By accepting membership, a Practitioner agrees to participate in this program including any requirement for monitoring or other observation initiated by the Member's respective Clinical Service Division or the Quality Management Committee. The Member understands that such monitoring is necessary for an effective

quality assurance/performance improvement program and shall be grounds for a hearing pursuant to Section 2.1 of the Medical Staff Rights Manual.

ARTICLE II CATEGORIES OF THE MEDICAL STAFF

2.1 PROVISIONAL

All Members shall serve a minimum of one (1) year and a maximum of two (2) years on a provisional basis prior to advancement. All Members shall be assigned to a Clinical Service Division, where the Clinical Service Director or the Section Chief shall observe their performance and clinical competence. Provisional Members are eligible to serve on Medical Staff and Clinical Service Division committees, and shall be eligible to vote on committee matters, but they may not hold office. Provisional Members shall not be eligible to vote on general medical staff and Clinical Service Division matters. If the Provisional Member fails to: (1) admit or treat the number of patients established by the Executive Committee (sufficient to permit observation and assessment), or (2) fulfill all requirements of appointment relating to completion of medical records, and/or cooperating with monitoring or observation conditions, at the expiration of the provisional period, all clinical privileges shall be automatically relinquished. The individual may reapply. Whenever provisional clinical privileges are terminated, revoked or restricted for other reasons, the individual shall be entitled to a hearing and appeal.

In the event a Member who fails to satisfy the provisional requirements is not otherwise barred from reapplying (i.e. because the failure is due to insufficient activity to satisfy proctoring requirements), the provisional category Member may submit re-application. If a Member fails to meet all provisional requirements by the end of the second consecutive provisional appointment, his/her membership shall be terminated and he/she shall not be entitled to submit a re-application for at least one year, unless such application is barred for two years.

Provisional Members, except those in the affiliate-consulting, affiliate-associate, or affiliate categories, shall be required to provide emergency room coverage according to the rules and regulations. Applicable dues shall be assessed newly appointed provisional staff Members on a pro-rated quarterly basis, based on the appointment date.

2.2 ACTIVE

The active category shall consist of Members who regularly admit, or who are regularly involved in the care of patients in the Hospital. Members who attend more than twenty-five (25) patients during their two (2) year reassessment-reappointment period, or who are regularly involved in Medical Staff functions as determined by the Medical Staff, shall be eligible for active staff membership. Such Members must be located close enough to the Hospital to provide continuous care to their patients, and shall assume all functions and responsibilities of the active staff membership, including emergency room coverage, according to the rules and regulations, and follow-up appointments. Active category Members shall be appointed to a specific Clinical Service Division, shall be eligible to vote, to hold office, and to serve on standing committees of the Medical Staff and Clinical Service Division. Annual dues shall be assessed.

2.3 AFFILIATE

The affiliate category shall consist of Members who only occasionally admit patients at the hospital, are recognized specialists with an appointment equivalent to active category at another hospital, who only admit or regularly attend patients in the Hospital's distinct part skilled nursing service (Villa Pomerado), or who are not active or have an equivalent appointment at another hospital, but who appear likely to provide a distinct service to the hospital, the Medical Staff, and the patients. Affiliate category Members shall be assigned to a Clinical Service Division. All appointments to this category shall be subject to the requirements for provisional status described in Section 4.1. Following advancement, the Member shall undergo biennial reassessment based on the renewal date of their California license as outlined in Section 4 of the Credentials Policy Manual. Affiliate Members shall not be eligible to vote or to hold office. They shall not be required, but are encouraged to attend Clinical Service Division meetings and annual or special meetings of the Medical Staff. Affiliate category Members shall be required to pay dues.

2.3.1 Affiliate-Courtesy

This category shall consist of Practitioners who only occasionally attend to or treat patients at Pomerado Hospital. An affiliate-courtesy Member is to attend no more than twenty-five (25) patients during a two (2) year reassessment-reappointment period, unless the Member is on the active staff at Palomar Medical Center in which case the twenty-five (25) patient limitation will be waived. When so requested by either the Clinical Service Director or the Chief of Staff, an affiliate –courtesy category Member may be required to serve on the Emergency Room back-up panel for his/her specialty.

2.3.2 Affiliate-Consulting

This category shall consist of Practitioners who are recognized specialists. These Members shall consult only at the request of an active Member of the Medical Staff. Their function shall be mainly to evaluate patients and make recommendations for therapy. Sub-specialty procedural privileges may be granted only when the specialty or sub-specialty services are not available from within the Pomerado Medical Staff. Affiliate-consulting Members shall not be required to serve on Emergency Room back-up call.

2.3.3 Affiliate-Associate

This category shall consist of Practitioners who only admit or regularly attend patients in the Hospital's distinct part skilled nursing service (Villa Pomerado). Clinical privileges shall only include care and treatment of patients admitted to Villa Pomerado. No acute-care privileges shall be granted to this category. Affiliate-associate Members shall not be eligible to take Emergency Room back-up call.

2.3.4 Affiliate

This category shall consist of Practitioners who are not active or who have an equivalent appointment at another area hospital, but who nevertheless appear likely to provide a distinct service to the Hospital, the Medical Staff, and the patients. This category shall mainly be comprised of family practitioners that have had no clinical activity through inpatient admissions to Pomerado Hospital or Palomar Medical Center during the biennial review period. Practitioners in other specialties may also be assigned to this category if they have not had any clinical activity, inpatient admissions or consultations, during the biennial reassessment period. No clinical privileges shall be granted to any Member in the affiliate category.

2.4 HONORARY

The honorary category shall consist of Members who are no longer actively practicing, and who are honored by emeritus positions. These may be Physicians who are of outstanding reputation who are not necessarily residing in the community. Any Clinical Service Division and not the Executive Committee shall make recommendations to this category to the Board of Directors. Honorary category Members shall not be eligible to attend patients, to vote, to hold office, or to serve on standing committees of the Medical Staff. Annual dues shall not be assessed.

**ARTICLE III
CLINICAL PRIVILEGES**

3.1 RESTRICTED

3.1.1 Members shall exercise only those clinical privileges specifically granted by the Board of Directors following recommendation by the Clinical Service Division and the Executive Committee.

3.1.2 Except for affiliate category applicants (Section 4.3.4), initial application for membership shall contain a request for the specific clinical privileges desired by the applicant. The evaluation of such requests shall be based on the applicant's education, training, experience, demonstrated competence, references and other relevant information, including an appraisal by the Director of the Clinical Service Division in which privileges are sought. The applicant shall have the burden of establishing his/her qualifications and competence in the clinical privileges he/she requests. Clinical privileges shall be delineated for every applicant and shall not be stated in general, broad terms.

