RENEW SOUTH MEADOWS MEDICAL CENTER

MEDICAL STAFF SERVICES

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PRINCIPLES OF MEDICAL ETHICS, JUNE 2001

PREAMBLE

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct, which define the essentials of honorable behavior for the physician.

PRINCIPLES OF MEDICAL ETHICS

I. A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.

II. A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements, which are contrary to the best interests of the patient.

IV. A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.

V. A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.

VII. A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.

VIII. A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

IX. A physician shall support access to medical care for all people.

Adopted by the AMA’s House of Delegates, June 17, 2001
RENOWN SOUTH MEADOWS MEDICAL CENTER MEDICAL STAFF BYLAWS

The most recent amendments to these Bylaws were approved at the __________________________, 2012, meeting of the Board of Governors of Renown South Meadows Medical Center.

ARTICLE I: DEFINITIONS

“ALLIED HEALTH PROFESSIONALS” mean all licensed psychologists who are privileged to attend patients in the Hospital.

“APPLICANT” means an individual who is in the process of applying for Membership and/or clinical privileges.

“APPOINTEE” or “MEMBER” means an individual who has completed the application process and has been appointed to the Medical Staff.

“BOARD OF GOVERNORS” means the Board of Governors of Renown South Meadows Medical Center, a Nevada nonprofit corporation.

“BOARD CERTIFIED” means possessing current certification from a specialty Board recognized by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA).

“CHIEF EXECUTIVE OFFICER” ("CEO") means the CEO and/or Administrator of Renown South Meadows Medical Center and Renown Rehabilitation Hospital, and his or her designees, collectively.

“HOSPITAL,” unless otherwise expressly stated in these Bylaws, collectively means Renown South Meadows Medical Center, a licensed acute care hospital, and Renown Rehabilitation Hospital, a licensed rehabilitation hospital, both of which are located in Reno, Nevada, and are owned and operated by Renown South Meadows Medical Center, a Nevada nonprofit corporation.

“MEDICAL EXECUTIVE COMMITTEE” means the Medical Executive Committee of the Medical Staff. When appropriate, the Medical Executive Committee may delegate functions to other Medical Staff committees, and specific reference to the Medical Executive Committee shall not prevent such delegation.

“MEDICAL STAFF” means all licensed physicians and dentists who are privileged to attend patients in the Hospital.
“MEDICAL STAFF SERVICES” means that office which is staffed by employees of the Hospital to serve as a resource for the entire Medical Staff and to support the Committees, Departments, Sections and Officers of the Medical Staff in the discharge of Medical Staff responsibilities and functions on behalf of the Chief of Staff and Hospital CEO.

“POLICIES,” when used in context, means those associated Policies and Procedures established by the Medical Executive Committee and approved by the Board of Governors.

“RULES,” when used in context, means those associated Rules and Regulations established by the Medical Executive Committee and approved by the Board of Governors.

“SPECIFIED PROFESSIONAL PERSONNEL” means all non-physicians employed by Members of the Medical Staff, Hospital or by contract to the Hospital whose work requires them to exercise independent judgment in the diagnosis and/or treatment of patients in the Hospital.

“SPECIAL NOTICE” means hand delivery, certified mail (return receipt requested), or overnight delivery service providing receipt.
ARTICLE II: PURPOSE

The purpose of this organization is to bring the Medical Staff who practice at Renown South Meadows Medical Center and/or Renown Rehabilitation Hospital into a cohesive body to promote the delivery of high quality medical care. To this end, among other activities, it will screen Applicants for staff Membership, review privileges of Members, participate in quality improvement and offer advice to the Hospital administration and the Board of Governors. These Bylaws, as well as the Medical Staff Rules and Regulations and Policies and Procedures, are intended to delineate the rights of Members and privileges accorded to those Members to effectuate this purpose.
ARTICLE III: MEMBERSHIP

SECTION 3.1: ELIGIBILITY TO APPLY FOR MEMBERSHIP

A. ELIGIBILITY REQUIREMENTS.

In order to obtain an application for appointment or reappointment to the Medical Staff, Applicants and Members must meet the eligibility requirements established by the Board of Governors and/or Medical Executive Committee from time to time, including, but not limited to, the following, as applicable:

1. Education and Training. Applicants to the Medical Staff will be graduates of a recognized medical or dental school. Applicants must have completed an ACGME or AOA approved residency.

2. License. Applicants and Members must maintain a current, unrestricted license to practice medicine, surgery, or dentistry, or such other profession recognized for Membership on the Medical Staff in the State of Nevada. In addition, Applicants and Members must maintain such other applicable certifications, licenses and registrations as are required by the Rules and Regulations for appointment and reappointment to the Medical Staff.

3. Federal Program Eligibility. Applicants and Members of the Medical Staff must be eligible to participate in the Medicare, Medicaid and other federally sponsored health programs.

4. No Prohibition or Restriction on Practice in Hospital. Applicants and Members shall not have any prohibition or restriction on their right to practice in or enter onto the premises of the Hospital and its related facilities not otherwise addressed by these Bylaws.

B. HONORARY STAFF NOT REQUIRED TO MEET ELIGIBILITY REQUIREMENTS.

Physicians appointed to the Medical Staff as Honorary Staff do not need to meet these eligibility requirements.

C. FAILURE TO MEET ELIGIBILITY REQUIREMENTS.

An Applicant or Member who does not meet these eligibility requirements is ineligible to apply for Medical Staff Membership.
D. RIGHTS OF APPLICANTS AND MEMBERS WHO DO NOT MEET ELIGIBILITY REQUIREMENTS.

An Applicant or Member who does not meet these eligibility requirements will not receive an application for membership and is not entitled to the procedural rights set forth in Article V.

SECTION 3.2: BASIC QUALIFICATIONS OF APPLICANTS AND MEMBERS APPLYING FOR APPOINTMENT OR REAPPOINTMENT TO THE MEDICAL STAFF.

All Applicants and Members applying for appointment or reappointment to the Medical Staff must have and document the following, as applicable:

A. COMPETENCE.

Current competence in their respective fields, ability to perform the clinical privileges requested, and adherence to standards of character and ethics established in their respective professions, including:

1. Board Certification:

a. For Members seeking reappointment, maintenance of certification in his or her primary area of practice by the appropriate specialty/subspecialty board of the AMBS, the AOA, or the American Board of Oral and Maxillofacial Surgery, as applicable except for those Members who have been appointed to the Medical Staff solely based upon their appointment to the Medical Staff of Renown South Meadows Medical Center prior to board certification being required in January 2006. A Member whose certification has lapsed due to a failure to take appropriate steps to renew such certification shall be allowed to be reappointed as long as he or she actively is pursuing recertification in accordance with the rules of the relevant board responsible for such certification.

b. For Applicants seeking initial appointment, certification in his or her primary area of practice by the appropriate specialty/subspecialty board of the AMBS, the AOA, or the American Board of Oral and Maxillofacial Surgery. An Applicant who is not board certified at the time of application but who has completed his or her residency or fellowship training shall be eligible to apply for Medical Staff appointment subject to the requirement
that he or she must achieve board certification in his or her primary area of practice within the board-allowed period following the date of completion of their residency or fellowship training.

2. The ability to work cooperatively with others in the provision of care, treatment, and services;

3. Relevant training and/or experience; and

4. Adequate physical and mental health, so as to demonstrate to the satisfaction of the Medical or Dental Board that they are competent to render to any patient, care of the generally-recognized professional level of quality established by the Medical Executive Committee and the Hospital’s Board of Governors.

B. PREVIOUS PRACTICE REQUIREMENTS.

Applicants must have practiced in at least 18 of the last 24 months and have actively practiced in an AOA and/or JCAHO accredited hospital at least 2 of the past 5 years. If an Applicant does not meet these requirements, he or she must write a letter explaining the reason for such failure, and the Applicant will not qualify for the streamlined credentialing process.

C. PROFESSIONAL LIABILITY INSURANCE.

Applicants and Members must maintain in force professional liability insurance which covers all privileges that the Applicant or Member plans to request, in not less than the minimum amounts, if any, as from time to time may be determined by, and with an insurance carrier acceptable to, the Board of Governors.

D. OFFICE LOCATION FACILITATES CONTINUOUS CARE OF PATIENTS IN HOSPITAL.

Applicants and Members, other than Hospital-based physicians, must maintain an office location sufficiently close to Hospital to provide continuous patient care, as provided by the Rules and Regulations and relevant Department or Section Policies & Procedures.

E. MEMBERSHIP AT RENOWN REGIONAL MEDICAL CENTER REQUIRED.

Members of the Medical Staff of Renown South Meadows Medical Center must maintain the same category of Medical Staff Membership at Renown Regional Medical Center for the duration of their Membership at Renown South Meadows Medical Center. This provision shall in no way preclude or restrict any Member of the Medical Staff from
applying for or maintaining privileges at any other facility or hospital. This rule does not
apply to Members of the Medical Staff at Renown Rehabilitation Hospital.

F. CONDITIONS OF APPOINTMENT.

All Applicants and Members seeking appointment or reappointment to the Medical Staff,
as applicable, acknowledge and understand that the following become conditions of their
appointment to and continuing membership on the Medical Staff upon submission of an
application for appointment or reappointment:

1. Each Member shall provide patients with continuous care and emergency
department call coverage that meets the professional standards established by
the Medical Staff. Each Member shall make appropriate arrangements for
coverage of that Member's patients as determined by the Medical Staff.

2. Each Member shall abide by all federal and state regulations with respect to
professional billing practices, including not cooperating or participating in the
division of any fee for professional services.

3. Each Member shall abide by the decisions of all duly-appointed Medical Staff
committees and cooperate in safe patient care, treatment, and services and
Medical Staff activities, including performance improvement, utilization review,
peer review, and attendance at Medical Staff and Clinical Service meetings.

4. Each member shall prepare and complete, in a timely, accurate and legible
manner, the medical record and other required records for all patients the
Member in any way provides care to while at the Hospital.

5. Each Member shall notify the Chief of Staff in writing immediately of any
accusation or adverse action by any health care entity or law enforcement
agency, including any conviction of any felony or any other criminal offense
related to the delivery of health care services or to the neglect or abuse of
patients; a voluntary or involuntary termination of Medical Staff Membership or
voluntary or involuntary limitation of privileges or imposition of a monitoring
requirement; reduction, loss or change of clinical privileges at another health care
entity; contact by an investigator from a regulatory agency such as FDA, DEA,
NSBME, etc. regarding an investigation of the practitioner. Health care entity
includes, but is not limited to, a state or federal licensing or certification agency,
another hospital, health care organization, professional society, health maintenance organization, independent practice association, or medical group.

6. Each Member shall notify the Chief of Staff within thirty days in writing of any arrest or conviction related to the use of alcohol or other drug use.

7. Each Member shall notify the Chief of Staff immediately of any termination of malpractice insurance coverage.

8. Each Member shall provide to the Chief of Staff in writing immediately information as to details of any prior or pending government agency or third-party payor proceeding or litigation challenging or sanctioning applicant's patient admission, treatment, discharge, charging, collection, or utilization practices, including, but not limited to, Medicare and Medicaid fraud and abuse proceedings and convictions.

9. Each Member shall abide by the Medical Staff Bylaws and Rules and Regulations; the Policies and Procedures and other requirements of the Clinical Service of which they are a member; the Bylaws of the Hospital; and other policies of the Medical Staff and Hospital, including: policies regarding discrimination and harassment; the Hospital Code of Ethics, and policies regarding the privacy, confidentiality and security of Protected Health Information.

10. Each Member shall fulfill necessary continuing education requirements for licensure.

11. Each member shall participate in emergency or other Clinical Service coverage as specified in the requirements of the Clinical Service of which they are a member, or any consultation panel responsibilities as may be determined by the Medical Staff, Chief of Staff, or Department or Section Chief.

12. Each Member shall participate in quality assurance and quality improvement activities of the Medical Staff and the Clinical Service of which they are a member, as requested, and to hold knowledge of the content of these activities as strictly confidential.

13. Each Member shall notify the Chief of Staff in writing of any geographical relocation of their practice or any limitation or cessation of professional practice of thirty (30) days or more in duration.
14. Each Member shall comply with all rules governing the required content and quality of history and physical examinations, as well as the time frames required for the completion of such examinations, as set forth in the Medical Staff Rules and Regulations. The requirements for history and physical examinations are attached in Appendix A to these Bylaws until such time that regulatory and accreditation authorities allow such requirements to be placed in the Rules and Regulations, at which time this sentence shall be deleted from the Bylaws and the requirements moved to Rule and Regulation 3.4 without further action by the Medical Staff, Medical Executive Committee or the Board of Governors.

SECTION 3.3: APPOINTMENT AND REAPPOINTMENT OF MEMBERS; CREDENTIALING AND PRIVILEGING OF MEMBERS.

A. RESPONSIBILITY OF BOARD OF GOVERNORS.

Initial appointments and reappointments to the Medical Staff, and the credentialing and granting of privileges to Members, will be made by the Board of Governors in accordance with the applicable Medical Staff Rules and Regulations and uniform application of professional criteria for delineated clinical privileges.

B. DURATION OF APPOINTMENTS.

Appointments to the Medical Staff will be for no more than twenty-four months.

C. APPOINTMENTS AND GRANTING OF PRIVILEGES MUST COMPLY WITH RULES AND POLICIES.

The process for appointment/reappointment and credentialing/privileging of Members is governed by the Medical Staff Rules and Regulations including, but not limited to, the following:

1. Rule 2-1 addresses the initial appointment of Applicants to the Medical Staff and includes the following:
   a. Basic qualifications for appointment;
   b. The obligations of Medical Staff Services in processing the application and the Applicant’s burden to provide the required information;
   c. The process by which the Medical Staff and Board of Governors reviews and approves the application;
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10.

d. The final action taken by the Board of Governors; and

e. The applicable time periods for using an application; completing the application, and processing and reaching a decision on the application.

2. Rule 2-2 addresses the reappointment of Members to the Medical Staff and includes the following:

a. Requirements for appointment;

b. The factors evaluated by the Medical Staff and Board of Governors in the reappointment process;

c. The obligations of Medical Staff Services in processing the application and the Applicant’s burden to provide the required information;

d. The process by which the Medical Staff and Board of Governors reviews and approves the application;

d. The final action taken by the Board of Governors; and

e. Other matters related to the reappointment process.

3. Rule 2-3 addresses the credentialing/privileging of Members of the Medical Staff and includes the following:

a. Eligibility requirements for obtaining clinical privileges;

b. Obtaining clinical privileges either as part of the appointment/reappointment process or during the Member’s appointment period;

c. The process by and purpose for which temporary privileges are granted;

d. The development of new procedure criteria;

e. Cross-specialty privileges; and

f. Privileges used in an emergency.

4. Rule 2-4 addresses the eligibility and process for streamlined credentialing.

D. NO CONTRACT CREATED.
These Bylaws shall not create any contractual or other rights in favor of any Applicant or Member against Renown South Meadows Medical Center and/or the Medical Staff, except for those rights expressly stated in these Bylaws. Medical Staff membership and clinical privileges granted are privileges accorded by the Hospital and its Medical Staff. No physician, dentist, or other clinician eligible for membership shall be entitled automatically to Medical Staff membership or to exercise any particular clinical privileges simply because he or she holds a certain degree; is licensed to practice in Nevada or any other state; is a member of any professional organization; is certified by any clinical board; previously was a member of the Medical Staff of Hospital; or has maintained, either presently or in the past, medical staff privileges at another institution.

SECTION 3.4: FAILURE TO MEET BASIC QUALIFICATIONS FOR APPOINTMENT OR REAPPOINTMENT.

An Applicant or Member who does not meet the basic qualifications for appointment or reappointment to the Medical Staff is ineligible to apply for Medical Staff Membership, as provided in Medical Staff Rules and Regulations 2-1 and 2-2.

SECTION 3.5: RIGHTS OF APPLICANTS AND MEMBERS WHO DO NOT MEET BASIC QUALIFICATIONS FOR APPOINTMENT OR REAPPOINTMENT.

An Applicant or Member who does not meet the basic qualifications is not entitled to the procedural rights set forth in Article V, but may submit comments and a request to the Medical Executive Committee for reconsideration of the specific qualifications that adversely affect such practitioner in accordance with Section 3.7, below.

SECTION 3.6: CLINICAL PRIVILEGES

Clinical privileges are granted by the Board of Governors in accordance with criteria that considers, at a minimum, current licensure, relevant training and experience, current demonstrated competence, ability to perform the privileges requested, and as otherwise stated in the Medical Staff Rules and Regulations and Policies and Procedures.

SECTION 3.7: WAIVER OF QUALIFICATIONS

Any Applicant or Member eligible to apply for appointment or reappointment to the Medical Staff who, upon review of his or her application, does not meet the basic qualifications for membership may submit comments and a request to the Medical Executive Committee for a waiver of the specific qualifications that adversely affect such practitioner. The Board of
Governors, in its sole discretion upon recommendation of the Medical Executive Committee, may waive any qualification requirements in this Article or any other Article of these Bylaws not required by law or governmental regulation upon making the determination that such waiver will serve the best interests of patients of the Hospital. If the Board of Governors grants a waiver in a particular case, that waiver shall not set a precedent for any other applicant or class of applicants. No applicant is entitled to a waiver, and the denial of a request for a waiver shall not constitute a denial of appointment or privileges.

SECTION 3.8: CATEGORIES

All appointments to the Medical Staff will be made by the Board of Governors to one of the following categories.

A. ACTIVE STAFF

1. Qualifications
   a. Appointed to the Medical Staff by the Board of Governors, meeting both the general requirements of Membership outlined in the Bylaws, Rules and Policies as well as the requirements of membership for the specific department to which the physician is assigned.
   b. Has satisfied Associate Staff requirements for advancement to Active Staff.

2. Responsibilities
   a. Participate in Medical Staff matters as assigned (such as committee appointments, quality improvement activities and proctoring of new physicians).
   b. Provide Emergency Department coverage as required by the Medical Staff Bylaws, Rules and Regulations, and Policies and Procedures and as assigned by the Department.

3. Prerogatives
   a. Admit and attend patients within the scope of granted privileges and proctoring requirements.
   b. Vote in all matters pertaining to the Medical Staff.
c. Hold office and sit on or be chairperson of committees as assigned, unless otherwise specified in these Bylaws.

B. ASSOCIATE STAFF

1. Qualifications

   a. Appointed to the Medical Staff by the Board of Governors, meeting both the general requirements of Membership outlined in the Bylaws and Rules and Regulations as well as the requirements of membership for the specific department to which the physician is assigned.

   b. New physicians are appointed to this category for at least 12 months and not more than 24 months. The Medical Executive Committee may extend appointment to this category beyond 24 months for good cause. All such appointments are made in accordance with Rule and Regulation 2-7.

2. Responsibilities

   a. Fulfill the proctoring guidelines as stipulated by the Department and/or Section and the assigned proctor. The Associate Staff physician is responsible for satisfying these requirements, enabling the proctor to make a recommendation for release from proctoring and elevation to the Active Staff category.

   b. Participate in Medical Staff matters as assigned (such as quality improvement activities).

   c. Provide Emergency Department coverage as required by the Medical Staff Bylaws, Rules and Regulations, and Policies and Procedures and as assigned by the Department.

   d. Attend at least 50% of all Department or Section meetings annually to be eligible to be elevated to the Active Staff.

3. Prerogatives

   a. Admit and attend patients within the scope of granted privileges and proctoring requirements.

   b. Participate in committees as assigned unless otherwise specified in these Bylaws.
4. Limitations

Physicians appointed to this category may not vote as a Member of the Medical Staff.

C. SENIOR ACTIVE STAFF

1. Qualifications
   a. Appointed to the Medical Staff by the Board of Governors, meeting both the general requirements of Membership outlined in the Bylaws, Rules and Policies as well as the requirements of membership for the specific department to which the physician is assigned.
   b. Physicians who have been granted this status at Renown Regional Medical Center will be granted this Medical Staff Category at Renown South Meadows Medical Center and/or Renown Rehabilitation Hospital.

2. Responsibilities

Participate in Medical Staff affairs as requested on a voluntary basis, or as otherwise required by the applicable Medical Staff Department or Section in accordance with the Medical Staff Bylaws, Rules and Regulations and Policies and Procedures.

3. Prerogatives
   a. Admit and attend patients within the scope of granted privileges and proctoring requirements.
   b. Vote in all matters pertaining to the Medical Staff.
   c. Sit on or be the chairperson of any committee, unless otherwise specified in these Bylaws.

D. NON-RESIDENT SPECIALIST STAFF

1. Qualifications
   a. Appointed to the Medical Staff by the Board of Governors, after the position and person are found acceptable to the Department and/or Section and Medical Executive Committee. Non-Resident Specialist Staff Members are not required to be Members of the Medical Staff of Renown Regional Medical Center.
b. Possess expertise not available locally. The Medical Executive Committee will evaluate the local availability of such expertise upon the Member’s application for reappointment, or upon request at any regularly scheduled meeting of the Medical Executive Committee. If the Medical Executive Committee determines that sufficient expertise exists locally, the Medical Executive Committee shall notify the Member of its determination, in writing. The Medical Executive Committee shall forward a recommendation to the Board of Governors consistent with that determination. If the Board of Governors accepts the recommendation of the Medical Executive Committee, the Member shall be notified via certified mail, return receipt requested, of such action. The Member shall have 60 days after the date of mailing of such notice to request a change to the appropriate Staff category. If the Member fails to request such a change within the 60-day time period, he or she shall relinquish his or her privileges automatically at the end of that time period without further notice required.

c. Sponsored by and assisted by local physicians who will commit to treatment of complications and follow-up care of patients.

d. Possess a Nevada license and appropriate malpractice insurance.

e. Complete the credentialing and re-credentialing process.

f. Document that he or she possesses at another institution the privileges requested.

2. Responsibilities

Abide by the general Medical Staff responsibilities as outlined in Article III, Section 3.2.

3. Prerogatives

Attend patients within the scope of granted privileges.

4. Limitations

Physicians appointed to this category may not:

a. Admit patients to the Hospital.
b. Vote as a Member of the Medical Staff.

E. AMBULATORY STAFF

1. Qualifications.
   a. Appointed to the Medical Staff by the Board of Governors upon the recommendation of the Medical Executive Committee, and meeting the general requirements of Membership outlined in the Bylaws, Rules and Policies, as applicable, except that the following general requirements either are inapplicable to this membership category or amended as follows:

   (1) Section 3.2(B) shall not apply. Instead, the Member must be Board certified, Board eligible, or enrolled in maintenance of certification in the applicable specialty.

   (2) Section 3.2(D) is amended to require that the Member have his or her primary practice in the Reno/Sparks metropolitan area.

   (3) Sections 3.2(E)(1), (3), (4), and (11) are inapplicable to this membership category.

b. Practices in a specialty defined by the U.S. Department of Health and Human Services Health Resources and Services Administration’s Bureau of Primary Health Care as “primary care.”

c. Provides evidence of malpractice insurance.

d. At the time of applying for Ambulatory Staff status and at all times that the Member retains Medical Staff Membership in such status, has a written agreement with a physician who maintains an Active, Associate, or Senior Active Medical Staff Membership at Hospital (including a physician group) for the care of the Member’s patients when admitted to the Hospital or requiring evaluation in the Emergency Department. The physician providing such coverage for the Ambulatory Staff Member must maintain appropriate Medical Staff Membership and privileges at Hospital.

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1 Health Professional Shortage Area Designation Criteria from 42 CFR Chapter 1, Part 5 (October 1, 1993) at pp34-48, Designation of Health Professional(s) Shortage Areas. Currently, the designated primary care specialties are Family Medicine, General Internal Medicine, Pediatrics or Obstetrics and Gynecology.
e. In order to be reappointed to this Medical Staff category, the Member must maintain all criteria required for initial appointment.

f. If an Active Staff Member changes his or her staff category to Ambulatory Staff status, he or she may request to return to Active Staff status at any time within two (2) years from the time of the initial appointment to Ambulatory Staff status. The Medical Executive Committee may recommend appointment of the individual back to the Active Staff based on an assessment of the Member’s clinical competency. If the Member remains on the Ambulatory Staff for more than two (2) years from his or her initial appointment date and wants to return to Active Staff status, he or she must reapply for such status in the same manner as new applicants.

2. Responsibilities

a. Abide by the general requirements for Medical Staff as outlined in Article III, Section 2, as applicable.

b. Participate on a rotational basis with other Ambulatory Staff Members in providing follow-up care to patients seen and discharged from the Emergency Department. Ambulatory Staff Members are not otherwise eligible to take Emergency Department call.

3. Prerogatives

a. Visit patients in the Hospital.

b. Write a note in the progress notes.

c. Review medical records.

d. Participate in continuing medical education activities.

e. May attend Department and/or Section meetings.

4. Limitations

Physicians appointed to this category may not:

a. Admit patients to the Hospital.

b. Assist in surgery.
c. Write orders.

d. Vote as a Member of the Medical Staff.

F. AMBULATORY SURGICAL STAFF

1. Qualifications.
   
a. Appointed to the Active, Senior Active or Associate Medical Staff of Renown Regional Medical Center by its Board of Governors upon the recommendation of its Medical Executive Committee, and meeting the basic and general requirements of Membership outlined in the Bylaws and Policies, as applicable.

b. Practices in a surgical specialty and performs outpatient surgical services at Renown Surgical Arts.

c. Provides evidence of malpractice insurance.

d. At the time of applying for Ambulatory Surgical Staff status and at all times that the Member retains Medical Staff Membership in such status, maintains Active, Senior Active or Associate Medical Staff Membership and privileges at Renown Regional Medical Center.

e. In order to be reappointed to this Medical Staff category, the Member must maintain all criteria required for initial appointment.

2. Responsibilities
   
a. Abide by the general requirements for Medical Staff as outlined in Article III, Section 2, as applicable.

b. Provide outpatient surgical services at Renown Surgical Arts, a department of the Hospital. The Member shall not be entitled to perform any surgeries in the on-campus surgical department unless otherwise provided below.

c. In the event that a patient of Member requires services at Renown Regional Medical Center due to complications arising after a surgical procedure performed by Member at Renown Surgical Arts, then the Member shall be responsible for the patient at Renown Regional Medical
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Center, including but not limited to seeing that patient in the Emergency Room if called by the Emergency Room physician.

d. In the event that a patient of Member requires services at Renown South Meadows Medical Center due to complications arising after a surgical procedure performed by Member at Renown Surgical Arts, then the Member shall be responsible for the patient at the hospital, including but not limited to seeing that patient in the Emergency Room if called by the Emergency Room physician. For that purpose, the Member shall be treated as having Associate Staff membership for purposes of that patient only, and may exercise those clinical privileges required to treat the patient at Renown South Meadows Medical Center.

e. Ambulatory Surgical Staff Members are not otherwise eligible to take Emergency Department call at Renown South Meadows Medical Center.

3. Prerogatives

a. Perform outpatient surgeries at Renown Surgical Arts.

b. Be responsible for the care of any surgical patient of Member admitted to either Renown South Meadows Medical Center or Renown Regional Medical Center due to complications arising from a surgery performed by Member at Renown Surgical Arts, including the exercise of any and all clinical privileges necessary.

c. May attend Department and/or Section meetings.

4. Limitations

Physicians appointed to this category may not:

a. Perform surgery in any Renown South Meadows Medical Center department other than Renown Surgical Arts.

b. Exercise any clinical privileges at Renown South Meadows Medical Center other than as provided above.

c. Vote as a Member of the Medical Staff.

G. HONORARY STAFF

1. Qualifications
a. Physicians not active in the Hospital and who are honored by emeritus positions. These may be physicians who have retired from active Hospital service or physicians of outstanding reputation.

b. Appointed by the Board of Governors on the recommendation of the Medical Executive Committee.

2. Responsibilities

Abide by the general Medical Staff responsibilities as outlined in Article III, Section 3.2.

3. Prerogatives

Physicians appointed to this category may visit patients in the Hospital.

4. Limitations

Physicians appointed to this category may not:

a. Admit patients to the Hospital.

b. Assist in surgery.

c. Write orders.

d. Vote as a Member of the Medical Staff.

H. RURAL AFFILIATED STAFF

1. Qualifications

a. Appointed at the discretion of the Governing Board upon recommendation of the Medical Executive Committee, and meeting the basic qualifications and general requirements of Membership outlined in the Bylaws, Rules and Policies, as applicable.

b. Practices only in rural areas outside of the Reno/Sparks metropolitan area or in a medical facility located on sovereign lands of and operated by or for the benefit of a federally-recognized Indian/Native American tribe, refers patients to Hospital for care, and does not hold Associate, Active or Senior Active membership status at any hospital within the Reno/Sparks metropolitan area.
c. If an Active Staff Member changes his or her staff category to Rural Staff status, he or she may request to return to Active Staff status at any time within two (2) years from the time of the initial appointment to Rural Staff status. The Medical Executive Committee may recommend appointment of the individual back to the Active Staff based on an assessment of the Member’s clinical competency. If the Member remains on the Rural Staff for more than two (2) years from his or her initial appointment date and wants to return to Active Staff status, he or she must reapply for such status in the same manner as new applicants.

2. Responsibilities

Abide by the general requirements for Medical Staff as outlined in Article III, Section 2, as applicable. Rural Affiliated Staff Members are not eligible to take Emergency Department call.

3. Prerogatives

a. Visit his or her patients in the Hospital.

b. Write a note in the progress notes.

c. Review medical records.

d. Order outpatient labs and studies for his or her patients.

e. Receive results of outpatient and inpatient labs and studies for his or her patients, as allowed under applicable federal and state laws.

f. Participate in continuing medical education activities

g. May attend appropriate Department and/or Section meetings.

4. Limitations

Physicians appointed to this category may not:

a. Admit patients to the hospital.

b. Assist in surgery.

c. Write orders.

d. Vote as a Member of the Medical Staff.
ARTICLE IV: REVIEW OF MEDICAL STAFF MEMBER CONDUCT

SECTION 4.1: BASIS FOR REVIEW

The procedures provided in this Article shall be invoked whenever it appears that the activities or professional conduct of any Member of the Medical Staff:

A. Jeopardizes or may jeopardize the safety or best interests of a patient, quality of care, treatment, or services, visitor, or employee;

B. Presents a question regarding the competence, character, judgment, ethics, stability of personality, including the ability to work cooperatively with others in the provision of safe patient care, treatment, and services, adequate physical and mental health, moral character, or qualification of the Member; or

C. Violates these Medical Staff Bylaws, Rules and Regulations, the Policies and Procedures and other requirements of the Clinical Services, or Hospital Bylaws and Policies and Procedures, including the Code of Ethics, or constitutes conduct that is, or is reasonably probable of being, disruptive to Hospital operations.

SECTION 4.2: MEDICAL STAFF PEER REVIEW

A. DEFINITIONS:

Peer: A Member of the Active or Senior Active medical staff in the same professional specialty as the physician under review, with expertise in the appropriate subject matter.

Circumstances: Elements of patient care for which the complexity of management or seriousness of outcome warrants critical review in order to assess opportunities for improvement in a practitioner’s performance or patient safety. These elements may come to review via patient or family complaints, quality, utilization review and risk management data, incidents, near misses or sentinel events, outside regulatory or accreditation agencies notices or any medical staff concern referred for peer review.

B. CONFIDENTIALITY OF REVIEW; REVIEWED PHYSICIAN INVOLVEMENT

1. All peer review information is privileged and confidential in accordance with federal and state laws and regulations pertaining to confidentiality and non-discoverability, as well as the Medical Staff and Hospital Bylaws.

2. Each practitioner will have access to his/her own peer review information.
3. If a department review is conducted, the individual whose performance is being reviewed will be present and participate primarily as an educational opportunity to improve the practitioner’s performance and to insure that the practitioner is fully informed of findings, conclusions, recommendation, and action taken to implement changes to improve performance.

4. When no other medical staff Member has adequate expertise in the specialty under review or when a clear conflict of interest exists, as determined by the Medical Executive Committee, an external peer review will be utilized. The external reviewer will be a licensed physician, board certified, and currently practicing with expertise in the same medical specialty as the individual under review.

5. The Medical Staff Office shall administer the peer review process in conjunction with the Medical Executive Committee. The Medical Executive Committee may delegate the administration of this process to the appropriate Hospital Department.

C. COLLEGIAL INTERVENTION.

1. The Medical Staff encourages the use of progressive steps, beginning with collegial and educational efforts, to address questions relating to an individual's clinical practice and/or professional conduct, with the goal of arriving at voluntary, responsive actions by the individual to resolve questions that have been raised.

2. Collegial efforts may include, but are not limited to, counseling, sharing of comparative data, monitoring, and additional training or education.

3. All collegial intervention efforts by Medical Staff leaders are part of the Hospital's confidential performance improvement and professional and peer review activities.

4. The relevant Medical Staff leader(s) (e.g., Chief of Staff, other officers, Department or Section Chief) shall determine whether it is appropriate to include documentation of collegial intervention efforts in an individual's confidential file. If documentation of collegial efforts is included in an individual's file, the individual will have an opportunity to review it and respond in writing. The
response shall be maintained in that individual's file along with the original documentation.

5. Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders.

6. The Chief of Staff shall determine whether to direct that a matter be handled in accordance with another Policy, such as the Policy on Practitioner Health or the Code of Conduct Policy, or to direct it to the Executive Committee for further determination consistent with this Article IV and the Rules and Regulations.

D. FORMAL LEVELS OF REVIEW

1. **Level I Review:** In a Level I Review, a single reviewer from the same specialty as the Member under review, usually the section chief or department chair, evaluates the circumstances of concern and makes one of the following determinations:

   a. The concern is unsubstantiated and should be dismissed.

   b. An isolated event involving a minor deviation from the applicable standard of care occurred and may be resolved through physician notification and education and without further formal action.

   c. An event occurred which involved a significant departure from the applicable standard of care, a serious outcome, or an apparent trend in the type of activity under review, and the case should be referred for a Level II Review.

   The Level I process must be completed within 45 days.

2. **Level II Review:** In a Level II Review, the Department chairperson or Section chief, as applicable, will appoint a panel comprised of three (3) members of the Department/Section to which the physician under review belongs. The panel will include the Department chairperson or Section chief, as applicable. If the review concerns a specialty treatment or procedure, the panel must contain at least one peer who is currently qualified and competent in that treatment or procedure.

   a. The panel shall evaluate the circumstances of concern and make one of the following determinations:
(1) That trending/monitoring of similar cases for outcome should occur after the physician has been notified and received appropriate education regarding the circumstances of concern.

(2) That the physician should obtain appropriate education through a literature search and review, and present the matter at a future Department or Section meeting, as appropriate, for the benefit and performance improvement of all practitioners.(3) That other corrective action deemed educational and likely to improve patient care should occur, as determined by the panel based upon the specifics of the case.

(4) That the practitioner’s clinical privileges and/or Medical Staff status should be restricted. In this case, the matter will be referred to the Medical Executive Committee for review pursuant to Section 4.3, below.

The Level II process must be completed within 90 days.

b. Any remedial activity assigned by the panel must be completed by the practitioner under review in a timely manner, as specified by the panel, and agreed upon by the panel and practitioner at the conclusion of the review.

c. For cases determined to have potential opportunities for system improvement, the panel will bring the issue to the attention of the Medical Staff Quality Management Committee for development of plans to address the issue.

d. If the review by the panel results in the discovery of a near miss or sentinel event, then Hospital’s Risk Management Department will be immediately notified for root cause analysis and appropriate corrective action.

SECTION 4.3: INVESTIGATIONS.

A. PRE-INVESTIGATION PROCESS

1. A request for an investigation of the conduct of a Member of the Medical Staff raising a question under Section 4.1. including but not limited to items referred
from peer review pursuant to Section 4.3(2)(a)(iv) or after collegial intervention efforts have failed to resolve an issue, may be made to the Chief of Staff, the chief of the department or section, the chairman of a standing committee, the Chief Executive Officer, or the Chairman of the Board of Governors.

2. Any such request must be in writing and supported by reference to specific activities or conduct alleged. The person to whom the request is made shall make sufficient inquiry to satisfy himself or herself that the question raised is credible and, if so, shall forward it in writing to the Chief of Staff and Medical Staff Office. The Medical Staff Office shall be responsible for providing a copy of the request to the CEO.

3. The Chief of Staff will refer the request for an investigation to the Medical Executive Committee at its next regular meeting for further consideration. At that time, the Chief of Staff may impose a precautionary suspension or restriction of clinical privileges as provided in Section 4.4 if the request for an investigation states facts that indicate the necessity of such interim action.

No action taken pursuant to this Section 4.3(A) shall constitute an investigation.

B. INITIATION OF INVESTIGATION.

1. Initiated by Medical Executive Committee.
   a. Upon receipt of a request for investigation made pursuant to Section 4.3(A) above, the Medical Executive Committee shall review the matter and determine whether to:
      (1) conduct an investigation; or
      (2) direct the matter to be handled pursuant to another policy, such as the Policy on Practitioner Health or the Code of Ethics; or
      (3) proceed in another manner.
   b. In making this determination, the Medical Executive Committee may discuss the matter with the individual. An investigation shall begin only after a formal determination is made by the Medical Executive Committee to conduct such an investigation.
   c. Upon making a formal determination to conduct an investigation, the Medical Executive Committee shall inform the individual and the CEO
that an investigation has begun. Notification may be delayed if, in the Medical Executive Committee’s judgment, informing the individual immediately would compromise the investigation or disrupt the operation of the Hospital or Medical Staff.

2. Initiated by Board of Governors.

The Board of Governors also may determine to commence an investigation.

4. The Chief of Staff and Chief Executive Officer shall keep each other fully informed of all action taken in connection with an investigation.

5. Nothing set forth herein shall prevent the appropriate authority from implementing a precautionary suspension or restriction of privileges at any time, in the exercise of its discretion pursuant to Section 4.4 below.

C. INVESTIGATIVE PROCEDURE.

1. Once a determination has been made to begin an investigation, the governing body initiating the investigation (the Board of Governors or the Medical Executive Committee) either shall investigate the matter itself or appoint an ad hoc committee to conduct the investigation. Additionally, the Board of Governors may delegate the investigation to the Medical Executive Committee or a subcommittee of the Board of Governors. The investigating body shall not include partners, associates, or relatives of the individual being investigated, but may include individuals not on the Medical Staff. At least 51% of the members of any Board of Governors subcommittee or other ad hoc committee formed shall be Active or Senior Active Members of the Medical Staff.

2. The committee conducting the investigation (“investigating committee”) shall have the authority to review relevant documents and interview individuals. It shall also have available to it the full resources of the Medical Staff and the Hospital, as well as the authority to use outside consultants, if needed. An outside consultant or agency may be used whenever a determination is made by the investigating committee that:

   a. the clinical expertise needed to conduct the review is not available on the Medical Staff; or
b. the individual under review is likely to raise, or has raised, questions about the objectivity of other practitioners on the Medical Staff; or

c. the individuals with the necessary clinical expertise on the Medical Staff would not be able to conduct a review without risk of allegations of bias or conflict of interest, even if such allegations are unfounded.

3. The investigating committee may require a physical and/or psychiatric examination of the individual by health care professional(s) acceptable to it. The individual being investigated shall execute an appropriate release allowing the investigating committee (or its representative) to discuss with the health care professional(s) conducting the examination the reasons for the examination and have access to documentation of the results of such examination.

4. The individual shall have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the individual shall be informed of the general questions being investigated. At the meeting, the individual shall be invited to discuss, explain, or refute the questions that gave rise to the investigation. A summary of the interview shall be made by the investigating committee and included with its report. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. The individual being investigated shall not have the right to be represented by legal counsel at this meeting.

5. The investigating committee shall make a reasonable effort to complete the investigation and issue its report within 30 days of the commencement of the investigation, provided that an outside review is not necessary. When an outside review is necessary, the investigating committee shall make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the results of the outside review. These time frames are intended to serve as guidelines and, as such, shall not be deemed to create any right for an individual to have an investigation completed within such time periods. In the event the investigating committee is unable to complete the investigation and issue its report within these time frames, it shall inform the individual of the reasons for the delay and the approximate date on which it expects to complete the investigation.
6. At the conclusion of the investigation, the investigating committee shall prepare a report with its findings, conclusions, and recommendations. This report will be forwarded to the Medical Executive Committee, the Chief Executive Officer and the individual.

