PALOMAR HEALTH
Reimagining Healthcare

Board of Directors

Meeting Agenda Packet

October 9, 2023

PALOMAR HEALTH
Reimagining Healthcare

Board of Directors

Linda Greer, RN, Chair
Jeffrey D. Griffith, EMT-P, Vice Chair
Laura Barry, Treasurer
Theresa Corrales, RN, Secretary
John Clark, Director
Laurie Edwards-Tate, MS, Director
Michael Pacheco, Director

Diane Hansen, President and CEO

Regular meetings of the Board of Directors are held on the second Monday of each month at 6:30 p.m., unless indicated otherwise.
For an agenda, locations or further information please call (760) 740-6375 or visit our website at www.palomarhealth.org

Our Mission

To heal, comfort, and promote health
in the communities we serve

Our Vision

Palomar Health will be the health system of choice for patients, physicians and employees, recognized nationally for the highest quality of clinical care and access to comprehensive services

Our Values

Compassion - Providing comfort and care
Integrity - Doing the right thing for the right reason
Teamwork - Working together toward shared goals
Excellence - Aspiring to be the best
Service - Serving others and our community
Trust - Delivering on promises

POSTED
Friday
October 6, 2023

PALOMAR HEALTH
Reimagining Healthcare

BOARD OF DIRECTORS
MEETING AGENDA

Monday, October 9, 2023
6:30 p.m.

PLEASE SEE PAGE 3 FOR MEETING LOCATION

	The Board may take action on any of the items listed below, unless the item is specifically labeled "Informational Only"	Time	Form A Page	Target
CALL TO ORDER				**6:30**
1.	**ESTABLISHMENT OF QUORUM**	2	-	6:32
2.	**OPENING CEREMONY**	3		6:35
	a. Pledge of Allegiance to the Flag			
3.	**PUBLIC COMMENTS**[1]	30	-	7:05
4.	**PRESENTATIONS – *Informational Only***			
	a. Patient Experience Moment	5		7:10
	b. Physician Introduction	5		7:15
	c. Emergency Department Presentation and Recognition	10		7:25
	d. Terms of Use for Palomar Health's Website	10		7:35
5.	**APPROVAL OF MINUTES** *(ADD A)*	5		7:40
	a. Board of Directors Meeting – Monday, September 11, 2023 *(Pp 7-12)*		2	
	b. Board of Directors Special Closed Session Meeting – Monday, September 11, 2023 *(Pp 13-14)*		3	
6.	**APPROVAL OF AGENDA** to accept the Consent Items as listed *(ADD B)*	5		7:45
	a. Palomar Medical Center Escondido Medical Staff Credentialing and Reappointments *(Pp 15-18)*		4	
	b. Palomar Medical Center Poway Medical Staff Credentialing and Reappointments *(Pp 19-49)*		5	
	c. Palomar Medical Center Medical Staff (Escondido Campus & Poway Campus) Bylaws (Including Credentials Policy Manual and Medical Staff Rights Manual) Rules and Regulations *(Redline Pp 50-145, Clean Pp 146-220)*		6	
7.	**REPORTS – *Informational Only***			
	a. Medical Staff			
	I. Palomar Medical Center Escondido – *Kanchan Koirala, MD*	5		7:50
	II. Palomar Medical Center Poway – *Sam Filiciotto, MD*	5		7:55
	b. Administration			
	I. President and CEO – *Diane Hansen*	5		8:00
	II. Chair of the Board – *Linda Greer, RN*	5		8:05
8.	**APPROVAL of BYLAWS, CHARTERS, RESOLUTIONS, and OTHER ACTIONS** *(ADD C)*	20		8:30

	Agenda Item	Committee or Dept.	Action
a.	Resolution No. 10.09.23(01)-16 of the Board of Directors of Palomar Health Proposing and Consenting to Amendment to CEO Employment Agreement *(Pp 221-227)*	Legal	Review/ Approve
b.	Vote of No Confidence in a Director; Request for Director to Show Cause (John Clark)	Board	Vote

	c. Vote of No Confidence in a Director; Request for Director to Show Cause (Laurie Edwards-Tate)	Board	Vote			
9.	**COMMITTEE REPORTS – *Informational Only*** *(ADD D)*			5		8:35
	a. Audit & Compliance Committee – Michael Pacheco, Committee Chair *(No meeting in September)*					
	b. Community Relations Committee – Terry Corrales, Committee Chair *(No meeting in September)*					
	c. Finance Committee – Laura Barry, Committee Chair *(No meeting in September)*					
	d. Governance Committee – Jeff Griffith, Committee Chair *(No meeting in September)*					
	e. Human Resources Committee – Terry Corrales, Committee Chair *(No meeting in September)*					
	f. Quality Review Committee – Linda Greer, Committee Chair *(Pp 228-230)*					
	g. Strategic & Facilities Planning Committee – Michael Pacheco, Committee Chair *(Pp 231-250)*					
FINAL ADJOURNMENT					-	8:35

NOTE: If you have a disability, please notify us by calling 760.740.6375, 72 hours prior to the event so that we may provide reasonable accommodations

[1] *3 minutes allowed per speaker with a cumulative total of 9 minutes per group.*
For further details, see Request for Public Comment Process and Policy available by clicking on or copying the URL below into your browser, or refer to page 4 of agenda.

https://www.palomarhealth.org/board-of-directors/meetings

Public Comments and Attendance at Public Board Meetings

PALOMAR HEALTH
Reimagining Healthcare

Board of Directors Meeting
Location Options

1st Floor Conference Room
Palomar Medical Center Escondido
2185 Citracado Parkway, Escondido, CA 92029

- **Elected Board Members of the Palomar Health Board of Directors will attend at this location, unless otherwise noticed below**
- **Non-Board member attendees, and members of the public may also attend at this location**

https://www.microsoft.com/en-us/microsoft-teams/join-a-meeting?rtc=1

Meeting ID: 292 740 851 974
or
Dial in using your phone at 929.352.2216; Access Code: 896 226 868#[1]

- **Non-Board member attendees, and members of the public may also attend the meeting virtually utilizing the above link**

120 Kaiulani Avenue, Honolulu, HI 96815
- **An elected member of the Board of Directors will be attending the meeting virtually from this location**

[1] ***New to Microsoft Teams? Get the app now and be ready when your first meeting starts:*** Download Teams

PALOMAR HEALTH

DocID:	21790
Revision:	9
Status:	Official

Source:	Applies to Facilities:	Applies to Departments:
Administrative Board of Directors	All Palomar Health Facilities	Board of Directors

Policy: Public Comments and Attendance at Public Board Meetings

I. PURPOSE:

A. It is the intention of the Palomar Health Board of Directors to hear public comment about any topic that is under its jurisdiction. This policy is intended to provide guidelines in the interest of conducting orderly, open public meetings while ensuring that the public is afforded ample opportunity to attend and to address the board at any meetings of the whole board or board committees.

II. DEFINITIONS:

A. None defined.

III. TEXT / STANDARDS OF PRACTICE:

A. There will be one-time period allotted for public comment at the start of the public meeting. Should the chair determine that further public comment is required during a public meeting, the chair can call for such additional public comment immediately prior to the adjournment of the public meeting. Members of the public who wish to address the Board are asked to complete a Request for Public Comment form and submit to the Board Assistant prior to or during the meeting. The information requested shall be limited to name, address, phone number and subject, however, the requesting public member shall submit the requested information voluntarily. It will not be a condition of speaking.

B. Should Board action be requested, it is encouraged that the public requestor include the request on the *Request for Public Comment* as well. Any member of the public who is speaking is encouraged to submit written copies of the presentation.

C. C. The subject matter of any speaker must be germane to Palomar Health's jurisdiction.

D. Based solely on the number of speaking requests, the Board will set the time allowed for each speaker prior to the public sections of the meeting, but usually will not exceed 3 minutes per speaker, with a cumulative total of thirty minutes.

E. Questions or comments will be entertained during the "Public Comments" section on the agenda. All public comments will be limited to the designated times, including at all board meetings, committee meetings and board workshops.

F. All voting and non-voting members of a Board committee will be seated at the table. Name placards will be created as placeholders for those seats for Board members, committee members, staff, and scribes. Any other attendees, staff or public, are welcome to sit at seats that do not have name placards, as well as on any other chairs in the room. For Palomar Health Board meetings, members of the public will sit in a seating area designated for the public.

G. In the event of a disturbance that is sufficient to impede the proceedings, all persons may be excluded with the exception of newspaper personnel who were not involved in the disturbance in question.

H. The public shall be afforded those rights listed below (Government Code Section 54953 and 54954).

1. To receive appropriate notice of meetings;
2. To attend with no pre-conditions to attendance;
3. To testify within reasonable limits prior to ordering consideration of the subject in question;
4. To know the result of any ballots cast;
5. To broadcast or record proceedings (conditional on lack of disruption to meeting);
6. To review recordings of meetings within thirty days of recording; minutes to be Board approved before release,
7. To publicly criticize Palomar Health or the Board; and
8. To review without delay agendas of all public meetings and any other writings distributed at the meeting. I. This policy will be reviewed and updated as required or at least every three years.

IV. ADDENDUM:

Original Document Date: 2/94

Reviewed: 8/95; 1/99; 9/05

Revision Number: 1 Dated: 9/20/05

Source Administrator	Hernandez, Lisa
Document Owner	DeBruin, Kevin
Collaborators:	Carla Albright, Deanna Peterson, Deborah Hollick, Douglas Moir, Jami Piearson, Jeffrey Griffith, Julie H Avila, Kelly Wells, Laurie Edwards-Tate, Megan Strole, Nancy Calabria, Nanette Irwin, Richard Engel, Sally Valle, Tanya L Howell, Thomas Kumura
Reviewers	
Approvals	
- Committees:	(10/12/2022) Policies & Procedures
- Signers:	Kevin DeBruin
Original Effective Date	Kevin DeBruin, Chief Legal Officer (10/25/2022 09:21AM PST)
Revised Reviewed	[09/20/2005 Rev. 1], [03/13/2009 Rev. 2], [04/14/2012 Rev. 3], [05/01/2014 Rev. 4], [02/03/2017 Rev. 5], [04/22/2019 Rev. 6],
Next Review Date	[07/10/2019 Rev. 7], [12/02/2021 Rev. 8], [10/25/2022 Rev. 9]
Attachments:	10/24/2025
(REFERENCED BY	Public Comment Form

Paper copies of this document may not be current and should not be relied on for official purposes. The current version is in Lucidoc at

https://www.lucidoc.com/cgi/doc-gw.pl?ref=pphealth:21790$9.

Minutes
Board of Directors Meeting
September 11, 2023

TO: Board of Directors

MEETING DATE: Monday, October 9, 2023

FROM: Carla Albright, Assistant to the Board of Directors

Background: The minutes from the September 11, 2023, Regular Board of Directors meeting are respectfully submitted for approval.

Budget Impact: N/A

Staff Recommendation: Recommend to approve the September 11, 2023, Regular Board of Directors meeting minutes.

Committee Questions: **N/A**

COMMITTEE RECOMMENDATION: N/A

Motion:

Individual Action:

Information:

Required Time:

Minutes
Special Closed Session
Board of Directors Meeting
September 11, 2023

TO: Board of Directors

MEETING DATE: Monday, October 9, 2023

FROM: Carla Albright, Assistant to the Board of Directors

Background: The minutes from the September 11, 2023, Special Closed Session Board of Directors meeting are respectfully submitted for approval.

Budget Impact: N/A

Staff Recommendation: Recommend to approve the September 11, 2023, Special Closed Session Board of Directors meeting minutes.

Committee Questions: **N/A**

COMMITTEE RECOMMENDATION: N/A

Motion:

Individual Action:

Information:

Required Time:

Palomar Medical Center Escondido Medical Staff Credentialing Recommendations

TO: Board of Directors

MEETING DATE: October 9, 2023

FROM: Kanchan Koirala, M.D., Chief of Staff, Palomar Medical Center Escondido

Background: Credentialing Recommendations from the Medical Executive Committee of Palomar Medical Center Escondido.

Budget Impact: None

Staff Recommendation: Recommend Approval

Committee Questions:

COMMITTEE RECOMMENDATION: Approval

Motion: X

Individual Action:

Information:

Required Time:

Palomar Medical Center Poway
Medical Staff Credentials Recommendations
September, 2023

TO: Board of Directors

MEETING DATE: Monday October 9, 2023

FROM: Sam Filiciotto, M.D., Chief of Staff, Palomar Medical Center Poway

Background: Monthly credentials recommendations from the Palomar Medical Center Poway Medical Executive Committee for approval by the Board of Directors.

Budget Impact: None

Staff Recommendation:

Committee Questions:

COMMITTEE RECOMMENDATION: Approval

Motion: X

Individual Action:

Information:

Required Time:

Palomar Medical Center Escondido/Poway
Medical Staff Recommendation
Joint Bylaws (Includes Credentials Policy Manual and Medical Staff Rights Manual)
Rules and Regulations
October, 2023

TO: Board of Directors

MEETING DATE: October 9, 2023

FROM: Kanchan Koirala, M.D., Chief of Staff, Palomar Medical Center Escondido

Sam Filiciotto, M.D., Chief of Staff, Palomar Medical Center Poway

Background: The attached Palomar Medical Center Medical Staff Bylaws (Escondido Campus & Poway Campus), under the guidance of the Medical Staff attorney, were approved by the MECs (Medical Executive Committees) and by vote of Active Medical Staff members of PMC Escondido and Poway. This interim set of Bylaws will facilitate our Administration to consolidate both hospitals under one license. Please see the redlined version, and the final version for your approval.

Budget Impact:

Staff Recommendation: Recommend Approval

Committee Questions:

COMMITTEE RECOMMENDATION: Approval

Motion: X

Individual Action:

Information:

Required Time:

ADDENDUM A

Board of Directors Meeting Minutes – Monday, September 11, 2023	
Agenda Item	
• ***Discussion***	***Conclusion / Action /Follow Up***
NOTICE OF MEETING	
Notice of Meeting was posted at the Palomar Health Administrative Office at 2125 Citracado Parkway, Suite 300, Escondido, CA 92029, as well as on the Palomar Health website, on Wednesday, September 6, 2023, which is consistent with legal requirements.	
CALL TO ORDER	
The meeting, which was held at the Linda Greer Board Room at 2125 Citracado Parkway, Suite 300, Escondido, CA. 92029, and called to order at 6:30 p.m. by Board Chair Linda Greer.	
1. ESTABLISHMENT OF QUORUM	
Quorum comprised of Directors Barry, Corrales, Edwards-Tate, Greer, Griffith, Pacheco Absences: Clark	
2. OPENING CEREMONY – Pledge of Allegiance to the Flag	
The Pledge of Allegiance to the Flag was recited in unison.	
MISSION AND VISION STATEMENTS ***The Palomar Health mission and vision statements are as follows:*** • *The mission of Palomar Health is to heal, comfort and promote health in the communities we serve* • *The vision of Palomar Health is to be the health system of choice for patients, physicians and employees, recognized nationally for the highest quality of clinical care and access to comprehensive services*	

Agenda Item	
• *Discussion*	*Conclusion / Action /Follow Up*
3. PUBLIC COMMENTS	
• No public comments	
4. PRESENTATIONS	
a. September 11th Reflection	
• Director Michael Pacheco shared a reflection with the Board.	
b. Patient Experience Moment	
• A patient experience video was shared with the Board.	
c. Physician Introduction	
• Omar Khawaja, MD, Chief Medical Officer introduced Michelle Lee, MD, to the Board.	
5. APPROVAL OF MINUTES	
a. Board of Directors Meeting - Monday, August 14, 2023	**MOTION:** By Director Edwards-Tate, 2nd by Director Corrales and carried to approve the Monday, August 14, 2023 Board of Directors Meeting minutes, as presented. Roll call voting was utilized. Director Corrales – Aye Director Griffith – Aye Director Greer – Aye Director Barry – Aye Director Clark – Absent Director Pacheco – Aye Director Edwards-Tate – Aye Chair Greer announced that six board members were in favor. None opposed. None abstention. One absent. Motion approved.

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Agenda Item	
• ***Discussion***	***Conclusion / Action /Follow Up***
• Director Michael Pacheco requested a formatting issue be corrected before posting of minutes.	
b. Board of Directors Special Session Meeting - Thursday, August 14, 2023	**MOTION:** By Director Corrales, 2nd by Director Barry and carried to approve the Thursday, August 14, 2023 Board of Directors Special Session Meeting minutes, as presented. Roll call voting was utilized. Director Corrales – Aye Director Griffith – Aye Director Greer – Aye Director Barry – Aye Director Clark – Absent Director Pacheco – Aye Director Edwards-Tate – Aye Chair Greer announced that six board members were in favor. None opposed. None abstention. One absent. Motion approved.
• No discussion	
6. APPROVAL OF AGENDA *to accept the Consent Items as listed*	
a. Palomar Medical Center Escondido Medical Staff Credentialing and Reappointments b. Palomar Health Center Poway Medical Staff Credentialing and Reappointments c. Palomar Medical Center Poway Nurse Practitioner (NP) Clinical Privileges – Continuing Care d. Palomar Medical Center Poway Pulmonary Medicine Clinical Privileges e. Palomar Medical Center Escondido Nurse Practitioner (NP) Clinical Privileges – Trauma f. Joint Nurse Practitioner (NP) Clinical Privileges – Wound Care g. Joint Medical Records Policy h. Executed, Budgeted, Routine Physician Agreements i. June 2023 & YTD FY 2023 Pre-Audit Financial Report	**MOTION:** By Director Griffith, 2nd by Director Corrales and carried to approve Consent Agenda items A through I as presented. Roll call voting was utilized. Director Corrales – Aye Director Griffith – Aye Director Greer – Aye Director Barry – Aye Director Clark – Absent Director Pacheco – Aye Director Edwards-Tate – Aye Chair Greer announced that six board members were in favor. None opposed. None abstention. One absent. Motion approved.
•	
7. REPORTS	

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Agenda Item

• *Discussion*	*Conclusion / Action /Follow Up*

a. Medical Staffs

I. Palomar Medical Center Escondido

Palomar Medical Center Escondido Chief of Staff, Dr. Kanchan Koirala, provided a verbal report to the Board of Directors.

II. Palomar Medical Center Poway

Palomar Medical Center Poway Chief of Staff, Dr. Sam Filiciotto, provided a verbal report to the Board of Directors.

b. Administrative

I. President and CEO

Palomar Health President & CEO Diane Hansen provided a verbal report to the Board of Directors:

- Thanked Director Pacheco for his presentation
- Thanked physicians for their work on single license
- Construction update

II. Chair of the Board

Palomar Health Chair of the Board Linda Greer yielded her time to Director Terry Corrales, who shared a poem of reflection.

8. COMMITTEE REPORTS *(information only unless otherwise noted)*

a. Audit and Compliance Committee

- Committee Chair Michael Pacheco reported the committee summary is included in the board-meeting packet.

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Agenda Item

• *Discussion*	*Conclusion / Action /Follow Up*
b. Community Relations Committee	
• Committee Chair Terry Corrales reported the committee was dark in the month of August.	
c. Finance Committee	
• Committee Chair Laura Barry reported the committee summary is included in the board-meeting packet.	
d. Governance Committee	
• Committee Chair Jeff Griffith reported the committee summary is included in the board-meeting packet.	
e. Human Resources Committee	
• Committee Chair Terry Corrales reported the committee summary is included in the board-meeting packet.	
f. Quality Review Committee	
• Committee Chair Linda Greer reported the committee was dark in the month of August.	
g. Strategic & Facilities Planning Committee	
• Committee Chair Michael Pacheco reported the committee was dark in the month of August.	
FINAL ADJOURNMENT	
• There being no further business, Chairwoman Linda Greer adjourned the meeting at 7:14 p.m.	

Signatures:	**Board Secretary**	Terry Corrales, R.N.
	Board Assistant	Carla Albright

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SPECIAL CLOSED SESSION BOARD OF DIRECTOR'S MEETING MINUTES – MONDAY, SEPTEMBER 11, 2023	
AGENDA ITEM	**CONCLUSION / ACTION**
• **DISCUSSION**	
I. CALL TO ORDER	
The meeting, which was held in the Linda Greer Board Room at 2125 Citracado Parkway, Suite 300, Escondido, CA. 92029, and virtually, was called to order at 5:30 p.m. by Board Chair Linda Greer.	
NOTICE OF MEETING	
Notice of Meeting was posted at the Palomar Health Administrative Office at 2125 Citracado Parkway, Suite 300, Escondido, CA 92029, as well as on the Palomar Health website, on Wednesday, September 6, 2023, which is consistent with legal requirements.	
II. ESTABLISHMENT OF QUORUM	
Quorum comprised of Directors Barry, Corrales, Edwards-Tate, Greer, Griffith, Pacheco Absences: Clark	
III. PUBLIC COMMENTS	
There were no public comments	

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AGENDA ITEM	CONCLUSION / ACTION
• DISCUSSION	
IV. ADJOURNMENT TO CLOSED SESSION	
a. Pursuant to California Government Code §54956.9(a) and (e); §54954.5—CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION—Case name(s) unspecified, disclosure would jeopardize service of process, existing negotiations, or result in other prejudice to the position of the District. *b. Pursuant to California Government Code §54956.9(a) and (e); §54954.5—CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION—Case name(s) unspecified, disclosure would jeopardize service of process, existing negotiations, or result in other prejudice to the position of the District.* *c. Pursuant to California Government Code §54956.9(a) and (e); §54954.5—CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION—Case name(s) unspecified, disclosure would jeopardize service of process, existing negotiations, or result in other prejudice to the position of the District.*	
V. RE-ADJOURNMENT TO OPEN SESSION	
VI. ACTION RESULTING FROM DISCUSSION – *IF ANY*	
• No action resulting from discussion	
VII. FINAL ADJOURNMENT	
There being no further business, Chair Greer adjourned the meeting at 6:10 p.m.	

SIGNATURES:	**BOARD SECRETARY**	_____ Terry Corrales, R.N.
	BOARD ASSISTANT	_____ Carla Albright

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ADDENDUM B

Palomar Medical Center Escondido
2185 Citracado Parkway
Escondido, CA 92029
(442) 281-1005 (760) 233-7810 fax
Medical Staff Services

October 2, 2023

To: Palomar Health Board of Directors

From: Kanchan Koirala, M.D., Chief of Staff
Palomar Medical Center Escondido Medical Executive Committee

Board Meeting Date: October 9, 2023

Subject: Palomar Medical Center Escondido Credentialing Recommendations

Provisional Appointment (10/09/2023 – 09/30/2025)
Cleary, Kevin M., M.D. – Family Practice
Gioioso, Valeria, M.D. – Diagnostic Radiology
Gootnick, Susan A., M.D. – Teleradiology
Green, Douglas A., M.D. - Teleradiology
Jacquez, Immanuel G., M.D. – Anesthesiology
Liang, Erin J., M.D. – Emergency Medicine
Mask, William K., M.D. – Teleradiology
Nissim, Lahav, M.D. – Teleradiology
Pakanati, Krishna C., M.D. – Internal Medicine
PIres-Menard, Alexandra P., M.D. – Internal Medicine
Toosie, Katayoun, M.D. – General Surgery
Vickers, Luke D., DDS – Oral & Maxillofacial Surgery
Vong, Vinson S., M.D. – Emergency Medicine

Advance from Provisional to Active Category
Afshar, Masoud, M.D. – Nephrology (eff. 10/09/2023 – 08/31/2024)
Arrieta, Iris R., - OB/Gyn (eff. 11/01/2023 – 11/30/2023)
Griesinger, Michael G., M.D. – Emergency Medicine (eff. 10/09/2023 – 04/30/2024)
Hawkins, Melissa, M.D. – OB/Gyn (eff. 10/09/2023 – 10/31/2024)
Karanikkis, Christos A., D.O. – OB/Gyn (eff. 10/09/2023 – 06/30/2024)
Leng, Poh H., M.D. – Critical Care Medicine (eff. 10/09/2023 – 07/31/2024)
Li, Xian, M.D. – Emergency Medicine (eff. 10/09/2023 – 08/31/2024)
Malkhasian, Armen M., M.D. – Internal Medicine (eff. 10/09/2023 – 07/31/2025)
Quan, Maria, M.D. – OB/Gyn (eff. 11/01/2023 – 10/31/2025)
Vohra, Jaspreet K., M.D. – Emergency Medicine (eff. 10/09/2023 – 12/31/2024)

Additional Privileges

Han, Tony, M.D. – Critical Care Medicine
- ECMO Management (effective 10/09/2023 – 07/31/2024)

Islam, Ibrahim, M.D. – Critical Care Medicine
- ECMO Management (effective 10/09/2023 – 07/31/2024)

Koirala, Kanchan, M.D. – Critical Care Medicine
- ECMO Management (effective 10/09/2023 – 07/31/2024)

Mazarei, Rahele, D.O. – OB/Gyn
- Obstetrics Core Clinical Privileges (effective 10/09/2023 – 06/30/2025)

Moreno Martinez, Enrique J., M.D. – Vascular Surgery
- Transcarotid Artery Revascularization (TCAR) (effective 10/09/2023 – 09/30/2024)

Soni, Ranju A., M.D. – Critical Care Medicine
- ECMO Management (effective 10/09/2023 – 12/31/2023)

Zgliniec, Steven W., M.D. – Critical Care Medicine
- ECMO Management (effective 10/09/2023 – 11/30/2024)

Voluntary Resignations

Chaudhary, Saadia, M.D. – Teleradiology (eff. 09/13/2023)
Chen, Kan J., M.D. – Internal Medicine (eff. 09/13/2023)
Chesler, Bradley H., M.D. – Physical Medicine & Rehab (eff. 09/06/2023)
DeZure, Chandani P., M.D. – Pediatrics (eff. 04/26/2023)
Gelberg, Anna, M.D. – Internal Medicine (eff. 10/31/2023)
Islam, Farina, M.D. – OB/Gyn (eff. 10/31/2023)
Kapner, Lorne D., M.D. – Ophthalmology (eff. 10/31/2023)
Nguyen, Daniel, M.D. – Anesthesiology (eff. 08/31/2023)
Olson, Scott E., M.D. – Neurology (eff. 06/23/2023)
Shiehmorteza, Masoud, M.D. – Teleradiology (eff. 09/22/2023)
Tarzy, Neil T., M.D. – Family Practice (eff. 07/01/2023)
Tseng, Warren H., M.D. – General Surgery (eff. 10/31/2023)

Allied Health Professional Appointment (10/09/2023 – 09/30/2025)

Anselmin, Dominique, PA-C – Physician Assistant (sponsor – Dr. Andrew Nguyen)

Allied Health Professional Resignations

Bierman, Andrew J., FNP (eff. 09/22/2023)
Egge, Marie C., PA-C (eff. 10/31/2023)
Lee, Jisoo, PA-C (eff. 07/19/2023)
Lee, Yong K., PA-C (eff. 08/26/2023)
Lopez, Cassondra R., NP (eff. 10/31/2023)

PALOMAR MEDICAL CENTER ESCONDIDO RECOMMENDATIONS FOR REAPPOINTMENT

Reappointment (effective 11/01/2023 – 12/31/2023)

Bessudo, Alberto, M.D.	Medical Oncology	Dept. of Medicine	Consulting

Reappointment (effective 11/01/2023 – 09/30/2025)

Watson, Nathan T., M.D.	Emergency Medicine	Dept. of Emerg. Med.	Active

Reappointments (effective 11/01/2023 – 10/31/2025)

Bhalla-Regev, Sandhya K., M.D.	Hospice, Palliative Medicine	Dept. of Medicine	Active
Bromley, Nicholle D., M.D.	Emergency Medicine	Dept. of Emerg. Med.	Active
Chen, Andrew K., M.D.	Cardiovascular Disease	Dept. of Medicine	Active
Crain, Donald S., M.D.	Surgery, Urology	Dept. of Urology	Courtesy
Ginther, Brett E., M.D.	Emergency Medicine	Dept. of Emerg. Med.	Active
Kim, Paul E., M.D.	Pain Management	Dept. of Anesthesia	Affiliate
Le, Lara L., M.D.	Internal Medicine	Dept. of Medicine	Active
Lee, Daniel Y., M.D.	Gastroenterology	Dept. of Medicine	Active
MacEwan, Jennifer H., M.D.	Otolaryngology	Dept. of Surgery	Courtesy
Nahavandi, Afshin A., M.D.	Internal Medicine	Dept. of Medicine	Active
Parsons, Colin M., M.D.	Surgery, General	Dept. of Surgery	Courtesy
Peters, Vanessa M., M.D.	Family Practice	Dept. of Fam. Practice	Affiliate
Pevoto, Patrick S., M.D.	OB/Gyn	Dept. of OB/Gyn	Active
Phillips, Jason M., M.D.	Surgery, Urology	Dept. of Urology	Active
Quan, Michele G., M.D.	Pulmonary/Critical Care	Dept. of Medicine	Active
Rose, Richard S., M.D.	Psychiatry	Dept. of Psychiatry	Active
Wilensky, Jonathan S., M.D.	Plastic Surgery	Dept. of Surgery	Active
Yalom, Anisa M., M.D.	Surgery, Hand	Dept. of Surgery	Active

Allied Health Professional Reappointments (effective 11/01/2023 – 10/31/2025)

Green, Kyle P., P.A.-C.	Dept. of Surgery	(Sponsors: Drs. Lin, Wu, Kadesky, Sorkhi, Leon)
Nyagaya, Linda M., F.N.P.	Dept. of Medicine	(Sponsor: Dr. Fadhil for Palomar Hospitalists)
Oeij, Oriesa W., P.A.-C.	Dept. of Emerg. Med.	(Sponsor: Dr. Friedberg for Palomar Emergency Physicians)
Rice, William M., Jr., P.A.-C.	Dept. of Emerg. Med.	(Sponsor: Dr. Friedberg for Palomar Emergency Physicians)

Certification by and Recommendation of Chief of Staff

As Chief of Staff of Palomar Medical Center Escondido, I certify that the procedures described in the Medical Staff Bylaws for appointment, reappointment or alteration of staff membership or the granting of privileges and that the policy of Palomar Health's Board of Directors regarding such practices have been properly followed. I recommend that the action requested in each case be taken by the Board of Directors.