- 3.1.3 Periodic re-determination of clinical privileges and the increase or curtailment of same shall be based upon the direct observation of care provided, review of the records of patients treated in the Hospital or other hospitals, review of the Member's participation in the delivery of medical care and any documented additional training and/or experience.
- 3.1.4 Applications for additional clinical privileges, including new procedures, shall be submitted in writing. The applicant's relevant training and/or experience shall be stated. When not previously established, monitoring requirements will be developed by the appropriate Clinical Service Division. Such applications shall be processed in the same manner as initial applications.
- 3.1.5 A Member who has not used a specific procedural privilege in five (5) years must be monitored for one (1) case by another qualified Member when he/she performs the procedure. If a Member has not used a previously granted procedural privilege in ten (10) years, the privilege is rescinded. The Member must reapply for that privilege(s) under the same guidelines as the initial application (Section 5.1.2 above).

3.2 TEMPORARY

3.2.1 Applicants

Following the receipt of a complete application and initial review by the Clinical Service Division Director, the Vice President/ Administrator, with the written concurrence of the Chief of Staff and the appropriate Clinical Service Division Director may, where unusual circumstances warrant it, grant temporary clinical privileges pending processing of the application. Such temporary privileges shall be time-limited and shall not exceed one hundred-twenty (120) days, during the pendency of the application. In such instances, the applicant shall be under the supervision of the appropriate Clinical Service Division Director. Special requirements of supervision and reporting may be required by the appropriate Clinical Service Division Director. Temporary clinical privileges shall be immediately terminated by the Vice President/Administrator, with the concurrence of the Chief of Staff or appropriate Clinical Service Division Director upon notice of any failure by the applicant to comply with such special requirements.

Eligibility to request Temporary Clinical Privileges:

- (a) Temporary privileges may be granted by the Chief Administrative Officer after consultation with the Clinical Service Division Director and the Chief of Staff to initial applicants only when an applicant for initial appointment is awaiting review by the Executive Committee and Board, following a favorable report on a complete application by the Clinical Service Division Director, and has no current or previously successful challenges to his or her licensure or registration and has not been subject to involuntary termination of medical staff membership, or involuntary limitation, reduction, denial or loss of clinical privileges, at another health care facility.

3.2.2 Non-Applicants

The Vice President/Administrator may grant temporary clinical privileges, with the written concurrence of the appropriate Clinical Service Division Director and the Chief of Staff, to a Practitioner who is not an applicant for membership for the sole purpose of assisting in a specific surgical procedure, provided that there shall first be obtained such Practitioner's signed acknowledgement that he/she has received and read a copy of the bylaws, rules and regulations of the Medical Staff, and that he/she agrees to abide by the terms thereof in all matters relating to his/her temporary clinical privileges. In addition, evidence of current California licensure must be submitted along with documentation of professional liability insurance with limits outlined in Section 3.2.5. Additional information may be elicited from the National Practitioner Data Bank, as required. Current competence shall be verified before temporary privileges are granted. The applicant shall notify the hospital, in writing, promptly and no later than fourteen (14) days from the occurrence of among other things a receipt of written notice of any adverse action against the applicant under any federal health care program, such as the Medicare/Medical program, including but not limited to fraud and abuse proceedings or convictions. Such temporary clinical privileges shall not be extended to Practitioners who desire to provide primary care to patients. The Vice President/Administrator upon recommendation of the Chief of Staff may grant an exception, if the expertise in a highly specialized field of medicine is not available

from the Medical Staff, and if such restriction might be detrimental to patient care. Temporary clinical privileges to non-applicants shall not be granted more than four (4) times in a calendar year.

A practitioner who desires privileges only to assist at surgery, without primary patient responsibility, shall submit an application for membership as provided in the Credentials Policy Manual, stating in the application that such are the only privileges requested. The application shall be processed in the same manner described in the Credentials Policy Manual. Requirements of supervision and reporting shall be imposed by the appropriate Clinical Service Division Director on any Practitioner granted temporary privileges. Temporary clinical privileges shall be immediately terminated by the Vice President/Administrator, with the concurrence of the Chief of Staff or the appropriate Clinical Service Division Director upon notice of any failure by the Practitioner to comply with such special conditions.

3.2.3 Termination

Except as provided in this Section, a Practitioner shall not be entitled to the procedural rights afforded by the Medical Staff Rights Manual because his or her temporary privileges are terminated or suspended. When the Executive Committee makes a determination that temporary privileges should be denied or terminated based on conduct of the Practitioner that is reasonably considered likely to be detrimental to patient safety or to the delivery of patient care, the Practitioner is entitled to request a hearing pursuant to the Medical Staff Rights Manual. If temporary privileges are suspended based on such conduct, as a result of a determination by the Executive Committee, the Practitioner will be entitled to request a hearing pursuant to the Medical Staff Rights Manual only when the suspension is reportable pursuant to Business and Professions Code Section 805.

3.2.4 Palomar Medical Staff Members

Temporary clinical privileges may be granted by the Vice President/Administrator, with the written concurrence of the appropriate Clinical Service Division Director and the Chief of Staff, to a Practitioner who is not an applicant for membership or whose application is pending if the Practitioner is currently an active member of the Medical Staff of Palomar Medical Center. Current licensure and competence will be verified through the Palomar Medical Staff Office before any such privileges are granted. These privileges may be granted only where there is an unusual circumstance, which warrants the granting of such privileges and shall be limited to those privileges the Practitioner could perform if he/she was a Member. Unusual circumstances include, without limitation, situations when a service usually performed at Palomar Medical Center cannot be performed due to space or staff limitations. The privileges will be granted, if at all, on a case-by-case basis and shall continue for the duration of the admission as required for patient care. However, such temporary privileges shall be limited to one-hundred twenty (120) days. All cases performed at the Hospital may be subject to review by the Quality Management Committee and the Quality Management Committee of Palomar Medical Center's Medical Staff. The cases performed at the Hospital may be utilized in reviewing the Practitioner's performance at Palomar Medical Center. The granting of temporary privileges for an individual case will not give a Practitioner the right to perform another case without the granting of additional privileges by the Vice President/Administrator. Such temporary privileges shall be terminated by the Vice President/Administrator with the concurrence of the Chief of Staff or appropriate Clinical Service Division Director at any time and for any reason.