7. In making its recommendations, the investigating committee shall strive to achieve a consensus as to what is in the best interests of patient care and the smooth operation of the Hospital, while balancing fairness to the individual, recognizing that fairness does not require that the individual agree with the recommendation. Specifically, the committee may consider:
   a. relevant literature and clinical practice guidelines, as appropriate;
   b. all of the opinions and views that were expressed throughout the review, including report(s) from any outside review(s); and
   c. information or explanations provided by the individual under review.

D. MEDICAL EXECUTIVE COMMITTEE ACTION ON RECOMMENDATION.

1. The Medical Executive Committee may accept, modify, or reject any recommendation it receives from an investigating committee. Specifically, the Medical Executive Committee may:
   a. determine that no action is justified;
   b. issue a letter of guidance, counsel, warning, or reprimand;
   c. impose conditions for continued appointment;
   d. impose a requirement for monitoring or consultation;
   e. recommend additional training or education;
   f. recommend reduction of clinical privileges;
   g. recommend suspension of clinical privileges for a term;
   h. recommend revocation of appointment and/or clinical privileges; or
   i. make any other recommendation that it deems necessary or appropriate.

2. A recommendation by the Medical Executive Committee that would entitle the individual to request a hearing pursuant to Article VI shall be forwarded to the Chief Executive Officer, who shall promptly inform the individual by special notice.
as required by Article VI. The Chief Executive Officer shall hold the recommendation until after the individual has completed or waived a hearing and appeal.

3. If the Medical Executive Committee makes a recommendation that does not entitle the individual to request a hearing pursuant to Article VI, it shall take effect immediately and shall remain in effect unless modified by the Board of Governors.

4. In the event that the Board of Governors considers a modification to the recommendation of the Medical Executive Committee that would entitle the individual to request a hearing, the Chief Executive Officer shall inform the individual by special notice. No final action shall occur until the individual has completed or waived a hearing and appeal.

5. When applicable, any recommendations or actions that are the result of an investigation or hearing an appeal shall be monitored by Medical Staff leaders on an ongoing basis through the Hospital’s performance improvement activities or pursuant to the applicable Rules and/or Policies regarding conduct, as appropriate.

SECTION 4.4: PRECAUTIONARY SUSPENSION/RESTRICTION OF CLINICAL PRIVILEGES

A. GROUNDS FOR PRECAUTIONARY SUSPENSION OR RESTRICTION.

1. The Chief of Staff, the chief of a clinical department or section, the Chief Executive Officer, and the Chairman of the Board of Governors each shall have the authority to suspend or restrict all or any portion of a physician's clinical privileges at Hospital whenever, in their sole discretion, the failure to take such action may result in imminent danger to the health and/or safety of any individual or may interfere with the orderly operation of the Hospital. The individual may be given an opportunity to refrain voluntarily from exercising some or all privileges in question pending an investigation.

2. Precautionary suspension or restriction is an interim step in the professional review activity, but it is not a complete professional review action in and of itself. It shall not imply any final finding of responsibility for the situation that caused the suspension or restriction.
3. A precautionary suspension or restriction shall become effective immediately upon imposition, shall immediately be reported in writing to the Chief Executive Officer and the Chief of Staff, and shall remain in effect unless it is modified by the Chief Executive Officer or Medical Executive Committee.

B. EXECUTIVE COMMITTEE PROCEDURE.

1. The Medical Executive Committee shall review the matter resulting in a precautionary suspension or restriction within a reasonable time under the circumstances, not to exceed 14 days. Prior to, or as part of, this review, the individual may be given an opportunity to meet with the Medical Executive Committee. The individual may propose ways other than precautionary suspension or restriction to protect patients, employees and/or the smooth operation of the Hospital, depending on the circumstances.

2. After considering the matters resulting in the suspension or restriction and the individual's response, if any, the Medical Executive Committee shall determine whether there is sufficient information to warrant a final recommendation, or whether it is necessary to commence an investigation pursuant to Section 4.3 above. The Medical Executive Committee shall also determine whether the precautionary suspension or restriction should be continued, modified, or terminated pending the completion of the investigation (and hearing, if applicable).

3. There is no right to a hearing based on the imposition or continuation of a precautionary suspension or restriction.

C. CONTINUING CARE OF PATIENTS.

Immediately upon the imposition of a precautionary suspension or restriction, the Chief of Staff shall assign to another individual with appropriate clinical privileges responsibility for care of the suspended individual's hospitalized patients, or to aid in implementing the precautionary restriction, as appropriate. The assignment shall be effective until the patients are discharged. The wishes of the patient shall be considered in the selection of a covering physician.
D. DUTY TO COOPERATE; ENFORCEMENT.

All Members of the Medical Staff have a duty to cooperate with the Chief of Staff, the Department Chief, the Medical Executive Committee, and the Chief Executive Officer to enforce precautionary suspensions and restrictions of clinical privileges.

SECTION 4.5: AUTOMATIC RELINQUISHMENT OF PRIVILEGES.

A. GROUNDS FOR AUTOMATIC RELINQUISHMENT

1. Failure to Maintain Qualifications. If a Member fails to maintain any qualifications for Membership or privileges required by the Bylaws and the Rules and Regulations, which failure does not relate to the quality of care provided and/or is not otherwise addressed in this Section 4.5, his or her privileges will be relinquished automatically for a period not to exceed 15 days. During the period of automatic relinquishment, the Member will have an opportunity to demonstrate that he or she meets these qualifications. If the Member fails to demonstrate his/her qualifications prior to the end of the automatic relinquishment period, the Medical Staff shall treat the Member as having resigned his or her Membership and privileges as provided in Rule and Regulation 2-9.

2. Failure to Complete Medical Records.

   a. Failure by a Member to complete medical records within the time required by the applicable Medical Staff Rules and Regulations shall result in an automatic relinquishment by the Member of all clinical privileges, after notification by the medical records department of delinquency. Relinquishment shall continue until all delinquent records are completed and reinstatement accomplished in accordance with the applicable Rules and Regulations. Failure to complete the medical records that caused relinquishment within the time required by applicable Rules and Regulations shall result in automatic resignation from the Medical Staff as provided in Rule and Regulation 2-9.

   b. During the period of automatic relinquishment the Member may not:

      (1) Admit patients;
(2) Write orders for patients admitted by another physician who had not been seen nor treated prior to the effective date of the suspension;

(3) Schedule or perform surgery, or assist at surgery; or

(4) Act as a consultant on any case.

c. Any Member fulfilling his or her service commitment to the Hospital may, in conjunction with that responsibility, admit only those patients requiring hospitalization due to emergency treatment evaluation while that Member is in relinquishment of Hospital activities for failure to complete patient records.

3. Action by Government Agencies or Insurers.

a. Any action taken by any licensing board, professional liability insurance company, court or government agency regarding any of the matters set forth below must be promptly reported to the Medical Staff Office.

b. An individual's appointment and clinical privileges shall be automatically relinquished if any of the following occur:

(1) Licensure. Revocation, expiration, suspension, or the placement of conditions or restrictions on an individual's license.

(2) Controlled Substance Authorization. Revocation, expiration, suspension or the placement of conditions or restrictions on an individual's DEA or state controlled substance authorization.

(3) Insurance Coverage. Termination or lapse of an individual's professional liability insurance coverage or other action causing the coverage to fall below the minimum required by the Hospital or cease to be in effect, in whole or in part.

(4) Medicare and Medicaid Participation. Termination, exclusion, or preclusion by government action from participation in the Medicare/Medicaid or other federal or state health care programs.

(5) Criminal Activity. Indictment, conviction, or a plea of guilty or no contest pertaining to any felony, or to any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid,
or insurance or health care fraud or abuse; or (iv) violence against another.

c. The automatic relinquishment of privileges under this Section 4.5(A)(3) shall take effect immediately and continue until the matter is resolved, if applicable, and request for reinstatement approved. Requests for reinstatement shall be reviewed by the relevant department chief, the Chief of Staff, and the Chief Executive Officer. If all these individuals make a favorable recommendation on reinstatement, the Medical Staff Member may immediately resume clinical practice at the Hospital. This determination shall then be forwarded to the Medical Executive Committee and the Board of Governors for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the Medical Executive Committee and Board of Governors for review and recommendation.

4. Failure to Provide Requested Information.

Failure to provide information pertaining to an individual's qualifications for appointment or clinical privileges, in response to a written request from the Medical Executive Committee, the Chief Executive Officer, or any other committee authorized to request such information, shall result in automatic relinquishment of all clinical privileges until the information is provided.

5. Failure to Attend Special Conference.

a. Whenever there is an apparent or suspected deviation from standard clinical practice involving any individual, the department chief or the Chief of Staff may require the individual to attend a special conference with Medical Staff leaders and/or with a standing or ad hoc committee of the Medical Staff.

b. The notice to the individual regarding this conference shall be given by special notice from the CEO and/or the Chief of Staff at least three days prior to the conference and shall inform the individual that attendance at the conference is mandatory.
c. Failure of the individual to attend the conference shall be reported to the Medical Executive Committee. Unless excused by the Medical Executive Committee upon a showing of good cause, such failure shall result in automatic relinquishment of all or such portion of the individual's clinical privileges as the Medical Executive Committee may direct. Such relinquishment shall remain in effect until the matter is resolved.

6. Inability to Locate a Member.

If, in the routine conduct of business, Medical Staff Services becomes aware that a Member is no longer at his or her specified office address, Medical Staff Services will contact the last known office via phone or mail to obtain a forwarding address. If no forwarding address or contact telephone number for the Member can be identified within a reasonable time, this will be considered an automatic relinquishment of all clinical privileges of the Member. Thereafter, the Member may be deemed to have voluntarily resigned from the Medical Staff pursuant to Rule and Regulation 2-8. This action will be processed through the Department, Medical Executive Committee and the Board of Governors.

B. RESPONSIBILITY FOR OBSERVING THE RELINQUISHMENT

If a Member’s privileges are relinquished pursuant to this Section 4.5, the Member physician shall be responsible for complying with all restrictions imposed during the period of relinquishment. If the member violates the restrictions imposed during the period of relinquishment, he or she shall be subject to permanent revocation of Medical Staff privileges, upon approval of the Board of Governors.

C. DUTY TO COOPERATE; ENFORCEMENT.

All Members of the Medical Staff have a duty to cooperate with the Chief of Staff, the Department Chief, the Medical Executive Committee, and the Chief Executive Officer to enforce any automatic relinquishment of privileges.

SECTION 4.6: ACTION TO ADDRESS INAPPROPRIATE CONDUCT AND/OR BEHAVIOR OR BEHAVIORS THAT UNDERMINE A CULTURE OF SAFETY.

A. PROFESSIONAL CONDUCT REQUIRED.

All Members of the Medical Staff, Allied Health Practitioners, other practitioners, residents, and Hospital staff will treat all other individuals within the Hospital in a
professional, cooperative, courteous, respectful, and dignified manner, and shall conduct themselves in a manner that fosters a culture of safety. The Renown Health Standards of Conduct and Code of Ethics shall guide the Medical Staff, other practitioners, and Hospital Staff in their dealings with others in the Hospital.

B. TYPES OF INAPPROPRIATE CONDUCT AND/OR BEHAVIOR OR BEHAVIORS THAT UNDERMINE A CULTURE OF SAFETY.

Unacceptable inappropriate conduct and/or behavior or behaviors that undermine a culture of safety may include, but is not limited to, the following:

1. Attacks (physical or verbal) leveled at other Members of or Appointees to the Medical Staff, Medical Center personnel or patients that are personal, irrelevant or go beyond the bounds of fair professional comment.

2. Impertinent and inappropriate entries placed in a patient medical record or other official document, impugning the quality of care in the Hospital, or attacking particular physicians, nurses or Hospital Policy.

3. Non-constructive criticism, addressed to its recipient in such a way as to berate, intimidate, undermine confidence, belittle or imply stupidity or incompetence.

4. Refusal to accept Medical Staff assignments, or to participate in committee or departmental affairs on anything but his or her own terms or to do so in a disruptive manner.

5. Egregious incidents such as sexual harassment, assault, felony convictions, fraudulent acts, stealing, throwing equipment/records, or similar inappropriate behavior.

6. Any other behavior that jeopardizes safety.

C. ENFORCEMENT.

If a Member of the Medical Staff or other practitioner acts in an inappropriate manner and/or behaves in a manner that undermines a culture of safety, the matter shall be addressed in a firm, fair and equitable manner as follows:

1. Documentation of Conduct. Documentation of such conduct shall be in the form of an Incident Report or patient complaint, or any other note to the Member’s file which the Chief of Staff may find necessary.

2. Investigation. A single egregious incident or repeated incidents shall result in an investigation to determine if sufficient cause exists for action. If sufficient cause
exists, the Chief of Staff shall refer the matter to the Medical Executive Committee. The Medical Executive Committee may take the following action:

a. determine that no action is warranted;

b. act upon the information presented; or

c. refer the matter to the Board of Governors, without comment, for further action.

3. Action.

a. Single Incident. A single confirmed incident might warrant a discussion with the offending physician, depending on the egregiousness of the conduct. The Chief of Staff shall initiate such a discussion and emphasize that such conduct is inappropriate and/or unsupportive of a culture of safety and must cease. The initial approach should be collegial and designed to be helpful to the physician and the Hospital.

b. Repeated Incidents. If it appears to the Chief of Staff that a pattern of conduct inappropriate and/or unsupportive of a culture of safety is developing, the Chief of Staff or designee shall take the following action:

   (1) Discuss the matter with the physician and emphasize that if such conduct continues, then formal action will be taken to stop it.

   (2) Notify the Medical Executive Committee and the CEO.

   (3) Document all meetings.

c. A follow-up letter shall be sent to the physician stating the basis for the problem and that the physician is required to behave in accordance with this Bylaw within the Hospital.

d. As with Incident Reports, the involved physician may submit a rebuttal to the charge. Such rebuttal will be maintained as a permanent part of the record.

D. SOLE PROCESS.

This Section 4.6 provides the sole process under the Medical Staff Bylaws for dealing with inappropriate conduct and/or behavior or behaviors that undermine a culture of safety, and shall be interpreted and enforced by the Medical Staff and Board of Governors.
E. RELATIONSHIP OF THIS SECTION TO SECTION 4.4.
This Section 4.6 shall not be construed to prevent the Chief of Staff, the chief of a clinical department or section, the Chief Executive Officer or the Chairman of the Board of Governors from taking appropriate action to address conduct that presents an imminent danger to the health and/or safety of any individual or interference with the orderly operation of the Hospital, pursuant to Section 4.4, above.

SECTION 4.7: ACTIONS INVOLVING PRACTITIONER HEALTH.

A. INCIDENTS REQUIRING ACTION.
If the Hospital or Medical Staff becomes aware that a Member, while practicing in the Hospital:
1. Has alcohol on his or her breath while providing services to patients in the Hospital;
2. Exhibits behavior and demeanor such that any reasonable person would assume that the Member is under the influence of drugs and/or alcohol; and/or
3. Exhibits behavior and demeanor such that any reasonable person would assume that the physician is impaired by a medical condition,

he or she immediately shall notify the Chief of Staff, Nursing Supervisor and the Department or Section Chief. If necessary, Security and Administration shall be notified. The identity of the individual making such notification shall be kept confidential.

B. IMMEDIATE SUSPENSION.
The Member shall be suspended immediately pursuant to Article IV, Section 4.4 of the Medical Staff Bylaws, and have his or her privileges rescinded. The Chief of Staff shall have the right to request a blood alcohol test and/or a urine/blood screen for drugs. The Hospital will be responsible for the cost of this screening.

C. OCCURRENCE REPORT.
The involved Nursing Supervisor shall ensure that a completed occurrence report is delivered to the Chief of Staff within 48 hours of the event. Such report should be dictated/written as soon as possible after the event. This occurrence report will become part of the physician’s confidential quality assessment file.
D. **CONFIDENTIALITY OF REPORT.**

The identity of the Member suspected to be impaired, as referenced in Section A, above, will be maintained confidentially except as limited by law, ethical obligation, or as necessary to protect the health and safety of a patient.

E. **CHIEF OF STAFF ACTION.**

The Chief of Staff will assess the situation using whatever data is available and will discuss the event with the physician in question. The Chief of Staff may involve the Department or Section Chief, other staff officers, or other physicians on the Medical Staff whose duties are pertinent to the problem. The Chief of Staff shall perform a preliminary inquiry into the facts of the matter to determine the merit of the conduct involved, including an evaluation of the credibility of a complaint, allegation, or concern. Based upon that determination, the Chief of Staff may take appropriate action including, but not limited to, the following:

1. Exonerate the Member.
2. Request an investigation of the matter pursuant to Section 4.3.
3. Provide written counseling of the Member regarding this and any other prior events (from the Member’s confidential quality assessment file).
4. Refer the Member to the Nevada State Board of Medical Examiners’ Diversion Program.
5. Recommend to the Medical Executive Committee the approval of a request for a voluntary leave of absence, as provided in Rule and Regulation 2-8, to allow the Member to enter a rehabilitation program, under the following conditions, which shall be set forth in a written contract signed by the Member and the Chief of Staff:
   a. The Member may return only upon presentation of a letter from the rehabilitation program director verifying the Member’s successful completion of the program, together with a written description of the Member’s aftercare rehabilitation program.
   b. Upon the Member’s return, he or she will be assigned an Associate or Active Staff Member to proctor the Member. The proctor may request random blood and/or urine tests for drugs and/or alcohol. The Member bears the expense for follow-up monitoring.
c. The Member agrees to resign from the Medical Staff for any unexplained positive drug/alcohol test.
d. The Chief of Staff may refer the monitoring of the Member to the Nevada Health Professionals Assistance Foundation, which administers the Nevada State Board of Medical Examiners’ Diversion Program.

6. Referral to the Member’s medical provider or another mutually agreeable physician for evaluation and treatment of the suspected medical condition.

F. VERIFICATION.
The Chief of Staff may require verification from the Member’s treating physician that the Member is under adequate treatment or has completed treatment for the condition before returning to medical practice at the Hospital. Periodic updates may be requested of the treating physician to assure continued successful treatment of the Member’s medical condition.

G. SOLE PROCESS.
This Section 4.7 provides the sole process under the Medical Staff Bylaws for addressing practitioner health issues that affect the health and safety of patients, and shall be interpreted and enforced by the Medical Staff and Board of Governors. In cases that do not affect the health and safety of patients, the non-disciplinary process of the Medical Staff used for educating physicians about practitioner health issues, addressing prevention of physical, psychiatric, or emotional illness, and facilitating confidential diagnosis, treatment and rehabilitation of such illnesses is addressed in Rule 4-5 of the Medical Staff Rules and Regulations.

ARTICLE V: HEARING AND APPEAL PROCEDURES

SECTION 5.1: INITIATION OF HEARING

A. GROUNDS FOR HEARING.

1. An individual is entitled to request a hearing whenever the Medical Executive Committee makes one of the following recommendations regarding that individual:
   a. Denial of initial appointment to the Medical Staff;
   b. Denial of reappointment to the Medical Staff;
   c. Revocation of appointment to the Medical Staff;
   d. Denial of requested clinical privileges;
e. Revocation of clinical privileges;

f. Suspension of clinical privileges for more than 14 days;

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

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

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

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

B. ACTIONS NOT GROUNDS FOR HEARING.

The following actions involving an individual shall not constitute grounds for a hearing, and such actions shall take effect without hearing or appeal:

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

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

3. The termination of temporary privileges;

4. The automatic relinquishment of appointment or privileges;

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

6. A precautionary suspension;

7. A denial of a request for a leave of absence, for an extension of a leave of absence, or for reinstatement from a leave of absence if the reasons do not relate to professional competence or conduct;
8. A determination that an application is incomplete;
9. A determination that an application will not be processed due to a misstatement or omission; or
10. A determination of ineligibility for Membership on the Medical Staff based on a failure to meet the basic qualifications or because of an exclusive contract.

C. NOTICE OF RECOMMENDATION.

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

1. a statement of the recommendation and the general reasons for it;
2. a statement that the individual has the right to request a hearing on the recommendation within thirty (30) days of receipt of such notice; and
3. a copy of this Article.

D. REQUEST FOR HEARING.

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

E. NOTICE OF HEARING AND STATEMENT OF REASONS.

1. The Chief Executive Officer, in consultation with the Chief of Staff, shall schedule the hearing and provide, by special notice, the following:
   a. the time, place, and date of the hearing;
   b. a proposed list of witnesses who will give testimony at the hearing and a brief summary of the anticipated testimony;
   c. the names of the Hearing Panel members and Presiding Officer (or Hearing Officer) if known; and
   d. a statement of the specific reasons for the recommendation, including a list of patient records (if applicable), and information supporting the
recommendation. This statement may be revised or amended at any time, even during the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications and the individual has had a reasonable opportunity of up to thirty (30) days to review and rebut the additional information.

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

F. WITNESS LIST.

1. At least fifteen (15) days before the pre-hearing conference, the individual requesting the hearing and the Medical Executive Committee each shall provide a written list of the names of all witnesses expected to offer testimony at the hearing.

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

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

G. HEARING PANEL, PRESIDING OFFICER, AND HEARING OFFICER.

1. Hearing Panel.

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

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

2. Presiding Officer.

a. In lieu of a Hearing Panel Chairman, the Chief Executive Officer, after consultation with the Chief of Staff, may appoint a Presiding Officer who may be an attorney. The Presiding Officer shall not act as an advocate for either side at the hearing.

b. If no Presiding Officer has been appointed, the Chairman of the Hearing Panel shall serve as the Presiding Officer and shall be entitled to one vote.

c. The Presiding Officer shall:

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

   (2) prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant or abusive or that causes undue delay;

   (3) maintain decorum throughout the hearing;

   (4) determine the order of procedure;

   (5) rule on all matters of procedure and the admissibility of evidence;

   (6) conduct argument by counsel on procedural points outside the presence of the Hearing Panel unless the Panel wishes to be present.

d. The Presiding Officer may be advised by legal counsel to the Hospital with regard to the hearing procedure.
3. Hearing Officer.
   a. If a Hearing Panel reasonably cannot be selected, the Chief Executive Officer, after consulting with the Chief of Staff, may appoint a Hearing Officer, preferably an attorney, to perform the functions of a Hearing Panel. The Hearing Officer may not be, or represent clients who are, in direct economic competition with the individual requesting the hearing. The Hearing Officer may not be an employee of or in a contractual relationship with the Hospital.
   b. If a Hearing Officer is appointed instead of a Hearing Panel, all references in this Article to the "Hearing Panel" or "Presiding Officer" shall be deemed to refer to the Hearing Officer.

4. Objections.
   Any objection to any member of the Hearing Panel, or the Hearing Officer or Presiding Officer, shall be made in writing to the Chief Executive Officer within 10 days of receipt of notice of their appointment or selection. A copy of such written objection must be provided to the Chief of Staff and must include the basis for the objection. The Chief Executive Officer, in consultation with the Chief of Staff, shall rule on the objection and give notice to the parties. The Chief Executive Officer may request that the Presiding Officer make a recommendation as to the validity of the objection.

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

SECTION 5.2: PRE-HEARING PROCEDURES.

A. GENERAL PROCEDURES.
   The pre-hearing and hearing processes shall be conducted in an informal manner. Formal rules of evidence and procedure shall not apply.
B. PROVISION OF RELEVANT INFORMATION.

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

2. Upon receipt of the above agreement and representation, the individual requesting the hearing will be provided with a copy of, or reasonable access for purposes of review to, each of the following:
   a. All patient medical records referred to in the statement of reasons, at the individual's expense;
   b. Reports of any experts relied upon by the Medical Executive Committee;
   c. Relevant minutes of Medical Staff meetings (with portions regarding other physicians and unrelated matters deleted); and
   d. Any other documents relied upon by the Medical Executive Committee.

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

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

5. Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges shall be excluded.
6. Neither the individual, his or her attorney, nor any other person acting on behalf of the individual, shall contact Hospital employees appearing on the Medical Executive Committee's witness list concerning the subject matter of the hearing, unless specifically agreed upon by counsel.

C. PRE-HEARING CONFERENCE.

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

D. STIPULATIONS.

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

E. PROVISION OF INFORMATION TO THE HEARING PANEL.

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

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

2. All exhibits offered by the parties following the pre-hearing conference (without the need for authentication); and

3. Any stipulations of the parties regarding evidentiary matters.
SECTION 5.3: THE HEARING.

A. FAILURE TO APPEAR.

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

B. RECORD OF HEARING.

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

C. RIGHTS OF THE PARTIES AND THE HEARING PANEL AT THE HEARING.

1. At a hearing, both sides shall have the following rights, subject to reasonable limits that may be determined and imposed by the Presiding Officer:
   a. The right to call and examine witnesses, to the extent they are available and willing to testify;
   b. The right to introduce exhibits;
   c. The right to cross-examine any witness on any matter relevant to the issues;
   d. The right to be represented by counsel who may be present. However, said counsel may not call, examine, or cross-examine witnesses, nor may counsel present the case;
   e. The right to submit a written statement at the close of the hearing (in the absence of a Hearing Panel request for the filing of such a statement); and
   f. The right to submit proposed findings, conclusions and recommendations to the Hearing Panel.

2. If the individual who requested the hearing does not testify on his or her own behalf, he or she may be called and questioned by the Medical Executive Committee and/or the Hearing Panel.
3. The Hearing Panel may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

D. ADMISSIONSIBILITY OF EVIDENCE.

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

E. ORDER OF PRESENTATION OF CASE.

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

F. POST-Hearing STATEMENT.

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

G. PERSONS TO BE PRESENT.

The hearing shall be restricted to those individuals involved in the proceeding. Administrative personnel may be present as requested by the Chief Executive Officer or the Chief of Staff.

H. POSTPONEMENTS AND EXTENSIONS.

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

I. PRESENCE OF HEARING PANEL MEMBERS.

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

SECTION 5.4: HEARING PANEL DELIBERATIONS, RECOMMENDATION AND REPORT.

A. BASIS OF HEARING PANEL RECOMMENDATION.

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

B. DELIBERATIONS AND RECOMMENDATION OF THE HEARING PANEL.

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

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

**SECTION 5.5: APPEAL PROCEDURE.**

A. **TIME FOR APPEAL.**

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

B. **GROUNDS FOR APPEAL.**

The grounds for appeal shall be limited to the following:

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

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

C. **TIME, PLACE AND NOTICE.**

Whenever a party requests an appeal as set forth in this Section 5.5, the Chairman of the Board of Governors shall schedule and arrange for a hearing of that appeal. The parties shall be given special notice of the time, place, and date of the appeal hearing. The appeal hearing shall be held as soon as arrangements reasonably can be made, taking into account the schedules of parties, but in any event not more than 30 days after receipt of the request for an appeal.
D. **NATURE OF APPELLATE REVIEW.**

1. The Board of Governors may act as the Review Panel if it elects to do so and can, as a body, hold the hearing within the time limits detailed in Section 5.5(C), above. Alternatively, the Chairman of the Board of Governors shall appoint a Review Panel composed of not less than three persons who are members of the Board of Governors or reputable persons in the community, and at least one of whom shall be a physician. The Review Panel shall review the grounds for the appeal by considering the record upon which the recommendation was made, any matters raised in the written statements of the parties on appeal or during any oral argument allowed, and any additional evidence that the Review Panel, in its discretion, chooses to accept as stated below.

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

3. The Review Panel (or Board) may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Hearing Panel proceedings. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence or that any opportunity to admit it at the hearing was improperly denied, and then only at the discretion of the Review Panel (or Board).

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

E. **FINAL DECISION OF THE BOARD.**

Within 30 days after receipt of the Review Panel’s written recommendation, the Board shall render a final written decision that includes specific findings supporting its decision, and shall send special notice thereof to the individual. In its decision, the Board may affirm, modify, or reverse the recommendation of the Review Panel or, in its discretion,
may refer the matter for further review and recommendation, or make its own decision based upon the Board's ultimate legal responsibility to grant appointment and clinical privileges. A copy of the final decision also shall be provided to the Medical Executive Committee for its information.

F. FURTHER REVIEW.

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

G. RIGHT TO ONE HEARING AND ONE APPEAL ONLY.

No Member of the Medical Staff shall be entitled to more than one hearing and one appellate review on any matter. If the Board denies initial appointment or reappointment to the Medical Staff or revokes the appointment and/or clinical privileges of a current Member of the Medical Staff, that individual may not apply for staff appointment or for those clinical privileges for a period of five (5) years unless otherwise provided by the Board.
ARTICLE VI: MEDICAL STAFF OFFICERS AND MEMBERS AT LARGE

SECTION 6.1: ELECTED OFFICERS OF THE MEDICAL STAFF

A. OFFICERS OF THE MEDICAL STAFF.

The officers of the Medical Staff shall be:

1. Chief of Staff;
2. Vice-Chief of Staff; and
3. Secretary of Staff.

B. QUALIFICATIONS & RESPONSIBILITIES OF OFFICERS

1. Qualifications.

Officers of the Medical Staff will have been a Member of the Medical Executive Committee for at least two years prior to his or her appointment as a Medical Staff officer. During that time, he or she will have demonstrated leadership in his or her department or on Medical Staff committees. Furthermore, officers must be Members of the Active or Senior Active Staff at the time of nomination and election and must remain Active or Senior Active Members in good standing during their terms of office. In addition, a Member should meet the following minimum qualifications to be elected as a Medical Staff Officer:

a. Has served on the Active Staff for at least five years;
b. Is not presently serving as a Medical Staff officer, Board Member, department chief, or in any other elected or appointed role (other than medical staff membership and accompanying privileges) at any facility not affiliated with Hospital and shall not so serve during their terms of office;
c. Is willing to faithfully discharge the duties and responsibilities of the position;
d. Has experience in a leadership position, or other involvement in performance improvement functions, for at least two (2) years;
e. Attends continuing education relating to Medical Staff leadership and/or credentialing functions prior to or during the term of the office;
f. Has demonstrated an ability to work well with others; and

g. Is not employed by, contracted with, and/or compensated to provide services to, a competitor of Hospital. For purposes of this section, the following shall apply:

(1) The term "competitor" shall include entities owned wholly or partially by a competitor, or under common ownership with a competitor, of Hospital and its affiliated entities.

(2) The term "contracted with" shall mean contracted with the competitor and not providing Hospital or its affiliated entities with the same or substantially similar services.

(3) The term "compensated" shall mean compensated by the competitor for services and not providing Hospital or its affiliated entities with the same or substantially similar services.

(4) Exceptions to this requirement may be recommended by the Medical Executive Committee to the Board of Governors for approval.

(5) Prior to being nominated for a Medical Staff Officer, the Member shall complete a disclosure form and list all actual and potential conflicts prohibited by this subsection g, which form shall be provided to Hospital Administration for review. In the event that a conflict arises subsequently to the Member taking office, the Member shall have a continuing duty to report such conflicts to Hospital Administration.

2. Responsibilities.

a. Chief of Staff

The Chief of Staff will call and preside at Medical Executive Committee meetings and will be a Member, ex-officio, of all committees. The Chief of Staff is responsible for general supervision over all professional work of the Hospital, including all physicians on the Medical Staff. The Chief of Staff is responsible for representing the Medical Staff as an ex-officio voting Member of the Board of Governors. The Chief of Staff may also
assume other responsibilities as approved and directed by the Board of Governors.

b. Vice-Chief of Staff

The Vice-Chief of Staff, in the absence of the Chief of Staff, shall assume all of his/her duties and have all of his/her authority. He will also be expected to perform other duties of supervision as may be assigned by the Chief of Staff. The Vice-Chief of the Medical Staff will serve as the chairperson of such Medical Staff Committees as may be assigned by the Chief of Staff, barring any extenuating circumstances that make such service unacceptable.

c. Secretary of Staff

The Secretary of Staff will be responsible for keeping accurate and complete minutes of all meetings of the Staff. If there are funds to be accounted for, the Secretary of Staff will also act as Treasurer. The Secretary, in the absence of the Chief of Staff and Vice-Chief of Staff, shall assume all of his/her duties and have all of his/her authority. The Secretary of the Medical Staff will serve as the chairperson of such Medical Staff Committees as may be assigned by the Chief of Staff, barring any extenuating circumstances that make such service unacceptable.

SECTION 6.2: MEMBERS AT LARGE

Members at Large must be Members of the Active or Senior Active staff at the time of nomination and election and must remain Active or Senior Active staff Members in good standing during their terms of office. In order to be nominated to be a Member at Large, the candidate must meet the qualifications for officers described in Section 6.1(B)(1)(c), (f) and (g); may not be a voting member of any governing body (including, but not limited to, the medical executive committee or similar body) of any competitor of Hospital, as that term is defined in Section 6.1(B)(1)(g)(1); and must meet such additional qualifications as may be defined in the Rules and Regulations. Prior to being nominated as a Member at Large, the Member shall complete a disclosure form and list all actual and potential conflicts prohibited by Section 6.1(B)(1)(g), which form shall be provided to the Chief of Staff for review. In the event that a conflict arises subsequently to the Member taking office, the Member shall have a continuing
duty to report such conflicts to the Chief of Staff. Members at Large are responsible for attending all Medical Executive Committee meetings and participating in the governance of the Medical Staff.

SECTION 6.3: ELECTION OF OFFICERS AND MEMBERS AT LARGE

A. On or before July 1 of each odd-numbered year, the Chief of Staff shall appoint a Nominating Committee. The Nominating Committee will be responsible for soliciting input from the Medical Staff regarding nominations for the Secretary of Staff and open Member-at-Large positions on the Medical Executive Committee. The Nominating Committee will offer one or more nominees for the Secretary of Staff and open Member-at-Large positions, which shall then be placed on the election ballot. Additionally, any physician who receives general nominations from at least 5 percent of the Active and Senior Active Staff on or before October 1 of that year will be placed on the ballot. All candidates must meet the qualifications for the office which they seek, as detailed in Sections 6.1 and 6.2.

B. Officers and three (3) Members at Large will be elected by Members of the Medical Staff. Only Active and Senior Active Staff Members are eligible to vote. A simple majority of returned ballots will determine the new officers and Members at Large.

SECTION 6.4: TERM OF OFFICE & ADVANCEMENT OF OFFICERS AND MEMBERS AT LARGE

The Chief of Staff, Vice-Chief of Staff and Secretary of Staff and Members-at-Large shall serve for two-year terms beginning January 1 of even numbered years. The Vice-Chief shall succeed the Chief of Staff and the Secretary shall succeed the Vice-Chief upon a vote of confidence of the Active and Senior Active Staff.

SECTION 6.5: VACANCIES IN OFFICE

If an officer of the Medical Staff or Member at Large is removed or resigns, the Chief of Staff will submit at least one name to the Medical Executive Committee for approval to fill the vacancy for the remaining duration of the term.

SECTION 6.6: DUTIES OF OFFICERS AND MEMBERS AT LARGE

Additional duties of officers of the Medical Staff and Members at Large may be delineated in the Medical Staff Rules and Regulations.
SECTION 6.7: REMOVAL FROM OFFICE

A. An officer or Member at Large may be temporarily suspended from the duties of his/her office by the Board of Governors, the Chief of Staff, or by a two-thirds vote of the Medical Executive Committee for a violation of the Medical Staff Bylaws or Rules and Regulations.

B. If an officer or Member at Large receives a temporary suspension, the officer or Member at Large shall have an opportunity to be heard by the Medical Executive Committee within 30 days.

C. A suspension from office may be made permanent by a two-thirds vote of the Medical Executive Committee following the opportunity to be heard or waiver thereof.
ARTICLE VII: DEPARTMENTS AND SECTIONS

SECTION 7.1: ORGANIZATION

The Medical Staff will be organized into Departments and Sections in order to conduct the business of the Medical Staff. The formation or deletion of a Department shall require the approval of a simple majority of Medical Staff Members eligible to vote who return ballots. Sections of a Department may form with the concurrence of the Department and the Medical Executive Committee. The Rules and Regulations shall detail the organization of and rules governing Departments and Sections.

SECTION 7.2: EMERGENCY DEPARTMENT COVERAGE

A. EMERGENCY DEPARTMENT COVERAGE RESPONSIBILITY.

Except as otherwise approved by the Board of Governors, each Department will provide 24/7 Emergency Department coverage for Hospital. Each department shall be responsible for establishing the mechanism to facilitate coverage, which mechanism shall be reviewed at least annually by the Medical Executive Committee and, if adequate based upon patient care needs and the legal and regulatory obligations of the Medical Staff and Hospital, recommend the same to the Board of Governors for approval.

B. PREPARATION OF CALL SCHEDULES.

Each Department or Section shall schedule Emergency Department call as provided by the Medical Staff Rules and Regulations.

SECTION 7.3: DEPARTMENT AND SECTION CHIEFS

A. QUALIFICATIONS, APPOINTMENT AND TENURE.

1. Each Department and Section Chief must be board certified in the appropriate specialty. However, the Chief of Staff may, with the approval of the Medical Executive Committee, select a Chief who is not board certified if the Medical Executive Committee objectively establishes that the individual selected possesses a level of competence comparable to that required for board certification.

2. Department and Section Chiefs will be appointed by the Chief of Staff, based upon a recommendation from the Department or Section. In order to be appointed, the proposed appointee must meet the qualifications for officers, described in Section 6.1(B)(1)(c), (d), (f) and (g); may not be a voting member of
any governing body (including, but not limited to, the medical executive committee or similar body) of any competitor of Hospital, as that term is defined in Section 6.1(B)(1)(g)(1); and must meet such additional qualifications as may be defined in the Rules and Regulations. Prior to being nominated as a Department or Section Chief, the Member shall complete a disclosure form and list all actual and potential conflicts prohibited by Section 6.1(B)(1)(g), which form shall be provided to the Chief of Staff for review. In the event that a conflict arises subsequently to the Member assuming the role of Department or Section Chief, the Member shall have a continuing duty to report such conflicts to the Chief of Staff.

3. Department and Section Chiefs will serve a two-year term, commencing on January 1, with one half appointed each biennium. The term will end on December 31.

B. DUTIES AND RESPONSIBILITIES.

Department and Section Chiefs shall be Members of the Active or Senior Active Staff during their tenure and shall have responsibility for the following:

1. All clinically related activities of the department or section;

2. All administratively related activities of the department or section, unless otherwise provided for by the Hospital;

3. Continuing surveillance of the professional performance of all individuals in the department or section who have delineated clinical privileges;

4. Recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the department or section;

5. Recommending clinical privileges for each Member of the department or section;

6. Assessing and recommending to the relevant Hospital authority off-site sources for needed patient care services not provided by the Hospital;

7. Integrating the department or section into the primary functions of the organization;

8. Coordinating and integrating interdepartmental and intradepartmental services;
9. Developing and implementing policies and procedures that guide and support the provision of services;

10. Recommending a sufficient number of qualified and competent persons to provide care or service;

11. Recommending to Administration the qualifications and competence of department personnel (Hospital staff) who are not Specified Professional Personnel and who provide patient care services;

12. Continuously assessing and improving the quality of care and services provided;

13. Maintaining quality programs, as appropriate;

14. Ensuring that all persons in the department or section receive orientation and continuing education;

15. Making recommendations regarding space and other resources needed by the department or section; and

16. Performing all functions authorized in the Medical Staff Rules and Regulations, including collegial intervention.
ARTICLE VIII: COMMITTEES

SECTION 8.1: MEDICAL EXECUTIVE COMMITTEE

A. COMPOSITION.

The Medical Executive Committee will include the Chief of Staff, who shall serve as its chairperson, Vice-Chief of Staff, Secretary of Staff, immediate past Chief of Staff, chief of each clinical Department, and the Members-at-Large. In addition, the Medical Executive Committee may recommend to the Board that a clinical Section be represented on the Medical Executive Committee, which recommendation shall be effective upon approval of the Board. The Chief Executive Officer and/or his/her designees will attend in a non-voting capacity.

B. DUTIES.

The duties of the Medical Executive Committee shall be:

1. To represent and act on behalf of the Medical Staff and to perform all duties cited or implied in any Article or Section of these Bylaws, Rules and Regulations or Policies and Procedures.