Palomar Medical Center Poway
Medical Staff Services
15615 Pomerado Road
Poway, CA 92064
(858) 613-4538 (858) 613-4217 fax

Date: October 2, 2023
To: Palomar Health Board of Directors – October 9, 2023 Meeting
From: Sam Filiciotto, M.D., Chief of Staff, PMC Poway Medical Staff
Subject: Medical Staff Credentials Recommendations – September, 2023

Provisional Appointments: (10/09/2023 – 09/30/2025)
Valeria Gioioso, M.D., Diagnostic Radiology
Susan Gootnick, M.D., Teleradiology
Douglas Green, M.D., Diagnostic Radiology
Immanuel Jaquez, M.D., Anesthesiology
Erin Liang, M.D., Emergency Medicine
William Mask, M.D., Teleradiology
Lahav NIssim, M.D., Teleradiology
Krishna Pakanati, M.D., Internal Medicine
Alexandra Pires-Menard, M.D., Internal Medicine
Vinson Vong, M.D., Emergency Medicine

Biennial Reappointments: (11/01/2023 - 10/31/2025)
Sandhya Bhalla-Regev, M.D., Palliative Medicine, Active (Includes The Villas at Poway)
Nicholle Bromley, M.D., Emergency Medicine, Active
Andrew Chen, M.D., Cardiology, Active
Donald Crain, M.D., Urology, Active
Bret Ginther, M.D., Emergency Medicine, Active
Daniel Lee, M.D., Gastroenterology, Active
Jennifer Macewan, M.D., ENT, Active
Afshin Nahavandi, M.D., Internal Medicine, Active
Jason Phillips, M.D., Urology, Active
Michele Quan, M.D., Pulmonary/Critical Care Medicine, Active (Includes The Villas at Poway)
Richard Rose, M.D., Psychiatry, Active (Includes The Villas at Poway)
Todd Wells, M.D., Family Practice, Affiliate

Reappointment Effective 11/01/2023 – 09/30/2025:
Nathan Watson, M.D., Emergency Medicine, Active

Reappointment Effective 11/01/2023 – 12/31/2023:
Alberto Bessudo, M.D., Medical Oncology, Consulting

Advancements to Active Category:
Ali Fadhil, M.D., Internal Medicine, Active, effective 10/09/2023 – 03/31/2024
Michael Griesinger, M.D., Emergency Medicine, effective 10/09/2023 – 04/30/2024

Xian Li, M.D., Emergency Medicine, effective 10/09/2023 – 08/31/2024
Poh Leng, M.D., Critical Care Medicine, effective 10/09/2023 – 07/31/2024
Armen Malkhasian, M.D., Internal Medicine, effective 10/09/2023 – 07/31/2025
Jaspreet Vohra, Emergency Medicine, effective 10/09/2023 – 12/31/2024

Advancement to Courtesy Category:
Masoud Afshar, M.D., Nephrology, effective 10/09/2023 – 08/31/2024

Request for Additional Privileges:
Vasken Keleshian, M.D., Cardiology – Additional Moderate and Deep Sedation Privileges, effective 10/09/2023 – 07/31/2025

Requests for 2-Year Leave of Absence:
Nicola Bugelli, M.D., Wound Care, effective 08/30/2023 – 08/29/2025
David Chang, M.D., Anesthesiology, effective 08/30/2023 – 08/29/2025
Martin Ismawan, M.D., Anesthesiology, effective 08/31/2023 – 08/30/2025

Voluntary Resignations:
Saadia Chaudhary, M.D., Teleradiology, effective 09/13/2023
Bradley Chesler, M.D., Phys Med & Rehab, effective 09/06/2023
Mitra De Cogain, M.D., Urology, effective 09/30/2023
Sandra Hayes, M.D., Wound Care, effective 06/01/2023
Karl Marzec, M.D., Emergency Medicine, effective 09/30/2023
Larry Presant, M.D., Internal Medicine, effective 09/30/2023
Masoud Shiehmorteza, M.D., Teleradiology, effective 09/22/2023

Allied Health Professional Appointment: (10/09/2023 – 09/30/2025)
Harper Smith, PA, Sponsors Drs. Burgess and Schultzel

Allied Health Professional Reappointments: (11/01/2023 – 10/31/2025)
Linda Nyagaya, FNP, Sponsor Dr. Fadhil
Oriesa Oeij, PA, Sponsor Dr. Friedberg
William Rice, PA, Sponsor Dr. Frieberg

Allied Health Professional Voluntary Resignations:
Megan Baumberger, PA, effective 09/02/2023
Andrew Bierman, FNP, effective 09/22/2023
Steven Lebowitz, PA, effective 09/30/2023
Jisoo Lee, PA, effective 07/19/2023
Yong Lee, PA, effective 08/29/2023

PALOMAR MEDICAL CENTER POWAY: Certification by and Recommendation of Chief of Staff: As Chief of Staff of Palomar Medical Center Poway, I certify that the procedures described in the Medical Staff Bylaws for appointment, reappointment, or alternation of staff membership or the granting of privileges and the policy of the Palomar Health's Board of Directors regarding such practices have been properly followed. I recommend that the Board of Directors take the action requested in each case.

PALOMAR HEALTH
ALLIED HEALTH PROFESSIONAL APPOINTMENT
October 2023

PERSONAL INFORMATION

Provider Name & Title	Dominique Anselmin, PA-C
Palomar Health Facilities	Palomar Medical Center Escondido

SPECIALTIES/BOARD CERTIFICATION

Specialties	Physician Assistant - Certified 2020

ORGANIZATIONAL NAME

Name	UCSD Dept. of Neurosurgery

EDUCATION/AFFILIATION INFORMATION

Education Information	Pace University Physician Assistant 07/01/2018 – 10/06/2020
Employment	Current Employment Lenox Hill Hospital - Northwell Health Physician Assistant From: 12/21/2020 To: Current Current Employment Jersey Shore University Medical Center Physician Assistant From: 12/21/2021 To: Current Current Employment UC San Diego Health From: 07/01/2023 To: Current
Current Affiliation Information	Jersey Shore Medical Center Lenox Hill Hospital

PALOMAR HEALTH
ALLIED HEALTH PROFESSIONAL APPOINTMENT
October 2023

PALOMAR HEALTH
PROVISIONAL APPOINTMENT
October 2023

PERSONAL INFORMATION

Provider Name & Title	Kevin M. Cleary, M.D.
Palomar Health Facilities	Palomar Medical Center Escondido

SPECIALTIES/BOARD CERTIFICATION

Specialties	Family Practice - Certified 2023

ORGANIZATIONAL NAME

Name	PHMG Graybill

EDUCATION/AFFILIATION INFORMATION

Medical Education Information	Medical School University of Nevada Reno, MD From: 07/01/2016 To: 05/30/2020
Internship Information	
Residency Information	Residency Creighton University School of Medicine (Phoenix) Family Medicine From: 07/01/2020 To: 07/01/2023
Fellowship Information	
Current Affiliation Information	

PALOMAR HEALTH
PROVISIONAL APPOINTMENT
October 2023

PALOMAR HEALTH
PROVISIONAL APPOINTMENT
October 2023

PERSONAL INFORMATION

Provider Name & Title	Valeria Gioioso, M.D.
Palomar Health Facilities	Palomar Medical Center Escondido Palomar Medical Center Poway

SPECIALTIES/BOARD CERTIFICATION

Specialties	Radiology, Interventional & Diagnostic - Certified 2021

ORGANIZATIONAL NAME

Name	San Diego Imaging Medical Group

EDUCATION/AFFILIATION INFORMATION

Medical Education Information	Medical School University of Maryland, MD From: 08/11/2011 To: 05/15/2015 University of Maryland School of Medicine
Internship Information	Internship University of Maryland Med Center - Midtown Campus Transitional From: 07/01/2015 To: 06/30/2016
Residency Information	Residency University of California, San Diego Interventional Radiology From: 07/01/2020 To: 06/30/2021 Residency NYP Columbia Univ Medical Center Radiology, Diagnostic Imaging From: 07/01/2016 To: 06/30/2020
Fellowship Information	
Current Affiliation Information	Bronx-Lebanon Hospital Center Scripps Mercy Hospital, San Diego Veterans Affairs Medical Center San Diego

PALOMAR HEALTH
PROVISIONAL APPOINTMENT
October 2023

PALOMAR HEALTH
PROVISIONAL APPOINTMENT
October 2023

PERSONAL INFORMATION

Provider Name & Title	Susan A. Gootnick, M.D.
Palomar Health Facilities	Palomar Medical Center Escondido Palomar Medical Center Poway

SPECIALTIES/BOARD CERTIFICATION

Specialties	Radiology - Certified 1977

ORGANIZATIONAL NAME

Name	The Radiology Group

EDUCATION/AFFILIATION INFORMATION

Medical Education Information	Medical School University of California, San Francisco, MD From: 09/01/1967 To: 06/30/1971 Doctor of Medicine Degree
Internship Information	Internship Santa Clara Valley Medical Center Transitional From: 06/01/1971 To: 06/30/1972
Residency Information	Residency Mount Zion Hospital and Medical Center Radiology, Diagnostic Imaging From: 07/01/1972 To: 06/30/1975
Fellowship Information	
Current Affiliation Information	Tri-City Medical Center Wilkes-Barre General Hospital Indiana Regional Medical Center Jackson Memorial Hospital

PALOMAR HEALTH
PROVISIONAL APPOINTMENT
October 2023

PALOMAR HEALTH
PROVISIONAL APPOINTMENT
October 2023

PERSONAL INFORMATION

Provider Name & Title	Douglas A. Green, M.D.
Palomar Health Facilities	Palomar Medical Center Escondido Palomar Medical Center Poway

SPECIALTIES/BOARD CERTIFICATION

Specialties	Diagnostic Radiology - Certified 2010

ORGANIZATIONAL NAME

Name	Self

EDUCATION/AFFILIATION INFORMATION

Medical Education Information	Medical School University of Pittsburgh, MD From: 08/01/1998 To: 07/01/2005
Internship Information	Internship Western Pennsylvania Hospital Medicine From: 07/01/2005 To: 07/01/2006
Residency Information	Residency UCSD Medical Center Radiology From: 07/01/2006 To: 07/01/2010
Fellowship Information	Fellowship UCSD Medical Center Neuroradiology From: 07/01/2010 To: 07/01/2011
Current Affiliation Information	Rancho Springs Medical Center Temecula Valley Hospital Inland Valley Medical Center

PALOMAR HEALTH
PROVISIONAL APPOINTMENT
October 2023

PALOMAR HEALTH
PROVISIONAL APPOINTMENT
October 2023

PERSONAL INFORMATION

Provider Name & Title	Immanuel G. Jacquez, M.D.
Palomar Health Facilities	Palomar Medical Center Escondido Palomar Medical Center Poway

SPECIALTIES/BOARD CERTIFICATION

Specialties	Anesthesiology - Certified 2022

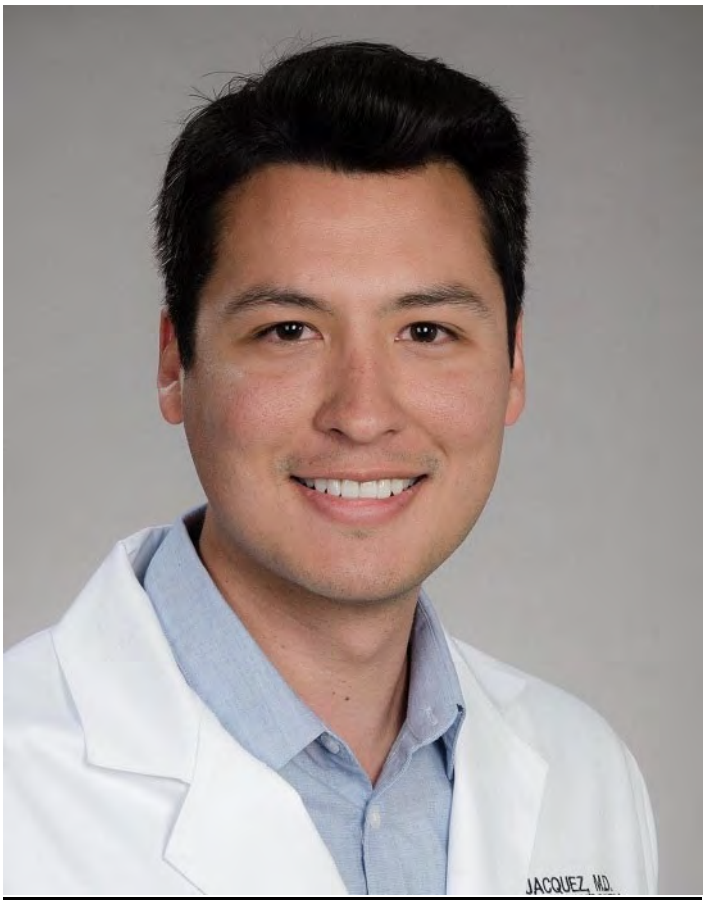
ORGANIZATIONAL NAME

Name	Anesthesia Consultants Medical Group

EDUCATION/AFFILIATION INFORMATION

Medical Education Information	Medical School Indiana University School of Medicine, MD From: 07/01/2012 To: 05/08/2016 Doctor of Medicine
Internship Information	Internship University of Washington Medical Center General Surgery From: 06/24/2016 To: 06/25/2017
Residency Information	Residency Indiana University School of Medicine Anesthesiology From: 07/01/2017 To: 06/30/2020
Fellowship Information	
Current Affiliation Information	

PALOMAR HEALTH
PROVISIONAL APPOINTMENT
October 2023



PALOMAR HEALTH
PROVISIONAL APPOINTMENT
October 2023

PERSONAL INFORMATION

Provider Name & Title	Erin J. Liang, M.D.
Palomar Health Facilities	Palomar Medical Center Escondido Palomar Medical Center Poway

SPECIALTIES/BOARD CERTIFICATION

Specialties	Emergency Medicine – Not Yet Certified

ORGANIZATIONAL NAME

Name	Palomar Emergency Physicians

EDUCATION/AFFILIATION INFORMATION

Medical Education Information	Medical School University of California, Riverside, MD From: 08/03/2015 To: 05/31/2019
Internship Information	
Residency Information	Residency Stanford Health Care Emergency Medicine From: 06/25/2019 To: 06/24/2023
Fellowship Information	
Current Affiliation Information	

PALOMAR HEALTH
PROVISIONAL APPOINTMENT
October 2023

PERSONAL INFORMATION

Provider Name & Title	William K. Mask, M.D.
Palomar Health Facilities	Palomar Medical Center Escondido Palomar Medical Center Poway

SPECIALTIES/BOARD CERTIFICATION

Specialties	Diagnostic Radiology – Certified 1998

ORGANIZATIONAL NAME

Name	The Radiology Group

EDUCATION/AFFILIATION INFORMATION

Medical Education Information	Medical School Duke University, MD From: 09/01/1983 To: 05/08/1988 Doctor of Medicine Degree
Internship Information	Internship Huntington Memorial Hospital, Pasadena General Surgery From: 06/25/1988 To: 06/24/1989
Residency Information	Residency Lenox Hill Hospital Radiology From: 07/01/1991 To: 06/30/1995 Residency Virginia Commonwealth University General Surgery From: 07/01/1989 To: 06/30/1990
Fellowship Information	Fellowship Louisiana State University Medical Center Radiology From: 07/01/1995 To: 06/30/1996

PALOMAR HEALTH
PROVISIONAL APPOINTMENT
October 2023

Current Affiliation Information	Adventist Health St. Helena Kindred Hospital Tarrant Co.Arlington/FWSW Kindred Hospital Houston Medical Center Regional Medical Center of Acadiana Louisiana State University Medical Center South Texas Health Systems Monte Cristo Adventist Health Tulare Regional Medical Center LSU Medical Center University Hospital

PALOMAR HEALTH
PROVISIONAL APPOINTMENT
October 2023

PERSONAL INFORMATION

Provider Name & Title	Lahav Nissim, M.D.
Palomar Health Facilities	Palomar Medical Center Escondido Palomar Medical Center Poway

SPECIALTIES/BOARD CERTIFICATION

Specialties	Radiology, Interventional & Diagnostic, Pediatric, Radiology, Diagnostic Radiology - Certified 2017, 2010, 2022

ORGANIZATIONAL NAME

Name	Synthesis Health Inc.

EDUCATION/AFFILIATION INFORMATION

Medical Education Information	Medical School University of Pennsylvania SOM, MD From: 08/01/2000 To: 05/01/2004
Internship Information	
Residency Information	Residency University of Arizona College of Medicine- Phoenix Radiology, Imaging/Interventional From: 10/01/2006 To: 09/30/2010 Residency Beth Israel Deaconess Medical Center General Surgery From: 06/24/2004 To: 06/23/2006
Fellowship Information	Fellowship Children's Hospital, Phoenix Radiology From: 01/06/2020 To: 01/05/2021 Fellowship Children's Hospital, Phoenix Pediatric Radiology From: 11/10/2010 To: 06/30/2011
Current Affiliation Information	Children's Hospital, Phoenix Steward Medical - Mountain Vista Medical Center

PALOMAR HEALTH
PROVISIONAL APPOINTMENT
October 2023

PALOMAR HEALTH
PROVISIONAL APPOINTMENT
October 2023

PERSONAL INFORMATION

Provider Name & Title	Krishna C. Pakanati, M.D.
Palomar Health Facilities	Palomar Medical Center Escondido Palomar Medical Center Poway

SPECIALTIES/BOARD CERTIFICATION

Specialties	Internal Medicine - Certified 2014

ORGANIZATIONAL NAME

Name	Palomar Hospitalist Medical Group

EDUCATION/AFFILIATION INFORMATION

Medical Education Information	Medical School Osmania Medical College, Hyderabad, AP, India, MD From: 10/17/2002 To: 11/15/2008
Internship Information	
Residency Information	Residency Advocate Illinois Masonic Medical Center Internal Medicine From: 07/01/2011 To: 06/30/2014
Fellowship Information	
Current Affiliation Information	Sharp Memorial Hospital O'Connor Hospital St. Mark's Hospital Desert Regional Medical Center Oviedo Medical Center Verde Valley Medical Center

PALOMAR HEALTH
PROVISIONAL APPOINTMENT
October 2023

PALOMAR HEALTH
PROVISIONAL APPOINTMENT
October 2023

PERSONAL INFORMATION

Provider Name & Title	Alexandra P. Pires-Menard, M.D.
Palomar Health Facilities	Palomar Medical Center Escondido Palomar Medical Center Poway

SPECIALTIES/BOARD CERTIFICATION

Specialties	Internal Medicine – Not Yet Certified

ORGANIZATIONAL NAME

Name	Palomar Hospitalist Medical Group

EDUCATION/AFFILIATION INFORMATION

Medical Education Information	Medical School The University of Queensland, Herston, QLD, Australia From: 01/01/2014 To: 12/31/2017
Internship Information	
Residency Information	Residency UHS Southern California Medical Education Cons Resident Physician From: 07/01/2020 To: 06/30/2023
Fellowship Information	Fellowship John H. Stroger, Jr. Hospital of Cook County From: 06/01/2019 To: 06/30/2020 Cook County Hospital Research Fellowship
Current Affiliation Information	

PALOMAR HEALTH
PROVISIONAL APPOINTMENT
October 2023

PALOMAR HEALTH
ALLIED HEALTH PROFESSIONAL APPOINTMENT
October 2023

PERSONAL INFORMATION

Provider Name & Title	Harper Smith, PA-C
Palomar Health Facilities	Palomar Medical Center Poway

SPECIALTIES/BOARD CERTIFICATION

Specialties	Physician Assistant - Certified 2023

ORGANIZATIONAL NAME

Name	United Medical Doctors

EDUCATION/AFFILIATION INFORMATION

Education Information	South University Physician Assistant 01/01/2021 – 03/24/2023
Employment	Current Employment United Medical Doctors Physician Assistant From: 07/17/2023 To: Current
Current Affiliation Information	

PALOMAR HEALTH
ALLIED HEALTH PROFESSIONAL APPOINTMENT
October 2023

PALOMAR HEALTH
PROVISIONAL APPOINTMENT
October 2023

PERSONAL INFORMATION

Provider Name & Title	Katayoun Toosie, M.D.
Palomar Health Facilities	Palomar Medical Center Escondido

SPECIALTIES/BOARD CERTIFICATION

Specialties	Surgery, General - Certified 2004

ORGANIZATIONAL NAME

Name	Coastal Surgeons

EDUCATION/AFFILIATION INFORMATION

Medical Education Information	Medical School New York University School of Medicine, MD From: 08/01/1990 To: 05/31/1994 Doctor of Medicine Degree
Internship Information	Internship Harbor/UCLA Medical Center General Surgery From: 06/01/1994 To: 06/28/2002
Residency Information	Residency Harbor/UCLA Medical Center General Surgery From: 06/01/1994 To: 06/28/2002
Fellowship Information	
Current Affiliation Information	Sharp Community Medical Group Center for Surgery of Encinitas Scripps Memorial Hospital, Encinitas Tri-City Medical Center

PALOMAR HEALTH
PROVISIONAL APPOINTMENT
October 2023

PALOMAR HEALTH
PROVISIONAL APPOINTMENT
October 2023

PERSONAL INFORMATION

Provider Name & Title	Luke D. Vickers, DDS
Palomar Health Facilities	Palomar Medical Center Escondido

SPECIALTIES/BOARD CERTIFICATION

Specialties	Surgery, Oral & Maxillofacial – Not Yet Certified

ORGANIZATIONAL NAME

Name	North County Oral & Facial Surgery

EDUCATION/AFFILIATION INFORMATION

Medical Education Information	Medical School University of California, Los Angeles, DDS From: 09/01/2014 To: 06/15/2018
Internship Information	
Residency Information	Residency Loyola University, Illinois Oral & Maxillofacial Surgery From: 07/01/2018 To: 06/30/2022
Fellowship Information	
Current Affiliation Information	Maui Health System (Kaiser Foundation Hospitals)

PALOMAR HEALTH
PROVISIONAL APPOINTMENT
October 2023

PALOMAR HEALTH
PROVISIONAL APPOINTMENT
October 2023

PERSONAL INFORMATION

Provider Name & Title	Vinson S. Vong, M.D.
Palomar Health Facilities	Palomar Medical Center Escondido Palomar Medical Center Poway

SPECIALTIES/BOARD CERTIFICATION

Specialties	Emergency Medicine – Not Yet Certified

ORGANIZATIONAL NAME

Name	Palomar Emergency Physicians

EDUCATION/AFFILIATION INFORMATION

Medical Education Information	Medical School University of California, Riverside, MD From: 07/01/2016 To: 05/31/2020 Doctor of Medicine Degree
Internship Information	
Residency Information	Residency Riverside Community Hospital Emergency Medicine From: 07/01/2020 To: 06/30/2023
Fellowship Information	
Current Affiliation Information	Kaiser Foundation Hospital - Riverside Kindred Hospital Ontario

PALOMAR HEALTH
PROVISIONAL APPOINTMENT
October 2023

REDLINE

Palomar Medical Center-
Medical Staff
(Escondido Campus & Poway Campus)

Bylaws-

(Includes Credentials Policy
Manual and-
Medical Staff Rights Manual)

Rules and Regulations

~~July 2022 versions consolidated together~~

Approved by:
Palomar Medical Center Escondido Medical Staff on September 25, 2023
Palomar Medical Center Poway Medical Staff on August 29, 2023

Palomar Health Board of
Directors on October 9,
2023
~~July 11, 2022~~

ARTICLE I: NAME AND REFERENCES

The name of the organization shall be the Palomar Medical Center ~~Escondido Pomerado Hospital*~~ Medical Staff~~.~~ (the "Medical Staff").

Reference throughout these Bylaws and in Medical Staff rules, regulations, policies, and other documents shall be made to the geographic subdivisions of the Medical Staff comprised of leaders and members at the separate facilities in Escondido (the "Escondido Campus") and Poway (the "Poway Campus"). The separate facilities may be referred to collectively as "Campuses" or individually as "Campus" as the context requires. Unless expressly provided otherwise, the terms, sections, and provisions of these Bylaws shall apply to the Medical Staff without regard to any particular campus.

General references to a campus in these Bylaws and in Medical Staff rules, regulations, policies, and other documents (e.g., the Campus Chief of Staff or the Campus Executive Committee) shall be construed to refer to either the Escondido Campus or the Poway Campus in particular, as the context reasonably requires.

ARTICLE II: PURPOSES

2.1 ~~2.1~~ The purposes of this organization shall be:

~~8.5.1~~2.1.1. To initiate and maintain the bylaws, rules and regulation for the self-governance of the Medical Staff.

~~8.5.2~~2.1.2. To provide a means whereby all Members authorized to practice in the Hospital have the appropriate delineation of clinical privileges that each Member may exercise in the Hospital and assuring ongoing review of each Member's future performance.

~~8.5.3~~2.1.3. To provide a means whereby issues concerning the Medical Staff and the Hospital may be discussed by the Medical Staff with Administration and the Board of Directors.

~~8.5.4~~2.1.4. To provide an appropriate educational setting that shall maintain scientific standards that shall lead to the continuous advancement of professional knowledge and skill.