3.3 SPECIAL CONDITIONS

3.3.1 Allied Health Professionals

Requests to perform specified patient care services from Allied Health Professionals are processed in the same manner specified in Article VI. Allied Health Professional personnel may, subject to any licensure requirements or other limitations, exercise independent judgement within the areas of his/her professional competence and participate directly in the management of patients under the supervision of a Member who has been accorded privileges to provide such care. Allied Health Professionals may not admit patients to the Hospital.

3.3.2 Affiliate-Associate Category Members

Affiliate-Associate Members may attend patients in the Hospital's distinct part skilled nursing facility service (Villa Pomerado) only. No other clinical privileges will be granted to such Members.

3.4 EMERGENCY

An emergency is defined as a condition where treatment appears to be immediately required and necessary to prevent deterioration or aggravation of the patient's condition.

In the case of an emergency, Members, to the degree permitted by their license and regardless of category, division or lack of same, shall be permitted and assisted to do everything possible to save the life of a patient using every facility of the Hospital necessary, including the calling for any necessary consultation.

When an emergency situation no longer exists, Members shall request the privileges necessary to continue to treat the patient. In the event such privileges are denied, or he/she does not desire to request privileges, the patient shall be assigned to an appropriate Member of the staff.

3.5 TELEMEDICINE PRIVILEGES

- (a) Telemedicine is the exchange of medical information from one site to another via electronic communications for the purpose of improving patient care, treatment, and services. The Board shall determine the clinical services to be provided through telemedicine after considering the recommendations of the appropriate Clinical Service Division Director and the Executive Committee.
- (b) This section applies only to those practitioners not appointed to the Medical Staff who will have total or shared responsibility for the care of a patient at the Hospital through the use of a telemedicine link. "Total or shared responsibility" is evidenced by the practitioner having the authority to write medical orders and direct a patient's care, treatment, or services.
- (c) This section shall not pertain to practitioners who are providing either official or preliminary readings of images, tracings, or specimens through a telemedicine link. Those practitioners shall be credentialed in a manner that ensures that the medical services are provided safely and effectively.
- (d) In processing a request for telemedicine privileges pursuant to this section, the Hospital may:
 - 1) credential and grant privileges to the practitioner in the same manner as any other applicant; or
 - 2) credential and grant privileges to the practitioner, but utilize the credentialing information from the practitioner's primary hospital, provided that hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations; or
 - 3) credential and grant privileges to the practitioner based on the credentialing and privileging decision from the practitioner's primary hospital, if the following conditions are met:
 - (i) the primary hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations;
 - (ii) the practitioner has clinical privileges at the primary hospital to perform the same service or procedure being requested at the Hospital; and
 - (iii) the Hospital reviews the practitioner's performance of the privileges being requested and provides information resulting from that review to the primary hospital.

**ARTICLE IV
ALLIED HEALTH PROFESSIONALS**

4.1 GENERAL QUALIFICATIONS

Allied Health Professionals are professionals, other than Practitioners, who hold a license, certificate, or such other legal credentials, if any, as required by California law, which authorizes the professional to provide certain services, and are qualified to render services upon an order from or under the supervision of a Practitioner on the Medical Staff.

4.2 BOARD OF DIRECTORS' ACTION

The Board of Directors shall review and identify the categories of Allied Health Professionals, which shall be entitled to apply for privileges at the Hospital. The Medical Staff shall make recommendations to the Board of Directors concerning such categories.

4.3 APPLICATION PROCEDURE

Upon application, Allied Health Professionals may be authorized by the Medical Staff, subject to the Board's approval, to perform their professional services at the Hospital. Applications shall be processed through the same channels as applications for Medical Staff membership and privileges. Allied Health Professionals shall not be Members of the Medical Staff.

4.4 SPECIFICATION OF SERVICES

Allied Health Professionals shall be individually authorized and assigned to an appropriate Clinical Service Division, and shall carry out their services under the supervision of the appropriate Clinical Service Director, or the appropriate attending staff Member assigned this responsibility, and are subject to Clinical Service Division and Section policies and procedures.

4.4.1 Prerogatives

The authorized scope of services for each Allied Health Professional member shall be determined by the Interdisciplinary Practice Committee with input from the appropriate Clinical Service Director and, in any event, shall not exceed the Allied Health Professional's training, experience, scope of licensure and demonstrated competence.

4.4.2 Limitation of Prerogatives

Allied Health Professionals shall not be eligible to admit patients to the Hospital or skilled nursing facility, nor shall they be eligible for appointment to the Medical Staff. Nothing herein shall create any vested rights in any Allied Health Professional to receive or to maintain any services in a District Facility. The authorization of Allied Health Professional Staff to render care in a District Facility may, at any time and for any reason, be terminated by the appropriate Clinical Service Division Director or the Chief of Staff, the Allied Health Professional's supervising Practitioner, or the Board of Directors. The provisions of "Section 2.1 *et. Seq.*" of the Medical Staff Rights Manual shall not apply to Allied Health Professionals, except to psychologists when an adverse action is taken which requires the filing of a report under Business and Professions Code 805.

4.4.3 Notice and Request for Hearing

- (a) In the event that the Executive Committee ("the Committee") recommends that an AHP's privileges be restricted or terminated, the individual shall be so notified by certified mail, return receipt requested ("special notice"). The notice shall include a general statement of the reasons for the recommendation and shall advise the individual that he or she may request a hearing before the recommendation is forwarded to the Board for final action.
- (b) A request for a hearing must be submitted in writing to the Chief Administrative Officer within thirty (30) days after receipt of written notice of the adverse recommendation.
- (c) If a hearing is so requested, the Chief Administrative Officer shall appoint an ad

Hoc hearing panel ("panel") composed of up to three (3) individuals (including, but not limited to, individuals not connected to the Hospital, or any combination of these individuals) and a Presiding Officer, who may be legal counsel to the Hospital. The panel shall not include anyone who previously participated in the recommendation, any relatives or practice partners of the AHP, or any competitors of the affected individual.

- (d) As an alternative to the panel, the Chief Administrative Officer may instead appoint a Hearing Officer to perform the functions that would otherwise be carried out by the Panel. The Hearing Officer shall preferably be an attorney at law. The Hearing Officer may not be in direct economic competition with the individual requesting the hearing and shall not act as a prosecuting officer or as an advocate to either side of the hearing. If the Hearing Officer is an attorney, he or she shall not represent clients who are in direct economic competition with the affected individual. In the event a Hearing Officer is appointed instead of a Panel, all references to the Panel and Presiding Officer shall be deemed to refer instead to the Hearing Officer.