2. To coordinate and approve the activities and general Policies and Procedures of the various departments.

3. To receive, review and act upon committee and department reports and to make recommendations concerning those reports to the Board of Governors on matters including, but not limited to, the following:

   a. The Medical Staff's structure;

   b. The mechanism used to review credentials and to delineate individual clinical privileges;

   c. Recommendations of individuals for Medical Staff Membership;

   d. Recommendations for delineated clinical privileges for each eligible individual;

   e. The participation of the Medical Staff in organization of performance-improvement activities;

   f. The mechanism by which Medical Staff Membership may be terminated; and
g. The mechanism for fair hearing procedures;

4. To investigate any breach of ethics and review all information available regarding the competence of Medical Staff Members and take action in accordance with these Bylaws, the Rules and Regulations, and Policies and Procedures;

5. To adopt Rules and Regulations, consistent with and/or interpretive of these Bylaws, that may be appropriate for the efficient and effective operation of the Medical Staff, as provided in Article XIII of these Bylaws. The Medical Staff shall be apprised of these Rules and Regulations through Department and Section meetings and other appropriate means of communication.

6. Upon referral from a Medical Staff Department or Section, to adopt Policies and Procedures, consistent with and/or interpretive of these Bylaws, that may be appropriate for the efficient and effective operation of the Medical Staff, as provided in Article XIII of these Bylaws. The Medical Staff shall be apprised of these Policies and Procedures through Department and Section meetings and other appropriate means of communication.

7. To represent the Medical Staff in any Hospital deliberation affecting the discharge of Medical Staff responsibilities.

8. To consult with Hospital Administration on quality-related aspects of contracts for patient care services.

9. To receive and act on reports and recommendations from Medical Staff committees, departments, and other groups as appropriate.

10. To form such committees as needed to discharge its duties.

SECTION 8.2: OTHER MEDICAL STAFF COMMITTEES

The Medical Executive Committee may establish such other standing and special committees that it deems necessary to perform the Medical Staff functions required in the Bylaws. Standing and special committees are described in and governed by the Rules and Regulations. Each such committee shall consist of Active Staff Members. Except as otherwise provided in the Medical Staff Bylaws and Rule and Regulations, the Chief of Staff shall appoint the chairperson and members of each committee annually. The Chief of Staff may appoint other, non-voting individuals to committees including, when appropriate, other Members of the Medical Staff (Senior Active, Associate, etc.), allied health professionals; Hospital management, nursing,
medical records, pharmacy, case coordination/management, social services, and other personnel. Committee members will be appointed by the Chief of Staff using the qualifications for officers described in Section 6.1(B)(1)(c), (d), (f) and (g). Prior to being appointed to a committee, a Member shall complete a disclosure form and list all actual and potential conflicts prohibited by Section 6.1(B)(1)(g), which form shall be provided to the Chief of Staff for review. In the event that a conflict arises subsequently to the Member’s appointment to a committee, the Member shall have a continuing duty to report such conflicts to the Chief of Staff. Committee members may not be a voting member of any governing body (including, but not limited to, the medical executive committee or similar body) of any competitor of Hospital, as that term is defined in Section 6.1(B)(1)(g)(1).

SECTION 8.3: MEDICAL STAFF FUNCTIONS

The Rules and Regulations shall provide, either through assignment and delegation to Departments and Sections, standing committees, Medical Staff officers, interdisciplinary committees, or Medical Staff Services, for the effective performance of the Medical Staff functions specified in this section. Those functions include:

A. Conducting or coordinating quality, appropriateness and improvement activities;

B. Conducting or coordinating utilization review activities;

C. Conducting or coordinating credentials investigations regarding Medical Staff Membership, granting of clinical privileges and structuring of the privileging process;

D. Providing continuing education opportunities responsive to quality assessment/improvement activities;

E. Coordinating the care provided by Members of the Medical Staff with the care provided by the nursing service and with the activities of other Hospital patient care and administrative services;

F. Directing staff organization activities, including staff Bylaws, review and revision, staff officer nominations and review and maintenance of Hospital accreditation; and

G. Engaging in other functions reasonably requested by the Medical Executive Committee and Board of Governors.
ARTICLE IX: MEDICAL STAFF MEETINGS

SECTION 9.1: ANNUAL GENERAL MEETING

A general meeting of the Medical Staff shall be held at a date and time to be determined by the Chief of Staff. At the annual meeting held in odd-numbered years, the annual election of officers shall be announced. The CEO and/or his designees shall be encouraged to attend these meetings to act as a liaison.

SECTION 9.2: FREQUENCY OF MEETINGS AND ATTENDANCE

A. MEDICAL EXECUTIVE COMMITTEE

The Medical Executive Committee shall meet monthly, unless canceled by the Chief of Staff, and maintain a permanent record of its proceedings and actions. The Chief of Staff may call special meetings of the Medical Executive Committee at any time.

B. OTHER MEDICAL STAFF COMMITTEES

Medical Staff committees (other than the Medical Executive Committee) shall meet at least quarterly. Participation by Active and Senior Active Staff Members shall be governed by the Rules and Regulations. Participation of all eligible Members is encouraged.

C. DEPARTMENTS AND SECTIONS

Medical Staff Departments and Sections shall meet at least quarterly. The conduct of the meetings and participation of Department and Section members shall be governed by the Rules and Regulations.

SECTION 9.3: MISCELLANEOUS

Issues of Attendance, Quorum and Agendas will be outlined in the Rules and Regulations.

SECTION 9.4: ROBERT’S RULES OF ORDER

Unless otherwise specifically provided in the Medical Staff Bylaws or Rules and Regulations, customs or practices of the Medical Staff, the Medical Executive Committee, a Committee, Department, or Section shall prevail at all meetings, and the Committee Chair or Department/Section Chief shall have the authority to rule definitively on all matters of procedure. The latest edition of Robert’s Rules of Order Revised may be used for reference at all meetings and elections, but shall not be binding.
SECTION 9.5: NOTICE OF MEETINGS

Members of the staff shall be apprised of meetings in writing no less than monthly. The appropriate committee, Department or Section may, as a courtesy, notify Members of the staff of meetings by other methods as well.

SECTION 9.6: MINUTES

Minutes of each Medical Staff meeting shall be prepared and shall include a record of the attendance of Members and the vote taken on each matter. Minutes shall be signed by the presiding committee chair or Department/Section Chief and submitted to the Medical Executive Committee.
ARTICLE X: ALLIED HEALTH PROFESSIONALS

SECTION 10.1: DEFINITION

Hospital recognizes the following categories of Allied Health Professionals:

A. Psychology

Each of the above categories shall be organized into sections and assigned to the appropriate Medical Staff department for the purpose of performance improvement and administration. Allied Health Professionals falling into these categories will hold either “probationary” status (during the proctoring period) or “active” status (after the successful completion of the proctoring period).

SECTION 10.2: LOCALITY

Applicants to the Allied Health Professions sections shall be graduates of recognized professional schools in their specialties, legally licensed to practice said profession in the State of Nevada, and practicing within sufficient proximity to provide for the continuous care of their patients.

SECTION 10.3: MEDICAL EVALUATION

A medical history and physical examination of each patient admitted by an Allied Health Professional shall be recorded by a Member of the Medical Staff. Patients admitted by Allied Health Professionals must be under the care of a specific Active, Senior Active or Associate Member of the Medical Staff who will have a continuing responsibility for the patient's medical condition throughout his/her hospitalization.

SECTION 10.4: PRIVILEGES

Allied Health Professionals are not Members of the Medical Staff and will not hold office or exercise voting privileges. The Applicant may request the privileges outlined on the privilege delineation request form approved by the Board of Governors. Applicants who wish to perform privileges not listed must submit a letter of request and justification to be considered by the applicable Medical Staff Department and Medical Executive Committee and acted upon by the Board of Governors. Each Applicant shall be under the overall review of the appropriate department.
SECTION 10.5: GUIDELINES AND STANDARDS

All procedural provisions or requirements and administrative and professional practices of the Medical Staff will apply also to Allied Health Professionals. Allied Health Professionals shall obtain consultations where medically indicated and comply with departmental Policies and Procedures in this regard.

SECTION 10.6: HEARING AND APPEAL

Allied Health Professionals shall be entitled to the Hearing and Appeal process set forth in the applicable Policy in the event of a recommendation adversely affecting privileges.
ARTICLE XI: CONFIDENTIALITY AND IMMUNITIES

SECTION 11.1: CONFIDENTIALITY OF INFORMATION

A. CONFIDENTIALITY OF INFORMATION GENERALLY

Medical Staff Services and Medical Staff Committee minutes, files, and records, including information regarding any Member or applicant to this Medical Staff, shall, to the fullest extent permitted by law, be confidential. Dissemination of such information and records shall only be made where expressly required by law, in the authorized conduct of Medical Staff proceedings, pursuant to officially adopted Rules and/or Policies of the Medical Staff, including the authorization of representatives of Hospital and the Medical Staff to solicit and provide information bearing upon the ability and qualifications of Members and Allied Health Professionals; or by express approval of the Medical Executive Committee.

B. BREACH OF CONFIDENTIALITY

Effective peer review, the consideration of the qualifications of Medical Staff Members and applicants to perform specific procedures, and the evaluation and improvement of the quality of care rendered in Hospital must be based on free and candid discussions. Any breach of confidentiality of the records, discussions, or deliberations of Medical Staff Services or Medical Staff Committees is considered outside of the appropriate standards of conduct for this Medical Staff, disruptive to the operations of the Hospital, and detrimental to quality patient care, treatment, and services. Further, all patient care, treatment, and services records and related activities shall be kept confidential and not be disclosed inappropriately by any Member of the Medical Staff. Any such breach of confidentiality shall be a basis for corrective action under Article V of these Bylaws.

SECTION 11.2: ACTIVITIES AND INFORMATION COVERED

The confidentiality described in this Article shall apply to all acts, communications, reports, or disclosures undertaken in connection with the activities of this or any other health care facility or organization.

SECTION 11.3: IMMUNITY FROM LIABILITY FOR ACTIONS TAKEN AND INFORMATION PROVIDED

Each representative of the Medical Staff and/or Hospital acting pursuant to these Bylaws shall be exempt, to the fullest extent permitted by law, from liability to an applicant or Medical Staff
Member for damages or other relief for any action taken, or statements or recommendations made within the scope of his/her duties, or for providing information concerning any person who is or has been an applicant to or Member of the Staff, or who did or does, exercise clinical privileges or provide services at Hospital.

**SECTION 11.4: INDEMNITY AND DEFENSE**

Hospital shall indemnify and defend Medical Staff Members for their good faith participation in peer review activities within the scope of their duties pursuant to these Bylaws.
ARTICLE XII: BYLAW REVIEW, REVISION AND ADOPTION

SECTION 12.1: CLERICAL ACTIONS

The Medical Executive Committee may make minor corrections and changes to the Bylaws when the correction or change is necessary due to spelling, punctuation, and grammar, or if required by law. No prior notice of such change is required.

SECTION 12.2: BYLAW AMENDMENT PROCESS.

These Bylaws may be amended in the following manner.

A. Amendments to these Bylaws may be proposed by a petition signed by 25% of the voting Members of the Medical Staff, by the Bylaws Committee, or by the Medical Executive Committee. A proposed amendment shall be submitted to the Bylaws Committee of the Medical Staff for review. The Bylaws Committee shall review the proposed amendment and present the same to the Medical Executive Committee at a duly noticed meeting, together with a recommended action regarding the proposed amendment.

B. The Medical Executive Committee shall vote to recommend approval or disapproval of the proposed amendment for further action by the Medical Staff by a vote of a simple majority of the Medical Executive Committee present at a duly noticed meeting.

C. A written ballot then will be sent to all Members of the Medical Staff eligible to vote.

D. If a simple majority of the responses returned indicate a concurrence with the proposed amendment and at least 20% of the Medical Staff eligible to vote returned ballots, then the proposed amendment will be forwarded to the Board of Governors for approval.

E. Amendments shall become effective upon the approval of the Board of Governors.

F. Neither the Board of Governors nor the Medical Executive Committee unilaterally may amend the Medical Staff Bylaws.
ARTICLE XIII: REVIEW, REVISION & ADOPTION OF RULES & REGULATIONS AND POLICIES

The Medical Staff shall adopt Rules & Regulations and Policies as may be necessary for the proper conduct of its work. The Rules & Regulations and Policies may be formulated or amended in the following manner:

SECTION 13.1: CLERICAL ACTIONS.

The Medical Executive Committee may make minor corrections and changes to the Rules & Regulations and Policies when the correction or change is necessary due to spelling, punctuation, and grammar, or if required by law. No prior notice of such change is required.

SECTION 13.2: PROCESS FOR AMENDING RULES AND REGULATIONS.

At any regular meeting of the Medical Executive Committee, any Medical Executive Committee member may propose a new or amended Rule & Regulation or Policy. Notice of all proposed amendments to these documents shall be provided to the voting Members of the Medical Staff at least 14 days prior to the vote by the Medical Executive Committee. Any voting Member may submit written comments on the amendments to the Medical Executive Committee. A simple majority vote of the Medical Executive Committee shall be required to approve a new or amended Rule & Regulation or Policy. Upon approval by the Medical Executive Committee, the proposed Rule & Regulation or Policy shall be forwarded to the Board of Governors with a recommendation for final approval. The new or amended Rule & Regulation or Policy shall become effective upon the approval of the Board of Governors. Neither the Board of Governors nor the Medical Executive Committee unilaterally may amend the Medical Staff Rules & Regulations or Policies. Amendments to Medical Staff Rules & Regulations and Policies also may be proposed by a petition signed by a majority of the voting Members of the Medical Staff. Any such proposed amendments will be reviewed by the Medical Executive Committee, which may comment on the amendments before forwarding the same to the Board of Governors for final action.

SECTION 13.3: URGENT AMENDMENTS TO RULES & REGULATIONS.

The Medical Executive Committee and the Board of Governors shall have the power to adopt provisionally urgent amendments to the Rules & Regulations that are needed in order to comply with a law or regulation without providing prior notice of the proposed amendment to the Medical Staff. Notice of all provisionally adopted amendments shall be provided to each Member of the Medical Staff as soon as possible. The Medical Staff shall have 14 days to review and provide
comments on a provisional amendment to the Medical Executive Committee. If there is not conflict between the Medical Staff and Medical Executive Committee, the provisional amendment shall stand. If there is a conflict over a provisional amendment, then the process for resolving conflicts set forth below shall be implemented.

SECTION 13.4: CONFLICT MANAGEMENT PROCESS.

When there is a conflict between the Medical Staff and the Medical Executive Committee (as evidenced by a petition signed by 25% of the voting Members of the Medical Staff) with regard to proposed amendments to the Medical Staff Rules & Regulations; a new policy proposed by the Medical Executive Committee; or proposed amendments to an existing policy that is under the authority of the Executive Committee, a Conflict Resolution Ad Hoc Committee, consisting of equal numbers of members of the Executive Committee and the members who signed the petition appointed by the Chief of Staff, will be convened. The agenda for that meeting will be limited to the amendment(s) or policy at issue. The purpose of the meeting shall be to resolve the differences that exist with respect to Medical Staff Rules & Regulations or Policies. If the differences cannot be resolved at the meeting, the Medical Executive Committee shall forward its recommendations, along with the proposed recommendations pertaining to the Medical Staff Rules and Regulations or policies offered by the petition, to the Board of Governors for final action. This conflict management section is limited to the matters noted above. It is not to be used to address any other issue, including, but not limited to, professional review actions concerning individual Members of the Medical Staff.

SECTION 13.5: BASIC STEPS AND DETAILS.

The details associated with the following Basic Steps are contained in Medical Staff Rules & Regulations:

A. QUALIFICATIONS FOR APPOINTMENT.

To be eligible to apply for initial appointment or reappointment to the Medical Staff or for the grant of clinical privileges, an applicant must demonstrate appropriate education, training, experience, current clinical competence, professional conduct and ability to safely and competently perform the clinical privileges requested.

B. PROCESS FOR PRIVILEGING.

Complete applications are transmitted to the applicable Department Chief, who prepares a written report to the Credentials & Privileges Committee, which then prepares a
recommendation and forwards it along with the Department Chief’s report to the Medical Executive Committee for review and recommendation and to the Board of Governors for final action.

C. PROCESS FOR CREDENTIALING (APPOINTMENT AND REAPPOINTMENT).

Complete applications are transmitted to the applicable Department Chief, who prepares a written report to the Credentials & Privileges Committee, which then prepares a recommendation and forwards it along with the Department Chief’s report to the Medical Executive Committee for review and recommendation and to the Board of Governors for final action.
ARTICLE XIV: ADOPTION

These Bylaws, when adopted by the Medical Staff as provided in Article XII, shall replace all previous Bylaws of the Medical Staff and shall become effective upon approval and adoption by the Renown South Meadows Medical Center Board of Governors. These Bylaws will be reviewed and/or revised at least once every two years.
APPENDIX A: HISTORY & PHYSICAL EXAMINATIONS

A. History and Physical Examination (H&P) Requirements.

1. A Member will document in the medical record of any patient he or she admits to the Hospital as an inpatient or outpatient (including outpatient surgery or other procedure that places the patient at risk and/or involves the use of sedation or anesthesia) a Complete H&P (defined below) within 24 hours of such admission or registration and prior to a surgery or a procedure requiring anesthesia services. The H&P will conform to the following requirements to ensure quality of care and comply with applicable regulatory requirements and The Joint Commission:

   a. A Member may record an H&P up to thirty (30) days prior to admission to the Hospital as long as he or she, within the first 24 hours after admission or registration and prior to a surgery or a procedure requiring anesthesia or sedation, and/or that places the patient at risk, completes an interval H&P that references the previously-performed H&P, and contains the elements described in Section B, below.

   b. For non-surgical obstetrical patients, a Member may use the entire prenatal record as the history and physical provided he or she performs a focused H&P to reflect the patient's condition upon admission.

   c. H&Ps performed more than 30 days prior to admission are invalid and the Member must perform another H&P.

2. All outpatients registered by the Emergency Department, held for observation, or scheduled for any surgical or invasive procedure not requiring sedation or anesthesia must have a Focused H&P (defined below) documented in the medical record.

3. In addition to the applicable H&P requirements, Members must perform a Pre-Anesthesia Assessment of all patients undergoing sedation or anesthesia care. The assessment must be performed prior to the induction of sedation/anesthesia and may reference data from other assessments.

4. If a patient requires emergency surgery, the Member must complete the H&P as soon as possible after completion of the surgery.
5. **H&P by Practitioner who is not Member of the Medical Staff.**
   
   a. Patients of Allied Health Professionals must have a medical history and physical examination signed by a Member with admitting privileges.
   
   b. Patients of a physician who is not a Member of the Medical Staff must have a medical history and physical examination signed by a Member.

B. **Required Components of History and Physical Examinations.**

1. **Complete H&P.** A complete H&P includes each of the following components, at a minimum:
   
   a. Identifying patient information.
   
   b. Presenting diagnosis/condition (chief complaint/reason for the visit).
   
   c. **Patient History:**
      
      (1) Medical History, including the following:
          
          (a) Current medications and dosages;
          
          (b) Allergies, including drug allergies; and
          
          (c) Significant past medical & surgical history.
      
      (2) Significant family history.
      
      (3) Significant social history.
      
      (4) If a pediatric patient:
          
          (a) Immunizations; and
          
          (b) Neonatal history (if applicable).
   
   d. For surgery or invasive procedure requiring moderate sedation or anesthesia:
      
      (1) Indications; and
      
      (2) Proposed procedures.
   
   e. Physical examination (should include as appropriate an examination of body areas/organ systems):
      
      (1) Vital signs.
(2) Cardiovascular system.
(3) Respiratory systems.
(4) Neurological system.
(5) Gastrointestinal system.
(6) Eye.
(7) Ear, Nose and Throat (ENT).
(8) Genitourinary system.
(9) Musculo-skeletal.
(10) Skin.

f. Results of pertinent diagnostic studies and labs.

g. Assessment.

h. Treatment Plan.

2. Interval H&P. The interval H&P must update any components of the patient’s current medical status, regardless of whether or not there were any changes, and confirm that the necessity for the procedure is still present. The Interval H&P must contain any changes in medical history or physical exam, or a statement indicating that no changes have occurred. For surgical cases, the Interval H&P will confirm the indications for the procedure are still present. In all cases, the Interval H&P will be written in sufficient detail to provide a reasonable picture of the patient’s clinical status since the original Complete H&P.

3. Focused H&P (also known as a “short form” H&P). The Focused H&P should provide the following components, at a minimum:

a. Identifying patient information.

b. Presenting diagnosis/condition (chief complaint/reason for the visit).

c. Patient History:

   (1) Medical History, including the following:

      (a) Current medications and dosages;

      (b) Allergies, including drug allergies; and
(c) Significant past medical & surgical history.

(2) Significant family history.

(3) Significant social history.

d. Indications and proposed procedures for any surgery or invasive procedure.

e. Physical examination as indicated.

f. Results of pertinent diagnostic studies and labs.

g. Assessment.

h. Treatment Plan.

4. **Focused Medical Assessments.** If a patient is undergoing an invasive procedure that does not require anesthesia or sedation, and that does not place the patient at risk, then the Member may record a focused medical assessment prior to the start of the procedure that includes the following components, at a minimum:

a. Identifying patient information.

b. Description of symptoms.

c. Medical History, including the following:

   (1) Current medications and dosages;

   (2) Allergies, including drug allergies; and

   (3) Significant past medical & surgical history.

d. Indications for the procedure.

e. Focused physical exam as indicated.

f. Proposed treatment or procedures.
RULE 1-1 Relationship between the Bylaws and Rules and Regulations

These Medical Staff Rules and Regulations are intended to be consistent with and complement the Medical Staff Bylaws. In the event that any provision in these Rules and Regulations conflicts with any Medical Staff Bylaw, the Bylaw provision shall control. The most current version of the Medical Staff Bylaws and Rules and Regulations is available electronically on the Renown Health website at www.renown.org/medicalstaffservices. A copy of the latest printed version of Medical Staff Bylaws and Rules & Regulations is available upon request from Medical Staff Services.
RULE 1-2 Medical Staff Organization

A. Medical Staff Committees.

1. Medical Executive Committee. The Medical Executive Committee is governed by Bylaw Articles VIII and IX. Additionally, the following provisions shall apply to the Medical Executive Committee:

   a. **Voting.** Only voting members of the Medical Executive Committee may vote. Other attendees shall not be eligible to vote, but may participate in deliberations and discussions during such meetings in the discretion of the chairperson.

   b. **Quorum.** The quorum necessary to conduct business at a Medical Executive Committee meeting shall be those committee members present at a regular or duly noticed special meeting and eligible to vote. At least two such members must be present.

2. Other Committees. Committees other than the Medical Executive Committee are governed by Bylaw Articles VIII and IX, and Rule and Regulation 1-5 (addressing Standing Committees). Additionally, the following provisions shall apply to those Medical Staff committees:

   a. **Membership.** Members of committees shall be assigned by the Chief of Staff as provided in the Bylaws. The Chief of Staff may solicit the input of the committee chairman and Hospital staff when appropriate.

   b. **Meetings.** Medical Staff committees, other than the Medical Executive Committee, shall meet as provided in the Bylaws and subject to the following:

      (1) **Frequency.** Committees will meet at least once each quarter, or as often as necessary to perform their functions. In addition, the chairperson or the Chief of Staff may call a special meeting if deemed necessary.

      (2) **Attendance.** All committee members shall attend meetings. The Chief of Staff may remove committee members who fail to attend meetings.
(3) **Voting.** Members of the Active and Senior Active Staff who are members of the committee are eligible to vote on matters arising at a meeting. Other attendees at meetings shall not be eligible to vote, but may participate in deliberations and discussions during such meetings.

(4) **Quorum.** The quorum necessary to conduct business shall be those committee members present at a regular meeting and eligible to vote, but at least two such members must be present.

B. **Departments and Sections.**

1. **Responsibilities of Departments and Sections.** Each Department and Section is charged with the responsibility for implementing and conducting specific monitoring, review and evaluation activities that contribute to the preservation and improvement of the quality of safe patient care, treatment and services provided by the Department or Section members. To carry out this responsibility, each Department and Section shall participate in the:

   a. Development of Department or Section policies and procedures, including but not limited to the establishment of guidelines for the granting of specific clinical privileges within the Department or Section;

   b. Development of recommendations regarding the need for continuing education programs relevant to the type and nature of services offered by Hospital and the findings of performance improvement activities; and

   c. Overseeing its members’ adherence to

      (1) the Medical Staff Bylaws, Rules and Regulations, Department or Section policies and procedures, and the Bylaws and Policies of the Hospital;

      (2) sound principles of clinical practice; and

      (3) regulations designed to promote patient safety.
2. **Clinical Organization of the Medical Staff.** The Medical Staff will be organized into clinical Departments to which Members are assigned in accordance with the privileges granted. Departments may, as outlined in this Rule, be divided into Sections to facilitate the efficient management of specialties within a Department. Currently, the Medical Staff is divided into the following clinical Departments and Sections:

- Department of Anesthesia
- Department of Cardiology
- Department of Dentistry
- Department of Emergency Medicine
- Department of Family Medicine
- Department of Hospital Medicine
- Department of Medicine
  - Gastroenterology Section
  - PM&R Section
- Department of Neurosurgery
- Department of Obstetrics & Gynecology
- Department of Oncology
- Department of Ophthalmology
- Department of Orthopedics
  - Podiatry Section (Allied Health)
- Department of Otolaryngology
- Department of Pathology
- Department of Pediatrics
- Department of Psychiatry
  - Psychology Section (Allied Health)
- Department of Pulmonary Medicine
- Department of Radiology
  - Radiation Therapy Section
- Department of Surgery
  - Cardiac Surgery Section
  - Plastic Surgery Section
  - Trauma Surgery Section
3. **Leadership of Departments and Sections.**

   a. **Appointment of Department and Section Chiefs.** Each Department and Section will have a Chief appointed by the Chief of Staff with the advice and recommendation of the Department or Section, pursuant to Article VII, Section 7.3(A) of the Bylaws.

   b. **Training.** Following appointment, the Chief of Staff shall ensure that all Department and Section Chiefs receive appropriate training. This training may take different formats, as appropriate for the number of incoming Chiefs. Each Department and Section chief will receive an orientation manual containing key information for execution of his or her responsibilities.

   c. **Duties and Responsibilities of Department and Section Chiefs.** The Department or Section Chief will be responsible to the Chief of Staff for the duties and responsibilities outlined in Article VII, Section 7.3(B) of the Bylaws.

4. **Department and Section Policies.** Departments or Sections may develop appropriate policies and procedures necessary for the effective and proper functioning of the Department or Section, and/or to be routinely administered to patients admitted to that clinical service. If Department or Section policies conflict with Medical Staff Bylaws or Rules and Regulations, the Medical Staff Bylaws and Rules and Regulations shall control. Departments and Sections may develop such policies in the following manner:

   a. At any regular meeting of a Department or Section, a new or amended policy and procedure may be proposed by a Member. Upon approval by a simple majority vote of the voting Members present, written ballots on the proposed new or amended policy and procedure will be mailed to all Department or Section members.
b. If a simple majority of the responses returned indicate a concurrence with the new or amended policy or procedure and at least 20 percent of the Department or Section Members eligible to vote returned ballots, then the matter will be forwarded to the Medical Executive Committee for action pursuant to Medical Staff Bylaw XIII, Section 13.2.

c. The new or amended policy and procedure will become effective upon approval by the Board of Governors.

d. Departments and Sections will review and/or revise any policies and procedures at least once every two (2) years.


Upon request of the Residency Committee, a Department or Section shall collaborate with that Committee and the Hospital to delineate the clinical responsibilities and services of medical students, interns, residents and other physicians in training applicable to the clinical services provided by that Department or Section.

6. Meetings of Departments and Sections.

Each Medical Staff Department and Section shall hold meetings necessary to conduct the business of the Department or Section. Meetings shall be held as provided in Article IX of the Bylaws and in accordance with the directives of the Medical Executive Committee, and are subject to the following:

a. Frequency. Departments and Sections will meet at least once each quarter. Meetings may be held at alternate sites as long as any business transacted at such alternate sites during such meeting is communicated to all members of the applicable Department or Section who do not have privileges at such alternate site.

b. Attendance. All Members of the Staff who are eligible for membership in a particular Department and/or Section based upon the Member’s specialty and/or the policies of the Department
or Section may attend meetings of the Department and/or Section and are encouraged to participate. Members of the Associate Staff are required to attend 50 percent of these meetings as a condition of advancement to the Active Staff.

c. **Voting.** Members of the Active and Senior Active Staff who are members of the Department or Section are eligible to vote on matters arising in the Department or Section. Other attendees at meetings shall not be eligible to vote, but may participate in deliberations and discussions during such meetings.

d. **Quorum.** The quorum necessary to conduct business shall be those Department or Section members present at a regular meeting and eligible to vote, but at least two such members must be present.
RULE 1-3  Conflicts of Interest

A. General Rule.

If a Medical Staff Member who is performing a function outlined in the Medical Staff Bylaws or Rules and Regulations has, or reasonably could be perceived as having, a conflict of interest or a bias in any matter involving another Member, the Member with the real or perceived conflict shall be excused from, and shall not participate in, that portion of the proceeding during which a discussion of or voting on the matter will occur. However, the Member with the real or perceived conflict may be asked, and may answer, any questions concerning the matter before leaving.

B. Determining Existence of a Conflict of Interest.

The evaluation of whether a conflict of interest exists shall be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. The fact that a Member is in the same specialty as a Member whose performance is being reviewed does not automatically create a conflict. No Member has the right to compel a determination that a conflict exists. Furthermore, the fact that a committee member or Medical Staff leader chooses to refrain from participation, or is excused from participation, in a discussion of or vote on a matter shall not be interpreted as a finding of an actual conflict.

C. Raising Issue of Conflict of Interest.

The existence of a potential conflict of interest or bias on the part of any Member may be raised by any Member and directed to the Chief of Staff or applicable Committee Chair or Department/Section Chief. The disclosure of a potential conflict of interest or bias should be made timely to avoid the appearance of any impropriety in the conduct of the affairs of the Medical Staff.
RULE 1-4  Delegation of Functions

When a function is to be carried out by a Member or committee, the Member, or the committee through its chair, may delegate performance of the function to one or more qualified designees.
RULE 1-5  Standing Committees

Rule 1-5.1  Bioethics Committee

A. Statement of Purpose.

The Bioethics Committee ("Committee") will emphasize work in the following areas:

1. Providing an educational resource for Hospital personnel (including physicians), patients and families of seriously ill patients.

2. Recommending institutional guidelines and policies concerning ethical principles in the care of patients.

3. Offering consultation and review on treatment decisions regarding critically or chronically ill patients especially when the foregoing of life-sustaining treatment is being considered.

B. Membership.

The following categories of membership on the Committee shall exist. Each category of membership will appoint its own representative.

1. A minimum of five practicing physicians, one of whom will be chairman.

2. Representative(s) from the Board of Governors.

3. Representative(s) from Hospital Administration.

4. A minimum of three representatives from the Nursing Department.

5. Representative(s) from Chaplain Services.

6. Representative(s) from Social Services.

7. Invited non-voting participants at the pleasure of the Committee.

C. Jurisdiction.

The Bioethics Committee will not supplant other existing means within Hospital for reaching good decisions about the care of critically ill patients. The processes of consultation and review established by the Committee will seek to assure that all decisions or recommendations, whenever possible, have had the benefit of prior appropriate consultations and discussion in patient care conferences. This
is particularly important when there is disagreement between family members and/or health care providers. The clarification provided by such processes may allow resolution on factual grounds of what may have seemed initially to be ethical disputes.

D. Meeting Schedule.

The Committee will meet bi-monthly. Changes to this schedule will be at the discretion of the Committee chairperson.

E. Committee Functions.

1. **Educational Functions.** The Committee will act as a resource to the Hospital staff, to families of patients, and to the community, as feasible, for information on ethical principles involved in medical decision-making, and about issues surrounding the treatment of critically ill patients, and programs for disabled persons and their families. The Committee will publicize itself with the goal that its functions are well-known, including the development of appropriate policies and procedures, and the method of contacting the Committee.

2. **Policy Development Functions.** The Committee will develop and recommend for adoption Hospital-wide policies and guidelines in areas such as:

   a. Decisions to forego life-sustaining treatment;

   b. Resolution of ethical disputes between family members and Hospital staff or between staff Members;

   c. Ability of various persons to consent;

   d. Procedures when a patient is incompetent to consent, and

   e. Other issues that inevitably arise.

In recommending these Policies and guidelines, the Committee will seek out consultation with relevant medical and other authorities with expertise in the area being considered. The Committee also will seek a dialogue with appropriate committees of the Medical Staff to ensure that Committee-recommended policies and guidelines serve to build on
existing Medical Staff Bylaws and Rules and Regulations. When policies and guidelines are approved, the Committee will inform and educate Hospital staff on the policies and guidelines it develops.

3. **Consultative Functions (Concurrent Review).** The Committee desires to achieve an atmosphere of collaborating regarding the difficult decisions about the care of patients in this institution. For this reason, the Committee expects that the majority of review cases will be from voluntary requests. In these cases, the Committee may meet as a whole, or, at the discretion of the Chairman, delegate to certain Committee members, as an ethics consulting team, the responsibility of consulting with the concerned parties. The scope of the Committee's discretionary review will include the following:

   a. The Committees may review the care of a hospitalized patient upon the request of any Member of the Hospital staff, or Member of the patient's immediate family, when a serious ethical issue is presented by a decision about the patient's care.

   b. The Committee may review any case of a hospitalized patient when serious ethical questions about the patient's care have been raised by a public agency. (Example: Child Protective Services, District Courts, Bureau of Health Facilities).

   d. The Committee will not become involved in the emergency management of patients. The Committee supports the right of physicians and families to make joint or independent decisions, depending on the circumstances, in short-term emergency situations.

4. **Consultative Functions (Retrospective Review).** The Committee may work with any Medical Staff Department of Section, or care unit of the Hospital to set up review of specified cases. The Committee will perform such reviews, but only upon request.

5. **Request for Review.** Ordinarily, the attending physician will initiate a request for review, but others may do so. The person requesting the review should contact the Chairman, but may contact other Committee
members if the Chairman is unavailable. The requesting person may also contact Hospital Administration or Nursing Administration, who will, in turn, relay the request to the Chairman.

The Committee will keep all of its actions strictly confidential, and will keep confidential the identity of any person requesting review, so that persons will not be hesitant unnecessarily to request a review.

6. Initial Assessment. The Chairman and/or his/her designee will review the case to determine if it is appropriate for Committee review. An inappropriate case is one which clearly does not raise serious ethical issues. In concurrent cases it may be necessary to contact the family and the attending physician(s) in making such a determination. In retrospective review, an examination of the medical record will suffice.

7. Invited Participants. Where sufficient reason exists for the Committee to consider a case, the Committee may invite those persons with interest in the case to appropriate parts of the meeting, but not necessarily at the same time, including the patient, the family of the patient, attending and consulting physicians, nursing staff, the social worker, the chaplain, the person requesting the meeting, outside experts, and others deemed appropriate.

8. Conduct of the Meeting.
   a. A designated Committee member will present the case from a neutral viewpoint.
   b. The concerned parties will have an opportunity to present their viewpoints, and, if appropriate to the case, to hear the viewpoints of others.
   c. This process will elicit the pertinent facts and clarify the issues raised by the case.
   d. The Committee will then assess the alternative course(s) of treatment proposed or possible, with the objective of facilitating consensus about the interests of the patient. The Committee will seek a collaborative atmosphere in the decision making process,
so that the Committee and those concerned with the case can agree on an appropriate course of action. Every effort will be made to support the dignity and integrity of the patient, the family, and health care providers involved in such decisions, as the interests of the patient are being defined.

9. **Recommendations.** In concurrent cases, the Committee's goal is to achieve consensus. The Committee will recommend a course of action only when agreement cannot be reached between the interested parties and the Committee and when it concludes that one or more of the proposed course(s) of action is (are) based upon clearly unreasonable premises about, or inappropriate evaluation of the interests of the patient. When there continues to be substantive disagreement between the principal parties and the Committee concerning the appropriate course of action, the Committee will report the case to the Hospital Administrator, who will make a determination as to whether to contact Hospital legal counsel, or a community agency with jurisdiction for the follow-up.

Because of the gravity of this step, the Committee establishes the procedure of documenting the degree of consensus about its recommendation through a formal vote, conducted by anonymous written ballot so that each Member is free to vote his or her conclusions free from any possibility of coercion. Only regular Committee Members will be allowed to vote his or her conclusions free from any possibility of coercion. Only regular Committee Members will be allowed to vote. Such formal procedures for identifying Committee recommendations shall be limited to those situations in which a consensus cannot be achieved, and in which Members of the Committee feel the proposed course of action is contrary to the interests of the patient.

The recommendation of the Committee shall be promptly conveyed to the attending physician, who should see that an appropriate notation is made in the patient's record. To avoid misunderstandings, especially in difficult cases, the attending physician may request the notation to be made by a Committee representative.
10. **Reporting and Record Keeping.** The Committee will report its activities on a monthly basis at the regular meetings of the Medical Executive Committee. The Committee shall maintain records of all its deliberations and summary descriptions of specific cases considered and the disposition of those cases. The Committee will approve Committee minutes before they become final. Records will be kept in accordance with applicable Medical Staff Bylaws and Rules and Regulations, including those pertaining to confidentiality and peer review. Whenever a request is made for release of Committee minutes, such request will be forwarded to Hospital legal counsel for determination.

11. **Legal Issues.** The Committee may seek legal advice if required to resolve issues or to assist it in arriving at a consensus ethical recommendation for the patient.
Rule 1-5.2  Bylaws Committee

A. Statement of Purpose.

The Bylaws Committee will prepare and present changes or additions to the Medical Staff Bylaws and Rules & Regulations, and Department and Section policies and procedures. The Committee will review the Bylaws at least every two (2) years and recommend appropriate amendments and changes to the Medical Executive Committee.

B. Meetings and Record Keeping.

This Committee will meet as often as deemed necessary by the chairperson, and will maintain a permanent record of its proceedings and actions.

C. Membership.

The Committee will consist of at least five (5) Members of the Active Staff including the preceding Chief of Staff and the present Chief of Staff. The Chairman will be the Secretary of Staff, if possible.
Rule 1-5.3  Cancer Committee

A. Statement of Purpose.

The Cancer Committee will meet at least quarterly and will concern itself with the entire spectrum of care for cancer patients admitted to Hospital. As an agent of the Medical Executive Committee and the Board of Governors, the Cancer Committee shall be responsible for maintaining optimal quality of cancer care, education, clinical research, the cancer registry, community services, peer review and clinical performance improvement. The Committee monitors and supervises reporting of tumor registry data. The Committee ensures accreditation standards of the ACOS are met. Educational and medical ethical standards are determined and monitored by the Cancer Committee.

B. Reporting and Record Keeping.

The Cancer Committee will maintain permanent records of its proceedings and report of its proceedings and report regularly to Medical Executive Committee.

C. Membership.

Members of the Committee will include representatives from the Active Staff in the following specialties: Surgery, Medical Oncology, Radiation Oncology, Pathology and Radiology, as well as Members from Urology, Gastroenterology, Pulmonology, General Surgery and Gynecology. Additionally, the ACOS Physician Liaison must be a member of this Committee. Multidisciplinary staff from the Cancer Registry, Social Services, Quality Services, Nursing, Pharmacy and Administration will also be available to facilitate communication between the Hospital and Medical Staff.
Rule 1-5.4 Continuing Medical Education Committee

A. Statement of Purpose.

The CME Committee will evaluate and promote improvement of the overall quality of care at Hospital by providing continuing education for Medical Staff. This includes evaluating requests for CME accreditation and proposing topics for education based on the results of performance improvement projects or recommendations made to the Committee. The Committee also will assist Administration in the prioritization of resources directed toward physician education.

B. Membership.

The Committee will be composed of at least five physicians on the Active Staff. Hospital personnel, including representatives from quality services, education and the medical library, may be invited to attend to facilitate communication between the Medical Staff and Administration.
Rule 1-5.5 Credentials and Privileges Committee

A. Statement of Purpose.

The Committee will be responsible for the review of the credentials of all Applicants for initial appointment and Members for reappointment, investigation and interviews of Applicants and Members as may be necessary, and for the review of requests for new or revised clinical privileges. The Committee also will recommend such Rules and Regulations as are necessary to facilitate the consideration of applications to the Medical Staff and for clinical privileges.