~~8.5.5~~2.1.5. To provide a framework of self-governance in order to permit the Medical Staff to discharge its responsibilities in matters involving the quality of medical care.

~~8.5.6~~2.1.6. To empower the Medical Executive Committee to impose such sanctions upon a Member that are necessary and appropriate to enforce the bylaws, rules, and regulations to the extent it believes is necessary and appropriate.

2.2 **Effective Date and Automatic Sunset of Bylaws**

These Bylaws shall be effective on the day the governing body of Palomar Medical Center approves the Bylaws pursuant to its authority under California law and the hospital has been issued a single consolidated license to operate the facilities known as Palomar Medical Center Escondido and Palomar Medical Center Poway (the "Effective Date"). Unless duly amended, modified, or withdrawn and superseded by a new set of bylaws in accordance with the provisions of these Bylaws and consistent with California law, these Bylaws shall remain in effect for one (1) year from the original Effective Date. The Medical Executive Committee may, as it deems appropriate, extend the term of these Bylaws by any number of days for a cumulative total of six months.

ARTICLE III: MEMBERSHIP

3.1.

~~4~~ Nature of Membership

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

3.2. General Qualifications

~~8.5.1~~3.2.1 Only Practitioners licensed to practice medicine, dentistry or podiatry in the State of California, who can document their background, experience, training and demonstrated competence, their adherence to the ethics of their profession, their good reputation, their ability to work with others and their ability to perform the privileges requested shall be admitted to the Medical Staff.

3.2.2 All practitioners who apply for membership ~~after the effective date (June 2, 2003) at Palomar Medical Center Escondido and (March 11, 1996) at Palomar Medical Center Poway~~ shall be certified as a member of the Board of the American Board of Medical Specialties or by the American Osteopathic Association or by the American Board of Foot and Ankle Surgery or by the American Board of Oral and Maxillofacial Surgery, and or another board with equivalent requirements, or shall be actively engaged in the Board application and certification process. Every applicant to the Medical Staff who is not board certified shall sign a statement at the time of application attesting that he/she is qualified and shall attain certification within forty-eight (48) months of appointment to the Medical Staff. Failure to obtain board certification within the permitted period of time shall result in automatic termination of privileges and membership. The Medical Executive Committee, with consultation from the appropriate Campus MEC, may grant an extension at its discretion. Physicians who are in the final months of an approved residency will be eligible to receive an application for membership. However, continued eligibility is contingent upon receipt of documentation that training has been successfully completed and that the applicant is actively engaged in the Board application process.~~-~~

~~3.2.2~~Any individual who does not attain board certification within forty-eight (48) months or within the time frame permitted by the American Board of Medical Specialties may request a waiver. The individual requesting the waiver bears the burden of demonstrating that his or her qualifications are equivalent to board certification. The Board may grant a waiver in exceptional cases after considering the findings of the Medical Executive Committee, the specific qualification of the individual in question, and the best interest of the hospital and the community it serves. The granting of a waiver in a particular case is not intended to set a precedent for any other individual. No individual is entitled to a waiver or a hearing if the Board determines not to grant a waiver. A determination that an individual is not entitled to a waiver is not a "denial" of appointment or clinical privileges.~~-~~

~~8.5.3~~3.2.3 Qualifications ~~for~~For Membership~~-~~

Only physicians, dentists, and podiatrists shall be deemed to possess basic qualifications for membership in the medical staff, and who

a) confirm (1) current licensure, (2) adequate experience, education, and training, (3)~~-~~ current professional competence, (4) good judgment, and (5) current adequate physical and mental health status, so as to demonstrate to the

satisfaction of the Medical Staff professional and ethically competence and patients can reasonably expect to receive quality medical care;

b) are determined (1) to adhere to the ethics of their respective professions, (2) to be able to work cooperatively with others so as not to adversely affect patient care, (3) to keep as confidential, as required by law, all information or records received in the physician-patient relationship, and (4) to be willing to participate in and properly discharge those responsibilities as reasonably determined by the Medical Staff~~.~~;

3.2.4 Basic Responsibilities ~~of~~Of Medical Staff Membership~~-~~

~~3.2.4~~The ongoing responsibilities of each member of the medical staff include:

~~c)~~a) Providing patients with the quality of care meeting the professional standards of the medical staff of this hospital;

~~d)~~b) Abiding by the medical staff bylaws, Medical Staff rules and regulations, and policies;

~~e)~~c) Discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the member by virtue of Medical Staff membership, including committee assignments;

~~f)~~d) Preparing and completing in timely fashion medical records for all the patients to whom the member provides care in the hospital;

~~g)~~e) Abiding by the lawful ethical principles of the California Medical Association or member's professional association:

(1) Provide for continuous care of his/her patients.

(2) Delegate in their absence the responsibility for diagnosis or care of their patients only to a Member who is qualified to undertake this responsibility.

(3) Seek consultation whenever indicated.

~~h)~~f) Working cooperatively with members, nurses, hospital administration and others so as not to adversely affect patient care;

~~i)~~g) Making appropriate arrangements for coverage of that member's patients as determined by the medical staff or Medical Executive Committee;

~~j)~~h) Refusing to engage in improper inducements for patient referral;

~~k)~~i) Participating in continuing education programs as determined by the Medical Staff or Medical Executive Committee;

~~l)~~j) Participating in such emergency service coverage or consultation panels as may be determined by the Medical Staff or Medical Executive Committee;

~~m)~~k) Discharging such other staff obligations as may be lawfully established from time to time by the Medical Staff or Medical Executive Committee; ~~and~~

~~n)~~l) Providing information to and/or testifying on behalf of the Medical Staff or an accused practitioner regarding any matter under an investigation, and those which are the subject of a hearing~~.~~;

~~o)~~m) Maintaining Board certification in the primary specialty~~, if appointed after the effective dates for Board certification required~~ as specified in 3.2.2~~.~~; and

~~p)~~n) Serving as a proctor or other peer reviewer, and otherwise participating in Medical Staff peer review as reasonably requested.

3.2.5 Effect of Other Affiliations

~~3.2.5~~No person shall be entitled to membership in the Medical Staff merely because that person holds a certain degree, is licensed to practice in this or in any other state, is a member of any professional organization, is certified by any clinical board, or because such person had, or presently has, staff membership or privileges at another health care facility. Medical Staff membership or clinical privileges shall not be conditioned or determined on the basis of an individual's participation or non-participation in a particular medical group, surgery center or other outpatient service facility, IPA, PPO, PHO, hospital-sponsored foundation, or other organization or in contracts with a third party which contracts with this hospital. Medical Staff membership or clinical privileges shall not be revoked, denied, or otherwise infringed based on the member's professional or business interests.

~~8.5.6~~3.2.6 Every member shall maintain in force professional liability insurance in the amount of $1~~-~~ million per occurrence and $3 million in the annual aggregate or as from time to time may be jointly determined by the board of directors and the Medical Executive Committee. The Medical Executive Committee, for good cause, shown may waive this requirement with regard to a member as long as such a waiver is not granted or withheld on an arbitrary, discriminatory, or capricious basis. In determining whether an individual exception is appropriate, the following facts may be considered:

~~q)~~a) Whether the member has applied for the requisite insurance;

~~r)~~b) Whether the member has been refused insurance, and if so, the reasons for such refusal; and

~~s)~~c) Whether insurance is reasonably available to the member, and if not, the reasons for its unavailability.

If a Member's insurance is restricted in any manner (such as not covering surgery or obstetrics), the Member must furnish a copy of the policy restriction to the Hospital, and the Member cannot exercise the privileges excluded from the insurance coverage. The Member shall immediately notify the Hospital if coverage lapses for any reason including failure to purchase tail or nose coverage for change in policy or it is expired. Alternative forms of financial security shall be in amounts equal to the required amounts of professional liability insurance, shall cover defense costs and liability, and cannot be used as a substitute for insurance without prior individual approval by the Medical Executive Committee and the Board of Directors.

~~8.5.7~~3.2.7 Acceptance of membership shall constitute an agreement that the Member will abide by these bylaws, rules and regulations and that throughout any period of membership that person will comply with the responsibilities of medical staff membership.~~-~~

~~8.5.8~~3.2.8 When a Member fails to make an appropriate response to a request sent by certified, return receipt mail, for reasonable information or action within thirty (30) days, it shall be deemed a voluntary resignation of his/her membership and clinical privileges.

3.3. 3.3Leave of Absence

~~8.5.1~~

~~8.5.1~~3.3.1 Leave Status

At the discretion of the Medical Executive Committee, a Medical Staff member may obtain a voluntary leave of absence from the staff upon submitting a written request to the Medical Executive Committee stating the approximate period of leave desired,

which may not exceed two (2) years. During the period of the leave, the member shall not exercise clinical privileges at the hospital, and membership rights and responsibilities shall be inactive.-

~~8.5.2~~3.3.2 Termination of Leave

At least thirty (30) days prior to the termination of the leave of absence, or at any earlier time, the Medical Staff member may request reinstatement of privileges by submitting a written notice to that effect to the Medical Executive Committee. The member shall submit a summary of relevant activities during the leave, if the Medical Executive Committee so requests. The Medical Executive Committee shall make a recommendation concerning the reinstatement of the member's privileges and prerogatives, and the procedure provided in Sections 2 and 3 of the Credentials Policy Manual shall be followed.

~~8.5.3~~3.3.3 Failure to Request Reinstatement

Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of membership, privileges, and prerogatives. A request for Medical Staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial membership

~~8.5.4~~3.3.4 Medical Leave of Absence

The Medical Executive Committee shall determine the circumstances under which a particular Medical Staff member shall be granted a leave of absence for the purpose of obtaining treatment for a medical condition or disability. In the discretion of the Medical Executive Committee, unless accompanied by a reportable restriction of privileges, the leave shall be deemed a "medical leave" which is not granted for a medical disciplinary cause or reason.

~~8.5.5~~3.3.5 Military Leave of Absence

Requests for leave of absence to fulfill military service obligations shall be granted upon notice and review by the Medical Executive Committee. Reactivation of membership and clinical privileges previously held shall be granted, notwithstanding the provisions of Sections 3.3.2 and 3.3.3, but may be granted subject to monitoring and/or proctoring as determined by the Medical Executive Committee.

3.4. ~~3.4~~Non-Eligibility

An applicant who has been denied membership, or whose membership was revoked at any Palomar Health facility (including, but not limited to, Palomar Medical Center Escondido and Palomar Medical Center Poway) within one (1) year prior to the submission of an application to another Palomar Health facility, shall be ineligible for membership on the ~~Medical Staffs~~medical staff of any Palomar Health facility. An applicant who has been denied requested privileges, or had privileges revoked or restricted at any Palomar Health facility shall be ineligible for membership at any Palomar Health facility. Information regarding an issue occurring at any one Palomar Health facility may be shared with other Palomar Health facilities.

3.5. ~~3.5~~Quality Improvement

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

shall not be grounds for a hearing pursuant to The Medical Staff Rights Manual. If requested by the Chief of Staff or the department chairman to attend a meeting to discuss quality, by notice of the time and place of the meeting using certified, return receipt requested mail, failure by a Member to attend such a meeting may result in automatic suspension of clinical privileges by the Chief of Staff as outlined in ~~The~~the Medical Staff Rights Manual 4.3. The advance notice to attend should include a statement of the suspected deviation from the standard of care and should state that attendance is mandatory.

3.6. ~~3.6~~**Harassment Prohibited**

Harassment by a Medical Staff member against any individual (e.g., against another Medical Staff member, hospital employee, or patient, on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex~~,~~ or sexual orientation is prohibited under law.

"Sexual harassment" is unwelcome verbal or physical conduct of a sexual or gender-based nature which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and visual harassment (such as the display of derogatory cartoons, drawings, or posters).

Sexual harassment includes unwelcome advances, requests for sexual favors, and any other verbal, visual, or physical conduct of a sexual nature when (1) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion, or other aspects of employment; or (2) this conduct substantially interferes with the individual's employment or creates and/or perpetuates an intimidating, hostile, or offensive work environment. Sexual harassment also includes conduct which indicates that employment and/or employment benefits are conditioned upon acquiescence in sexual activities.

All allegations of sexual harassment shall be promptly investigated within a reasonable time frame by the Medical Staff and, if confirmed, will result in appropriate corrective action.~~-~~

3.7. ~~3.7~~**Nondiscrimination**

No aspect of Medical Staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, religion, ancestry, national origin, disability, physical or mental impairment, marital status, or sexual orientation that does not pose a threat to the quality of patient care.

ARTICLE IV: MEMBERSHIP CATEGORIES

Palomar Medical Center and its Campuses at Escondido ~~Pomerado Hospital is~~and Poway operate under a consolidated license and are part of Palomar Health ("System"). Among the purposes of the System is to maintain high professional standards among its patient care facilities and to strive to provide efficient patient care and support services. In keeping with the foregoing, cooperative credentialing is hereby authorized, in accordance with the guidelines set forth in these bylaws. Each Medical Staff member shall be assigned to a Medical Staff category based upon the qualifications defined in the Bylaws. The members of each Medical Staff category shall have the prerogatives and carry out the duties defined in the Bylaws and Rules and Regulations. Action may be initiated to change the Medical Staff category or terminate the membership of any member who fails to meet the qualifications or fulfill the duties described in the Bylaws or Rules and Regulations. Changes in Medical Staff category shall not be grounds for a hearing unless they adversely affect the member's privileges.

All Medical Staff members shall be assigned to one or both Campuses that comprise Palomar Medical Center, depending on the requests of the member, their department assignment, and the privileges they are granted. Members' privileges at one or both of the separate Palomar Medical Center hospitals prior to the Effective Date, including any restrictions, limitations, or other conditions, shall transfer

automatically upon the Effective Date and be assigned to one or both Campuses as appropriate. Unless otherwise specified in these Bylaws or Rules and Regulations, Campus assignment does not create, modify, waive, or terminate any duties, obligations, rights, and entitlements that are generally applicable to all Medical Staff members by virtue of their membership on the Medical Staff.

4.1. **~~4.1~~Provisional**

All Members shall serve a minimum of one (1) year and a maximum of two (2) years on a provisional basis prior to advancement. All Members shall be assigned to a Campus Department, where the Campus Department Chairperson or his/her designee shall observe his/her performance and clinical competence. Provisional Members are eligible to serve on Medical Staff and Department committees and shall be eligible to vote on committee matters, but they may not hold office. Provisional Members shall not be eligible to vote on general medical staff and Department matters. ~~Such provisional~~ Provisional category Members assigned to the Escondido Campus, except those intending to become consulting and affiliate categories, shall be required to attend meetings of their Campus Department, unless waived (preferably in advance) by the ~~Medical~~Escondido Campus Executive Committee and the appropriate Campus Department. This meeting requirement shall have no application at the Poway Campus.

If, at the end of the provisional time, an individual has satisfied the provisional requirements, as determined by the appropriate committee(s) and Department(s) he/she shall be recommended to the Board of Directors for appropriate advancement, if applicable. If, at the end of the provisional time, an individual has not satisfied the provisional requirements, his/her provisional membership shall automatically terminate, and the Member shall be given written notice of such termination and of his/her entitlement to procedural rights specified in the Medical Staff Rights Manual, as applicable.

Members in the Provisional category have the same obligations to provide Emergency Room coverage as Active members.

Dues shall be assessed newly appointed provisional Members, if applicable, on a prorated basis, beginning with the quarter of initial appointment. Any provisional Member who does not pay dues within forty (40) days of the dues notice, shall have his/her clinical privileges suspended, and shall remain so suspended until the Member pays the delinquent dues or until the parameters in Section 4.5(d) of the Medical Staff Rights Manual are met. Provisional category Members shall not be required to serve on ~~the~~a Trauma Services consultation panel.

In the event a Member who fails to satisfy the provisional requirements is not otherwise barred from reapplying, such Member may reapply. If a Member fails to meet all Provisional requirements by the end of the second consecutive provisional appointment, the membership shall be terminated.~~-~~

4.2. **~~4.2~~Active**

~~8.5.1~~4.2.1 Active ~~with~~With Clinical Activity

This category shall consist of Members who regularly admit, or who are regularly involved in the care of patients in the Hospital. Members who attend more than twenty-five (25) patients at a specific Campus during their two (2) year reassessment-reappointment period shall be eligible for active staff membership~~. Such Members must be located close enough to the Hospital~~ on the Medical Staff and assignment to that particular Campus. Counting toward the twenty-five (25) patients requirement shall not be cumulative across the Campuses; Members must instead satisfy this requirement at one Campus to be eligible for assignment to that Campus. Such Members must be located close enough to the Campus(es) to which they are assigned to provide continuous care to their patients, and shall assume all functions and

responsibilities of the active staff membership, including emergency room coverage, according to the rules and regulations. ~~These Members shall~~ Active membership does not ~~be required~~require a Member to serve on ~~the~~a Trauma Services consultation panel. These Members shall be appointed to a specific department~~,~~ at their assigned Campus(es), shall be eligible to vote, to hold office, to serve on standing committees of the Medical Staff and departments, and shall be required to attend departmental meetings and meetings of the Medical Staff designated as mandatory by the Medical Executive Committee~~(s),~~ or a Campus Executive Committee, unless waived (preferable in advance) by the Medical Executive Committee, the appropriate Campus Executive Committee, and/or the approved department. Annual dues shall be assessed. Should the Member have no clinical activity at a Palomar Health facility during their two-year reassessment-reappointment period~~,~~ they will automatically be transferred to ~~the~~ Active Without Clinical Activity ~~category.~~ unless that Member has maintained Active or equivalent status at a non-Palomar Health facility, in which case the Member will be automatically transferred to Courtesy status. Nothing herein restricts, affects, modifies, or supersedes department or committee rules concerning scheduling, response times for ER calls, or other similar requirements.

~~8.5.2~~4.2.2 Active Without Clinical Activity

This category shall consist of Members who are regularly involved in Medical Staff functions as determined by the Medical Staff. These Members shall request "refer and follow" privileges if privileged in Family Practice or Internal Medicine. Members in this category are:

~~t)~~a) Appointed to a specific department~~,~~ at one or both Campuses,

~~u)~~b) Eligible to vote,

~~v)~~c) Allowed to be a departmental officer,

~~w)~~d) Eligible to serve on standing committees of the Medical Staff and departments, and

~~x)~~e) Required to attend departmental meetings and meetings of the Medical Staff designated as mandatory by the Medical Executive Committee~~(s)~~ or Campus Executive Committee unless waived (preferably in advance) by the Medical Executive Committee, the Campus Executive Committee, and/or the approved department.

Annual dues will be assessed.

"Refer and follow" shall apply only to Members privileged in either Family Practice or Internal Medicine. This allows the Member to perform outpatient preadmission, history and physicals, order non-invasive outpatient diagnostic tests and services; visit patients in the hospital, review medical records, consult with attending physicians; and observe diagnostic or surgical procedures with the approval of the attending physician or surgeon.

4.3. ~~4.3~~Consulting

The Consulting category shall consist of Members who are recognized specialists who have an appointment equivalent to active category at another hospital where they are required to participate in patient care assessment or other quality care review. These physicians shall consult only at the request of a Member of the Medical Staff. The consulting member's role shall be to evaluate patients, and make recommendations for therapy. This category precludes any procedural privileges except when the procedural privileges are not available from a member of the Medical Staff of that facility. The Chief of Staff or Department Chairman will be required to confirm that monitoring has been completed. Such consulting category Members

shall submit a completed application. Initial appointment to this category shall be provisional for one year. A review will be conducted at the end of the first year. Consulting members shall have no admitting privileges, shall not be eligible to vote or hold office in the Medical Staff, and shall not be required, but shall be encouraged to attend department meetings. Annual dues shall be assessed.

4.4. ~~4.4~~Courtesy

The courtesy category shall consist of Members who only occasionally attend patients at the Hospital. In order to allow for assessment of a member's performance, the Member shall have an appointment equivalent to active category status on the medical staff of another hospital in San Diego County, or at a hospital or surgery center approved by the Medical Executive Committee, where they are required to participate in patient care assessment, and other quality care reviews. A Courtesy ~~Category~~category Member is to attend and/or consult upon no more than twenty-five (25) individual patients during a two (2) year assessment-reappointment period. Should a Courtesy Category Member wish to admit and/or consult upon more than twenty-five (25) individual patients in such a time period, they shall apply for Active Category status. Should a Member be on the Active staff of another Palomar Health facility, they may exceed the twenty-five (25) individual patient admit and/or consultation limitation on the Courtesy staff while they maintain their Active staff membership at another Palomar Health facility. Courtesy category Members shall be appointed to a specific Department where attendance, while encouraged is not required unless specifically requested by the Department Chairperson. Courtesy category Members shall not be eligible to vote or to hold office. Courtesy category Members shall not automatically be eligible to serve on the emergency room backup panel but may be required, at the discretion of the Chief of Staff or Department Chairperson, to be on emergency room call. Courtesy category Members may voluntarily serve but also may be required, at the discretion of the Chief of Staff or department chairperson, to serve on standing committees of the Medical Staff or department committees. When assigned to committee responsibility, courtesy category Members shall have the right to vote in that committee. Annual dues shall be assessed. Should a Member have no clinical activity at a Palomar Health facility during their two-year reassessment-reappointment period, they will be required to transfer to the appropriate category.

4.5. ~~4.5~~Affiliate

The Affiliate category shall consist of members who meet any one of the following categories:

~~y)~~a) Only admit or regularly attend patients at a Palomar Health distinct part skilled nursing/rehabilitation service~~.~~;

~~z)~~b) Only act in a surgery assist capacity~~.~~;

~~aa)~~c) Desire no active involvement with the Medical Staff but request "refer and follow" privileges~~.~~; or

~~bb)~~d) Only desire an affiliation with the hospital without any clinical privileges but appear likely to provide a distinct service to the hospital, Medical Staff, and patients. This category shall mainly be comprised of family practitioners that have had no clinical activity through inpatient admissions to Palomar Medical Center ~~Poway or Palomar Medical Center Escondido~~, at either of its campuses, during the biennial review period. Practitioners in other specialties may be assigned to this category if they have not had any clinical activity, inpatient admissions, or consultations, during the biennial reassessment period.

Appointment to this category shall be for a period of two (2) years. Affiliate Members shall not be required to live or practice in the Hospital's service area and shall not be required to provide emergency department coverage. Affiliate category members shall not be eligible to vote or

hold office and shall not be required, but shall be encouraged to attend departmental and Medical Staff meetings designated as mandatory by the Medical Executive Committee. Annual dues shall be assessed.

4.6. ~~4.6~~Retired

The retired category shall consist of members who have been in the active category for a minimum of five~~-~~
(5) years and who have retired from practice but wish to maintain affiliation. Such members shall not have admitting or clinical privileges, shall not be eligible to vote, to hold office, or serve on standing~~-~~
committees of the Medical Staff. Meeting attendance shall not be required. Retired category members may avail themselves to all educational and social activities. Annual dues shall not be assessed.

4.7. ~~4.7~~Administrative

The administrative category shall consist of members who only serve in an administrative capacity at a Palomar Health facility. They shall have no admitting privileges, shall not be eligible to vote or to hold office in the Medical Staff, shall not be required to attend meetings, and shall not represent the Medical Staff at meetings. Annual dues will be assessed.

4.8. ~~4.8~~Medical Staff Categories Grid

	PROVISIONAL	ACTIVE	CONSULTING	COURTESY	AFFILIATE	RETIRED	ADMINISTRATIVE
PREROGATIVES~~-~~							
Admits, consults and refers~~-~~ inpatients and outpatients	Yes[3]	Yes[3]	Yes (consults only)[8]	Yes[5]	Yes[7]	No	No
Eligible for~~-~~ clinical privileges	~~Yes~~	~~Yes~~	Yes	~~Yes~~	~~Refer and Follow only~~	~~No~~	~~No~~
Vote	No[2]	Yes	No	No[2]	No	No	No
Hold office	No	Yes	No	No	No	No	No
Serve as Committee Chair	Yes[9]	Yes	No	Yes[9]	No	No	No
Serve on~~-~~ Committees	Yes	Yes	Yes	Yes	No	No	No
RESPONSIBILITIES							
Medical staff~~-~~ functions	Yes	Yes	Yes	Yes	No	No	No
Consulting	Yes	Yes	Yes	Yes	No	No	No
ER call	Yes	Yes	No	Yes[6]	No	No	No
Attend~~-~~ Meetings	Yes	Yes	No[4]	No[4]	No[4]	No	No
Pay App/~~Reapplicati on~~Reapplication Fee	Yes	Yes	Yes	Yes	Yes	No	No
Pay Dues	Yes	Yes	Yes	Yes	Yes	No	Yes
ADDITIONAL PARTICULAR QUALIFICATIONS							
Must first complete~~-~~ provisional	N/A	Yes	Yes	Yes	Yes	No	No

Malpractice Insurance	Yes	Yes	Yes	Yes	Yes	No	No
File application and apply for reappointment	Yes	Yes	Yes	Yes	Yes	No	No

1. Provisional members serve a minimum of 1 year and a maximum of 2 years.
2. May vote on committee matters but are not eligible to vote on general Medical Staff and Departmental matters.
3. Includes members with clinical activity and without clinical activity that have only "refer and follow" privileges.
4. Consulting, courtesy, and affiliate category members are encouraged but not required to attend meetings.
5. Courtesy category members are to attend and/or consult on no more than 25 individual patients during a 2 year reappointment period. If they are a member on the active staff of another Palomar Health facility they may exceed the 25 patient limitation as long as they maintain active category status at another Palomar Health facility.
6. May be required at the discretion of the Chief of Staff or Department Chairperson.
7. Only admit or attend patients at a Palomar Health distinct part skilled nursing facility, act in a surgery assist capacity, may have "refer and follow" privileges.
8. Except when the procedural privileges are not available from a Member of the Medical Staff (Bylaws 4.3)
9. Provisional and Courtesy Members may serve as Committee Chairs as needed.

ARTICLE V: CLINICAL PRIVILEGES

5.1. ~~5.1~~Clinical Privileges Overview

~~8.5.1~~5.1.1 Members shall exercise only those clinical privileges specifically granted by the Board of Directors following recommendation by the Department and the Medical Executive Committee. Privileges shall be granted specific to the Campus(es) to which a member has applied and is eligible or consistent with the Palomar Medical Center hospital(s) at which the Member held privileges prior to the Effective Date.

~~8.5.2~~5.1.2 Initial application for membership shall contain a request for the specific clinical privileges desired by the applicant and the Campus(es) where such privileges will be exercised, except for categories Affiliate (unless requesting surgery assist or refer and follow privileges) (Section 4.5), and Administrative (Section 4.7). The evaluation of such requests shall be based on the applicant's education, training, experience, demonstrated competence, references and other relevant information, including an appraisal by the Chairperson of the Campus Department in which privileges are sought. The applicant shall have the burden of establishing his/her qualifications and competence in the clinical privileges he/she requests. Clinical privileges shall be delineated for every applicant and shall not be stated in general, broad terms.

~~8.5.3~~5.1.3 Applicants who wish to request privileges in a specialty other than the specialty in which they maintain board certification may submit their request for such privileges in writing along with documentation of his/her qualifications and competence in support of the request. The appropriate Campus Department and the ~~Medical~~Campus Executive Committee will review the request for a waiver of eligibility criteria in accordance with Section 1.2 of the Credentials Policy Manual and determine if the applicant should be permitted to apply for these privileges outside of their recognized specialty. A determination that the applicant is not eligible to request such privileges is not a "denial~~""~~ of clinical privileges and the applicant is not entitled to a hearing. The waiver is in the sole discretion of the ~~Medical~~Campus Executive Committee and the

Department.-

~~8.5.4~~5.1.4 Periodic re-determination of clinical privileges and the increase or curtailment of same may be based upon the direct observation of care provided, review of the records of patients treated in the Hospital or other hospitals, review of the Member's participation in the delivery of medical care and any documentation of additional training and/or experience.