4.4.4 Hearing Process

- a) The hearing shall be convened as soon as practical, but no sooner than thirty (30) Days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to by the parties.
- (b) A record of the hearing shall be maintained by a stenographic reporter or by a recording of the hearings. Unless otherwise agreed to by the parties, testimony shall be taken on oath.
- (c) At the hearing a representative of the Committee shall first present the reasons for the recommendation. The AHP may present information, both orally and in writing, to refute the reasons for the recommendations, subject to a determination by the Hearing Officer that the information is relevant. The AHP shall not have the right to present other witnesses unless he or she can demonstrate to the satisfaction of the Presiding Officer that the failure to permit witnesses to appear would be fundamentally unfair. The Hearing Officer shall have the discretion to determine the amount of time allotted to the presentation of the parties.
- (d) Neither the AHP nor the Committee may be represented by counsel at the hearing.
- (e) The AHP shall have the burden of demonstrating that the recommendation of the Committee was arbitrary, capricious or not supported by credible evidence. The quality of care provided to patients and the smooth operation of the Hospital shall be the paramount considerations.
- (f) The Hearing Officer shall prepare a written report and recommendation within Twenty (20) days after the conclusion of the hearing and shall forward it, along with all supporting information, to the Chief Administrative Officer. The Chief Administrative Officer shall send a copy of the written report by special notice to the AHP and to the Committee.

4.4.5 Appeal:

- (a) Within ten (10) days after receipt of the report, either the AHP or the Committee may request an appeal, in writing, to the Chief Administrative Officer. The request must include a statement of the reasons, including specific facts, which justify an appeal. The grounds for appeal shall be limited to an assertion that there was substantial failure to comply with this policy and/or other applicable bylaws or policies of the Hospital and/or that the recommendation was arbitrary, capricious or not supported by substantial evidence.
- (b) If a written request for appeal is not submitted within ten (10) days, the Chief Administrative Officer shall forward the report, recommendation and supporting information to the Chairperson of the Board for final action.
- (c) If an appeal is requested, the Chairperson of the Board or an appellate review

Committee appointed by the Chairperson of the Board, shall consider the record upon which the adverse recommendation was made. New or additional written information that is relevant and could not have been made available to the Hearing Officer may be considered at the discretion of the Chairperson or the appellate review committee. The AHP and the Executive Committee shall each have the right to present a written statement in support of its position on appeal within a time period established by the Chairperson.

- (d) Upon completion of the review, the Chairperson or the appellate review committee shall provide a report and recommendation to the Board for action. The Chairperson may also refer the matter to any committee or individual deemed appropriate for further review and recommendation to the Board. The Board shall make its final decision based upon the Board's ultimate legal responsibility to grant privileges and to authorize the performance of clinical activities at the Hospital.

4.5 QUALIFICATIONS GENERALLY

All Allied Health Professionals must maintain all applicable licenses, certificates, or such other legal credentials, if any, as from time to time may be required by authority such as the State of California or another appropriate body. Such individuals must provide documentation of sufficient experience as, in the sole discretion of the Medical Staff is necessary and desirable to an individual to render the services requested. Allied Health Professionals must maintain the same liability coverage as required for Medical Staff membership, and shall be responsible for participating in continuing education programs as are required by their respective licensing authorities or the societies with which they are affiliated. They shall be subject to a review of their qualifications on a periodic basis. As Allied Health Professionals privileges shall automatically terminate without the right to a hearing pursuant to the Medical Staff Rights Manual in the event the Allied Health Professional's certificate or license expires, is revoked, or is suspended.

ARTICLE V MEDICAL STAFF OFFICERS

5.1 OFFICERS OF THE MEDICAL STAFF

5.1.1 Identification

The officers of the Medical Staff shall be the Chief of Staff, Chief of Staff-Elect, Immediate Past Chief of Staff and the Secretary-Treasurer.

5.1.2 Eligibility Criteria

Only those Members of the active category who satisfy the following criteria initially and continuously shall be eligible to serve as an officer of the Medical Staff. They must:

- (1) have no pending adverse recommendations concerning medical staff appointment or clinical privileges;
- (2) not presently be serving as a medical staff officer, Board member or department chairperson at any other hospital and shall not so serve during their term of office;
- (3) be willing to faithfully discharge the duties and responsibilities of the position;
- (4) attend continuing education relating to medical staff leadership and/or credentialing functions prior to or during the term of office; and
- (5) have demonstrated an ability to work well with others.

5.1.2 Nominations

The Executive Committee shall nominate candidates as outlined in Section 8.3.2(q) below and shall submit the Committee's nominations to the then current Chief of Staff (or his/her designee) by no later than October 15 of any election year.

Further nominations may be made for any office by any voting Member, provided that the name of the candidate is submitted, in writing, to the Chief of Staff, is endorsed by the signature of at least ten (10) other voting Members, and bears the candidate's written consent. These nominations shall be delivered to the Chief of Staff (or his/her designee) as soon as reasonable practicable, but in no event later than November 1 of any election year. The Chief of Staff (or his/her designee) shall include the name(s) of any nominee(s) for office timely received pursuant to this Section on the election ballot.

5.1.3 Elections

The Chief of Staff-Elect and Secretary-Treasurer shall be elected biennially by popular/majority vote of the Members entitled to vote to be conducted by secret mail ballot. A ballot and a return-addressed, stamped envelope shall be mailed to each voting Member's primary office address on or before November 15 of each election year. Mail ballots must be completed, signed (for signature verification only), sealed and returned to Medical Staff Services on or before December 1 to be included in the vote count. A space shall be provided on the return envelope for the voting Member's signature, which shall be used to verify the Member's identify in the ballot-counting process.

If no candidate for a particular office receives a majority (i.e. 51% or greater) vote, a runoff election between the two (2) candidates receiving the highest number of votes shall be conducted by secret mail ballot as soon as practicable. In the case of a tie on the second ballot, the majority vote of the Executive Committee shall decide the election by secret ballot conducted in the manner described above.

Mail ballots that are timely received shall remain unopened in their envelopes until counted confidentially in a private locate by the Chief of Staff (or his/her designee). Following each election, written notice shall be provided to the Medical Staff informing them of those candidates elected to office, which notice may occur at the annual meeting.

5.1.4 Terms of Elected Office

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

At the end of his/her term, the Chief of Staff shall automatically assume the office of Past Chief of Staff and the Chief of Staff-Elect shall automatically assume the office of Chief of Staff.