The Credentials & Privileges Committee will receive the recommendations for such application and privileges from the Departments and Sections in which the individual has privileges and make a recommendation to the Medical Executive Committee, as provided in Part 2 of the Rules and Regulations.

B. Membership.

The Committee will consist of at least five Members of the Active Staff appointed to serve up to a five-year term. These members shall be selected from among past officers and Department or Section Chiefs, or others experienced in leadership roles. The chairman, if possible, will be the Vice Chief of Staff.
Rule 1-5.6  Critical Care Committee

A.  Statement of Purpose.

The purpose of the Committee is to oversee and monitor the performance and quality of care provided to critical care patients from a multi-disciplinary perspective. The Committee’s functions will include:

1. Review of monthly performance improvement data relating to critical care patients,

2. Development and recommendation of policies & procedures relating to the care of critical care patients throughout the Hospital; and

3. Review of local, state and national developments, which affect critical care.

B.  Meetings, Record Keeping and Reporting.

The Committee will meet at least quarterly and maintain a permanent record of its proceedings and actions, and report to the Medical Executive Committee on a regular basis.

C.  Membership.

The Committee will consist of Members of the Active Staff from the following departments generally representing the following Departments and Sections: ICU, radiology, emergency medicine, pediatrics intensive care, cardiac intensive care, trauma, pathology and the intensive care nursery. Hospital personnel, particularly from Quality Services, Emergency Room, Nursing, Cardiovascular Services and Surgery, will be available to the Committee to facilitate communication.
Rule 1-5.7  Infection Control Committee

A. Statement of Purpose.

The purpose of the Infection Control Committee includes the following activities:

1. Review new infection control policies and/or changes in established Policies.

2. Review surveillance data and recommend intervention strategies for identified problems or special studies as necessary.

3. Direct appropriate departments, committees or individuals to investigate infection control problems.

4. Direct appropriate departments, committees or individuals to implement corrective action. The results of that action are analyzed in committee to assure resolution of the problem.

B. Membership.

Members of the Committee will include Active Staff representatives from the following specialties (if possible): Infectious Disease, Pathology, Surgery, OB and Emergency Medicine. Multidisciplinary staff from Quality Services, Environmental Services, Maintenance and Central Processing will also be available to facilitate communication between the Hospital and Medical Staff. The Chairman may also see fit to invite the Washoe County Health Department or other individuals or groups relevant to the topic being discussed at any meeting.
Rule 1-5.8 Institutional Review Board

A. Statement of Purpose.

The IRB will meet as needed to review and approve modalities and research protocols such as drugs, devices or procedures. All such modalities will be reviewed by this IRB prior to utilization within the Hospital to assure appropriate rationale, procedure, safety and supporting evidence of usefulness. This IRB will maintain a permanent record of its proceedings and actions and will report to the Medical Executive Committee.

B. Membership.

The IRB will consist of at least five (5) and not more than fifteen (15) members comprised of a diverse group (based upon race, gender, cultural backgrounds, and community attitudes) and consisting of the following:

1. Chairperson. The Chairperson will be appointed by the Chief of Staff, with concurrence by the Hospital Administrator, for a two-year term. The Chairperson may serve more than one (1) term. The Chairperson will be selected in consideration of the following:
   a. Expressed an interest in the position;
   b. Previously participated on an IRB;
   c. Documented knowledge of, and experience in, medical research and methodology (MD, PhD, or PharmD preferred); and
   d. Supported by written professional references.

   To enhance the transition in leadership, it is desirable that the immediate-past Chairperson remain a member on the IRB for at least one additional year after the end of his or her term.

2. Vice-Chairperson. At the discretion of the Chairperson, a Vice-Chairperson may be nominated and approved by majority vote of the IRB in consideration of the same criteria as the Chairperson. The Vice-Chairperson shall, in the absence of the Chairperson, assume all of his or her duties and exercise all of his or her authority. The term of the Vice-Chairperson will run concurrently with that of the Chairperson.
3. **Members-at-Large.** The remaining members of the IRB shall represent the following:
   
a. At least one person whose concerns are in a non-scientific area (such as clergy, legal profession, social services).
   
b. At least one member of the community who is unaffiliated with the institution directly or through an immediate family member.
   
   **Note:** Requirements a. and b. may be met by a single individual.
   
c. Pharmacy.
   
d. At least three (3) members of the Active Medical Staff representing at least three different medical specialties.

C. **Selection and Term.**

Members-at-large will be nominated by the Chairperson from the categories described above and approved by a majority vote of then-current IRB members. Members-at-large shall serve a term of four (4) years, and may serve for additional terms. Members-at-large shall serve on a revolving basis so that no more than one-third are replaced at one time. Each Committee member will be oriented by the Chairperson of his/her designee. The Chairperson will be responsible for keeping members informed of changes in federal and local policies, and for recommending continuing education to the membership.

D. **Payment to IRB Members.**

Federal regulations do not preclude a member from being compensated for services rendered or for reasonable expenses incurred (such as continuing education and travel costs). However, IRB members may not receive any compensation related to or contingent upon making specific decisions.

E. **Alternate Members.**

The IRB may appoint alternate members to serve in the place of regular members in order to satisfy voting and quorum requirements. Ad hoc substitutes for members will not be allowed. To ensure an appropriate quorum, an alternate's qualifications should be comparable to that of the designated member on whose behalf he or she is serving. To accomplish that objective, the official
membership roster will identify the regular member(s) for whom each alternate member may substitute. The alternate member must receive and review in advance the relevant material that the regular member would have received. The IRB minutes will document alternates replacing regular members.

E. Consultants.

At the discretion of the IRB Chairperson, Consultants may attend in place of an absent member to gather information for that member. Additionally, the IRB may, in its discretion, invite individuals with competence in special areas to assist in the review of issues which require expertise beyond that available on the IRB, including written recommendations from other WHS committees or departments that might be affected by a proposed protocol. Consultants may not be counted in determining a quorum, and may not participate in either deliberation or voting on matters before the IRB.

F. Removal.

Any member may be removed by the Chairperson for unprofessional conduct, breach of confidentiality, inappropriate behavior, or lack of consistent attendance. The Chairperson may be removed only by the Chief of Staff, with concurrence of the Hospital Administrator, for unprofessional conduct, breach of confidentiality, inappropriate or delayed responses to submitted protocols or protocol violations, noncompliance with these Policies & Procedures, or violation of federal regulations.

G. Liability.

Hospital shall provide liability coverage for IRB members in an amount equal to that required of Active Members of the Medical Staff.
Rule 1-5.9 Nominating Committee

A. Statement of Purpose.

The Committee shall nominate Active or Senior Active Members of the Medical Staff for open positions as officers and Medical Executive Committee Members-at-Large ("elected positions") of the Medical Staff.

B. Duties.

1. On or before July 1 of each odd-numbered year, the Chief of Staff shall appoint the members of the Committee, as detailed in Section C, below.

2. The Committee shall submit at least one name for each office of eligible Medical Staff Members qualified and willing to serve.

3. Following their appointment, the Nominating Committee will solicit input from the Medical Staff regarding nominations for open elected positions. Any Active or Senior Active Member may be nominated for an elected position if, on or before October 1, the following occurs:
   a. he or she receives general nominations from at least five (5) percent of the Active and Senior Active Staff; or
   b. the Nominating Committee nominates him or her for an elected position; and
   c. the Member nominated confirms, in writing, to the Nominating Committee that he or she is willing to serve in the elected position if elected.

4. Following the closure of nominations on October 1 and before October 15 of each odd-numbered year, the Nominating Committee will review the list of nominees against the qualifications and requirements of Article VI, Sections 6.1(B)(1) and 6.2(B) of the Bylaws.

5. On or before November 1 of each odd-numbered year, the Nominating Committee will hold a final meeting to review and finalize the list of nominees. The Hospital’s CEO shall be invited to participate in this final meeting to provide relevant input on any or all nominees. All nominees on the final list shall be placed on the ballot.
6. Following the final meeting of the Nominating Committee, ballots will be mailed and/or e-mailed to all Active and Senior Active Members of the Medical Staff. Alternatively, the Medical Staff may provide an online voting mechanism for Members to vote for candidates and provide notice of such mechanism and directions for its use to all voting Members via mail and/or e-mail.

7. Two weeks will be allowed for voting Members to return their ballots to Medical Staff Services or go online and vote (if such a mechanism is provided).

8. Results of the election shall be announced at the Annual Medical Staff Function, or in such other manner as may be determined by the Medical Executive Committee.

C. Membership.

The Nominating Committee is comprised of five Active Staff and Senior Active Staff Members appointed by the Chief of Staff, and the immediate past Chief of Staff. The immediate past Chief of Staff shall chair the Committee.
Rule 1-5.10 Operating Room Committee

A. Statement of Purpose.

General duties of the Operating Room Committee shall be to consider, recommend and implement actions relative to professional matters, Medical Staff Rules and Regulations, relevant Department and Section policies, and proper utilization of operating room services. Specifically, such duties shall include, but need not be limited to, the following:

1. Routinely review reserved line utilization, turnover and delay reports and allocate operative block time based on historical data.

2. Study the professional delivery of peri-operative and operative patient care and recommend policies for such units and services as required to promote positive patient outcomes.

3. Define a general taxonomy of operative cases for use in prioritizing emergent versus urgent elective procedures.

4. Enforce Medical Staff Rules and Regulations and Department and Section policies for surgical care and recommend appropriate action to the Chief of Staff and/or Department or Section Chief when violations are identified.

5. Establish, periodically review, and revise Medical Staff Rules and Regulations and Department and Section policies regarding surgical care and utilization of surgical services.

6. Review surgical practice questions involving professional judgment and refer to specific department or committee for appropriate action.

7. Identify problems regarding operating room policies and procedures and develop corrective solutions.

8. Engage in strategic planning in order to achieve anticipated future goals in regard to the efficient delivery of operative services.

9. Mediate problems of a professional nature between Members of the surgical staff and Hospital employees.
B. Membership.

The Committee will consist of at least five (5) Members of the Active Staff, broadly representing the surgical specialties and anesthesia. Hospital personnel, particularly from Surgical Services and Administration, will be available to the Committee to facilitate communication.
Rule 1-5.11 Pharmacy & Therapeutics Committee

A. Statement of Purpose.

The Committee will be responsible for the surveillance of pharmacy and therapeutic policies and practices within the Hospital to assure optimum utilization with minimum potential hazard. A formulary will be maintained and reviewed by this Committee. This Committee will also function as an advisory committee in the use of extraordinary or investigative drugs, investigative adverse drug reactions and serve in an advisory capacity to the Staff on all matters relating to the use of drugs.

B. Meetings, Record Keeping and Reporting.

The Committee will meet at least quarterly and maintain a permanent record of its proceeds and actions, and report to the Medical Executive Committee on a regular basis.

C. Membership.

The Committee will consist of at least five Members of the Active Staff. Hospital personnel, particularly from Pharmacy, Nursing Departments and Administration, will be available to the Committee to facilitate communication.
Rule 1-5.12  Quality Management Committee

A. Statement of Purpose.

As an agent of the Medical Executive Committee and the Board of Governors, this Committee shall be responsible for the promotion of optimal quality of care and clinical performance improvement. The Committee also will make recommendations to correct identified problems. In the performance of these duties, the Committee will review clinical performance, resource utilization and documentation processes that impact patient care (such as medical records).

B. Meetings, Record Keeping and Reporting.

The Secretary of the Medical Staff shall serve as the Committee chairperson. The Committee will maintain permanent records of its proceedings and report to the Medical Executive Committee regularly.

C. Membership.

The Committee will include approximately 10 Members of the Active and/or Senior Active Staff appointed by the Chief of Staff. The Chief of Staff may appoint members of the Associate Staff in a non-voting capacity. In addition, the Chief of Staff will request representation from Administration, Quality Services, Utilization Management, Medical Records and Medical Staff Services. Hospital personnel also will be available to the Committee at the request of the Chairman. These individuals will facilitate communication between the Hospital staff and the Medical Staff. The Chairman of the Committee may excuse these individuals if sensitive topics are discussed which do not require staff input.
Rule 1-5.13 Residency Committee

A. Statement of Purpose.

The Residency Committee will be responsible for the review of Residency practices that impact the quality of care at Hospital. These issues include, but are not limited to, the supervision of residents and their interface with private Medical Staff in the delivery of care, assuring that each participant in a professional graduate education program is supervised in his/her patient care responsibilities by an LIP(s) who has been granted clinical privileges through the Medical Staff process.

B. Membership.

The Committee will consist of the Residency Directors and Members of the Active Staff, as well as representatives from Administration and Nursing Administration.

C. Responsibility.

The Residency Committee will be responsible to the Medical Staff Medical Executive Committee. Minutes of meetings will be copied to the Medical Executive Committee for review.

D. Responsibility.

The Residency Committee will meet quarterly, or as deemed appropriate by the Committee Chairman. The Clinical Competency Committees will report annually to the Resident Supervision Committee regarding resident performance and promotions.

E. Resident Supervision.

The Policies of resident supervision will be routinely reviewed by the Residency Supervision Committee of the Medical Staff. This Committee will recommend any necessary changes to the Medical Executive Committee for approval. Approved Policies will reside in the Housestaff Guide. Medical Staff Members have the option of not participating in the teaching program without jeopardizing their privileges.
Rule 1-5.14 Trauma Committee

A. Statement of Purpose.

The purpose of the Committee is to oversee and monitor the performance and quality of care provided to trauma patients managed by the trauma service from a multi-disciplinary perspective. The Committee's functions will include:

1. Review of monthly QA reports on preventable deaths, complications, return to the O.R., etc.;
2. Review of the financial performance of trauma services;
3. Review of pre-hospital performance data;
4. Review of selected cases, which typify program strengths and weaknesses;
5. Review of local, state and national developments which affect trauma; and
6. Review of hospital sponsored community education activities related to trauma.

B. Meetings, Record Keeping and Reporting.

This Committee will meet at least quarterly and maintain a permanent record of its proceeds and actions, and report to the Medical Executive Committee on a regular basis.

C. Membership.

The Committee, at a minimum, will consist of Members of the Active Staff from the following departments: anesthesiology, neurosurgery, orthopedic surgery, pathology, radiology, pediatric intensive care, and emergency medicine. Hospital personnel, particularly from Trauma Services, Administration/Nursing, the Emergency Department, ICU, OR and Pediatric ICU, will be available to the Committee to facilitate communication.
Rule 1-5.15  Physician-Administration Advisory Council

A. Statement of Purpose.

The purpose of this Committee is to create an informal setting for Members of the Medical Staff and Administration to discuss issues of mutual concern including, but not limited to, quality, peer review, Hospital operations, reduction of bureaucracy, improved negotiation success between Medical Staff and Administration, and leadership development/motivation.

B. Membership.

Members of the Committee will include the three Medical Staff Officers and an additional physician, appointed by the Chief of Staff. Administrative members of the Committee will include the Renown Health President/CEO, the Hospital CEO, the Hospital COO, and one other member from Administration appointed by the President/CEO.

C. Reporting.

This Committee will not report formally to any other body. Members will be responsible for forwarding information from the Committee to appropriate bodies as needed.
RULE 2-1 Initial Application for Membership and Appointment to the Medical Staff

A. Basic Qualifications for Appointment to the Medical Staff.

Every Applicant seeking appointment to the Medical Staff must meet the following basic qualifications:

1. The Applicant maintains, or plans to maintain, an office location sufficiently close to Hospital to provide continuous patient care as defined by the department to which the Applicant is applying. This provision does not apply to Non-Resident Specialist, Ambulatory, or Rural Affiliated Staff.

2. The Applicant actively has practiced for 18 of the last 24 months or has met the applicable departmental requirement and as approved by the Credentials & Privileges Committee and the Medical Executive Committee.

3. The Applicant actively has practiced in an accredited hospital for 2 of the last 5 years.

4. The Applicant has completed satisfactorily an ACGME- or AOA-approved postgraduate residency training program (applicable to those applying after the date of the adoption of this Policy). Dentists must be graduates of a school accredited by the Council of Dental Education by the American Dental Association.

5. The Applicant must provide proof of:
   a. a current license to practice in Nevada, or be scheduled to take the next exam offered by the applicable licensing body;
   b. a current federal DEA registration;
   c. professional liability insurance coverage of at least $1,000,000/$3,000,000;
   d. certification in their primary area of practice at the Hospital by the appropriate specialty/subspecialty board of the ABMS, the AOA, or the American Board of Oral and Maxillofacial Surgery. Those applicants who are not board certified at the time of application but who have completed their residency or fellowship training within the last five years shall be eligible for Medical Staff appointment.
However, in order to remain eligible for reappointment to remain on the Medical Staff, those applicants must achieve board certification in their primary area of practice within five (5) years from the date of completion of their residency or fellowship training. (This requirement is applicable only to those individuals who apply for initial staff appointment after January 2006):

e. to the extent required by the applicable specialty/subspecialty board, satisfaction of recertification requirements. (Recertification will be assessed at reappointment.)

6. The Applicant previously has not been:

a. convicted of Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse;

b. excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care program; or

c. convicted of (including the entry of a plea of guilty or no contest to) any felony; or to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, or violence.

B. Application Process.

1. **Initial Review of Application by Medical Staff Services.** Upon receipt of a Medical Staff Application submitted by an Applicant requesting appointment to the Medical Staff, and prior to processing of the application, Medical Staff Services shall perform an initial review to ensure that the applicant has completed the application and meets the basic qualifications to be appointed to the Medical Staff. An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied (including adequate responses from references), and the Applicant has signed the application and certified that he or she is able to perform the privileges requested and the responsibilities of appointment to the Medical Staff. An application will be forwarded for processing except in the following circumstances:
a. **Incomplete Application.** An incomplete application that is submitted will not be processed. Medical Staff Services will notify the Applicant that the application is incomplete. The Applicant shall provide all missing information within 30 days from the date of notification. If the Applicant fails to provide the information necessary to complete the application within such time period, the application will be deemed withdrawn.

b. **Applicant who does not Meet Basic Qualifications.** If an Applicant does not meet the basic qualifications for appointment to the Medical Staff, Medical Staff Services will notify the Applicant that the basic qualifications have not been met and that the application will not be considered. In such instances, the Applicant shall have those rights provided in Article III, Section 3.1 of the Medical Staff Bylaws.

2. **Processing the Application.** Upon completion of the initial review of the application, Medical Staff Services shall commence processing of the application by gathering and verifying relevant information provided by the Applicant or other sources, and confirming that all references and other information or materials deemed pertinent have been received.

a. **Applicant's Burden.** The Applicant shall have the burden of providing accurate and adequate information for proper evaluation of his or her education, training, experience, demonstrated competence, ability to perform the privileges requested and all other qualifications, as well as providing evidence that all statements made and information contained in the application are accurate. The information requested shall include, but not be limited to, the following:

   (1) information regarding any voluntarily or involuntarily relinquishment, withdrawal, probationary or conditional status, denial, revocation, suspension, limitation, termination, non-renewal, investigation, or reduction of, or
challenges to, the Applicant’s medical staff privileges at any other hospital or health care facility;

(2) information regarding any voluntarily or involuntarily suspension, modification, termination, restriction, investigator or relinquishment of, or challenge to, the Applicant’s license to practice any relevant profession in any state, his or her DEA registration, or any state-issued controlled substance license;

(3) information concerning the Applicant’s professional liability experience, including past and pending claims, final judgments, or settlements; the substance of the allegations involved in those matters, as well as the findings and ultimate disposition of each such claim or case; and any additional information concerning such proceedings or actions as the Credentials & Privileges Committee, the Medical Executive Committee, or the Board may request; and

(4) current information regarding the Applicant’s ability to safely and competently exercise the clinical privileges requested.

b. National Practitioner Data Bank Report. As part of the application process, Medical Staff Services shall obtain a report from the National Practitioner Data Bank, as prescribed by the Health Care Quality Improvement Act.

c. Additional Information Required. If, during the processing of the application, the Medical Staff and/or Medical Staff Services determine that additional or clarifying information is required, then the Applicant shall be notified that further processing will be delayed pending receipt of such information. The Applicant shall provide the additional or clarifying information within 30 days from the date of notification. If the Applicant fails to provide the
information necessary to complete the application within such time period, the application will be deemed withdrawn.

d. Misrepresentations and Omissions in Application. If the Medical Staff determines that an Applicant has provided information containing significant misrepresentations or omissions, the Medical Staff may stop processing the application and deem it to be withdrawn by the Applicant.

4. Forwarding Application for Review and Approval. Upon satisfactory completion of processing, Medical Staff Services shall forward the application to the appropriate Department and/or Section chief, as applicable, for review and approval as provided in part C of this Rule, below.

C. Review and Approval of Application.

Upon completion of the processing of the application by Medical Staff Services, the following review and approval process shall be followed.

1. Department/Section Review and Approval. The application will be reviewed by the Section Chief (if applicable) and the Department Chief. The Department and/or Section Chiefs will review the application and privilege delineation request and make a recommendation on the Applicant's ability to perform the privileges requested based upon his or her education, training and experience. The Department and/or Section Chiefs will take the following action on the application:
   a. Recommend the approval of the application and request for privileges by signing the application, and forward the application, together with any additional comments, to the Credentials & Privileges Committee for review.
   b. Recommend the denial of the application and request for privileges, and forwarding the application to the Credentials & Privileges Committee for review.

2. Review and Approval by the Credentials & Privileges Committee.
a. **Determination of Qualification for Appointment.** The Credentials & Privileges Committee will determine whether the Applicant is qualified for appointment to the Medical Staff and the requested privileges based upon all information reasonably available, including, but not limited to, the application and request for privileges, and the recommendation(s) from the Department and/or Section Chiefs.

b. **Questions regarding Applicant’s Ability to Perform.** If the Credentials & Privileges Committee determines that the Applicant otherwise is qualified for appointment to the Medical Staff and requested privileges, the Credentials & Privileges Committee then shall determine if any question exists regarding the Applicant’s ability to perform responsibilities of appointment and the privileges requested. If such a question exists, the Credentials & Privileges Committee may require that the applicant undergo a physical and/or mental examination by a physician (or physicians) satisfactory to the Credentials & Privileges Committee. The results of this examination shall be made available to the Committee for its consideration. If an Applicant fails or refuses to undergo an examination within a reasonable time after being requested to do so in writing by the Credentials & Privileges Committee, the Applicant shall be deemed to have voluntarily withdrawn the application from further consideration by the Medical Staff, and all review and approval activities shall cease.

c. **Recommendations to Medical Executive Committee.** Upon completion of its review, the Credentials & Privileges Committee may take one of the following actions:

   (1) Recommend that the Medical Executive Committee approve the application without conditions;

   (2) Recommend that the Medical Executive Committee approve the application, and the Applicant’s membership
on the Medical Staff, subject to the imposition of specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring, etc.). The Credentials & Privileges Committee also may recommend that appointment be granted for a period of less than two years in order to permit closer monitoring of an Applicant's compliance with any conditions imposed.

(3) Recommend that the Medical Executive Committee deny the application.

d. If the recommendation of the Credentials & Privileges Committee is delayed longer than 60 days, the Chairman of the Credentials & Privileges Committee shall send a letter to the applicant, with a copy to the Chief Executive Officer, explaining the reasons for the delay.

3. **Review and Approval by the Medical Executive Committee.**

a. The Medical Executive Committee will determine whether an the Applicant is qualified for appointment to the Medical Staff and the requested privileges based upon all information reasonably available, including, but not limited to, the application and request for privileges, and the recommendation(s) from the Department and/or Section Chiefs. If the Credentials & Privileges Committee determines that the Applicant otherwise is qualified for appointment to the Medical Staff and requested privileges, the Credentials & Privileges Committee then shall determine if any question exists regarding the Applicant's ability to perform responsibilities of appointment and the privileges requested. If such a question exists, the Credentials & Privileges Committee may require that the applicant undergo a physical and/or mental examination by a physician (or physicians) satisfactory to the Credentials & Privileges Committee. The results of this
examination shall be made available to the Committee for its consideration. If an Applicant fails or refuses to undergo an examination within a reasonable time after being requested to do so in writing by the Credentials & Privileges Committee, the Applicant shall be deemed to have voluntarily withdrawn the application from further consideration by the Medical Staff, and all review and approval activities shall cease.

b. Recommendations to the Board of Governors. Upon completion of its review, the Medical Executive Committee will make a recommendation to the Board of Governors that the application and request for privileges be accepted, deferred, made subject to certain delineated conditions, or denied. Any recommendation that the application be approved subject to certain delineated conditions related to privileges will be transmitted to the Board of Governors. Where a recommendation is made to defer the application for further consideration or additional investigation, the Medical Executive Committee will make a recommendation to the Board of Governors within two months. If the recommendation of the Medical Executive Committee would entitle the applicant to request a hearing pursuant to Article V of the Bylaws, the Medical Executive Committee shall forward its recommendation to the Chief Executive Officer, who shall promptly send special notice of such recommendation to the Applicant. The Chief Executive Officer shall hold the application until the applicant has exhausted his or her rights under Article V.

4. Review and Approval by the Board of Governors.

Upon receipt of a recommendation for action on an application for Medical Staff membership, the Board of Governors may:

a. Accept the recommendation of the Medical Executive Committee and approve the application for membership, with or without conditions;
b. Refer the application back to the Medical Executive Committee for further consideration together with a statement of the reasons for taking such action;

c. Table the application if it determines that additional information is required to formulate a decision; or

d. Deny the application.

If the Board of Governors rejects a recommendation to approve the application from the Medical Executive Committee, it should first discuss the matter with the Chairman of the Credentials & Privileges Committee and the Chairman of the Medical Executive Committee. If the determination of the Board of Governors remains unfavorable to the Applicant, the Chief Executive Officer shall promptly send special notice of such determination to the Applicant so that the Applicant may exercise his Article V rights. The Chief Executive Officer shall hold the application until the Applicant has exhausted his or her rights under Article V.

D. Final Action on Application.

The Applicant shall be appointed as a Member of the Medical Staff upon approval by the Board of Governors. The Applicant will be apprised of his/her mentor, as well as such Rules and Regulations, policies and other requirements that may be of immediate interest. This decision will be transmitted in writing to the Applicant.

E. Applicable Time Periods.

1. Application Form. The Applicant must apply on the current application form in use by the Medical Staff, or may use the previous application form if it is received within 30 days of the institution of the new application form.

2. Verification Process. All responses to inquiries seeking verification of information must be received no more than 5 months from the date of the Applicant's signature on the application.

3. Entire Process. The entire application process should be completed within six (6) months from the date on which Medical Staff Services
completes its initial review of the application through the final action by the Board of Governors. This time period is intended to be a guideline only and shall not confer any rights on the Applicant in the event that the entire process takes more than 6 months.
RULE 2-2 Reappointment to the Medical Staff

A. Requirements for Reappointment to the Medical Staff.

Every Member seeking reappointment to the Medical Staff and a renewal of clinical privileges must satisfy the following:

1. The Member must meet all terms, conditions and eligibility requirements applicable to new Applicants, as detailed in Rule 2-1;

2. During their previous term of appointment, the Member must have completed:
   a. all medical records; and
   b. all continuing medical education requirements;

3. The Member must have satisfied all Medical Staff responsibilities, including the payment of dues (if any), fines and assessments;

4. The Member must have had a sufficient number of patient contacts in the Hospital to enable the assessment of current clinical competence and judgment for the privileges requested. Any Member seeking reappointment who has minimal patient activity at the Hospital must submit such information as may be requested by the Medical Staff (e.g., a copy of his or her confidential quality profile from his or her primary hospital, clinical information from his or her office, and/or a quality profile from a managed care organization) before the application for reappointment will be deemed complete for processing by Medical Staff Services.

B. Factors for Evaluation.

Throughout the reappointment application process, the Medical Staff reviewers and Board of Governors will evaluate the following factors in determining whether to reappoint a Member to the Medical Staff:

1. The Member’s current clinical competence, judgment and technical skill in the treatment of patients, including the ability to safely and competently exercise the clinical privileges requested;

2. The Member’s compliance with the Medical Staff Bylaws and Rules and Regulations, as well as clinical and Hospital Policies and Procedures;
3. The Member’s ability to perform the responsibilities of Medical Staff appointment and participation in Medical Staff duties, including committee assignments and emergency call;

4. The Member’s behavior at the Hospital, including cooperation with the Medical Staff and Hospital staff to:
   a. provide quality patient care; and
   b. maintain the orderly operation of the Hospital; and
   c. resolve patient, Medical Staff and Hospital staff complaints in an appropriate and timely manner; and

5. Such other reasonable factors that evidence the continuing qualifications of the Member to serve on the Medical Staff.

C. Application Process.

1. Initial Review of Application by Medical Staff Services. Upon receipt of an application for reappointment to the Medical Staff, and prior to processing of the application, Medical Staff Services shall perform an initial review to ensure that the Member has completed the application and meets the requirements for reappointment to the Medical Staff. An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied (including adequate responses from references), and the Member has signed the application and certified that he or she is able to perform the privileges requested and the responsibilities of appointment to the Medical Staff. An application will be forwarded for processing except in the following circumstances:
   a. Incomplete Application. An incomplete application that is submitted will not be processed. Medical Staff Services will notify the Member that the application is incomplete. The Member shall provide all missing information within 30 days from the date of notification. If the Member fails to provide the information necessary to complete the application within such time period, the application will be deemed withdrawn.
b. **Applicant who does not Meet Requirements for Reappointment.** If an Applicant does not meet the requirements for reappointment to the Medical Staff, Medical Staff Services will notify the Applicant that the requirements have not been met and that the application will not be considered. In such instances, the Member shall have those rights provided in Article III, Section 3.1 of the Medical Staff Bylaws.

2. **Processing the Application.** Upon completion of the initial review of the application, Medical Staff Services shall commence processing of the application by gathering and verifying relevant information provided by the Member or other sources, and confirming that all references and other information or materials deemed pertinent have been received.

   a. **Member's Burden.** The Member’s burden shall be the same as that for initial applicants to the Medical Staff, as provided in Rule 1-1.

   b. **National Practitioner Data Bank Report.** As part of the application process, Medical Staff Services shall obtain a report from the National Practitioner Data Bank, as prescribed by the Health Care Quality Improvement Act.

   c. **Additional Information Required.** If, during the processing of the application, the Medical Staff and/or Medical Staff Services determine that additional or clarifying information is required, then the Member shall be notified that further processing will be delayed pending receipt of such information. The Member shall provide the additional or clarifying information within 30 days from the date of notification. If the Member fails to provide the information necessary to complete the application within such time period, the application will be deemed withdrawn.

   d. **Misrepresentations and Omissions in Application.** If the Medical Staff determines that a Member has provided information containing significant misrepresentations or omissions, the
Medical Staff may stop processing the application and deem it to be withdrawn by the Member.

4. **Forwarding Application for Review and Approval.** Upon satisfactory completion of processing, Medical Staff Services shall forward the application to the appropriate Department and/or Section chief, as applicable, for review and approval as provided in part D of this Rule, below.

D. **Review and Approval of Application.**

Upon completion of the processing of the application by Medical Staff Services, the following review and approval process shall be followed.

1. **Department/Section Review and Approval.** The application will be reviewed by the Section Chief (if applicable) and the Department Chief, who will make a recommendation on the Member's application as follows:
   a. Recommend approval of the application for reappointment and request for privileges by signing the application, and forward the application, together with any additional comments, to the Credentials & Privileges Committee for review. Such a recommendation will serve as a peer recommendation as well.
   b. Recommend the denial of the application for reappointment and request for privileges, and forward the application to the Credentials & Privileges Committee for review.

2. **Review and Approval by the Credentials & Privileges Committee.**
   a. The Credentials & Privileges Committee will review the application for reappointment and request for privileges to determine whether an the Member meets the requirements for reappointment to the Medical Staff and the requested privileges. If the Credentials & Privileges Committee intends to make a recommendation either denying reappointment or reducing clinical privileges of a Member, the chairman of the Credentials & Privileges Committee may notify the Member of the general tenor of the possible recommendation and invite the Member to an informal meeting to discuss, explain,
or refute the information supporting the recommendation. This meeting does not constitute a hearing under Article V of the Bylaws. In making its final recommendation to the Medical Executive Committee, the Credentials & Privileges Committee shall indicate in its report whether such a meeting occurred and include a summary of the meeting with its minutes.

b. The Credentials & Privileges Committee shall make a recommendation on the Member's application as follows:

(1) Recommend that the Medical Executive Committee approve the application, with or without conditions;

(2) Recommend that the Medical Executive Committee deny the application.

3. **Review and Approval by the Medical Executive Committee.**

a. The Medical Executive Committee will review the application for reappointment and request for privileges to determine whether an the Member meets the requirements for reappointment to the Medical Staff and the requested privileges. If the Medical Executive Committee intends to make a recommendation either denying reappointment or reducing clinical privileges of a Member, the chairman of the Medical Executive Committee may notify the Member of the general tenor of the possible recommendation and invite the Member to an informal meeting to discuss, explain, or refute the information supporting the recommendation. This meeting does not constitute a hearing under Article V of the Bylaws. In making its final recommendation to the Board of Governors, the Medical Executive Committee shall indicate in its report whether such a meeting occurred and include a summary of the meeting with its minutes.

b. The Medical Executive Committee shall make a recommendation on the Member's application as follows:
(1) Recommend that the Board of Governors approve the application, with or without conditions;

(2) Recommend that the Board of Governors deny the application. The Medical Executive Committee will make a recommendation to the Board of Governors that the application and request for privileges be accepted, deferred, made subject to certain delineated conditions, or denied. Any recommendation that the application be approved subject to certain delineated conditions related to privileges will be transmitted to the Board of Governors. Where a recommendation is made to defer the application for further consideration or additional investigation, the Medical Executive Committee will make a recommendation to the Board of Governors within two months. If the recommendation of the Medical Executive Committee would entitle the Member to request a hearing pursuant to Article V of the Bylaws, the Medical Executive Committee shall forward its recommendation to the Chief Executive Officer, who shall promptly send special notice of such recommendation to the Member. The Chief Executive Officer shall hold the application until the Member has exhausted his or her rights under Article V.

4. Review and Approval by the Board of Governors.

Upon receipt of a recommendation for action on an application for reappointment to the Medical Staff, the Board of Governors may:

a. Accept the recommendation of the Medical Executive Committee and approve the application for membership, with or without conditions;

b. Refer the application back to the Medical Executive Committee for further consideration together with a statement of the reasons for taking such action;
c. Table the application if it determines that additional information is required to formulate a decision; or
d. Deny the application.

If the Board of Governors rejects a recommendation to approve the application from the Medical Executive Committee, it should first discuss the matter with the Chairman of the Credentials & Privileges Committee and the Chairman of the Medical Executive Committee. If the determination of the Board of Governors remains unfavorable to the Member, the Chief Executive Officer shall promptly send special notice of such determination to the Member so that the Member may exercise his or her rights under Article V of the Bylaws. The Chief Executive Officer shall hold the application until the Member has exhausted his or her rights under Article V.

E. Final Action on Application.

The Member shall be reappointed as a Member of the Medical Staff upon approval by the Board of Governors. This decision will be transmitted in writing to the Member.

F. Rotation of Reappointments.

To facilitate the timely administration of the reappointment process, Members will be reappointed as a group based upon their Medical Staff Department assignment.

G. Availability of Application.

Applications for reappointment will be mailed to Members by Medical Staff Services six (6) months prior to the expiration of the current reappointment cycle.

H. Term of Reappointment.

Reappointment shall be for a period of not more than two years.

I. Failure to Return Application Timely.

If a Member fails to return an application for reappointment at least two (2) months prior to the expiration of the current appointment:

1. The Medical Staff may assess a reappointment processing fee; and
2. The Member’s current appointment and clinical privileges will expire automatically at the end of the then current term of appointment.

J. Delay in Action on Timely Application by Board of Governors.
   If an application for reappointment is submitted timely, and, through no fault of the Member, the Board of Governors fails to take action on the application prior to the expiration of the current appointment and attendant privileges, the Board of Governors subsequently may act to grant reappointment and renewal of clinical privileges retroactively to the date of expiration of the current appointment.

K. Temporary Privileges.
   In accordance with Rule 1-4, temporary privileges may be granted if the Board of Governors has not acted on a pending application for reappointment and there is an important patient care need that mandates an immediate authorization to practice.

L. Applying for Reappointment Pending Investigation or Hearing.
   In the event that a Member is the subject of a Medical Staff investigation or hearing at the time the Member’s application for reappointment is being considered, the Board of Governors may grant conditional reappointment for a period of less than two years pending the completion of that process.
RULE 2-3  Clinical Privileges

A. Eligibility to be Granted Clinical Privileges.

The clinical privileges of each Medical Staff Member will be granted, renewed and revised based upon the Applicant's education, training, current clinical competence, and ability to perform the clinical privileges requested. An Applicant may apply for those clinical privileges for which:

1. Criteria have been developed by the Medical Staff and approved by the Board of Governors; and

2. He or she meets the minimum criteria.

B. Obtaining Clinical Privileges.

1. Granting of Clinical Privileges upon Appointment or Reappointment. Clinical privileges will be granted to an Applicant upon the initial approval of the Applicant's application to be a Member of the Medical Staff (Rule 1-1), and upon reappointment of a Member to the Medical Staff (Rule 1-2).

2. Other Requests for Privileges. For such privileges as criteria has been developed by the Medical Staff and approved by the Board of Governors, a Member of the Medical Staff may request such privileges by writing a letter requesting such privileges to the Chief of his or her Department or Section, and delivering said letter to Medical Staff Services. The Member must provide any documentation showing that he or she satisfies the minimum criteria established for such privileges.

   a. Evaluation of Request by Medical Staff. The request will be evaluated and a recommendation made regarding the approval of the request by the Section Chief and/or the Department Chief to the Credentials & Privileges Committee, and by the Credentials & Privileges Committee to the Medical Executive Committee.

   b. Outside Evaluation of Request. If the Section Chief and/or the Department Chief, the Credentials & Privileges Committee, and Medical Executive Committee lacks the expertise to evaluate the request appropriately, then the Credentials & Privileges Committee shall recommend an external authority to the Medical
Executive Committee to evaluate the request. The Medical Executive may appoint the recommended authority or another authority to conduct the evaluation.

c. **Recommendations to the Board of Governors.** Upon completion of its review, the Medical Executive Committee will make a recommendation to the Board of Governors that the application and request for privileges be accepted, deferred, or denied. If the recommendation of the Medical Executive Committee would entitle the Member to request a hearing pursuant to Article V of the Bylaws, the Medical Executive Committee shall forward its recommendation to the Chief Executive Officer, who shall promptly send special notice of such recommendation to the Member. The Chief Executive Officer shall hold the application until the Member has exhausted his or her rights under Article V.

d. **Review and Approval by the Board of Governors.**

Upon receipt of a recommendation for action on an application for Medical Staff membership, the Board of Governors may:

1. Accept the recommendation of the Medical Executive Committee and approve the request for privileges;

2. Refer the request back to the Medical Executive Committee for further consideration together with a statement of the reasons for taking such action; or

3. Deny the request.

The final action will be transmitted to the Member in writing. If the Board of Governors rejects a recommendation to approve the request, the Chief Executive Officer shall promptly send special notice of such determination to the Member, together with a statement of the reasons for such action, so that the Member may exercise his Article V rights. The Chief Executive Officer shall hold the application until the Member has exhausted his or her rights under Article V.
C. Granting of Temporary Privileges.

1. Appropriate Circumstances for Granting Temporary Privileges.

   a. Specific Patient Care Need; Locum Tenens; Proctoring or Teaching. The Chief Executive Officer, upon recommendation of the Chief of Staff, may grant temporary privileges when there is an important patient care, treatment, or service need. Prior to the granting of temporary privileges in these situations, current licensure and current competence shall be verified. Specifically, temporary privileges may be granted for:

      (1) the care of a specific patient;
      (2) an individual serving as a locum tenens for a member of the Medical Staff; or
      (3) the purpose of proctoring or teaching.

   b. Application for Membership Pending Review. The Chief Executive Officer, upon recommendation of the Chief of Staff, may grant temporary privileges to an Applicant seeking initial appointment (Rule 1-1) or Member seeking reappointment (Rule 1-2) when the individual has submitted a completed and timely application and the application is pending review by the Medical Executive Committee or the Board of Governors, following a recommendation for approval from the Credentials & Privileges Committee (or its Chairman). Prior to temporary privileges being granted in this situation, Medical Staff Services shall have completed its processing of the application and credentialing process, including verification of current licensure; relevant training or experience; current competence; ability to exercise the privileges requested; compliance with privileges criteria; and appropriate consideration of information from the Data Bank. Additionally, the Applicant or Member must demonstrate that no current or previous challenges to his or her licensure or registration have been successful, and that he or she has not
been subject to an involuntary termination of medical staff membership, or an involuntary limitation, reduction, denial, or loss of clinical privileges, at another health care facility.