~~8.5.5~~5.1.5 Requests for additional clinical privileges, modification of clinical privileges, changes in medical staff status, including new procedures, shall be submitted in writing. The applicant's relevant training and/or experience shall be stated. When not previously established, monitoring requirements will be developed by the appropriate Department. Such requests shall be processed in the same manner as initial applications.

5.2. ~~5.2~~**Temporary**

~~8.5.1~~5.2.1 Applicants

Following the receipt of a completed application and initial review by the Department Chairperson or the Credentials Committee, where applicable, the Chief Administrative Officer, with the written concurrence of the Chief of Staff and the appropriate Department Chairperson may grant temporary clinical privileges pending processing of the application in accordance with the Medical Staff Procedure for Temporary Privileges. Such temporary privileges shall be time- limited and shall not exceed ninety (90) days, subject to renewal of up to an additional thirty (30) days during the pendency of an application. Temporary privileges shall in no circumstances exceed a total of 120 days in a two- year reappointment cycle. In such instances, the applicant shall be under the supervision of the appropriate Department Chairperson or designee. Special requirements of supervision and reporting may be required by the appropriate Department Chairperson. Temporary clinical privileges shall be immediately terminated by the Chief Administrative Officer, with the concurrence of the Chief of Staff or appropriate Department Chairperson upon notice of any failure by the applicant to comply with such special requirements.

~~8.5.2~~5.2.2 Locum Tenens

Following receipt of a fully completed application and supporting documentation and initial review by the Department Chairperson or Credentials Committee, where applicable, the Chief Administrative Officer, with the written concurrence of the Chief of Staff, and appropriate Department Chairperson, may grant temporary clinical privileges to a person serving as locum tenens for a current member of the Medical Staff. Such privileges shall be granted for a period not to exceed ninety (90) days in a calendar year or one hundred twenty (120) days in a two-year period. The locum tenens physician must apply for the appropriate category of staff membership if a longer period of coverage is requested.

~~8.5.3~~5.2.3 Non-Applicants

The Chief Administrative Officer may grant temporary privileges for an important care need, with the written concurrence of the appropriate Department Chairperson and the Chief of Staff. The following criteria must be met and documented in order to grant temporary privileges to meet an important care need:

~~cc)~~a) The individual must have a current license to practice in California.

~~dd)~~b) The individual must meet the qualifications for membership as

specified in Section 3.2 of these bylaws.

c) The individual must have current competence to perform the privileges requested. Evidence of current competence can be demonstrated by meeting the following:

~~ee)~~d) Evidence of recent relevant (past 2 years) education, training or experience in the area of privileges being requested, or verification that the individual maintains an active affiliation at a hospital where they are required to participate in patient care assessment and other quality care reviews and where they maintain the same privileges as the temporary privileges being sought.

~~ff)~~e) Additional criteria (if any) for the specific privileges requested.

Non-Applicant ~~Temporary Privileges~~temporary privileges shall in no circumstance exceed one hundred twenty (120) days in a two-year period.

~~8.5.4~~5.2.4 Criteria for "Cross-Specialty" Privileges Within the Hospital

Any request for clinical privileges that are either new to the Hospital or that overlap more than one Department shall initially be reviewed by the appropriate Departments, in order to establish the need for, and appropriateness of, the new procedure or services. The Medical Executive Committee shall facilitate the establishment of hospital-wide credentialing criteria for new or trans-specialty procedures, with the input of all appropriate Departments, with a mechanism designed to ensure that quality patient care is provided for by all individuals with such clinical privileges. In establishing the criteria for such clinical privileges, the Medical Executive Committee may establish an ad-hoc committee with representation from all appropriate Departments.

~~8.5.5~~5.2.5 Termination

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

5.3. ~~5.3~~Emergency

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

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

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

staff.

5.4. **~~5.4~~Telemedicine Privileges**

~~gg)~~a) Telemedicine is the exchange of medical information from one site to another via electronic communications for the purpose of improving patient care, treatment, and services. The Board shall determine the clinical services, if any, to be provided through telemedicine after considering the recommendations of the appropriate Department Chairperson and the Medical Executive Committee.

~~hh)~~b) This section applies only to those Practitioners appointed to the Medical Staff who will have total or shared responsibility for the care of a patient at the Hospital through the use of a telemedicine link. "Total or shared responsibility" is evidenced by the Practitioner having the authority to write medical orders and direct a patient's care, treatment, or services. This section shall not pertain to Practitioners who are providing either official or preliminary readings of images, tracings, or specimens through a telemedicine link. Those Practitioners shall be credentialed in a manner that ensures that the medical services are provided safely and effectively.

~~ii)~~c) In processing a request for telemedicine privileges pursuant to this section, the Hospital will credential and grant privileges to the Practitioners in the same manner as any other applicant.

5.5. **~~5.5~~Lapse of Application**

If a medical staff member requesting a modification of clinical privileges or reappointment fails to furnish within 90 days after request being made, the information reasonably necessary to evaluate the request, the application shall automatically lapse, and the applicant shall not be entitled to a hearing under these bylaws.

ARTICLE VI: ALLIED HEALTH PROFESSIONALS

6.1. **~~6.1~~General Qualifications**

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

6.2. **~~6.2~~Board of Directors' Action**

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

6.2. **~~6.3~~Application Procedure**

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

6.4. **~~6.4~~Specifications of Services**

Allied Health Professionals shall be individually authorized and assigned to an appropriate Department of one or both Campuses, and shall carry out their services under the supervision of the appropriate Department, or the appropriate attending staff Member assigned this

responsibility, and are subject to Department policies and procedures.

~~8.5.1~~6.4.1 Prerogatives

The authorized scope of services for each Allied Health Professional member shall be determined by the Interdisciplinary Practice Committee and the appropriate Medical Staff Department and, in any event, shall not exceed the Allied Health Professional's training, experience, scope of licensure and demonstrated competence.

~~8.5.2~~6.4.2 Limitation of Prerogatives

Allied Health Professionals shall not be eligible to admit patients to the Hospital or Skilled Nursing Facility, nor shall they be eligible for appointment ~~to~~for membership on the Medical Staff, except as may otherwise be required by law. Nothing herein shall create any vested rights in any Allied Health Professional to receive or to maintain any services in a District Facility. The authorization of Allied Health Professional Staff to render care in a District Facility may, at any time and for any reason, be terminated by the appropriate Department Chairperson or the Chief of Staff, the Allied Health Professional's supervising Practitioner, or the Board of Directors. The ~~professions of Section 2 of~~peer review rights and procedures required under the Business and Professions Code section 809 *et seq.* as further delineated in the Medical Staff ~~Right~~Rights Manual shall not apply to Allied Health Professionals, unless otherwise required by law, except to psychologists when an adverse action is taken which required the filing of a report under Business and Professions Code 805.

6.5. ~~6.5~~Hearing Rights

~~8.5.1~~6.5.1 Hearing and Appeal Rights~~-~~

~~jj)~~a) Any Allied Health Professional shall have the right to challenge any action that would constitute grounds for a hearing under these Bylaws by filing a written grievance with the Interdisciplinary Practice Committee (IPC) within fifteen (15) days of such action. On receipt of such a grievance, the IPC or its designee shall conduct an investigation that shall afford the AHP an opportunity for an interview concerning the grievance. Any such interview shall not constitute a "hearing," as that term is defined in Section 5 of the Medical Staff Rights Manual ~~of these Bylaws~~, and the procedural rules applicable to such hearings shall not apply. Before the interview, the AHP shall be informed of the general nature and circumstances giving rise to the action, and that AHP may present information relevant at the interview. A record of the interview shall be made. The IPC, or its designee, shall make a recommendation to the Medical Executive Committee based on the interview and all other information available to it. The IPC shall give the AHP written notice of its recommendation to the Medical Executive Committee.~~-~~

~~kk)~~b) The AHP shall have the right to file a written appeal with the Medical Executive Committee within thirty (30) days of receiving notice of the IPC's recommendation. The proceeding by the Medical Executive Committee shall be to review the record of the IPC's interview with the AHP and other information available to the IPC. At its discretion, the Medical Executive Committee may request the IPC or its designee, and the AHP to appear before it to provide information. Within thirty (30) days of meeting to review the AHP's appeal, the Medical Executive Committee shall issue a final decision, which shall be submitted to the Board of Directors for final approval.~~-~~

6.6. ~~6.6~~Qualifications Generally

All Allied Health Professionals must maintain all applicable licenses, certificates, (including CPR)

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

ARTICLE VII: MEDICAL STAFF AND CAMPUS OFFICERS

7

7.17.05. Officers of the Medical Staff

The Medical Staff shall not have any officers while these Bylaws are in effect and until such time as a new, permanent set of Medical Staff bylaws be adopted and provides for the selection of officers.

All references to the Chief of Staff or any other Medical Staff officer in these Bylaws and in Medical Staff regulations, policies, and other documents shall be construed to refer to the Medical Executive Committee, which shall hold all authority and responsibility to govern the Medical Staff in a manner consistent with these Bylaws.

7.1. Officers of Each Campus

8.5.17.1.1 Identification

The officers ofEach Campus may have the Medical Staff shall befollowing Campus Officers: the Campus Chief of Staff, Campus Chief of Staff-Elect, Campus Immediate Past Chief of Staff, Campus Secretary-Treasurer, and the Campus Organized Medical Staff Section Representative. (who shall work cooperatively with the counterpart OMSS representative from the other Campus to represent the Medical Staff before the California Medical Association's Organized Medical Staff Section).

8.5.27.1.2 Eligibility Criteria

Campus Officers shall be Members of the active category of the Medical Staff atassigned to the time of their nomination and electionCampus over which they preside and shall remain Members in good standing during their term of office. Failure to maintain such status shall create a vacancy in the office involved. In addition, Campus Officers must satisfy the following criteria initially and continuously to be eligible to serve as an officer of the Medical Staff.

To be eligible for office, candidates must:

ll)a) Have no pending adverse recommendations concerning medical staff appointment or clinical privileges;

mm)b) Not presently be serving as a medical staff officer, Board member or department chairperson at a non-Palomar Health hospital and shall not so serve during their term of office;

nn)c) Be willing to faithfully discharge the duties and responsibilities of the position; and

oo)d) Have demonstrated an ability to work well with others.

~~7.1.3~~Nominations

~~The Medical Executive Committee serving as a Nominating Committee as outlined in Section 8.3.2 (q) shall nominate candidates. A general announcement will be distributed to the Medical Staff no later than September 15 soliciting nominations. Nominations shall be submitted to the Chief of Staff or their designee by no later than October 15 of any election year.~~

~~Further nominations may be made for any office by any voting Member, provided that the name of the candidate is submitted, in writing, to the Chief of Staff or Nominating Committee, is endorsed by the signature of at least ten (10) other voting Members, and bears the candidate's written consent. These nominations shall be delivered to the Chief of Staff or the chairperson of the Nominating Committee as soon as reasonably practicable, but no later than October 15 of any election year. The Chief of Staff or their designee shall include the name(s) of any nominee(s) for office, timely received pursuant to this Section, on the election ballot.~~

~~8.5.4 Elections~~

~~Elections shall be held every 3 years The Chief of Staff Elect, Secretary-Treasurer, and the Hospital Organized Medical Staff Section Representative shall be elected by popular/majority vote of the Members entitled to vote, to be conducted by a confidential, secure and validated ballot method. A ballot process must be initiated on or before November 1 of each election year. The Medical Staff will designate a method to ensure the integrity of the voting process. Ballots must be received by Medical Staff Services on or before December 1 to be included in the vote count. If no candidate for a particular office receives a majority (i.e. 51% or greater) vote of returned ballots, a runoff election between the two candidates receiving the highest number of votes shall be conducted by secret ballot as soon as practicable. In case of a tie on the second ballot, the majority vote of the Medical Executive Committee shall decide the election by secret ballot conducted in the manner described above. Following each election, written notice shall be provided to the Medical Staff informing them of those candidates elected to office, which notice may occur at the annual meeting.~~

~~7.1.5~~7.1.3 Terms of Elected Office

~~Each officer shall serve a specific term to be determined by the Medical Executive Committee and Medical Staff at that hospital, commencing on the first day of the staff year following his/her election. Each officer~~Except as otherwise provided in this paragraph, each Campus Officer shall serve the longer of the effective period of these Bylaws or the remainder of their term as an elected officer of the separate medical staff at the Poway and Escondido hospitals prior to the merger of the medical staffs. If these Bylaws are repealed and superseded with a new set of bylaws before the end of a Campus Officer's term, unless otherwise provided in the new set of bylaws, the Campus Officer shall complete the term under the new set of bylaws for the Medical Staff. Each Campus Officer shall serve in each office until the end of his or her term, or until a successor is elected, unless he/she shall resign or be removed from office.

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

~~7.1.6~~7.1.4 Recall of Officers

A ~~Medical Staff~~Campus Officer may be recalled from office for any valid cause, including but not limited to, failure to comply with applicable policies, Bylaws, and Rules and Regulations; failure to perform the duties of the position held; conduct detrimental to the interests of the Medical Staff; an infirmity that renders the individual incapable of fulfilling the duties of his or her office or serious acts of moral turpitude. Except as otherwise provided, recall of ~~an officer~~a Campus Officer may be initiated by the Medical Executive Committee, or shall be initiated by a petition signed by at least one-third of

the voting members. of the Campus from which the Campus Officer serves. Recall shall be considered at a special meeting called for that purpose. At least ten (10) days prior to the initiation of any removal action, the individual shall be given notice of the date of the meeting at which such action is to be considered. The individual shall be afforded an opportunity to speak to the appropriate Campus of the Medical Staff present at a special meeting. If a mail or electronic ballot is used the individual will be afforded the opportunity to speak to the Medical Executive Committee or the Board prior to the vote on removal. Recall shall require a two-thirds (2/3) vote of the voting Members who actually cast votes at the special meeting in person or by mail or electronic ballot.

7.1.77.1.5 Vacancies in ElectedCampus Office

Vacancies in office occur upon the death or disability, resignation, or removal of the officer or such officer's loss of membership. Vacancies, other than that of Chief of Staff, shall be filled by appointment by the Medical Executive Committee until the next regular election, unless otherwise provided herein. If there is a vacancy in the office of Campus Chief of Staff, the Campus Chief of Staff, the Chief of Staff - Elect serves out the remaining term. He/she shall immediately request a meeting of, and the Medical Executive Committee acting as the Nominating Committee, to decide shall promptly upon nominees for the office of Chief of Staff-Elect. Such nominees shall be reported to the Medical Executive Committee and the Medical Staff. A special election to fill the position shall occur at the next regular staff meeting. If so determined and desired by the Medical Executive Committee a special election via secret mail or electronic ballot to fill the position shall occur as soon as practicable instead. If there is a vacancy in the office of Chief of Staff-Elect, that office need not be filled by election, but the Medical Executive Committee can appointnominate an eligible Member to serve on an interim basis until the next regular election or until a secret mail or electronic ballot election as determined by the Medical Executive Committee is held. If the special election occurs at the next regular staff meeting such election shall also include the office of Chief of Staff.as Campus Chief of Staff - Elect, who shall assume the office upon ratification by the appropriate Campus Officers.

7.2. 7.2Duties of Campus Officers

8.5.17.2.1 Campus Chief of Staff

The ChiefCampus Chiefs of Staff shall serve as the chief officer of the Medical StaffCampus over which they preside. He/she shall receive a stipend for this service that shall be of an amount determined by the Medical Executive Committee. The duties of the ChiefCampus Chiefs of Staff shall include but not be limited to:

pp)a) Enforcing the bylaws, rules and regulations of the Medical Staff as applied to their Campus, implementing sanctions where indicated, and promoting compliance with the procedural safeguards where corrective action has been requested or initiated.

qq)b) Calling, presiding at, and being responsible for the agenda of all meetings of the Medical StaffCampus.

rr)c) Serving as Chair of the MedicalCampus Executive Committee and serving as a member of the Joint Conference Committee. Serving as a nonvoting member of all other committees of the Medical StaffCampus unless his/her membership on a particular committee is required by these bylaws.

ss)d) InteractingIn coordination with and by delegation of the Medical Executive Committee, interacting with the Chief Administrative Officer and the Board of

Directors in all matters of mutual concern ~~within~~between his/her Campus and the Hospital.

~~tt)~~e) Appointing members for all standing and special liaison, multi-disciplinary, or ~~Medical Staff~~Campus committees, except where otherwise provided by these bylaws, and except where otherwise indicated, designating the chairpersons of these committees.

~~uu)~~f) ~~Representing~~In coordination with and by delegation of the Medical Executive Committee, representing the views and policies of the ~~Medical Staff~~Campus to the Board of Directors and to the Chief Administrative Officer.

~~vv)~~g) ~~Being~~In coordination with and by delegation of the Medical Executive Committee, being a spokesperson for the ~~Medical Staff~~Campus in external professional and public relations.

~~ww)~~h) Serving on liaison committees with the Board of Directors and administration, as well as outside licensing or accreditation agencies.

~~xx)~~i) Performing such other functions as may be assigned to them by these Bylaws, the Medical Staff, or by the Medical Executive Committee.

~~yy)~~j) The Campus Chief of Staff or his/her designee may coordinate with administration in the annual evaluation of physician administrative positions, such as ~~VPMA~~vice president of medical affairs or chief medical officer, if in existence

~~zz)~~k) ~~Certifying~~Recommending to the Medical Executive Committee, who shall certify to the Board, that applicants recommended by the ~~Medical~~Campus Executive Committee for appointment, advancement, or reappointment to the Medical Staff and assigned to their Campus, or to receive authorization to provide patient care services as allied health professionals , have satisfied all requirements specified by the Medical Staff and the Board.

~~8.5.2~~7.2.2 Campus Chief of Staff-Elect

The Campus Chief of Staff-Elect shall assume all duties and authority of the Campus Chief of Staff in the absence of the Campus Chief of Staff. The Campus Chief of Staff-Elect shall be a member of the ~~Medical~~Campus Executive Committee, and any other ~~Committees~~committees as specified by the ~~Medical~~Campus Executive Committee ~~of Palomar Medical Center Pomerado Hospital~~. He/she shall chair the Campus Credentials Committee and the Bylaws Committee~~, as a~~ or the equivalent subcommittee of the Campus Executive Committee ~~per Section 8.3.2(r).~~. He/she shall perform such other duties as the Campus Chief of Staff may assign, or as may be delegated by these Bylaws or by the Medical Executive Committee. The Campus Chief of Staff-Elect shall receive a stipend for their services that shall be of an amount determined by the Medical Executive Committee.

~~8.5.3~~7.2.3 Immediate Past Campus Chief of Staff

The ~~immediate~~Immediate Past Campus Chief of Staff's role shall be advisory in nature. He/she shall be a member of the Medical Executive Committee and any other Committee as specified by the Medical Executive Committee ~~of Palomar Medical Center Pomerado Hospital.~~ .

~~8.5.4~~7.2.4 Campus Secretary-Treasurer

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

~~aaa)~~a) Attend meetings of the Campus, Medical Staff, and ~~Medical~~Campus

Executive Committee and ~~cause~~ensure minutes ~~to be~~are maintained.

~~bbb)~~b) Be the custodian of all records and papers belonging to ~~the Medical Staff~~his/her Campus.

~~ccc) Supervise the addition of any amendments to the Bylaws, Rules and Regulations~~

~~ddd)~~c) Cause to be collected all dues and assessments from Members assigned to the Campus and deposit such funds into the account of the Medical Staff to be segregated for each Campus, make payments, and generally manage the fiscal affairs of the ~~Medical Staff~~Campus, subject to oversight of the Medical Executive Committee.

~~8.5.5~~ Organized Medical Staff Section (OMSS) Representative

7.2.5 The Organized Medical Staff Section Representative shall:

~~eee)~~a) Be a member of the American Medical Association, the California Medical Association, and the San Diego County Medical Society.

~~fff)~~b) Attend meetings of the Campus Medical Executive Committee.

~~ggg)~~c) ~~Serve~~Working cooperatively with the counterpart Campus OMSS member, serve as the representative to the Medical Staff Section of the American Medical Association, California Medical Association, and the San Diego County Medical Society.

~~hhh)~~d) Report to the Campus Medical Executive Committee after attending meetings of the American Medical Association, California Medical Association, and the San Diego County Medical Society.

~~iii)~~e) From time to time the Campus Medical Executive Committee shall establish appropriate compensation for the OMSS representative for expenses incurred to fulfill the duties of the position.

~~8.5.6~~7.2.6 Chain of Command

~~jjj)~~a) Campus Chief of Staff

~~kkk)~~b) Campus Chief of Staff-Elect

~~lll)~~c) Immediate Past Campus Chief of Staff

~~mmm)~~d) Chairperson, Campus Department of Surgery

~~nnn)~~e) Chairperson, Campus Department of Medicine

~~ooo)~~f) Chairperson, Campus Department of Obstetrics and Gynecology

7.2.7 References to Officers

Any references to a chief of staff, chief of staff - elect, immediate past chief of staff, and secretary-treasurer in existing Medical Staff bylaws, rules, regulations, and policies shall be construed to refer to the corresponding Campus Officer for the appropriate Campus, as dictated by the context.

ARTICLE VIII: COMMITTEES OF THE MEDICAL STAFF AND THE CAMPUSES

8.1. ~~8.1~~**Designation**

The Committees described in this article shall be the standing committees of the Medical Staff~~.~~, including Campus-specific committees where so specified. Special or ad hoc committees may be created by the Medical Executive Committee or a Campus Executive Committee to perform specified tasks.

Appointment and removal of committee members are subject to consultation with and approval by the Medical Executive Committee~~.~~ in the case of Medical Staff Committees or Campus Executive Committee in the case of Campus Committees. All committees of the Medical Staff shall be responsible to the Medical Executive Committee, but Campus Committees shall be preliminarily responsible to the appropriate Campus Executive Committee. Nothing in these Bylaws or any Medical Staff rules, regulations, or policies shall limit or nullify the authority of the Medical Executive Committee as the ultimate governing body of the Medical Staff.

8.2. ~~8.2~~General Provisions

8.2.1 Appointment of Committee Members

Unless otherwise specified in these Bylaws, committees of the Medical Staff and Campus committees shall be composed of all those members of the equivalent or corresponding committees of the medical staffs who were seated on the day immediately prior to the effective date of the single consolidated license for Palomar Medical Center, which resulted in the consolidation of the medical staffs into this Medical Staff. To the extent any seat on a committee was vacant on such day, such seat shall remain vacant on the corresponding or equivalent Medical Staff or Campus committee and may be filled pursuant to these Bylaws.

~~8.2.1~~8.2.2 Terms

Unless ~~otherwise specified~~removed from their committee position as provided in these Bylaws, and except as provided below in this section, committee members shall ~~be appointed for a term of one (1) or two (2) year(s) as specified at a particular Palomar Health facility. Members shall~~ serve ~~until~~ the ~~end~~longer of ~~this~~the effective period ~~or until~~of these Bylaws or the remainder of their term as a committee member on the separate medical staff at the Poway and Escondido hospitals prior to the merger of the medical staffs. If these Bylaws are repealed and superseded with a new set of bylaws before the end of the committee member's term, unless otherwise provided in the new set of bylaws, the committee member shall complete the term under the new set of bylaws for the Medical Staff or the member's successor is appointed, unless the ~~Member~~member shall be removed from the committee. ~~If a member is appointed to one of the following Committees: Medical Executive, Credentials or Quality Management, mandatory attendance is required for~~Members of the Campus Executive Committee shall attend at least 50% of the scheduled meetings of such committees at their campus annually~~. Meeting attendance may be~~, unless excused by ~~either the Medical Executive Committee or the Chief of Staff upon application for excusal by the Member. This provision is in effect only when meeting attendance requirements are present at a particular facility.~~the committee.

Notwithstanding the foregoing, any appointments of committee members that are made prior to but will not commence until after the Effective Date shall be carried out as originally planned, including installing new committee members and replacing old committee members. Such committee appointments shall carry terms consistent with this section.

~~8.2.2~~8.2.3 Removal

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

~~8.2.3~~8.2.4 Vacancies

Unless otherwise specifically provided~~, vacancies on any committee shall be filled~~ in ~~the same manner in which an original appointment to such a committee is made; provided however, that~~

~~if an individual who obtains membership by virtue of~~ these Bylaws ~~is removed for cause, a successor may be selected by the Chief of Staff and ratified by,~~ the Medical Executive Committee

~~8.3~~ shall appoint a successor to fill any vacancies on a Medical Staff committee and the appropriate Campus Executive Committee shall appoint a successor to fill any vacancies in a Campus committee.

~~8.5.1 Composition~~

8.3. ~~ppp)~~ ~~Officers~~**Medical Executive Committee of the Medical Staff**

~~qqq) Department Chairpersons~~

~~rrr) Chair, Quality Management Committee~~

8.3.1 ~~The Chief Executive Officer of Palomar Health or his/her designee shall attend as a non-voting ex-officio member. He/she may not attend executive sessions of this committee, unless requested~~Composition (4 total) and Authority to ~~do so by the~~Act

a) Campus Chief of Staff from each Campus (2); and

b) Campus Chief of Staff~~,~~ – Elect from each Campus (2).

~~sss)~~ The Medical Executive Committee is the exclusive governing body vested with ~~approval~~authority to act on behalf of and for the benefit of the Medical ~~Executive Committee.~~Staff. The Medical Executive Committee shall operate and act by majority vote of its members. Tiebreakers shall be determined in the following order:

~~ttt) The Medical Director of the Trauma program, as a non-voting member.~~

~~uuu) Chair, Medical Staff Peer Review Committee (MSPRC), as a non-voting member.~~

~~vvv) At-large members are to be elected by the Medical Staff, with up to a maximum of three (3) members at each facility. The at-large member may be selected by a nominating committee, by the Medical Executive Committee or the Medical Staff (upon a petition of three Medical Staff members). The three (3) persons with the most number of votes at each facility will be selected as the at-large members. The three (3) at-large members will serve staggered terms. One member shall be designated to serve a one-year term, one member shall be designated to serve a two-year term, and one member shall be designated to serve a three-year term. Thereafter, one member shall be elected annually and shall serve for a term of three years. At-large members of the Medical Executive Committee may be removed by unanimous vote of the remaining Medical Executive Committee members.~~

1. If the Medical Executive Committee is acting upon a formal recommendation as recognized in these Bylaws (e.g., a recommendation on a privileging application) from a Campus officer or a Campus Executive Committee, or any campus department or campus committee, such recommendation shall be adopted as the decision of the Medical Executive Committee in the event of a tie vote in the Medical Executive Committee.
2. If the Medical Executive Committee is acting upon an issue that exclusively affects one Campus, the Medical Executive Committee shall adopt the position of the affected Campus Executive Committee in the event of a tie vote in the Medical Executive Committee.

Notwithstanding any provision in these Bylaws, the Medical Executive Committee may delegate its authority to any one or more of its individual members or to any committee, department, or Campus Officer as the Medical Executive Committee deems proper. The

Medical Executive Committee reserves the right to modify, terminate, or rescind any delegation of authority.

~~8.5.2~~8.3.2 Duties

The duties of the Medical Executive Committee as delegated by the Medical Staff shall include, but not be limited to, the following below. Such delegated authority may be removed by two- thirds vote of those Members of the Medical Staff voting.

~~wwww)~~a) Representing and acting on behalf of the Medical Staff in the intervals between meetings of the Medical Staff, subject to such limitations as may be imposed by these bylaws.