5.1.5 Recall of Officers

A Medical Staff Officer may be recalled from office for any valid cause, including, but not limited to, failure to comply with applicable policies, Bylaws, and rules and regulations; failure to perform the duties of the position held; conduct detrimental to the interests of the Hospital and/or its Medical Staff; or an infirmity that renders the individual incapable of fulfilling the duties of his or her office. Except as otherwise provided, recall of an officer may be initiated by the Executive Committee, or shall be initiated by a petition signed by at least one-third of the voting Members. Recall shall be considered at a special meeting called for that purpose. A least ten (10) days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which such action is to be considered. The individual shall be afforded an opportunity to speak to the Medical Staff present at a

special meeting. If a mail ballot is used the individual will be afforded the opportunity to speak to the Executive Committee or the Board prior to vote on removal. Recall shall require a two-thirds (2/3) vote of the voting Members who actually cast votes at the special meeting in person or by mail ballot.

5.1.6 Vacancies in Elected Office

Vacancies in office occur upon the death or disability, resignation, or removal of the officer or such officer's loss of membership. Vacancies, other than that of Chief of Staff, shall be filled by appointment by the Executive Committee until the next regular election, unless otherwise provided herein. If there is a vacancy in the office of Chief of Staff, the Chief of Staff-Elect serves out the remaining term. He/she shall immediately request a meeting of the Executive Committee to decide promptly upon nominees for the office of Chief of Staff-Elect. Such nominees shall be reported to the Medical Staff. A special election via secret mail ballot to fill the position shall occur soon as practicable in the manner provided above. If there is a vacancy in the office of Chief of Staff-Elect, the Executive Committee shall appoint an eligible Member to serve on an interim basis until a secret mail ballot election for the Chief of Staff-Elect is held. Nominees for the Chief of Staff-Elect replacement shall be reported to the Medical Staff. A special election via secret mail ballot to fill the position of Chief of Staff-Elect shall take place as soon as practical in the manner provided above. The newly elected Chief of Staff-Elect shall serve out the remaining term of his/her predecessor.

5.2 DUTIES OF OFFICERS

5.2.1 Chief of Staff

The Chief of Staff shall serve as the chief officer of the Medical Staff. He/she shall receive a stipend for this service that shall be of an amount determined by the Medical Staff. The duties of the Chief of Staff shall include but not be limited to:

- (a) Enforcing the bylaws, rules and regulations of the Medical Staff, implementing sanctions where indicated, and promoting compliance with the procedural safeguards where corrective action has been requested or initiated.
- (b) Calling, presiding at, and being responsible for the agenda of all meetings of the Medical Staff.
- (c) Serving as Chair of the Executive Committee.
- (d) Serving as a nonvoting member of all other committees of the Medical Staff unless his/her membership on a particular committee is required by these bylaws.
- (e) Interacting with the Vice President/Administrator and the Board of Directors in all matters of mutual concern within the Hospital.
- (f) Appointing members for all standing and special liaison, multi-disciplinary, or Medical Staff committees, except where otherwise provided by these bylaws, and except where otherwise indicated, designating the chairpersons of these committees.
- (g) Representing the views and policies of the Medical Staff to the Board of Directors and to the Vice President/Administrator.
- (h) Being a spokesperson for the Medical Staff in external professional and public relations.
- (i) Serving on liaison committees with the Board of Directors and administration, as well as outside licensing or accreditation agencies.
- (j) Performing such other functions as may be assigned to them by these bylaws, the Medical Staff, or by the Executive Committee.
- (k) Conducting an annual evaluation of the VPMA and conveying the results to the Chief Executive Officer.

5.2.2 Chief of Staff-Elect

The Chief of Staff-Elect shall assume all duties and authority of the Chief of Staff in the absence of the Chief of Staff. The Chief of Staff-Elect shall be a member of the Executive Committee. He/she shall chair the Bylaws Committee, as a subcommittee of the Executive Committee per Section 8.3.2(r), shall serve as the Vice Chair of the Quality Management Committee, and shall perform such other duties as the Chief of Staff may assign, or as may be delegated by these bylaws or by the Executive Committee. The Chief of Staff-Elect shall receive a stipend for their service that shall be of an amount determined by the Medical Staff.

5.2.3 Immediate Past Chief of Staff

The immediate Past Chief of Staff's role shall be advisory in nature. He/she shall be a member of the Executive Committee. She/he shall perform such other duties as may be assigned by the Chief or Staff or delegated by these bylaws or by the Executive Committee.

5.2.4 Secretary-Treasurer

The Secretary-Treasurer shall be a member of the Executive Committee and shall:

- (a) Attend meetings of the Medical Staff and Executive Committee and cause minutes to be maintained.
- (b) Be the custodian of all records and papers belonging to the Medical Staff.
- (c) Supervise the addition of any amendments to the bylaws, rules and regulations.
- (d) Cause to be collected all dues and assessments, make payments, and generally manage the fiscal affairs of the Medical Staff.

5.2.5 Chain of Command

- (a) Chief of Staff
- (b) Chief of Staff-Elect
- (c) Immediate Past Chief of Staff
- (d) Clinical Service Director of Surgery
- (e) Clinical Service Director of Primary Care
- (f) Clinical Service Director of Maternal-Child Medicine
- (g) Clinical Service Director of Diagnostic Services

ARTICLE VI COMMITTEES

6.1 DESIGNATION

The Committees described in this article shall be the standing committees of the Medical Staff. Special or ad hoc committees may be created by the Executive Committee to perform specified tasks. Unless otherwise specified, the chairperson and members of all committees shall be appointed by and may be removed by the Chief of Staff. Appointment and removal are subject to consultation with and approval by the Executive Committee. Committees of the Medical Staff shall be responsible to the Executive Committee.

6.2 GENERAL PROVISIONS

6.2.1 Terms

Unless otherwise specified, committee members shall be appointed for a term of two (2) years and shall serve until the end of this period or until the member's successor is appointed, unless the member shall be removed from the committee. Service on a committee to which a Member is appointed is mandatory, and can only be excused by either the Executive Committee or the Chief of Staff.

6.2.2 Removal

If a committee member ceases to be a Member in good standing, or loses a contractual relationship with the Hospital, suffers a loss or significant limitation of practice privileges, or if any other good cause exists, that member may be removed by the Executive Committee.

6.2.3 Vacancies

Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to such a committee is made; provided however, that if an individual who obtains membership by virtue of these bylaws is removed for cause, a successor may be selected by the Chief of Staff.