2. **Acceptance of Bylaws and Rules.** Prior to the Chief Executive Officer granting temporary privileges to an individual, the individual must agree in writing to be bound by the Medical Staff Bylaws, Rules and Regulations, policies, procedures and protocols of the Medical Staff and the Hospital.

3. **Time Limitation.** Temporary privileges shall be granted for a specific period of time, as warranted by the situation. The initial grant of temporary privileges shall not exceed a period exceeding 120 days. Temporary privileges for an important patient care need may be renewed for an additional period of up to 120 days by action of the Chief Executive Officer in consultation with the Chief of Staff. Temporary privileges automatically shall expire at the end of the time period for which they are granted without further action by the Hospital or the Medical Staff.

4. **Conditions.**
   a. **Supervision Requirements.** In exercising temporary privileges, the individual shall act under the supervision of the department chief. Special requirements of supervision and reporting may be imposed on any individual granted temporary clinical privileges.
   b. **Termination of Temporary Clinical Privileges.** Temporary Clinical Privileges may be terminated as follows:
      (1) The Chief Executive Officer may, at any time after consulting with the Chief of Staff, the Chairman of the Credentials & Privileges Committee, or the department chief, terminate temporary privileges. Clinical privileges shall be terminated when the individual's inpatients are discharged.
      (2) If continued treatment by an individual granted temporary privileges might endanger the care or safety of patients, the Chief Executive Officer, the Chief of Staff, or the
Department chief immediately may terminate all temporary privileges. The Department chief or the Chief of Staff shall assign responsibility for the care of such individual's patients to another member of the Medical Staff until the patients are discharged. When possible, consideration shall be given to the wishes of the patient in the selection of a substitute physician.

c. The granting of temporary privileges is a courtesy and may be terminated for any reason.

d. Neither the denial nor termination of temporary privileges shall entitle the individual to any rights under Bylaw Article V.

5. The Chief of Staff shall notify the chairman of the Credentials & Privileges Committee and chief of the Department in which temporary privileges are granted in a timely manner.

D. Development of New Procedure Criteria.

When a Member or Department/Section is interested in performing a potentially new procedure or treatment at Hospital, the Member or Department/Section shall be responsible for determining whether the procedure or treatment qualifies as a new procedure or treatment by contacting the appropriate Department or Section Chief. If the procedure or treatment qualifies as new, the interested party will make an appropriate request to the Credentials & Privileges Committee to establish such privileges. The request will include the following information:

1. A description of the procedure/treatment;
2. A description of the risks and benefits of the procedure/treatment;
3. Improvements offered over existing technology/treatments;
4. Differences between the new procedure/treatment and existing procedures/treatments;
5. Indications for use;
6. Additional skills needed by a physician to perform the procedure/treatment; and
7. Recommended criteria/minimum qualification for the privilege.
Upon receipt of such information, the Credentials & Privileges Committee will propose appropriate criteria for such privileges. Following development of the proposed criteria, the proposal will be sent to the Medical Executive Committee and Hospital Administration for review. Both the Medical Executive Committee and Hospital Administration shall make recommendations regarding the approval of the proposed criteria to the Board of Governors. In certain cases, it may be inappropriate for a new procedure to be performed at Hospital due to technology or staffing constraints.

E. "Cross Specialty" Privileges.

1. **Uniformity of Privileges.** The Medical Staff recognizes the responsibility of its Members to provide the same high quality of care to patients regardless of the treating Member’s specialty. Therefore, in the establishment of criteria for delineated privileges, the standards or requirements for those privileges should be uniform across all affected specialties.

2. **Different Standards for Privileges.** Certain procedures fall within the scope of training and experience of a particular specialty, and the same procedure may not be as common in another specialty. In such situations, and when appropriate, the Credentials & Privileges Committee may recommend different criteria (mainly relating to experience and supervised mentoring) for the same privilege practiced in different specialties. If a clinical privilege may be requested appropriately by multiple specialties, the Credentials & Privileges Committee will investigate the relevant facts, taking into consideration the views of all affected specialties. Based upon such investigation, the Credentials & Privileges Committee will make a recommendation to the Medical Executive Committee for additional comment, and then transmitted to the Board of Governors for action.
F.  Emergencies.

In an emergency, any Member of the Medical Staff or individual who has been granted clinical privileges is permitted to do everything possible within the scope of his or her license to save a patient's life or to save a patient from serious harm, regardless of the individual's staff status or clinical privileges.
RULE 2-4 Streamlined Credentialing

A. Purpose of Streamlined Credentialing.
If specified criteria are met, streamlined credentialing provides an expedited review and approval process for Medical Staff Membership applications (both initial and reappointment applications), requests for changes in Medical Staff Membership category, and requests for privileges without compromising the overall quality of review. Streamlined Credentialing is not an entitlement, privilege or right of any Applicant or Member. Only Applicants or Members who meet the criteria for streamlined credentialing will be processed in under this Rule.

B. Criteria for Eligibility for Streamlined Credentialing.

1. Initial and Reappointment Applications. All references provided and verifications of information submitted must contain positive information only, without any suggestion(s) that the Applicant or Member is anything other than a highly qualified individual capable of exercising good clinical judgment. Any information contained in an Applicant’s file that reasonably suggests a need for further investigation will make an Applicant ineligible for streamlined credentialing. Information in the file of a Member arising during the current term of appointment that reasonably suggests a need for further investigation will make an Applicant ineligible for streamlined credentialing. Examples of information that may exclude an Applicant or Member from the streamlined credentialing process include the following:
   a. Difficulty verifying information or obtaining references;
   b. Letters of reference which contain information that the practitioner may be disruptive or have problems in interpersonal relations with patients, families or other health care professionals;
   c. Prior malpractice actions filed against the practitioner;
   d. Derogatory information received from hospital affiliations;
   e. Reports of disciplinary action, licensure restrictions or any type of investigation;
f. Disciplinary action initiated or taken by a state licensure board or federal organization or criminal conviction;
g. Documentation that privileges have been revoked, diminished or otherwise altered by another health care organization;
h. Time periods that are unaccounted for by the practitioner; or
i. Information presented in the application that conflicts with the findings of Medical Staff Services inquiries.

2. Category Changes.
Category changes may be approved pursuant to the streamlined credentialing process if all criteria established for the category change has met by the Member and all references and recommendations are positive. If a Member seeks to resign his or her Membership using the streamlined credentialing process, the Member must have completed all of his or her medical records and fulfilled any outstanding emergency department call coverage obligations.

3. Privileges.
Privileges may be approved pursuant to the streamlined credentialing process if all criteria established for the privilege have been met and the Applicant or Member provides documentation evidencing his or her satisfaction of the criteria. Additionally, all references and recommendations must be positive.

C. Streamlined Credentialing Process.
Any application (for initial appointment, reappointment, category change, and/or privileges) that is eligible for Streamlined Credentialing shall be subject to the following process:

1. Upon receipt of a complete application, Medical Staff Services will review and complete verifications for the application. If the application meets the criteria for Streamlined Credentialing, the application will be forwarded to the Department and/or Section Chief for review. If the individual reviewing the application has any concerns about the application or reasonably believes that additional information is required, he or she will
return the application for routine processing and request that the Applicant or Member provide the additional information needed.

2. The Department and/or Section Chief will review the application with specific attention to the Applicant's ability to perform the privileges requested (if applicable) and either make a favorable recommendation to the Vice-Chief of Staff or return the application to Medical Staff Services for routine processing.

3. The Vice Chief of Staff will review the application on behalf of the Credentials & Privileges Committee and either make a favorable recommendation to the Chief of Staff or return the application to Medical Staff Services for routine processing.

4. The Chief of Staff will review the application and either make a favorable recommendation to the Board of Governors or return the application to Medical Staff Services for routine processing.

5. The Board of Governors will review the application and either approve the application or return the application to Medical Staff Services for routine processing.

6. Approvals will be noted at the Medical Executive Committee and as part of the Chief of Staff report to the Board of Governors.
RULE 2-5 SEDATION PRIVILEGES

RULE 2-5.1 MODERATE SEDATION. Members of the Medical Staff who maintain moderate sedation as part of their core privileges (including anesthesiologists, trauma surgeons, pulmonologists, adult and pediatric intensivists, emergency medicine physicians, neonatologists and otolaryngologists) may direct moderate sedation for procedures performed at the Hospital. Any other Active (including Senior Active) or Associate Member of the Medical Staff who seeks to direct moderate sedation for procedures performed at the Hospital first must be granted moderate sedation privileges as follows:

A. Initial Privileges. The Member must submit a written request for moderate sedation privileges to the Medical Staff Services Office along with:

1. Completion of mandatory education materials and a score of 100% on an examination that reviews the applicable pharmacology, adverse effects, administration, dosage and emergency interventions for the sedative(s) used (at least once every two (2) years); and

2. Maintenance of current ACLS certification. If the Member does not maintain current ACLS certification, then an individual certified in ACLS must be present every time the Member exercises his or her moderate sedation privileges.

B. Reappointment Privileges. The Member must submit a Request for moderate sedation privileges to the Medical Staff Services Office along with:

1. Completion of mandatory education materials and a score of 100% on an examination that reviews the applicable pharmacology, adverse effects, administration, dosage and emergency interventions for the sedative(s) used (at least once every two (2) years); and;

2. Maintenance of current ACLS certification. If the Member does not maintain current ACLS certification, then an individual certified in ACLS must be present every time the Member exercises his or her moderate sedation privileges.
RULE 2-5.2 Deep Sedation

Members of the Medical Staff who maintain deep sedation as part of their core privileges (including anesthesiologists, trauma surgeons, pulmonologists, adult and pediatric intensivists, emergency medicine physicians, neonatologists and otolaryngologists) may direct deep sedation for procedures performed at the Hospital. Any other Active (including Senior Active) or Associate Member of the Medical Staff who seeks to direct deep sedation for procedures performed at the Hospital first must be granted moderate sedation privileges as follows

A. Initial Privileges. The Member must submit a written request for deep sedation privileges to the Medical Staff Services Office along with:

1. Completion of mandatory education materials and a score of 100% on an examination that reviews the applicable pharmacology, adverse effects, administration, dosage and emergency interventions for the sedative(s) used (at least once every two (2) years); and

2. Maintenance of current intubation privileges at Hospital. If the Member does not maintain current intubation privileges, then an Active (including Senior Active) or Associate Member of the Medical Staff with both current intubation and deep sedation privileges at Hospital must be immediately available during every procedure in which the Member exercises his or her deep sedation privileges.

B. Reappointment Privileges. The Member must submit a Request for deep sedation privileges to the Medical Staff Services Office along with:

1. Completion of mandatory education materials and a score of 100% on an examination that reviews the applicable pharmacology, adverse effects, administration, dosage and emergency interventions for the sedative(s) used (at least once every two (2) years); and

2. Maintenance of current intubation privileges at Hospital. If the Member does not maintain current intubation privileges, then an Active (including Senior Active) or Associate Member of the Medical Staff with both current intubation and deep sedation privileges at Hospital must be immediately available during every procedure in which the Member exercises his or her deep sedation privileges.
RULE 2-6  Credentialing Physicians in the Event of a Disaster

A.  Definition of a Disaster.

For purposes of this Rule, a “disaster” shall mean any state of emergency declared by the federal, state or local government that activates the Hospital's Emergency Management Plan and results in the Hospital being unable to handle immediate patient needs.

B.  Authority for Granting Disaster Privileges.

The Chief Executive Officer, Chief of Staff, Vice-Chief of Staff, Secretary of Staff, or Immediate Past Chief of Staff shall have the authority to grant disaster privileges to a volunteer practitioner if the Hospital's Emergency Management Plan is activated and the Hospital cannot meet patient needs. The individual granting disaster privileges will take into consideration the qualifications of each volunteer practitioner.

C.  Process for Granting Disaster Privileges.

1.  The following information must be available for an authorized individual to grant disaster privileges to a volunteer practitioner:

   a.  Valid government issued photo ID issued by the state or Federal agency (driver's license or passport) and at least ONE of the following:

      (i)  Current health care organization picture ID that clearly identifies the profession designation.

      (ii) Current license to practice in the State of Nevada or another state.

      (iii) Primary source verification of the license.

      (iv)  ID indicating a member of a Disaster Medical Assistance Team (DMAT) or Medical Reserve Core (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) or other recognized state of Federal organizations or groups.
(v) ID indicating authority to render patient care, treatment and services in disaster circumstances (federal, state or municipal entity).

(vi) Identification by current organization member who possesses personal knowledge regarding the volunteer’s ability to as a LIP during a disaster.

b. List of current hospital affiliations where the practitioner holds active staff privileges.

c. Malpractice insurance (if situation enable verification of same).

d. National Practitioner Data Band and OIG query.

2. A record of the information provided by each volunteer practitioner granted disaster privileges will be retained in the Medical Staff Services Office.

3. Medical Staff Services will perform primary source verification of the volunteer physician as soon as the disaster is under control or within 72 hours of the time that the volunteer licensed practitioner presents to the Hospital, whichever occurs first. If primary source verification cannot be completed within such time frame due to extraordinary circumstances, then Medical Staff Services shall document the reasons for the delay including, but not limited to, the conditions preventing primary source verification within the specified time frame; evidence of the licensed independent practitioner’s demonstrated ability to continue to provide adequate care, treatment and services; and evidence of the attempt(s) to perform primary source verification during the specified time period.

4. Medical Staff coordination is accomplished by the Medical Staff Services Manager in the Medical Staff Services Office or other designated area as circumstances of the situation allow. The Medical Staff Services Manager or his/her designee will assign physicians to appropriate hospital departments as requested by those departments through the Incident Command Center. Each practitioner will be paired with and should act only under the direct supervision of a currently credentialed Medical Staff
Member. Based on its oversight of each volunteer licensed independent practitioner, the Medical Staff Office shall determine within 72 hours of the practitioner’s arrival if granted disaster privileges should continue. The practitioner’s privileges will be for the period needed during the duration of the disaster or emergency only. The privileges will be automatically cancelled at the end of needed services.

5. The Medical Staff and Hospital shall use the information obtained during the disaster credentialing process to determine the duration of the volunteer practitioner’s disaster privileges. This determination should take place within 72 hours. The volunteer practitioner’s privileges shall terminate immediately upon the deactivation of the Hospital’s Emergency Management Plan, or if the Hospital or Medical Staff receive any information through the verification process that indicates that the practitioner is not capable of rendering the services required.

6. Medical Staff Services will issue a temporary identification card to the volunteer practitioner that easily may be distinguished from the card issued to Members of the Medical Staff.

D. Oversight of Volunteer Practitioners.

The Chief Medical Officer (“CMO”) of the Hospital shall provide oversight of all volunteer practitioners. The CMO shall:

1. Ensure timely record review of volunteer practitioners during the disaster;

2. Use practitioner-specific outcome data for volunteer practitioners when conducting record reviews after the disaster situation is resolved; and

3. Conduct staff and patient satisfaction surveys to assess the care provided by the volunteer practitioners.
RULE 2-7  Reserved.
RULE 2-8 Leaves of Absence

A. Duration of and Reasons for Leaves of Absence.

A Member of the Medical Staff may request a leave of absence if the Member will be absent from the Medical Staff for at least three (3) months due to illness, further formalized training, military service, or any other reason considered adequate by the Medical Executive Committee. Prior to commencement of such leave, the Member is required to fulfill all normal responsibilities of Medical Staff Membership, including, but not limited to, completion of medical records and coverage of previously scheduled emergency department coverage assignments, unless such requirements are waived by the Member's Department Chief or the Medical Executive Committee due to extenuating circumstances. The length of the absence shall be specified in the original request made to the Medical Executive Committee and shall not exceed one (1) year. An additional year of absence may be requested. The total time of any leave of absence shall not exceed two (2) years. Voluntary leaves of absence are not reported to the National Data Bank.

B. Process for Making Request.

Medical Staff Members may request a leave of absence by submitting a written request to the Medical Executive Committee. The request must state the beginning and ending dates of the leave, and the reasons for the leave. The Medical Executive Committee will determine whether to grant a request for a leave of absence. The Medical Executive Committee may condition the granting of a leave of absence, or reinstatement from a leave of absence, upon the individual's completion of all medical records.

C. May not Exercise Privileges.

During the term of any leave of absence, the individual shall not exercise any clinical privileges. In addition, the individual shall be excused from all Medical Staff responsibilities (e.g., meeting attendance, committee service, emergency department coverage obligations) during this period.

D. Reinstatement.
1. Individuals requesting reinstatement shall submit a written summary of their professional activities during the leave, and any other information that may be requested by the Medical Staff or Hospital. Requests for reinstatement shall be reviewed by the relevant department chief, the Chief of Staff, and the Chief Executive Officer. Upon the favorable recommendation for reinstatement by each reviewer, the Medical Staff member may immediately resume clinical practice at the Hospital. This determination shall be forwarded to the Medical Executive Committee, and the Board of Governors for ratification.

2. If any of the individuals reviewing the request have any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the full Medical Executive Committee and Board of Governors for review and recommendation. If a request for reinstatement is not granted for reasons related to clinical competence or professional conduct, the individual shall be entitled to request a hearing pursuant to Article V of the Bylaws.

3. If the leave of absence was taken for health reasons, the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is physically and/or mentally capable of resuming a Hospital practice and safely exercising the clinical privileges requested.

4. If an individual's current appointment is due to expire during the leave of absence, the individual must apply for reappointment, or appointment and clinical privileges shall lapse at the end of the appointment period.

5. Leaves of absence are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for taking a leave of absence, or where a request for extension is not granted, the determination shall be final, with no recourse to a hearing and appeal.

E. **Automatic Leave of Absence.**
Members of the Medical Staff must report to the Chief of Staff any time they are away from Medical Staff and/or patient care responsibilities for longer than 30 days and the reason for such absence is related to their physical or mental health or otherwise due to their inability to care for patients safely and competently. Under such circumstances, the Chief of Staff, in consultation with the appropriate Department Chief, may trigger an automatic leave of absence.
RULE 2-9 Resignation from the Medical Staff

Resignation from the Medical Staff may be accomplished by Members as follows:

A. Voluntary Resignation by a Member.
   1. Process. A Member of the Medical Staff may submit a notification of resignation to the Medical Staff by delivery of the same to the Medical Staff Services Officer. Such notice shall be in writing. Upon receipt of the written notification of resignation, will be transmitted to the Credentials & Privileges Committee, Medical Executive Committee and the Board of Governors for information. The effective date of resignation will be the date specified by the Member in his or her notice of resignation. In the absence of a specified date of resignation, the effective date of the Member's resignation shall be the date of the meeting of the Board of Governors at which the resignation notice is reported.
   2. Completion of Obligations. In order to resign in good standing, a Member must complete his or her Medical Records and fulfill any outstanding emergency department coverage obligations as required by the Medical Staff Bylaws and Rules and Regulations.

B. Failure to Maintain Qualifications or Complete Medical Records.
   If a Member's privileges are relinquished automatically pursuant to Article IV, Sections 4.5(A) or (B) of the Medical Staff Bylaws, and the Member fails to take such action as is required by those Bylaws during the specified relinquishment period, the Member shall be deemed to have resigned his or her Medical Staff Membership effective 15 days after Medical Staff Services sends special notice to the Member of such inaction. The Member shall have the rights afforded under Article V of the Bylaws only if the Medical Staff is required by applicable laws to report the matter to the National Practitioner Data Bank.

C. Inability to Locate a Member.
   If a Member's privileges are relinquished automatically pursuant to Article IV, Section 4.5(E) of the Medical Staff Bylaws, and after referral of the matter to the Department Chief and Credentials & Privileges Committee for review and comment, the Medical Executive Committee may recommend to the Board of

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Governors that the Member be deemed to have resigned his privileges automatically. If the Member has completed his or her Medical Records and fulfilled any outstanding emergency department coverage obligations as required by the Medical Staff Bylaws and Rules and Regulations, the Member shall be deemed to have resigned in good standing.
RULE 2-10 Residents in Training

A. Status of Residents.
Residents are not Members of the Medical Staff or otherwise appointed to the Medical Staff, and shall not be granted specific privileges. The applicable Residency Director shall be responsible for verifying and evaluating the qualifications of each Resident. Residents in training who are supervised by the University of Nevada School of Medicine are authorized to practice in the Hospital upon acceptance into the University of Nevada School of Medicine Residency Program. The performance of each Resident will be assessed annually by the applicable Residency Director. The Residency Director and clinical faculty shall be responsible for the direction and supervision of the patient care activities of each Resident. Residents shall be permitted to perform only those clinical functions set out in curriculum requirements and training protocols approved by the Medical Staff and the Hospital.

B. Obligations of Residents.
Residents must abide by the Bylaws, Rules & Regulations, and Policies and Procedures of the Medical Staff and Hospital, as well as the Residency Handbook. Residents may attend regular Departmental meetings of the Medical Staff and may be assigned to committees as directed by the Chief of Staff. Residents’ rights are defined by their respective Residency Program, not by the Medical Staff Bylaws.
RULE 2-11 Medical Staff Professional Practice Evaluation

A. Policy Statement. It is the policy of Renown Regional Medical Center and its Medical Staff to comply with statutory and regulatory requirements regarding Ongoing Professional Practice Evaluation (“OPPE”) and Focused Professional Practice Evaluation (“FPPE”). The findings of the committees defined in this policy will be included in the information used to assess the quality of care of each practitioner at the time of reappointment to the Medical Staff and on an ongoing basis as appropriate. These committees’ findings will also be forwarded (with safeguards to ensure confidentiality of individual practitioners) to the appropriate venue for potential system improvements.

B. Purpose and Goals.

1. The purpose of Medical Staff Professional Practice Evaluation is to ensure that the Medical Staff assesses the ongoing professional practice and competence of its members, conducts professional practice evaluation, and uses the results of such assessments and evaluations to improve professional competency, practice, and the system of care. This attention to the care patterns of individual practitioners is also considered an integral component of our ongoing efforts to evaluate and improve performance of clinical groups and enterprise-based systems of care.

2. The goals of Medical Staff Professional Practice Evaluation are to:
   a. Monitor practice and performance to identify improvement opportunities for both individuals and systems of care;
   b. Monitor for significant trends in performance by analyzing aggregate data and case findings; and
   c. Ensure that the process for professional practice evaluation is clearly defined, objective, equitable, defensible, timely, and helpful.

C. Definitions.

1. Professional Practice Evaluation Committee (PPEC).
a. The PPEC is a peer care review committee authorized by the Medical Executive Committee (MEC) to pursue the quality improvement goals outlined in this policy.

b. The PPEC ultimately is accountable to the (MEC) and the Board of Governors for oversight of the professional practice evaluation process.

2. Ongoing Professional Practice Evaluation (“OPPE”). OPPE is a process which allows the Medical Staff to identify professional practice trends and systems issues that may affect quality of care and patient safety. The program includes:

a. The evaluation of systems and processes: identification of issues which may impair optimal provision of care or which do not adequately protect the care process against foreseeable human error.

b. The evaluation of an individual practitioner’s professional performance, including opportunities to improve care based on recognized standards.

c. Professional practice evaluation is conducted using multiple sources of information, including the review of individual cases, the review of aggregate data (including rate comparisons against established benchmarks or norms), compliance with clinical standards, Bylaws, Rules and Regulations of the Medical Staff and relevant hospital policies.

d. Individual evaluation is based on generally recognized standards of care. This process provides practitioners with feedback for personal improvement or confirmation of personal achievement related to the effectiveness of their professional, technical, and interpersonal skills in providing patient care. The Department or Section Chief is provided information on a regular basis as part of OPPE. This information allows him or her to address performance on an on-going basis and to provide feedback to individual medical staff members as appropriate.
3. Focused Professional Practice Evaluation (FPPE). FPPE is a process whereby the Medical Staff more closely evaluates the competency and professional performance of a practitioner. FPPE is not considered a formal Medical Staff investigation, and is not subject to regulations afforded in the investigation process.

   a. The proctoring program is a component of FPPE (see Rule 2-12).

   b. FPPE is used when a question arises regarding a currently privileged practitioner's ability to provide safe, high quality patient care.

4. Care Ratings: Practitioner

   a. Care Appropriate: Despite a complication (or some other question about the quality of care), it is determined that a majority of peers may have responded similarly under similar circumstances (substitution test). No clear deviation from standards of practice.

   b. Practitioner Care Improvement Opportunity: Care that involves simple errors of diagnosis, treatment or judgment by the index physician. This includes instances in which a practitioner has drifted into a practice pattern that may increase the likelihood of human error and requires coaching and/or education to correct this practice pattern.

   c. Inappropriate Care: Care that raises concerns with the reviewing committee as whether the practitioner might require education and/or coaching to prevent recurrence.

   d. Inappropriate Severe: Care that suggests a reckless disregard of the practitioner's duty to the patient through gross negligence, general incompetence or actual intent to provide substandard care. Such cases will be referred immediately to the Chief of Staff and Department or Section Chief.

5. Peer. For purposes of this Rule:

   a. A "peer" is an individual who is practicing in the same profession and who has expertise in the appropriate subject matter.
b. The PPEC will determine the degree of subject matter expertise required for a provider to be considered a peer for all professional practice evaluations performed by the Medical Staff.

D. Process and Procedure.

1. OPPE review

   a. Rule and rate based indicators:

      (1) The PPEC identifies relevant rule and rate based indicators for its divisions and/or services.

      (2) Predetermined thresholds for each indicator are identified as appropriate.

      (3) When a threshold is exceeded, the PPEC determines whether additional review is required.

      (4) Rule and rate based indicators are evaluated periodically to determine if the indicator(s) and threshold(s) should be modified.

   b. Individual case reviews:

      (1) Cases for individual case review will be based on “significant clinical events” identified by the Chief of Staff or his/her designee from the following sources:

         (a) Incident reports

         (b) Patient/family complaints

         (c) Sentinel events/adverse events

         (d) As required by regulatory agencies

         (e) Referral from clinician(s)

         (f) Referral from Morbidity and Mortality conferences

         (g) Referral from Risk Management

      (2) Individual case reviews may also be performed when a threshold for a rule or rate based indicator is exceeded.
2. Indications for focused professional practice evaluation (FPPE)
   a. Any single egregious case or sentinel event as judged by the Chief of Staff may be referred to the PPEC for consideration of FPPE.
   b. When indicator thresholds are exceeded within the agreed upon time.
      (1) The number of cases rated "care inappropriate" or "improvement opportunity" exceeds a threshold defined by the PPEC.
      (2) A rate or rule based indicator exceeds a predetermined threshold defined by the PPEC.
      (3) These indicators do not result in automatic referral to PPEC for consideration of FPPE. The PPEC will consider whether referral is indicated based on the individual circumstances.
   c. FPPEs are personalized and individualized to the specific physician and the issues present. The PPEC identifies a timeframe and individualized plan for the completion of the FPPE process, monitors the physician's compliance with the process, and communicates directly with the physician regarding the expectations and timeline.
   d. Upon referral, the PPEC will determine whether FPPE is warranted.

3. OPPE Review Process
   a. OPPE is conducted continuously and reported to the PPEC for review and action.
   b. Each case for review will be assigned to a PPEC member for presentation to the committee.
   c. The attending physicians identified in a case for full review will be notified in advance and invited to attend the PPEC meeting and/or
submit a written summary of the case. The Chief of the identified physicians’ department and/or section will be notified and invited to attend the PPEC meeting as well.

d. The reviewer will report the reason for the referral and review the medical record. The reviewer may recommend that further information be obtained before further committee review.

e. The reviewer will present the case to the committee and, if applicable, the attending physician(s) involved in the case may provide additional information before being excused.

f. If the attending physician did not attend the meeting and further information is needed, the attending physician will be asked to respond in writing, or in person, at the next PPEC meeting.

g. The PPEC rates each case.

h. The attending physician(s) or other licensed independent practitioner is notified in writing of the outcome. If a practitioner disagrees with any finding of the PPEC, he or she may submit written comments that will be filed with the committee's findings.

i. If corrective action is recommended by the PPEC and the practitioner disagrees, the case will be referred to the Medical Executive Committee. In such a case, one member of the Medical Executive Committee will be asked to review the case from the practitioner’s perspective. This member may be selected by the practitioner if the practitioner so desires.

j. All recommended coaching, education, or other corrective measures will be conveyed to the practitioner by the Department or Section Chief, or his or her designee, and will be tracked by the Hospital Quality Department with results reported to the PPEC.

k. Any corrective measures recommended and accepted at the PPEC level will be reported to the MEC before and after completion of those measures.
l. Care provided by resident physicians will be attributed to the attending/supervising physician during the evaluation and rating process. Concerns about resident performance issues will be referred to the Director of Medical Staff Quality, as will any process issues relating to resident supervision. The Director of Medical Staff Quality will be asked to provide feedback to the PPEC as to the results of any such referrals.

m. Decisions of the PPEC will be determined by simple majority vote of members present.

4. FPPE Review Process. The FPPE process will be essentially parallel to the OPPE process, with the following exceptions:

a. Any FPPE (with the exception of routine proctoring) will be overseen by the PPEC.

b. Review is not restricted to individual cases, rates and rules, but may extend to all areas of practice, as determined by the PPEC.

c. All recommended coaching, education, or other corrective measures will be conveyed to the practitioner by the the Chief of Staff or the Department or Section Chief, and will be tracked by the Quality Department with results reported to the PPEC.

d. The MEC will receive regular summaries of such focused reviews, including major findings, conclusions, recommendations and required actions, at least annually.

5. Reliability and Consistency of the Review Process

a. Professional practice evaluation will be conducted in a manner that is objective, equitable, and consistent.

(1) Case selection will be done by use of pre-selected indicators and also through criteria outlined in the quality plans for each Department or Section.

(2) Review of cases will be performed by the PPEC in accordance with procedures outlined in this document.
b. The MEC will monitor reliability and consistency of the PPEC based on quarterly activity reports submitted.

6. Participants in the Review Process
   a. PPEC members will be chosen by the Chief of Staff subject to review and approval by the MEC. Every PPEC must include at least three active Medical Staff members in good standing. For purposes of all PPEC meetings, a quorum shall be established when three (3) or more PPEC members are physically present at a meeting.
   b. The Chief of Staff will consider rotation of members at least once every two years.
   c. The PPEC chair shall be appointed by the Chief of Staff with the approval of the MEC and subject to the requirements of the Medical Staff Bylaws and Rules & Regulations. The term of appointment is two years. The chair may be reappointed by the Chief of Staff for up to two terms (four years) in total. Extending beyond 4 years requires prior MEC approval.
   d. The PPEC shall provide informational reporting to the Hospital's Quality Department on at least a quarterly basis.
   e. Support staff will participate in the review process as deemed appropriate based on their job responsibilities.

7. Professional practice evaluation (PPE) time frames.
   a. The PPE will be conducted by the Medical Staff in a timely manner. The goal is for routine cases to be completed as quickly as possible and within 120 days from the date of referral.
   b. Complex cases may require additional review time beyond 120 days. The status of complex cases will be monitored by the PPEC and the practitioners involved will be kept apprised of the process. A complex case may be one where multiple services are involved, or one which requires external review for reasons identified in
section D.10. The PPEC shall appraise the Hospital Quality Department of the status of PPE matters.

c. An FPPE may also take longer to complete, but the involved practitioner should be kept well informed as to the proceedings.

8. Oversight and reporting

a. Direct oversight of the professional practice evaluation process is delegated by the MEC to the PPEC.

b. The PPEC will report to the MEC at least quarterly.

c. The Chief of Staff will report on issues of professional behavior at least annually to the MEC.

9. Circumstances Requiring External Professional Practice Evaluation

a. External professional practice evaluation may take place under the following circumstances when deemed appropriate by the PPEC, the MEC, or the Chief of Staff.

(1) When ambiguity exists in the conclusions reached in a professional practice review (e.g., vague or conflicting recommendations from internal reviewers or Medical Staff committees) and those conclusions will directly affect a practitioner's privileges.

(2) When no Member of the Medical Staff has adequate expertise in the specialty or specific issues under review, or when the only practitioners on the Medical Staff with that expertise is determined to have a conflict of interest regarding the practitioner under review as described below.

(3) When the Medical Staff needs an expert witness for a fair hearing, for evaluation of a credential file, or for assistance in developing a benchmark for quality monitoring. In addition, the PPEC, C&P, MEC or Chief of Staff may
obtain external professional practice evaluation in any circumstances deemed appropriate.

b. The Chief of Staff will inform the MEC when there is a request for external professional practice evaluation. Input from the relevant Department or Section Chief, as well as the practitioner being reviewed, should be solicited and considered prior to engaging external evaluation, when appropriate.

10. Conflict of Interest

a. A member of the Medical Staff asked to perform professional practice evaluation has a conflict of interest if, for example, he or she might not be able to render an unbiased opinion due to either involvement in the patient's care or a relationship with the physician involved as direct competitor or partner.

b. It is the individual reviewer's obligation to disclose any potential conflict to the PPEC.

c. Procedures for addressing potential conflicts of interest are outlined in the Medical Staff Conflict of Interest Rule.

E. CONFIDENTIALITY. Professional practice evaluation information is privileged and confidential in accordance with Medical Staff and Hospital bylaws, state and federal laws and regulations pertaining to confidentiality and nondisclosure.

1. PPEC members will sign a statement of confidentiality and will be subject to disciplinary action for violations of confidentiality, as outlined in the Medical Staff Bylaws.

2. The Hospital Medical Staff Office will keep provider-specific professional practice evaluation and other quality information concerning a practitioner in secure locations approved and controlled by the MEC and Chief of Staff. Provider specific professional practice evaluation information includes information related to:

a. Performance data for all dimensions of performance measured for that individual physician.
b. The individual physician’s role in sentinel events, significant incidents, or near misses.

c. Correspondence to the physician regarding recommendations, comments regarding practice performance, or corrective action.

d. Reports and correspondence regarding alleged disruptive behavior.

3. Professional practice evaluation information is available only to authorized individuals who have a legitimate need for this information based upon their quality improvement responsibilities as a Medical Staff leader or hospital employee. Individuals shall have access to the information only to the extent necessary to carry out their assigned responsibilities. All individuals with allowed access to such information will sign a statement of confidentiality. Any questions regarding authorization shall be resolved by the Chief of Staff and/or MEC.

4. On request, any practitioner may review his or her own quality data. Reports filed by another individual (incident reports) will be redacted to protect that person’s identity. Practitioners may provide a written response to anything in their quality file, and this response will be kept with the other quality information.

5. No copies of professional practice evaluation documents will be created and distributed except as authorized by this policy, which includes giving authority to do so to the Chief of Staff, or in unusual circumstances, certain designees of the Chief of Staff.
RULE 2-12  Proctoring

A.  **Purpose.** The Medical Staff shall require Members, allied health professionals, and advanced practice professionals to be proctored in order to establish a systematic process of ensuring that sufficient information is available to confirm the current competency of practitioners in certain situations. This process, termed Focused Professional Practice Evaluation (FPPE), will provide the basis for obtaining organization-specific information of current competence for those providers.

B.  **Scope of Proctoring.** For purposes of this policy, FPPE is performed to confirm a Member’s current competence to perform the clinical privileges granted or maintained by that Member. Applicants requesting membership but not requesting specific privileges are not subject to the provisions of this policy. Such Members do not require FPPE and may not act as proctors. The decision and process to perform FPPE for current Members with existing privileges based on trends or patterns of performance identified by OPPE are outside the scope of this rule (see FPPE rule).

C.  **Definitions.**

   1.  **Practitioner.** For purposes of this Rule, the term “practitioner” refers to any medical staff member, allied health professional, or advanced practice professional (APP) granted clinical privileges.

   2.  **Proctor.** For purposes of this Rule, the term “proctor” refers to the medical staff member or designated expert appointed by the Medical Staff to perform FPPE to evaluate the current competency of the practitioner for some or all general competencies.

   3.  **Proctoring.** For purposes of this Rule, the term “proctoring” refers to the process of obtaining information as a FPPE to confirm the current competence in all general competencies of a practitioner at the time initial privileges are granted, for specific privileges if a currently privileged practitioner requests additional privileges, or for low/no volume providers. Proctoring may be prospective, concurrent, or retrospective.
4. **Practitioner FPPE plan.** For purposes of this Rule, the term “practitioner FPPE plan” refers to the specific methods and extent of evaluation for a given practitioner recommended by the Department/Section chief and by the Credentials & Privileges Committee and approved by the Medical Executive Committee at the time of recommending approval of the practitioner's privileges.

5. **FPPE start date.** For purposes of this Rule, the term “FPPE start date” shall mean that date on which a practitioner is granted initial privileges; is granted a new privilege; or at the request of the Credentials & Privileges Committee when proctoring is initiated due to low/no clinical volume at Hospital.

6. **On-site proctoring.** For purposes of this Rule, the term “on-site proctoring” refers to FPPE performed at facilities that are part of Renown Regional Medical Center (“Hospital”) or an affiliated Renown Health entity.

7. **Off-site proctoring.** For purposes of this Rule, the term “off-site proctoring” refers to documented evidence of FPPE performed at an alternative hospital after the physician has been granted privileges at Hospital.

8. **FPPE site.** For purposes of this Rule, the term “FPPE site” refers to the site at which FPPE will be performed. Generally, all FPPE will be performed on-site. Off-site FPPE may be permitted in situations in which a practitioner has skills that are needed at Hospital on an occasional basis, when the skills and competence of the practitioner in question are known to members of the Medical Staff, or when practitioners are needed from local area hospitals to provide occasional coverage at Hospital. It is up to the appropriate Department/Section Chief to make a recommendation related to the use of off-site FPPE for a specific practitioner situation.

9. **Prospective Proctoring.** For purposes of this Rule, the term “prospective proctoring” refers to the presentation of cases with planned treatment outlined for review by the proctor.
10. **Concurrent Proctoring (Direct Observation).** For purposes of this Rule, the term “concurrent proctoring” refers to the real-time observation of a procedure by the proctor. The term also may also be used for real-time observation of the patient’s clinical history and physical, and review of treatment orders. 

11. **Retrospective Evaluation (Chart Review).** For purposes of this Rule, the term “retrospective proctoring” refers to a review of case record by the proctor after the case has been completed by the practitioner. The review also may involve interviews of personnel directly involved in the patient’s care.

D. Proctoring of Members

1. Situations that require Proctoring.
   
a. **New Members.** All new Members who are requesting clinical privileges at Hospital shall be appointed for a provisional period, during which proctoring shall be completed as a means of determining clinical/technical competence of the applicant prior to advancement to regular active status. All providers requesting privileges are required to be proctored and are placed in a "Associate" status until such time that proctoring has been completed.

b. **Current Members requesting additional privileges.** If a current Member seeks additional privileges at any time during a current appointment, then proctoring will be required to determine the clinical/technical competence of the Member to be granted such privileges.

c. **Low Volume Members.** If a current Member’s clinical activity in the Hospital is not sufficient to evaluate his/her professional competence on an ongoing basis, proctoring may be imposed by the Department/Section Chief with the approval of the Credentialing & Privileges Committee.

2. **Methods.** Proctoring methods are determined by each Department/Section and may include direct observation (both clinical and surgical), review of medical records (both concurrent and retrospective),
and an evaluation of the proctored practitioner’s six general competencies including, but not limited to, interpersonal skills with peers, nursing and ancillary personnel, and hospital administration.

3. **Term.**

   a. The term of proctoring may vary among Departments and Sections as outlined in the applicable Department and Section policies; however, procedures crossing Department/Section lines should have uniform proctoring requirements.

   b. If a sufficient amount of clinical activity has not occurred during the provisional period, the proctoring period may be extended beyond the provisional period as stated in the Medical Staff Bylaws, Rules and Regulations, and Policies upon formal request of the Department/Section Chief and approval by the Credentialing & Privileges Committee.