~~xxx)~~b) Coordinating and implementing the professional and organizational activities and policies of the Medical Staff.

~~yyy)~~c) Receiving and acting upon reports and recommendations from Departments, committees, and assigned activity groups of the Medical Staff.

~~zzz)~~d) Recommending action to the Board of Directors on matters of a medical-administrative nature.

~~aaaa)~~c) Establishing the structure of the Medical Staff, the mechanism to review credentials and delineate individual clinical privileges, the organization of quality management activities and mechanisms of the Medical Staff, termination of membership and fair hearing procedures, as well as other matters relevant to the operation of an organized Medical Staff, including a cooperative working relationship with other District Facilities, as to each of these obligations.

~~bbbb)~~f) Evaluating the medical care rendered to patients in the Hospital.

~~cccc)~~g) Participating in the development of policies, practices, and planning of the Medical Staff and Hospital.

~~dddd)~~h) Reviewing the qualifications, credentials, performance and professional competence and character of applicants and Members. Making recommendations to the Board of Directors regarding appointment, reappointment, assignment to Departments, clinical privileges, and corrective action.

~~eeee)~~i) Taking reasonable steps to promote ethical and competent clinical performance on the part of the Members including the initiation of and participation in corrective or review measures when warranted.

~~ffff)~~j) Designating such committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the Medical Staff and approving or rejecting recommendations ~~to~~from those committees ~~by the Chief of Staff~~.

~~gggg)~~k) Reporting to the Medical Staff at meetings of the Medical Staff.

~~hhhh)~~l) Assisting in the obtaining and maintaining of accreditation.

~~iiii)~~m) Developing and maintaining methods for the protection and care of patients and others in the event of internal or external disaster.

~~jjjj)~~n) Appointing such special or ad hoc committees as may seem necessary or appropriate to assist the Medical Executive Committee in carrying out its functions and those of the Medical Staff.

~~kkkk)~~o) Reviewing the quality and appropriateness of services provided by contract physicians.

~~llll)~~p) ~~Functioning as a~~ Undertaking the functions of the Credentials Committee~~,~~ ~~to~~ for any Campus without such committee, including the following activities:

review and evaluate the credentials of all applicants to be assigned to the ~~Medical Staff~~relevant Campus and Allied Health Professional Staff after receiving applications~~. In addition, to~~; investigate, review, and recommend on matters referred by the Campus Chief of Staff or Campus Department Chairpersons regarding the conduct, professional character, or competence of any applicant to ~~either~~ the ~~Medical Staff~~relevant Campus or Allied Health Professional Staff~~. Review of~~; review any such referral in regard to re-application at the time of reappointment to the Medical Staff or the Allied Health Professional Staff~~. Charge~~; and charge the creation of an Interdisciplinary Practice Committee, to perform functions consistent with the requirements of law and regulation and to receive reports from same.~~-~~

~~mmmm) Functioning as a Nominating Committee at the direction of the Chief of Staff, to select nominations for consideration by the Medical Staff at the time of the biennial election of officers. The Committee shall nominate one or more nominees for each office except for the Chief of Staff, who automatically succeeds to the office.~~

~~nnnn) Functioning as a Bylaws Committee, to fulfill the following functions:~~

~~(1) Conducting periodic review of the Medical Staff Bylaws/Rules and Regulations, and forms promulgated by the Medical Staff.~~

~~(2) Submitting recommendations for changes in these documents, as necessary, to reflect the current practice of the Medical Staff.~~

~~(3) Receiving and evaluating recommendations and suggestions for revisions to the Medical Staff Bylaws/Rules and Regulations.~~

~~oooo)~~q) Making Medical Staff recommendations to the Board of Directors for its approval, pertaining to at least the following:

(1) The Medical Staff structure

(2) ~~-~~The mechanism used to review credentials and to delineate individual clinical privileges.

(3) Appointment and Reappointment of Medical Staff Members, and restricting, reducing, suspending, terminating and revoking Medical Staff membership.

(4) Granting, modifying, restricting, reducing, suspending, terminating, and revoking clinical privileges, and assignments to Departments.

(5) The participation of the Medical Staff in organization performance improvement activities.

(6) The mechanism by which Medical Staff membership may be terminated.

(7) The mechanism for fair hearing procedures.

~~pppp)~~r) Developing and approving Medical Staff policies and procedures. The Medical Executive Committee will communicate such policies and procedures to the Medical Staff. Any Members, responsible committee, or department may also formulate and propose policies and procedures to the Medical Executive Committee.

~~8.5.3~~8.3.3 Conflict Management.

In the event of conflict between the Medical Executive Committee and the Medical Staff (as represented by a petition signed by at least ~~10~~20% of the voting members of the Medical Staff~~),~~ on issues affecting both Campuses, or by at least 20% of the ~~Chief of Staff~~voting members of a Campus on issues affecting only that Campus), the Medical Executive Committee or its designee(s) (including representatives from a Campus on

issues affecting only that Campus) shall convene a meeting as soon as possible with the petitioners' representative(s) to identify the conflict. The foregoing petition shall include a designation of up to (five) members of the voting Medical Staff who shall serve as the petitioners' representative(s). The Medical Executive Committee ~~shall be represented by an equal number of Medical Executive Committee members. The Medical Executive Committee's~~or its designee(s) and the petitioners' representative(s) shall gather and exchange information relevant to the conflict and shall work in good faith to resolve differences in a manner that respects the positions of the Medical Staff, the leadership responsibilities of the Medical Executive Committee, and the safety and quality of patient care at the hospital. At all times, the parties will ensure the safety and quality of patient care. Resolution at this level requires a majority vote of the Medical Executive ~~Committee's representatives.~~Committee after recommendation from its designee(s), if any. Unresolved differences shall be submitted to the Board of Directors for final resolution.~~-~~

~~8.5.4~~8.3.4 Meetings

The Medical Executive Committee shall usually meet ~~monthly but not less than nine (9) times per year.~~at least semiannually. It shall maintain a record of its proceedings and actions. Nothing herein shall prevent the Medical Executive Committee from functioning or discharging its duties via remote meetings or via email or similar electronic communications.

~~37.2 Credentials Committee~~

~~8.5.1 Composition~~

~~**The Credentials Committee shall consist of the**~~ **8.4 Campus Executive Committees**

8.4.1 Composition. There shall be a Campus Executive Committee at each Campus of the Medical Staff, which shall be comprised of all members seated on the medical executive committee of the medical staff at that Campus on the day immediately prior to the effective date of the single consolidated license for Palomar Medical Center, which resulted in the consolidation of the medical staffs into this Medical Staff. To the extent any seat on the medical executive committee was vacant on such day, such seat shall remain vacant on the Campus Executive Committee. For purposes of illustration only, each Campus Executive Committee may consist of the following seats:

a) Campus officers of the Campus (Campus Chief of Staff ~~Elect as Chairperson, the~~ , Campus Chief of Staff~~, the~~ – Elect, and Campus Immediate Past Chief of Staff~~, the Chair of the Interdisciplinary Practice Committee and~~);

b) Campus Department Chairpersons~~, may be invited to participate as members of the Credentials~~;

c) Chair, Campus Quality Management Committee ~~from time~~ ;

d) The Chief Executive Officer of Palomar Health or his/her designee shall attend as a non-voting ex-officio member. He/she may not attend executive sessions of this committee, unless requested to ~~time.~~do so by the Campus Chief of Staff, with approval of the Campus Executive Committee;

e) For the Escondido Campus only, the Medical Director of the Trauma program, as a non-voting member;

f) Chair, Campus Medical Staff Peer Review Committee (MSPRC), as a non-voting member; and

g) At-large members elected by the Campus, who are subject to removal by unanimous vote of the remaining Campus Executive Committee members.

8.4.2 Duties

~~8.5.2~~8.4.1 ~~Duties~~

~~The Credential Committee shall:~~

~~Review~~The duties of the Campus Executive Committee are delegated from and derivative of the authority and duties of the Medical Executive Committee of the Medical Staff. The Medical Executive Committee may, at its discretion, revoke or modify these duties at any time as it deems appropriate.

a) Representing and acting on behalf of the Campus in the intervals between meetings of the Campus, subject to such limitations as may be imposed by these bylaws.

b) Coordinating and implementing the professional and organizational activities and policies of the Campus.

c) Receiving and acting upon reports and recommendations from Campus Departments, committees, and assigned activity groups of the Campus.

d) Recommending action to the Medical Executive Committee on matters of a medical-administrative nature.

e) Establishing the structure of the Campus, the mechanism to review credentials and delineate individual clinical privileges, the organization of quality management activities and mechanisms of the Campus, termination of membership and fair hearing procedures, as well as other matters relevant to the operation of an organized Medical Staff, including a cooperative working relationship with other District Facilities, as to each of these obligations.

f) Evaluating the medical care rendered to patients in the Hospital.

g) Participating in the development of policies, practices, and planning of the Campus and Hospital.

h) Reviewing the qualifications, credentials, performance and professional competence and character of applicants and Members at the Campus. Making recommendations to the Medical Executive Committee regarding appointment, reappointment, assignment to a Campus or Campus Departments, clinical privileges, and corrective action.

i) Taking reasonable steps to promote ethical and competent clinical performance on the part of the Members including the initiation of and participation in corrective or review measures when warranted.

j) Designating such Campus committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the Medical Staff and approving or rejecting recommendations from those Campus committees.

k) Reporting meetings of the Medical Staff for that Campus.

l) Assisting in the obtaining and maintaining of accreditation.

m) Developing and maintaining methods for the protection and care of patients and others in the event of internal or external disaster.

n) Appointing such special or ad hoc Campus committees as may seem necessary or appropriate to assist the Campus Executive Committee in carrying out its functions and those of the Medical Staff.

o) Reviewing the quality and appropriateness of services provided by contract physicians at

the Campus.

~~qqqq)~~ For the Poway Campus only, undertaking the functions of the Credentials Committee, including the following activities: review and evaluate the credentials of all applicants to the Medical Staff and Allied Health Professional Staff at the Poway Campus after receiving applications~~.~~

~~rrrr) Submit timely recommendations to the Medical Executive Committee and/or Departments.~~

~~ssss) Investigate~~; investigate, review, and ~~report~~recommend on matters referred by the Campus Chief of Staff, the Medical Executive Committee, or ~~Departments~~Campus Department Chairpersons regarding the conduct, professional character, or competence of any applicant~~.~~

~~tttt)~~p) ~~Charge~~ to either the Medical Staff or Allied Health Professional Staff at the Poway Campus; review any such referral in regard to re-application at the time of reappointment to the Medical Staff or the Allied Health Professional Staff at the Poway Campus; and charge the creation of an Interdisciplinary Practice Committee, to perform functions consistent with the requirements of law and regulation and to receive reports from same.

q) Making Medical Staff recommendations to the Medical Executive Committee for its approval, pertaining to at least the following:

(1) The Medical Staff structure

(2) The mechanism used to review credentials and to delineate individual clinical privileges.

(3) Appointment and Reappointment of Medical Staff Members, and restricting, reducing, suspending, terminating and revoking Medical Staff membership.

(4) Granting, modifying, restricting, reducing, suspending, terminating, and revoking clinical privileges, and assignments to Departments.

(5) The participation of the Medical Staff in organization performance improvement activities.

(6) The mechanism by which Medical Staff membership may be terminated.

(7) The mechanism for fair hearing procedures.

r) Developing and approving Medical Staff policies and procedures for the Campus. The Campus Executive Committee will communicate such policies and procedures to the Medical Executive Committee and the Medical Staff at its Campus. Any Members, responsible committee, or department may also formulate and propose policies and procedures to the Campus Executive Committee.

~~8.5.3~~8.4.3 Meetings

The ~~Credentials~~Campus Executive Committee shall ~~meet as necessary,~~ usually ~~quarterly.~~meet monthly but not less than nine (9) times per year. It shall maintain a record of its proceedings and ~~report its activities and recommendations to~~actions.

8.5 Campus Credentials Committee for the ~~Medical Executive Committee.~~Escondido Campus

~~37.3 Nominating Committee~~

8.5.1 Composition

~~Every 3rd Medical Staff Year, the Nominating~~There shall be a Campus Credentials Committee for

the Escondido Campus, which shall consist of the Campus Chief of Staff - Elect as Chairperson, the Campus Chief of Staff, ~~Chief of Staff-Elect, and one (1) representative from the Departments of Surgery, Medicine, Pediatrics, OB/GYN, Anesthesia, Emergency Medicine, Radiology, Pathology, Family Medicine and Trauma. The~~the Campus Immediate Past Chief of Staff ~~shall be~~, the ~~Chairperson~~Chair of the Campus Interdisciplinary Practice Committee; Campus Department Chairpersons, may be invited to participate as members of the Credentials Committee from time to time.

8.5.2 Duties

The ~~Nominating~~Campus Credential Committee for the Escondido Campus shall ~~meet at the direction of~~ :

a) Review and evaluate the ~~Chief~~credentials of ~~Staff~~all applicants to ~~select nominees for the consideration of~~ the Medical Staff ~~as its officers for~~ and Allied Health Professional Staff at the Escondido Campus after receiving applications.

a) Submit timely recommendations to the ~~next year. The Nominating~~Medical Executive Committee ~~shall nominate one~~ and/or ~~more nominees for each office except for~~Campus Departments.

b) Investigate, review, and report on matters referred by the Campus Chief of Staff ~~who automatically succeeds to that office~~, the Medical Executive Committee, the Campus Executive Committee, or Campus Departments regarding conduct, professional character, or competence of any applicant.

c) Charge the creation of an Interdisciplinary Practice Committee to perform functions consistent with the requirements of law and regulation and to receive reports from same.

8.5.3 Meetings

The ~~Nominating~~Campus Credentials Committee for the Escondido Campus shall meet as necessary, usually quarterly. It shall maintain a record of its proceedings and report its activities and recommendations to the ~~Medical~~Campus Executive Committee ~~in accordance with Article 7.1.3~~.

~~8.6~~8.6 Quality Management Committee

There shall be a Quality Management Committee of the Medical Staff. The composition, responsibilities, meeting and reporting requirements and functions (blood usage, drug usage, pharmacy and therapeutics, nutrition, medical records timeliness and pertinence, surgical case review, special care unit review, utilization review, Palomar Health skilled nursing facilities, and infection control) are specified in the Palomar Health System Performance Improvement Plan, the pertinent provisions of which are incorporated herein by this reference.

~~8.7~~8.7 Campus Critical Care Committee

There shall be a Campus Critical Care Committee at each Campus of the Medical Staff. The composition, responsibilities, meeting, and reporting requirements of the ~~joint~~Campus Critical Care Committee are as specified in the Critical Care Committee ~~section of *Patient Safety Plan*,~~Plan present in Attachment 2 of the Palomar Health Performance Improvement ~~(Lucidoc ID 11234),~~Plan, the pertinent provisions of which are incorporated herein by this reference.

~~8.8~~Bylaws8.8 Physician Well Being Committee of the Medical Staff

~~8.5.1~~8.8.1 Composition

~~The Bylaws Committee shall consist of five (5) members which shall include the immediate past Chief of Staff and Chief of Staff-Elect. The Chief of Staff-Elect will serve as chairperson.~~

~~8.8.2~~8.14.1There shall be a ~~Duties~~

~~The duties of the Bylaws Committee shall include:~~

~~uuuu) Conducting periodic review of the Bylaws, Rules and Regulations and forms promulgated by the Medical Staff. Submitting recommendations to the Medical Executive Committee for changes in these documents as necessary to reflect current practices of the Medical Staff.~~

~~vvvv) Receiving and evaluating for recommendation to the Medical Executive Committee suggestions for modifications of the items specified in (a).~~

~~8.5.3 Meetings~~

~~The Bylaws Committee shall meet as often as necessary at the call of its chairperson. It shall maintain a record of its proceedings and shall report its activities and recommendations to the Medical Executive Committee.~~

~~8.9~~8.8 Physician Well Being Committee of the Medical Staff to serve both Campuses, which shall be~~Composition~~

~~The Physician Well Being Committee shall be a combined committee of the Medical Staffs of Palomar Health Hospitals~~ comprised of no less than five (5) active members of the Medical Staffs, each serving a two (2) year term, a majority of which, including the chair, shall be physicians. ~~Except for initial appointments, each member shall serve a term of two (2) years, and the terms shall be staggered as deemed appropriate by the Medical Executive Committees to achieve continuity.~~ Insofar as possible, members of this committee shall not serve as active participants on other peer review or quality assessment and improvement committees while serving on this committee.

~~8.9.2~~8.8.2 Duties

The Physician Well Being Committee may receive reports related to the health, well-being, or impairment of Medical Staff members and, as it deems appropriate, may investigate such reports. With respect to matters involving individual Medical Staff members, the committee may, on a voluntary basis, provide such advice, counseling, or referrals as may seem appropriate. Such activities shall be confidential; however, in the event information received by the committee clearly demonstrates that the health or known impairment of a Medical Staff member poses an unreasonable risk of harm to hospitalized patients, that information may be referred for corrective action. The committee shall also consider general matters related to the health and well-being of the Medical ~~Staffs~~Staff and, with the approval of the Medical Executive ~~Committees~~Committee, develop educational programs or related activities.

~~8.9.3~~8.8.3 Meetings

The Physician Well Being Committee may meet as often as necessary, but at least twice a year. It shall maintain a record of its proceedings, as it deems advisable, but shall report on its activities as needed to the Medical Executive ~~Committees~~Committee.

~~8.10~~8.9 Biomedical Ethics Committee of the Medical Staff

~~8.10.1~~8.9.1 Composition

The Biomedical Ethics Committee shall be a combined committee of the two Campuses of the Medical ~~Staffs of Palomar Health Hospitals.~~Staff. The Committee shall consist of three (3) physician representatives from each ~~hospital~~Campus and other members, as the Medical Executive Committee may deem appropriate. It may include lay representatives, social services, clergy, ethicists, attorneys, nursing staff, administrators (or their designees), and representatives from the Board of Directors as non-voting members. Physician members will be appointed by the ~~Chiefs of Staff~~Medical Executive Committee, including a chairperson ~~for each hospital. The~~

~~chairperson of the combined committee will alternate yearly.~~. A subcommittee of the committee shall be formed at each ~~hospital~~Campus composed of the three (3) representatives for the respective ~~hospital~~Campus.

~~8.10.2~~8.9.2 Duties

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

~~8.10.3~~8.9.3 Meetings

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

~~8.11~~8.10 Education/ Library Committee

~~8.5.1~~8.8.1 ~~Composition~~

8.10.1 Composition

The Education/Library Committee is a joint committee for both Campuses and shall be composed of broad physician representation. The following ancillary representatives shall serve as non-voting members: The Director of Organizational Learning, the Tumor Registrar and a representative from the Department of Pharmacy, all of which are district positions.

~~8.11.2~~8.10.2 Duties

~~The duties of the Education/Library Committee shall include:~~

~~wwww)~~a) Coordinating all continuing medical education activities including recording of attendance at educational meetings.

~~xxxx)~~b) Assuring that any deficiencies in patient care as revealed by peer review and disease audits are made subjects of educational sessions.

~~yyyy)~~c) Prioritizing hospital sponsored continuing education.

~~zzzz)~~d) Reviewing library policies and procedures, establishing priorities in the selection of new texts, online and digital educational content and selecting or reviewing journal subscriptions.

~~aaaaa)~~e) Evaluating effectiveness of the library in meeting the informational and educational needs of users.

~~8.5.3 Meetings~~

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

~~8.12~~8.11 Long Term Care Committee of the Poway Campus

8.11.1 Composition

~~8.5.1~~8.12.1~~Composition~~

~~The~~The Long Term Care Committee of the Poway Campus serves that Campus, in which

the Medical Director of the Palomar Health Skilled Nursing Facility (SNF) shall serve as the Chair. At least three (3) physician representatives shall be appointed from the Poway Campus Departments of Medicine and Surgery by the Campus Chief of Staff. Non-voting members shall include the SNF Administrator, the Director of Nursing, the Director of Staff Development, the UR Coordinator, the Director of Environmental Services, EP&S Committee Chairperson, Infection Surveillance Nurse, Director of Health Information Services, a Pharmacist, and the Director of Quality Management.

~~8.12.2~~8.11.2 Duties

The duties of the Long Term Care Committee of the Poway Campus shall include:

~~bbbbb)~~a) Advisory review and revision of administrative policies and procedures.

~~ccccc)~~b) Coordinating the functioning of the facility, including equipment purchases and operating policies.

~~ddddd)~~c) Performing utilization review activities for the facility. In this capacity, the Committee or a subcommittee of it, shall function as the UR subcommittee for the facility.

~~eeeee)~~d) Review results of current improvement activities, including ongoing measurements and focus studies, to prioritize opportunities for improvement.~~-~~

~~8.12.3~~8.11.3 Meetings

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

~~8.13~~8.12 Infection Surveillance Committee

There shall be an Infection Surveillance Committee of the Medical Staff. The composition, responsibilities, meeting, and reporting requirements of this committee are as specified in the Infection Prevention and Control Committee section of *Patient Safety Plan, Performance Improvement* (Lucidoc ID 11234), and pertinent provisions of which are incorporated herein by this reference.

~~8.14~~8.13 Pharmacy and Therapeutics Committee

There shall be a Pharmacy and Therapeutics Committee of the Medical Staff. The composition, responsibilities, meeting, and reporting requirements of this committee are as specified in the Pharmacy and Therapeutics Committee section of *Patient Safety Plan, Performance Improvement* (Lucidoc ID 11234), and pertinent provisions of which are incorporated herein by this reference.

~~8.15~~8.14 Utilization Review Committee

There shall be a Utilization Review Committee of the Medical Staff. The composition, responsibilities, meeting, and reporting requirements of this committee are as specified in *Patient Safety Plan, Performance Improvement* (Lucidoc ID 11234), and pertinent provisions of which are incorporated herein by this reference.

~~8.16~~8.15 Interdisciplinary Practice Committee

8.15.1 Composition

~~8.5.1 Composition~~

~~The~~There shall be a Interdisciplinary Practice Committee at each Campus of the Medical Staff. The Campus Interdisciplinary Practice Committee (IPC) shall have an equal number of Medical Staff members and nursing staff members. It shall include the

Chief Nurse Executive or his/her designee~~.~~ for the appropriate Campus. In addition, representatives of the categories of Allied Health Professionals granted privileges ~~in~~for the ~~hospital~~Campus should serve as consultants on an as-needed basis, and shall participate~~,~~ in the committee proceedings when invited.

~~8.16.2~~8.15.2 Duties

~~fffff)~~a) Standardized Procedures

(1) The IPC shall develop and review standardized procedures that apply to Advanced Practice Nurses; identify functions that are appropriate for standardized procedures; initiate such procedures; and review and approve standardized procedures.

(2) Standardized procedures can be approved only after consultation with the Department involved, and by affirmative vote of (i) the administrative representatives, (ii) a majority of physician members, and (iii) a majority of nurse members.

~~ggggg)~~b) Credentialing Allied Health Professionals

(1) The IPC shall recommend policies and procedures for expanded role privileges for assessing, planning, and directing the patients' diagnostic and therapeutic care.

(2) The IPC shall participate in AHP peer review and quality improvement. It may initiate corrective action, when indicated, against AHPs in accordance with the Medical Staff Bylaws that govern AHPs

(3) The IPC shall serve as a liaison between the AHPs and the Medical Staff.

~~8.16.3~~8.15.3 Meetings

The IPC shall meet as often as necessary, but at least quarterly. It shall maintain a record of its proceedings and report its activities and recommendations to the ~~Medical~~Campus Executive Committee.

8.16 Joint Conference Committee of the Medical Staff

~~8.17.1~~8.16.1 Purpose

The purpose of the Joint Conference Committee is two-fold:

~~hhhhh)~~a) To facilitate communication amongst the Board, ~~Administrations~~Administration of Palomar Health ~~Hospitals~~Medical Center, and the Medical ~~Staffs of Palomar Health Hospitals~~Staff involving medical staff issues such as credentialing, quality improvement, corrective action, and bylaws amendments.

~~iiiii)~~b) To address and confer in good faith to resolve medical staff disputes including but not limited to those set forth in Section 2282.5 of the Business and Professions Code.

~~8.17.2~~8.16.2 Composition~~—~~

The Joint Conference Committee shall be a joint committee of ~~the Medical Staffs of Palomar Health Hospitals~~with Members from both Campuses consisting of the following: Three Board members selected by the Board; the Chief Executive Officer of Palomar Health; the Chief Medical Officer; ~~Chief~~the Campus Chiefs of Staff~~, Chief~~ from both Campuses, Campus Chiefs of Staff-Elect~~,~~ from both Campuses; and the Campus Immediate Past ~~Chief~~Chiefs of Staff ~~of each Palomar Health Hospital~~from both Campuses; an ~~at~~At Large member of ~~one of the~~ Medical ~~Staffs~~Staff selected by members of the Joint Conference Committee to represent the Medical ~~Staffs~~Staff. The chairperson shall alternate between the Campus Chiefs of Staff for each successive

convening of the Joint Conference Committee.

~~8.17.3~~8.16.3 Meetings

The Joint Conference Committee shall meet as often as necessary (usually on a quarterly basis). It shall maintain a record of its proceedings, as it deems advisable and report to the Medical Executive ~~Committees of both Medical Staffs~~Committee.

~~8.18~~8.16 Campus Operating Room Committee

~~8.18.1~~8.14.1~~Composition~~

8.16.1 Composition

There shall be a Campus Operating Room Committee at each Campus of the Medical Staff. The Operating Room Committee shall function as a multi-disciplinary committee with physician and other voting representatives from the following departments, service areas, and committees, to the extent applicable for a given Campus: Campus Departments of Anesthesia~~,~~ (two members), OB/GYN, Surgery~~,~~ (including a general surgeon, orthopedic surgeon, and ophthalmologist), Orthopedic Surgery/Rehabilitation, Urology ~~and~~, Trauma~~, as well as the~~; Cardiac Catheterization, Interventional Radiology, GI Endoscopy and Bronchoscopy procedural areas~~. The Department of Anesthesia shall be allowed two (2) representatives on the committee. The~~ ; the Chair of the Campus Robotics Committee, ~~and Surgery (to include a general surgeon, orthopedic surgeon and an ophthalmologist) as well as the Cardiac Catheterization, Interventional Radiology, GI Endoscopy and Bronchoscopy procedural areas,~~ the Director of Surgery Procedure Services or his/her designee, and the Chief Nursing Officer or his/her designee ~~shall serve as voting members of this committee.~~. The Chairperson will be selected from the membership by majority vote ~~for a two-year period~~.

~~8.18.2~~8.14.1~~Duties~~

8.16.2 Duties

The duties of the Campus Operating Room Committee shall include:

~~jjjjj)~~a) To recommend guidelines for the efficient and safe functioning of the Perioperative Platform.

~~kkkkk)~~b) Promotion of a coordinated, multi-disciplinary approach to overseeing the functioning of the Perioperative Platform.

~~lllll)~~c) Establishment of OR Scheduling Guidelines with responsibility for application of and revision of the Scheduling Guidelines.

~~mmmmm)~~d) The Committee shall serve as a forum for the discussion of problems that are multi- disciplinary in nature. Meetings will allow for exchange of ideas and information among Anesthesiologists, Surgeons, Proceduralists and the OR Staff.

~~nnnnn)~~e) The Committee shall review volume reports of the OR activity, as appropriate.

~~8.18.3~~8.16.3 Meetings

The Campus Operating Room Committee shall meet as determined by the Committee, but at least quarterly. It shall maintain a record of its proceedings and shall report its activities and recommendations to the Medical Executive Committee.