6.3 EXECUTIVE COMMITTEE

6.3.1 Composition

- (a) Officers of the Medical Staff
- (b) Clinical Service Division Directors and Section Chiefs. Refer to Sections 9.4. (b) and 10.3(b)
- (c) Chair, Quality Management Committee
- (d) Representatives of administration, including the President/Chief Executive Officer, the Vice President/Administrator, the Chief Nurse Executive, and the Vice President Support Services. These members shall serve as nonvoting members and may not attend executive sessions of this committee, unless requested to do so by the Chief of Staff, with approval of the Executive Committee.

6.3.2 Duties

The duties of the Executive Committee shall include, but not be limited to:

- (a) Representing and acting on behalf of the Medical Staff in the intervals between meetings of the Medical Staff, subject to such limitations as may be imposed by these bylaws.
- (b) Coordinating and implementing the professional and organizational activities and policies of the Medical Staff.
- (c) Receiving and acting upon reports and recommendations from Clinical Service Divisions, committees and assigned activity groups of the Medical Staff.
- (d) Recommending action to the Board of Directors on matters of a medical-administrative nature.
- (e) Establishing the structure of the Medical Staff, the mechanism to review credentials and delineate individual clinical privileges, the organization of quality management activities and mechanisms of the Medical Staff, termination of membership and fair hearing procedures, as well as other matters relevant to the operation of an organized Medical Staff.
- (f) Evaluating the medical care rendered to patients in the Hospital.

- (g) Participating in the development of policies, practices, and planning of the Medical Staff and Hospital.
- (h) Reviewing the qualifications, credentials, performance and professional competence and character of applicants and members.
- (i) Taking reasonable steps to promote ethical and competent clinical performance on the part of the Members including the initiation of and participation in corrective or review measures when warranted.
- (j) Designating such committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the Medical Staff and approving or rejecting appointments to those committees by the Chief of Staff.
- (k) Reporting to the Medical Staff at meetings of the Medical Staff.
- (l) Assisting in the obtaining and maintaining of accreditation.
- (m) Developing and maintaining methods for the protection and care of patients and others in the event of internal or external disaster.
- (n) Appointing such special or ad hoc committees as may seem necessary or appropriate to assist the Executive Committee in carrying out its functions and those of the Medical Staff.
- (o) Reviewing the quality and appropriateness of services provided by contract physicians.
- (p) Functioning as a Credentials Committee to investigate, review, and recommend on matters referred by the Chief of Staff, Clinical Service Division Directors, or Section Chiefs regarding the conduct, professional character or competence of any applicant to either the Medical Staff or Allied Health Professional Staff. Review any such referral in regard to re-application at the time of reappointment to the Medical Staff or the Allied Health Professional Staff.
- (q) Functioning as a Nominating Committee to select nominations for consideration by the Medical Staff at the time of the biennial election of officers. The Committee shall nominate one or more nominees for each office except for the Chief of Staff, who automatically succeeds to the office.
- (r) Functioning as a Bylaws Committee to fulfill the following functions:
 - (1) Conducting an annual review of the Medical Staff Bylaws/Rules and Regulations, and forms promulgated by the Medical Staff.
 - (2) Submitting recommendations for changes in these documents, as necessary, to reflect the current practice of the Medical Staff.
 - (3) Receiving and evaluating recommendations and suggestions for revisions to the Medical Staff Bylaws/Rules and Regulations.
- (s) Making Medical Staff recommendations to the Board of Directors for its approval, pertaining to at least the following:
 - (1) The Medical Staff's structure.
 - (2) The mechanism used to review credentials and to delineate individual clinical privileges.
 - (3) Appointment and reappointment of Medical Staff members, and restricting, reducing, suspending, terminating, and revoking Medical Staff membership.
 - (4) Granting, modifying, restricting, reducing, suspending, terminating, and revoking clinical privileges, and assignments to Clinical Service Divisions.
 - (5) The participation of the Medical Staff in organizational performance improvement activities.
 - (6) The mechanism by which Medical Staff membership may be terminated.

- (7) The mechanism for fair hearing procedures.

6.3.3 Meetings

The Executive Committee shall meet at least once per month, and more often as necessary. It shall maintain a record of its proceedings and actions.

6.4 QUALITY MANAGEMENT COMMITTEE

The composition, responsibilities, meeting and reporting requirements of the Quality Management Committee are as specified in the Quality Management Committee Plan, the pertinent provisions of which are incorporated herein by this reference.

6.5 SPECIAL CARE UNIT COMMITTEE

The composition, responsibilities, meeting and reporting requirements of the Special Care Committee are as specified in the Special Care Unit Committee Plan, the pertinent provisions of which are incorporated herein by this reference.

6.6 CANCER COMMITTEE

6.6.1 Composition

The Cancer Committee shall function as a multi-disciplinary committee with representatives from the Sections of Surgery, medical oncology, radiation oncology, diagnostic radiology and pathology. Non-voting members must include representatives from administration, nursing, social services, cancer registry and quality assurance.

Other physician members and non-physician members should be included based on the cancer experience seen at the institution to include physician representatives from the five major sites seen at the institution.

6.6.2 Duties

The duties of the Cancer Committee shall include:

- (a) Develop and evaluate annual goals and objectives for the clinical, educational and programmatic activities related to cancer.
- (b) Promote a coordinated, multi-disciplinary approach to patient management and ensure that an active supportive care system is in place for patients, families and staff.
- (c) Ensure that educational and consultative cancer conferences cover all major sites and related issues.
- (d) Monitor quality management and improvement through completion of quality management studies that focus on quality, access to care and outcomes, and disseminate appropriate information to other medical staff committees, as appropriate.
- (e) Supervise the cancer registry and ensure accurate and timely abstracting, staging and follow-up reporting through performance of quality control of registry data.
- (f) Encourage data usage and regular reporting.
- (g) Ensure that the content of the annual report meets the requirements and is published by November 1 of each year.
- (h) Promote clinical research and uphold medical ethical standards.

6.6.3 Meetings

The Cancer Committee shall meet at least quarterly. It shall maintain a record of its proceedings and shall report its activities and recommendations to the Executive Committee.

6.7 INVESTIGATIONAL REVIEW COMMITTEE

The composition and responsibilities are specified in the Palomar Medical Center/Pomerado Hospital Investigational Review Committee Policies and Procedures, the pertinent provisions of which are incorporated herein by this reference.

