



**SoHum** Health

Southern Humboldt Community Healthcare District

# **MEDICAL STAFF COMMITTEE BYLAWS**

Approved by Med Staff  
March 8, 2023

**Sprowel Creek Campus  
286 Sprowel Creek Road  
Garberville, CA 95542**



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**MEDICAL STAFF BYLAWS  
RULES  
AND  
REGULATIONS**

**ADOPTED by the Medical Staff on: September 21, 2022**

**APPROVED by the Board of Directors on: September 29, 2022**



# SoHum Health

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## MEDICAL STAFF BYLAWS, RULES AND REGULATIONS AND SUPPLEMENTAL ATTACHMENTS

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## MEDICAL STAFF BYLAWS

### INTRODUCTION

These Bylaws constitute a structure for the self-governance of the Medical Staff of Southern Humboldt Community Healthcare District. Through the Bylaws and the Supplemental Attachments, the Medical Staff will address its responsibilities regarding the quality of medical care, the orderly resolution of Medical Staff issues, the conduct of specific Medical Staff functions, and the Medical Staff accountability to the District governing body.

### DEFINITION OF TERMS

**Administrator** means the person appointed by the governing body to act on its behalf in the overall management of the District. An Administrator designee means a person responsible directly to the Administrator.

**Allied Health Practitioner (AHP)** means any Nurse Practitioner or Physician Assistant.

**Chief of Staff** means the chief officer of the Medical Staff.

**Committee of the Whole (CW)** means the executive body of the Medical Staff that carries out the legal and District responsibilities as defined in these Bylaws and state law for the Medical Staff.

**Date of receipt** means the date any special notice or other communication was delivered personally; or if such special notice or communication was sent by US mail, it shall mean 48 hours after the special notice or communication was deposited in a post office, mailbox, substation, or mail chute, or other like facility regularly maintained by the United States Postal Service, in a sealed envelope, with postage paid, addressed to the person on whom it is to be served, at the office address as last given by that person on any document provided to the Administrator or its designee.

**District** means Southern Humboldt Community Healthcare District.

**Governing body** means the Southern Humboldt Community Healthcare District Board of Directors. As appropriate to the context and consistent with the District Bylaws, it may also mean any governing body committee or individual authorized to act on behalf of the governing body.

**Hospital** means the Southern Humboldt Community Healthcare District Jerold Phelps Community Hospital.

**Limited license practitioner** means a practitioner who is licensed as a dentist, podiatrist or clinical psychologist.

**Medical Staff** means the organizational component of the District that includes all physicians

(MD or DO), dentists, podiatrists, and clinical psychologists who have been granted recognition

as members pursuant to these Bylaws.

**Medical Staff year** means the period from January 1 to December 31.

**Medico-Administrative Officer** means a practitioner, employed by or otherwise serving the District on a full or part-time basis, whose duties include certain responsibilities that are both administrative and clinical in nature. Clinical responsibilities, as used herein, are those responsibilities that require a practitioner to exercise clinical judgment with respect to patient care, including the supervision of professional activities of practitioners under his or her direction.

**Member** means any physician, dentist, or podiatrist that has qualified for membership in the District Medical Staff.

**Non-Physician Provider** means an individual, other than a licensed physician, dentist, or podiatrist, who exercises independent judgment within the areas of the non-physician provider's competence and the limits established by the governing body, the Medical Staff, and the applicable state practice acts. A qualified non-physician provider renders direct or indirect medical or pediatric care under the supervision or direction of a Medical Staff member possessing privileges to provide such care in the District facilities. Non physician providers are not eligible for Medical Staff membership.

**Physician** means an individual with a M.D. or D.O. degree who is currently licensed to practice medicine in the State of California.

**Practitioner** means, unless otherwise expressly limited, any currently licensed physician (MD or DO), dentist, podiatrist, clinical psychologist, nurse practitioner (NP), and physician assistant (PA).

**Prerogative** means a participatory right granted to a Medical Staff member, by virtue of staff category or otherwise, that is exercisable subject to and in accordance with the conditions imposed by these Bylaws and by other District and Medical Staff rules, regulations, or policies.

**Privileges or clinical privileges** means the permission granted to a Medical Staff member to render specific diagnostic, therapeutic, medical, dental, podiatric, or surgical-services.

**Special notice** means a written communication sent by certified mail return receipt requested.

Supplemental attachment **means those documents, in addition to these Bylaws, that govern the Medical Staff. Special attachments include Medical Staff rules, procedures for credentialing and privileging Medical Staff members.**

**Commented [KJ1]:** Why is clinical psychologist not listed here? Should it be?



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## MEDICAL STAFF BYLAWS

### ARTICLE 1 NAME AND PURPOSES

#### 1.1 ORGANIZATIONAL NAME

The name of the Medical Staff organization is the Southern Humboldt Community Healthcare District (SHCHD) Medical Staff ([the “Medical Staff”](#)).

#### 1.2 MEDICAL STAFF MISSION AND RESPONSIBILITIES

The ~~SHCHD~~ Medical Staff organization has been established to assure the provision of ~~high-quality~~high-quality health care to the citizens of Southern Humboldt who seek services from Southern Humboldt Community Healthcare District. Towards accomplishing this end the Medical Staff shall:

- ❖ Assure that all patients treated ~~in any of~~ in any of the facilities or departments of the District in receive a level of professional care at or above a level of quality consistent with generally accepted standards that are attainable within the District’s means and circumstances.
- ❖ Support professional education and community health education.
- ❖ Initiate and enforce the rules that guide the conduct of practitioners pursuant to the authority delegated to it by the governing body.
- ❖ Assist the governing body and administration with resolving health care issues of mutual concern to the Medical Staff and District governance.
- ❖ Keep the governing body fully informed of Medical Staff activities, needs and patient care changes which impact the Community as a whole.
- ❖ Participate in the District’s quality improvement program.

### ARTICLE 2 MEDICAL STAFF ORGANIZATION

#### 2.1 ORGANIZATION OF MEDICAL STAFF SERVICES

Medical Staff members shall conduct Medical Staff affairs as a Committee of the Whole (“CW”). ~~As such, it CW~~ will carry out all functions of the Medical Staff that are required by state law, these Bylaws, and as deemed appropriate by the Medical Staff and CMS standards. The CW may appoint ad hoc task forces to address specialized Medical Staff issues.

#### 2.2 DUTIES OF THE COMMITTEE OF THE WHOLE

The CW shall perform the duties specified in state law, the Medical Staff Bylaws and as



specified in 2.1 of the Medical Staff Rules and Regulations.

### 2.3 MEETINGS

The CW shall meet as often as necessary, but no less than once in each two-month period.

### 2.4 MEETING ATTENDANCE

Active Staff members and Provisional Active Staff members are expected to attend department, committee, CW and Medical Staff meetings, however, there are no specific meeting attendance requirements. Associate Members, Associate Provisional Members and Courtesy Members may attend CW meetings without vote.

## ARTICLE 3 CATEGORIES OF MEDICAL STAFF MEMBERSHIP

### 3.1 CATEGORIES

- a. The categories of the Medical Staff shall be ~~Active, Provisional Active, Associate, Provisional Associate, Active membership, Associate membership~~ and Courtesy ~~Staff-membership~~. ~~AHP Staff shall be similarly assigned.~~
- b. Each practitioner shall be assigned to a Medical ~~or AHP~~ Staff category based upon the criteria contained in these Bylaws and the Credentialing and Privileging Supplemental Attachment. ~~Each time membership is granted or renewed, their staff category shall be assessed to determine whether the applicant meets the staff category qualifications.~~
- c. The prerogatives and responsibilities of each membership category are general in nature and may be subject to limitation by special conditions attached to a particular ~~individual membership~~ or by action of other sections of these bylaws, rules and regulations or Supplemental Attachment.
- d. The members of each Medical ~~or AHP~~ Staff category shall ~~have the prerogatives and~~ carry out the duties defined in the Bylaws and supplemental attachment.
- e. Action may be initiated ~~by any member~~ to change the Medical ~~or AHP~~ Staff category or terminate the membership of any member who fails to meet the qualifications or fulfill the duties described in these Bylaws and supplemental attachments.
- f. Changes in Medical Staff category, ~~clinical privileges or membership~~ shall not be grounds for a hearing unless ~~required by law they adversely affect the member's privileges.~~

### 3.2 MEMBERSHIP

#### 3.2-1 Active Staff

##### a. Qualifications

The Active Staff shall consist of members who:

- i. Exhibit satisfactory performance for at least twelve months as a Provisional Staff member;
- ii. Meet the qualifications of Medical Staff membership;
- iii. Commit to support the District's patient care programs;

iv. Regularly admit, or are otherwise regularly involved in the care of at least fifteen (15) patients per year at the Hospital as measured by patient contacts, which are defined as admissions, consultations, procedures (inpatient or outpatient), and/or evaluations and services performed in the Emergency Department; and

**Commented [SC2]:** Should there be a minimum number of patient contacts to distinguish Active from Associate?

**Commented [KJ3R2]:** Not in our small setting.

~~Have offices or residences which, in the opinion of the CW, are located closely enough to the Hospital to provide appropriate continuity of quality care to their patients.~~

**Commented [SC4]:** Is this reasonable, given location and current staff?

**Commented [KJ5R4]:** No. We have a hard time filled MD positions. It's not reasonable to have them in close proximity. One even lives in Texas.

b. Prerogatives

Active Staff Members may:

- i. Exercise only those privileges specifically granted within District inpatient and outpatient programs, including the admission of patients to the Hospital;
- ii. Attend meetings, with the right to vote; and
- iii. Hold positions of leadership and serve on committees;

c. Responsibilities

Active Staff Members shall:

- i. Fulfill all responsibilities of membership;
- ii. Actively assist the Medical Staff and Hospital, as requested; and

~~Pay dues and assessments in accordance with schedules determined from time to time by the CW.~~

**Commented [SC6]:** Do members pay dues?

**Commented [KJ7R6]:** No

~~Active Medical Staff Members may vote, hold positions of leadership, and exercise approved privileges within District inpatient and outpatient programs. Qualifications for membership in this category include:  
(1) Satisfactory performance for at least twelve months on an initial appointment as a provisional member of the Medical Staff.  
(2) Commitment to support the District's patient care programs.  
(3) Participate in Medical Staff governance activities addressed in these Bylaws.~~

3.2-2 Associate Staff

a. Qualifications

The Associate Staff shall consist of members who:

- i. Exhibit satisfactory performance for at least twelve months as a Provisional Staff member;
- ii. Meet the qualifications of Medical Staff membership;
- iii. Commit to support the District's patient care programs; and
- iv. Are an Active Staff member at another healthcare organization.

b. Prerogatives

Associate Staff Members may:

- i. Exercise only those privileges specifically granted within District inpatient and outpatient programs, including the admission of patients to the Hospital; and
- ii. Attend meetings, with no right to vote.

c. Responsibilities

Associate Medical Staff Members shall:

- i. Fulfill all responsibilities of membership;
- ii. Maintain Active medical staff membership at another health care organization; and
- iii. Provide, upon request, clinical activity and quality data reports, and other peer review documentation outlining the outcome of each case reviewed from the hospital(s) where the member actively practices to allow for validation of competency for membership and any privileges requested and

~~— Pay dues and assessments in accordance with schedules from time to time determined by the CW.~~

~~Associate Medical Staff members may exercise approved privileges within District outpatient and inpatient services. They may not vote or hold positions of leadership.~~

~~Qualifications for membership in this category include:~~

- ~~(1) Satisfactory performance for at least twelve months on an initial appointment as a provisional member of the Medical Staff.~~
- ~~(2) Commitment to support the District's patient care programs. Current possession of staff membership at another health care organization.~~

3.2-3 Courtesy Staff

a. Qualifications

The Courtesy Staff shall consist of members who:

- i. Meet the qualifications of Medical Staff membership;
- ii. Are an Active Staff member at another healthcare organization;

b. Prerogatives

Courtesy Staff members may:

- i. Order laboratory and radiologic tests and observe procedures performed by Active or Associate members, but may not otherwise hold clinical privileges; and
- ii. Attend meetings, with no right to vote.

c. Responsibilities

Courtesy Staff Members shall:

- i. Fulfill all responsibilities of membership;

- ii. Maintain Active medical staff membership at another health care organization;
  - ~~— Provide, upon request, clinical activity and quality data reports, and other peer review documentation outlining the outcome of each case reviewed from the hospital(s) where the member actively practices to allow for validation of competency for membership and any privileges requested and~~
  - ~~i. Pay dues and assessments in accordance with schedules from time to time determined by the CW.~~
- iii. \_\_\_\_\_
- iv. ~~Attend meetings, with no right to vote. Courtesy Medical Staff members may order laboratory and radiological tests, and observe procedures performed by Active or Associate members. Courtesy members will not be granted clinical privileges and must be currently practicing at a health care organization.~~

3.2-4 Provisional ~~Period~~Staff

a. Qualifications

The Provisional Staff shall consist of members who:

- i. The Provisional Staff shall consist of practitioners who meet the qualifications of Medical Staff membership, who have been Medical Staff members for less than twelve (12) months;
- ii. Meet the qualifications of Medical Staff membership;
- iii. Commit to support the District’s patient care programs;

b. Prerogatives

Provisional Staff members may:

- i. Admit and care for patients
- ii. Attend meetings.
- iii. Provisional Active Staff have the right to vote, while Provisional Associate Staff have no right to vote; and
- iv. All Provisional Staff may serve on committees as requested by the CW, but may not hold positions of leadership;

c. Responsibilities

Provisional Staff members shall:

- i. Complete proctoring requirements;
- ii. Fulfill all responsibilities of membership;
- iii. Actively assist the Medical Staff and Hospital, as requested; and
- ~~— Pay dues and assessments in accordance with schedules determined from time to time by the CW.~~

~~During the provisional period, the membership categories shall be designated-~~

Commented [SC8]: Do members pay dues?  
 Commented [KJ9R8]: No

Provisional Active and Provisional Associate.

d. Competency Validation of Provisional Staff Members

- i. Each Provisional Staff member shall undergo a period of Focused Professional Practice Evaluation (Proctoring) as described in these Bylaws. The purpose of this provisional period shall be to evaluate the member's proficiency in the exercise of clinical privileges initially granted, and overall eligibility for continued staff membership and advancement within staff categories. Evaluation of Provisional Staff members shall follow the frequency and format determined by the CW to be appropriate in order to adequately evaluate the Provisional Staff member including, but not limited to, concurrent or retrospective chart review, mandatory consultation, and/or direct observation. Appropriate records shall be maintained.
- ii. The CW shall determine the Provisional Staff member may advance to another staff category when the Provisional Staff member meets all of the qualifications for advancement; has discharged all of the responsibilities, including completion of all required proctoring; and has not exceeded or abused the prerogatives of the Provisional Staff category.
- iii. The governing body may extend the provisional status (after recommendation from the Chief of Staff) if further evaluation is necessary up to a period of two years following appointment to the provisional staff.
- iv. Failure to meet all of the qualifications for advancement within twenty-four (24) months shall result in disqualification for reappointment. A Provisional Staff member is not entitled to the procedural rights of appeal as set forth in the Fair Hearing Process unless required by law.

**Commented [SC10]:** What is the difference between Provisional Active and Provisional Associate?

**Commented [KJ11R10]:** Associates and Courtesy don't have the right to vote, while Active do.

3.3 GENERAL EXCEPTIONS TO MEMBERSHIP PREROGATIVES

Regardless of the category of membership in the Medical Staff, limited license members (dentists, podiatrists or Clinical Psychologists) may not hold any general Medical Staff office. A limited licensed practitioner may only admit and treat patients by co-admitting each patient with a physician member of the Medical Staff who has privileges to admit patients and who assumes responsibility for the medical care of the patient.

**ARTICLE 4 MEMBERSHIP**

4.1 NATURE OF MEMBERSHIP

A practitioner, including one who does not have~~has~~ a contract with the District to provide medical care, can provide patient care within District services only if the practitioner is a member of the Medical Staff or has been granted temporary privileges in accordance with these Bylaws and supplemental documents. Appointment to the Medical Staff shall confer only such privileges and prerogatives as granted by the governing body.

4.2 QUALIFICATIONS FOR MEMBERSHIP

4.2-1 General Qualifications Nature of Medical Staff Membership

- a. Medical Staff membership and the granting of clinical privileges shall be extended only to practitioners who are professionally competent and continuously meet the qualifications, standards, and requirements set forth in these Medical Staff Bylaws and supplemental attachments.

b. Medical Staff membership shall be limited to practitioners who are currently licensed to practice medicine, dentistry, podiatry or clinical psychology in California. An Allied Health Practitioner (AHP) (Nurse Practitioner or Physician Assistant) is not eligible for Medical Staff membership but may be appointed to the AHP Staff.

c. No person shall be entitled to Medical Staff membership in the District merely because that person holds a certain degree or is licensed to practice in the state of California or any other state.

d. No person will be entitled to Medical Staff membership due solely to professional organization membership, certification by any clinical specialty board, or membership in a Medical Staff of another health care organization.

e. Appointment to, and membership on the Medical Staff or AHP Staff shall confer only such clinical privileges or practice prerogatives as have been specifically granted by the governing body in accordance with these Bylaws.

**Commented [KJ12]:** Currently, mid-levels only get approved by CoS, and haven't gone to MEC or the Board. I assumed this is because they are also employees. With that said, clinic MD & DO are employees too, and do go to MEC and the Board. What are your thoughts? We'd like the mid-levels to start going to MEC and the Board.