~~8.19~~8.17 Robotics Committee of the Escondido Campus

8.17.1 Composition

~~8.18.1 Composition~~

The Robotics Committee of the Escondido Campus is comprised of at least one

representative from each of the subspecialties that utilize the DaVinci Robot(s) at ~~Palomar Medical Center.~~the Escondido Campus. The Director of Perioperative Services and other administrative support personnel shall be included as non-voting members as determined by the Chairperson. The Chairperson shall be selected by the Escondido Campus Chief of Staff ~~for a two-year term~~.

8.17.2 Duties

~~8.18.2 Duties~~

The duties of the Robotics Committee of the Escondido Campus shall include:

a) To recommend guidelines for the efficient and safe functioning of the Robotic Surgery Program.

b) Promotion of a coordinated, multi-disciplinary approach to overseeing the functioning of the Robotic Surgery Program.

c) Establishment of OR Scheduling Guidelines with responsibility for application of and revision of the Scheduling Guidelines.

d) Serve as a forum for the discussion of problems that are multi-disciplinary in nature. Meetings will allow for exchange of ideas and information among Anesthesiologists, Surgeons and the OR Staff.

e) Review volume reports of the OR activity, as appropriate.

f) Work with administration, surgeons and marketing to promote the growth and development of the Robotic Surgery Program.

g) Ensure financial viability of the Robotic Surgery Program.

8.17.3 ~~8.18.3~~ Meetings

The Robotics Committee of the Escondido Campus shall meet as determined by the Committee, but at least quarterly. It shall maintain a record of its proceedings and shall report its activities and recommendations to the Operating Room Committee.

~~8.20~~8.18 Campus Medical Staff Peer Review Committee (MSPRC)

There shall be a Campus Medical Staff Peer Review Committee at each Campus of the Medical Staff. The composition, responsibilities, meeting, and reporting requirements of this committee are specified in the Palomar Health Medical Staff Peer Review Committee Manual, pertinent provisions of which are incorporated herein by this reference.

~~52.1 Data Trends Council (DTC)~~

~~The composition, responsibilities, meeting, and reporting requirements of this committee are specified in the Data Trends Council Charter in the Palomar Health Medical Staff Peer Review Committee Manual, pertinent provisions of which are incorporated herein by this reference.~~

ARTICLE IX: CLINICAL DEPARTMENTS

9.1. **~~9.1~~Organization**

~~The~~Each Campus of the Medical Staff shall be divided into clinical departments. Each Campus Department shall be organized as a separate component and shall have a chairperson selected and entrusted with the authority, duties and responsibilities specified in 9.4. When appropriate, the Medical Executive Committee may recommend to the Medical Staff the creation, elimination, modification, or combination of departments.

9.2. **~~9.2~~Campus Departments**

The current Campus Departments for each Campus (unless otherwise specified) are:

~~ooooo)~~a) Anesthesiology

~~ppppp)~~b) Emergency Medicine

~~qqqqq)~~c) Family Medicine (for Escondido Campus only)

~~rrrrr)~~d) Medicine

~~sssss)~~e) Obstetrics and Gynecology (for Escondido Campus only)

f) Gynecology (for Poway Campus only)

~~ttttt)~~g) Orthopedic Surgery and Rehabilitation (for Escondido Campus only)

~~uuuuu)~~h) Pathology

~~vvvvv)~~i) Pediatrics

~~wwwww)~~j)Psychiatry

~~xxxxx)~~k) Radiology

~~yyyyy)~~l) Surgery

~~zzzzz)~~m) Trauma (for Escondido Campus only)

~~aaaaaa)~~n) Urology (for Escondido Campus only)

9.3. **~~9.3~~Membership**

Department assignments from the prior medical staffs at Palomar Medical Center Escondido and Palomar Medical Center Poway shall be preserved for the Campus Departments at each Campus. The Medical Executive Committee, following the recommendation of the appropriate Campus Department, shall recommend initial Department assignments for all new members of the Medical Staff. Representatives from the Hospital Administration may be invited to attend departmental meetings, and when so present, shall not be entitled to vote.

Each Member will be assigned to the Department in which he/she does the majority of his/her work. The Member shall hold voting rights only in that Department, with the exception of the Department of Trauma. Members may be granted privileges by additional Departments (except contract departments, unless approved by these departments) at the Member's request and with the approval of the other Department(s). Members with privileges in other Departments shall be subject to all the rules of such Department and to the jurisdiction of the Department Chairperson. The Member is encouraged to attend meetings held each year by his/her assigned Department. ~~Each Member, active and provisional, must attend at least twenty-five (25) percent of the business meetings held each year by each Department of which he/she is a Member.~~ The Department Chairperson may require the attendance of any Member or Physician with privileges in the Department at a specific Department meeting for review of particular cases or for the purpose of continuing medical education.

Each member must also comply with all requirements of Departmental membership, including Emergency Department consultation panel service pursuant to applicable rules and regulations, for each Department for which he/she is a Member. Only Department Members shall be entitled to vote on departmental matters and hold departmental office. Members may be granted privileges in other departments without membership, but shall not be required to attend departmental meetings or serve on the Emergency Department consultation panel of those departments.

9.4. **~~9.4~~Campus Department Chairperson~~-~~**

The Campus Department Chairperson shall be an active category Member and shall have served as Chairperson- Elect for the previous one (1) or two (2) years, as determined by Department rules and regulations, except in Departments, which do not provide for a Chair-

Elect in their rules and regulations. The Department Chairperson shall be certified by the appropriate specialty board, unless it shall be affirmatively established, through the privilege delineation process, that the Department Chairperson possesses comparable competence. The Department Chairperson or Chairperson-Elect shall be elected by the voting members of each Department at least thirty (30) days prior to the annual staff meeting. Terms of office shall be for at least one (1) or two (2) years as determined by Departmental rules and regulations.

Unless removed as provided in these Bylaws, and except as provided below in this section, Campus Department Chairpersons shall serve the longer of the effective period of these Bylaws or the remainder of their term as a Department Chairperson on the separate medical staff at the Poway and Escondido hospitals prior to the merger of the medical staffs. If these Bylaws are repealed and superseded with a new set of bylaws before the end of the Department Chairperson's term, unless otherwise provided in the new set of bylaws, the Department Chairperson shall complete the term under the new set of bylaws for the Medical Staff or the member's successor is appointed.

Notwithstanding the foregoing, any Member who is a Department Chair-Elect from the separate medical staffs at the Poway and Escondido hosptials prior to the merger of the medical staffs prior to the Effective Date of these Bylaws shall assume the Department Chairperson position and replace the outgoing chairperson at the appropriate Campus Department as originally planned. Such Department Chairperson shall serve their term consistent with this section.

The roles and responsibilities of the Campus Department Chairperson shall include:

~~bbbbbb)~~a) Clinically related activities of the department.

~~cccccc)~~b) Administratively related activities of the department, unless otherwise provided by the hospital.

~~dddddd)~~c) Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges.

~~eeeeee)~~d) Recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the department.

~~ffffff)~~e) Recommending clinical privileges for each member of the department.

~~gggggg)~~f) Assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the hospital.

~~hhhhhh)~~g) The integration of the department or service into the primary functions of the hospital.

~~iiiiii)~~h) The coordination and integration of interdepartmental and intradepartmental services.

~~jjjjjj)~~i) The development and implementation of policies and procedures that guide and support the provision of care, treatment, and services.

~~kkkkkk)~~j) The recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services.

~~llllll)~~k) The determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services.

~~mmmmmm)~~l) The continuous assessment and improvement of the quality of care, treatment, and services.

~~nnnnnn)~~m) The maintenance of quality control programs, as appropriate.

~~oooooo)~~n) The orientation and continuing education of all persons in the department or service.

~~pppppp)~~o) Recommending space and other resources needed by the department service.

~~8.5.1~~9.4.1 Compensation ~~Of~~of Campus Department Chairs

Campus Department Chairs should be compensated for their work spent representing and leading the medical staff. Such compensation shall come from the Medical Staff bank account, for which the medical staff has sole responsibility. The payment to individual physicians should be in the amount determined by the ~~MEC.~~Medical Executive Committee. If the hospital provides any funds specifically earmarked for such compensation, those funds should be requested and accounted for in the Medical Staff Services Department budget for hospital approval. Payment to each physician shall be contingent upon each physician's proper performance of those duties.

~~8.5.2~~9.4.2 Removal

~~After election, removal~~Removal of department chairs and vice-chairs from office may occur by a two-thirds vote of the department members eligible to vote on department matters with approval of the Medical Executive Committee.

9.5. **~~9.5~~Campus Department Functions**

Campus Departments shall:

~~qqqqqq)~~a) Establish criteria relevant to the care provided in the Department, consistent with the policies of the Medical Staff and the Board of Directors for granting privileges and monitoring as described in the Department rules and regulations.

~~rrrrrr)~~b) Participate in the evaluation of the medical care provided by Members of the Department.

~~ssssss)~~c) Review minutes and requests of Department committees and forward recommendations to the ~~Medical~~Campus Executive Committee.

~~tttttt)~~d) Review Department Rules and Regulations annually. The Medical Executive Committee and the Board of Directors must approve revisions.

~~uuuuuu)~~e) Provide education.

~~vvvvvv)~~f) Provide the Emergency Department with a panel of physicians to do consultation admit patients to the Hospital, and to see outpatient referrals only when the ED coverage system in place fails to provide adequate coverage for patients that present to the Emergency Department. Failure to participate according to these Bylaws when necessary may result in suspension in the case of a physician failing to provide Emergency Department consultation services or corrective action in the case of a physician failing to provide requested outpatient follow-up.

~~wwwwww)~~g) Provide the Campus Department of Trauma Services with a panel of physicians to do consultations and provide continuing care of designated trauma patients (trauma services consultation panel) meeting the criteria of the County of San Diego; provided, however, participation on such panel shall be voluntary for any provisional or active category Member and therefore, no Department shall be compelled to provide a trauma services consultation panel.

~~xxxxxx)~~h) Recommend, when appropriate, annual exemptions from department attendance requirements.

9.6. **~~9.6~~Committees**

Campus Departments may create committees and/or subsections when necessary to accomplish the goals and required functions of the Department.

9.7. **~~9.7~~Creation of New Campus Departments**

When there are sufficient Members of a specialty to allow the effective ~~operating~~operation of a new Campus Department, the Medical Executive Committee shall review a petition signed by at least seventy-five percent (75%) of the prospective Members of the Department. If approved,

the request shall be drafted as a Bylaw amendment and acted upon in accordance with Article XV.

ARTICLE X: CONFIDENTIALITY, IMMUNITY FROM LIABILITY AND RELEASES

10.1. ~~10.1~~Authorizations and Conditions

By applying for or exercising clinical privileges within the hospital, an applicant:

~~8.5.1~~10.1.1 Authorizes representatives of the hospital and the medical staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the applicant's professional ability and qualifications;

~~8.5.2~~10.1.2 Authorizes persons and organizations to provide information concerning such practitioners to the medical staff;

~~8.5.3~~10.1.3 Agrees to be bound by the provisions of this Article and to waive all legal claims against any representative of the Medical Staff or the hospital who would be immune from liability under Section 10.3 of this Article; and~~-~~

~~8.5.4~~10.1.4 Acknowledges that the provisions of this Article are express conditions to an application for Medical Staff membership, the continuation of such membership, and to the exercise of clinical privileges at this hospital.

10.2. ~~10.2~~Confidentiality of Information

~~8.5.1~~10.2.1 General

Records and proceedings of all medical staff committees having the responsibility of evaluation and improvement of quality of care rendered at Palomar Health, including, but not limited to, meetings of the Medical Staff meeting as a committee of the whole, meetings of departments and divisions or subsections, meetings of committees, and meetings of special or ad hoc committees created by the Medical Executive Committee or by departments and including information regarding any member or applicant to this medical staff, shall to the fullest extent permitted by law, be confidential.

~~8.5.2~~10.2.2 Breach ~~Of~~of Confidentiality

As effective peer review and consideration of the qualifications of medical staff members and applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of medical staff departments, divisions, or committees, except in conjunction with other hospital, professional society, or licensing authority, is outside appropriate standards of conduct of this medical staff, violates the medical staff bylaws, and will be deemed disruptive to the operations of the hospital. If it is determined that such a breach has occurred, the Medical Executive Committee may undertake such corrective action as it deems appropriate.

10.3. ~~10.3~~Immunity from Liability

~~8.5.1~~10.3.1 For Action Taken

Each representative of the Medical Staff and hospital shall be immune, to the fullest extend provided by law, from liability to an applicant or member for damages or other relief for any action taken or statements or recommendations made within the scope of duties exercised as a representative of the Medical Staff or hospital.

~~8.5.2~~10.3.2 For Providing Information

Each representative of the Medical Staff and hospital and all third parties shall be immune, to the fullest extent provided by law, from liability to an applicant or member

for damages or other relief by reason of providing information to a representative of the Medical Staff or hospital concerning such 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 Palomar Health.

10.4. **~~10.4~~Activities and Information Covered**

The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health care ~~facility's~~facilities or organization's activities concerning, but not limited to:

~~8.5.1~~10.4.1 application for membership, renewal of membership, or clinical privileges;

~~8.5.2~~10.4.2 corrective action;

~~8.5.3~~10.4.3 hearings and appellate reviews;

~~8.5.4~~10.4.4 utilization reviews;

~~8.5.5~~10.4.5 other department, or division, committee, or medical staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and

~~8.5.6~~10.4.6 queries and reports concerning the National Practitioner Data Bank, peer review organization, the Medical Board of California, and similar queries and reports.

10.5. **~~10.5~~Releases**

Each applicant or member shall, upon request of the Medical Staff or Palomar Health, execute general and specific releases in accordance with the express provisions and general intent of this Article. ~~Execution of such release shall not be deemed a prerequisite to the effectiveness of this Article.~~

Execution of such release shall not be deemed a prerequisite to the effectiveness of this Article.

10.6. **~~10.6~~Indemnification**

To the extent allowed by law, Palomar Health shall indemnify, defend and hold harmless the Medical Staff and its individual members from and against losses and expenses (including attorneys' fees, judgments, settlements, and all other costs, direct or indirect) incurred or suffered by reason of or based upon any threatened, pending or completed action, suit, proceeding, investigation, or other dispute relating or pertaining to any alleged act or failure to act within the scope of peer review or quality assessment activities including, but not limited to (1) as a member of or witness for a medical staff department, service, committee or hearing panel, (2) as a member of or witness for the hospital board or ay hospital task force, group, or committee, and (3) as a person providing information to any medical staff or hospital group, officer, board member or employee for the purpose of adding in the evaluation of the qualifications, fitness or character of a medical staff member or applicant. The Medical Staff or Member may seek indemnification for such losses and expenses under this bylaws provision, statutory and case law, and any available liability insurance or otherwise as the Medical Staff or Member sees fit, and concurrently or in such sequence as the Medical Staff or Member may choose. Payment of any losses or expenses by the Medical Staff or Member is not a condition precedent to Palomar Health's indemnification obligations hereunder.

10.7. **~~10.7~~Placenta Disposition**

The Medical Executive Committee will develop a policy regarding disposition of placentas.

ARTICLE XI: MEDICAL STAFF MEETINGS

11.1.

~~11.1~~Regular Meetings

~~8.5.1~~11.1.1 Regular meetings shall be held annually. Active and provisional Members are encouraged to attend all meetings and shall be required to attend any meetings designated by the Medical Executive Committee as mandatory. Representatives from the Hospital may be invited to attend and when so present, shall not be entitled to vote.

~~8.5.2~~11.1.2 The annual meeting shall be held within thirty (30) days of the end of the Medical Staff year.

11.2. ~~11.2~~Special Meetings

~~8.5.1~~11.2.1 The ~~Chief of Staff~~ Medical Executive Committee may call a special meeting of the Medical Staff and Campus Chiefs of Staff may call a special meeting of the Campus Medical Staff at any time. In addition, the ~~Chief~~Medical Executive Committee and the Campus Chiefs of Staff shall call a special meeting of the Medical Staff or Campus, respectively, within thirty (30) days after receipt of a written request for same signed by not less than one-fourth (1/4) of the voting Members of the Medical Staff or Members of the Campus, as appropriate, and stating the purpose for such a meeting. The ~~Chief~~Medical Executive Committee or the Campus Chiefs of Staff shall designate the time and place of any special meeting.

~~8.5.2~~11.2.2 Written or oral notice stating the place, day, and hour of any special meeting shall be given, either personally or by ~~email,~~ mail or FAX, to each active and provisional category Member not less than seven (7) nor more than thirty (30) days before the date of such meeting, by or at the direction of the Medical Executive Committee or Campus Chief of Staff. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

~~8.5.3~~11.2.3 ~~-~~Active and provisional Members are encouraged to attend all special meetings and shall be required to attend any meetings designated by the Medical Executive Committee or the Campus Chief of Staff as mandatory. Representatives from the hospital may be invited to attend and, when so present, shall not be entitled to vote. Failure to attend a majority of these meetings may result in a recommendation for sanctions by the Medical Executive Committee as described in the Medical Staff Rights Manual.

~~8.5.4~~11.2.4 A ~~Membe`r~~Member of the Medical Staff may arrange for a proxy vote at special meetings if the Member is unable to attend. In order for the proxy to be valid, the Member must so inform the Medical Executive Committee or Campus Chief of Staff at least one (1) week in advance of the meeting in writing as to why he/she is unable to attend and to designate the individual who hold his/her proxy vote.

11.3. ~~11.3~~Quorum

Fifty percent (50%) of the total membership of the active Members ~~present~~eligible to vote shall constitute a quorum for meetings of the Medical Staff. Fifty percent (50%) of the total membership of the active Members eligible to vote and assigned to a Campus shall constitute a quorum for meetings of that Campus.

11.4. ~~11.4~~Attendance Requirements

Each active and provisional category Member, except those intending to become consulting or affiliate shall be encouraged to attend the regular meeting and shall be encouraged to attend a majority of all other meetings in each year. Notwithstanding the foregoing, the Medical Executive Committee or Campus Chiefs of Staff may designate any meeting of the Medical Staff

or a Campus, respectively, as a mandatory meeting if attendance at such meeting is deemed essential to the accomplishment of the Medical Staff's or Campus's responsibilities and functions. The Medical Executive Committee or Campus Chief of Staff shall have given notice of any such meeting at least thirty (30) days in advance. A Member who is compelled to be absent from any annual or other mandatory meeting, shall promptly submit to the Medical Executive Committee or Campus Chief of Staff, either prior to or not more than three (3) days after the meeting, in writing, his/her reason for such absence. ~~At Palomar Medical Center, failure~~Failure to attend a mandatory meeting, or to receive an excused absence ~~from the Medical Executive Committee,~~ may result in sanctions as described in Section 12.7.1 ~~of these bylaws.~~, which may include the Member being assessed a fine in the amount of $250 per unexcused absence. Any information deemed important by ~~the~~a Campus Chief of Staff, which is disseminated at any ~~Medical Staff~~Campus meeting, ~~shall~~may be distributed to Members not in attendance at such meeting. ~~Failure to attend a mandatory meeting, or to receive an excused absence from the Medical Executive Committee, shall result in the Member being assessed a fine in the amount of $250.00 per unexcused absence.~~ Members shall be notified of ~~the~~any fine authorized herein by certified, return receipt requested mail. Failure to pay such fine within thirty (30) days of the date of the notice ~~shall~~may result in sanctions as described in the Medical Staff Rights Manual.

~~8.5.1~~11.4.1 Attendance Requirements

Attendance via web conferencing or electronic means (if available) may be accepted. Each member of the temporary, consulting, or courtesy staff and members of the provisional staff who qualify under criteria applicable to courtesy or consulting members shall be required to attend such meetings as may be determined by the Medical Executive Committee.

11.5. ~~11.5~~**Agenda**

~~8.5.1~~11.5.1 The agenda of the annual meeting of the Medical Staff shall include such items as call to order, introduction of guests, approval of minutes of the previous meeting and of any special meetings, unfinished business, communications, reports of standing and special committees, ~~Treasurer's Report~~Campus Treasurers' Reports, new business, approval of granting, renewing or terminating contracts held between Members and Palomar Health, and election of officers.

~~8.5.2~~11.5.2 The agenda of the special meetings shall be reading of the notice calling the meeting, transaction of business for which the meeting was called, and adjournment. No formal action may be taken at any general or special meeting on any item, which has not been specifically described in a notice of the meeting provided thirty (30) days before the meeting.

ARTICLE XII: CAMPUS COMMITTEE AND CAMPUS DEPARTMENT MEETINGS

12.1. ~~12.1~~**Regular Meetings**

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

12.2. ~~12.2~~**Special Meetings**

A special meeting of any committee or Department may be called by, or at the request of, the appropriate Chairperson, the Campus Chief of Staff, or by one-third (1/3) of the committee or Department's voting Members. At least two (2) members are required to make the request.

12.3. ~~12.3~~**Notice of Meeting**

Written or oral notice stating the place, day and hour of any special meeting or of any regular

meeting held pursuant to resolution shall be given to each committee or Department Member not less than three ~~(3) days before the time of such meeting by the person or persons calling the meeting.~~
(3) days before the time of such meeting by the person or persons calling the meeting.

12.4. ~~12.4~~**Manner of Action**

A quorum shall consist of those voting Members present. The action of the majority of Members present shall be the action of a committee, or Department with the exception of the Medical Executive Committee, which shall require that fifty percent (50%) of the voting membership be present in order to act. Action may be taken without a meeting by unanimous consent, in writing, signed by each voting Member.

12.5. ~~12.5~~**Rights of Nonvoting Members**

Persons serving under these bylaws as nonvoting Members of a committee or Department shall have all rights and privileges of regular Members, except that they shall not be counted in determining the existence of a quorum or allowed to vote.

12.6. ~~12.6~~**Minutes**

Minutes of each regular and special meeting of a campus committee or Campus Department shall be prepared and shall include a record of the attendance of Members and the action taken on each matter. The minutes shall be signed by the presiding officer and forwarded to the ~~Medical~~appropriate Campus Executive Committee. Each campus committee and Campus Department shall maintain a permanent file of the minutes of each meeting. Minutes of all Medical Staff meetings shall be maintained in Medical Staff Services and shall be maintained as a permanent confidential record. In this regard, meeting minutes shall not be removed from Medical Staff Services except for distribution at a meeting for review and approval purposes, or for regulatory review.

12.7. ~~12.7~~**Attendance Requirements**

Each Member is encouraged to attend meetings of each campus committee or Campus Department of which he/she may be a Member. The Chairperson of any committee or Department may designate certain meetings of the committee or Department as mandatory.

~~8.5.1 Palomar Medical Center~~

12.7.1 Provisional Members at Escondido Campus

Except as provided in Section 4.1 of these Bylaws, each active or provisional Member assigned to the Escondido Campus shall be required to attend twenty-five percent (25%) of Campus Department meetings, and fifty percent (50%) of any specified Medical Staff committee of which he/she may be a Member. Campus Departments at the Escondido Campus may, with the approval of the ~~Medical~~Campus Executive Committee, increase meeting attendance requirements up to fifty percent (50%) of Department meetings. The failure to meet the attendance requirement during the Medical Staff year shall be grounds for sanctions as stated below to the same effect as provided in Section 4.5 of the Medical Staff Rights Manual. Campus Committee and Campus Department Chairpersons shall report all such failures to the ~~Medical~~Campus Executive Committee for action. The Campus Departments may, with the approval of the ~~Medical~~Campus Executive Committee, exempt Members of the Department from attendance for reasons, which justify such exemption. These exemptions would need to be re-approved annually if appropriate. Nothing herein shall be deemed to restrict the discretion of the Medical Executive Committee to impose corrective action.

Failure to satisfy meeting attendance requirements for one (1) year shall, at a minimum, double the amount of dues required from the Member for the next Medical

Staff year. If the Member fails to satisfy attendance requirements a second time within three (3) years of the first violation, the Member's dues shall be tripled. If he fails to satisfy subsequent requirements a third time within the following three (3) years the Member's dues shall quadruple. Each subsequent violation within a three (3) year period of the most recent violation shall result in a similar increase in the amount charged following such violation.

12.7.2 Members at Poway Campus

~~12.7.2~~No such Committee Chairperson or Department Chairperson shall mandate attendance at more than fifty percent (50%) of all meetings of a committee or Department. Failure to attend mandatory meetings, or to receive an excused absence from the Campus Committee, Campus Department Chairperson or the ~~Medical~~Campus Executive Committee shall result in the Member being assessed a fine of $250.00 per unexcused absence. Any information deemed important by the Committee Chairperson or Department Chairperson which is disseminated at any meeting, shall be distributed to Members not in attendance at such meeting.

12.7.3 Mandatory Attendance of Certain Members

~~12.7.3~~A Member, whose patient's clinical course is scheduled for discussion at a regular Department meeting, shall be so notified and shall be expected to attend such meeting. If such Member is not otherwise required to attend the regularly scheduled Campus Department meeting, the Campus Chief of Staff shall give the Member advance written notice of the time and place of the meeting at which his/her attendance is expected. Whenever apparent or suspected deviation from standard clinical practice is involved, the notice to the Member shall so state, shall be given by certified, return receipt requested mail, and shall include a statement that his/her attendance at the meeting at which the alleged deviation is to be discussed is mandatory. Failure by a Member to attend such meeting may result in limited suspension of clinical privileges by the Campus Chief of Staff.

12.8. ~~12.8~~**Conduct of Meetings**

Unless otherwise specified, meetings shall be conducted according to Robert's Rules of Order or Sturgis Standard Code of Parliamentary Procedure. Technical or non-substantive departures from such rules shall not invalidate action taken at such a meeting.

12.9. ~~12.9~~**Executive Session**

Executive session is a meeting of a Medical Staff committee, department, or of the Medical Staff as a whole which only voting Medical Staff members may attend, unless others are expressly requested to attend by the Chair. Executive session may be called by the presiding member at the request of any Medical Staff committee member and the session shall be called by the Chair pursuant to a duly adopted motion. Executive session may be called to discuss peer review issues, personnel issues, or any other sensitive issues requiring confidentiality.

ARTICLE XIII: MEDICAL STAFF YEAR

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

ARTICLE XIV: DUES AND FINES

~~8.1~~14.1 Annual dues shall be assessed to Members in an amount to be determined by the ~~respective~~ Medical Executive Committee, considering any recommendation from a Campus

Executive Committee, and approved at the annual meeting. Such dues shall be due and payable no later than May 1 of each year. Any Member not paying dues on or before the above date shall receive by certified, return receipt requested mail, a notice of delinquency advising the Member of his/her obligation to pay dues. Any Member who does not pay the delinquent dues shall have his/her clinical privileges suspended, and shall remain so suspended until the member pays the delinquent dues or until the parameters of Section 4.5 of the Medical Staff Rights Manual are met.

~~**86.2**~~14.2 Fines for failure to comply with the requirements, as specified in 12.7.1 shall be considered delinquent if not paid within three (3) months of the date of the notice, to the Member, imposing the fine. Delinquent payments shall result in automatic suspension of the member's clinical privileges.

~~**86.3**~~14.3 Failure to pay either delinquent dues pursuant to this Article or delinquent fines pursuant to this Article, for three (3) months after the suspension becomes effective shall be deemed a voluntary resignation as specified in the Medical Staff Rights Manual.

~~**86.4**~~14.4 The Medical Staff dues shall be utilized for the purposes of the Medical Staff as deemed appropriate by the Medical Executive Committee. If the Medical Staff desires, a budget shall be submitted at the Annual Medical Staff Meeting, and may include stipends for officers of the Medical Staff including Chairpersons of departments or other committee Chairpersons as from time to time may be established.