6.8 PHYSICIAN WELL BEING COMMITTEE

6.8.1 Composition

In order to improve the quality of care and promote the competence of the medical staffs, the Executive Committee shall establish a combined committee of the Medical Staffs of Palomar Medical Center and Pomerado Hospital comprised of five (5) active category Members from each Medical Staff. A subcommittee of this committee shall be formed at each hospital, composed of the five (5) representatives from the respective hospital, with the provision that at least one (1) member shall be a psychiatrist. Except for initial appointments, each member shall serve a term of two (2) years and the terms shall be staggered as deemed appropriate by the Executive Committee to achieve continuity. Insofar as possible, members of the committee shall not serve as active participants on other peer review or quality assurance committees while serving on the Physician Well Being Committee. The Chiefs of Staff shall appoint the chairperson in alternate years.

6.8.2 Duties

The Physician Well Being Committee may be contacted by a Member or receive reports concerning the ability of a Member to perform all of the essential mental and physical functions related to his/her clinical privileges due to impairment by mental illness or chemical dependency, without posing a significant risk of harm to hospitalized patients. As it deems appropriate, the Committee, or its Chairperson, may meet with the Member and work cooperatively with him/her to develop and implement a plan addressing any issues pertaining to the Member's ability to perform all of the essential mental and physical functions related to the exercise of his/her clinical privileges. The activities of and the information collected by the Committee shall be confidential. However, if the Committee determines that the Member poses a significant risk of harm to hospitalized patients, and the Member refuses or is unable to arrive at a mutually acceptable resolution of the problem, this determination may be referred to the Chief of Staff or the Executive Committee for purposes of corrective action. The Committee shall also consider general matters related to the ability of the Member of the Medical Staff to perform all of the essential mental and physical functions related to the specific clinical privileges, and with the approval of the Executive Committee, shall develop educational programs on related activities.

6.8.3 Meetings

The Medical Staff-specific subcommittee may meet as often as necessary, and the combined Physician Well Being Committee shall meet as often as necessary, but at least twice a year. It shall maintain a record of its proceedings as it deems advisable, but shall report on its activities on a quarterly basis to the Executive Committee.

6.9 BIOMEDICAL ETHICS COMMITTEE

6.9.1 Composition

The Biomedical Ethics Committee shall be a combined committee of the Medical Staffs of Palomar Medical Center and Pomerado Hospital. The Committee shall consist of three (3) physician representatives from each hospital and other members, as the Executive Committee may deem appropriate. It may include lay representatives, social services, clergy, ethicists, attorneys, nursing staff, administrators, and representatives from the Board of Directors as non-voting members. Physician members will be appointed by the Chiefs of Staff, including a chair for each hospital. The Chair of the combined committee will alternate yearly.

6.9.2 Duties

The Biomedical Ethics Committee shall participate in the development of guidelines for consideration of cases having bio-ethical implications; development and implementation of procedures for the review of such cases; development and/or review of institutional policies regarding the care and treatment of such cases; retrospective review of cases for

the evaluation of bio-ethical policies; consultation with concerned parties to facilitate communication and aid in conflict resolution; and education of the hospital staffs on bio-ethical matters.

6.9.3 Meetings

The Biomedical Ethics Committee shall meet as often as necessary at the call of the chair who shall maintain a record of its activities and report to the Executive Committees. For bio-ethical issues specific to Pomerado Hospital, the Pomerado Hospital physician members will function as a hospital-specific committee and report to the Pomerado Executive Committee.

6.10 LONG TERM CARE COMMITTEE

6.10.1 Composition

The Medical Director of Villa Pomerado shall serve as the Chair. At least three (3) physician representatives shall be appointed from the Primary Care and Surgery Clinical Service Divisions by the Chief of Staff. Non-voting members shall include the Administrator of Villa Pomerado, the Director of Nursing, the Director of Staff Development, and the UR Coordinator of Villa Pomerado, the Director of Environmental Services, EP&S Committee Chairperson, Infection Surveillance Nurse, Director of Health Information Services, a Pharmacist, and the Pomerado Hospital Director of Quality Management

6.10.2 Duties

The duties of the Long Term Care Committee shall include:

- (a) Monitoring and management of the quality of care of all patients admitted to the facility, including appropriate review of medical records.
- (b) Advisory review and revision of administrative policies and procedures.
- (c) Coordinating the functioning of the facility, including equipment purchases and operating policies.
- (d) Performing utilization review activities for the facility. In this capacity, the Committee or a subcommittee of it, shall function as the UR subcommittee for the facility.

6.10.3 Meetings

The Long Term Care Committee shall meet at least quarterly. It shall maintain a record of its proceedings and report to the Quality Management Committee. The committee chair shall be a member of the Quality Management Committee.

6.11 OPERATING ROOM COMMITTEE

6.11.1 Composition

The Operating Room Committee shall function as a multi-disciplinary committee with representatives from the Sections of Anesthesia, OB/GYN, and Surgery. Surgery representatives shall include a general surgeon, an orthopedic surgeon, and an ophthalmologist. Non-voting members shall include a representative from Administration and the Director of Operating Room Services.

6.11.2 Duties

The duties of the Operating Room Committee shall include:

- (a) To recommend guidelines for the efficient and safe functioning of the Pomerado Hospital Operating Room Suite.
- (b) Promotion of a coordinated, multi-disciplinary approach to overseeing the functioning of the Pomerado Hospital Operating Room Suite.
- (c) Establishment of Operating Room Scheduling Guidelines with responsibility for application of and revision of the Scheduling Guidelines.

- (e) The Committee shall serve as a forum for the discussion of problems that are multi-disciplinary in nature. In this context meetings will allow for exchange of ideas and information among anesthesia, surgery, and the OR staff.
- (f) The Committee shall review volume reports of the OR activity.

6.11.3 Meetings

The Operating Room Committee shall meet at least quarterly. It shall maintain a record of its proceedings and shall report its activities and recommendations to the Executive Committee.

6.12 INFECTION SURVEILLANCE COMMITTEE

The composition, responsibilities, meeting and reporting requirements of this committee are as specified in the Infection Surveillance Committee Plan, pertinent provisions of which are incorporated herein by this reference.

6.13 PHARMACY AND THERAPEUTICS COMMITTEE

The composition, responsibilities, meeting and reporting requirements of this committee are as specified in the Pharmacy and Therapeutics Committee Plan, pertinent provisions of which are incorporated herein by this reference.

6.14 HEALTH CARE RESOURCE COMMITTEE

The composition, responsibilities, meeting and reporting requirements of this committee are as specified in the Health Care Resource Committee Plan pertinent provisions of which are incorporated herein by this reference.