#### 4.2-2 Professional Minimum Qualifications

An application Applicants for membership on the Medical or AHP staffs must meet the following membership standards:

##### ❖ Education and Licensure



##### a. Licensure / Certification:

- i. **Physicians & Surgeons:** must hold a MD or DO degree, or the equivalent, and a valid and unsuspended license issued by the Medical Board of California or the Board of Osteopathic Medical Board of California ~~Examiners and for initial applicants, the practitioner's license must not be subject to any term of probation or restriction.~~ The term "or equivalent" means any degree (i.e. foreign) recognized by the Medical Board of California or the Board of Osteopathic Examiners.
- ii. **Dentists:** ~~M~~ must hold a DDS degree, or the equivalent, and a valid, unrestricted, and unsuspended license to practice dentistry and/or dental surgery issued by the Dental Board of Dental Examiners of California ~~and for initial applicants, the practitioner's license must not be subject to any term of probation or restriction.~~ The term "or equivalent" means any degree (i.e. foreign) recognized by the Board of Dental Examiners of California.
- iii. **Podiatrists:** ~~M~~ must hold a DPM degree, or the equivalent, and a valid, unrestricted, and unsuspended license to practice podiatry issued by the Medical Board of California Board of Podiatric Medicine ~~and for initial applicants, the practitioner's license must not be subject to any term of probation or restriction.~~ The term "or equivalent" means any degree (i.e. foreign) recognized by the Medical Board of California.
- iv. **Clinical Psychologist:** Must hold a clinical psychologist degree, or equivalent, and a valid, unrestricted, and unsuspended license to practice psychology issued by the California Board of Psychology. ~~the Medical Board of California. The term "or equivalent" means any degree (i.e. foreign)~~

**Commented [KJ13]:** Dr. Newdow thought adding "...or restriction" was redundant. Is there a need for it?

recognized by the Medical Board of California.

- v. **Nurse Practitioner:** Must be a licensed registered nurse who holds a valid, unrestricted and unsuspended Nurse Practitioner Certification in the State of California and must meet the standards for a nurse practitioner as established ~~issued~~ by the California Board of Registered Nursing (BRN) in order to be appointed to the AHP Staff.
- vi. **Physician Assistant:** Must ~~be hold a valid, unrestricted and unsuspended~~ unsuspended license issued certified by the State of California and must meet the standards for a physician assistant as established by the California Physician Assistant Board (CAB) in order to be appointed to the AHP Staff.
- b. Each applicant must meet the minimum standards for experience, training, current clinical competence, good judgment, current adequate physical and mental status and ability to work cooperatively with others in District facilities that corresponds to District Medical Staff expectations
- c. Each applicant has current, unrestricted federal DEA registration, and no initial applicant ~~has~~ must have a pending adverse action by the DEA. Schedules 2, 2N, 3, 3N, 4 and 5 are required. Providers whose specialty does not involve prescribing and/or who solely work remotely, are not required to provide a DEA certificate of registration, but in such case may not prescribe controlled substances.
- d. Every initial applicant must provide current board certification by a member board of the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA), American Board of Dental Specialties (ABDS), American Board of Oral and Maxillofacial Surgery (ABOMS), American Board of Podiatric Medicine (ABPM), American Board of Foot and Ankle Surgery (ABFAS), or other board accepted by the MEC; or current enrollment in a graduate medical education program which, upon successful completion, shall result in board admissible eligibility in the specialty area for which the applicant seeks clinical privileges; or current board eligibility in the specialty area for which the applicant seeks clinical privileges. The applicant must become board certified within the time frame specified by their specialty after completion of their formal education and/or training. Applicants for reappointment must maintain board certification if it was required at the time of initial appointment. This requirement may be waived for good cause by the CW and governing body, for good cause in their sole determination.
- e. For physicians practicing in the Emergency Department: The purpose of ABEM board certification is to objectively and independently confirm that physicians who complete an Emergency Medicine residency demonstrate core knowledge, skills, and abilities needed to practice Emergency Medicine at the highest standards. It is also expected that physicians practicing in Emergency Medicine will maintain continuing certification to demonstrate clinically oriented and highly relevant (COHR) knowledge and skill in the practice of Emergency Medicine.

The CW and governing body may, in their sole discretion, recommend and

grant clinical privileges to physicians who are not ABEM~~S~~ certified if they demonstrate COHR knowledge, skill and ability to practice Emergency Medicine and also provide certificates of completion of courses such as ~~PALS/APLS~~, ACLS, ATLS, or other similar courses, or the completion of ~~25~~ ~~number of CME hours per year or 50 CME hours per 2 years~~ in a specified content area of Emergency Medicine, in satisfaction for the granting of clinical privileges.

- f. Each applicant must possess any current, valid and unrestricted special certification as required by requested clinical privileges, e.g. fluoroscopy.
- g. Every applicant must maintain professional liability insurance coverage in amounts not less than \$1,000,000/\$3,000,000.
- h. Each Medical Staff member must meet the requirements of all Hospital and Medical Staff infectious and communicable disease policies and requirements, as well as local, state, and federal public health orders, laws, or regulations, including, but not limited to: screening, immunization and vaccinations; proof of vaccinations; hand hygiene; masks and other personal protective equipment; social distancing; and testing. Those members who provide solely telemedicine services and are not physically present in the ~~hospital~~ may be excepted from this requirement unless compliance is otherwise required by local, state, or federal public health orders, laws, or regulations;
- i. No applicant may apply who is or has been excluded by any federal or state agency, including but not limited to OIG exclusion related to Medicare, Medicaid, or participation in any federal or state health care program, nor may an initial applicant have any such exclusion pending.
- j. No initial applicant may have record of revocation, suspension, restriction, or probation of licensure in any state which became final within the past ten (10) years; record of admonishment, citation, or reprimand from a licensing board or certification agency within the past five (5) years; or have any such action currently pending.
- ~~—No applicant may have record, from any time period, of conviction, no contest plea or guilty plea of a felony, nor such charge be pending -~~
- k. In addition to subsection ~~k~~, above, no applicant may have a pending charge and no applicant may have a ~~or~~ record of a misdemeanor conviction, no contest plea, guilty plea or civil monetary penalties, within the past ten (10) years, related to: (i) the provider's professional practice; (ii) other health care matters (including third-party reimbursement); (iii) violence; or (iv) self-use, mis-use, inappropriate prescribing, improper distribution, or inappropriate furnishing of DEA scheduled drugs (Schedules I through V).
- l. No initial applicant may have record of a denial, revocation, summary suspension, termination, restriction, limitation, loss, reduction or relinquishment of medical staff membership, clinical privileges, employment or participation in any hospital, health plan or other health care entity, for a medical disciplinary cause or reason, that has become final within the past seven (7) years. Nor may any initial applicant have any such action or recommendation pending. An action is deemed final after the practitioner has completed any applicable fair

**Commented [SC14]:** Deleted: "The CW and governing body may, for good cause shown in their sole determination, waive this requirement with regard to such member as long as such waiver is not granted or withheld on an arbitrary, discriminatory or capricious basis." It is not a good idea to waive the insurance requirement. Any liability would then fall on the HCD.



hearing and appeal at that other entity and does not include any judicial proceeding that may be brought to challenge that action.

- m. No initial applicant may have had a leave of absence, withdrawal, abandonment, or resignation of membership, clinical privileges, employment or participation in any hospital, health plan or other health care entity, after the applicant received notice of investigation or discipline, within the past ten (10) years. Any such action may be grounds for corrective action or recommended denial for an applicant for reappointment.

#### 4.2-2 Lack of Minimum Qualification

- a. An applicant who does not meet the minimum qualifications set forth above, is ineligible for appointment to the Medical Staff or AHP staff and such application shall not be accepted for review.
- b. If it is determined during the evaluation process that an applicant does not meet the minimum qualifications, the review of such application shall be discontinued.
- c. An applicant who fails to meet minimum qualifications is not entitled to ~~to~~ the procedural rights of appeal as set forth in the Fair Hearing Process in Article 9. But a practitioner may submit comments to the Chief of Staff and a request for reconsideration for the specific qualification that disqualified the application. These comments shall be reviewed by the Committee of the Whole (CW).

~~Provide a complete Application for Appointment including all requested documentation. (See Medical Staff Appointment Process 2.1 in Medical Staff Appointment Process, A Supplemental Attachment to the Southern Humboldt Community Healthcare District Medical Staff Rules & Regulations for further details.) Applications which are incomplete in any manner or form will not be forwarded to the Medical Staff for review and are not covered under the Fair Hearing Process.~~

~~Provide evidence of performance that corresponds to District Medical Staff expectations and standards for experience, training, current clinical competence, good judgment, current adequate physical and mental status and ability to work cooperatively with others in District facilities.~~

~~Conduct an individual medical practice in accordance with the following Medical Staff requirements: (1) adhere to the lawful ethics of the medical profession, (2) work cooperatively with others in the District setting so as not to adversely affect patient care or hospital operations; and (3) be willing to participate in and properly discharge Medical Staff responsibilities.~~

~~4.2-3— Maintain professional liability insurance coverage in amounts not less than \$1,000,000/\$3,000,000. The CW for good cause shown, may waive this requirement with regard to such member as long as such waiver is not granted or withheld on an arbitrary, discriminatory or capricious basis.~~

~~❖~~  
~~4.2-4— Failure to meet all standards for membership~~

~~If for any reason it is determined during the membership application review process that an applicant does not meet all of the professional qualifications indicated in sections 4.2-1 through 4.2-3, the review of the application shall be~~

~~discontinued. An applicant who does not meet the basic standards is not entitled to the procedural rights of appeal as set forth in the Fair Hearing Process. But a practitioner may submit comments to the Chief of Staff and a request for reconsideration for the specific qualification that disqualified the application. These comments shall be reviewed by the Committee of the Whole (CW).~~

#### 4.2-35 Waiver of Qualifications

Insofar as is consistent with applicable laws and governing body policies, the Chief of Staff, after consulting with the CW, has the discretion to deem a practitioner to have satisfied any questionable qualification, providing that the practitioner has demonstrated the possession of substantially comparable qualifications and that the waiver is in the best interests of the District. A waiver may be granted by the governing body after consultation with the Chief of Staff. There is no obligation to grant any such waiver, and practitioners have no right to have a waiver considered and/or granted. A practitioner who is denied a waiver or consideration of a waiver shall not be entitled to any hearing and appeal rights under these Bylaws and supplemental attachments.

4.2-4 Every applicant shall provide a complete Application for Appointment including all requested documentation. (See Medical Staff Appointment Process 2-1.2 in Medical Staff Appointment Process, A Supplemental Attachment to the Southern Humboldt Community Healthcare District Medical Staff Rules & Regulations for further details.) An application which is incomplete in any manner or form will not be forwarded to the Medical Staff for review and is not entitled to the procedural rights of appeal as set forth in the Fair Hearing Process.

#### 4.3 NONDISCRIMINATION

Membership to Medical Staff or AHP Staff or privileges shall not be denied on the basis of sex, race, age, creed, religion, color, national origin, or any physical or mental impairment if, after any necessary reasonable accommodation, the applicant is able to comply with the Bylaws ~~or and~~ supplemental attachments of the Medical Staff ~~or and~~ District Bylaws.

#### 4.4 BASIC RESPONSIBILITIES ~~OF MEDICAL STAFF MEMBERSHIP~~

Each ~~Medical Staff member and each~~ practitioner exercising temporary clinical privileges and all members shall continuously meet all of the following basic responsibilities:

- ❖a. Provide patients with care at or exceeding the generally recognized professional level of quality and endeavor to provide cost-effective, non-futile medical care.
- ❖b. Retain responsibility, within the practitioner's area of professional competence, for the -continuous- care and supervision of each District patient to which the practitioner is providing services. If there is an interruption in the care provided by a practitioner, the practitioner must arrange for a suitable replacement that can 1) assure continuous care and supervision of the patient, 2) holds unrestricted similar clinical privileges and 3) has agreed to provide backup coverage for the practitioner's patients. This includes assuring there is coverage for any AHP Staff under the member/s supervision.

- ~~Abide by the 1) all applicable laws and regulations of governmental agencies and 2.)~~ comply with applicable CMS and state standards, the Medical Staff Bylaws and supplemental attachments and all other reasonable and lawful standards, policies, rules and regulations of the Medical Staff, and the District.—This includes timely providing information, including that required for reappointment to the Medical Staff.
- ❖ ~~c. Cooperating with the implementation of electronic methods of communicating and executing daily business, such as the use of electronic records. Further, this includes timely providing information, including that required for reappointment to the Medical Staff.~~
- ❖ ~~Abide by all applicable laws and regulations of governmental agencies and comply with applicable CMS and state standards as designated by the CW and governing body.~~
- ❖ d. Regularly ~~participate~~, cooperate and support the Medical Staff and District in activities intended to provide, monitoring and ~~improvd~~improving patient care. The practitioner's participation in patient monitoring and quality improvement. Such activities includes but ~~is~~ are not limited to: emergency service, on-call responsibilities, backup functions, evaluation, measurement, assessment, peer review, Ongoing Professional Practice Evaluation (OPPE), Focused Professional Practice Evaluation (FPPE), proctoring, new provider ~~orientation, of medical records, tissue removal, infection~~orientation, infection control compliance, communicable disease screening and procedures, immunization requirements, utilization management, and pharmacy and therapeutics utilization and other activities as may be required by the Medical Staff from time to time.
- ❖ ~~e. Prepare and complete in a timely and legible manner all patient-s'-. medical records.~~
- f. Cooperate with the implementation of electronic methods of communicating and executing daily business, such as the use of electronic records, providing a current e-mail address, and agreeing to accept electronic service of communications at the email address provided to the Medical Staff.
- g. Keep as confidential and secure all patient protected health information, medical records, peer review information, Hospital and District confidential information and passwords.
- h. Complete continuing medical education (CME) that meets all licensing requirements and is appropriate to the practitioner's specialty.
- ❖ i. Aid in any education of other practitioners or healthcare personnel as requested by the Medical Staff.
- ❖ j. Refrain from unlawful fee splitting or unlawful inducements relating to patient referrals.
- k. Refrain from any:
  - i. disruptive behavior (including, but not limited to physical or verbal behavior that would be characterized by a reasonable person as inappropriate, intimidating, hostile, belittling, degrading, derogatory, demeaning, mocking profane or offensive and may include repeated refusal to abide by basic requirements);
  - ii. harassment;

iii. retaliation or attempted retaliation (including, but not limited to reprisals or threat of reprisal to those who complain about or report potentially improper conduct or actions); or

iv. unlawful discrimination (based upon the person's age, sex, religion, race, creed, color, national origin, health status, ability to pay, or source of payment);

~~a. unlawful harassment or discrimination~~ against any person (including any patient, District employee, District independent contractor, Medical Staff member, volunteer, or visitor) ~~based upon the person's age, sex, religion, race, creed, color, national origin, health status, ability to pay, or source of payment.~~

❖

l. Refrain from delegating the responsibility for diagnosis or care of patients to any practitioner ~~or non-physician provider~~ who is not qualified to undertake this responsibility or who is not adequately supervised.

m. Seek consultation whenever warranted by the patient's condition or when required by these Bylaws and rules.

n. Abide by the lawful ethical principles of the medical profession;

o. Upon request, provide information from the practitioner's office records or from outside sources as necessary to facilitate the continuity and provision of care, or upon request for review of the care of specific patients.

p. Immediately communicate with appropriate Medical Staff officers when obtaining credible information indicating that a fellow Medical Staff member may have engaged in unprofessional or unethical conduct, or may have a health condition that poses a significant risk to the wellbeing of patients. The practitioner shall cooperate, as necessary, toward the appropriate resolution of any such matter.

q. Accept responsibility for participating in Medical Staff proctoring in accordance with the Supplemental Attachment on Credentialing and Privileging.

r. Work cooperatively with Medical Staff members, nurses, District administrative staff, and others so as not to adversely affect patient care or District operations.

s. Cooperate with the Medical Staff in assisting the District to meet its uncompensated or partially compensated patient care obligations.

t. Continuously inform the Medical Staff of any significant changes in the information relative to the appointment and reappointment documents.

~~Continuously~~ Immediately inform the Medical Staff of any changes to demographic information including, but not limited to current address, phone number, fax number and email address

~~Continuously~~ Meet the qualifications for membership as set forth in these Bylaws ~~are met at all times.~~

~~Continuously~~ Notify the Medical Staff of the practitioner learning of any pending action or action, accusation or investigation taken by:

i. Government authorities, including but not limited to CMS, OIG, DEA, FBI, law enforcement or a licensing authority;

❖ ~~ii. Any healthcare organization, including but not limited to a hospital, medical staff, health plan, medical group for medical disciplinary cause or reason as that term is defined in California law;~~

4.5 Failure of a practitioner to meet any of the basic responsibilities listed above may be grounds for informal or formal corrective action.

#### 4.5.4.6 DEMONSTRATED PERFORMANCE

Upon the reasonable request, but no later than ~~fiveten (540)~~ days after the request of the CW, a member may be required to demonstrate satisfactory compliance with any of the basic responsibilities of the Medical Staff Bylaws. A member may be required to make a special appearance before the CW to discuss the compliance level of all or any of the above Medical Staff responsibilities.

**Commented [SC15]:** Ten days is a long time after the Med Staff discovers a need for information. . . consider reducing to five.

#### 4.6.4.7 DURATION OF APPOINTMENT

Initial appointments to the Medical or AHP Staffs shall be for a period of no more than 12 months. Reappointment to Medical or AHP Staffs shall be for a period of no more than 24 months. ~~The credentials files for Nurse Practitioners and Physician Assistants shall be credentialed in the same manner as physicians and their credentials files are~~ credentialed every two years by the Medical Staff and their credentials files are shall be maintained separately from any employment file, which is maintained by Human Resource Department.

#### 4.7.4.8 LEAVE OF ABSENCE

Members may obtain a voluntary leave of absence from the Medical Staff by notifying the Chief of Staff in writing. The request should state the approximate period of time of the leave. A leave cannot exceed an absence of more than two years. Reinstatement at the end of the leave must be approved in accordance with the standards and procedures set forth in the credentialing and privileging procedures for reappointment review. The member must provide information regarding professional activities during the leave of absence. During the period of the leave, the member shall not exercise privileges at District facilities, and membership rights and responsibilities shall be inactive.

### **ARTICLE 5 OFFICERS**

#### 5.1 OFFICER DESIGNATIONS

There shall be the following general officers of the Medical Staff:

- ❖ Chief of Staff
- ❖ Vice Chief of Staff

#### 5.2 QUALIFICATIONS

Officers must be members of the Active Medical Staff at the time of nomination and election and they must remain members in good standing during their terms of office. At the discretion of the active Medical Staff members, failure to maintain such status may create a vacancy in the office involved.

#### 5.3 NOMINATIONS

Nominations for the office of Vice Chief of Staff may be made from the floor by any member of the CW at the last meeting of the Medical Staff year. When there are three or more candidates for the office and no candidate receives a majority, there shall be successive balloting, whereby the name of the candidate receiving the fewest votes will be omitted from each successive slate until one candidate obtains a majority vote.