~~**86.5**~~14.5 A Member may petition for a waiver of dues by submitting reasons to the ~~Chief of Staff~~Medical Executive Committee, who, with the concurrence of the ~~Medical Executive Committee~~appropriate Campus Chief of Staff, may waive payment.

~~**86.6**~~14.6 Hospital-Provided Funds Deposited to the Medical Staff Fund
Any funds authorized by Palomar Health to the Medical Staff shall be deposited into the Medical Staff account. The Medical Staff shall have the financial ability to solely administer the funds. Any funds authorized by Palomar Health to the Medical Staff shall be under the sole discretion of the Medical Staff.

14.7 Allocation and Maintenance of Medical Staff Funds

All dues and other funds for use of the Medical Staff, including any funds of the separate medical staffs of Palomar Medical Center Escondido and Palomar Medical Center Poway prior to the Effective Date, shall be segregated and subject to the control and direction of the Campus Executive Committee for the campus from which the funds came or are collected, subject to oversight of the Medical Executive Committee.

ARTICLE XV: ADOPTION/AMENDMENTS OF BYLAWS

15.1. ~~**15.1**~~**Bylaws**

Adoption ~~or~~of amendments to or repeal and complete replacement of the Bylaws of this Medical Staff may be made at either a regular or special meeting, ~~electronic ballot~~ or by mail ballot. A two-thirds (2/3) majority of returned votes, which must represent a quorum of ~~voting~~all active Members eligible to vote shall be required for the change. ~~Proposed changes shall be distributed to each voting Member at least thirty (30) days before a vote. Members of the active Medical Staff shall be offered the opportunity to include in the distribution a pro or con statement.~~ Changes shall become effective when approved by the ~~Board of Directors. Approval of changes to the Medical Staff Bylaws cannot be unreasonably withheld by the~~ Palomar Health Board of Directors, which approval shall not be unreasonably withheld.

~~Changes are usually recommended by the Bylaws Committee via the Medical Executive Committee.~~

~~Proposed changes may also be submitted in writing by the Members of the Medical Staff, provided they have the endorsing signature of three (3) voting Members. Such proposed amendments shall be referred to the Bylaws Committee and the Medical Executive Committee for their recommendation. Endorsing signatures of 10% of voting Members is required for an amendment to be automatically sent out by vote. If approved, the matter shall be sent directly to the Board. A copy of any proposed amendment that affect the Medical Staffs of both Palomar Medical Center Escondido and Palomar Medical Center Poway will be exchanged between the Chiefs of Staff, thirty (30) days prior to the amendment being distributed to the Members of a particular Medical Staff~~

~~8.5.1~~15.1.1 ~~Change~~ Procedure for Amendments to the Bylaws

Upon request of (1) the Medical Executive Committee~~,~~ or ~~the~~a Campus Chief of Staff ~~or~~with the ~~bylaws committee after~~ approval ~~by~~of the Medical Executive Committee, or (2) upon timely written petition signed by at least ~~10~~20% of the members of the Medical Staff entitled to vote, consideration shall be given to the ~~adoption,~~ amendment~~, or repeal~~ of these bylaws. ~~Such action~~Repeal and replacement of these Bylaws shall be recommended only by the Medical Executive Committee in consultation with the Campus Executive Committees. Such actions shall be taken at a regular or special meeting of the Medical Staff, provided (1) written notice of the proposed change was sent to all ~~members on or before the last~~ Members at least thirty (30) days prior to the regular or special meeting ~~of the Medical Staff~~, and (2) such ~~changes were offered at such prior meeting and (2)~~ notice ~~of the next regular or special meeting at which action is to be taken included notice that a bylaw change would be considered. Both notices shall include~~includes the exact wording of the existing bylaw language, if any, and the proposed change(s). Notwithstanding the foregoing, repeal and replacement of these Bylaws require written notice of such proposed change no less than forty-five (45) days prior to the regular or special meeting and distribution of the new proposed bylaws to replace these Bylaws.

15.2. ~~15.2~~**Rules and Regulations**

~~8.5.1 A new rule, regulation, or amendment shall be made in the same manner~~Except as ~~the Bylaw amendments. Proposals may also be submitted in writing by any responsible committee, department, or the Members~~otherwise provided in this subsection, a new rule or regulation of the Medical Staff, ~~(provided they have the endorsing signature of three (3) voting Members). A simple majority of voting members shall be required for adoption.~~

~~15.2.2~~15.2.1 ~~A~~a new rule~~,~~ or regulation~~, or amendment to the~~ of a Medical Staff or ~~Departmental Rules~~ Campus committee or department, and ~~Regulations~~any amendment thereof shall be ~~distributed to all voting Members~~adopted if a simple majority of the Medical Staff, committee, or ~~Department thirty (30) days prior to the vote at a scheduled Medical Staff~~department, respectively, approves. Proposals to change a committee or ~~Department meeting. Adoption shall require a simple majority of voting members. Adoption becomes effective after recommendation by the Medical Executive Committee and approval by the Board of Directors~~department rule or regulation may be submitted in writing by any chair of such committee or department.

15.2.2 Changes to committee and department rules or regulations shall become effective upon final approval by the appropriate Campus Executive Committee and the Medical Executive Committee. Changes to Medical Staff-wide rules and regulations after approval of the Campus Executive Committee and Medical Executive Committee shall become effective upon final approval by the Palomar Medical Center Board of Directors, which approval shall not be unreasonably withheld.

15.3. ~~15.3~~**Mandated Amendments**

In the event any amendment to the ~~Rules and Regulations~~Bylaws, rules, or regulations is required based on any provision of state or federal statute or regulation, such amendment may be provisionally adopted by the Medical Executive Committee and presented to the Board of Directors. The Medical Staff has the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the Medical Staff and the Medical Executive Committee, the provisional amendment stands. If there is a conflict over the provisional amendment, the process resolving the conflict between the Medical Staff and the Medical Executive Committee is implemented. If necessary, a revised amendment is then submitted to the Board for action. Notwithstanding any other provision of this article, such amendment shall become effective upon approval by the Board, and shall be distributed to Members as soon as reasonably possible.

15.4. ~~15.4~~**Effect of the Bylaws**

These ~~bylaws~~Bylaws may not be unilaterally amended or repealed by the medical staff or board of directors.

No medical staff governing document and no hospital corporate bylaws or other hospital governing document shall include any provision purporting to allow unilateral amendment of the medical staff bylaws or other medical staff governing document. Hospital corporate bylaws, policy, rules, or other hospital requirements that conflict with medical staff bylaw provisions, rules, regulations and/or policies and procedures, shall not be given effect and shall not be applied to the medical staff or its individual members.

15.5. ~~15.5~~**Successor in Interest**

These bylaws, and privileges of individual members of the medical staff accorded under these bylaws, will be binding upon the medical staff, and the board of directors of any successor in interest in this hospital, except where hospital medical staffs are being combined. ~~In the event that the staffs are being combined, the medical staffs shall work together to develop new bylaws which will govern the combined medical staffs, subject to the approval of the hospital's board. Until such time as the new bylaws are approved, the existing bylaws of each institution will remain in effect.~~

ARTICLE XVI: CONTRACT PHYSICIANS

~~16.1.1~~16.1 All contract physicians shall have Medical Staff membership and shall undergo the same individual evaluation and appointment and reappointment process as the other Members. Upon termination of a contract, membership shall continue unaltered, unless otherwise provided for in the contract. If termination is for a medical disciplinary cause or reason, the Medical Staff Rights Manual may apply.

~~16.1.2~~16.2 The Board of Directors with input from the Medical Staff shall make an annual determination with respect to the quality and availability of contract physician services to the patients at the Hospital in such areas as emergency medicine, anesthesiology, pathology, radiology, hospitalists, and any other physician services for which the Hospital may choose to contract. Evaluation shall include use of a Medical Staff questionnaire approved by the Medical Executive Committee, criteria for which will be developed and revised as needed, for the Departments of Emergency Medicine, Anesthesiology, Pathology, Hospitalists, and Radiology.

The Medical Executive Committee, with input from the appropriate Campus Executive Committee(s), will prepare a recommendation regarding contract renewal annually based on the questionnaire evaluation and review of quality improvement functions of the services and departments. The recommendation of the Medical Staff will be presented to the Board of Directors who has the responsibility and duty to make the final decision and arrangement with

respect to contract services.

~~16.1.3~~16.3 Medical Staff Role in Exclusive Contracting

The Medical Staff shall review and make recommendations to the board regarding quality of care issues related to exclusive arrangements for physician and/or professional services, and as soon as an issue arises, prior to any decision being made by the board, in the following situations:

~~yyyyyy)~~a) The decision to execute an exclusive contract;

~~zzzzzz)~~b) The decision to renew or modify an exclusive contract; or

~~aaaaaaa)~~c) The decision to terminate an exclusive contract.

~~16.1.4~~16.4 The Medical Staff shall review and make recommendations to the Board of Directors regarding the selection, performance evaluation, and any change in retention or replacement of physicians with whom the hospital has a contract. Prior to any decision being made, the Board of Directors shall be required to review and approve the recommendations of the Medical Staff regarding these contracts, which approval shall not be unreasonably withheld.

ARTICLE XVII: INDEPENDENT LEGAL COUNSEL

The Medical Staff has the right to retain and be represented by independent legal counsel at any time at the expense of the Medical Staff. Such independent legal counsel shall be retained under terms and circumstances authorized by the Medical Executive Committee, including assignment to represent only one Campus.

ARTICLE XVIII: SYSTEMWIDE AFFILIATION AND COOPERATION

This hospital is part of a system. Palomar Health (the System) strives to maintain professional standards among its patient care facilities and to provide efficient patient care and support services. In keeping with the foregoing, cooperative credentialing, peer review, corrective action, and procedural rights are hereby authorized in accordance with the guidelines set forth in these Bylaws.

18.1. ~~18.1~~**Credentialing**

The Medical Staff may develop in conjunction with other facilities or entities in the System, a cooperative appointment and reappointment process that includes, but is not limited to, a single application form, cooperative investigation of background information, sharing of information about the applicant, and cooperative processing of the applications. Any such process should be developed cooperatively among the participating facilities and entities in the System, and shall be subject to approval by each Hospital's Medical Executive Committee and the Board of Directors prior to implementation.

18.2. ~~18.2~~**Peer Review**

The Medical ~~Staffs~~Staff may assist ~~each~~ other facilities or entities in the System in peer review activities. This may include, without limitation, relying on information in other System facilities' credentials and peer review files, and utilizing the other System facilities' medical or professional staff resources to conduct or assist in conducting peer review activities.

18.3. ~~18.3~~**Corrective Action**

~~8.5.1~~18.3.1 Notice of Investigations/Joint Investigations

~~bbbbbbb)~~a) The Campus Chief of Staff may notify the Chief of Staff or other leader in a similar position of any other System ~~facility~~facilities whenever a request for investigation has been received.

~~ccccccc)~~b) The Medical Executive Committee or appropriate Campus Executive

Committee may authorize a coordinated investigation and may appoint other Medical Staff members of other System facilities to assist in the coordinated investigation.

dddddddc) TheThe Medical Executive Committee or relevant Campus Chief of Staff is authorized to disclose to the peer review body (or an authorized representative of that body) of another System facility information from Hospital and Medical Staff records to assist in the other System facility's independent or joint investigation of any Member (as that term is defined in Section 2.1 of the Medical Staff Rights Manual).

eeeeeeed) The results of any joint investigation shall be reported to the Medical Executive Committee and appropriate Campus Executive Committee of each System facility that participated in the joint investigation for its independent determination of what, if any, corrective action should be taken.

8.5.218.3.2 Notice of Actions

fffffffa) TheThe Medical Executive Committee or appropriate Campus Chief of Staff (or the Chief Administrative Officer at the request of the Campus Chief of Staff) shall inform the Chief of Staff or equivalent leader at any other System facility where the practitioner is known to hold privileges whenever any of the following actions have been taken:

(1) Summary suspension or restriction of clinical privileges for a medical disciplinary cause or reason. The action or basis for such action shall be promptly reported after the imposition of the summary suspension or restriction.

(2) Any corrective action set forth in Section 5.1 of the Medical Staff Rights Manualmanual. The action and basis for such action shall be promptly reported after such action or recommendation is taken.

gggggggb)The effect of such action on the Member's privileges at another System facility shall be determined by the Medical Staff Bylaws of that other System facility.

hhhhhhhc) TheThe Medical Executive Committee or appropriate Campus Chief of Staff is authorized to disclose to another System facility's peer review body information from the Hospital and Medical Staff records regarding the Member and/or the action taken.

8.5.318.3.3 Effect of Actions Taken by Other System Facilities

Whenever the appropriate Campus Chief of Staff or Medical Executive Committee receives information about an action taken at another System facility and involving a Member holding privileges at the hospital, thethat Campus Chief of Staff, or Medical Executive Committee shall, if time permits, independently assess the facts and circumstances to ascertain whether to take comparable action. However, when the Member was summarily suspended or restricted at another System facility, the appropriate Campus Chief of Staff, Campus Chief of Staff- Elect (or the Chief Administrative Officer (if neither the Campus Chief or Chief-Elect is available) is authorized to immediately impose a comparable suspension or restriction at this hospital, subject to review by the Medical Executive Committee or appropriate Campus Executive Committee in accordance with the provisions of the Medical Staff Rights Manual. The facility may share the information regarding the nature of the summary suspension or restriction with other System facilities at such time that the other System facility initiates its own investigation.

18.4. **~~18.4~~Joint Hearings~~.~~**

A joint Hearing may be conducted if the Executive Committees of more than one System facility give notice of substantially similar actions or recommendations to the Member. The Medical Executive Committees, the Chiefs of Staff and the Chief Executive Officers will coordinate their efforts to assure the joint Hearing is conducted pursuant to the provisions of the Medical Staff Rights Manual. With regard to the composition of the joint Hearing Panel, each Chief of Staff shall appoint two members. The Chiefs of Staff shall jointly select an additional member who shall serve as the Chairperson of the Hearing Panel.

The decision of the joint Hearing Panel shall be delivered in accordance with Section 5.21 of the Medical Staff Rights Manual provided~~. However~~, however, each Medical Executive Committee shall be furnished with a copy of the recommendations and report.

Notwithstanding the foregoing, if a Member can demonstrate to the Medical Executive Committee (in the case of a Hearing based on the recommendation of the Medical Executive Committee) or the Board of Directors (in the case of a Hearing based on the recommendation of the Board of Directors), prior to the initiation of a joint Hearing, that the benefits of quasi-judicial economy and efficiency are outweighed by particular burdens or unfairness unique to the Member's particular circumstances, the Medical Executive Committee or the Board of Directors may, in its sole discretion, order that a separate Hearing be conducted solely with respect to privileges at this Hospital, in accordance with this Medical Staff Rights Manual. Examples of such unique burdens or unfairness would include but not be limited to unavailability of witnesses or documents at the joint Hearing. The mere fact that the outcome would affect privileges at more than one Hospital would not ordinarily be deemed sufficient to preclude a joint Hearing.~~.~~

ARTICLE XIX: HISTORY AND PHYSICAL POLICY

It is the responsibility of the Member to assure that a medical history and appropriate physical examination (H&P) is performed on patients being admitted for inpatient care as well as prior to operative and complex invasive procedures and OB admissions for vaginal deliveries in either an inpatient or outpatient setting.~~.~~

Patients requiring an H&P will receive a full H&P,~~ a~~ focused H&P, or an update note as set forth in these rules and regulations. The minimum required content of each H&P is noted below:

~~iiiiii)~~a) Full H&P

A full H&P is defined as a documentation that contains the following data elements and may be fulfilled by a consultation ~~if~~of it includes all the elements:

~~1)~~(1) A chief complaint

~~2)~~(2) History of present illness

~~3)~~(3) Allergies

~~4)~~(4) Current Medications

~~5)~~(5) Past medical and surgical history

~~6)~~(6) Relevant past psycho-social and family history (appropriate to the patient's age)

~~7)~~(7) Pertinent ~~Review~~review of ~~Systems~~systems

~~8)~~(8) A full physical examination~~.~~

~~9)~~(9) A statement on the conclusions or impressions drawn from the history and physical examination~~.~~

~~10)~~(10) A statement on the course of action planned for the patient for that episode of care~~.~~

~~11)~~(11) Signature with date /time

(12) Code status

~~jjjjjjj)~~**b) Focused H&P**

A focused H&P is defined as an H&P that contains the following data elements:

~~1)~~(1) Chief complaint

~~2)~~(2) History of present illness

~~3)~~(3) Allergies

~~4)~~(4) Current Medications

~~5)~~(5) Relevant past medical and surgical history pertinent to the operative or invasive procedure being performed.

~~6)~~(6) Relevant past psycho-social history pertinent to the operative or invasive procedure being performed.

~~7)~~(7) Focused review of systems.

~~8)~~(8) A focused physical examination of those body systems pertinent to the operative or invasive procedure performed including an appropriate assessment of the ~~patient's~~patients cardio-respiratory status

~~9)~~(9) A statement on the conclusions or impressions drawn from the history and physical examination~~.~~

~~10)~~(10) A statement on the course of action planned for the patient for that episode of care~~.~~

~~11)~~(11) Signature with date/time

(12) Code status

~~kkkkkkk)~~**c) Update Note**

An update note is defined as a statement entered into the patient's medical record that the H&P was reviewed and that~~:~~;

~~1)~~(1) There are no significant changes to the findings contained in the H&P since the time it was performed, or

~~2)~~(2) There are significant changes and such changes are subsequently documented in the patient's medical record.

The update note must be performed by the individual performing the procedure.

The requirement as to which type of H&P must be performed, and associated time frames are noted in the following table:

PATIENT TYPE	H&P REQUIREMENTS
Inpatient Admission~~-~~	A full H&P is required. The H&P must be completed no more than 30 days prior to admission or within 24 hours after admission. If the H&P is performed within 30 days prior to admission, an update note must be entered into the record within 24 hours after admission.

Inpatient Surgical Procedure	A full H&P is required. If the surgery is performed more than 24 hours after admission, then the admission H&P is considered the surgical procedure H&P as well. No update is needed since the physician progress notes constitute an "updating" of the patient's condition. If surgery is to be performed within the first 24 hours of admission, but an admission H&P has not been done, then an H&P must be completed on the day of surgery prior to the start of the procedure. In an emergent situation, the H&P should be completed as soon as possible after surgery. If surgery is to be performed within the first 24 hours of admission, and an H&P was performed prior to admission, then an update note must be entered into the record on the day of surgery prior to the start of the procedure. In an emergent situation, the update note should be completed as soon as possible after surgery.
Outpatient Surgical Procedure	A full or focused H&P is required. The H&P must be completed no more than 30 days prior to surgery or on the day of surgery prior to the start of the procedure. If the H&P was performed within 30 days prior to surgery, an update note must be entered into the record on the day of surgery prior to the start of the procedure.
Outpatient Complex Invasive Procedure	A full or focused H&P is required. The H&P must be completed no more than 30 days prior to admission or within 24 hours after admission. If the H&P is performed within 30 days prior to admission, an update note must be entered into the record within 24 hours after admission prior to the start of the procedure.

19.1. ~~19.1~~**Oral and Maxillofacial Surgeons**~~-~~

Oral and Maxillofacial Surgeons may perform an H&P if they possess the clinical privileges to do so in order to assess the medical, surgical, and/or anesthetic risks of the proposed operative and/or other procedure.

19.2. ~~**19.2**~~**Dentists and Podiatrists**

Doctors of dentistry or podiatry are responsible for that part of the patient's history and physical examination that relate, respectively, to dentistry and podiatry whether or not they are granted clinical privileges to take a complete history and perform a complete examination. Doctors of dentistry or podiatry may perform a complete H&P if they possess the clinical privileges to do so. If the Dentist or Podiatrist does not possess such privileges, then a qualified Physician must perform the H&P.

19.3. ~~**19.3Allied Health Professionals**~~ **Licensed Dependent Practitioners**

If an Allied Health Professional (e.g. physician assistant, nurse practitioner, etc.) is granted privileges to perform part or all of an H&P, the findings and conclusions are co-signed by the supervising Physician the same day.

RULES AND REGULATIONS

1. Admission of Patients

1.1. The Hospital shall admit patients for care and treatment except for those patients with critical burns.

1.2. Only Members, as per these bylaws, may admit a patient to the Hospital. No patient shall be admitted to the Hospital without a provisional diagnosis. In the case of an emergency, the provisional diagnosis shall be recorded as soon as possible.

1.3. A Member, designated as the attending physician, shall be responsible for the medical care, the accuracy of medical records, necessary special instruction, and transmitting reports of the condition of the patient to relatives of the patient. Whenever consultations are requested or required, physician-to-physician contact is required. In accepting the consultation, the physician agrees that he/she will see the patient within 24 hours or as requested by the attending physician. A short-~~consultation~~ progress note containing the impression and plan shall be entered into the electronic health record at the time of consultation followed by a full consult note dictation, unless the full consult note is entered into the record at the time of the consult. Referral or transfer of patient responsibility to another attending physician or surgeon shall be with the consent of the referral physician and the accepting physician. This may be either temporary for a specific procedure, a period of time, or for the remainder of the hospitalization. Orders on the chart must clearly reflect this transfer of responsibility. For trauma patients, the Trauma Surgeon or Trauma Neurosurgeon will remain the attending physician until the patient is transferred out of the ICU with specific written orders transferring care to an accepting physician as appropriate. The consultant shall be responsible for transmitting reports of the condition of the patient to the referring physician and/or family as may be appropriate. It is the responsibility of all caregivers involved in a patient's care to communicate regarding treatment and services.

1.4. In any emergency in which it appears the patient will have to be admitted to the hospital, the member shall first contact the admitting department or bed control coordinator to ascertain whether there is an available bed.

1.5. Any patient without an assigned physician shall be provided with a physician from the E.D. on-call roster

1.6. Each member must assure timely (no more than thirty-minute response time) adequate professional care of his/her patients in the hospital by being available, or having available through his/her office, an eligible alternative Member with whom prior arrangements have been made and who has at least equivalent clinical privileges at the Hospital. Failure of an attending Member, to fulfill these requirements may result in loss of clinical privileges.

1.7. The admitting Member shall be held responsible for giving such information as may be necessary to assure the protection of the patient from self-harm and to assure the protection of others whenever his/her patient might be a source of danger from any cause whatever.

1.7.1. Any patient known or suspected to be suicidal shall have consultation with a Member who specializes in psychiatry.

1.8. Pathology specimens will not be processed or interpreted, or radiological examinations/procedures performed unless they are accompanied by the appropriate clinical information.

1.9. Time requirements for physicians seeing an admitted patient will be designated in the policy: *Medical Staff Time Requirements for Seeing a Patient after Admission*.

2. Consultation Policies

2.1. Any individual with clinical privileges at this Hospital may be requested to provide consultation within his or her area of expertise. Consultations should be dictated and include all information appropriate to the consultation.

2.2 If a nurse employed by the Hospital has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, that nurse shall notify the nursing supervisor who, in turn, may refer the matter to the nursing director. The nursing director may discuss the matter with the attending physician, or may bring the matter to the attention of the department chairperson in which the member in question has clinical privileges. Thereafter, the-

~~2.2.~~ Department Chair may request a consultation after discussion with the attending Medical Staff Member. In the absence of the Chairperson, the appropriate Campus Chief of Staff shall be notified.

~~2.3.~~2.3 In circumstances of grave urgency, or where consultation is required by these Rules and Regulations or imposed by the Medical Executive Committee, the Board, or the appropriate Campus Chief of Staff, the appropriate Department Chair shall at all times have the right to call in a consultant or consultants.

~~2.4.~~2.4 Required consultations:

~~2.4.1.~~2.4.1 Consultations shall be required in all non-emergency cases whenever requested by the patient or the patient's representative if the patient is incompetent.

~~2.4.2.~~2.4.2 Consultations are also required in all cases which in the judgment of the attending Medical Staff Member fulfill the below criteria:

~~lllllll)~~a) The diagnosis is obscure after ordinary diagnostic procedures have been completed;

~~mmmmmmm)~~b) There is doubt as to the best therapeutic measures to be used;

~~nnnnnn)~~c) Unusually complicated situations are present that may require specific skills of other practitioners, or

~~ooooooo)~~d) The patient exhibits severe symptoms of mental illness or psychosis.

~~2.5.~~2.5 Psychiatric consultation and treatment shall be requested for, and offered to all patients who have engaged in self-destructive behavior (e.g. attempted suicide, chemical overdose). If psychiatric care is recommended, evidence that such care has at least been offered and/or appropriate referral made must be documented in the patient's medical record.

~~2.6.~~2.6 Whenever a consultation (medical or surgical) is requested prior to surgery, the anesthesiologist shall ascertain that an adequate notation of the consultation, including relevant findings and reasons, appears in the patient's medical record. If it does not so appear, surgery and anesthesia shall not proceed.

~~2.7.~~2.7 Each consultation report shall be completed in a timely manner and shall contain a written opinion and recommendations by the consultant that reflect, when appropriate, an actual examination of the patient and the patient's medical record.-

~~2.8.~~2.8 Where non-emergency operative procedures are involved, the consultant's report must be recorded in the patient's medical record prior to the surgical procedure. The consultation report shall contain the date and time of the consultation, an opinion based on the relevant findings and reasons, and the signature of the consultant.

~~2.9.~~2.9 The consultation policy for the ICU and IMC units is defined in *Consultations to ICU Patients, Medical Staff* (Lucidoc ID 10362).

3. Discharge of Patients

~~3.1.~~3.1 The patient shall be discharged only on a written order of the Member, or their designee or by verbal order if dictated to a registered nurse and signed by the Member at the earliest opportunity. It is the responsibility of the Member to assure that a history and physical is entered into the record.

~~3.2.~~3.2 The physician of record or their alternate must prepare a discharge summary. This summary shall include admission diagnosis, discharge diagnosis, as well as pertinent history, physical findings, laboratory abnormalities, a brief description of the patient's course, major diagnosis or diagnoses

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relevant to the admission, procedures performed, condition on discharge, and instructions given to the patient or his/her family regarding diet, activity, medications, code status, and follow up date.

~~3.3.~~3.3 All deaths require a full discharge summary.

~~3.4.~~3.4 The Discharge Summary must be completed within 24 hours prior to or at the time of transfer to a skilled nursing facility or other acute care facility.

4. Medical Records and Protected Health Information

~~4.1.~~4.1 All medical records shall be completed within fourteen (14) days after discharge as stated in the Medical Staff Rights Manual.

4.2 All records are the property of the Hospital. X-rays and charts, or copies thereof shall be released from the Hospital only as provided by law. In cases of readmission of the patient, all previous records shall be-

~~4.2.~~ made available to the attending physician. Unauthorized removal of medical records from the Hospital is grounds for suspension.

~~4.3.~~4.3 Pertinent progress notes shall be recorded at the time of observation sufficient to permit continuity of care and transferability. Where possible, each of the patient's clinical problems should be clearly identified in the progress notes, and correlated with specific orders as well as the results of tests and treatment. Patients shall be seen and progress notes shall be written at least daily, with the exception of the skilled nursing patients. In lieu of daily physician visits, daily visits may be made and progress notes written, by an approved Allied Health Professional (nurse practitioner or physician's assistant) with appropriate privileges, subject to any specific requirements set forth in the applicable department's rules and regulations. The department requirements should be based upon any applicable state or federal regulations. The progress note done by the Allied Health Professional must be co-signed by the supervising ~~physician~~physicians the same day.

~~4.3.1.~~4.3.1 Patients shall be seen and progress notes written in accordance with the level of care and policies of the extended care unit.

~~4.3.2.~~4.3.2 Other than members, only the individuals referenced in *Medical Record - Entries, Content and Completeness* (Lucidoc ID 15287) may initiate entries in the physician progress notes.