4. **Responsibilities of Proctored Members.** It is the responsibility of the proctored Member to make every attempt to schedule surgery/procedures in cooperation with the proctor(s), if applicable. The proctored Member shall also inform the proctor(s) of any unusual incident in any way associated with his/her patients.

E. **Medical Staff Oversight.** The Credentialing & Privileges Committee is charged with the responsibility of monitoring compliance with this Rule. The C & P Committee accomplishes this oversight by reviewing the proctoring reports for providers and dealing with any issues or problems involved in implementing this Rule. The appropriate Department/Section Chief shall be responsible for overseeing the proctoring process for all applicants assigned to their clinical areas. The Medical Staff committee(s) involved with Ongoing Professional Practice Evaluation (OPPE) will provide the C & P Committee with data collected for these providers to confirm current competence during the FPPE period.

1. **Proctoring Methods.** Each Department/Section shall be responsible for:

   a. Establishing a minimum number of cases/procedures to be proctored and determining how proctoring will be performed on
that service. Proctoring may be performed using prospective, concurrent, or retrospective approaches. These criteria are contained in the Proctoring Guidelines for each hospital. These Guidelines should be reviewed annually by the Credentials Committees.

b. Identifying the Medical Staff Members eligible to serve as proctors. Proctors should be qualified and credentialed to perform the procedures being reviewed. The Department/Section Chief automatically shall be assigned as the applicant's proctor unless the Department/Section Chief assigns this responsibility to another member of the Service. The proctor shall charge no fee for this service. If no other Member is qualified or credentialed to serve as a proctor, an outside consultant may be retained and granted temporary membership to serve in a proctoring capacity.

2. **Role of Proctor.** The proctor's role is typically that of an evaluator, not of a consultant or mentor. A Member serving as a proctor is an agent of the hospital while assessing and reporting on the competence of another practitioner. The proctor shall receive no compensation directly or indirectly from any patient for this service, and shall have no duty to the patient to intervene if the care provided by the proctored practitioner is deficient or appears to be deficient. The proctor or any other practitioner, however, may nonetheless render emergency medical care to the patient for medical complications arising from the care provided by the proctored practitioner. The hospital will defend and indemnify any Member who is subjected to a claim or suit arising from his/her acts or omissions in the role of proctor.

F. **Responsibilities of Members Involved in the Proctoring Process.**

1. **Proctors.**
   a. Proctors must be members in good standing of the active medical staff of Hospital and have unrestricted privileges to perform any procedure to be concurrently observed.
b. Based on the Department/Section Policy requirements for proctoring, the proctor must:

(1) Directly observe the procedure being performed, if required, and complete the appropriate proctoring form.

(2) Retrospectively review the completed medical record following discharge, if required, and complete the appropriate proctoring form.

(3) Ensure the confidentiality of the proctoring results and forms. All proctoring forms must be delivered in a timely manner to Medical Staff Services.

(4) If, at any time during the proctoring period, the proctor has concerns about the practitioner's competency to perform specific clinical privileges or care related to a specific patient, the proctor shall promptly notify the Department/Section chief and may recommend appropriate departmental/section intervention or review.

2. Practitioner Being Proctored. Practitioners being proctored shall:

a. Notify the proctor of each case in which care is to be evaluated and, when required, do so in sufficient time to enable the proctor to observe or review the case concurrently.

b. Provide the proctor with information about the patient's clinical history; pertinent physical findings; pertinent lab and x-ray results; planned course of treatment or management; and direct delivery of any documents that the proctor may request.

c. Have the prerogative of requesting from the Department/Section Chief a change of proctor if disagreements with the current proctor may affect adversely his or her ability to complete the proctorship satisfactorily.

d. Inform the proctor of any unusual incidents associated with his/her patients. e. Ensure documentation of the satisfactory completion of his/her proctorship, including the completion and
delivery of proctorship forms. If the proctoring forms are not completed and returned at the end of the 12 month proctoring period, the practitioner may be granted an extension at the request of the Department/Section Chief to the Credentials & Privileges Committee in instances involving proctoring cases that require observation. The Credentials & Privileges Committee also may grant an extension up to three (3) months to allow the proctor additional time to review charts. If the person being proctored has not met the timelines set forth by the Credentials & Privileges Committee, then a privilege suspension shall be imposed due to non-compliance with Medical Staff requirements. If proctoring still has not been completed at the end of the extended time period, the practitioner may be required to reapply for privileges through the initial application process.

3. **Department/Section Chiefs.** Each Medical Staff Department and Section, through its chief, shall:
   a. Assign proctors for all new Applicants, Members requesting additional privileges, or low volume Members. The Department or Section Chief may consider proctored assignments completed at another Renown Health-affiliated hospital; however, the Credentials & Privileges Committee has the final authority to accept proctoring completed at such hospital.
   b. Establish proctoring guidelines for the Department/Section and review annually.
   c. Review all proctoring reports to ensure Member competence.

4. **Credentials & Privileges Committee.** The Credentials & Privileges Committee shall monitor compliance with this Rule. If, at any time during a practitioner’s provisional appointment, the Department/Section Chief or Credentials & Privileges Committee determines that the practitioner is not competent to perform specific clinical privileges and his/her continued exercise of those privileges jeopardizes patient safety, the Credentials & Privileges Committee shall review the medical records of patients treated
by the practitioner and make a recommendation regarding the appointee's continued appointment and clinical privileges to the Medical Executive Committee. If necessary, the clinical privileges of the practitioner may be summarily suspended as outlined in the Medical Staff Bylaws.
RULE 3-1  Physician Proximity

A.  Members of the Medical Staff.

1.  Physical Location.  At a minimum, Medical Staff Members shall be physically available within thirty (30) minutes of the Hospital to fulfill their patient care responsibilities under the Medical Staff Bylaws and Rules & Regulations, and applicable Department and Section policies, including, but not limited to, Emergency Room call.  This time requirement shall be based on the time of day during which it takes an individual the longest amount of time to travel to Hospital based upon reasonable travel conditions for that time of day, day of the week, season of the year, and any other reasonably foreseeable events that would impact travel time to the Hospital.  For purposes of this Rule, a Member who is at another community hospital located within the Truckee Meadows shall be deemed to be within 30 minutes of Hospital.

2.  Requirement for Responding to Calls for Consultations or Emergency Room Call.  When a Member of the Medical Staff is on Emergency Room call, he or she shall respond to a call or page from the Emergency Room or for in-house consultative services by telephone or in person within fifteen (15) minutes of receipt of the call or page.  Thereafter, if the Member initially responded by telephone, he or she shall respond in person to the Emergency Room within a reasonable time after being notified by the Emergency Room physician to appear.  Telephonically responding to the Emergency Room or physician requesting a consult shall not relieve the Member from his or her obligation to respond in person.

3.  On Call Physician Taking Simultaneous Call at another Hospital.  When a Member of the Medical Staff is on Emergency Room call, he or she is permitted to be on-call simultaneously at two or more facilities as long as Hospital knows of such an arrangement in advance.  The Member on simultaneous call must have planned back-up in the event the he or she is called while responding to a call from another hospital and is unable to respond to an on-call request from Hospital in a reasonable time as required by section 2, above.
4. On Call Physician Performing Scheduled Procedures or Elective Surgeries. When a Member of the Medical Staff is on Emergency Room call, he or she is permitted to perform scheduled elective procedures and surgeries. However, the Member must have planned back-up in the event that he or she is called while performing the procedure/elective surgery and is unable to respond to the on-call request in a reasonable time as required by section 2, above.

B. Allied Health Professionals. Allied Health Professionals shall be available within 30 minutes of the Hospital to fulfill their responsibilities under the Medical Staff Bylaws and Rules & Regulations, as well as applicable Department and Section policies.
RULE 3-2  Patient Types and Admissions

A. Definitions of Patient Types.

Patients at the Hospital will fall into two (2) general types: inpatient and outpatient. These types are based on the service being provided at Hospital as well as on specific regulatory requirements including, but not limited to, federal and state law and the Medicare Conditions of Participation. These types are defined as follows:

1. “Inpatient” means a patient who has been admitted to a licensed bed in the Hospital for the purpose of receiving inpatient services and with the expectation that the patient will remain overnight. A subsequent determination that that patient can be discharged before midnight on the day of admission does not change this patient definition.

2. “Outpatient” means a patient who has not been admitted to the hospital as an inpatient but is registered on the hospital records as an outpatient and receives services (rather than supplies alone) from the hospital.

   a. Ambulatory Care Procedure. Ambulatory procedures, including same-day surgeries, angiograms, bronchoscopes, and endoscopies, are generally invasive and require coding and abstracting by HIMS.

   b. Observation. Observation services are those services furnished on the hospital's premises, including the use of a bed and periodic monitoring by nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition in order to determine whether the patient should be admitted as an inpatient or discharged.

   c. Emergency. Emergency services are those services rendered in the Emergency Room or any other area staffed and equipped at all times to provide prompt care for any patient presenting with emergent medical conditions.
d. **Other Outpatient Episodes/Services.**

(1) **Clinic Visits:** Encounters during which diagnoses and other related information are provided by the Member who performs the examination or who is overseeing the activities of another clinician.

(2) **Diagnostic and Treatment Services:** Services such as laboratory and radiological studies, chemotherapy, radiation therapy, and physical therapy, which are performed based on the order of a qualified physician who is also responsible for providing the patient’s diagnosis and other clinical justification for the test or therapy.

B. **Admission Criteria.**

Only Members of the Medical Staff who have the appropriate privileges to admit patients to the patient types listed in this Rule, as provided by the appropriate laws and the criteria established by the Medical Staff, may admit patients to the Hospital as an inpatient or for acceptance by the Hospital for outpatient hospital registration, including ambulatory care procedures, observation services and emergency services. Any patient admitted to the Hospital shall be under the direct care or supervision of a Member of the Medical Staff.

1. **Provisional Diagnosis Required.** Members must record a provisional diagnosis for the patient at the time of admission. In an emergency, the Member may admit the patient and record the provisional diagnosis as soon as possible thereafter.

2. Members shall provide relevant and appropriate information to Hospital Staff as may be necessary to enable the Hospital to protect the patient from self-harm and to protect other patients, staff and visitors from possible sources of danger.

3. Members shall report all cases of reportable diseases in accordance with applicable laws and Hospital policies.
C. Admission of Patients.

1. Members with appropriate privileges may admit patients to the Hospital. A patient’s attending physician shall be responsible for executing all physician responsibilities as to the admission and discharge of patients as expressed in the Hospital’s Policies and Procedures governing admitting and discharging of patients from the Hospital.

2. The admitting order must specify whether the patient is being admitted as an inpatient or an outpatient (including observation or other outpatient services).

3. Changes in patient admission type after the patient is admitted require a new order. However, absent specific regulatory exception and involvement of the Hospital Utilization Review Committee, a patient admitted as an inpatient cannot be changed to Observation status retroactively.
RULE 3-3 Medical Records

A. Definition.

A medical record consists of medical information in the custody of the Hospital Health Information Management (HIM, or Medical Records) Department that is specific to the patient and pertinent to the patient’s care and treatment. The information contained in the medical record, and any other patient-specific information, shall be treated in accordance with all applicable legal and ethical rules related to the confidentiality of patient medical information.

B. Access.

Medical Staff Members, Hospital staff and others may access patient medical records only if they are involved in the care of the patient, or are engaged in peer review, risk management, Medical Staff credentialing, approved research, educational pursuits, or some other appropriate authorized activity. This applies regardless of the format in which the records are maintained or stored, i.e., on paper or electronically.

C. Required Elements.

Patient medical records include identification data; appropriate comprehensive history and physical examination; reports and consultations (including phone consultations); clinical laboratory, radiology and other special reports; provisional diagnosis; medical or surgical treatments; operative reports; anesthesiology records; pathological findings; progress notes; final diagnosis; discharge notes; clinical summary; autopsy report; and other pertinent information such as Patient Advance Directives and Consent forms. Clinical e-mail correspondence must be maintained in the medical record as well. In addition, education and instructions provided to the patient and/or family should be documented in the medical record, as well as documentation of telephone consultations.

D. Responsibility and Timeliness. The attending Member is responsible for the timely preparation and completion of the patient’s medical record. All medical record entries must be authenticated within thirty (30) days following the patient’s discharge.
E. Documentation Rules. Except as otherwise states in these Rules, Members shall comply with the documentation requirements contained herein as follows:

1. Legible. All entries in the medical record must be legible.

2. Authenticated.
   
   a. Signature. A Member or other practitioner authorized to make an entry in the medical record of a patient must sign the entry either in writing or electronically, and provide his or her printed name and discipline.

   (1) Ink Required for Written Signatures. All authenticating signatures written in patient medical records shall be made in ink. Pencil entries in patient records are prohibited.

   (2) Co-signing Records. Members participating in legal entities in the community who desire to have the privilege of co-signing on records of all patients in whose care they participate with other Members of the same legal entity may do so only after notifying the Hospital in writing. All Members of the legal entity who will participate in co-signing records to authenticate patient treatment will be required to sign the request. These letters shall state that those Members of the entity participating in co-signing of records share equal rights and responsibilities to their patients.

   b. Medical Students. Medical student entries must include the identification of the student’s status and be counter-signed by the supervising Member.

3. Dated. All entries must be dated. Time-sensitive entries involving the delivery or documentation of care shall include the time using the 24 hour clock. The following entries must be timed using 24 hour clock:

   a. Orders;

   b. Post-operative notes immediately following surgery;
c. Forms that specify a time documentation requirement;
c. Documentation regarding the administration of medications;
e. Restraint and/or seclusion application and removal;
f. Emergency Room log of patient arrival/discharge times; and
g. Anesthesia notes immediately prior to induction.

4. Abbreviations.

a. **When Allowed.** During the course of care and treatment of a patient, Members may use abbreviations in all parts of the medical record of a patient, except for Discharge Summaries and Final Summaries.

b. **Certain Abbreviations Prohibited.**

(1) **General Rule.** Certain abbreviations have been associated with medication errors and shall not be used. If a Member uses a prohibited abbreviation in a written order, the order will not be carried out until the Member has been contacted and the order clarified. The prohibited abbreviations are as follows:

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Preferred Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>U (unit)</td>
<td>Write “unit”</td>
</tr>
<tr>
<td>IU (International Unit)</td>
<td>Write “International unit”</td>
</tr>
<tr>
<td>Q.D., QD, q.d, (daily)</td>
<td>Write “daily”</td>
</tr>
<tr>
<td>Q.O.D., QOD, q.o.d., qod (every other day)</td>
<td>Write “every other day”</td>
</tr>
<tr>
<td>Trailing zero (x.0 mg)</td>
<td>Write X mg</td>
</tr>
<tr>
<td>Lack of leading zero (.X mg)</td>
<td>Write (0.X mg)</td>
</tr>
<tr>
<td>MS</td>
<td>Write “morphine sulfate”</td>
</tr>
<tr>
<td>MSO4 and MgSO4</td>
<td>Write “magnesium sulfate”</td>
</tr>
</tbody>
</table>

(2) **Exception to General Rule.** If, in the judgment of the Hospital staff providing care to the patient (e.g., the registered nurse, pharmacist, etc.), an order that includes a prohibited abbreviation is nonetheless clear and complete and a delay to obtain confirmation from the
ordering Member prior to execution of the order would place the patient at greater risk, then the order may be carried out; and the confirmation obtained as soon as possible thereafter.

(3) **Repeated Use of Prohibited Abbreviations.** Repeated use of prohibited abbreviations by a Member is considered a patient safety issue. Such conduct will be reported in the Member’s file, may be grounds for disciplinary action at the discretion of the CEO, Chief of Staff, Department or Section Chief, and will be considered upon a Member’s application for reappointment.
RULE 3-4  Reserved
RULE 3-5  Physician Orders

A. Orders.
   1. General Rule. All orders entered into the patient’s record either electronically or in writing by a qualified Member of the Medical Staff shall:
      a. contain appropriate information about the patient’s diagnosis, or the signs or symptoms providing the basis for ordering the service or treatment;
      b. be legible and use appropriate terminology;
      c. be signed by the issuing practitioner and reference the Member’s transcription number (if applicable);
      c. be dated and timed; and
      e. follow Rule 3-3(E)(4) regarding the use of abbreviations.
   2. Orders written by practitioners other than a qualified Member of the Medical Staff must be co-signed by the Member supervising the practitioner prior to the implementation of that order.

B. Verbal/Telephone Orders.
   1. Authentication Required. Verbal orders by Members, including orders given by telephone, will be authenticated by the Member giving the verbal order within 24 hours. The protocol listed in listed in section 3, below, must be followed in each instance. Members may give verbal orders to the following practitioners and other professionals (as appropriate to the practitioner’s discipline):
      a. RNs;
      b. Physical, Occupational and Respiratory Therapists;
      c. Imaging Technologists;
      d. Echo, Vascular and EEG Lab Technologists;
      d. Pharmacists, Dietitians;
      e. Speech and Language Pathologists; and
      f. Case Coordinators.
g. Phlebotomists, Clinical Scientists, Laboratory Medical Technicians and Laboratory Assistants.

2. **When Appropriate.** Verbal/telephone orders shall be issued only if the circumstances require an immediate order and it would be impractical for the prescribing Member to write an order, such as:
   a. A patient emergency;
   b. Physical unavailability of the ordering Member; or
   c. The ordering Member is performing a procedure.

3. **Protocol.** The ordering Member shall allow the receiver of the order to write out the complete order and then read the order back to the Member to ensure the accuracy of the order.

4. **Signing of Order.** A verbal/telephone order must be signed within 24 hours by the prescribing Member or other Member authorized by these Rules and Regulations to sign the order on his or her behalf.
RULE 3-6 Consent and Disclosure

A. Informed Consent Required.

1. Non-Emergent Situations. A patient in the Hospital shall not receive care or treatment without a written consent signed by the patient. Proper informed consent is a prerequisite to performing any procedure or providing treatment for which such consent is appropriate, including transfusions and the use of blood products, planned use of moderate sedation, surgery, or other invasive procedures.

   a. Required Information. The information provided shall include the specific procedure and/or treatment, the reasonably foreseeable risks of the procedure and/or treatment, and reasonable alternatives for care and treatment.

   b. Surgeon Present. In all surgical procedures, the Member in whose name the permission for the operation is obtained shall participate in person as a member of the operating team and shall be present during the critical portion(s) of the procedure. Such participation shall not be delegated without the informed consent of the patient or the patient’s authorized representative.

2. Emergent Situations. In those situations in which the patient’s life is in jeopardy and consent cannot be obtained prior to written consent being obtained, the Member or other practitioner proposing to provide or responsible for providing the care or treatment to the patient shall follow the applicable laws and Hospital policies and procedures in either proceeding with care and treatment or obtaining consent from an appropriate surrogate decision-maker.

B. Disclosure of Unanticipated Outcomes and Medical Errors.

1. Definitions.

   a. “Adverse Event” means a negative result from a diagnostic test, defect, failure and/or error within the healthcare system, medical treatment or surgical intervention.
b. “Unanticipated Outcome” means a result that differs significantly from the anticipated result of a treatment or procedure.

2. Disclosure Required. The attending physician responsible for the patient’s care, or his/her designee as appointed by the Chief of Staff, shall serve as the primary communicator of an unanticipated outcome or adverse event to the patient and/or family/legal guardian. The primary communicator shall document in the progress notes of the patient’s medical record the nature of the information communicated to the patient/family and any ensuing response or discussion.

C. Sterilization.

Any sterilization procedures performed must comply with applicable federal and state law, as well as applicable policies of the Medical Staff and the Hospital.
RULE 3-7 Medications

A. Compliance with Clinical and Hospital Policies. An order for medication must comply with the Medical Staff-approved clinical policies and procedures, including applicable Hospital policies and procedures, that govern the content of, abbreviations and nomenclature permitted in, medication orders, both generally and for specific types of medications.

B. Requirements. Complete medication orders shall include the name of the drug, dosage, frequency of administration, route of administration, date, time, and signature of the prescribing Member or practitioner, and a documented diagnosis, condition or indication for each medication ordered. Orders written by medical students must be reviewed and counter-signed by a qualified supervising Member prior to administration.

C. Administration of Patient’s Outside Medication. Medications brought by or with the patient to the Hospital shall not be administered to the patient unless all of the following conditions are met:

1. The drugs have been specifically ordered by the patient’s licensed physician and the order entered in the patient’s medical record. The order must include the drug name, dosage, frequency, and route.

2. The drugs have been positively identified and examined for lack of deterioration by a Hospital pharmacist or attending physician and have been re-labeled, if necessary, by the pharmacist to provide adequate identification for those responsible for administering the drug.

D. Medications of Patients Transferred to the Operating Room. Upon transfer of the patient to the Operating Room, all medication orders shall be canceled and new orders shall be written. References to prior medication orders are not; complete orders for each medication must be written. If there is a change in Service (e.g. Medicine, Surgery) and/or the Member responsible for the patient, all orders for the patient must be reviewed by the new Service and/or Member, and reaffirmed or discontinued via written order in the patient’s chart.

E. Other Areas of Hospital. In the following areas (Radiology, Nuclear Medicine, MRI, Emergency Room, Operating Room, Post-Anesthesia Care Unit, Cardiac
Catheterization, Dialysis, Endoscopy, Bronchoscopy and Echo) the attending physician Member controls the ordering, preparation, and administration of medications and is responsible for ensuring that an indication or diagnosis is present in the medical record for every medication prescribed.
RULE 3-8 Providing Care, Treatment and Services

A. Daily Care of Patients.

The attending physician Member, or appropriate covering Member, must see his or her patients in the Hospital at least daily, or more frequently if required by the patient’s condition or circumstances. The Member shall write a progress note on each patient daily that contains sufficient detail to provide a reasonable picture of the patient’s clinical status at the time the Member rounded and observed the patient. Once a patient clearly meets criteria for transfer and an order is written to extended care or skilled nursing, daily visits are no longer required, but the physician must round on the patient at least twice per week or as required by the patient’s condition or circumstances.

B. Consultations.

1. The Medical Staff, through its Department and Section Chiefs and Medical Directors, shall be responsible for ensuring that Members obtain consultations when appropriate and when requested by the Department or Section Chiefs, Medical Directors, or Chief of Staff. Each Department and Section may specify the minimum criteria for requesting a consultation in its policies. In addition, a Member shall request a consult in the event that the patient requires a scope of care that is outside the expertise and/or clinical privileges of the attending Member or practitioner, or if uncertainty exists regarding the appropriate course of treatment for a given patient.

2. Timing of Consultation Notes. Within 48 hours of performing a patient consultation, a Member shall prepare written (or otherwise recorded) notes of the consultation that contain the findings made by the Member through interviewing the patient, review of the patient’s medical record, examination of the patient, and a diagnosis and recommendations for care and treatment. The Member shall include in such notes the date of the request of consultation and the date on which the consultation occurred. The notes shall be contained in the patient medical record. Members requesting consultations shall record the request as an order.
and verbally communicate with the consultant to clarify and confirm the request.

3. **Readmitted Patients.** Physicians consulting on patients and continuing to participate in their care and treatment upon readmission shall not be required to provide another formal report of consultation, but will, instead, be required to provide an update note for the medical record, following the same guidelines as imposed for the use of interval notes.

C. **Sedation/Anesthesia Assessments.**

1. **Pre-Anesthesia Assessment.** Prior to administering sedation or anesthesia to a patient, a Member must complete a pre-anesthesia evaluation that includes:

   a. **History:**

      (1) Medical History performed by a physician with a review of systems (specific to cardiovascular disease);

      (2) Any adverse or allergic drug reactions with anesthesia or sedation;

      (3) Level of consciousness;

      (4) NPO status;

      (5) Airway assessment; and

      (6) ASA classification.

   b. **Physical Assessment:**

      (1) Prior to induction update vital signs and oxygen saturation;

      (2) Physiological monitoring is measured and assessed throughout anesthesia and documented on the anesthesia record or procedure room record;

      (3) Brief description of the planned procedure(s);

      (4) Planned anesthesia type, including risks, benefits, and alternatives; and
2. **Post-Anesthesia Assessment.** The Member or other practitioner who administered the anesthesia must write a post-anesthesia follow-up report within 48 hours after completion of surgery. The report should:

   a. Be recorded on the Anesthesia Assessment Form; and
   b. Specifically document any intra-operative or postoperative anesthesia complications.

D. **Operative Care of Patients.**

1. **Immediate Progress Note after Surgery.** A Member shall write a brief operative note in the progress notes immediately following inpatient or outpatient surgery before the patient leaves the surgery suite or recovery area. The written note must include the following elements:

   a. name of primary surgeon;
   b. post-operative diagnosis;
   c. procedure performed;
   d. estimated blood loss; and
   e. any complications.

2. **Post-Operative Report.** An operative report must be dictated for transcription within 24 hours after surgery. The report should contain the following:

   a. Pre-operative diagnosis;
   b. Post-operative diagnosis;
   c. Operations performed;
   d. Names of principal surgeon, assistant surgeons;
   e. Type of anesthesia administered;
   f. Intra-operative findings;
   g. Description of the procedures performed;
h. Intra-operative complications, if any; and
i. Specimens removed.

E. **Off-Service Notes.**
When an attending physician signs off of a case, he or she shall enter a written order that clearly identifies the new attending physician. Off-service notes are encouraged in those cases when an attending physician appropriately is transferring care of the patient to another Member due to the complexity of the case or a prolonged length of stay.

F. **Termination of Physician-Patient Relationship.**
In the event that the physician-patient relationship is terminated for any reason (by the physician Member or the patient), the Member shall use his or her best reasonable efforts to assist the patient in obtaining a new physician qualified to provide the care required by the patient.
RULE 3-9  Coordination of Care and Treatment of Patients

A. Discharge.

1. Order Required. Patients shall be discharged only on the order of the responsible attending physician Member or Allied Health Practitioner. It is the responsibility of the attending physician, dentist, or podiatrist to plan discharge in a timely and coordinated fashion. The responsible attending physician Member or Allied Health Practitioner shall communicate all appropriate medical information to any practitioner and/or any agency, entity or institution to which a patient is referred following discharge from the hospital.

2. Patient Leaving Hospital AMA. If a patient leaves the Hospital against medical advice, the attending physician Member or other practitioner shall document in the patient’s decision in the medical record and the patient should be requested to sign the appropriate release form.

3. Discharge Summary.

a. When Required. For patients who have been in the Hospital for a period of more than 48 hours, the attending physician Member of other practitioner shall dictate or write a patient discharge summary within 48 hours of discharge. For patients who have been in the Hospital for less than 48 hours, the attending physician Member of other practitioner shall dictate or write a discharge note.

b. Form and Contents of the Discharge Summary.

(1) The discharge summary can be handwritten or dictated for transcription.

(2) The content of the discharge summary should be consistent with the rest of the record and include:

(a) Admitting date and reason for hospitalization;
(b) Discharge date;
(c) Final diagnoses;
(d) Succinct summary of significant findings, treatment provided and patient outcome;

(e) Documentation of all procedures performed during current hospitalization and complications (if any);

(f) Condition of patient upon discharge and to where the patient is discharged; and

(g) Discharge medication, follow-up plan, and specific instructions given to the patient and/or family, particularly in relation to activity, diet, medication, and rehabilitation potential.

B. Patient Death. In the event of a patient's death, the patient shall be pronounced dead by a qualified Member of the Medical Staff or by two registered nurses in accordance with Hospital policy. That Member shall determine whether the death is reportable to the Washoe County Coroner's Office and, if so, shall make such report in accordance with applicable laws. The patient's attending physician Member of other practitioner shall dictate or write a discharge summary (as described above) within seven (7) days after the patient's discharge, after which time the Hospital shall release the body.

C. Progress Notes. Members shall write progress notes in the medical record that are adequate to reflect the continuing course of the case and include references to pertinent test results and diagnostic findings, as well as any new problems encountered during the course of the patient's admission to the Hospital. Progress notes will be completed prior to discharge of the patient.
RULE 3-10  Documentation Requirements for Nursing and other Hospital Support Staff.

Documentation of patient care ordered by a Member and provided by Hospital staff shall be entered into and become a permanent part of the patient's medical record. Each non-physician discipline shall record such treatment, testing, or other care on forms approved for use by the Medical Staff. Nursing Department personnel shall document their participation in the patient's care as prescribed by the applicable Hospital policies established by Nursing Administration.
RULE 3-11 Emergency Room Coverage
A. Duty of Medical Staff Members.
   1. Obligation of Members. Members of the Medical Staff shall provide coverage to the Emergency Room ("ER") of the Hospital as provided in Article VII, Section 7.2(A) of the Medical Staff Bylaws. Members also are required to respond to requests for in-house consultative services when they are scheduled to provide ER coverage. This obligation requires Members providing ER coverage, at a minimum, to:
      a. Respond to any call without regard to any individual's race, color, age, creed, sex, national origin, ancestry, marital status, sexual orientation, disability, financial status or participation in any private or governmental, except to the extent that such circumstance is medically significant to the provision of appropriate medical care to that individual.
      b. Assist in the diagnosis and treatment of the patient, and when the patient's condition so warrants, accept continuing primary responsibility for the patient's care, including admission to the hospital and/or subsequent outpatient care.
      c. Assist in the decision to and arrangement for transfer in concurrence with the Emergency Room physician when the patient's condition so warrants and in accordance with applicable federal and state laws, Hospital transfer policies and procedures, and these Bylaws and Rules & Regulations.
      d. Respond to the Emergency Room in a timely manner, as provided in Rule 3-1. Members are expected to assume responsibility for a patient in a time frame appropriate for the patient's medical condition. If unable to do so, the Member must inform the ER of his or her back-up physician. If a Member does not have a back-up available, or the critical patient's stay in the ER is prolonged and/or necessary stabilizing treatment is delayed because of physician issues, the ER physician will notify the appropriate
Department or Section Chief of the situation. The Department or Section Chief will be responsible for arranging appropriate and prompt care for the patient.

e. Respond to any case in the ER when scheduled to provide coverage of any kind at the Hospital (e.g., trauma call or hand call) if the Member maintains core privileges in the required specialty, regardless of the actual specialty for which the Member is scheduled to provide coverage.

2. Responsibilities of Department and Section Chiefs. Department and Section Chiefs shall ensure that adequate coverage is provided in all cases, including specialty cases, in conformance with Article VII, Section 7.2 of the Medical Staff Bylaws.

B. Assignment to Schedule.

1. Written Schedule Required. Members of a Department or Section will be assigned to cover the ER according to a written schedule prepared and delivered as provided in Article VII, Section 7.2(A) of the Medical Staff Bylaws.

2. Allocation of Emergency Room Coverage. Department and Section Chiefs will allocate ER coverage equally between the Department or Section members eligible and/or required to provide such coverage. If a Member requests additional time on the coverage schedule, the Department or Section Chief may allocate such time to the Member if appropriate.

3. Coverage in Extreme Emergency Situations. In cases of extreme emergency, an Emergency Room physician may obtain the services of any Member, regardless of Medical Staff category, who is immediately available to cope with the situation. Such Member shall provide whatever medication or treatment is deemed necessary by that physician, given the urgency of the situation.

4. Multiple Specialties Available. When two or more specialties maintain core privileges in a required specialty, including, but not limited to, hand
call or facial fracture call, and an ER patient requires the services provided by those specialties, then the Emergency Room Physician ("ERP") may contact a Member on call in either specialty to cover the patient. The Member called must see the patient or obtain coverage from a Member in the other on call specialty.

C. Failure to Fulfill Emergency Department Coverage Obligations. If a Member scheduled to provide ER coverage fails to respond to the Emergency Room Physician after multiple attempts, then the ERP immediately will contact the scheduled Member's Department or Section Chief or, if said Chief is unavailable, the Chief of Staff. If the Department or Section Chief is contacted, he or she will notify the Chief of Staff promptly of such contact. The Chief of Staff will take immediate corrective action against the scheduled Member, in the following sequence:

1. First Instance. In the first instance of a Member failing to fulfill his or her ER coverage obligations, the Chief of Staff will direct the Department or Section Chief to send a written warning to the Member.

2. Second Instance. If the Member fails to fulfill his or her ER coverage obligations for a second time within a 12 month period, the Chief of Staff will send a letter to the Member requesting that the Member prepare and submit a written request for a plan of action to eliminate further instances of failing to fulfill his or her ER coverage obligations. If appropriate, the Member also will be referred to the Physician Aid Committee of the Nevada State Medical Association for intervention or assistance.

3. Third Instance. If the Member fails to fulfill his or her ER coverage obligations for a third time within 12 months of the second instance, the Member will be suspended as provided in Article VI, Section 4.4 of the Medical Staff Bylaws, and be entitled to the procedures outlined therein.
RULE 3-12 Private Patients in the Emergency Room

A. Emergent Patients. Members will assume the responsibility for care of their own patients who present in the Emergency Room with an emergency medical condition, provided that delays in the arrival of a private physician do not in any way compromise the care of the patient.

B. Non-Emergent Patients. A Member’s private patient who presents in the Emergency Room for care in a situation not involving an emergency medical condition, as that term is defined by federal and state law, is, and will continue to be, the responsibility of the Member and not the responsibility of the Emergency Room physician. If the patient lists a Member as his or her private physician, that Member will be contacted as soon as possible after the patient has presented in the Emergency Room.
RULE 3-13  Blood Services

A. Blood Usage and Release. All blood cross-matched and not used will be released from cross-match the day following cross-match with two exceptions:

1. The attending physician Member orders the blood to be held for the patient for a longer period.

2. Blood for pre-surgical patients will be held until the day following surgery.

B. Blood will be reserved for any given patient no more than 24 hours, unless there is a written request otherwise, and will be dispensed to the floor or to Surgery upon written request only, except in a patient emergency.
RULE 3-14  Autopsies

A.  When Performed.  An autopsy may be performed only if required by the Washoe County Coroner or other authorized government official, or upon the written consent of an authorized individual as provide by law. The circumstances in which an autopsy may be performed include, but are not limited to, the following circumstances:

1. Deaths in which an autopsy may help explain unknown and unanticipated medical complications.

2. Deaths in which the cause is not known with certainty on clinical grounds.

3. Cases in which an autopsy may help allay concerns of the family and/or public regarding the death.

4. Deaths occurring in patients who have participated in clinical trials approved by institutional review boards.

5. Sudden, unexpected or unexplained deaths that apparently are natural and not subject to a forensic medical jurisdiction.

6. Deaths for which the County Coroner requires an autopsy.

7. Natural deaths that are subject to but waived by a forensic jurisdiction such as the following:
   a. persons dead on arrival at the Hospital
   b. deaths occurring in the Hospital within 24 hours of admission
   c. deaths in which the patient sustained, or apparently sustained, an injury while hospitalized
   e. obstetric deaths
   f. neonatal and pediatric deaths
   g. deaths at any age in which it is felt that an autopsy would disclose a known or suspected illness, and which may also have a bearing on survivors or recipients of transplant organs.

B. Performance of Autopsy.  All autopsies shall be performed by pathologists who are qualified Members of the Medical Staff, or by a physician to whom they may delegate this duty. The post-mortem report should be made part of the medical record within a reasonable time.
RULE 3-15 Use of Restraints and Seclusion to Protect Patients and Others

A. Suicidal Patients. For the protection of patients, the Medical, Nursing and Hospital Staffs, and the Hospital, the following standards shall be met for a patient determined to be potentially suicidal:

1. The attending physician Member or other practitioner shall obtain a psychiatric consultation as soon as possible after a patient has made a suicide attempt or if the Member or practitioner reasonably believes that the patient reasonably may attempt suicide.

2. Prior to the consultation, the practitioner in charge of providing the patient’s care should evaluate the type of immediate medical care required by the patient and write the appropriate orders to obtain the care necessary to stabilize the patient medically.

3. If a patient’s medical history or symptoms suggest a problem with alcohol and/or other drugs, the attending physician Member is encouraged to seek appropriate information and/or consultation for the patient.

B. Restraints and Seclusion. A patient may be restrained or secluded for either behavioral or medical-surgical purposes only if necessary to improve the patient’s wellbeing and/or to protect the safety of other patients and/or others if:

1. Other, less restrictive interventions have been determined to be ineffective; and

2. The order for restraint or seclusion complies with applicable laws and the Medical Staff-approved Hospital interdisciplinary policy on the use of restraints and seclusion; and

3. A qualified Member of the Medical Staff writes an appropriate order:

   a. Behavioral Purposes. The ordering Member evaluates the patient in person within one (1) hour of the application of the restraints or seclusion if for behavioral purposes.

   b. Medical-Surgical Purposes. A physician order is required within 12 hours of the application of restraints or seclusion if for medical-surgical purposes.
RULE 3-16 Member Objection to Withholding/Withdrawing Life-Sustaining Treatment.

If a Member of the Medical Staff is unwilling or unable to honor a Hospital patient’s advance directive to withhold or withdraw life-sustaining treatment, as provided in Nevada Revised Statute 449.628, the Member and/or Hospital will take all reasonable steps to transfer the patient to a Member who will honor the patient’s advance directive. Under no circumstances will a patient be abandoned or put in a situation where care is compromised or not provided as a result of a Member’s conscientious objection to a patient’s advance directive.
RULE 3-17  Organ and Tissue Donation
Members of the Medical Staff shall follow applicable law and the Hospital’s clinical interdisciplinary policy regarding organ and tissue donations.
RULE 3-18  Tissue Specimens

All tissue specimens removed during an operation that are clinically relevant to the indication for the procedure or subsequent therapy shall be read by a Medical Staff member with privileges to read specimens at the Hospital, who shall make such examination as he or she may consider necessary to arrive at a tissue diagnosis. The pathologist’s signed report shall be made a part of the patient’s medical record.
RULE 3-19  Treatment of Family Members

A. AMA Guideline. Members of the Medical Staff should not act as a physician to their immediate family members (first degree relatives, spouse, and children) unless no viable alternative treatment options exist in the Northern Nevada region. See, American Medical Association Code of Medical Ethics Opinion 8.19. This requirement applies to the following situations

1. any procedure requiring written informed consent in any setting;
2. any procedure that might be life-threatening or that uses life-threatening modalities as part of the treatment (e.g., cancer chemotherapy);
3. any condition that involves the use of Schedule III or greater drugs; and
4. any hospital-based treatment (inpatient or outpatient).

B. Rule for Members Treating Family Members

1. If a Medical Staff Member desires to act as physician to a family member in any Hospital facility, the Member first must notify the Chief of Staff to review the situation prior to the initiation of the diagnostic/therapeutic plan, or as soon thereafter as such notification reasonably may be made, and attest to:
   a. the necessity of the plan/procedure;
   b. the lack of viable treatment alternatives in the Northern Nevada region; and
   c. the provision of informed consent by the patient that addresses the patient’s understanding of the risks of:
      (1) coercion;
      (2) conflict of interest;
      (3) the complexities that might arise in the event that the patient experiences a bad outcome; and
      (4) an awareness of the issues surrounding reimbursement and insurance fraud.

2. The Member should consult with the Bioethics Committee as soon as reasonably practicable.

3. The Chief of Staff may review the case at the conclusion of the treatment episode to assure that appropriate technical and professional standards have been met.
RULE 4-1  Contacting Physicians at Home in a Disaster

A. Need to Contact Physicians at Home. In the event of a phone company or answering service breakdown, Nursing Services may need to contact Medical Staff Members at home to ensure communication between the Hospital and Members of the Medical Staff is available.

B. Protocol. Upon notification of a service breakdown, the Medical Staff Coordinator will be notified of the need to access the home numbers of members. The Medical Staff Coordinator, Administrator on Call, or the Senior Emergency Department Physician will direct the Shift Coordinator or Security Personnel to a sealed envelope containing the home numbers of all Members. The sealed envelope will be kept in the front of the Medical Staff Services Department Safety Handbook and in the HEICS box. This envelope will be sealed. If a member of the Hospital staff opens the envelope without appropriate authorization, the Hospital will take appropriate action in accordance with its policies and procedures. After being utilized, the list will be returned to the Medical Staff Office to be updated and placed in a new sealed envelope.

C. Guidelines for acceptable circumstances to access:

1. Phone company trunk failure or answering service problems, e.g., power failures, phone failures; computer failures, inability to contact the answering service, or inability for the answering service to function.
2. Officially declared disasters.
3. Circumstances requiring implementation of disaster protocols.
RULE 4-2  Access to Member Profiles

A. Confidentiality. To ensure that the confidentiality of Member profiles is maintained, such information will be kept in a separate area from Member credential files in such a manner that preserves the confidentiality of that information. Member profile information includes monthly generic screens, notification forms, and other pertinent confidential information.