#### 5.4 ELECTION

Upon approval of a majority of the active Medical Staff members present at the CW meeting, the current Vice Chief of Staff will be advanced to the office of Chief of Staff and a new Vice Chair will be elected. If the existing Vice Chief of Staff fails to receive a majority vote to advance to Chief of Staff, the above nomination procedures shall be followed. Officers will take office on the first day of the Medical Staff year.

#### 5.5 TERM OF ELECTED OFFICER

The Chief of Staff and the Vice Chief of Staff each shall serve a one-year term. Each officer shall serve until the end of his or her term or until a successor is elected, unless the officer dies, resigns or is removed from office.

#### 5.6 REMOVAL OF ELECTED OFFICER

A Medical Staff officer may be recalled from office for failure to carry out the duties of the office. Except as otherwise provided, removal of a Medical Staff officer may be initiated by a petition signed by at least 50 percent of the members of the Medical Staff eligible to vote for officers. Removal shall be considered at a special meeting called for that purpose. Removal shall require a majority vote of the active Medical Staff members.

#### 5.7 FILLING VACANCIES

Vacancies created by resignation, removal, death, or disability shall be filled as follows: The Vice Chief of Staff shall fill a vacancy in the office of Chief of Staff. A vacancy in the office of Vice Chief of Staff shall be filled by special election held in general accordance with these Bylaws.

#### 5.8 CHIEF OF STAFF DUTIES

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:

- ❖
- ❖ Enforce the Medical Staff Bylaws and supplemental attachments.
- ❖ Call and preside at CW meetings and be responsible for the agenda preparation of all meetings of the CW.
- ❖ Appoint Medical Staff ad hoc, liaison, or multidisciplinary committees and designate the chairs of these committees.
- ❖ In the interim between CW meetings, perform those responsibilities of the CW that in the opinion of the Chief of Staff must be accomplished prior to the next regular or special meeting of the CW.
- ❖ Perform such other functions as may be assigned to the office by these Bylaws and supplemental attachments or the CW.
- ❖ Consult with the Administrator regarding medico-administrative matters.
- ❖ Serve on liaison committees with the governing body and administration.
- ❖ Regularly report to the governing body on the performance of Medical Staff functions and communicate to the Medical Staff any concerns expressed by the governing body.

5.9 ❖

**VICE CHIEF OF STAFF**

The Vice Chief of Staff shall perform the duties of secretary/treasurer of the CW. This office shall also perform such other duties as the Chief of Staff may assign. In the absence of the Chief of Staff, the Vice Chief of Staff shall assume all duties and authority of the office.

**ARTICLE 6 COMMITTEES**

6.1 GENERAL

6.1-1 CW Responsibilities

The CW serves as the executive body of the Medical Staff. The CW will address all the functions often associated with standing Medical Staff committees. The CW may appoint members to ad hoc task forces and by law the CW must appoint members to the Interdisciplinary Practice Committee (IDPC).

All Medical Staff committees or task forces will conduct their business in accordance with the following procedures:

6.1-2 Appointments

Appointments to the CW are addressed in Section 6.4 of these Bylaws and not subject to the approval of the Chief of Staff. The chief of staff will appoint all Medical Staff members to the IDPC and any Medical Staff task force. The appointments may include any category of Medical Staff member. As appropriate, appointments may include non-physician providers, District administration, representatives of the community, and anyone with special expertise.

6.1-3 Removal of Committee or Task Force Members

A member who ceases to be in good standing, loses a contractual relationship with the District, suffers a significant limitation of privileges, or any other good cause may be removed by the Chief of Staff. A member may also be removed if after review of the circumstances which prompts consideration of removal, the Chief of Staff in his exclusive review finds good cause.

6.1-4 Records of Meetings

Minutes of the CW and ad hoc task force meetings shall be prepared and retained. They shall include, at a minimum, a record of the attendance of members and the recommendations, conclusions, or actions adopted by the CW or ad hoc task force. The chairperson of the committee or task force shall review and signify by signature that the minutes are an accurate representation of the proceedings of the meeting.

6.1-5 Quorum

A quorum will consist of the voting members present for CW meetings. For all other meetings, a quorum shall consist of 33 percent of the voting members but in no event less than two voting members. Medical Staff Bylaws changes and elections of the Chief of Staff

**Commented [KJ16]:** These 2 sentences seem to conflict. Does the CoS have the ability to appoint non-physician providers, administration, representatives...?

and Vice Chief of Staff Officer positions shall require a minimum of 3 voting members for approval.

6.1-6 Manner of Action

Except as otherwise specified, the actions of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members. Committee action may be conducted by telephone conference that shall be deemed to constitute a meeting for the matters then discussed.

6.1-7 Rules of Order

Unless otherwise specified, meetings shall be conducted according to ~~Robert's~~ Rosenberg's Rules of Order; however, technical failures to follow such rules will not invalidate action taken at such a meeting.

6.1-8 Hospital Representation

The CEO/Administrator or designee shall be a member without vote of the CW and may serve on any task force of the Medical Staff.

6.2 REPRESENTATION ON DISTRICT COMMITTEES AND PARTICIPATION IN DISTRICT DELIBERATIONS

The Medical Staff may discharge duties delegated to it by the District relating to licensure, certification, disaster planning, facility and services planning, and physical plant safety by providing Medical Staff representation on District committees established to perform such functions.

6.3 COMBINED OR JOINT COMMITTEE MEETINGS

The members of the CW collectively or individually may participate in combined or joint committee meetings with staff members from other healthcare entities, the county Medical Society or other groups deemed appropriate by the Chief of Staff and the governing body. Precautions shall be taken to assure that confidential Medical Staff information is not inappropriately disclosed. Participation in external meetings is contingent upon access to and approval authority of all minutes prepared in conjunction with any such meetings by the District Medical Staff representative.

6.4 COMMITTEE OF THE WHOLE COMPOSITION

The CW shall be composed of the Medical Staff officers listed in these Bylaws, including both active and provisional active members. Associate, associate provisional and courtesy members may attend CW meetings without the right to vote. In addition to the Administrator, other administrative representatives and/or governing body representatives may serve, without vote, on the CW if approved by the CW.

6.5 PHYSICIAN SUPPORT COMMITTEE

In accordance with state law, this ad hoc committee shall serve as a resource for Medical Staff members who have concerns regarding potential chemical, substance abuse, or disability impairments, or comparable health limitations. Given the very limited size of the Medical Staff and the mode of operation as a Committee of the Whole, this ad hoc committee will consist of members from the Humboldt-Del Norte County Medical Society Physician Support Committee. Concerns will be directed to the Chief of Staff



who shall, as appropriate, enlist the help of the Medical Society's resources. Annually, the Medical Staff may appoint or reappoint a Medical Staff member as our representative for the Physician Support Committee.

- 6.6 HUMBOLDT-DEL NORTE CONSORTIUM FOR CME  
The Medical Staff recognizes the Humboldt-Del Norte Medical Society as a provider of Continuing Medical Education. Annually, the Medical Staff may appoint or reappoint a Medical Staff member to act as our representative for the consortium.

## ARTICLE 7 CONFIDENTIALITY, IMMUNITY, AND RELEASES

- 7.1 GENERAL  
The CW and Medical Staff ad hoc task force minutes, files and records, including information regarding any member or applicant to this Medical Staff shall, to the fullest extent permitted by law, be considered confidential. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall become a part of the CW files and shall not become part of any particular patient's file or of the general District records. Dissemination of such information and records shall be made only when expressly required by law, or pursuant to officially adopted policies of the Medical Staff or District. When no officially adopted policy exists, release of material will only be made with the expressed approval of the Chief of Staff, the Administrator, or designee and any involved Medical Staff member or applicant.
- 7.2 BREACH OF CONFIDENTIALITY  
Effective credentialing, quality improvement, peer review, and consideration of the qualifications of Medical Staff members and applicants to perform specific procedures must be based on free, candid, and confidential discussions. Practitioners and others who participate in credentialing, quality improvement, and peer review activities may assume that confidentiality will be preserved and maintained, unless in conflict with applicable state law. Any breach of confidentiality by members of the CW or member of an ad hoc task force when participating in activities related to credentialing, quality assurance, peer review, or qualifications of individuals for Medical Staff membership and privileges, is outside the appropriate standard of conduct for this Medical Staff. Approved dissemination of confidential information to another health facility, professional society, or licensing authority, or peer review activities will not be considered a breach of confidentiality. If it is determined by the Chief of Staff that a breach of confidentiality has occurred, corrective action will be taken by the CW or referred to the governing body for action if non-members of the Medical Staff are involved.
- 7.3 IMMUNITY AND RELEASES  
7.3-1 Immunity from Liability for Providing Information or Taking Action  
Each representative of the Medical Staff or District and all third parties shall be exempt from liability to an applicant, member, or practitioner for damages or other relief by reason of providing information to a representative of the Medical Staff, District, or any other health-related organization. This exemption extends to information regarding an individual who is, or has been, an applicant to or member of the Medical Staff or who did, or does, exercise privileges or provide

services within the District. The exemption also extends to individuals who otherwise participate in Medical Staff or District credentialing, quality improvement, or peer review activities.

#### 7.3-2 Activities and Information Covered

##### **Activities**

The immunity provided by this Article shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with District or any other health-related organization's activities. Activities included with the scope of this section include, but are not limited to, the following:

- ❖ Applications for appointment
- ❖ Requests for privileges, or specified services
- ❖ Periodic reappraisals for reappointment
- ❖ Corrective action
- ❖ Hearings and appellate reviews
- ❖ Quality assurance review, including patient care audits
- ❖ Peer review
- ❖ Utilization reviews
- ❖ Morbidity and mortality conferences
- ❖ Other District or committee activities related to monitoring and improving quality of patient care and appropriate professional conduct

##### **Information**

The acts, communications, reports, recommendations, disclosures, and other information referred to in this Article may relate to a practitioner's professional qualifications, clinical ability, judgment, character, physical and mental health, emotional stability, professional ethics, or other matters that might directly or indirectly affect patient care.

#### 7.4 CUMULATIVE EFFECT

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

### **ARTICLE 8 DISCIPLINARY ACTION**

## 8.1 CAUSE AND NOTICE OF ACTION

Any person may provide information to the Medical Staff regarding the conduct, performance, or competence of its members. When reliable information indicates a member may have exhibited acts, demeanor, or conduct either within or outside the District that are reasonably likely to be: (1) Detrimental to patient safety or to the delivery of quality patient care within the District, (2) unethical, (3) inappropriate, (4) contrary to the Medical Staff Bylaws or supplemental documents, (5) below applicable professional standards, (6) disruptive of Medical Staff or District operations, or (7) an improper utilization of District resources, as determined by the Medical Staff and District board there shall be a proposal for disciplinary action or the request for an investigation.

The proposal for disciplinary action, or the request for an investigation, must be submitted to an officer of the Medical Staff. The request must identify the specific activities or conducts that are alleged to constitute the grounds for proposing an investigation or specific corrective action. The Medical Staff officer shall promptly notify the Administrator of all requests for corrective action and the Medical Staff officer shall continue to keep the Administrator fully informed of actions taken in conjunction with corrective action activities.

## 8.2 INVESTIGATION

### 8.2-1 Conducting an Investigation

Upon receipt of a request for corrective action or investigation, the Medical Staff officer shall, in consultation with other members, decide whether to act on the proposal and direct that an investigation be undertaken. If the situation warrants, the medical staff officer may immediately initiate an expedited review without seeking consultation from CW members. The results of the expedited review will be presented to the CW for a decision to initiate a corrective action investigation. If an investigation is undertaken, a Medical Staff officer not connected with the alleged offense or an ad hoc Medical Staff task force may conduct the investigation. If the practitioner being investigated is on the CW, then the practitioner will be removed from the corrective action investigation team. A Medical Staff officer, or a consensus thereof, will decide who will conduct the investigation. The investigating process shall, within 30 days of initiation of the investigation, include an interview with the affected practitioner who shall be advised of the reasons for the investigation. The practitioner shall be given an opportunity to comment on the charges. The investigative process shall not be deemed as a "hearing" as that term is used in the Fair Hearing Process. An investigation shall be conducted expeditiously and it will be brought to a conclusion as quickly as a thorough investigation permits, but no later than 90 days after initiation of the investigation.

In a complaint involving patient harassment or discrimination, an expedited review shall be conducted as referenced earlier in Section 8.2-1 of this article. The Administrator or designee shall participate in the expedited review. When the Medical Staff officer receives a non-patient complaint from sources within or

without the Medical Staff regarding harassment or discrimination by a Medical Staff member, the Administrator or designee will participate in an expedited joint review.

#### 8.2-2 Written Report

The investigator shall forward a written report on all investigations to the CW as soon as is practicable after completion of the assignment. The CW may at any time within its discretion terminate the investigative process and proceed with action as provided below.

Information obtained in a joint expedited review regarding a complaint of harassment or discrimination may be used, as necessary, to meet District legal obligations when a charge of harassment or discrimination is made. The findings or recommendations of an expedited report must be submitted to the CW within 30 days after completing the investigation(s). If additional time is required to complete the investigation, an interim report shall be forwarded to the CW and it shall specifically request additional time to complete the investigation.

#### 8.3 COMMITTEE OF THE WHOLE ACTION/RECOMMENDATION

As soon as is practicable after the conclusion of the investigative process the CW shall act thereon. Such actions may include the following options:

- ❖ No corrective action to be taken and, if the CW determines that no credible evidence existed for the complaint, the removal of the complaint and any related information from the member's file. If the CW recommends that no corrective action be taken, such recommendation, together with such supporting documentation as may be required by the governing body, shall be transmitted thereto.
  - Rejection or modification by the CW of a proposed corrective action by an investigator.
  - Letters of admonition, censure, reprimand, or warning.
  - Prepare recommendations for corrective action that are presented to the Governing body for approval. The range of potential recommendations include:
    - (1) Probation or special limitations or restrictions to be imposed on continued Medical Staff membership or exercise of privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring.
    - (2) Reduction or revocation of privileges.
    - (3) Suspension of privileges until completion of specific conditions or requirements.
    - (4) Reduction of membership status or limitation of any prerogatives directly related to the practitioner's delivery of patient care.
    - (5) Suspension of Medical Staff membership until completion of specific condition or requirements.
    - (6) Revocation of Medical Staff membership.
    - ~~(7)~~ Other actions appropriate to the facts that prompted the investigation.

- ❖
- ❖ If the CW recommends an admonition, reprimand, or warning to a practitioner, it shall, at the practitioner's request, grant an interview with the CW. Following the interview, the CW will consider the merits of the information divulged in the interview. If the CW decides to issue an admonition, reprimand, or warning, this shall conclude the matter and notice of the final decision shall be provided to the practitioner.



#### ❖ 8.4 INTERVIEWS

Interviews or meetings that are preliminary to corrective action involving a Medical Staff member shall neither constitute nor be deemed a "hearing," as that term is used in the fair hearing process. They shall be preliminary in nature and shall not be conducted according to the procedural rules applicable to a fair hearing process. The CW shall be required, at the practitioner's request, to grant the practitioner an interview or meeting only when so specified in the fair hearing process. In all other cases and when the CW has before it an adverse recommendation, it may, but shall not be required to, furnish the member an interview. In the event an interview or meeting is granted, the practitioner shall be informed of the general nature of the circumstance leading to such recommendation or action and may present information relevant thereto. A record of the matters discussed and findings shall be made.

#### 8.5 PROCEDURAL RIGHTS

Any recommendation by the CW that constitutes grounds for a hearing shall entitle the practitioner to the procedural rights provided in the fair hearing process. In such cases, the Chief of Staff shall give the practitioner written notice of the adverse recommendation and of the practitioner's right to request a hearing in the manner specified.

#### 8.6 OTHER ACTION BY THE GOVERNING BODY

- ❖ Any action of the governing body that constitutes grounds for a hearing as set forth in the Bylaws of the governing body shall entitle the practitioner to procedural rights incorporating, as much as practicable, the rights provided in the Fair Hearing Supplemental Attachment. In such cases, the governing body shall give the practitioner written notice of the tentative adverse recommendation and the right to request a hearing.



- ❖ Should the governing body determine that the CW failure to investigate, or initiate disciplinary action, is contrary to the weight of the evidence, the governing body may direct the CW to initiate an investigation or a disciplinary action after consultation with the CW. In the event that the CW fails to take action in response to a direction from the governing body, the governing body, after notifying the CW in writing, may take action on its own initiative. If such action is unfavorable to the practitioner, or constitutes an admonition, reprimand or warning to the practitioner, it shall become effective as of the final decision of the governing body. If such action is one of those set forth in the Fair Hearing Supplemental Attachment, the governing body shall give the practitioner written notice of the adverse recommendation. The

practitioner shall also be advised of the right to request a hearing incorporating, as much as possible, the rights provided in the Fair Hearing Procedure.

## 8.7 SUMMARY SUSPENSION

### 8.7-1 Medical Staff Initiation of a Suspension

The Chief of Staff or Vice Chief may suspend a practitioner's membership status or suspend or restrict a member's privileges if, in their exclusive judgment, an immediate or potential act would result in a clear and imminent threat to the health or safety of any patient, prospective patient, employee, or other persons present in a District facility.

### 8.7-2 Non-Medical Staff Initiation of a Suspension

The Administrator or the governing body shall also have the authority to suspend a practitioner's membership or suspend or restrict privileges if, in their exclusive judgment an immediate or potential act would result in a clear and imminent threat to the health or safety of any patient, prospective patient, employee, or other persons present in a District facility. However, the governing body or CEO/Administrator must make a reasonable attempt to contact the Chief of Staff or Vice Chief of Staff before the suspension or restriction becomes effective. A suspension or restriction by the governing body or CEO/Administrator that has not been ratified by the CW within two working days after the suspension or restriction shall automatically terminate.

### 8.7-3 Notice

Summary suspension or restrictions by a Medical Staff officer or the CW shall become effective immediately upon imposition. Prompt written notice shall be given to the practitioner, governing body, Administrator, and others of the Medical Staff as appropriate. The notice of the suspension or restriction given to the practitioner shall constitute a request for corrective action or a corrective action investigation as provided in the procedures set forth in the Supplemental Attachment.