6.15 INTERDISCIPLINARY PRACTICE COMMITTEE

6.15.1 Composition

The Interdisciplinary Practice Committee (IPC) shall have an equal number of Medical Staff members and nursing staff members. It shall include the Assistant Vice President/Nurse Executive (i.e. Director of Nursing) or his/her designee. In addition, representatives of the categories of AHP's granted privileges in the hospital should serve as consultants on an as-needed basis, and shall participate, when available in the committee proceedings when a member of the same specialty is applying for privileges.

6.15.2 Duties

- (a) Standardized Procedures
 - (1) The IPC shall develop and review standardized procedures that apply to nurses or AHP's; identify functions that are appropriate for standardized procedures; initiate such procedures; and review and approve standardized procedures.
 - (2) Standardized procedures can be approved only after consultation with the Medical Staff Clinical Service Division involved, and by affirmative vote of (i) the administrative representatives, (ii) a majority of physician members, and (iii) a majority of nurse members.
- (b) Credentialing Allied Health Professionals
 - (1) The IPC shall recommend policies and procedures for expanded role privileges for assessing, planning and directing the patients' diagnostic and therapeutic care.
 - (2) The IPC shall review AHP applications and requests for privileges and forward its recommendations and the application to the appropriate Clinical Service Division.
 - (3) The IPC shall participate in AHP peer review and quality improvement. It may initiate corrective action, when indicated, against AHP's in accordance with the Medical Staff Bylaws, governing AHP's.
 - (4) The IPC shall serve as a liaison between the AHP's and the Medical Staff.

6.15.3 Meetings

The IPC shall meet as often as necessary, but at least quarterly.

6.16 JOINT CONFERENCE COMMITTEE

6.16.1 Purpose

The purpose of the Joint Conference Committee is two-fold: (1) to facilitate communication between the Board, administrations of Palomar Medical Center and Pomerado Hospital, and the medical staffs of both hospitals involving medical staff issues such as credentialing, quality improvement, corrective action and bylaws amendments; and (2) to address and confer in good faith to resolve medical staff disputes including but not limited to those set forth in Section 2282.5 of the Business & Professions Code.

6.6.2 Composition

The Joint Conference committee shall be a joint committee of the medical staffs of Palomar Medical Center and Pomerado Hospital consisting of the following: Three Board members selected by the Board; the Chief Executive Officer of Palomar Pomerado Health; Chief of Staff and Chief of Staff –Elect of Palomar Medical Center; Chief of Staff and Chief of Staff-Elect of Pomerado Hospital; an At-Large Member of one of the medical staffs selected by members of the Joint Conference Committee to represent both medical staffs. The chairman shall alternate annually between the Chiefs of Staff.

6.6.3 Meetings

The Joint Conference Committee shall meet as often as necessary (usually quarterly.) It shall maintain a record of its proceedings, as it deems advisable and report to the executive committees of both medical staffs.

ARTICLE VII CLINICAL SERVICE DIVISIONS

7.1 ORGANIZATION

The Medical Staff shall be divided into Clinical Service Divisions. Each Clinical Service Division shall be organized as a separate component and shall have a Clinical Service Director selected and entrusted with the authority, duties and responsibilities specified in 9.4. When appropriate, the Executive Committee may recommend to the Medical Staff the creation, elimination, modification or combination of Clinical Service Divisions or Sections.

7.2 CURRENT CLINICAL SERVICE DIVISIONS

- (a) Primary Care
- (b) Surgery
- (c) Maternal and Child Medicine
- (d) Diagnostic Services

7.3 MEMBERSHIP

The Executive Committee, following the recommendation of the Clinical Service Division, shall recommend initial Clinical Service Division assignments for all Members.

Each Member will be assigned to the Clinical Service Division in which he/she does the majority of his/her work. The Member shall hold voting rights only in that Clinical Service Division. Members are encouraged to attend meetings held each

year by his/her assigned Clinical Service Division. Members may be granted privileges by additional Clinical Service Divisions, but shall not be voting Members of more than one Clinical Service Division. Members with privileges in other Clinical Service Divisions shall be subject to all of the rules of such Clinical Service Division and to the jurisdiction of the Clinical Service Division Director. The Director of any Clinical Service Division may require the attendance of any Member or Physician with privileges in the Division at a specific Division meeting for review of particular cases or for the purpose of continuing medical education.

7.4 CLINICAL SERVICE DIRECTOR

The Clinical Service Division Director shall be an active category Member and shall have served as a Clinical Service Division Director or Section Chief during the previous six (6) years. The Clinical Service Division Director shall be certified by the appropriate specialty board, or it shall be affirmatively established, through the privilege delineation process, that the Clinical Service Division Director possesses comparable competence for those active category Members appointed prior to 3/11/1996, or who are within the thirty-six (36) month time provision set forth in Section 3.2.2. The Clinical Service Division Director and Section Chief shall be elected by the voting members of each Clinical Service Division and/or Section at least thirty (30) days prior to the annual staff meeting. Terms of office shall be for at least two (2) years. Clinical Service Division Directors may be removed by a two-third (2/3) vote by the Clinical Service Division with approval of the Executive Committee and the Board of Directors.

The duties of the Clinical Service Division Director shall include:

- (a) Supervising the professional, medical and administrative activities within the clinical areas of the Clinical Service Division.
- (b) Serving on the Executive Committee in accordance with Section 8.3.1
- (c) Maintaining continuing review of the professional performance of all Members with privileges in the Clinical Service Division and performing biennial assessment of all Members for consideration by the Section, Clinical Service Division, Executive Committee, and Board of Directors.
- (d) Transmitting to the Executive Committee the Clinical Service Division's recommendations concerning the granting of privileges to Members and the results of any disciplinary measure or change in privileges.
- (e) Responsibility for implementing any actions taken by the Executive Committee.
- (f) Supervising by means of assignment to section Chiefs:
 - (1) Peer review of individual Members holding privileges in the Clinical Service Division, including an ongoing program of non-disciplinary physician observation;
 - (2) Audit of disease entities and morbidity and mortality;
 - (3) The presentation of educational programs using any deficiencies or sub-optimal patterns of care detected by review as subjects; and
 - (4) Subsequent review to assure that improved performance has occurred.
- (g) Participating in every phase of administration of the Clinical Service Division through cooperation with nursing and administration in matters affecting patient care, including personnel, supplies, special regulations, standing orders, and techniques.
- (h) Providing an Emergency Department back-up list.
- (i) Assisting in the preparation of such annual reports, including budgetary planning, pertaining to his/her Clinical Service Division as may be required by the Executive Committee and Administration.
- (j) Assessing and recommending off-site sources for needed patient care services not provided by the department or the Hospital.