B. Use of Member Profiles.

1. Credentialing/Peer Review. Member profiles will be available to the Department or Section Chief and Credentials & Privileges Committee during the reappointment process, as well as to the appropriate individuals conducting peer review pursuant to Article VI of the Medical Staff Bylaws. Member profiles are not taken before the Medical Executive Committee.

2. Other Uses. Outside of the credentialing and peer review processes, a Member’s profile may only be accessed by the Member and the Chief of Staff. In special circumstances, the Chief of Staff may give permission to the Department or Section Chief to examine the Member’s profile. In order to preserve confidentiality of the profile, no copies may be made of the contents of the profile.

3. If any question exists regarding the use of a Member profile, the Chief of Staff, Department or Section Chief, and the Credentials & Privileges Committee should review the profile to determine appropriate course of action.
RULE 4-3 Occurrence Reports

A. Process.
   1. An occurrence report regarding a Member, Allied Health Professional, or other practitioner, including a resident, will be forwarded from the Clinical Risk Manager to the Chief of Staff.
   2. The individual who is the subject of the report will be notified and allowed to review, but not copy, the occurrence report.
   3. The Chief of Staff may:
      a. Refer the matter to the Member’s Department or Section Chief, with a request for a timely written response.
      b. If appropriate, the Chief of Staff may contact the individual who submitted the occurrence report to determine whether the issue that gave rise to the incident report has been resolved or improved.
      c. Request a written response from the Member.

B. Action.
   The Chief of Staff may exercise the following options:
   1. No Action (insignificant event).
   2. Referral the matter for Medical Staff Peer Review, as provided in Article IV, Section 4.2 of the Medical Staff Bylaws.
   3. Refer the matter for investigation, as provided in Article IV, Section 4.3 of the Medical Staff Bylaws.
   4. Any other action allowed by the Medical Staff Bylaws or Rules and Regulations.

If the occurrence report involves a resident, the process will be the same with the exception that the residency director will also be asked to review the report and resident’s response.

C. Documentation of Action Taken. Any action taken as the result of an occurrence report will be maintained in the individual’s quality assessment file. All actions taken at the Department level will be reviewed by the Medical Staff Quality Management Committee and assessed for a system problem. The Quality
Management Committee reserves the right to make recommendations back to the Department or Section Chief if the Committee is not satisfied with the actions of the Department.

D. **Availability of Occurrence Reports.** Occurrence reports will be included in the Member’s file during the biennial reappointment process. The occurrence reports also will be available to the residency directors for the evaluation of residents.
RULE 4-4  Confidentiality of Medical Staff Records

A. **Applicability.** As provided in Article XI of the Medical Staff Bylaws, all records maintained by or on behalf of the Medical Staff, including the records and minutes of all meetings of Medical Staff committees, Departments, Sections and the credentials and peer review files for Members, Allied Health Practitioners, and other practitioners, shall remain confidential and privileged to the extent allowed by law.

B. **Location of Records.** All Medical Staff records shall be maintained in Medical Staff Services. Additional quality improvement records are secured in Quality Services, Utilization Management, Trauma Services and Emergency Services. These records will be kept in locked file cabinets under the direction of the Department head of these areas.

C. **Access to Records.** All requests under this section for Medical Staff records shall be made to the Medical Staff Services Manager, who shall allow access to the records as provided in this Rule. Unless otherwise stated, a person permitted access under this Rule shall be given a reasonable opportunity to inspect the records and make notes, but may not remove or make copies of records. Only the Chief of Staff, or his or her designated representative, may authorize the removal and/or copying of records.

1. **Access for Official Hospital or Medical Staff Functions.** Medical Staff officers, Department and Section Chiefs, Medical Staff committee members, Members of the Board of Governors, the Medical Staff Services staff, and the CEO, or his or her designated representative, shall have access to Medical Staff records to the extent necessary to perform official functions as follows:
   a. Medical Staff Officers shall have access to all Medical Staff records.
   b. Medical Staff Department and Section Chiefs shall have access to all Medical Staff records pertaining to the activities of their respective sections.
c. Medical Staff Committee Members shall access to the files of the committees on which they serve and to the credential and peer review files of practitioners whose competency or performance the committee is reviewing.

d. Consultants (who may or may not be Members of the Medical Staff) reviewing a practitioner’s performance at the request of a Medical Staff committee or section shall have access to the credentials and peer review files of the practitioner being reviewed and any other pertinent Medical Staff committee records.

e. The CEO (or designated representatives) shall have access to all Medical Staff records.

2. General Access by Practitioners to Medical Staff Records.

a. Credentialing and Peer Review Files. A practitioner shall have the right to copies of any document in his or her own credentialing and peer review files that he submitted (i.e., his or her application, reapplication, privileges list, or correspondence from him or her) or which were addressed to him or her. A practitioner shall be allowed access to any further information in his or her credentialing and peer review file only if, following a written request by the practitioner, the Medical Executive Committee and the Board of Governors, or its designated representative, grants written permission for good cause.

b. Medical Staff Committee Files. A practitioner shall be allowed access to Medical Staff committee files (to include committee minutes) only if, following a written request by the practitioner, the Medical Executive Committee and the Board of Governors, or its designated representative, grants written permission for good cause.

3. Access by Outside Persons or Organizations.

a. Credentialing Or Peer Review At Other Hospitals.
(1) **Routine Requests for Information.** If a practitioner has not encountered disciplinary or peer review problems or been denied privileges at the Hospital, the CEO or Chief of Staff may release information contained in the practitioner's credentials and peer review file in response to a request from another hospital or its medical staff. Such requests must include notification that the practitioner is a member of that hospital's medical staff, exercises privileges at that hospital, or is an applicant for medical staff membership or privileges. Disclosure shall be limited to the information requested.

(2) **Non-Routine Requests for Information.** If a practitioner has encountered disciplinary or peer review problems or been denied privileges at the Hospital, then no information shall be released until a copy of a signed release, deemed satisfactory by legal counsel, has been received from the requesting institution. Additionally, all responses to such requests shall be reviewed and approved by the Chief of Staff, who may consult with legal counsel.

b. **Other Requests.** All other requests by persons or organizations outside the Hospital for information contained in Medical Staff records shall be forwarded to the Chief of Staff. The release of any such information shall require the concurrence of the Medical Executive Committee, or its designated representative, and the Board of Governors, or its designated representative. The Medical Executive Committee and the Board of Governors may enact disclosure policies applying to specific types of requests. When such disclosure policies are enacted, they shall be appended to this Rule and shall be controlling.

D. **Subpoenas.** All subpoenas of Medical Staff records shall be referred to the CEO or his or her designee, who shall consult the Chief of Staff and legal counsel.
RULE 4-5 Practitioner Health Issues

A. Applicability. The Medical Staff shall provide assistance to any Member who is referred, by himself/herself or another person, for assistance with an individual health issue on a confidential, non-punitive basis if the conduct of the Member is not subject to Section 4.7 of the Bylaws.

B. Assistance Provided. The Medical Staff shall provide education about practitioner health issues, address the prevention of physical, psychiatric, or emotional illness, and facilitate the confidential diagnosis, treatment and rehabilitation of such illnesses. The Medical Staff may use resources provided by the Nevada Health Professionals Assistance Foundation, which administers the Nevada State Board of Medical Examiners’ Diversion Program. The goal of such assistance is rehabilitation, rather than discipline, to aid a Member in retaining and regaining optimal professional functioning that is consistent with the protection of patients.

C. Method of Requesting Assistance. A request for assistance shall be directed to the Chief of Staff, who will assess the situation using whatever data is available and discuss the issue with the Member in question. If an individual other than the Member allegedly requiring assistance makes the request for assistance, the Chief of Staff shall evaluate the credibility of the alleged claim through reasonable efforts. If the Chief of Staff determines that the matter is credible, he or she may involve the Member’s Department Chief and/or Section Chief, other Medical Staff officers, and other Medical Staff Members whose duties are relevant to the issues.

D. Confidentiality. At all times throughout the process, the Chief of Staff shall ensure that the confidentiality of the referral and any other action taken throughout the process is maintained, except as limited by law, ethical obligation, or when the health and safety of a patient is threatened.

E. Appropriate Action.

1. Action per Bylaws Section 4.7(E). The Chief of Staff may take such action as determined to be reasonably sufficient to address the Member’s
health issue, as those actions are detailed in Section 4.7(E) of the Bylaws.

2. Other Action. If the Medical Staff takes action other than that specified in Section 4.7(E) of the Bylaws, the Member must enter into a written contract with the Medical Staff that specifies the action to be taken and requirements for compliance by the Member. The types of action that may be taken include any or all of the following:

a. Rehabilitation Program. The Member may be required to enter into a recognized rehabilitation program. A Member may be allowed to take a voluntary leave of absence to enter such a rehabilitation program, which shall not be reported to the National Data Bank. The Member may return from such a leave of absence upon successful completion of the rehabilitation program, as verified in writing by the rehabilitation program director. The Member also must have a written aftercare rehabilitation program, a copy of which shall be provided to the Medical Staff.

b. Mentorship. The Member will be assigned a mentor from the Associate or Active Staff to assist in monitoring the Member and the safety of his or her patients.

c. Random Drug Testing. The Member may be required to submit to random drug and alcohol testing for a specified period of time. The Member bears the expense for all such testing. The Chief of Staff may refer the Member to the Nevada Health Professionals Assistance Foundation for monitoring at the sole cost of the Member. In the event that any random blood or urine test for drugs or alcohol is positive without a legitimate reason, then the Member immediately shall resign from the Medical Staff.
RENOWN REGIONAL MEDICAL CENTER
MEDICAL STAFF DEPARTMENT AND SECTION POLICIES & PROCEDURES

DEPARTMENT OF ANESTHESIA

SECTION 1: QUALIFICATIONS
Physicians will be appointed to the Medical Staff in accordance with the Bylaws. Physicians who have completed residency training in Anesthesia are eligible for membership in the Department of Anesthesia.

SECTION 2: SCOPE OF SERVICE
The Department of Anesthesia, in concert with Renown Regional Medical Center, will endeavor to provide anesthesia care for a wide range of conditions, including critical care. When deemed necessary for the optimal care of the patient, a physician may transfer a patient to another facility for care.

SECTION 3: MEETINGS
The Department will meet quarterly or as determined appropriate by the Department Chief.

SECTION 4: QUALITY IMPROVEMENT
The Department of Anesthesia will participate in ongoing quality improvement at its regular department meeting and through the various meetings of the Department of Anesthesia.

SECTION 5: CONTINUING MEDICAL EDUCATION
The Department of Anesthesia will participate in continuing medical education through the elective attendance of its Members at CME presentations.

SECTION 6: PRIVILEGES
Privileges are granted in accordance with the Bylaws and Credentialing Policies and Procedures.

SECTION 7: REAPPOINTMENT/CURRENT CLINICAL COMPETENCE
All Members of the Department are reappointed every two years in accordance with the Bylaws and Credentialing Policies of the Medical Staff. Since reappointment is an affirmation of good clinical practice, each Applicant will provide evidence of activity sufficient to demonstrate current clinical competence for the privileges requested. All Members should have a minimum of 50 cases during the last reappointment period.

SECTION 8: MENTORING AND ELEVATION TO ACTIVE STAFF
Members will be directly supervised for their first three cases by an Active Staff anesthesiologist and are eligible to request elevation to Active Staff consistent with the
Bylaws and Credentialing Policies of the Medical Staff. Each Associate Staff Member will be assigned three mentors, one from the Member’s group and the remaining two from outside his or her group. All anesthesiologists requesting elevation will have a minimum of fifty charts reviewed by their mentors. Medical Records will pull these charts at the request of the mentor. A recommendation, based of the review of these charts will be forwarded to Medical Staff Services for consideration by the department chief of their elevation to the Active Staff.
DEPARTMENT OF CARDIOLOGY (reviewed 11/10)

SECTION 1: QUALIFICATIONS

Physicians will be appointed to the Medical Staff in accordance with the Bylaws. Physicians who have completed residency training in Internal Medicine and a fellowship in Cardiology are eligible for membership in the Cardiology Department. Members appointed to the Section as of July 1, 1977 will maintain membership. Other interested physicians may participate in the general business at Section meetings.

SECTION 2: SCOPE OF SERVICE

The Cardiology Section in concert with Renown Regional Medical Center will endeavor to provide care for a wide range of Cardiac conditions, including critical care. When deemed necessary for the optimal care of the patient, a physician may transfer a patient to another facility for care.

SECTION 3: MEETINGS

The Section will meet quarterly. Special meetings or the cancellation of a meeting may be called at the Chief's discretion.

SECTION 4: QUALITY IMPROVEMENT

The Cardiology Section will participate in ongoing quality improvement at its monthly meetings and through the various meetings of sections of the Section of Cardiology.

SECTION 5: CONTINUING MEDICAL EDUCATION

The Cardiology Section will participate in continuing medical education through the elective attendance of its Members at CME presentations. This will include Medical Staff, residents, medical school faculty and invited speakers.

SECTION 6: PRIVILEGES

Privileges are granted in accordance with the Bylaws and Credentialing Policies and Procedures.

SECTION 7: REAPPOINTMENT/CURRENT CLINICAL COMPETENCE

All Members of the Cardiology Section are reappointed every two years in accordance with the Bylaws and Credentialing Policies of the Medical Staff. Since reappointment is an affirmation of good clinical practice, each Applicant for reappointment shall provide evidence of 10 patient contacts. If an Applicant has not had 10 patient contacts at Renown Regional Medical Center, the Applicant will be asked to provide evidence of 10 patient contacts at another local hospital accredited by The Joint Commission. The facility will be queried to ascertain whether or not the physician is in good standing. If the Applicant can not provide evidence of 10 patient contacts at a local hospital, the
physician will be asked to submit in writing, his or her reasons for wanting to remain on
the Medical Staff. The Department Chief will consider these reasons, and if sufficient,
the Applicant will be recommended for reappointment.

Minimum of Cardiac procedures to be performed during a two-year period prior to
reappointment are:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Minimum Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coronary Angiographies</td>
<td>25</td>
</tr>
<tr>
<td>Rotablator</td>
<td>5</td>
</tr>
<tr>
<td>AICD Placement</td>
<td>10</td>
</tr>
<tr>
<td>Subcostal Generator</td>
<td></td>
</tr>
<tr>
<td>Implantation</td>
<td>10</td>
</tr>
<tr>
<td>Radio Frequency Ablation</td>
<td></td>
</tr>
<tr>
<td>For Atrial or Ventricular Arrhythmias</td>
<td>15</td>
</tr>
<tr>
<td>EPS</td>
<td>5</td>
</tr>
<tr>
<td>PTCA and/or Stents</td>
<td>50</td>
</tr>
<tr>
<td>IVUS</td>
<td>5</td>
</tr>
<tr>
<td>Permanent Pacer with Subcostal Generator Lead Placement</td>
<td>10</td>
</tr>
<tr>
<td>Pacemaker Lead Extraction</td>
<td>3</td>
</tr>
<tr>
<td>Radio Frequency Ablation</td>
<td></td>
</tr>
<tr>
<td>AV Node</td>
<td>5</td>
</tr>
<tr>
<td>TEE</td>
<td>8</td>
</tr>
</tbody>
</table>

SECTION 8: MENTORING AND ELEVATION TO ACTIVE STAFF

Formalized Members are eligible to request elevation to Active Staff, consistent with the
Bylaws and Credentialing Policies of the Medical Staff. All physicians requesting
elevation will have a minimum of ten charts reviewed by their mentor. Medical Records
will pull these charts at the request of the mentor. Mentor Report Forms will be used to
evaluate each chart. These forms are available in Medical Staff Services and in Medical
Records and should be turned in to Medical Staff Services upon completion.
DEPARTMENT OF DENTISTRY

SECTION 1: QUALIFICATIONS

The Applicant for membership to the Department of Dentistry shall be a graduate of an accredited school by the Council of Dental Education by the American Dental Association and legally licensed to practice dentistry or medicine in the State of Nevada.

SECTION 2: MEDICAL RECORD REQUIREMENTS

Appropriate medical records shall be maintained. Compliance with Medical Staff Rules and Regulations governing medical records shall apply. Dental medical records are to contain a dental history, an oral examination, and a preoperative diagnosis recorded prior to surgery. A consultation note is required from Members of the Active Dental Staff when in attendance with an Associate Dental Staff Member. All patients who are to undergo general anesthesia shall have a history and physical examination, prior to surgery performed by any Hospital staff physician, and the physician shall be responsible for clinically evaluating the patient throughout the hospital stay.

SECTION 3: PRIVILEGES, REAPPOINTMENT, AND MENTORING

Initial granting, and biennial renewal, of privileges in the Department of Dentistry shall be reviewed by the Dental Privileges Committee, which shall meet as necessary and make appropriate recommendations to the Credentials & Privileges Committee. Privileges shall be granted to Applicants in accordance with training, experience and demonstrated ability. An Associate Staff Member of the Department of Dentistry must be proctored by an Active Staff Member of the Department of Dentistry who is not affiliated with the Associate Staff Member. Surgical privileges shall be limited to those procedures approved by the Dental Privileges Committee and as listed on the Surgical Privileges Card.

SECTION 4: ASSISTANTS

In all major surgical procedures, where appropriate, there shall be a first assistant present.
DEPARTMENT OF EMERGENCY MEDICINE (REVIEWED 10/10)

SECTION 1: QUALIFICATIONS
Physicians will be appointed to the Medical Staff in accordance with the Bylaws. Membership in the Department is confined to physicians who are independent contractors of Renown Regional Medical Center and who are board certified in Emergency Medicine, or who have comparable training, experience, and demonstrated proficiency.

SECTION 2: SCOPE OF SERVICE
The Department of Emergency Medicine, in concert with Renown Regional Medical Center, will endeavor to provide care for a wide range of emergency conditions. As a designated Trauma Center, Emergency physicians will also work closely with the Trauma service to provide optimal care to trauma patients.

SECTION 3: MEETINGS
The Department will meet every other month at Renown Regional Medical Center, or as determined appropriate by the Department Chief.

SECTION 4: QUALITY IMPROVEMENT
The Department of Emergency Medicine will participate in ongoing quality improvement at its department meetings and special projects.

SECTION 5: CONTINUING MEDICAL EDUCATION
The Department will participate in continuing medical education through the elective attendance of Members at CME presentations. Members of the department also participate in the development of CME presentations.

SECTION 6: PRIVILEGES
Privileges are granted in accordance with the Bylaws and Policies and Procedures. Although Emergency Physicians do not have privileges to admit a patient to his or her own care, the Emergency Physician may initiate the admitting process by writing orders in consultation with the patient's admitting physician. Once the patient leaves the Emergency Department, the patient is under the care of the admitting physician, and as such the admitting physician should be contacted for any further information regarding the patient's care.

It is the prime responsibility of Members of the Emergency Medicine Department to provide medical care to patients in the Emergency Department. However, instances will arise when it is appropriate for Emergency Medicine physicians to provide emergency care in the Hospital (e.g., codes, etc.).
SECTION 7: REAPPOINTMENT/CURRENT CLINICAL COMPETENCE

All Members of the Department are reappointed every two years in accordance with the Bylaws and Policies of the Medical Staff. Since reappointment is an affirmation of good clinical practice, each Applicant for reappointment must provide evidence of an active practice.

SECTION 8: MENTORING AND ELEVATION TO ACTIVE STAFF

Each Associate Staff member will be assigned a mentor. All Associate Emergency Medicine Staff will have a minimum of 20 randomly selected charts reviewed by their mentor. A recommendation based on the review of these charts will be forwarded to Medical Staff Services for consideration by the Department Chief of their elevation to the Active Staff.
DEPARTMENT OF FAMILY MEDICINE

SECTION 1: QUALIFICATIONS

The Medical Executive Committee and the Board of Governors will assign membership to the Family Practice Department. Membership will consist of those individuals who have demonstrated appropriate training and experience as well as meet the Department's requirements listed below.

The Applicant shall meet the requirements for Medical Staff membership as outlined in the Medical Staff Bylaws. In addition, the Applicant shall:

- Have successfully completed a family practice residency accredited by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association, or
- Be currently board certified by the American Board of Family Practice or the American Osteopathic Board of Family Practice, or
- Be an active member of the American Academy of Family Physicians and be able to document a minimum of 12 months of post graduate American Osteopathic Association or Accreditation Council for Graduate Medical Education-approved medical education (internship) which includes pediatrics, internal medicine, surgery, obstetrics, and gynecology; and have demonstrated competency in the specialty of Family Practice by being actively involved in the practice of Family Medicine, including Hospital practice, for the five-year period immediately preceding application; and must have letters of recommendation from either two Members of the Renown Regional Medical Center Department of Family Practice or two members of the American Academy of Family Practice.

All Members of the Department of Family Practice are reappointed every two years in accordance with the Bylaws and Credentialing Policies of the Medical Staff. Since reappointment is an affirmation of good clinical practice, each Applicant for reappointment shall demonstrate current clinical competence through documentation of 5 patient contacts at any local JCAHO-accredited hospital. Patient contacts may include consultations, assisting in surgery, same day surgery and Emergency Department contacts. Members wishing to maintain Active status who are unable to document 5 patient contacts will undergo concurrent review of any admissions.

SECTION 2: MEETINGS

The Family Practice Department will meet six times a year.

SECTION 3: PRIVILEGES
A Privileges Committee will be established within the department to determine privileges based upon the Applicant's training, experience and examination of records where indicated. Advancement in privileges will be determined upon demonstrated competence and proficiency during the Member's Associate Staff tenure.

Where a specific privilege is requested by a Member of the Family Practice Department in an area normally regulated by the Family Practice Department (Category I Privileges), it may be granted upon the recommendation of the Family Practice Department Privileges Committee.

When a specific privilege request is within areas normally regulated by another department (Category II and III Privileges), it shall first be considered by the Family Practice Department Privileges Committee. If this committee feels that the Applicant's training, experience and competence justifies the granting of a specialty privilege, that recommendation shall be made to the Medical Executive Committee and forwarded via the relevant specialty department privilege committee for endorsement. Should the specialty privilege committee fail to make a favorable endorsement, they shall meet jointly with the Family Practice Privileges Committee, with the Applicant present. When agreement cannot be reached, specific responses shall be made by each privileging committee involved and referred to the Medical Executive Committee for a decision.

SECTION 4: MENTORING

There is no minimum number of charts that should be reviewed by the mentor as the basis for making a responsible recommendation for a physician being considered for elevation to Active Staff.
DEPARTMENT OF HOSPITALIST MEDICINE

SECTION 1: TBA
DEPARTMENT OF MEDICINE

SECTION 1: QUALIFICATIONS

Physicians will be appointed to the Medical Staff in accordance with the Bylaws. Physicians who have completed residency training in Internal Medicine are eligible for membership in the Department of Medicine. Other physicians will be considered for membership in the Department on a case-by-case basis.

SECTION 2: SCOPE OF SERVICE

The Department of Medicine in concert with Renown Regional Medical Center will endeavor to provide care for a wide range of Medical conditions, including critical care. When deemed necessary for the optimal care of the patient, a physician may transfer a patient to another facility for care.

SECTION 3: MEETINGS

The Department will meet 6 times a year at Renown Regional Medical Center, or as determined appropriate by the Department Chief.

SECTION 4: QUALITY IMPROVEMENT

The Department of Medicine will participate in ongoing quality improvement at its regular department meeting and through the various meetings of sections of the Department of Medicine.

SECTION 5: CONTINUING MEDICAL EDUCATION

The Department of Medicine will participate in continuing medical education through the elective attendance of its Members at CME presentations. This will include Medical Staff, residents, medical school faculty and invited speakers.

SECTION 6: PRIVILEGES

Privileges are granted in accordance with the Bylaws and Credentialing Policies and Procedures.

SECTION 7: REAPPOINTMENT/CURRENT CLINICAL COMPETENCE

All Members of the Department of Medicine are reappointed every two years in accordance with the Bylaws and Credentialing Policies of the Medical Staff. Since reappointment is an affirmation of good clinical practice, each Applicant for reappointment shall provide evidence of 10 patient contacts. If an Applicant has not had 10 patient contacts at Renown Regional Medical Center, the Applicant will be asked to provide evidence of 10 patient contacts at another local, JCAHO accredited hospital. The facility will be queried to ascertain whether or not the physician is in good standing. If the Applicant can not provide evidence of 10 patient contacts at a local hospital, the
physician will be asked to submit in writing, his or her reasons for wanting to remain on the Medical Staff. These reasons will be considered by the Department Chief, and if sufficient, the Applicant will be recommended for reappointment.

SECTION 8: ELEVATION TO ACTIVE STAFF

Members are eligible to request elevation to Active Staff, consistent with the Bylaws and Credentialing Policies of the Medical Staff. All physicians requesting elevation will have a minimum of ten charts reviewed by their mentor. Medical Records will pull these charts at the request of the mentor. Mentor Report Forms will be used to evaluate each chart. These forms are available in Medical Staff Services and in Medical Records and should be turned in to Medical Staff Services upon completion.
GASTROENTEROLOGY SECTION

SECTION 1: QUALIFICATIONS
The chief of the department will assign membership to the Gastroenterology Section. The membership will consist of staff Members who are Board Eligible or Board Certified by the sub-specialty Gastroenterology Board of the American Board of Internal Medicine, or who have comparable training, experience and have demonstrated proficiency in the field. Associate membership may be assigned in the Gastroenterology Section to those Members of the Medical Staff with an interest in Gastroenterology who do not qualify under the requirements above.

SECTION 2: SCOPE OF SERVICE
The Gastroenterology Section will comply with the Bylaws, Rules and Regulation of the Medical Staff of Renown Regional Medical Center. A section chief will head the section, selected by Members of the Gastroenterology Section, with concurrence of the Medical Executive Committee, duration of tenure being two years. It shall be the responsibility of the Section of Gastroenterology to provide leadership and medical directorship to the Hospital's Gastroenterology Endoscopy Laboratory.

SECTION 3: MEETINGS
There will be a regular meeting at quarterly intervals of the Gastroenterology Section. Special meetings will be held on call of the Chief or two (2) Members of the department.

SECTION 4: QUALITY IMPROVEMENT
The Gastroenterology Section will participate in ongoing quality improvement at its monthly meetings and through the various meetings of sections of the Section of Gastroenterology.

SECTION 5: CONTINUING MEDICAL EDUCATION
Continuing medical education will be provided to the Hospital employees on a regular basis.

SECTION 6: PRIVILEGES
A Privileges Committee, composed of Members of the Active Staff, will be established within the Section that will include the Section Chief. Recommendation of specific Gastroenterology privileges shall be made by the Privileges Committee of the Gastroenterology Section on formal written application. Privileges will be recommended on the basis of the Applicant's training, experience and examination of the records of the previous cases handled. Maintenance of privileges will depend upon demonstration of continued competence in the field.
SECTION 7: REAPPOINTMENT/CURRENT CLINICAL COMPETENCE

All Members of the Department of Medicine are reappointed every two years in accordance with the Bylaws and Credentialing Policies of the Medical Staff. Since reappointment is an affirmation of good clinical practice, each Applicant for reappointment shall provide evidence of 10 patient contacts. If an Applicant has not had 10 patient contacts at Renown Regional Medical Center, the Applicant will be asked to provide evidence of 10 patient contacts at another local, JCAHO accredited hospital. The facility will be queried to ascertain whether or not the physician is in good standing. If the Applicant cannot provide evidence of 10 patient contacts at a local hospital, the physician will be asked to submit in writing his or her reasons for wanting to remain on the Medical Staff. The Department will consider these reasons, and if sufficient, the Applicant will be recommended for reappointment. The Gastroenterology Section requires the following: 10 EGDs, 10 colonoscopies, 5 polypectomies, 10 ERCPs, and 3 sphincterotomies.
DEPARTMENT OF NEUROSURGERY

SECTION 1: PRIVILEGES

Initial granting and biennial renewal of privileges in the Department of Neurosurgery shall be delegated to the Department Privileges Committee that shall meet as necessary and make appropriate recommendations to the Medical Executive Committee. Privileges shall be extended to Applicants in accordance with training, experience and demonstrated ability. Consultation privileges shall be granted at the discretion of the Neurosurgery Privileges Committee.

SECTION 2: MEETINGS

The Department of Neurosurgery shall meet on a quarterly basis (excluding July and August) at a time convenient to the Members, and the meetings will be appropriately announced to Members.

SECTION 3: CONSULTATIONS

Consultations shall be required as defined in the Rules and Regulations for the Department of Surgery, viz.:

- Critically ill patients.
- Prolonged hospitalization with obscure diagnosis; and
- In all major procedures, where appropriate, there must be a first assistant present.

SECTION 4: CONSENTS

The operative permit must be approved by one of the patient’s parents or legal guardian before surgery if the patient is a minor. The consent form should designate the name of the anesthesiologist administering the anesthetic, the operating surgeon(s), and the procedures contemplated.

All procedures carried out in the operating room require a permit to be signed. In the case of minors, the District Attorney’s ruling must be followed.

All outpatient procedures carried out in the operating room should have a covering operative note.

In emergency situations where a delay could endanger the life or bodily function of the patient and a properly executed consent is not obtainable, the attending physician will sign the operative permit.
SECTION 5: MENTORING

Associate Staff Members of the Neurosurgery Department shall have a consulting Member of the staff, with privileges in the procedure involved, present in Surgery. (Exceptions may be granted for specific procedures upon written application to the Department Privileges Committee.)

SECTION 6: ELEVATION TO ACTIVE STAFF

Fifty (50) cases must be reviewed prior to being eligible for elevation to Active Staff.

SECTION 7: REAPPOINTMENT/CURRENT CLINICAL COMPETENCE

All Members of the Department are reappointed every two years in accordance with the Bylaws and Credentialing Policies of the Medical Staff. Since reappointment is an affirmation of good clinical practice, each Applicant will provide evidence of activity sufficient to demonstrate current clinical competence for the privileges requested. All Members should (1) be Board certified within the last five years on staff; (2) have one or more CME sessions per year; and 3) maintain community neurosurgery standards.
DEPARTMENT OF OBSTETRICS & GYNECOLOGY

SECTION 1: QUALIFICATIONS
Physicians will be appointed to the Medical Staff in accordance with the Bylaws. Physicians who have completed residency training in OB/GYN are eligible for membership in the Department of OB/GYN.

SECTION 2: SCOPE OF SERVICE
The Department of OB/GYN in concert with Renown Regional Medical Center will endeavor to provide care for a wide range of obstetrical conditions. When deemed necessary for the optimal care of the patient, a physician may transfer a patient to another facility for care. Patients under the age of 18 who are pregnant or within 6 weeks postpartum and who present to the Emergency Department will be referred to an OB/GYN physician.

SECTION 3: MEETINGS
The Department will meet six times a year at Renown Regional Medical Center, or as determined appropriate by the Department Chief. Two of these meetings will be the full Department and the remaining will be the Administrative Committee. The Administrative Committee has the authority to act on behalf of the Department and is composed of six Active or Senior Active Staff Members, including the Chief. Two members will be elected by the Department each year for a two-year term. The meeting schedule will be published and other Members of the Department may attend the Administrative meeting.

SECTION 4: QUALITY IMPROVEMENT
The Department of OB/GYN will participate in ongoing quality improvement at its monthly department meeting and through the various meeting of sections of the Department of OB/GYN.

SECTION 5: CONTINUING MEDICAL EDUCATION
The Department of OB/GYN will participate in continuing medical education through the elective attendance of its Members at CME presentations. This will include Medical Staff, residents, medical school faculty and invited speakers.

SECTION 6: PRIVILEGES
Privileges are granted in accordance with the Bylaws and Credentialing Rules and Regulations.

SECTION 7: MENTORING
Obstetrical
New Members of the Department will be mentored by two or three Active Staff OB/GYNs for at least twenty-five (25) deliveries, of which:

a. The first five will be monitored with the mentor in attendance.

b. A minimum of five more will be monitored from among the remaining twenty deliveries.

c. There will be a minimum of five complicated obstetrical cases (including two C-sections).

d. All twenty-five deliveries will be reviewed by the Department. Following completion of these criteria, the physician may request to be released from Mentoring.

Gynecological

New Members of the Department will be mentored for fifteen (15) major and ten (10) minor surgical procedures prior to consideration of advancement to Active Staff. Of these cases:

1. All fifteen cases require an assistant who has GYN privileges and should involve at least three different gynecologists. Major procedures are defined as those cases that involve entering the abdominal cavity. If any questions arise regarding case definition, the Active Staff Member mentoring the case will make the decision.

2. Of the ten minor cases, a gynecologist with full Active Staff privileges will monitor the first five. After ten minor procedures, there is no need for further mentoring of minor procedures, regardless of whether or not the physician qualifies for advancement to the Active Staff.

3. The first three laparoscopies are to be monitored and identified as major cases. Therefore, a laparoscopy may be identified as either a major or minor procedure according to personal preference, but no more than five of fifteen laparoscopies are to be identified as minor procedures. Regardless, a laparoscopy procedure is to be considered a minor procedure by the O.R. staff and it the responsibility of the Associate Staff physician to know when it is necessary to obtain a proctor on the first three laparoscopies he or she performs.

If proficiency has been demonstrated to the satisfaction of the Department Chief prior to the completion of the proctoring requirements as outlined above, the balance of the cases to be proctored may be waived.
It is the responsibility of the physician undergoing proctoring to provide all information needed to fulfill the preceding requirements and to identify major and minor procedures as defined by ACOG.

SECTION 8: REAPPOINTMENT/CURRENT CLINICAL COMPETENCE

Obstetrical

Participation in One shoulder dystocia drill every two years required for reappointment.

Category I

A physician who has OB privileges at RRMC and has had less than 12 total deliveries in the past year at RRMC and SMRMC combined.

Category II

A physician who has OB privileges at RRMC but has performed less than 12 deliveries at RRMC, but a total greater than 12 deliveries at RRMC and SMRMC combined.

Category III

A physician who has OB privileges at RRMC and has performed more than 12 deliveries at RRMC in the past year.

Criteria

Category I

The physician will need to provide at least 12 hours of CME in obstetrics biennially and will be required to have an OB consultant on all deliveries and is subject to mandatory review of the Department.

Category II

The physician will need to provide RRMC's OB Department, on an annual basis, a summary of OB activity and outcome and his or her privileges will be maintained without a consultant.

Category III

Privileges to be maintained.

Gynecological

Demonstration of 5 major and 5 minor gynecological surgeries over the past two years.

SECTION 9. OPERATIVE REPORT

An operative report is required for all forceps and vacuum extractor vaginal deliveries in addition to all operative procedures.

SECTION 10. C-SECTION ASSISTANCE

There must be an assistant who is a qualified physician on all scheduled elective and emergency C-section.
DEPARTMENT OF ONCOLOGY

Section 1: Qualifications
DEPARTMENT OF OPHTHALMOLOGY (REVIEWED 10/10)

SECTION 1: QUALIFICATIONS

Admission requirements defined in Rules and Regulations for the Department of Surgery shall be followed.

SECTION 2: MEETINGS

The Department of Ophthalmology shall hold at least four meetings a year at a time convenient to and appropriately announced to Members.

SECTION 3: PRIVILEGES

Initial granting, and biennial review, of privileges in the Department of Ophthalmology shall be delegated to the Department Privileges Committee, which shall meet as necessary and make appropriate recommendations to the Medical Executive Committee. Privileges shall be recommended in accordance with training, experience and demonstrated ability. Consultation privileges shall be recommended by the Ophthalmology Privileges Committee.

SECTION 4: ELEVATION TO ACTIVE STAFF

The Associate Staff Member must serve a minimum of at least 12 months.

A Member of the Active Staff will assist a minimum of 12 major ophthalmic surgeries. At least three different Active Staff ophthalmologists will be utilized for the purposes of assisting and observation. An individual in a group practice should make an effort to obtain cases mentored by Active Staff Members outside his/her group. The 12 cases can be a combined community experience and do not necessarily reflect cases performed only at Renown Regional Medical Center. Arrangements for surgical assistance shall be the responsibility of the evaluating staff ophthalmologists prior to advancement to Active Staff status shall be submitted.

SECTION 5: REAPPOINTMENT/CURRENT CLINICAL COMPETENCE

Reappointment will be on a biennial basis and will be based on unbiased, objective review of care according to the Hospital's quality assurance mechanisms.
DEPARTMENT OF ORTHOPAEDICS

SECTION 1: QUALIFICATIONS
Admission requirements defined in Rules and Regulations for the Department of Surgery shall be followed. An Applicant must be able to document board certification or eligibility or be able to document equivalent training and/or experience which is deemed acceptable on an individual basis by the Orthopaedic Department (minimum equivalency required that a physician must have completed an approved 5-year orthopedic residency.) Certification or eligibility must be by a board recognized by the American Board of Medical Specialties. A physician's orthopaedic practice must be confined to the immediate Reno-Sparks area.

SECTION 2: MEETINGS
The Department of Orthopaedics shall meet on a quarterly basis (excluding any months such as July and August) at a time convenient to and appropriately announced to the Members.

SECTION 3: PRIVILEGES
Initial granting reappointment of privileges in the Department of Orthopaedics shall be reviewed by the Department Chief who shall make appropriate recommendations to the Credentials and Privileges Committee. Privileges shall be extended to Applicants in accordance with training, experience and demonstrated ability.

SECTION 4: PROCTORING AND ASSOCIATE STAFF
Associate Staff
Must be proctored by an Active Staff Orthopaedic Department Member who is not affiliated with the Associate Staff Member.
May be assigned to ER call while being proctored but cannot transfer call other than to another Active Staff Orthopaedic Department Member.
Can provide alternate coverage only by an Active Staff Orthopaedic Department Member.

SECTION 5: REAPPOINTMENT/CURRENT CLINICAL COMPETENCE
All Members of the Department are reappointed every two years in accordance with the Bylaws and Credentialing Policies of the Medical Staff. Since reappointment is an affirmation of good clinical practice, each Applicant will provide evidence of activity sufficient to demonstrate current clinical competence for the privileges requested. All Members should have a minimum of 50 cases during the last reappointment period.
PODIATRY SECTION

ARTICLE I: MEMBERSHIP

SECTION 1: QUALIFICATIONS AND APPLICATION

1. Podiatrists will be appointed to the Medical Staff in accordance with the Bylaws and applicable policies.

2. Privileges with consultation carry with them the requirement that the practitioner have consultation in case management prior to performing certain procedures. This pertains to complex situations (clubfoot, metatarsal adductus and abductus, flatfoot, cavus foot) where the necessary procedures may be within the capabilities of the practitioner when performed individually, but not be when performed in combination. The practitioner has the responsibility to arrange the consultation with the consultant of his/her choice from the Active Staff list. The requirements for consultation do not necessarily imply participation of the consultant and may be removed by the Evaluating Committee after a review of the practitioner’s performance and at the suggestion of the consultant.

3. If, in the opinion of the consultant, the necessary procedures are too difficult for the practitioner to perform, the case will be canceled.

4. In this event, the practitioner may assist a qualified staff Member in performing the procedures. With the recommendation of the consultant, and documentation of having assisted in enough cases, a practitioner may upgrade his/her privileges with consultation to that of privileges with supervision.

5. Privileges with supervision carry with them the requirement that a practitioner have direct supervision and/or case management in performing certain procedures.

6. The practitioner may not proceed with diagnosing, treating, or caring for a patient until he/she has arranged for an appropriate podiatrist to accept responsibility for supervision.

7. The requirement for supervision may be removed by the Evaluating Committee upon recommendation of the supervising podiatrist.

8. A current list of supervising/consulting podiatrists will be available through the offices of the Medical Staff and the head of the Operating Room.

SECTION 2: CLASSIFICATION OF MEMBERSHIP

1. Active Staff: Those Members actively participating at Renown Regional Medical Center (are geographically located within 30 miles of the Hospital) who are
required to attend all regularly scheduled meetings, attend regular committee functions, and are eligible to vote and hold office as set forth by RRMC Bylaws.