### 8.7-4 Assignment of Patients

In the event of any suspension or restriction, a Medical Staff officer shall assign the practitioner's patients whose treatment by such practitioner is affected by the summary suspension or restriction to another practitioner. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner.

### 8.7-5 CW Action

After such summary suspension or restriction, the affected practitioner may request a meeting with the CW. The meeting shall be scheduled as soon as reasonably possible. The CW may, at any time, before or after that meeting, modify, continue, or terminate the terms of the summary suspension or restriction order and shall give the practitioner written notice of its decision.

8.7-6 Procedural Rights

Non-terminated suspensions or restrictions shall remain in effect until completion of the corrective action process and any subsequent hearing and appellate review. Until the CW or the governing body takes an adverse action against a practitioner regarding a suspension or restriction of privileges, the practitioner shall not be entitled to the procedural rights afforded by the fair hearing process. The practitioner may request a hearing when the adverse action is within the scope of the fair hearing process. Reportable actions to the Medical Board of California under the provisions of Section 805 of the Business and Professional Code are an exception to this rule. The practitioner may request a hearing upon notice of the reportable action

8.8-7 AUTOMATIC DISCIPLINARY ACTION

8.8-1 State Licensure

Whenever a practitioner's license authorizing practice in this state is revoked, suspended, restricted, expired (without an application pending for renewal) or the practitioner is placed on probation, Medical Staff membership or privileges shall automatically change to correspond to the state action as of the date such action becomes effective. The change in the practitioner's membership status or privileges shall last for at least the term of the state action. The practitioner shall not be entitled to the procedural rights afforded by the fair hearing process.

8.8-2 DEA Certificate

Whenever a practitioner's Drug Enforcement Administration (DEA) certificate is revoked, suspended or has expired, practitioner shall immediately and automatically be divested of the right to prescribe medications covered by the certificate. ~~The A~~ District suspension to prescribe becomes effective upon the DEA effective date and it shall last for at least the term of the DEA suspension. The practitioner shall not be entitled to the procedural rights afforded by the fair hearing process.

8.8-3 Failure to Satisfy Special Appearance Requirement

A member, who fails without good cause, to appear before state and federal authorities or the CW and satisfy the requirements of these Bylaws and supplemental attachments, shall automatically be suspended from exercising all or such portion of privileges as specified by the CW. Corrective action may be initiated at the discretion of the CW.

8.8-4 Removal of Medical Records

Unauthorized removal of patient charts/medical records from the District facilities by a member shall result in the automatic suspension of the privileges to admit or treat patients in District facilities. Once the records have been returned to the District, admitting privileges shall resume although corrective action may be initiated at the discretion of the CW.

8.8-5 Cancellation of Professional Liability Insurance

Failure to maintain professional liability insurance as required by these Bylaws shall be grounds for automatic suspension of a member's privileges. Failure to maintain professional liability insurance for certain procedures shall result in the automatic suspension of privileges to perform those procedures. The suspension shall be effective until appropriate coverage is reinstated, including coverage of any acts or potential liabilities that may have occurred or arisen during the period of any lapse in coverage. Such practitioners shall not be entitled to the procedural rights afforded by the fair hearing process.

## **ARTICLE 9 FAIR HEARING**

### **9.1 PREAMBLE AND DEFINITIONS**

#### **9.1-1 Intra Organizational Remedies**

The intra-organizational remedies and the hearing and appellate review bodies provided for in this document are quasi-judicial in structure and function. No participant in the Fair Hearing Procedure (FHP) shall have power or authority to hold quasi-legislative, notice and comment type hearings or to make legislative determinations, or determinations as to the substantive validity of Bylaws, rules, regulations or other intra-organizational legislation. Notwithstanding the foregoing, the governing body otherwise may entertain challenges to the substantive validity of intra-organizational legislation and in all proper cases shall hear and decide those questions. Where the substantive validity question is the sole issue, the practitioner may be permitted a direct meeting, in the first instance, with the governing body. The final determination by the governing body shall be a condition precedent to practitioner's right to seek judicial review in a court of law.

#### **9.1-2 Exceptions to Hearing Rights**

The procedures described herein do not apply to a practitioner whose application for Medical Staff membership or privileges was denied on the basis that the privileges the applicant sought were the subject of an agreement or arrangement providing for exclusive or limited access to a particular service. Such practitioners shall have the right, however, to request that the governing body review the denial. The governing body shall have the discretion to determine:

- ❖ Whether to review such request;
- ❖ To determine whether the practitioner may personally appear before and/or submit a statement in support of the practitioner's position.

#### **9.1-3 Exhaustion of Remedies**

An applicant or Medical Staff member who receives an adverse decision regarding staff membership, staff status, or privileges must exhaust the intra-organizational remedies afforded by the Bylaws, rules, and the FHP before resorting to formal legal action. Exhausting intra-organizational remedies applies to a decision, the procedure used to arrive at a decision, or a



practitioner's claim against the District or participants in the ~~decision-making~~decision-making process.

#### 9.1-4 Definitions

Except as otherwise provided in the Bylaws, the following definitions shall apply:

**Responsibility for decision that prompted the hearing decision** refers to:

- ❖ The Medical Staff's Chief of Staff, or authorized officer, who took the action or rendered the decision that resulted in a hearing being requested.
- ❖ The governing body in all cases where the governing body or authorized officers, directors, or committees of the governing body took the action or rendered the decision which resulted in a hearing being requested.

**Notice** refers to a written communication delivered personally to the required addressee or sent by United States Postal Service, certified mail, return receipt requested, addressed to the required addressee at the address as it appears in the records of the District.

**Practitioner** refers to the practitioner who has requested a hearing pursuant to this document.

**Date of receipt** of any notice or other communication shall be deemed to be the date such notice or communication was delivered personally to the required addressee. Or, if delivered by mail, such notice or communication shall be deemed received 48 hours after being deposited, postage prepaid, in the United States Postal Service in compliance with paragraph 2 above.

## 9.2 CAUSE FOR HEARING

### 9.2-1 Grounds for Hearing

The grounds for hearing specified in these Bylaws are intended to comply with those required by law and not to expand upon such rights. Therefore, a member who is the subject of an adverse action or recommendation which, if adopted by the ~~HCB~~Southern Humboldt Community Healthcare District's Board of Directors, will require a report to be filed under Business and Professions Code §805 is entitled to a hearing, including when:

- ❖ An application for clinical privileges and/or membership is denied or rejected for a medical disciplinary cause or reason.
- ❖ Membership and/or clinical privileges are terminated or revoked for a medical disciplinary cause or reason.
- ❖ Restrictions are imposed, or voluntarily accepted, on membership or privileges for accumulative total of thirty (30) days or more during any twelve (12) month period for a medical disciplinary cause or reason.
- ❖ Summary suspension of membership or clinical privileges which remains in effect for more than fourteen (14) days.



Commented [KJ17]: What is this HCB?

### 9.3.1 ADVERSE RECOMMENDATIONS

Recommendation of any of the above actions shall constitute an "adverse recommendation" for the purposes of the FHP.

## 9.4 REQUESTS FOR A HEARING

### 9.4-1 NOTICE OF ACTION OR PROPOSED ACTION

Under the FHP, the person or body that has the authority and pursuant to that authority has recommended or taken any of the actions constituting grounds for hearing as set forth above, shall provide the affected practitioner with the following:

- ❖ Notice of an adverse recommendation, or action.
- ❖ Whether the action will be reported pursuant to California Business and Professions Code Section 805.
- ❖ Notice of the applicant's or member's right to request a hearing pursuant to paragraph 9.4-2.
- ❖ The right to representation by legal counsel.

### 9.4-2 REQUEST FOR HEARING TIME LIMITS

The practitioner shall have 30 days, following the date of receipt of notice of such action, to request a hearing by the CW. Said request shall be affected by notice to the Chief of Staff with a copy to the Administrator. In the event the practitioner does not request a hearing within the time and in the manner herein above set forth, the practitioner shall be deemed to have accepted the recommendation or action involved and it shall thereupon become final.

### 9.4-3 TIMES AND PLACE FOR HEARING

Upon receiving a request for hearing, the Chief of Staff, on behalf of the CW, shall schedule and arrange for a hearing and give notice to the practitioner of the time, place, and date of the hearing. The practitioner may choose to appear in person, by telephone or video conference. The date of the commencement of the hearing shall not be fewer than 30 calendar days from the date of the notice of hearing, or more than 60 calendar days after the receipt of the request for a hearing by the Chief of Staff. However, a practitioner who is under a suspension, which is then in effect, has the right to a hearing as soon as the arrangements can reasonably be made. The date of the hearing for a suspended practitioner shall not exceed 30 calendar days from the date of receipt of the request for hearing by the Chief of Staff.

The date of a hearing may be postponed upon a decision issued by the Chief of Staff based upon good cause and in accord with this FHP.

### 9.4-4 NOTICE OF CHARGES OR GROUNDS FOR ACTION

As a part of or together with the notice of hearing required by paragraph 9.4-1, the Chief of Staff shall state in writing the acts or omissions with which the

practitioner is charged. The Chief of Staff's statement shall include a list of the charts being questioned, or the grounds upon which the application or request was denied.

9.4-5 FAILURE TO APPEAR

Failure of the practitioner to appear without good cause and failure of the practitioner to be prepared to proceed at a set hearing time and date shall be deemed to constitute voluntary acceptance of the recommendations or actions involved and it shall thereupon become final.

9.4-6 CONTINUANCES

The presiding hearing officer on a showing of good cause may grant continuances upon agreement of the parties.

9.5 HEARING PROCEDURE

9.5-1 JUDICIAL HEARING OFFICER

When a hearing is requested, the CW and governing body shall jointly appoint a Judicial Hearing Officer who is qualified by experience or training to conduct a fair hearing. The Judicial Hearing Officer shall:

- ❖ Have no direct financial interest in the outcome of the hearing.
- ❖ ~~Have-Has~~ not acted as accusers, investigators, fact finders, or initial decision-makers in the matter.
- ❖ Where feasible, be knowledgeable regarding the appellant practitioner's specialty.

The governing body and the CW will jointly appoint a hearing officer to conduct the hearing and report to the governing body and CW on findings and recommendations. The hearing officer may be an attorney at law or otherwise qualified individual who can preside over a quasi-judicial hearing, preferably with experience in Medical Staff matters. The hearing officer shall gain no direct financial benefit from the outcome of the hearing. The hearing officer must not act as a prosecuting officer, or as an advocate for the governing body, CW, or the practitioner. The hearing officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner and that proper decorum is maintained.

The hearing officer shall be entitled to determine the order and procedure for presenting evidence and arguments during the hearing. The hearing officer shall have the authority and discretion to make all rulings on questions pertaining to matters of law, procedure, or the admissibility of evidence.

If the hearing officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the hearing officer may take action, including disciplinary action as seems warranted by the circumstances. The CW

and governing body may authorize legal counsel for consultation by the hearing officer, as appropriate.

The hearing officer shall prepare a written report of the findings of the hearings and recommendations for action. The hearing officer will present the report to the CW. A copy of the report will be sent to the governing body.

The hearing officer shall maintain a record of the hearing by one of the following methods:

- ❖ A certified shorthand reporter present to make a record of the hearing.
- ❖ A recording of the proceedings.

The cost of attendance of the shorthand reporter shall be borne by the District, but the cost of the transcript, if any, shall be borne by the party requesting it. The hearing officer may order that oral evidence shall be taken only on oath administered by any person entitled to notarize documents in California or by affirmation, under penalty of perjury, to the hearing officer.

The cost of conducting hearing will be borne by the District.

#### 9.5-2 PRE-HEARING PROCEDURE

9.5-1a At the request of either party, an exchange of witness lists of individuals expected to testify shall be made available to requesting parties. Copies of all documents that are expected to be introduced as part of the hearing shall be made available to requesting parties. If witnesses are added after this list has been provided, it shall be the duty to notify the other party of the change. Failure to disclose the identity of a witness or produce copies of all documents used as part of the hearing at least ten days before the commencement of the hearing shall constitute good cause for a continuance.

9.5-1b It shall be the duty of the practitioner and the Chief of Staff or authorized Medical Staff officer, to exercise reasonable diligence in notifying the hearing officer of any pending or anticipated procedural disputes. Notification should be as far in advance of the scheduled hearing as possible so that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be made at the hearing.

9.5-1c The practitioner shall have the right to inspect and copy, at the practitioner's expense, any documentation relevant to the charges and in possession or under control of the Chief of Staff. The aforementioned individuals will provide the requested information as soon as practicable.

9.5-1d The Chief of Staff shall have the right to inspect and copy, at the

Ⓧ District's expense, any documentation relevant to the charges in possession or control of the practitioner. The practitioner will provide the requested information to the aforementioned individuals as soon as practicable.

9.5-1e The failure by either party to provide access to such information at least 30 days before the hearing shall constitute good cause for a continuance.

9.5-1f The right to inspect and copy by either party does not extend to confidential information referring to individually identifiable practitioners other than the practitioner involved in the hearing.

The hearing officer shall consider and rule upon any request for access to information, and the hearing officer may impose any safeguards for the protection of the peer review process. When ruling upon requests for access to information and determining the relevancy thereof, the Hearing Officer shall, among other factors, consider at least the following:

- ❖ Whether the information sought may be introduced to support or defend the charges.
- ❖ The exculpatory or inculpatory nature of the information sought, if any.
- ❖ The burden imposed on the party in possession of the information sought, if access is granted.
- ❖ Any previous requests for access to information submitted or resisted by the parties to the same proceeding.

#### 9.5-2 REPRESENTATION AT THE JUDICIAL HEARING

The practitioner and District shall be entitled to representation by legal counsel in any phase of the hearing, and the practitioner shall receive notice of the right to obtain representation. In the absence of legal counsel, the practitioner shall be entitled to be accompanied by and represented at the hearing by a practitioner licensed to practice in the State of California who is not an attorney at law. If the practitioner is not so represented by legal counsel, legal counsel shall not represent the District.

#### 9.5-3 RIGHTS OF THE PARTIES

Both sides shall have the following rights during the fair hearing process:

- ❖ To question the qualification and impartiality of the hearing officer to serve in accordance with this FHP procedure.
- ❖ To call and examine witnesses.
- ❖ To introduce exhibits or other documents.
- ❖ To cross-examine or otherwise attempt to impeach any witness who shall have testified orally on any matter relevant to the issues, and otherwise to rebut any evidence.
- ❖ To be provided with all information made available during the hearing.

and to the hearing officer.

- ❖ The practitioner may be called by the body whose decision prompted the hearing and examined as if under cross-examination.
- ❖ Ruling on any challenge directed at the hearing officer shall be done by a knowledgeable and impartial resource.

#### 9.5-4 MISCELLANEOUS RULES

The rules of law relating to the examination of witnesses and presentation of evidence shall not apply in any hearing conducted under these procedures. Any relevant evidence, including hearsay, shall be admitted by the hearing officer provided the evidence can be characterized as information commonly accepted or used by responsible persons 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 written statement supportive of each party's respective position. The hearing officer may request a statement to be filed following the conclusion of the presentation of oral testimony. The hearing officer may question witnesses or call additional witnesses as a means of obtaining a full and complete exposition of the relevant facts. The Administrator or designee may attend and observe FHP and CW meetings.

#### 9.5-5 BURDENS OF PRESENTING EVIDENCE AND PROOF

- ❖ The Chief of Staff or authorized Medical Staff officer shall have the initial burden to present evidence that reasonably supports the corrective action.
- ❖ An ~~applicant-practitioner~~ shall bear the burden of presenting evidence that clearly allows for an evaluation and resolution of reasonable doubt regarding the applicant's ability and earnestness to perform requested privileges and fitness for Medical Staff membership. Initial applicants shall not be permitted to introduce information not produced upon request of the CW during the credentialing process, unless the initial applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

#### 9.5-6 ADJOURNMENT AND CONCLUSION

The hearing 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 and argument, the hearing shall be closed.

#### 9.5-7 HEARING OFFICER DECISION

Within 30 working days after final adjournment of the hearing (in the event the practitioner is currently under suspension, this time shall be 15 calendar days), the hearing officer shall render a written decision. The decision report shall include findings of fact and any conclusions explaining the connection between the evidence and the decision of the hearing officer. The decision report shall be delivered to the Chief of Staff, the Administrator, and the governing body. At

the same time, a copy of the report and decision shall be delivered to the practitioner by certified mail, return receipt requested. The practitioner shall be advised of the appeal rights to the governing body. The decision of the hearing officer shall be considered final, subject only to the right of appeal to the governing body as provided below.

## 9.6 APPEAL TO GOVERNING BODY

### 9.6-1 TIME FOR APPEAL

Within 30 calendar days after the date of receipt of the CW decision, either the practitioner or the Chief of Staff or authorized Medical Staff officer whose decision prompted the hearing may request an appellate review by the governing body. Said request shall be delivered to the Administrator in writing either in person, or by certified mail, return receipt requested. The request shall include a brief statement of the reasons for the appeal. If such appellate review is not requested within such period, both sides shall be deemed to have accepted the action involved and it shall thereupon become the final action of the Medical Staff.

### 9.6-2 GROUNDS FOR APPEAL

The written request for an appeal shall include the grounds for appeal, and a clear and concise statement of the facts that support the appeal. The grounds for appeal from the hearing shall be:

- ❖ Substantial noncompliance with the procedures that are required by the FHP or applicable law so as to deny a fair hearing.
- ❖ The decision was not supported by substantial evidence based on the hearing record or such additional information as may be permitted.

### 9.6-3 TIME, PLACE, AND NOTICE

The governing body shall schedule and arrange for an appellate review. The governing body shall give the practitioner notice of the time, place, and date of the meeting with the parties that are to be included in the appellate review. The date of an appellate review meeting shall not be less than 30 calendar days or more than 60 calendar days from the date of receipt of the request for appellate review. However, when a request for appellate review is from a practitioner who is under suspension then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made. The review shall not exceed 30 days from the date of receipt of the request for appellate review if the practitioner is under suspension. The time for appellate review may be extended for good cause by the governing body, its chair or its designee.

### 9.6-4 APPEAL BOARD

When an appellate review is requested, the governing body shall sit as the appeal board. Knowledge of the matter involved shall not preclude any person from serving as a member of the appeal board, so long as that person did not take part

in a prior investigation or hearing on the same matter.

9.6-5 APPELLATE PROCEDURE

The proceedings by the governing body shall be an appellate hearing that is based upon the record of the hearing before the hearing officer. The appeal board may accept additional oral or written evidence, subject to the condition that such evidence could not have been made available to the hearing officer consistent with reasonable diligence. New evidence is subject to the same rights of cross-examination or confrontation provided at the hearing. The governing body may remand the matter to the CW for the taking of further evidence and for decision. Each party shall have the right:

- ❖ To present a written statement in support of the party's position on appeal.
- ❖ To appear and respond; and
- ❖ To be represented by an attorney or any other representative designated by the party.

At the conclusion of the arguments, the governing body may thereupon conduct deliberations, at a time convenient to itself, outside the presence of the appellant and respondent and their representatives.

9.6-6 DECISION

Within 30 working days after the conclusion of the appellate review proceedings, the governing body shall render a final decision in writing. The governing body may affirm, modify, or reverse the Hearing Officer's decision, or, in its discretion, remand the matter for further review and recommendation by the CW. Copies of the decision shall be delivered to the practitioner, Chief of Staff, and the Administrator by personal delivery or by certified mail, return receipt requested.

9.6-7 FURTHER REVIEW

Except where the matter is remanded for further review and recommendation the final decision of the governing body following the appeal procedures set forth herein shall be effective immediately and shall not be subject to further review. However, if the matter is remanded to the CW, it shall promptly conduct its review and render its decision to the governing body in accordance with the instructions given by the governing body.

9.6-8 RIGHT TO ONE HEARING

Notwithstanding any other provision of this FHP, no practitioner shall be entitled to more than one hearing and one appellate review on any matter that shall have been the subject of action by either the CW or the governing body or by both.



## ARTICLE 10 GENERAL PROVISIONS

### 10.1 DUES OR ASSESSMENTS

Active and Provisional Active Medical Staff members may be required to pay annual dues at the beginning of the Medical Staff year. The CW shall have the power to set the amount of annual dues or assessments, if any, for each category of Medical Staff membership. The CW shall determine the manner of expenditure of funds received. At the end of six (6) months, members with unpaid staff dues are reported to the Chief of Staff for further action.

### 10.2 AUTHORITY TO ACT

Any member who acts in the name of this Medical Staff without proper authority shall be subject to such disciplinary action as the CW may deem appropriate.

### 10.3 CONSTRUCTION OF TERMS AND HEADINGS

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

### 10.4 DISCLOSURE OF INTEREST

All nominees for election or appointment to Medical Staff offices shall disclose in writing to the CW those foreseeable personal, professional or financial affiliations or relationships, that could result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff. The conflict-of-interest statement shall be sent to the CW at least 20 days prior to the date of election or appointment.

### 10.5 MEDICAL STAFF ROLE IN EXCLUSIVE CONTRACTING

The Medical Staff shall be notified and may make recommendations to the governing body regarding quality of care issues related to exclusive arrangements for physician and/or professional services prior to a decision being made, in the following situations:

- ❖ A decision to execute an exclusive contract in a previously open service;
- ❖ A decision to renew or modify an exclusive contract in a particular service;
- ❖ A decision to terminate an exclusive contract in a particular service.



## ARTICLE 11 -ACCESSORY DOCUMENTS

In addition to the Bylaws, the Medical Staff shall be directed by supplemental attachments. The attachments include the following:

- ❖ Medical Staff Rules and Regulations containing the specific information regarding conduct and requirements expected of all members.
- ❖ Medical Staff ~~credentialing of members~~ Appointment Process.
- ❖ ~~Delineation of Medical Staff privileges~~ Clinic Privilege Delineation Process.

Upon adoption by the CW and the governing body, such additional documents as occur in this

section are incorporated by reference as part of these Bylaws.

## **ARTICLE 12 AMENDMENTS, FORMATTING AND ADOPTION**

### **12.1 AMENDMENTS**

#### **12.1-1 Bylaws**

These Bylaws are amended when a majority vote of those voting from the active staff is sustained by the governing body. The member voting shall occur at a CW meeting.

#### **12.1-2 Rules and Regulations, Supplemental Attachments**

Amendments to the Medical Staff Rules, the Appointment and Privileging Attachments, and any other supplemental attachments pertaining to the operation of the Medical Staff are amended when a majority of the voting members of the CW are sustained by the governing body. The member voting shall occur at a CW meeting.

### **12.2 FORMATTING**

These Bylaws, Rules and Regulations and any other supplemental attachments can be corrected for typographical errors, adding previously approved wording or reformatting, without approval of the Medical Staff as long as content is not changed.

### **12.3 ADOPTION**

These Bylaws, upon adoption by the SHCHD Medical Staff, shall replace any previous Bylaws and they shall become effective when approved by the governing body. They shall, when adopted by the Medical Staff and approved by the governing body, be equally binding on the governing body and the Medical Staff, subject, however, to the rights of the governing body to require that these Bylaws be amended.

**MEDICAL STAFF BYLAWS ADOPTION AND APPROVAL**

Adopted ~~September 21, 2022~~ March 8, 2023

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Michael Newdow, M.D., Chief of Staff

Approved ~~September 29, 2022~~ March 30, 2023

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Corinne Stromstad, President, SHCHD Board of Directors



## MEDICAL STAFF RULES & REGULATIONS

### INTRODUCTION

The following Medical Staff rules and regulations serve as a part of the SHCHD Medical Staff Bylaws. As such, the rules and regulations shall be interpreted in a manner to be consistent with the bylaws.

### ARTICLE 1 CONDUCT OF MEDICAL CARE

#### 1.1 ADMISSIONS TO DISTRICT SERVICES

##### 1.1-1 General Requirements

- ❖ The responsibility for admitting and providing medical care or supervising the care of all patients seeking services in District programs shall be limited to appropriately privileged physicians who are members of the SHCHD Medical Staff.
- ❖ A physician assigned to “on call” responsibility will admit or care for patients who have no established relationship with a Medical Staff member and who have an urgent need for medical care. Upon a patient’s request, transfer to an appropriate alternative practitioner shall be made consistent with Medical Staff rules (Section 1.6-8 below) as soon as possible.
- ❖ Practitioners who have been granted temporary privileges under appropriate Medical Staff procedures may admit or care for patients in all District facilities as deemed appropriate by the practitioner.
- ❖ Except for emergencies, no patient shall be admitted to the Hospital until a provisional diagnosis has been stated. In case of emergency, the provisional diagnosis shall be stated as soon after admission as possible.

##### 1.1-2 Suicidal Patients

Suicidal patients are referred to a qualified practitioner or hospital designated as appropriate for such a patient. If referral of the patient is not immediately possible, the following guidelines are followed:

- ❖ The patient is admitted to the Hospital with documented suicide precautions.
- ❖ Consultation with a psychiatrist is recommended. Further, the attending physician must offer such consultation to the patient or patient's representative.
- ❖ To assure the protection of the patient from self-harm, the attending physician shall order, if necessary, observation and application of restraints for the patient. An order for constraints shall be made in accordance with

**Commented [SC18]:** What about Provisional Active? Provisional Associate? Associate?

**Commented [KJ19R18]:** We use the Associate/Provisional Associate statuses for those who don't have admitting privileges. Most are teleradiologist, and we have our Lab Director in there too. Admitting privileges would be Active and Provisional Active only.

Hospital policy.

## 1.2 CONTINUOUS MEDICAL COVERAGE

In accordance with the law and SHCHD Medical Staff Bylaws, practitioners will provide uninterrupted medical services by adhering to the following guidelines:

### 1.2-1 Inpatients (Acute and Skilled Nursing Services)

To provide continuous inpatient care at District facilities, physicians shall be called in the following order: (1) primary physician, (2) physician designated by the primary practitioner as being on-call for the primary physician, and (3) the Chief of Staff.

### 1.2-2 Emergency Service Patients

Physician coverage for emergency service patients shall be provided as follows: (1) emergency contract service physician, when scheduled, (2) District assigned Medical Staff member when scheduled, and (3) the Chief of Staff.

Physicians who are regularly scheduled to work in the Emergency Department will be available to respond within a 30-minute timeframe as dictated by/in the Medical Staff Bylaws, Rules and Regulations which are reviewed and overseen by the District's ~~Governing Board of Directors~~ governing body.

It is the policy of ~~Southern Humboldt Community Healthcare~~ the District (SHCHD) to maintain a list of credentialed physicians, nurse practitioners, and physician assistants who are on staff in the hospital and the Southern Humboldt Community Clinic (SHCC) and available to be on-call and who can respond to the Emergency Department to complete a Medical Screening Examination (MSE) and stabilizing treatment under the following circumstances: (1) when the Emergency Department physician is unavailable due to unforeseen circumstances or becomes incapacitated. (2) when the Emergency Department physician is already caring for a critical patient and is not able to leave the bedside. (3) during a local emergency situation or a community wide disaster when an influx of patients dictates the need for more than one provider to complete a MSE to rule out an Emergency Medical Condition (EMC) and provide stabilizing treatment.

### 1.2-3 District Outpatient Services

Regarding District outpatient services, the practitioner shall maintain continuity of care through appropriate patient scheduling or, in the absence of the primary practitioner, designation of an alternate practitioner to provide or supervise medical services to patients.

### 1.2-4 Transfer to Another Physician

When care of a patient(s) is transferred from the primary physician to an alternate physician, the primary physician must so state in clear language on the progress and order sheets of the patient's medical record. The primary practitioner must take the additional step of informing the nursing staff of the

**Commented [SC20]:** Is there a requirement that such a MD be ABEM certified? or have the other certifications?

**Commented [KJ21R20]:** This is not a requirement, as we've put in a clause that there can be an exception granted for someone who shows the education, skills and practice for EM.

**Commented [KJ22]:** MEC to REVIEW

**Commented [SC23]:** Elsewhere it is "governing body" - What is the correct terminology and should be consistent throughout.

**Commented [SC24]:** District is defined at the beginning of the Bylaws.

**Commented [KJ25]:** CNO to address in January's MEC

change in coverage. Nursing staff will notify others as appropriate. Verbal and telephone orders to nursing staff regarding a change in physician coverage must be signed by the transferring physician within 24 hours, if possible.

It is the responsibility of the primary physician to ensure that the alternate physician assuming responsibility for providing care to the transferred patient has the necessary clinical privileges.

### 1.3 CONSULTATION

The primary practitioner is responsible for requesting consultations when indicated, and for contacting a qualified consultant.

#### 1.3-1 Consultation Guidelines

Except in emergency conditions, the primary physician shall seek a consultation with another qualified physician under the following circumstances:

- ❖ The patient is not a good risk for treatment.
- ❖ The diagnosis is obscure.
- ❖ There is doubt as to the best therapeutic measures.
- ❖ Upon request of the patient or such other individual who is acting for the patient when the condition of the patient precludes such responsibility.

#### 1.3-2 Consultant Qualifications

Consistent with a practitioner's expertise, any District Medical Staff member with Medical Staff privileges can be called for consultation. Non-member consultants must be qualified to give an opinion in the field in which an opinion is being sought. The Medical Staff shall determine the qualifications of a consultant on the basis of the individual's training, experience and competence.

#### 1.3-3 Consultation Documentation.

A complete consultation shall include the following documentation:

- ❖ Evidence of the review of the patient's medical record by the consultant.
- ❖ Pertinent findings on examination of the patient.
- ❖ The consultant's opinion and recommendations.

The consultant's report shall be part of the permanent medical record. When the consultation is obtained by telephone, it is recorded and signed by the physician who receives the telephone consultation. When invasive procedures are involved, consultation notes, except in emergencies, are recorded prior to the performance of the procedure.

#### 1.3-4 Non-Physician Request for Consultation

The Administrator has the right to request a consultation. If the Administrator believes that appropriate consultation is needed and has not been obtained, the Administrator will call this to the attention of the Chief of Staff who will determine the appropriateness of the request for a consultation.

A nurse who believes that appropriate consultation is needed but it has not been

obtained shall first call the concern to the attention of the physician caring for the patient. In the absence of appropriate action by the physician, the matter will be referred to the nurse's supervisor, who in turn will refer the matter to the Chief of Staff.

#### **1.4 DISCHARGE AND TRANSFER**

Medical Staff members shall follow the guidelines presented below for discharges and transfers from District facilities:

##### 1.4-1 Discharges

- ❖ Discharge of patients should occur as soon as medically stable and reasonably practical. When a patient leaves a District inpatient facility against the advice of the primary physician or without proper discharge procedures, a notation of the incident will be made in the patient's medical record by the primary physician. Nursing Service will complete an Against Medical Advice form and a Quality Review form.
- ❖ Inpatients shall be discharged only by order of the primary practitioner. A patient may be discharged by telephone order if the primary practitioner has seen the patient that day or an alternate physician or the patient meets predetermined discharge criteria as documented by the primary practitioner.

##### 1.4-2 Inter-Facility Transfers

- ❖ No patient will be transferred to an outside facility without approval of the responsible primary District practitioner and the receiving institution. Consent of receiving physician and confirmation by the receiving facility will be obtained by telephone and documented by the transferring practitioner prior to the patient's release. The receiving facility's consent including the time and date thereof, will be documented in the patient's chart. Such documentation shall identify the physician and facility representative who has consented to accept the patient. The transferring practitioner will determine when a patient is appropriate for transfer.
- ❖ The patient or the patient's authorized representative will be advised, if possible, of the need and the reason for the transfer and the alternatives, if any, to the transfer. Additionally, the proposed transportation plans and the benefits and risks of the proposed transfer will be divulged to the patient or authorized representative. A note will be made in the patient's medical record regarding the discussion with the patient or patient representative.
- ❖ Appropriate transfer forms and/or copies of all medical records shall accompany patients transferred to other facilities for acute or convalescent care to assure adequate continuity of care.

#### **1.5 DISTRICT SERVICES POLICIES AND PROCEDURES**

Individual District clinical services develop policies and procedures in collaboration with other district departments and the medical staff. All policies and procedures are discussed at and approved by the CW. When these policies and procedures contain practice guidelines, they must be followed by all practitioners.

## 1.6 MEDICAL RECORDS

### 1.6-1 Contents

Physicians responsible for providing overall patient care management or supervision of a patient's care shall provide sufficient data to support the diagnosis, justify the treatment, document the course and results of treatment and promote continuity of care among health care providers. Specific practitioner provided data to be included in the medical record as per the following table:

Required Medical Record Data	Inpatient	Outpatient
Emergency care prior to <del>patients</del> patients' arrival	Y	Y
Record and findings of patient assessment (physical, social, psychological)	Y	Y
Conclusions or impressions drawn from medical history and physical examination	Y	Y
Diagnosis or diagnostic impression	Y	Y
Reason for admission or treatment	Y	
Goals for treatment and treatment plan	Y	Y
Evidence of known Advanced Directive	Y	
Evidence of Informed Consent	Y	Y
Diagnostic and therapeutic orders	Y	Y
Diagnostic and therapeutic procedures and test results	Y	Y
Progress notes made by practitioner and other authorized individuals	Y	Y
Reassessments and revisions of treatment plans	Y	Y
Patient's response to care	Y	Y
All medications ordered, prescribed, or dispensed	Y	Y
Medications administered and any drug reaction	Y	Y
All relevant diagnoses established during course of care	Y	Y
Any referrals and communications from and communications made to external providers or community agencies	Y	Y
Clinical observations	Y	Y
Conclusions at termination of treatment	Y	Y
Discharge instructions to patients and family	Y	Y
Clinical resume and discharge summary, or final progress note, or transfer summary (see section 1.6-8 for details)	Y	Y
A summary list containing significant diagnosis, procedures, drug allergies and medications (established after third visit)	Y	Y

### 1.6-2 History and Physical

- a. Admission History and Physical examinations are to be completed within twenty-four (24) hours of admission or registration, and prior to surgery or a procedure requiring anesthesia services.
- b. If a complete ~~h~~HHistory and ~~p~~PPhysical examination was performed and recorded within 30 days prior to the patient's admission to the ~~District h~~Hospital, a durable, legible copy of the History and Physical report may be provided as part of the ~~h~~HHospital medical record and shall be included in lieu of the admission History.



~~and Physical examination. A History and Physical H&P~~ conducted prior to admission to inpatient status must contain the required elements as defined by the Medical Staff. ~~The record shall be included in the medical record in lieu of the admission history and physical examination.~~ In such instances, an interval history and physical examination must be performed and recorded within twenty-four (24) hours of admission or registration, and prior to surgery or a procedure requiring anesthesia services. The interval ~~history and physical examination~~note must include all additions ~~to the history~~necessary to complete the required elements, as well as ~~and any~~ changes in the patient's condition and physical findings. If no additions ~~are necessary and no~~ or changes ~~were~~are found, the practitioner must so record in the interval note in the medical record.  
~~History and physicals are to be dictated no later than 24 hours after the patient is admitted to District inpatient facilities.~~

1.6-3 Progress Notes

Pertinent progress notes shall try to be recorded at the time of observation and they shall be sufficient to clearly establish a record of the progress of a patient undergoing treatment in any District service. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes shall be written at least daily on all acute-care patients. Progress notes for skilled nursing patients shall be in accordance with the law.

1.6-4 Physician's Orders

- ❖ **Written:** Practitioners are encouraged to ensure orders be written clearly, legibly, and completely. Orders that are illegible or unclearly written will not be carried out until clearly understood by the nurse. The order must be signed by the responsible practitioner or alternate practitioner designated by the primary practitioner.
- ❖ **Verbal.** Verbal orders for medications may be received and recorded by a registered nurses, licensed vocational nurses, pharmacist or physician assistant. The person receiving the telephone order shall sign orders dictated over the telephone. The name of the ordering physician must also be noted on the order. The medication ordered must be limited to those approved by the Medical Staff. The ordering practitioner must authenticate the order within 48 hours.
- ❖ **Verbal orders** for diagnostic laboratory, x-ray, dietary, physical therapy and other clinical support services provided by the District may be received by authorized employees for support department when these orders are clearly from a person recognized as an authorized representative of a Medical Staff member.

1.6-5 Standing, Specialty, or Protocol Orders

Standing orders, specialty orders, protocol orders or a practitioner's routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet in the patient's record, dated and signed by the practitioner. Standing orders shall be reviewed and authenticated by the physician on an annual basis.