2. Associate Staff: The original appointment of Members will be provisional, during which time they shall not vote nor hold office but shall be required to attend a minimum of 25 percent of departmental and committee meetings to which they may be assigned. To be eligible for elevation to Active Staff, the following mentored cases must be documented:
   - Class I: Minimum 5 cases
   - Class II: Minimum 10 cases
   - Class III: Minimum 2 cases

3. Courtesy Staff: Those practitioners who do not meet the requirements for Active Staff, but who do, from time to time, accompany referred patients to RRMC for the purpose of assisting in the patient's surgery.

4. Honorary Staff: Members with full voting privileges may be granted to particular individuals held in honorary status by the section. The Section must nominate the individual and nomination is approved by a majority of the voting Members of the section and recommended by the Medical Executive Committee.

SECTION 3: REAPPOINTMENT/CURRENT CLINICAL COMPETENCE

For reappointment of Class I privileges, demonstrate 10 cases within the class during the reappoint period at a JCAHO or AAAHC accredited facility. For reappointment of Class II, demonstrate 20 cases within the class for the reappoint period at a JCAHO or AAAHC accredited facility. For Class III reappointment, demonstrate five hindfoot (Class III) procedures within the reappoint period. If five varied cases from Class III procedures previously privileged at Renown are not attained, the balance of the five cases will be mentored.

ARTICLE II: MEETINGS

SECTION 1: REGULAR MEETINGS

Regular monthly meetings of the section shall be held on the odd-numbered months at 5:30 p.m. Chart review will be handled for the even numbered months by two podiatrists assigned on an alphabetical rotating basis.

SECTION 2: SPECIAL MEETINGS

Special meetings of the section may be called at any time by the chief of the section or at the request of a majority of the voting Members of the department.

SECTION 3: ANNUAL MEETINGS
The annual meeting of the section shall be held at the regular meeting in December of each year. The election of officers is held in December. The newly elected officers assume office at the January meeting.

SECTION 4: ATTENDANCE AT MEETINGS
Voting Members of the section shall be required to attend fifty (50 percent) percent of all regular or special meetings of the section.

SECTION 5: QUORUM
Those voting Members of the section present, but at least two, shall constitute a quorum.

SECTION 6: VOTING
Only Active Staff Members shall be granted the right to vote on any issue at any regular or special meeting.

SECTION 7: AGENDA
The agenda at any regular meeting of the section shall include:
- Call to order
- Recording of attendance
- Educational session and clinical review:
  - Lecture or educational presentation
  - Case presentation and review by resident or staff Member
  - Clinical review of the section, conducted by an assigned Member
- Business session
- Minutes
- Committee reports, if any.
- Old Business
- New Business
- Announcements
- Adjournment

ARTICLE III: OFFICERS AND DUTIES
Section 1: OFFICERS
The officers of the Section shall be a chief and a vice-chief, elected at the annual meeting in December. The Chief and Vice-Chief shall be voted upon for confirmation and appointment by the Board of Governors.

SECTION 2: DUTIES
Chief: The chief of the Section shall be responsible for all activities of the section. He shall be the liaison between the Section and the Medical Executive Committee of the Medical Staff.
He shall conduct all meetings, appoint all committees and maintain the organization and operation of the Section.

Vice Chief: The vice-chief of the Section shall, in the absence of the chief, assume his/her responsibilities.

ARTICLE IV: COMMITTEES

The chief shall appoint committees, from time to time, as necessary.

SECTION 1: THE EVALUATING COMMITTEE SHALL CONSIST OF THE CURRENT CHIEF OF THE SECTION AND AT LEAST TWO MEMBERS OF THE SECTION.

1. The committee shall meet bi-monthly and maintain minutes of its review and actions.

2. The responsibility and authority of the Evaluating Committee are as follows:
   a. Review and make recommendations on applications and reapplicant referred by the Credentials & Privileges Committee. This includes categorization of privileges.
   b. To conduct performance reviews of those Members of the section who have privileges subject to supervision or consultation. Such conditions may be removed at the suggestion of the supervising or consulting staff Member and with proper documentation to clinical work. This action shall then be reported to the Credentials & Privileges Committee.
   c. Shall review and take action on problems referred by the Quality Assessment Committee of the Medical Staff.

ARTICLE V: AMENDMENTS

The Policies & Procedures governing the Section of Podiatry may be altered or amended at any regular or special meeting of the Section by a simple majority vote (51%) of the Members present and voting; providing the Secretary has caused notice including a copy of the proposed alterations or amendments, to be given at least ten (10) days prior to the meeting at which it is to be presented for a vote.

The Medical Executive Committee of the Medical Staff and the Board of Governors of Renown Regional Medical Center must approve the amendments before they become effective.

ARTICLE VI: ADOPTION

These Policies & Procedures shall be adopted at any regular meeting of the Section of Podiatry and then shall replace any previous Policies & Procedures. These Policies & Procedures shall, when adopted and approved by the Medical Executive Committee of
the Medical Staff and the Board of Governors of Renown Regional Medical Center, be equally binding on the full membership of the Section of Podiatry
DEPARTMENT OF OTOLARYNGOLOGY

SECTION 1: QUALIFICATIONS
Admission requirements defined in Rules and Regulations for the Department of Surgery shall be followed.

SECTION 2: MEETINGS
The Department of Otolaryngology shall meet on a quarterly basis with chart review being done on a monthly basis by rotation of Members.

SECTION 3: PRIVILEGES
Initial granting, and annual renewal, of privileges in the Department of Otolaryngology shall be delegated to the Department Privileges Committee that shall meet as necessary and make appropriate recommendations to the Medical Executive Committee. Privileges shall be recommended in accordance with training, experience and demonstrated ability. Consultation privileges shall be recommended by the Otolaryngology Privileges Committee.

SECTION 4: CONSULTATIONS
Consultations shall be required as defined in the Rules and Regulations for the Department of Surgery, viz.:
Subsection 1
Critically ill patients
Subsection 2
Prolonged hospitalization with obscure diagnosis.
Subsection 3
Associate Staff Members of the Otolaryngology Department shall have a consulting Member of the Staff, with privileges in the procedure involved, present in surgery. (Exceptions may be granted for specific procedures upon written application to the Department Privileges Committee.

SECTION 5: CONSENTS
Subsection 1
The operative permit must be approved by one of the patient's parents or legal guardian before surgery if the patient is a minor. The consent form should designate the name of the anesthesiologist administering anesthetic, the operating surgeons(s), and the procedures contemplated.
Subsection 2
All procedure carried out in the operating room require a permit to be signed.
Subsection 3
All outpatient procedures carried out in the operating room should have a covering operative note.

Subsection 4
In emergency situations where a delay could endanger the life or bodily function of the patient and a properly executed consent is not obtainable, the attending physician will sign the operative permit.

SECTION 6: ASSISTANTS
In all major procedures, where appropriate, there must be a first assistant present.

SECTION 7: REAPPOINTMENT/CURRENT CLINICAL COMPETENCE
All Members of the Department are reappointed every two years in accordance with the Bylaws and Credentialing Policies of the Medical Staff. Since reappointment is an affirmation of good clinical practice, each Applicant will provide evidence of activity sufficient to demonstrate current clinical competence for the privileges requested.
DEPARTMENT OF PATHOLOGY (REVIEWED 10/10)

SECTION 1: QUALIFICATIONS
Physicians will be appointed to the Medical Staff in accordance with the Bylaws. Members must have successfully completed a postgraduate residency program in Pathology approved by the ACGME. Membership or eligibility for the American Board of Pathology is also required.

SECTION 2: SCOPE OF SERVICE
The Pathology Department will maintain Anatomic and Clinical Pathology facilities and services to meet the needs of patients as approved by the Board of Governors.

SECTION 3: MEETINGS
The Department will meet six times a year. The Department Chief or one-half of the Department’s membership may call special meetings.

SECTION 4: QUALITY IMPROVEMENT
The Department will participate in ongoing quality improvement at its department meetings and through participation in various hospital and Medical Staff committees.

SECTION 5: CONTINUING MEDICAL EDUCATION
The Department will participate in continuing medical education through the elective attendance of its Members at CME presentations.

SECTION 6: PRIVILEGES
Physicians requesting limited privileges may specify the privileges requested. The Department Chief will make a recommendation based on the Applicant’s education, training and demonstrated clinical competence.

Autopsy:
1. Board certification or eligibility in Anatomical Pathology.
2. Demonstration of two cases that will be reviewed by the Department Chief.

Surgical Anatomic Pathology:
1. Board certification or eligibility in Anatomical Pathology.
2. Demonstration of 100 cases, which will be reviewed by the Department Chief.

Clinical Pathology:
1. Board certification or eligibility in Clinical Pathology

For Grossing Only:
2. To be released from mentoring a total of 20 gross descriptions must be mentored.
Special request privileges require documentation as specified on the Delineation of Privileges form.

SECTION 7. ELEVATION TO ACTIVE STAFF & REAPPOINTMENT

Volume Requirements
1. Autopsies: The pathologist must either be actively performing autopsies or have privileges at Renown Regional Medical Center for Surgical Pathology.
2. Surgical Pathology specimens (inpatient and/or outpatient): 200 with at least 150 from inpatient.
3. Bone Marrow (procedure and microscopic): 2
4. Cytology Specimens (gynecological and/or non gynecological combined): 50
5. Frozen sections: 10
6. Currently practicing clinical consultations and review.

Quality Indicators
1. Unjustified frozen section discrepancies.
2. Errors found on daily review.
3. Any cases not completed at RRMC will undergo review by the Department.

Other Review Items
As aggregated by Medical Staff Services for Department Chief review.

Procedure
The Department Chief, with the aid of the department staff, will maintain a list of the indicators mentioned above for each pathologist. At reappointment, the information will be reviewed by the Department Chief and forwarded to Medical Staff Services for the physician’s confidential profile.

SECTION 8: AUTOPSIES

On all Hospital autopsies, the treating doctor will be called before the autopsy is started. Following the autopsy, usually within 24 hours, a written preliminary autopsy diagnosis will be placed on the chart. The autopsy will be completed within 30 days for uncomplicated cases. Autopsies will be requested as defined by the Medical Staff in Policy.

SECTION 9: SURGICAL SPECIMENS

All surgical specimens removed in the Hospital, with the exception of 1) orthopedic hardware, 2) grossly normal fat, skin and subcutaneous tissue, 3) specimen from liposuction and abdominoplasty, 4) hernia sac, 5) foreign bodies, 6) toenails and fingernails, 7) breast implants, 8) varicose veins, 9) cataracts, 10) bunions, and 11) teeth
will be examined by a pathologist who will determine the extent of examination and issue a report with the diagnosis.

SECTION 10: USE OF LABORATORY BY NON-PATHOLOGISTS

The laboratory facilities of Renown Regional Medical Center will be available to the Members of the Medical Staff and Allied Health Professionals as appropriate in each case, and in other instances based upon medical need at the discretion of the Medical Director, Department Chief or designee.
DEPARTMENT OF PEDIATRICS (REVIEWED 10/10)

SECTION 1: QUALIFICATIONS

Members of the Pediatric Department will be assigned to the Department by the Medical Executive Committee and Board of Governors. The type of privileges will be recommended by the Pediatric Privileges Committee. Privileges in the Pediatric Department shall be extended to the physicians according to their training, experience and ability. Consultation privileges shall be granted at the discretion of the Pediatric Privileges Committee. Privileges to perform special pediatric procedures will also be granted by the Pediatric Privileges Committee.

If a physician has not actively practiced in a JCAHO, or equivalent, hospital setting the last 18 of 24 months, he/she:

1. Must provide evidence of continuing education with a minimum of 30 Category I hours per calendar year when not actively practicing.
2. Must provide proof of current certification in any two of the following:
   a. Neonatal Life Support
   b. Pediatric Advanced Life Support
   c. Advanced Cardiac Life Support
3. Must be board certified or board eligible in Pediatrics
4. Must have letters from at least three Medical Staff pediatricians (at least one of whom is board certified) who can attest to the character and integrity of the Applicant.
5. Demonstrate absence from active practice is not more than three (3) years.

SECTION 2: CONSULTATIONS

Subsection 1

Consultations will be required of Members of the Pediatric Department on all patients as noted below. Consultations will be from a Member of the Pediatric consulting panel.

a. Critical patients;

b. Complications of the newborn; and

c. Suspected cases of child abuse or neglect.

Subsection 2

In suspected cases of child abuse or neglect, consultation will be from the physician on pediatric call. A pediatrician will be available for the Pediatric Consulting Panel if
additional consultation is needed. Refer to CHILD ABUSE PROTOCOL in ER, Pediatrics, ICN, Nursing, and Social Services.

SECTION 3: DELIVERIES AND NEWBORN RESUSCITATION

Subsection 1
A physician trained and credentialed in newborn resuscitation shall be present for cesarean section deliveries and any deliveries determined by the attending obstetrician to be high risk. The attending obstetrician shall contact the physician attending the newborn regarding plans for delivery and pertinent pre- and peri-natal history and physical findings.

Subsection 2
Privileges in newborn resuscitation may be granted to physicians who demonstrate current clinical competence by having fulfilled the following criteria:

a. Attendance at a minimum of six cesarean or high risk vaginal deliveries during the previous 12 months as attending physician for the newborn. This criteria is not satisfied if the physician acted as obstetrician at these deliveries as well.

b. The physician must have also attended a neonatal resuscitation course and passed a post test within the past two years or have participated in the resuscitation of three or more pediatric patients requiring intubation during the past 12 months.

Privileges in newborn resuscitation will be granted at the time of reappointment for Active Staff Members if the criteria have been satisfied.

Subsection 3
Privileges for Associate Staff Members may be granted upon documentation of competence in newborn resuscitation from a residency program director, or from the Medical Staff office at the hospital where the physician has previously practiced.

A mentor shall be assigned and shall accompany the Associate Staff Member at deliveries until the mentor is satisfied of the Associate Staff Member's competence.

Advancement to Active Staff privileges in newborn resuscitation may be recommended when the following are accomplished:

a. A letter has been received from the mentor stating competence demonstrated after a satisfactory observation period.

b. Competence in endotracheal intubation has been demonstrated either in a clinical situation on three occasions or by attendance at a newborn resuscitation class and completion of a posttest.
SECTION 4: ABO GROUPING AND TYPING FOR RH

Subsection 1
All mothers admitted for delivery will have the results of ABO grouping and typing for Rh (D) D on their prenatal records. If the results of this testing are not available for any reason, ABO grouping and Rh (D) D typing will be ordered on admission.

Subsection 2
To exclude hemolytic disease, all babies born of Group O positive or Rh (D negative) mothers will have appropriate testing, including ABO grouping, Rh (D) testing and may include hemoglobin, hematocrit and direct Coombs test.

SECTION 5: ICN SUB-COMMITTEE

This committee will report to the Pediatric Department and Medical Executive Committee. Appointed Members will represent: ICN physician; ICN nursing staff; Nursing Administration; Social Services; Pharmacy; Laboratory; Respiratory Therapy; and Transport Team.

The ICN Subcommittee will meet bimonthly and also be responsible for data collecting, case review, and quality improvement in the ICN. The Medical Director of the ICN will chair this committee and be responsible for reporting on-going activities and progress to the Pediatrics Department.

SECTION 6. PICU SUB-COMMITTEE

This committee will report to the Pediatric Department and Medical Executive Committee. Appointed Members will represent: PICU physician, general pediatrician, ER physician, pediatric surgeon, neurosurgeon, PICU nurse manager, PICU nursing staff, nursing administration, and respiratory therapy.

The PICU Subcommittee will meet bimonthly. It will be responsible for data collecting and quality improvement in the PICU. The Medical Director of the PICU will chair this committee and be responsible for reporting on-going activities and progress to the Pediatric Department.

SECTION 7: REAPPOINTMENT/CLINICAL COMPETENCE

At reappointment (every two years) it is assumed that physicians who are actively taking call for the Pediatrics Department have performed a sufficient number of varied procedures to be considered competent for core privileges, assuming that Hospital quality indicators do not indicate otherwise. Physicians who wish to regain certain privileges they have not held are eligible to request said privileges with a two-month mentoring period. The following privileges also require the demonstration of
competence by providing proof that the indicated number of procedures has been performed during the last two years.

Ventilator Care (Pediatric or Neonatal): 10 cases

Arterial Catheter: 10 cases
DEPARTMENT OF PSYCHIATRY

SECTION 1: QUALIFICATIONS

Members of the Psychiatric Department will be assigned to that Department by the Medical Executive Committee and the Board of Governors. The types of privileges will be recommended by the Psychiatric Privileges Committee according to training, experience and ability of the Applicant. Any privileges, including consultation privileges, in psychiatry at Renown Regional Medical Center will require board eligibility training in psychiatry as a minimum. All Members of the Psychiatric Staff shall abide by the Bylaws, Rules and Regulations for all departments of the Medical Staff at Renown Regional Medical Center.

SECTION 2: PRIVILEGES

Physicians are assigned to one of several categories of membership. A complete listing is found in the Categories section (3.6) of the Medical Staff bylaws.

SECTION 3: REAPPOINTMENT/CURRENT CLINICAL COMPETENCE

All Members of the Department are reappointed every two years in accordance with the Bylaws and Credentialing Policies of the Medical Staff. Since reappointment is an affirmation of good clinical practice, each Applicant will provide evidence of activity sufficient to demonstrate current clinical competence for the privileges requested.

Core Privileges: Inpatient services (including consultation) to at least four patients in the past 24 months. (May be conducted at SMH or WHH also)  
Child Psychiatry: Two inpatient consultations in the past 24 months. Four CME credits in the past 24 months

Adolescent Psychiatry: Two inpatient consultations in the past 24 months.

Chemical Dependency: Four inpatient consultations in the past 24 months.

ECT: One procedure in the past year.

Hypnosis: One procedure in the past year

Drug Interviews: One procedure in the past year.

SECTION 4: HYPNOSIS

Hypnosis is recognized as one of the forms of medical treatment and will be performed in this Hospital only by Members of the Medical or Dental Staff.
SECTION 5: CONVULSIVE THERAPY
Consultation will be required from an appropriate Member of the Department of Medicine, as well as other staff Members if indicated, on all patients who are to be administered convulsive therapy. In the event that psychiatrists who have training or experience in the treatment of children and adolescents and who are not directly involved in the treatment of the patient, must examine the patient, consult with the psychiatrist responsible for the patient, and document in the patient's medical record their concurrence with the decision to administer such therapy. A permit for convulsive therapy will be signed by the patient and/or other responsible persons as indicated, and be part of the patient's permanent medical record.

SECTION 6: SPECIAL TREATMENT PROCEDURES FOR CHILDREN AND ADOLESCENTS
Consultation with a qualified child psychiatrist will be required whenever special treatment procedures are considered for children and adolescents. In addition to justification for the special treatment procedure by the attending psychiatrist, the medical record will contain the concurrence of the consultants. A qualified child psychiatrist is defined as one who has training or experience in the treatment of children and adolescents.

SECTION 7: BREACH OF REGULATIONS
The Nursing Department Head shall report any breach of these regulations to the Chief of Psychiatry.
PSYCHOLOGY SECTION

SECTION 1: QUALIFICATIONS

All psychologists granted clinical privileges at Renown Regional Medical Center shall be Members of the Psychology Section.

Subsection 1

A psychologist is herein defined as a doctoral Psychologist certified in accordance with the stipulations of NRS 641. In order to be eligible for staff privileges, the Psychologist must have at least two years post-doctoral clinical experience in a recognized health setting; and must also be eligible for the National Register or Health Service Providers in Psychology; or other such reasonable requirements as set by the Staff of Governance.

Subsection 2

Professional activities of Members of the Psychology Section will be under the overall supervision of the Department of Psychiatry of the Medical Staff of Renown Regional Medical Center.

Subsection 3

Application for appointment to and membership in the Psychology Section of the Department of Psychiatry for the practice of psychology will follow the procedure and criteria as outlined in Article IX of the Bylaws of the Medical Staff of Renown Regional Medical Center.

Subsection 4

Privileges will be defined at all levels, with one Active Staff representative from the AHP Section of Psychology being on the Department of Psychiatry Privileges Committee to act upon all matters pertaining to Psychologists and to vote on their own Members for recommendation to the Board of Governors for appointment to temporary or permanent privileges, as outlined in Article IX of the Bylaws of the Medical Staff of Renown Regional Medical Center. Privileges will be applied for and reviewed for recommendation to the Board of Governors annually. One Active Staff Member of the Psychology Section will attend appeal hearings.

The Psychology Section is responsible for monitoring the quality of care rendered by Psychologists who are Members of the Staff subject to the ultimate authority of the Hospital governing body.

Members of the Psychology Section may engage in the delivery of direct preventive, assessment and therapeutic intervention services to individuals or groups whose growth,
adjustment, or functioning is actually impaired or demonstrably at high risk of impairment provided the Psychologist is granted such privileges by Psychology Section.

Psychologists may accept and act upon direct referrals from non-psychiatric physicians within RRMC except on the Psychiatric Ward (Station 18) where referrals must be made directly from a staff psychiatrist.

The Psychology Section shall elect a Chief and Vice Chief biennially, with a vote of confidence taken on the non-election year. Nominations will be presented by a nominating committee and from the floor. Elections shall be by a secret ballot. A Medical Staff secretary will tabulate ballots. Elections will ordinarily occur in January of each year.

SECTION 2: MEMBERSHIP

Membership in the Psychology Section shall be divided into three classifications: (a) Associate Staff Members (b) Active Staff Members and (c) Courtesy Staff Members.

All newly elected Associate Staff Members shall be in the Associate status until they have fulfilled the following criteria: (1) Demonstrated competence through work sample reviewed by the mentor. A mentor needs to be satisfied that he or she has adequately sampled the work of the Psychologist, and the Chief of the Psychology Section likewise has approved that adequate work has been sampled and competency approved; (2) Served a minimum of 12 months in the Associate status. Following completion of Associate term, a Member may then advance to Active status, providing they have met the necessary requirements (see Bylaws).

Mentor must write a letter recommending psychologist be released from mentoring; Psychologist must submit a letter requesting to be released from mentoring for consideration by the Section Chief, Department Chief, Credentials & Privileges Committee, Medical Executive Committee and Board of Governors.

SECTION 3: MEETINGS

The Psychology Section shall meet quarterly and at the call of the Chairman.

SECTION 4: QUALITY ASSURANCE COMMITTEE

Not less than monthly this committee will review a random sampling of medical records in which psychologists have participated. The committee shall attend to such items as adequacy of the recorded personal history, diagnostic impression, treatment plan and goals, progress notes, treatment termination process, discharge planning, family interactions, and utilization of community resources when such items are pertinent. Deficiencies will be noted and the involved psychologist notified of the committee
findings. If, in the opinion of the committee, a deficiency seriously affects the quality of patient care, such deficiency shall be corrected by the following meeting.

SECTION 5: MENTORING

Associate Members shall have all of the rights and privileges of Active Staff except for the following: (1) A mentor shall be assigned who will monitor the performance of the Associate Member with respect to quality patient care and compliance with Renown Regional Medical Center Rules and Regulations; (2) The Associate Member will not be eligible to vote on Psychology Section matters.

SECTION 6: REAPPOINTMENT/CURRENT CLINICAL COMPETENCE

All Members of the Department are reappointed every two years in accordance with the Bylaws and Credentialing Policies of the Medical Staff. Since reappointment is an affirmation of good clinical practice, each Applicant will provide evidence of activity sufficient to demonstrate current clinical competence for the privileges requested.
DEPARTMENT OF PULMONARY MEDICINE

SECTION 1: QUALIFICATIONS

Membership within the Department will be those physicians on the Staff who are board certified in the sub-specialty board of Pulmonary Medicine of the American Board of Internal Medicine or who have comparable training, experience and demonstrated proficiency. Associate membership to the Pulmonary Department of the Department of Medicine may be assigned to Members with an interest in pulmonary medicine but who do not qualify under the above qualification.

SECTION 2: SCOPE OF SERVICE

The Pulmonary Medicine Department will comply with all Bylaws, Rules and Regulations of the Medical Staff of Renown Regional Medical Center. The Section Chief of the Pulmonary Medicine Department will be selected by Members of the Pulmonary Medicine Department, and such appointment confirmed by the Department of Medicine and the Medical Executive Committee of the Medical Staff.

It shall be the responsibility of the Department of Pulmonary Medicine to provide leadership and medical directorship to the Hospital's Pulmonary Function Laboratory and Respiratory Therapy Departments. Members will be available for consultation on complex pulmonary problems, both for clinical management of patients and performance and interpretation of pulmonary function studies. Members of the Department will also provide continuing education to Hospital employees for maintenance of skills within the Department of Respiratory Therapy and pulmonary function studies.

SECTION 3: MEETINGS

There will be regular meetings of the Pulmonary Medicine Department, at least quarterly, to be determined. Special meetings may be held on call of the chairman or two (2) Members of the department.

SECTION 4: PRIVILEGES; REAPPOINTMENT

Privileges within the Department of Pulmonary Medicine will be determined by a committee formed from Members of that department, including the chief of the Department of Medicine and the chief of the department. Members making application for privileges within the Pulmonary Department will do so in writing. Such application will be by the Pulmonary Medicine Department Privileges Committee. All privileges shall be by the Pulmonary Medicine Department Privileges Committee. All privileges shall be recommended upon review of the Applicant’s training, experience and examination of records of cases cared for by the Applicant. Privileges will be reviewed biennially and
biennial assignment will be based upon demonstrated continued competence and proficiency.
DEPARTMENT OF RADIOLOGY

SECTION 1: QUALIFICATIONS

Physicians will be appointed to the Medical Staff in accordance with the Bylaws. Physicians who are certified by the American Board of Radiology, or eligible for certification by that Board (have completed residency training in Radiology) are eligible for membership in the Department of Radiology.

SECTION 2: SCOPE OF SERVICE

The Department of Radiology in concert with Renown Regional Medical Center will endeavor to provide care for a wide range of diagnostic and therapeutic radiological services, including general diagnostic radiology, diagnostic ultrasound, computed tomographic, magnetic resonance and nuclear medicine studies. Additionally, diagnostic neuroradiology and body imaging procedures will be performed. Therapeutic and interventional procedures performed include radionuclide therapy, image-guided percutaneous biopsies, aspirations and drainages, vascular arteriography and venography, vascular angioplasty, vascular stent placement, percutaneous urologic procedures, neurointerventional procedures and other complex peripheral and visceral percutaneous procedures. When deemed necessary for the optimal care of the patient, a physician may transfer a patient to another facility for care.

SECTION 3: MEETINGS

The Department will endeavor to meet bi-monthly at Renown Regional Medical Center. A special meeting may be called by the Chief of upon request of one-half the Members of the Department.

SECTION 4: QUALITY IMPROVEMENT

The Department participates in ongoing quality improvement at its department meetings.

SECTION 5: CONTINUING MEDICAL EDUCATION

The Department of Radiology will participate in continuing medical education through the elective attendance of its Members at CME presentations. This will include Medical Staff, residents, medical school faculty and invited speakers.

SECTION 6: PRIVILEGES

Privileges are granted in accordance with the Bylaws and Credentialing Policies and Procedures.

SECTION 7: REAPPOINTMENT; CONTINUING CLINICAL COMPETENCE

All Members of the Department are reappointed every two years in accordance with the Bylaws and Credentialing Policies of the Medical Staff. Since reappointment is an
affirmation of good clinical practice, each Applicant for reappointment will provide evidence of a sufficient active practice to satisfy the review committees and the Board of Governors that such a judgment can be made. Applicants must demonstrate that they have maintained competence by successfully performing at least ten percutaneous vertebroplasty procedures in the past twenty-four months.
RADIATION THERAPY SECTION

SECTION 1: QUALIFICATIONS

Membership will be assigned to the Radiation Therapy Section by the Chief of the Department after approval by the Board of Governors. Membership in the Radiation Therapy Section will be limited to those physicians who are on the Medical Staff of Renown Regional Medical Center and who are also board certified or eligible in Oncology of the American Board of Radiology or those certified in Radiology with recognition of competence in radiation therapy. Membership in the Radiation Therapy Section will also include those physicians who currently have privileges in Radiation Therapy at Renown Regional Medical Center.

Membership with non-voting status may be assigned to Members with an interest in radiation therapy but do not qualify under the above.

SECTION 2: SCOPE OF SERVICE

The Renown Regional Medical Center and its Radiation Therapy staff shall maintain therapeutic radiologic facilities and services adequate to meet the needs of the patient as defined by the Medical Staff and approved by the Board of Governors. The Radiation Therapy Section will comply with all Bylaws, Rules and Regulation of the Medical Staff of Renown Regional Medical Center.

Subsection 1
To establish standards of care for patients receiving radiation therapy at Renown Regional Medical Center and to establish standards for those in the Department administering this care.

Subsection 2
To provide a means whereby problems of a medico-administrative nature may be discussed by the Medical Staff with the governing body and administration.

Subsection 3
To initiate and maintain rules and regulations for proper and efficient function of the Radiation Therapy Section and government of the Radiation Therapy staff. It will be the responsibility of the Section Chief to provide leadership and continuing education for the Radiation Therapy Section.

SECTION 3: MEETINGS

Regular meetings of the Section will be announced by the Section Chief and Section Members are required to attend at least 50 percent of the regularly scheduled meetings.

SECTION 4: QUALITY IMPROVEMENT
It shall be the responsibility of the Section to ensure Quality Assurance in the field of Radiation Therapy.

SECTION 5: REAPPOINTMENT/CURRENT CLINICAL COMPETENCE

All Members of the Department are reappointed every two years in accordance with the Bylaws and Credentialing Policies of the Medical Staff. Since reappointment is an affirmation of good clinical practice, each Applicant will provide evidence of activity sufficient to demonstrate current clinical competence for the privileges requested.
DEPARTMENT OF SURGERY

SECTION 1: QUALIFICATIONS
Physicians will be appointed to the Medical Staff in accordance with the Bylaws and applicable policies. Physicians who have completed residency training and/or fellowship training in general, vascular, thoracic, cardiac, pediatric, plastic, and urologic surgery are eligible for membership in the Department of Surgery.

SECTION 2: SCOPE OF SERVICE
The Department of Surgery in concert with Renown Regional Medical Center will endeavor to provide for a wide range of surgical conditions, including trauma. When deemed necessary for the optimal care of the patient, a physician may transfer a patient to another facility for care.

SECTION 3: MEETINGS
The Department will meet quarterly and on call of the Chief.

SECTION 4: QUALITY IMPROVEMENT
The Department of Surgery will participate in ongoing quality improvement at its regular department meeting and through the various meetings of sections of the Department of Surgery.

SECTION 5: CONTINUING MEDICAL EDUCATION
The Department of Surgery will participate in continuing medical education through the elective attendance of its Members at CME presentation. Members of the Department also participate in presenting educational topics at various CME programs.

SECTION 6: PRIVILEGES
Privileges are granted in accordance with the Bylaws and Credentialing Policies and Procedures.

SECTION 7: APPOINTMENT/CURRENT CLINICAL COMPETENCE
All Members of the Department of Surgery are reappointed every two years in accordance with the Bylaws and Policies and Procedures. Since reappointment is an affirmation of good clinical practice, each Applicant for reappointment to the Active Staffs shall provide evidence of 50 surgical cases. If an Applicant has not had 50 surgical cases at Renown Regional Medical Center, the Applicant will be asked to provide evidence of additional cases at another local, JCAHO accredited hospital which will total 50 cases. The facility will be queried to ascertain whether or not the physician is in good standing. If the Applicant cannot provide evidence of 50 surgical cases at a local hospital, the physician will be asked to submit in writing, his or her reasons for desiring
to remain on the Medical Staff. The Department Chief will consider these reasons, and, if sufficient, the Applicant will be recommended for reappointment.

Upon review, if the Department Chief does not believe the cases submitted warrant the range of privileges requested, the Chief may request additional documentation to support the current clinical competence of the Applicant for specific privileges.

SECTION 8: RELEASE FROM MENTORING

New Members of the Associate Staff are subject to mentoring. The mentor will monitor the new physician as he or she feels is necessary. This monitoring will include in-room supervision, chart review.

SECTION 9: ADVANCEMENT TO ACTIVE STAFF

Advancement to the Active Staff will be considered after 12 months, with satisfactory completion of the following:

1. A minimum of twenty mentored major general or subspecialty surgical procedures and six ICU cases (with the exception of Plastic Surgery not needing ICU cases) at Renown Regional Medical Center, 40 percent of which will be mentored by an Active Staff Member not in the individual's group.

2. A minimum of ten major thoracic, pediatric or vascular cases mentored in any community hospital. This excludes endoscopy, access procedures, vein stripping, etc. Again, an Active Staff Member not in the individual's group shall mentor 40 percent of cases. (This paragraph is not applicable to Plastic Surgery).

SECTION 10: SCHEDULING

Operating Room scheduling will be performed in accordance with the Policies set forth by the Operating Room Committee.

SECTION 11: ASSISTANTS

In all major procedures, where appropriate, there must be a first assistant present.
CARDIAC SURGERY SECTION

SECTION 1: SCOPE OF SERVICE

To oversee and monitor the performance and quality of care to cardiac surgery patients managed by the Cardiac Surgery Service.

SECTION 2: FUNCTIONS

1. To review monthly performance statistics for Cardiac Surgery.
   a. Volume and type of cases
   b. Patient disposition from catheterization laboratory
   c. Average length of stay, Cardiac Surgery Unit
   d. Total length of stay in hospital, disposition from hospital.

2. To review monthly Q.A. reports on Cardiac Surgery
   a. Complications
   b. Return to O.R., etc.

3. To establish computerized long-term follow-up data on Cardiac Surgery.
   a. Patients via tracking of patients through local and non-local cardiologists and primary care physicians.

4. To provide formalized Section representation to Cardiology Section and departments of Surgery and Anesthesia.

5. To develop and coordinate Hospital and community education regarding Cardiac Surgery.

SECTION 3: MEMBERSHIP

Voting Members
Chief(s), Board Certified or Board Eligible Cardiac Surgeons

Non Voting Members:
- Cardiac Anesthesia representative
- O.R. Cardiac Surgery Nursing representative
- Cardiac Recovery Nursing representative
- Administration representative
- Social Service representative
- Cardiovascular Perfusion representative
SECTION 4: REAPPOINTMENT/CURRENT CLINICAL COMPETENCE

All Members of the Cardiac Surgery Section are reappointed every two years in accordance with the Bylaws and Credentialing Policies of the Medical Staff. Since reappointment is an affirmation of good clinical practice, each Applicant will provide evidence of activity sufficient to demonstrate current clinical competence for the privileges requested.
PLASTIC SURGERY SECTION (reviewed 10/10)

SECTION 1: QUALIFICATIONS

The Members of the Section of Plastic Surgery shall be either certified or eligible to be certified by the American Board of Plastic Surgery and shall comply with the rules and regulations of the Department of Surgery. Members of the Section of Plastic Surgery will be assigned to the Department of Surgery by the Medical Executive Committee and the Board of Governors.

SECTION 2: QUALITY IMPROVEMENT

The Section will work with the Quality Services department to identify mechanisms by which Members of the Section can continuously evaluate and improve the quality of patient care.

SECTION 3: PRIVILEGES

Surgical privileges will be granted on the basis of previous training, demonstrated competence, and ability both as to technical proficiency and surgical judgment.

Whereas it is desirable from a Hospital administrative standpoint to have available a list of plastic surgery procedures, from a practical standpoint it is impossible to predict every circumstance a plastic surgeon might encounter. Therefore, a list will be maintained, recognizing its inherent incompleteness. Such a list identifying most of the procedures of the Plastic surgery Section will be on file in the Medical Staff Office and will be reviewed by the Section and amended as necessary.

SECTION 4: REAPPOINTMENT/CURRENT CLINICAL COMPETENCE

All Members of the Department are reappointed every two years in accordance with the Bylaws and Credentialing Policies of the Medical Staff. Since reappointment is an affirmation of good clinical practice, each Applicant will provide evidence of activity sufficient to demonstrate current clinical competence for the privileges.

SECTION 5: MENTORING, ASSOCIATE STAFF

Associate Staff Members, after six months of observation, may petition the Section to do specific procedures without mentoring.

Advancement to the Active Staff will be considered after twelve (12) months, with satisfactory completion of a minimum of 20 mentored major plastic surgery procedures performed at either Saint Mary's Regional Medical Center or Renown Regional Medical Center operating facilities, at least 10 of which are performed at Renown Regional Medical Center, which are a representative cross section of plastic surgery and which have been approved by the Plastic Surgery Section.
TRAUMA SURGERY SECTION

The Trauma Section will comply with the Bylaws, and Rules and Regulations of the Medical Staff of Renown Regional Medical Center.

SECTION 1: QUALIFICATIONS

Membership will consist of the Surgical Trauma Team assembled and maintained by the Trauma Director and be assigned to the Trauma Section at the beginning of the calendar year.

The membership will consist of staff Members who are board certified by the American Board of Surgery, or are board eligible, have completed ATLS certification, and have either had trauma training as part of a residency program or demonstrated proficiency and competency in care of trauma patients.

SECTION 2: SCOPE OF SERVICE

All Members of the trauma section are expected to attend monthly trauma grand rounds and to lead these rounds on an assigned basis.

The trauma section will develop and maintain protocols for treatment of trauma patients. The trauma director shall maintain these protocols. All Trauma Section Members will be expected to participate in development and revision.

SECTION 3: MEETINGS

All Members of the Trauma Section are expected to actively participate in trauma mortality and morbidity review as scheduled by trauma director. Annual attendance at 75 percent of the meetings is required.

SECTION 4: PRIVILEGES

Subsection 1
A privileges committee, composed of Members of the active trauma staff will be established within the section, which will include the trauma director.

Subsection 2
Determination of specific trauma privileges will be based upon the Applicant's training, experience and examination of the records of previous cases handled. (Reasonable number of cases/year if out of training two or more years.)

Subsection 3
Privileges will be based upon attaining ATLS certification, demonstrated competence and proficiency.

SECTION 5: REAPPOINTMENT/CURRENT CLINICAL COMPETENCE
All Members of the Department are reappointed every two years in accordance with the Bylaws and Credentialing Policies of the Medical Staff. Since reappointment is an affirmation of good clinical practice, each Applicant will provide evidence of activity sufficient to demonstrate current clinical competence for the privileges.
UROLOGY SECTION

SECTION 1: QUALIFICATIONS

Members of the Section of Urology will be assigned to the Department of Surgery by the Medical Executive Committee and the Board of Governors. The Members of the Section of Urology shall be either certified or eligible to be certified by the American Board of Urology and shall comply with the rules and regulations of the Department of Surgery.

SECTION 2: PRIVILEGES

Whereas it is desirable from a Hospital administrative standpoint to have available a list of urological procedures, from a practical standpoint it is impossible to predict every circumstance a urologic surgeon might encounter. Therefore, a list will be maintained recognizing its inherent incompleteness. Such a list identifying most of the procedures of the Urology Section will be on file in the Medical Staff Office and will be reviewed by the Section and amended as necessary.

SECTION 3: REAPPOINTMENT AND CURRENT CLINICAL COMPETENCE

A reappraisal is conducted at the time of reappointment which includes confirmation of adherence to Medical Staff membership requirements stated in the Bylaws, relevant results from quality improvement activities reflecting evaluation of professional performance, judgment, and clinical/technical skills. At reappointment, privileges may be increased, reduced, or terminated because of (1) assessments of documented performance, or (2) non-use of privileges for a high-risk procedure or treatment over the last two years. Because Hospital practices and clinical techniques change over time, it would be unusual if clinical privileges were not to change also.

1. The successful Applicant must be able to demonstrate performance of at least 20 major urological procedures during the past 24 months. These procedures must indicate sufficient experience for the privileges the physician intends to exercise.

2. If a physician cannot demonstrate performance of 20 major urological procedures in the last 24 months, the physician may request specific privileges, commensurate with current clinical competence. Current clinical competence is generally indicated by having successfully completed at least five cases involving the procedure/treatment.
SECTION 4: MENTORING, ELEVATION TO ACTIVE STAFF

Associate Staff Members, after six months of observation may petition the Section to do specific procedures alone.

Advancement to the Active Staff will be considered after twelve (12) months, with satisfactory completion of:

A minimum of twenty (20) mentored major urological procedures performed at any of the Medicare approved operating facilities in the Reno area which are a representative cross section of urological surgery and which have been approved by the Urology Section of which 25 percent are mentored by individuals not in the Associate Staff physician's group.
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