1.6-6 Authentication

| All clinical entries in the patient's medical record shall be legible, accurately dated, timed, and signed by the responsible practitioner.

1.6-7

**Final Diagnosis**

A final diagnosis shall be recorded for inpatients. The documentation is made without the use of symbols or abbreviations. The entry of the final diagnosis is dated and signed by the responsible practitioner at the time of discharge of all patients.

1.6-8 **Discharge Documentation**

**Clinical resumes or summaries** shall be completed at the time of discharge for all inpatients. The content of the discharge summary shall be sufficient to justify the diagnosis, treatment and end result. The summary should be concise and include the following information:

- ❖ The reason for the hospitalization.
- ❖ Significant findings.
- ❖ Procedure performed and treatments rendered.
- ❖ Consultations.
- ❖ Final diagnosis.
- ❖ The patient's condition at discharge.
- ❖ Instructions to the patient and family, if any.
- ❖ Signature of primary practitioner.

**Progress note** instead of a clinical resume may be substituted for normal newborns or minor problems requiring less than 48-hour hospitalization. The progress note includes:

- ❖ Patient's condition on discharge.
- ❖ Discharge instructions.
- ❖ Follow up care required.

**Internal transfer** of a patient from hospital care to skilled nursing care with continuing care provided by the same practitioner may be documented by a progress note.

**Transfer summary** can be substituted for the clinical resume when a patient is transferred to another practitioner for any reason. The transfer summary shall include:

- ❖ The patient's condition at the time of transfer; and
- ❖ The reason for the transfer.

1.6-9 **Completion of the Medical Record**

Medical record completion shall be in accordance with the following provisions:

- ❖ The medical record shall not be permanently filed until it is completed by the primary practitioner or is authorized for filing by the Chief of Staff.
- ❖ An inpatient medical record shall be completed promptly and authenticated or signed by the primary practitioner within two weeks following an inpatient discharge. The Director of Medical Records notifies the primary practitioner of incomplete records. The Chief of Staff and the Administrator are also be notified in writing. The practitioner is placed on automatic suspension within four days following notification if delinquent records are not promptly

- completed.
- ❖ Failure to complete an inpatient history and physical within three days following admission to inpatient care by the responsible primary practitioner may lead to automatic suspension of the practitioner.
  - ❖ Emergency room and outpatient medical records are completed at the time care is provided or within 24 hours of the provision of care. A dictated history and physical and course of treatment note are acceptable.

#### 1.6-10 Members' Access to the Medical Record

Access to District medical records by Medical Staff members shall be in accordance with the following provisions:

- ❖ A member of the Medical Staff shall be permitted access to a patient's medical records for periods during or before the time the member provides medical services to a patient. In case of return of a patient to the District for medical services, all previous records shall be available for the use of the responsible practitioner.
- ❖ Access to medical records by the Chief of Staff, and the CW shall be permitted for quality-of-care review purposes.
- ❖ Access to all medical records of all patients shall be permitted to members of the Medical Staff for bona fide clinical studies when done in a manner consistent with preserving the confidentiality of personal information concerning the individual patients. The Administrator and CW shall approve all such projects. Subject to the discretion of the Administrator, former members of the Medical Staff shall be permitted free access to information from the medical records of their patients covering all periods during which the practitioner provided medical services in District facilities.

#### 1.6-11 Release/Removal of Medical Records

The following provisions will govern release and removal of medical records:

- ❖ Original records may be removed from District facilities only in accordance with a court order, subpoena, or statute. All records are the property of the District and shall not be taken off premises without permission of the Administrator or designate. Unauthorized removal of original charts from District facilities by a practitioner is grounds for withdrawal of staff privileges for a period to be determined by the CW.
- ❖ Written consent of the patient is required for release of medical information to persons or agencies not otherwise authorized by law, regulation, statute or contract to receive such information.

#### 1.6-12 Utilization Review

Regarding inpatient care, the attending physician shall document the need for continued care as defined in the District utilization review plan for all inpatients. This documentation contains:

- ❖ An adequate written record of the reason for continued hospitalization (a simple reconfirmation of the patient's diagnosis is not sufficient evidence for continued hospitalization).

- ❖ The estimated period of time the patient required for inpatient care and plans for care post-discharge.

## 1.7 DEATHS

### 1.7-1 Inpatient and Emergency Services

A deceased patient shall be pronounced dead by the primary physician or alternate physician designee within a reasonable time. The body shall not be released until a practitioner has completed a signed and dated entry in the medical record of the deceased. Exceptions shall be made in those instances of incontrovertible and irreversible terminal disease wherein the patient's course had already been adequately documented to within a few hours of death. Policies with respect to release of the body shall conform to local law and District policies.

### 1.7-2 Autopsies

Medical Staff members should actively attempt to secure permission to do an autopsy in all cases of unusual deaths and of medical-legal and educational interest. Discussion with family for the purposes of education and to obtain permission must be documented in the Physician Progress Notes or the Discharge Summary of the patient's hospital medical record. Results of autopsies are sent, by the pathologist or coroner, to the hospital medical records department. A copy will be forwarded to the attending physician and ordering physician and the Medical Staff Coordinator will be notified that an autopsy has been done. The Medical Staff Coordinator will notify the Medical Staff of the autopsy at the next Medical Staff meeting.

### 1.7-3 Organ Donation and Transplantation

Medical Staff members must follow hospital policy and procedure in regards to identifying patients who are potential organ donors. This policy was written in conjunction with the contracted tissue and transplantation service and clearly defines donor criteria as well as procedures for referral and obtaining consents. Medical Staff members must assure that the family of each potential donor knows its options in regards to donation. Discussions with the patient and/or family must be documented in the Physician Progress Notes or in the Discharge Summary of the patient's hospital medical record.

## 1.8 DRUGS AND MEDICATIONS

Drugs and medications administered to patients shall be listed in the latest edition of United States Pharmacopoeia, National Formulary, American Hospital Formulary Service, or A.M.A. Drug Evaluations. Other provisions regarding drugs and medications follow below:

- ❖ Medications brought to the hospital by patients are labeled and stored at the nurse's station. In special cases in which patients are allowed to administer their own medication, District policies established for these cases are followed.
- ❖ Only physicians, physician assistants or the pharmacist may dispense medication

from the emergency service. The amounts of medications dispensed must be limited to meet the immediate needs of the patient or until a local retail pharmacy is open. Under no circumstances will more than a seventy-two (72) hour supply be dispensed. Directions for administration must be clearly written on each envelope given to the patient.

- ❖ Medications and I.V. solutions will be renewed as follows:
  - (1) IV solutions will be reordered every three (3) days in conjunction with I.V. medication renewals. **Exception:** Hyperalimentation and intra lipids are reordered daily.
  - (2) IV additives and any IV push or IV piggyback medications must be reordered every three (3) days.
  - (3) Oral anticoagulants, antibiotics, narcotics, or hypnotics must be reordered every five (5) days.
- ❖ Orders that specify total days or doses of therapy are administered as ordered.
- ❖ All prior drug orders are cancelled when the patient is transferred to another District service.
- ❖ Hold orders must specify the date and time of restart. If the date and time are not specified, the order is considered an order to discontinue.
- ❖ A registered nurse that has reason to question the dosage of medication ordered directs such question or doubt to the primary physician. If the nurse still feels that the question has not been resolved, the nurse's supervisor is contacted. The supervisor shall contact the Chief of Staff who considers the nurse's concern.

## 1.9 DNR ORDERS

### 1.9-1 Definition and Policy

The definition of DNR is that no cardiopulmonary resuscitation will be performed. It is the policy of the Medical Staff that a physician is not required to give a DNR order. In the event a physician wishes to do so the order must be written in the patient's medical record. The Code Status form is completed for all inpatients with exceptions documented in the progress notes.

### 1.9-2 DNR Guidelines

The Medical Staff recognizes that certain circumstances exist under which a DNR order is medically justified. The following are suggested guidelines for such an order:

- (1) When a patient is at the end stage of an irreversible and/or incurable disease process and death is inevitable, a DNR order is medically justified.
- (2) If an order is written, the physician must discuss the order with the patient and/or family member(s) and indicate such communication in the progress notes of the patient's medical record.
- (3) The DNR order must be written in the patient's medical record.

1.9-3 DNR Order Time Limits

A DNR order for an acute patient automatically expires seven (7) days from the time that it is entered in the medical record unless renewed in writing by the primary physician. A DNR order for a DP/SNF patient automatically expires thirty (30) days from the time that it was entered in the medical record unless renewed in writing by the primary physician.

**ARTICLE 2 COMMITTEES**

**2.1 COMMITTEE OF THE WHOLE**

2.1-1 Role

The CW coordinates and implements the professional and organizational activities and policies of the Medical Staff as required by law and these Bylaws. It serves in the capacity of a Medical Staff executive committee thereby assuming the responsibilities of an executive committee required by law and convention.

2.1-2 Assigned Responsibilities of the CW

- ❖ Appoint ad hoc task forces and consider and, as appropriate, act on their recommendations.
- ❖ Provide liaison between the Medical Staff and the governing body and its designees.
- ❖ Make recommendations to the governing body on matters of a medico-administrative nature.
- ❖ Participate in the development of all District policy, practice, and planning relevant to the Medical Staff.
- ❖ Review and evaluate practitioners' performance for at least but not limited to removal of tissue, infection control compliance, pharmacy and therapeutic utilization, and completeness, timeliness and accuracy of patient medical record entries. As appropriate, establish generic screens to identify problematic situations in the above review and evaluate the results of the screening process.
- ❖ Make specific recommendations to the governing body regarding:
  - ❖ (1) The structure of the Medical Staff.
  - ❖ (2) A mechanism to evaluate credentials and to delineate individual clinical privileges for members of the Medical Staff.
  - ❖ (3) A mechanism to determine the suitability of individuals for Medical Staff membership.
  - ❖ (4) Recommendations for clinical privileges for each eligible individual.
  - ❖ (5) Participation in the District's Quality Assessment and Improvement Program.
  - ❖ (6) A mechanism by which a Medical Staff member can be terminated.
  - ❖ (7) A process for fair hearing procedures for Medical Staff members.
- ❖ As required by these Bylaws and state and federal law, investigate and take corrective action, when indicated, regarding a member's ethical conduct or clinical competence.
- ❖ Take steps to develop continuing education activities and programs for the Medical Staff.

- ❖ Review the quality and appropriateness of services provided by contract physicians.
- ❖ Assist Medical Staff members impaired by chemical dependency and/or mental illness to obtain rehabilitation services.
- ❖ Review at least biennially the Bylaws and Supplemental Attachments of the Medical Staff and recommend any revisions therein as may be necessary to meet licensing regulations or changes in Medical Staff procedures or structure.
- ❖ Perform any other functions arising from these Bylaws and related documents assigned by the Governing Board.
- ❖ Approve credentials and privileges of Physician Assistants who provide patient care in District facilities.
- ❖ Conduct in-service training, as appropriate, for District staff.

## **2.2 INTERDISCIPLINARY PRACTICES COMMITTEE**

### **2.2-1 Role**

Develop policies, procedures and oversee implementation of standardized procedures for nursing staff and, as appropriate, other healing arts professionals that are not members of the Medical Staff. The committee shall report to the governing body through the CW.

### **2.2-2 Responsibilities**

- ❖ Perform functions consistent with the requirements of the law.
- ❖ The Interdisciplinary Practice Committee shall be responsible for policies and procedures recommendations that address granting of privileges to registered nurses and other healing arts professionals as appropriate.
- ❖ The committee shall also review credentials and make recommendations to the governing body, through the CW, for granting or rescinding of privileges.

### **2.2-3 Committee Composition and Meeting Schedule**

The committee provides a joint conference mechanism between the Medical Staff, nursing service and non-physician practitioners. The committee shall be composed of the Director of Nursing, Administrator or designee, and an equal number of registered nurses and members of the Medical Staff. Non-physician providers may also serve as members of the committee, as appropriate. The chairperson of the committee shall be a member of the Medical Staff appointed by the Chief of Staff. The committee shall meet on the call of the chairperson.





**MEDICAL STAFF APPOINTMENT PROCESS  
A SUPPLEMENTAL ATTACHMENT TO THE  
SOUTHERN HUMBOLDT COMMUNITY HEALTHCARE DISTRICT  
MEDICAL STAFF RULES & REGULATIONS**

**ARTICLE 1. GENERAL PROVISIONS**

1.1. GENERAL

1.1-1 Unless otherwise stated, for purposes of this article, all references to “applicant” or “member” shall include practitioners who submit applications for initial appointment and reappointment to the Medical Staff or AHP Staff, as well as requests for clinical privileges, temporary privileges, service authorization, and practice prerogatives.

1.1-2 By applying for appointment or reappointment to the Medical or APP staffs or for clinical privileges, service authorization, or practice prerogatives, the applicant acknowledges responsibility to review these Bylaws, applicable Rules and Regulations, as well as all policies of the Medical Staff, and agrees, throughout any period of membership, to comply with applicable professional responsibilities as they exist and as they may be modified from time to time.

~~1.1. EFFECT OF APPLICATION~~

~~By applying for appointment to the Medical Staff, reappointment, advancement or modification of privileges, each applicant signifies a willingness to appear for interviews as required by the CW or governing body.~~

1.2. MEDICAL STAFF APPLICATIONS

1.2-1 All applications for appointment to the Medical Staff shall be in writing with all requested data completed (or an explanation of why data are unavailable). All entries and required attachments to the application must be legible, comprehensive and substantively responsive on each point of inquiry. To orient the applicant to the requirements, duties, rights, and procedures of a Medical Staff member, a copy of the Bylaws will be given to the applicant undergoing initial appointment.

1.2-2 The Medical Staff application forms are peer review and evaluation documents, an official record of the MEC and are afforded all protections pursuant to California Evidence Code section 1157. These forms shall require detailed information related to the qualifications, competence and conduct of an applicant, including but not limited to information concerning:

- a. specification of the requested Staff category and clinical privileges, or practice prerogatives, if seeking membership on the AHP Staff;
- b. the applicant’s qualifications, as required by Articles 3 and 4 of the Medical Staff Bylaws;
- c. all past and current employment, any hospital staff affiliations and any other health care entity affiliation;

- d. peer references from at least three (3) individuals who hold a license in the same professional field of licensure as the applicant, at least one of whom is from the same specialty; all of whom shall have observed and worked with the applicant, have personal knowledge of and be willing to provide information related to the applicant's professional competence and conduct, ethical character and any effects of health status on privileges being requested;
- e. the name of the applicant's carrier for professional liability insurance, a "certificate of insurance" covering all privileges requested, disclosure of any professional liability claim filed or reported to a carrier, a notice/letter of intent to sue, any settlement or final judgment made in any professional liability case within the past seven (7) years;

**Commented [SC26]:** 3.1-7 states that both initial and reappointments require 3 peer references. Consider whether less is necessary for reappointment on the basis of the fact that members are "known" more than initial applicant

**Commented [KJ27R26]:** 3 is industry standard, and sometimes 5 are requested in the field. One concern is our current Courtesy, for example. He isn't able to meet this standard because he's from a really small office and there is only one other at his level, and most are below him. Maybe add that it could be waived if the Chief of Staff determines its appropriate, based on a case by case basis and as long as it's documented well.

1.2-3 The applicant must sign the application, including attestation, certification and acknowledgment that everything in the application is true, correct and complete and is furnished in good faith.

1.2-4 An application is not deemed complete until the applicant has complied with all requests for information, interview, and/or evaluation from the Medical Staff. The applicant shall submit all information required within fifteen (15) days of request from the Medical Staff. If the applicant does not submit the information required to complete the application or credentialing request(s) within this timeframe, the application or credentialing request(s) shall be deemed incomplete and withdrawn from further processing, and the applicant shall be required to submit a new application or credentialing request(s).

### 1.3. APPLICATION FOR REAPPOINTMENT

1.3-1 Approximately one hundred and twenty (120) days prior to expiration of their current appointment, each member of the Medical Staff or AHP Staff shall submit an application for reappointment, including any request for addition, renewal or modification of clinical privileges if a member of the Medical Staff, or practice prerogatives if a member of the AHP Staff. The application for renewal shall be in writing and on a form prescribed by the Medical Staff. It is expected that, at the time of submission, the applicant will include all information requested in the application.

1.3-2 In addition to meeting the requirements set forth in Sections 1.1 and 1.2, unless specified otherwise, an application for reappointment to the Medical Staff, for additional or renewal of clinical privileges or practice prerogatives shall be based upon a reappraisal of the applicant's adherence to Medical Staff membership requirements as stated in these Bylaws, Rules and Regulations, Medical Staff policies, and Hospital policies applicable to Medical Staff members. Consideration shall also be given to the practitioner's ethics and conduct, attendance at required staff and department meetings and participation in Medical Staff affairs, compliance with the Medical Staff Bylaws, Rules and Regulations, continuing medical education, cardiopulmonary resuscitation training, utilization of the Hospital's facilities for patients, cooperative relations with other practitioners, service on Medical Staff or Hospital committees when requested, cooperation with others working in the Hospital, and general attitude towards patients, the Hospital and the public.

1.3-3 Such reappraisal should also include relevant member-specific information, such as clinical and technical skill, OPPE, FPPE (if any) and current proficiency in the Hospital's general competencies in light of his/her performance at this Hospital and in other settings, performance improvement activities and, where appropriate, comparisons to aggregate information about performance, morbidity and mortality reviews, judgment and clinical or technical skills, reappraisal of the Hospital's patient care needs and ability to provide adequate support services and facilities for the practitioner.

1.3-4 Where applicable, the results of specific peer review activities shall also be considered. If

sufficient review information is unavailable, information provided by the hospital(s) where the practitioner routinely practices may be considered.

- 1.3-5 The applicant is required to provide detailed information concerning any changes in his/her qualifications since the last appointment, and any other information relevant to his/her qualifications, including that which was not disclosed previously.
- 1.3-6 The failure of a member of the Medical Staff or AHP Staff to provide a completed application at least sixty (60) days prior to the expiration of current appointment, absent good cause, shall be deemed a voluntary resignation from the Medical Staff at the end of the current Medical Staff appointment. The CW may, in its sole discretion and based upon good cause, extend the time by which an application must be complete. The procedural rights of appeal as set forth in the Fair Hearing Process shall not apply for actions taken pursuant to this subsection.
- 1.3-7 A member who has resigned for failure to submit a reappointment application may reapply as an initial applicant, subject to the same requirements for membership and clinical privileges, including completion of proctoring, unless the provisions of Section ~~1.3-6~~ apply.

#### 1.4. MISSTATEMENTS AND OMISSIONS

- 1.4-1 By signing an application for initial appointment or reappointment, an applicant certifies that the information submitted is true, complete, and correct; is furnished in good faith; and acknowledges his/her understanding that any misstatement or omission shall result in immediate cessation of the processing of the application and no further processing shall occur.
- 1.4-2 Any misstatement in, or omission from, the application is grounds to stop processing the application. The applicant will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response.
- 1.4-3 If membership or privileges were granted prior to the discovery of a misstatement or omission, such misstatement or omission may be grounds for termination, as permitted by law.
- 1.4-4 Action taken pursuant to this Article will entitle the applicant or member to the procedural rights of appeal as set forth in the Fair Hearing Process only when required by law.

#### 1.5. APPLICANT'S BURDEN

- 1.5-1 In connection with an application for appointment or any other credentialing request, the applicant shall have the burden of producing adequate information for proper evaluation of the applicant's qualifications and general competencies with respect to both membership and the requested privileges, as evidenced by attributes that include, but are not limited to, the applicant's experience, background, training, demonstrated current clinical competence, character, ethics, qualifications, communication skills, physical and mental health status, and suitability for staff category and clinical privileges requested; resolving any reasonable doubts about these matters; and satisfying requests for information.
- 1.5-2 This burden may include submission to a medical (including, but not limited to blood, urine or other biological testing) or psychiatric/psychological examination, at the applicant's expense, if determined to be appropriate by the CW and based on its sole determination as to the terms and conditions of such examination.
- 1.5-3 The applicant is responsible to assist in the identification and, as necessary in the solicitation of the requisite number of references, written evaluations and affiliation verifications and may include the requirement that the applicant sign an authorization.

release or other document.

1.5-4 By applying for appointment to the Medical Staff, reappointment, advancement or modification of privileges, each applicant signifies a willingness to appear for interviews as required by the CW or governing body.

1.5-5 The applicant's failure to sustain the burden of producing adequate information for proper evaluation of the applicant's qualifications and general competencies with respect to both membership and requested privileges, within the deadlines prescribed by the Medical Staff, shall result in the withdrawal of the application or credentialing request(s). The procedural rights of appeal as set forth in the Fair Hearing Process shall not be available, unless required by law.

#### 1.6. CONTINUING DUTY OF COMPLETENESS

1.6-1 In order for the Medical Staff to make a proper recommendation to the governing body concerning an application for appointment or reappointment to the Medical Staff, the Medical Staff must have in its possession adequate information for an evaluation of the applicant, as measured against the unique professional standards of this Hospital. Accordingly, the Medical Staff will not take action on an application which is not complete.

1.6-2 An application is not deemed complete until the applicant has complied with all requests for information, interview, and/or evaluation from the Medical Staff. The applicant shall submit all information required within thirty (30) days of request from the Medical Staff. If the applicant does not submit the information required to complete the application or credentialing request(s) within this timeframe, the application or credentialing request(s) shall be deemed incomplete and withdrawn from further processing, and the applicant shall be required to submit a new application or credentialing request(s).

1.6-3 The applicant has an ongoing and continuous duty to keep the application current and complete by informing the Medical Staff, in writing, within twenty four (24) hours of the applicant learning of any and all information that would otherwise correct, change, modify or add to any information provided in the application or most recent reapplication when such correction, change, modification or addition may substantively change any portion of the application, including but not limited to information which may reflect adversely on current qualifications for membership or privileges.

#### 1.7. EFFECT OF APPLICATION

By signing and submitting an application for initial appointment or reappointment to the Medical Staff, each applicant:

1.7 -1 ~~With reference to evaluation of an applicant for membership and requested privileges, the applicant~~ authorizes the District Medical Staff or its designee to consult with members of Medical Staffs at other health organizations or knowledgeable persons who may have information bearing on the professional competence and conduct following attributes of the applicant, including, but not limited to, skill, knowledge, training, and judgment, ~~character~~ character, ethics, ability to work cooperatively with others, physical and mental capabilities to exercise the requested clinical privileges or practice prerogatives for AHP Staff;

1.1.1 Current competence (skill, knowledge, training, and judgment);

- ~~1.1.2 Character.~~
- ~~1.1.3 Professional ethical qualifications.~~
- ~~1.1.4 Ability to cooperate with others.~~
- ~~1.1.5 Physical and mental ability to carry out requested privileges.~~

~~1.7 -2~~ The applicant authorizes and requests that all contacts made with external sources provide information requested by the District for evaluation purposes. A request for information from external sources includes the request for and the authorization for the Medical Staff ~~right~~ to inspect and copy records and documents pertinent to the Medical Staff's evaluation of the applicant's request for membership and privileges if applying to the Medical Staff, or practice prerogatives if applying to the AHP Staff;

~~1.7 -3~~ consents to the Medical Staff's disclosure to other hospitals, medical staffs, medical groups and other similar organizations any information regarding the applicant's professional competence or conduct, ethical standing and releases the Medical Staff, the Hospital, District and any of their representatives from liability, to the fullest extent permissible by law for any- such disclosure;

~~1.7 -4~~ The applicant releases from any liability, to the fullest extent permitted by law, all individuals and organizations providing information to the District, Hospital or Medical Staff concerning the applicant. ~~And~~ The applicant also releases from any liability ~~at District representatives,~~ to the fullest extent permitted by law, all representatives of the Medical Staff, Hospital, District, and governing body for their acts performed in connection with evaluating the applicant's ~~credentials.~~

~~1.7 -5~~ acknowledges the continuing obligation to report any changes in the information submitted on the application to the Medical Staff during the application process and while maintaining membership on the Medical Staff or AHP Staff;

~~1.7 -6~~ acknowledges ~~acknowledges~~ that any procedural rights of appeal as set forth in the Fair Hearing Process must be exhausted with respect to any action taken by the Medical Staff or governing body prior to seeking outside legal remedies.

## **ARTICLE 2. MEDICAL STAFF APPOINTMENT- PROCESS**

### ~~2.4.~~ MEDICAL STAFF APPLICATION

~~All applications for appointment to the Medical Staff shall be in writing with all requested data completed (or an explanation of why data are unavailable). The applicant must sign the application. To orient the applicant to the requirements, duties, rights, and procedures of a Medical Staff member, a copy of the Bylaws will be given to the applicant undergoing initial appointment.~~

#### ~~2.1~~ VERIFICATION OF INFORMATION

~~2.1-1~~ Upon receipt of ~~The applicant shall deliver~~ a completed application, the Medical Staff shall expeditiously seek to collect ~~and to the Administrator or designee who shall, in timely fashion, seek to collect or verify and verify:~~

- a. the practitioner requesting approval is the same practitioner identified in the credentialing documents by viewing either a current picture hospital ID card or a valid picture ID issued by a state or federal agency (e.g., drivers' license, passport, etc.);
- b. ~~the references, licensure or professional certification, DEA certification and any~~

- special certifications required by requested clinical privileges;
- c. Board certification;
- d. Professional liability insurance coverage covering all clinical privileges requested, in the amounts determined by the CW and claims history; and other evidence submitted in support of the application.
- ~~a-c.~~ Relevant training and experience, including but not limited to peer references, work history, affiliations with other health care entities, quality data such as OPPE/FPPE; and
- f. Information from the Medical Board of California and the National Practitioner Data Bank will be included as part of the information collected regarding the applicant.

~~2.1 - 2~~ The applicant ~~Administrator or designee shall be promptly notified by the applicant~~ of any problems in obtaining the required information. The burden of collecting this information shall be an obligation of the applicant.  
~~The burden of collecting this information shall be an obligation of the applicant.~~

## 2.2 TIME LIMITATIONS

- 2.2-1 All individuals and groups required to act thereon shall consider applications in a timely and good faith manner. ~~While special or unusual circumstances may constitute good cause and warrant exceptions,~~ the application process shall ordinarily be completed within 90 working days ~~or less, after receipt of all necessary documentation. The Administrator or designee shall transmit the application to the Chief of Staff after all collected and verified information has been completed.~~
- 2.2-2 In the event of a delay in ~~collecting, verifying or receiving~~ information and materials that is outside the control of the ~~Administrator or designee~~ Medical Staff, the applicant and Chief of Staff shall be notified.
- 2.2-3 The application shall remain pending until the Administrator or designee has received the material or the expiration of any deadline for further information;
- ~~2.2-4~~ ~~four months from the date of application, whichever is later. If not all materials have not been received after within three (3) months from the date of the application, a letter to the applicant will be notified of impending withdrawl withdrawal of the application - mailed notifying them of the deadline. After 4 months from the date of application, a single extension of up to 6 additional months may be granted.~~
- ~~2.2-5~~ Applications not completed within four months after receipt or the extension date, whichever is later, shall automatically be removed from consideration. The CW may, in its sole discretion, grant a single extension of up to two (2) additional months.
- ~~2.2-6~~ ~~Withdrawal of the application by the applicant shall not be considered an adverse decision.~~ The time period specified for the expected application processing is a guideline and it shall not create any right for the applicant to have an application processed within the specified times.

**Commented [SC28]:** This would make the information in the application ten months old. . . that is not a best practice. 180 days is standard.

**Commented [SC29]:** Bus. & Prof. Code 805(c)(2) and (3) require reporting after a withdrawing or abandoning an application or request for privileges after receiving notice of a pending investigation. See new case *Wisner v. Dignity*.

## ~~2.5.~~ 2.3 CHIEF OF STAFF ACTION

- ~~2.43-1~~ Upon receipt of a completed application from the Administrator, the Chief of Staff shall review and evaluate the application and supporting documentation in consultation with CW members.

2.3-2 The Chief of Staff and CW shall evaluate each applicant for appointment, reappointment, clinical privileges, service authorization, or practice prerogatives, and make an objective, evidence-based recommendation, based upon assessment of the applicant in relation to the qualifications and standards set by the Medical Staff and approved by the governing body, as further described in the Bylaws.

~~2.43-23~~ Effect of Chief of Staff Action

~~a.~~ **Interviews, Further Documentation, Deferral.** Action by the Chief of Staff to interview the applicant, seek further documentation, or defer the application for further consideration ~~must~~will be followed up within a reasonable period of time. Based on the findings and in consultation with the CW, a written recommendation will be prepared by the Chief of Staff. The Chief of Staff shall clearly state the recommended action with respect to membership and requested privileges.

- ❖ **b. Favorable Recommendation.** If the Chief of Staff recommendation is favorable to the applicant, the recommendation shall include the membership category and clinical privileges to be granted, modified or terminated for Medical Staff members, the clinical privileges to be granted for temporary privileges, or the staff category and practice prerogatives for an AHP Staff member. The recommendation may indicate whether the application should be for a specified duration. ~~The~~ Administrator or designee shall promptly forward the application and MECs recommendation, together with all supporting documentation, to the governing body for ~~a final~~ decision.
- ❖ **c. Adverse Recommendation.** When the Chief of Staff recommends an adverse action in respect to the applicant's request for appointment or requested privileges, the Chief of Staff shall also assess and determine whether the adverse recommendation is for a "medical disciplinary cause or reason," meaning that aspect of a practitioner's competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care. All other adverse recommendations are deemed administrative. ~~give~~ The applicant shall promptly be given written notice of the adverse recommendation. If the adverse recommendation is for a medical disciplinary cause or reason and the ~~If the adverse recommendation is for a medical disciplinary cause or reason and the~~ ~~The applicant shall be~~ is entitled to the procedural rights as provided in the Fair Hearing Procedures and required by law, notice shall be provided as required in the Bylaws. An "adverse recommendation" by the Chief of Staff is as defined in the Fair Hearing Procedures. ~~Where the adverse recommendation affords hearing rights, the~~ governing body shall be informed, but no action shall be taken until the fair hearing procedural rights have been exhausted or waived by the applicant.

**Commented [KJ30]:** Currently, the applications go the the Chief of Staff, then to MEC when the CoS says it's ready. Then MEC recommends it goes to the Board. I want to make sure we aren't giving the CoS the right to send it directly to the Board.

#### 2-6-2.4. EFFECT OF ACTION BY THE GOVERNING BODY

- 2.54-1 The governing body shall give great weight to the recommendation from the Chief of Staff and CW. Further, the governing body shall not act in an arbitrary or capricious manner and shall keep in mind its legal responsibilities to act to protect the quality of medical care provided, the competency of the Medical Staff and to ensure the responsible governance of the Hospital.
- 2.4-2 If the governing body tentatively disagrees with the Favorable R recommendation from Chief of Staff,
- ~~The~~ Ggoverning ~~B~~body shall first remand the matter back to the Chief of Staff and the CW, with a written statement of the governing body's concerns and may recommend further action, including but not limited to interviews, gathering of information, etc., within a reasonable period of time approve or disapprove, in whole or in part, a favorable recommendation of the Chief of Staff. If the recommendation is rejected in whole or part, it will be referred back to the Chief of Staff for further interviews, documentation, or consideration in consultation with the CW. The governing body will state in writing the reason(s) for the return of the recommendation. ~~The governing body will set a reasonable time limit within which the Chief of Staff in consultation with the CW shall make a subsequent recommendation to the governing body.~~



2.4-3 If the governing body action is adverse to the applicant and the governing body's action falls within the scope of the Fair Hearing Process, the governing body Administrator or designee shall promptly notify give the applicant, written notice of the tentative adverse action of the governing body. The Administrator or designee shall also advise the applicant of the right to request a hearing in the manner specified in the Fair Hearing Process. The governing body shall also inform the Chief of Staff and CW. If the CW declines to fulfill its role in a Fair Hearing, then the governing body shall assume the role of the CW in fulfillment of the procedures, including the appointment of a Judicial Review Committee. In such case, the adverse decision shall not be final until t-The applicant has exhausted or waived shall be entitled to a hearing that precedes in general conformity to the procedural rights in the Fair Hearing Process. The fact that an adverse decision is not final shall not be deemed to confer privileges where none existed before.

2.4-4 For the purpose of this section, an adverse decision shall be considered final:

- ❖ Upon completion of all procedural rights, including hearing and appellate review by the District.
- At the completion of all judicial proceedings bearing upon the decision that are filed and served after the completion of the District proceedings described above.
- ❖

2.4-54 In the event of unwarranted delay on the part of the Chief of Staff, the governing body may act on an individual's appointment status without the Chief of Staff's recommendation, employing the same type of information usually considered by the Chief of Staff and CW. Prior to taking such action, the governing body will notify the Chief of Staff and CW of its intent and the date prior to which the Chief of Staff and CW may still fulfill their responsibility.

~~2.5 2~~ ~~Without Benefit of Chief of Staff Recommendation~~

~~An application that is not received by the governing body within 90 working days of the date of submission of the completed application may cause the governing body to issue the Chief of Staff a written notice of such unwarranted delay. The notice will contain a date certain upon which the Chief of Staff should send a recommendation to the governing body. The date certain shall be within 60 days after the Chief of Staff receives the date notice from the governing body. If the Chief of Staff fails to act by date certain, the governing body may take action on its own initiative. If such action is favorable, it shall become effective as the date of the final action of the governing body. If the governing body's action is adverse as defined in Fair Hearing Process, the Administrator or designee shall promptly inform the applicant by written notice and the matter shall precede in general conformity with the provisions of the Fair Hearing Process.~~

~~2.5.3~~ After Procedural Rights

~~In the case of an adverse Chief of Staff recommendation an adverse governing body action as noted above, the governing body shall take final action in the matter only after the applicant has exhausted or has waived the procedural rights as provided in the Fair Hearing Process. Action taken shall be the final and conclusive decision of the governing body. However, the governing body may defer final determination and refer the matter, in writing, back for further reconsideration by the Chief of Staff. The referral notice shall state:~~

- ~~❖ \_\_\_\_\_ The reasons, therefore;~~
- ~~❖ \_\_\_\_\_ A time limit within which a subsequent recommendation to the governing body shall be made, and~~
- ~~❖ \_\_\_\_\_ An optional directive that an additional hearing be conducted to clarify those issues that are in doubt.~~

~~After governing body receipt of the Chief of Staff's recommendation, the governing body shall make a final decision.~~

2.5. NOTICE OF FINAL DECISION

~~2.7.~~

Notice of the governing body's final decision shall be given, through the Administrator, to the Chief of Staff, ~~and~~ the applicant. A decision and notice to appoint shall ~~include~~ include:

- ~~e.~~
- a. \_\_\_\_\_ The Staff category to which the applicant is appointed.
- ~~❖~~ b. \_\_\_\_\_ The privileges that may be exercised by the applicant.
- ~~❖~~ c. \_\_\_\_\_ Any special conditions attached to the appointment.

~~For the purpose of this section, an adverse decision shall be considered final:~~

- ~~❖ At the time of completion of all hearing, appellate review, and other quasi-judicial proceedings conducted by the District and that have a bearing on the applicant.~~
- ~~❖ At the completion of all judicial proceedings bearing upon the decision that are filed and served after the completion of the District proceedings described above.~~

~~2.8.2.6~~ REAPPLICATION REAPPLICATION

~~2.76-1~~ Conditions for Reapplication

An applicant or member who has received a final adverse decision, under circumstances listed below, may not reapply for Medical Staff membership and/or ~~addition~~ clinical privileges for five years from the date of the final adverse decision or the date the application or request was withdrawn. Conditions subject to the five-year requirement are as follows:

- ~~❖~~ a. \_\_\_\_\_ Denial or rejection of an application for membership or clinical privileges, for a medical disciplinary cause or reason; to an initial request for Medical Staff membership
- ~~❖~~ b. \_\_\_\_\_ Withdraws or abandons al of an application for membership

~~and or request for clinical privileges after receiving notice of a pending investigation, or after receiving notice that the application for membership or clinical privileges is denied or will be denied, for a medical disciplinary cause or reason; subsequent to an adverse recommendation by the Chief of Staff or decision by the governing body.~~

❖ ~~c. Termination or revocation of Medical Staff membership for a medical disciplinary cause or reason;~~

❖ ~~d. Resignation or taking a leave of absence from membership or staff privileges after receiving notice of a pending investigation, or after receiving notice that the application for membership or clinical privileges is denied or will be denied, for a medical disciplinary cause or reason; of a member from the Medical Staff following the issuance of a Medical Staff recommendation or governing body decision adverse to the~~

- ~~member's Medical Staff membership or privileges.~~
- ~~❖ Termination or restriction of a member's privileges~~
- ~~❖ Denial of a member's request for additional privileges.~~

- 2.76-2 Date of Reapplication  
The date for reapplication is governed by the date of application withdrawal, date of final adverse decision, or resignation date, whichever is applicable.
- 2.76-3 Consideration of Reapplication  
After the five-year period, the former applicant ~~or former~~ Medical Staff member ~~or Medical Staff member~~ may submit an application for Medical Staff membership and/or privileges. The application shall be processed as an initial application. A former applicant or former Medical Staff member shall also furnish evidence that the basis for the earlier adverse recommendation or action no longer exists. Satisfactory evidence shall be presented to the Chief of Staff that indicates that the specific cause(s) related to an adverse decision has been satisfactorily addressed. In the absence of satisfactory evidence, the application shall be determined to be incomplete, withdrawn from consideration and no action will be taken. ~~initiated by the Chief of Staff to process an application.~~
- 2.67-4 Waiver of Waiting Period  
The governing body, in consultation with the Chief of Staff, may waive the ~~one five-~~ year waiting period when the applicant can present compelling evidence that the cause(s) of an adverse recommendation or decision has been remedied.

~~2-9-2.7~~ PROVISIONAL APPOINTMENTS

Each initial appointment of an applicant for Active Staff or Associate Staff Medical Staff membership shall be a provisional appointment for at least twelve (12) months. The governing body may extend the provisional status (after recommendation from the Chief of Staff) if further evaluation is necessary up to a period of two years following appointment to the provisional staff.

**ARTICLE 3. REAPPOINTMENTS**

**3.1 APPLICATION FOR REAPPOINTMENT**

- ~~3.1.1 One hundred and twenty days prior to expiration of their current appointment, each Staff member shall submit to the Medical Staff Administration Department an application for renewal of the member's appointment to the Medical Staff for the coming period, and for addition, renewal or modification of clinical privileges. The application for renewal shall be in writing and on a form prescribed by the Medical Staff. It is expected that, at the time of submission, the applicant will include all information requested in the application.~~
- ~~3.1.2 In addition to meeting the requirements of an initial applicant, recommendation for reappointment to the Medical Staff for renewal of privileges shall be based upon reappraisal of the professional performance, competence, and clinical judgment in the treatment, care and services provided to patients; clinical and~~

~~technical skill; the member's health status; and current proficiency in the Hospital's general competencies in light of his/her performance at the Hospital and in other settings. The reappraisal is to include confirmation of adherence to Medical Staff membership requirements as stated in these Bylaws, Rules and Regulations, Medical Staff policies, and Hospital policies applicable to Medical Staff members.~~

~~3.1.3 Such reappraisal should also include relevant member specific information, such as OPPE, FPPE (if any), performance improvement activities and, where appropriate, comparisons to aggregate information about performance, morbidity, and mortality reviews, judgment and clinical or technical skills, reappraisal of the Hospital's patient care needs and ability to provide adequate support services and facilities for the practitioner. Consideration shall be given to the practitioner's ethics and conduct, attendance at required staff and department meetings and participation in Medical Staff affairs, compliance with the Medical Staff Bylaws, Rules and Regulations, continuing medical education, cardiopulmonary resuscitation training, utilization of the Hospital's facilities for patients, cooperative relations with other practitioners, service on Medical Staff or Hospital, and general attitude towards patients, the Hospital and the public.~~

~~3.1.4 Where applicable, the results of specific peer review activities shall also be considered. If sufficient review information is unavailable, information provided by the hospital(s) where the practitioner routinely practices may be considered.~~

~~3.1.5 The applicant is required to provide detailed information concerning any changes in his/her qualifications since the last appointment, and any other information relevant to his/her qualifications, including that which was not disclosed previously.~~

~~3.1.6 The applicant must provide a specific request for clinical privileges, including:~~

~~a. A request for reduction in, or deletion of, and specified privileges previously granted; and~~

~~b. If the applicant's request includes any additional privileges to be granted, it shall be supported by the type and nature of evidence that would be necessary for such privileges to be granted in an initial application for same.~~

~~3.1.7 Both an initial applicant and an applicant for reappointment are required to submit at least three (3) peer references. Peer recommendations shall be obtained from a practitioner who holds a license in the same professional licensure as the applicant, and at least one of whom is from the same specialty; all of whom shall have observed and worked with the applicant, have personal knowledge of the applicant's ability to practice and be able to provide information pertaining to the applicant's relevant training, experience, current professional competence, and ethical character in the past two years and any effects of health status on privileges being requested. Peer recommendations cannot be relatives (whether by blood, marriage or cohabitation).~~

~~3.1.8 The applicant must attest, certify and acknowledge that everything in the application is true, correct and complete.~~

### ~~3.2 VERIFICATION OF INFORMATION~~

**Commented [SC31]:** This repeats 2.1 . . .why?

The Administrator or designee shall seek to collect or verify the additional information made available on each reappointment application. The Administrator or designee will also collect additional materials and information that includes:

- ❖ The Medical Staff member's professional improvement activities,
- ❖ Performance and conduct within District medical programs,
- ❖ Fulfillment of Medical Staff membership obligations,
- ❖ Performance in the exercise of privileges.
- ❖ A written statement from a knowledgeable Medical Staff member regarding the performance of clinical activities of the applicant.
- ❖ A statement regarding the physical and mental ability of the applicant to perform the requested privileges.

The Administrator or designee shall promptly notify the Medical Staff member of any problems in obtaining the information required, and it shall be the Medical Staff member's burden to furnish the required information. When collection and verification are accomplished, the Administrator or designee shall transmit the completed reappointment application form and supporting materials to the Chief of Staff.

### ~~3.3 TIME LIMITATIONS~~

All individuals required to act thereon shall consider reappointment applications in a timely and good faith manner. Except for good cause, the reappointment application shall be processed within the time period specified above for new applications. Reapplication requests should be processed in the same manner as specified above for new applications.

### ~~3.4 EFFECT OF CHIEF OF STAFF ACTION~~

#### ~~3.4.1 Favorable Recommendation~~

Prior to expiration of the Medical Staff member's appointment date, the Chief of Staff, in consultation with other voting members of the CW, shall review all relevant information available regarding a member reappointment. For favorable findings, the Chief of Staff shall prepare a corresponding recommendation that is forwarded to the governing body, for approval.

#### ~~3.4.2 Adverse Recommendation~~

When the Chief of Staff makes an adverse recommendation with respect to reappointment or privileges, the applicant will be sent a written notice of the adverse recommendation and the right of the applicant to request a hearing in accordance with the Fair Hearing Procedures. The governing body shall be informed thereof, but no action shall be take regarding the Chief of Staff's recommendation until the applicant has exhausted or waived all procedural rights. Thereafter, the procedures specified in the Fair Hearing Procedure shall be followed.

### ~~3.5 EXTENSION OF APPOINTMENT~~

If it appears that an application for reappointment will not be completely processed by the expiration date of the member's appointment, the Chief of Staff will recommend to the governing body an extension of time not to exceed 60 working days. The extension

will be available when a delay is not attributable to the applicant's failure to provide information or documentation regarding reappointment. Any extension of an appointment pursuant to this section does not create a vested right in the member for continued appointment into the next term. The extension only applies to the application processing period for reappointment.

### ~~3.6~~ **FAILURE TO FILE REAPPOINTMENT APPLICATION**

- ~~3.6-1~~ Applications for reappointment must be submitted at least one hundred twenty (120) days before expiration of current appointment. Failure to have a complete application for reappointment, at least sixty (60) days prior to the expiration of current appointment shall be deemed a voluntary resignation from the Medical Staff at the end of the current Medical Staff appointment. The MEC may, in its sole discretion and based upon good cause, extend the time by which an application must be complete. The hearing and appeal procedures set forth in Article nine (9) shall not apply for actions taken pursuant to this subsection.
- ~~3.6-2~~ A member who has resigned for failure to submit a reappointment application may, unless resignation occurred under adverse action, reapply as an initial applicant, including payment of all application fees, and if appointed, will be subject to a provisional period.
- ~~3.6-3~~ A practitioner who, while under investigation for a medical disciplinary cause or reason, resigned or whose appointment expired, is subject to the provisions of reapplication after adverse action.

## **ARTICLE 34 LEAVES OF ABSENCE**

### ~~1.2-2~~ 3.1-1 LEAVE STATUS

At the discretion of the Chief of Staff, a Medical Staff member may obtain a voluntary leave of absence from the Medical Staff. The request for voluntary leave must be submitted in writing to the Chief of Staff. The request will state the reason for the leave and the approximate length of time. The governing body will be advised of the member's leave status. Voluntary leaves cannot exceed six months unless approved for good cause by the governing body. During the leave period, the member shall not exercise clinical privileges in District facilities. Membership rights and responsibilities shall be inactive.

### ~~1.2-3~~ 3.1-2 TERMINATION OF LEAVE OF ABSENCE

Prior to returning from leave, the member will notify the Chief of Staff, in writing, of the date of return. Based on the member's activity during the leave period, the Chief of Staff will determine the status of the member's privileges and prerogatives. The Chief of Staff determination will be guided by the reappointment procedures addressed in these Bylaws.

### ~~1.2-4~~ 3.1-3 FAILURE TO REQUEST REINSTATEMENT

A member's failure to request reinstatement, without good cause, shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of

membership, privileges, and prerogatives. A member whose membership is automatically terminated shall be entitled to the procedural rights provided in the Fair Hearing Procedure for the sole purpose of determining whether or not the failure to request reinstatement was unintentional or excusable. A subsequent request for Medical Staff membership that is received from a member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

~~4-2-53.1-4~~ **MILITARY LEAVE**

The Chief of Staff upon written notice shall grant a member's request for leave to fulfill a military obligation from the member. The Chief of Staff shall grant reactivation of the membership and privileges previously held by the member. However, the reactivation of the privileges may be subject to monitoring as determined by the Chief of Staff.





**CLINICAL PRIVILEGE DELINEATION PROCESS  
A SUPPLEMENTAL ATTACHMENT TO THE  
SOUTHERN HUMBOLDT COMMUNITY HEALTHCARE DISTRICT  
MEDICAL STAFF RULES & REGULATIONS**

**ARTICLE 1 CLINICAL PRIVILEGES**

**1.1 EXERCISE OF PRIVILEGES**

Except as otherwise provided in these Bylaws or Rules, every practitioner or non-physician provider, nurse practitioner or physician assistant rendering direct clinical services in District facilities shall be entitled to exercise only those privileges specifically granted to the practitioner.

**1.2 DELINEATION OF PRIVILEGES IN GENERAL**

**1.2-1 Requests**

Each application for appointment and reappointment to the Medical Staff must contain a request for the privileges desired by the applicant. A request for privileges or modification of privileges must be supported by documentation of training and/or experience supportive of the request.

**1.2-2 Basis for Privileges Determination**

Requests for Privileges shall be evaluated on the basis of the practitioner's education, training, experience, demonstrated professional competence and judgment. The evaluation will also include the documented results of patient care and other quality improvement review and monitoring activities. Privilege determinations shall also be based on pertinent information concerning clinical performance obtained from other sources, especially other health care settings where the practitioner exercises privileges.

**1.3 DELINEATION OF LIMITED LICENSED PRACTITIONERS' PRIVILEGES**

**1.3-1 Admissions**

Dentists, podiatrists and clinical psychologists that are members of the Medical Staff may only admit and treat patients by co-admitting each patient with a physician member of the Medical Staff. The physician must have admitting privileges and assume responsibility for the care of the patient's medical condition. The physician member must conduct or directly supervise the admitting history and physical examination (except the portion related to dentistry or podiatry).

**1.3-2 Medical Appraisal**

All patients admitted by a dentist or podiatrist for care shall receive the same basic medical appraisal as patients admitted for medical services. A physician member shall determine the risk and effect of any proposed treatment on the general health status of the patient. Dispute between a physician member and a limited licensed practitioner regarding a proposed treatment shall be resolved by seeking appropriate consultation.

#### 1.4 TEMPORARY PRIVILEGES

##### 1.4-1 Care of Specific Patients

Temporary clinical privileges may be granted to a physician or limited licensed practitioner for the care of a specific patient when justified by the needs of the patient and the special qualifications of the practitioner.

##### 1.4-2 Locum Tenens

Temporary clinical privileges may be granted to a physician or limited licensed practitioner who serves as a locum tenens for a current member of the Medical Staff. A review of the practitioner's credentials will be conducted as indicated below. Locum tenens status shall not exceed six months unless approved by the governing body.

##### 1.4-3 Pending Applications

Temporary clinical privileges may be granted to a physician or limited licensed practitioner who has completed a Medical Staff application. A review of the practitioner's credentials will be conducted as indicated below. A determination to grant temporary privileges shall not be binding or conclusive with respect to an applicant's request for appointment to the Medical Staff.

##### 1.4-4 Process for Granting Temporary Privileges

Request for temporary privileges addressed above will be accompanied by a completed application and supporting documentation. The applicant must be authorized to practice in California. The governing body or its designee may grant temporary privileges to an applicant after receiving favorable information on the following sources:

- ❖ The National Practitioner Data Bank will be queried regarding the applicant's request for temporary privileges.
- ❖ The Chief of Staff will interview the applicant and contact at least one person who has worked with the applicant. The individual contacted should be able to reliably comment on the applicant's current competence, ethical character, and ability to work with others.
- ❖ Proof of current professional liability insurance.

##### 1.4-5 Granting Temporary Privileges

After the Chief of Staff has collected and evaluated all relevant information regarding the applicant, a recommendation shall be prepared for the governing body's approval. Or, on the recommendation of the Chief of Staff, the

Administrator may grant temporary privileges if authorized by the governing body.

1.5 EMERGENCY PRIVILEGES

“Emergency” is defined as a condition in which a patient is in imminent danger of serious permanent harm or death and any delay in administering treatment would add to that danger. In the case of an emergency, any practitioner, family nurse practitioner (FNP) or physician assistant (PA), to the degree permitted by law, and regardless of Medical Staff status or privileges, shall be permitted to do everything possible to protect a patient from such danger. District personnel shall assist the practitioner, FNP or PA who is treating the patient. When an emergency situation no longer exists, the Chief of Staff shall assign the patient to an appropriate member of the staff if the practitioner, FNP or PA treating an emergent condition does not have appropriate privileges for ongoing treatment. Or, the practitioner may request the privileges necessary to continue to treat the patient.

1.6 DISASTER PRIVILEGES

“Disaster” is defined as any officially declared emergency, whether it is local, state, or national. Any practitioner who volunteers to assist the District shall be asked to present a current license to practice, photo identification, and the name and telephone numbers of health care organization at which the practitioner practices.

The Chief of Staff or designee, or the Administrator or designee, shall attempt to contact the facility where the practitioner has recently practiced to verify that the practitioner is in good standing. The Administrator or designee shall also attempt to verify that the practitioner holds a presently valid license to practice. To the extent that such contacts cannot be made in a timely manner given the circumstances, the Administrator or designee may still issue disaster privileges.

Disaster privileges shall be exercised consistent with the District’s disaster plan and under the supervision of a Medical Staff member or a District employee. The Administrator, designee, or the Chief of Staff may rescind privileges at any time. Fair hearing rights shall not be available to volunteer practitioners.

**ARTICLE 2 PROCTORING**

2.1 GENERAL PROCTORING REQUIREMENTS

2.1-1 Proctoring Requirements

Except as otherwise recommended by the CW and approved by the governing body, all initial appointees to the Medical Staff and all members granted new privileges shall be subject to a period of proctoring. The term of proctoring for initial appointment shall extend for a minimum period of six months and for a minimum of ten cases, whichever takes longer.

2.1-2 Time Limits

The period of proctoring may be extended for a total proctoring period of not more than 24 months. Proctoring may be implemented whenever the CW determines that additional information is needed to assess a practitioner's performance. Proctoring is not viewed as a disciplinary measure. It is an information gathering measure. Therefore, it should be imposed only for such period as is reasonably necessary to complete the assessment of the Medical Staff member.

2.1-3 Appeals

Proctoring does not ordinarily give rise to the procedural rights described in these Bylaws and rules. If, however, a member, due to the lack of a qualified proctor, cannot exercise privileges, the member has recourse to the Fair Hearing Procedures.

2.1-4 Monitoring Mechanisms

Proctoring may include direct observation of the practitioner's performance and chart review. Practitioners providing locum tenens coverage are not required to obtain concurrent proctoring if the applicant currently holds active staff privileges of a like nature without monitoring at another facility. Retrospective monitoring will be done through the usual quality assessment process.

During the proctoring period, practitioners must demonstrate they are qualified to exercise the privileges that were granted and they are carrying out the duties of their Medical Staff category.

2.2 COMPLETION OF PROCTORING

Proctoring shall be deemed successfully completed when the practitioner completes the required number of proctored cases within the timeframe established in these Bylaws. The practitioner's professional performance must meet the standard of care of the District for the proctored cases.

2.3 EFFECT OF FAILURE TO COMPLETE PROCTORING

Any Member who fails to complete the required number of proctored cases within the timeframe established in the Bylaws and rules shall be deemed to have voluntarily withdrawn his or her request for membership (or the relevant privileges). The applicant shall not be afforded the procedural rights provided in these Bylaws. However, the CW has the discretion to extend the time for completion of proctoring in appropriate cases. The inability to obtain such an extension shall not give rise to procedural rights described in these Bylaws and rules.

If a practitioner completes the necessary volume of proctored cases but fails to perform satisfactorily during proctoring, the practitioner may be terminated (or the relevant privileges may be revoked), and the practitioner shall be afforded the procedural rights as provided in the Fair Hearing Procedures.

The failure to complete proctoring for any specific privilege shall not, by itself, preclude

advancement from provisional staff. If advancement is approved prior to completion of proctoring, the proctoring will continue for the specific privileges. The specific privileges may be voluntarily relinquished or terminated if proctoring is not completed thereafter within a reasonable time.