~~4.4.~~4.4 All orders and progress notes shall be dated and timed in writing. Orders and progress notes from Allied Health Professionals have to be countersigned by the responsible attending Physician the same day in accordance with the Allied Health Professional admission and co-signature requirements (see Appendix A~~).~~.) Relevant verbal orders can be accepted by a licensed nurse, registered pharmacist, registered physical, occupational, or speech therapist, registered dietician or any qualified respiratory therapy personnel, or other specialist allowed by law if such specialist has been approved for the same by the Medical Executive Committee or the appropriate Campus Executive Committee and the Board of Directors. All verbal orders shall be signed by the person to whom dictated with the name of the Physician and his/her own name.

~~4.5.~~4.5 The Member shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current. The record shall include identification data, complaints, history and physical examination, special reports and other consultations, clinical history and radiology reports, provisional diagnoses, medical or surgical treatment, operative reports, pathological findings, progress notes, final diagnosis, condition on discharge, summary for discharge note, clinical resume and autopsy report when performed.

~~4.5.1.~~4.5.1 A complete history and physical examination shall be dictated within 24 hours of admission and signed within fourteen (14) days following discharge. The report shall reflect a comprehensive current physical assessment by a Medical Staff Member or appropriate Allied Health Professional who has been approved to perform histories and physicals.~~-~~

~~4.6.~~4.6 If a complete history has been recorded and a physical examination performed prior to the patient's admission to the Hospital, either a dictated copy through the hospital or a reasonable durable, legible copy of these reports may be used in the patient's hospital medical record in lieu of the admission history and physical examination, described in Section 1.4 of these Rules and Regulations. To be acceptable, outside records should be in a form approved by the Medical Executive Committee or the appropriate Campus Executive Committee and should be compatible with current hospital medical records system as determined by the Medical Executive Committee~~.~~ or the appropriate Campus Executive Committee. The history and physical examination cannot be performed more than thirty (30) days prior for the same medical condition. An interval admission note that includes all additions to the history and subsequent changes in physical findings must always be recorded within twenty-four hours of admission. Prenatal records shall be accepted for thirty (30) days before the expected date of confinement. An interval admission note is required.~~-~~

~~4.7.~~4.7 Record of an adequate history and physical examination must be part of the patient's chart before they may be transferred to the operating room and the performance of surgery. When the history and

physical examination are not recorded before a surgical procedure or any potentially hazardous diagnostic procedure, the procedure shall be cancelled unless the attending practitioner states in writing that an emergency situation exists, or that such delay would be detrimental to the patient. However, in these rare instances, a late chart note will be placed in the chart and the history and physical examination shall be recorded within twenty-four (24) hours of admission. A brief note must be entered to indicate the nature of the problem.

~~4.8.~~4.8 Operative reports shall include a detailed account of the findings at surgery, as well as the details of the surgical technique. Operative reports shall be performed immediately upon completion of the operative or other high risk procedure for outpatients, as well as for inpatients. An operative report (brief) with all the required elements as outlined in the electronic health record (EHR) template must be entered directly into the electronic medical record within 30 minutes after the patient reaches the Recovery Room when the full operative report is dictated via transcription. If the full operative report is generated electronically and immediately available, no brief operative report is required.

~~4.9.~~4.9 Symbols and abbreviations may be used only when they have been approved by the Medical Staff. There shall be available in Medical Staff Services, an explanatory legend of those symbols and abbreviations used. Unapproved abbreviations as determined by the Medical staff and by outside agencies such as the Joint Commission shall not be used in the Medical Record.

4.10 For purposes of complying with the Health Insurance Portability and Accountability Act Standards for Individually Identifiable Health Information, 45 C.F.R. Parts 160 and 164 ("Privacy Standards) and Hospital Policies and Procedures relating to compliance with the Privacy Standards, such medical records shall be part of the "Designated Record Set."

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~~4.10.~~ The Medical Staff and Hospital jointly treat patients in a clinically integrated setting and need to share information relating to their common patient's medical, mental, physical, and/or general health condition. Protected health information (as defined below) must be shared between the Hospital and its Medical Staff for purposes of treatment, payment, and the health care operations of the Hospital. Health care operations of the Hospital which require Medical Staff participation, and thus access to patient identifiable health information, include but are not limited to mortality and morbidity board review, other peer review, training of medical students, medical departmental operations, such as developing clinical guidelines, and other activities consistent with the definition of "Health Care Operations" at 45 C.F.R. Section 164.501 and the Hospital's Policies and Procedures.

~~4.11.~~4.11 Medical Staff obligations with respect to confidentiality of patient Protected Health Information include the following:

4.11.1 Generally: Medical Staff shall to the best of their ability and consistent with professional standards, respect and maintain the confidentiality of all "Protected Health Information" (which includes any electronic or paper-based Protected Health Information) (as defined below) with respect to all Hospital patients and to comply with the terms and conditions of the (i) Confidentiality of Medical Information Act of 1981, California Civil Code Section 56 et seq. (General Patient Medical Records); (ii) California Welfare & Institutions Code §5328.6 and

~~4.11.1.~~ §5328.7 (Mental Health Records); and (iii) 42 U.S.C. §§290dd-2; 42 C.F.R.., Part 2, §2.31 (Alcohol and Drug Abuse Records); (iv) Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Regulations promulgated there under (42 U.S.C. Sections 1320d-2 and 1320d-4; 45 C.F.R. Subtitle A, Subchapter C, parts 160-164), as amended from time to time, and all Hospital Policies and Procedures relating to confidentiality and protection of patient information.

~~4.11.2.~~4.11.2 Definition of Protected Health Information: For purposes of these rules and regulations, patient "Protected Health Information" or "PHI" shall include without limitation, all information regarding a patient's (1) Medical treatment and condition; (2) Psychiatric and Mental Health; and (3) Substance abuse and chemical dependency, which a Medical Staff member may receive in the course of treating Hospital patients consulting with other Medical

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Staff or as a participant in Health Care Operations of the Hospital, and which is defined as "identifiable pursuant to the Hospital's applicable policies and procedures.

~~4.12.~~4.12 ~~-~~The duties with respect to confidentiality of Protected Health Information are as follows:

4.12.1 General Duty: Physicians have the duty to keep all information about Hospital patients confidential and to treat such information with the utmost discretion. No Hospital Patient Protected Health Information may be accessed by a Medical Staff member, in any manner,~~-~~

~~4.12.1.~~ including, without limitation; (i) direct medical record access; (ii) access by electronic means; or (iii) access by querying persons involved in a patients care, unless the member is one of the patient's direct healthcare provider and requires such Protected Health Information for purposes of diagnosis or treatment of the patient; requires such Protected Health Information for official peer review purposes or to participate in Hospital Health Care Operations; or is otherwise authorized by the patient or appropriate representative, or permitted to be used or disclosed under applicable federal and state laws and regulations, as amended from time to time, and applicable Hospital policies and procedures.

~~4.12.2.~~4.12.2 Authorized Use or Purpose; Appropriate Setting for Discussions of PHI. Discussions of Protected Health Information may be held only in the course of patient care, peer review, Hospital Health Care Operations and/or for any other use or purpose authorized under applicable federal and state laws and regulations. Necessary discussions that include patient PHI must be held in an appropriate setting, and to the best of each Medical Staff's ability, where it cannot be overheard by others (e.g., elevators and lobbies are inappropriate settings for such discussions.

~~4.12.3.~~4.12.3 Minimum Necessary Requirement. Except with respect to Protected Health Information necessary for treatment of a Hospital patient (including referrals and consults with other Medical Staff), access to, discussion of, release of and/or disclosure of Protected Health Information shall be limited to the extent "minimum necessary" to achieve the purpose. The definition of minimum necessary for certain standard uses and disclosures of protected health information may, to the extent applicable, be defined by Hospital Policies and Procedures

~~4.12.4.~~4.12.4 Electronic PHI. Medical Staff Members are responsible for any Protected Health Information accessed electronically using their password. All electronic access to patient PHI, including remote access into Hospital information systems, shall be conducted pursuant to Hospital Policies and Procedures using an approved electronic device or pathway.~~-~~

~~4.12.5.~~4.12.5 Any violation of these Sections 4.11 and 4.12, or any Hospital Policy and Procedure regarding the protection of Hospital ~~Patients'~~patients' Protected Health Information, shall be considered unprofessional conduct and shall be referred to the appropriate peer review body.

5. Medications

Medical Staff requirements, policies, and procedures related to medication use at Palomar Health are delineated in the policies and procedures of the Department of Pharmacy the pertinent provisions of which are incorporated herein by this reference.

6. Patient Death

~~6.1.~~6.1 In the event of a patient death, the deceased shall be pronounced dead by the attending Member or his/her designee.

~~6.2.~~6.2 The Medical Staff will attempt to secure autopsies in all cases of unusual deaths and of medico-legal and educational interest. Clinical situations in which autopsy shall be requested will be defined by the Medical Staff procedure.

7. Informed Consent

7.1 It is the treating member's responsibility to obtain informed consent for all surgical or other procedures, other than simple, common, or routine procedures, which do not entail significant risks. Examples of such procedures are venipuncture, arterial blood gas puncture, and routine injections of medications.~~-~~

~~7.1.~~ The Member's responsibility to obtain informed consent cannot be delegated to personnel of the Hospital.

~~7.2.~~7.2 In order to give informed consent, the patient is to be informed of:

~~ppppppp)~~a) Name of Procedure-

~~qqqqqqq)~~b) The nature of the treatment.

~~rrrrrrr)~~c) Risks, possible complications and expected benefits or effects from such treatment including potential problems related to recuperation.

~~sssssss)~~d) Alternatives to the procedures and their risks and benefits, including the possible results of non-treatment.

~~ttttttt)~~e) Likelihood of success.

~~uuuuuuu)~~f) The name of the physician or other practitioner who has primary responsibility for the patient's care.

~~vvvvvvv)~~g) The identity and professional status of individuals responsible for authorizing and performing procedures or treatment.

~~wwwwwww)~~h) Any professional relationship to another health care provider or institution that might suggest a conflict of interest.

~~xxxxxxx)~~i) When indicated, any limits on the confidentiality of information learned from or about the patient.

~~yyyyyyy)~~j)Any business relationship between individuals treating the patient or between the organization and any other health care, service, or educational institutions involved in the patient's care, or other potentially conflicting interests, including but not limited to financial or research related matters.

~~zzzzzzz)~~k) In addition, patient should be given an opportunity to ask questions about the information presented by the physician.~~-~~

~~7.3.~~7.3 An informed consent is the verbal exchange of information between physician and patient, and this shall be documented in the physician's progress notes, history and physical, or x-ray report in the medical record and should include all procedures contemplated other than simple, common, or routine procedures described in ~~Section~~section 7.1.

~~7.4.~~7.4 Informed consent shall be obtained prior to any pre-procedure medication, which might render the patient incapable of giving consent.

~~7.5.~~7.5 A procedure for which informed consent is required may not be performed unless the consent has been obtained except in the emergency as described in Section 7.8 below.

~~7.6.~~7.6 When consent cannot be obtained from the patient, consent should be obtained, whenever possible, from a competent "adult." For purpose of this rule, "competency" is defined as the ability to understand the nature and consequences of the medical procedure to which one is asked to consent. For purposes of these rules, an "adult" is:

~~aaaaaaaa)~~a) A person who has reached the age of 18, or

~~bbbbbbbb)~~b) A minor who has entered into a valid marriage (whether or not the marriage was terminated by dissolution), who was on active duty with the armed forces of the United States~~,~~ or who has been declared emancipated pursuant to Civil Code Section 64.

~~7.7.~~7.7 In the event the patient is not a competent adult who is able to give valid informed consent, informed consent must be obtained from an appropriate surrogate decision maker except in an emergency as described in 7.8 below. If the patient is a minor, the surrogate is a court appointed guardian, if one exists, or if none exists, then the parents. If the patient is an incompetent adult the surrogate is:

~~ccccccc)~~a) The attorney in fact appointed pursuant to a durable power of attorney for health care or if none, then;

~~ddddddd)~~b) A court appointed guardian or conservator who has been granted to make medical decisions, or if none, then

~~eeeeeee)~~c) The patient's closest available relative; generally~~,~~ the patient's spouse will be the closest available relative, followed by a child or a parent, and then a brother or a sister. However, individual cases may vary depending upon which of the relatives is in the best position to know and articulate the patient's wishes. If no immediate family member can reasonably be located or contacted, other relatives may act as surrogate. In unusual circumstances, "significant others" or close friends may be acceptable as surrogate decision makers; however, before

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relying on such persons, the Administrator and Chief of Staff (or their respective designees) shall be consulted to determine whether judicial proceedings should be instigated.

7.8 In the event a patient requiring a surgical or other procedure is incompetent to give informed consent by age or physical or mental status, and no surrogate decision maker as described in Section 7.7 is-

~~7.8.~~ reasonably available to consent on the patient's behalf, the treating physician shall make a determination whether an emergency exists. A progress note shall be written documenting:

~~fffffff)~~a) The immediate need for the procedure and why the procedure is necessary.

~~ggggggg)~~b) The nature and circumstances of the emergency, and

~~hhhhhhh)~~c) The unavailability of any surrogate decision maker.

For the purpose of this rule, an emergency is defined as a situation in the hospital, whether or not it occurs in the emergency department, requiring immediate services for alleviation of severe pain. Or immediate diagnosis and treatment of unforeseen medical conditions, which if not immediately diagnosed and treated can reasonably be expected to lead to serious disability or death. In these cases, if it is reasonable to assume that the patient would have consented to the treatment if he/she were capable of doing so, treatment may proceed. If the patient is a minor and the parents are not available to give consent, the same documentation is required by the treating physician.

If the physician has obtained a consultation, the consulting physician should also document his/her findings and opinion in the patient's medical record.-

~~7.9.~~7.9 Consent via Telephone: Informed consent should be obtained by telephone only if the person having legal capacity to consent for the patient is not otherwise available. The physician must, in so far as possible, provide the patient's legal representative with information regarding risks, benefits, alternatives and consequences of refusing treatment, and any potentially conflicting interests the physician may have, such as research or financial interests. Hospital personnel will verify that consent for treatment has been given by the patient's legal representative by being a third party on the phone.

~~7.10.~~7.10 Consent via E-Mail.

~~7.11.~~7.11 Consent via Facsimile.-

~~7.12.~~7.12 In all cases dealing with informed consent, the Member shall refer to the hospital's procedure on who may give consent to medical treatment and the Member shall comply with hospital administrative requirements for documenting consent (see *Consent or Informed Consent for Surgery or Special Procedures*, Lucidoc ID 17201).

8. Authority to Act

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

9. Division of Fees

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

10. Disclosure of Interest

All nominees for election or appointment to office of the Medical Staff, Department Chairpersonships, or the Medical Executive Committee shall, within thirty (30) days prior to the date of election or appointment, disclose, in writing, to the Medical Executive Committee those personal, professional or financial affiliations or relationships of which they are reasonably aware which could foreseeable result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff.

11. Confidentiality

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

~~11.1.~~11.1 The records of the Medical Staff and its committees responsible for the evaluation and improvement of the quality of patient care as rendered in the hospital shall be maintained as confidential.

~~11.2.~~11.2 Access to such records shall be limited to Medical Staff members who are duly appointed officers or serve on committees of the Medical Staff or of the Medical Staffs of other System Facilities for the

sole purpose of discharging Medical Staff responsibilities and subject to the requirement that confidentiality be maintained.

~~11.3.~~11.3 Information which is disclosed to the Board of Directors or its appointed representatives, in order that the Board of Directors may discharge its lawful obligations and responsibilities, shall be maintained by that body as confidential.

~~11.4.~~11.4 Information contained in the credentials file of any Member may be disclosed with the Member's consent to any Medical Staff, Hospital, Professional Licensing Board, or medical school. However~~,~~ any disclosure outside of the Medical Staff, except with the Member's consent, or to the Medical Staffs of other System Facilities as authorized in the Medical Staff Bylaws~~,~~ and Rules and Regulations, shall require the authorization of the appropriate Campus Chief of Staff. If such were to occur~~,~~ then the Member will be alerted prior to the disclosure.

12. Emergency Department Consultation

~~12.1.~~12.1 All active category Members, and all provisional category Members, who have completed their respective department requirements, shall participate on the Emergency Department call panel~~.~~ for the Campus to which they are assigned. When so requested by either the Campus Department Chairperson or the Campus Chief of Staff, a courtesy Member may be required to serve on the Emergency Department call panel.

~~12.2.~~ Participation on a separate trauma services call panel, if present, will be voluntary.

~~12.3.~~12.2 For those Members who volunteer to serve on the trauma service call panel, if present, call schedules may be combined with the Emergency Department call panel. Nothing contained herein shall prevent any Member from receiving compensation for his participation on either a dedicated call schedule or the trauma services call panel.

~~12.4.~~12.3 Notwithstanding 13.1, any Member sixty (60) years of age or older (or any Member who is from age fifty-five (55) to fifty-nine (59), and who has completed twenty (20) years of service on ER Call at Palomar Health), shall upon the Member's request, be excused from participation on the panel.

~~12.5.~~12.4 Unless a shorter period is specified to comply with a Department rule or trauma designation, or other contractual or legal mandate, the Member shall be able to respond by phone to the Emergency Department approximately fifteen (15) minutes from the initial attempt to contact the Member. The member shall only be required to come to the Emergency Department if specifically requested. If so requested, the Member must be present in the Emergency Department within thirty (30) minutes from the time of phone contact.

~~12.6.~~12.5 The Member shall respond and evaluate the patient in the Emergency Department and be responsible for the disposition of the patient (i.e., transfer, inpatient care, discharge). The Member should determine if hospitalization is required for the appropriate care of complaints or medical problems within his/her area of specialty or expertise. If a transfer is necessary but cannot be accomplished within six (6) hours of the time of the request for consultation, the Member shall admit the patient to the appropriate inpatient unit of the hospital.

~~12.7.~~12.6 Patients presenting to the Emergency Department who have an established Practitioner-patient relationship will be referred to that Practitioner or his/her on-call coverage. Any patient who has no prior existing relationship with a Member and who requires follow-up care will be referred to an appropriate facility or to the appropriate primary care or specialty Practitioner who is on call for the Emergency Department when the patient presented. A patient referred for follow-up care shall receive an offer to be seen at least once.

~~12.8.~~12.7 The Emergency Department can assume that a Practitioner-patient relationship does not exist if the patient has been under the care of a specialist whose practice is limited to a specialty and the patient presents with a problem outside the specialty.

~~12.9.~~12.8 If the Practitioner-patient relationship does exist, the Practitioner or his/her on-call coverage is obligated to care for the patient. If a Practitioner-patient relationship does not exist or has been ended, the physician who is on call on the Emergency Department roster is obligated to care for the patient. If a patient, who has been sent a letter of discharge, presents to the Emergency Department

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

~~12.10.~~12.9 When a Practitioner-patient relationship does not exist and a patient is referred for outpatient follow-up, the term "at least once" is interpreted to mean that the Practitioner must offer to see the patient in his/her office one time. In cases when it is necessary to prevent serious harm to the patient, an offer to treat the illness will be required, regardless of the patient's ability to pay or the payment source of the patient.

~~12.11.~~12.10 7:00 a.m. shall be the official time for changing the on-call schedule in the Emergency Department. The Member on-call for the twenty-four (24) hour period starting at 7:00~~-~~ a.m., in the required specialty, shall be responsible for the patient referred from the Emergency Department according to the time the consult is requested.~~-~~

13. Monitoring Procedure

~~13.1.~~13.1 General Policy~~-~~

In accordance with TJC Standards and with the accepted standard of care, all new Medical Staff appointees shall undergo a period of ~~Focused Professional Practice Evaluation~~focused professional practice evaluation (FPPE). Specific monitoring requirements shall be established by each Department and shall be a part of the applicable specialty specific checklist. Monitoring guidelines as set forth in this section refer to monitoring for newly appointed Members and when new procedural privileges have been granted.

~~13.2.~~13.2 Documentation of Monitoring

Monitoring reports will be completed and returned to Medical Staff Services. Monitoring reports are considered confidential and should be routed in sealed envelopes. Such reports should be completed and returned to Medical Staff Services within 2 weeks after monitoring has occurred.

~~13.2.1.~~13.2.1 Responsibility for Reporting

The monitored Member is ultimately responsible for seeing that appropriate monitoring reports are completed and filed on his/her behalf. The monitored Member is responsible for obtaining monitoring. A list of Members who are eligible to carry out retrospective monitoring shall be kept in Medical Staff Services. Participating as a monitor is an obligation of membership on the Medical Staff.

~~13.2.2.~~13.2.2 Access to Reports

Monitoring reports are considered confidential. The physician who was monitored will not have access to these except under certain, legally specific circumstances. In the event additional monitoring is recommended, a separate written communication should be sent to the Member from the Department Chairperson to advise the Member of the questions or problems contained in the monitoring reports. The reason (s) why additional monitoring or other recommendations have been made should also be stated.~~-~~

~~13.3.~~13.3 Qualifications for Monitors

Medical Staff Members, with the exception of consulting, or ~~affiliate~~associate, may serve as monitors provided they have satisfactorily completed monitoring, and provided they have been granted full privileges for the procedure or admission to be monitored. A department may develop more specific qualifications for monitors.

~~13.4.~~13.4 Responsibilities of Monitors

~~13.4.1.~~13.4.1 Concurrent Monitoring

The monitor must be present for the major portion of the surgical procedure. He/she may or may not serve as the assistant surgeon. The monitor has the option of talking to or examining the patient pre and postoperatively (pre and post procedure), but he/she is expected to inform the monitored physician in advance as a courtesy.

~~13.4.2.~~13.4.2 Filing of Monitoring Reports

These reports shall be completed and returned to Medical Staff Services within two (2) weeks of notification of the requirement to perform such monitoring (concurrent and retrospective).

~~13.5.~~13.5 Assignment of Monitors

As a general policy, more than one individual should serve as a monitor for procedural monitoring. For the retrospective/admission monitoring, one Member may serve as the monitor for the basic number of admissions. Monitoring shall be accomplished in accordance with Departmental Rules and Regulations and policies.

~~13.6.~~13.6 Completion of Monitoring

When the required number of monitoring reports have been submitted to Medical Staff Services, the reports will be sent to the appropriate ~~Departments~~Campus Department(s) for review. If the appropriate number of monitoring reports have been submitted, the Campus Department Chair shall determine that monitoring is complete. The Member shall be informed of such recommendation by a letter from the Campus Department Chairperson. Notification of completion of monitoring shall also be sent to the appropriate Nursing Unit Directors.

~~13.6.1.~~13.6.1 All required monitoring must be satisfactorily completed in order for a provisional Member to be considered eligible for advancement to either active or courtesy category. Individual Departments may permit advancement to courtesy category without completion of monitoring but such advancement does not negate the need to complete monitoring.

~~13.6.2.~~13.6.2 As a general rule, Members should not be assigned to serve on the Emergency Department consultant panel until all required monitoring has been satisfactorily completed.

14. Compliance with Policies and Procedures

All Practitioners shall comply with all reasonable Medical Staff policies and procedures, including relevant Palomar Health policies and procedures which have be reviewed and ratified by the Medical Executive Committee.

15. Requirements for Establishing Clinical Privileges for New Procedures

~~15.1.~~15.1 Purpose

To establish a process to determine whether sufficient space, equipment, staffing, and financial resources are in place or available within a specified period of time to support each requested privilege.

To assure that the organization consistently determines the resources needed for each requested privilege.

Requests for clinical privileges to perform a significant procedure or service not currently being performed at a Palomar Health facility (or a significant new technique to perform an existing procedure ("new procedure") will not be processed until:

~~iiiiiii)~~a) A determination has been made that the procedure will be offered by the hospital, and

~~jjjjjjj)~~b) Criteria to be eligible to request those clinical privileges ~~have~~has been established.

~~15.2.~~15.2 Policy

Prior to the establishment of a clinical privilege, the medical staff and the organization will ensure the following:

~~kkkkkkkk)~~a) That criterion ~~has~~have been developed defining current competence for practitioners who may request the privilege (see below).

~~lllllll)~~b) That the setting in which the privilege may or may not be performed has been determined.

~~mmmmmmmm)~~c) That the privilege is within the scope of services provided by the organization.

~~nnnnnnnn)~~d) That appropriate policies ~~–~~ where necessary ~~–~~ have been developed to support the privilege

~~oooooooo)~~e) That the organization has the appropriate equipment and supplies to support the privilege.

~~ppppppp)~~f) That the organization has an adequate number of qualified staff to support the privilege.

~~qqqqqqqq)~~g) That financial resources necessary to support the privilege have been committed.

~~15.3.~~15.3 ~~————~~New Privileges

If it is recommended that the new procedure be offered, the appropriate Campus Department and/or Credentials Committee (or oin the Poway Campus, the Campus Executive Committee) shall conduct research and consult with experts, including those on the Medical Staff or those outside the hospital, and review guidelines published by professional organizations and develop recommendations regarding: a) the minimum education, training, and experience necessary to perform the new procedure, and b) the extent of monitoring and supervision that should occur if the privileges are granted. The Campus Department and/or the Credentials Committee may also develop criteria and/or indications for when the new procedure is appropriate.

For new privileges added after January 1, 2007, a new privilege information form must be completed by the individual or department(s) that is requesting the privilege. The form will be reviewed by the originating department(s) and a recommendation made to the Medical Executive Committee on whether or not to establish the privilege. The Medical Executive Committee will review the recommendation and the privilege information form and make a final determination as to whether or not the privilege will be established. If established, the privilege may be requested and granted under processes otherwise codified by the Medical Staff.

~~15.4.~~15.4 ~~————~~Existing Privileges

The Medical Staff Office will facilitate a review of existing privileges against the requirements of this policy by each department. This will be accomplished by reviewing each department's privilege list and will include a determination by the organization that there continues to be sufficient space, equipment, staffing and financial resources in place to support the privileges. If a privilege no longer meets the requirements set forth in this policy, the department(s) will remove the privilege from availability and inform applicable practitioners and the Medical Executive Committee of this action.

1. General

Except as otherwise specified herein, no person (including persons engaged by the hospital in administratively responsible positions) shall exercise clinical privileges in the hospital unless and until that person applies for and obtains membership on the medical staff and is granted privileges as set forth in these bylaws, or, with respect to allied health practitioners, has been granted a service authorization or privileges under applicable medical staff policies. By applying to the medical staff for initial membership or renewal of membership (or, in the case of members of the honorary staff, by accepting membership in that category), the applicant acknowledges responsibility to first review these bylaws and medical staff rules, regulations and policies, and agrees that throughout any period of membership that person will comply with the responsibilities of medical staff membership and with the bylaws, rules and regulations and policies of the medical staff as they exist and as they may be modified from time to time. Membership on the medical staff shall confer on the member only such clinical privileges as have been granted in accordance with these bylaws.

All privileges possessed by members on the medical staffs of the Poway Campus and Escondido Campus prior to the effective date of the single consolidated license that resulted in the merger of the medical staffs into this Medical Staff shall be transferred to privileges for Members of this Medical Staff, including any restrictions, limitations, and conditions. All investigations, peer review actions, and related actions affecting members' privileges likewise shall be transferred and remain active under this Medical Staff.

1.1. Eligibility Criteria for Appointment

To be eligible to apply for initial appointment or reappointment to the medical staff, physicians, oral surgeons, dentists, and podiatrists must:

~~rrrrrrrr)~~a) Have a current, unrestricted license to practice in this state and have never had a license to practice revoked or suspended by any state licensing agency;

~~sssssssss)~~b) Where applicable to their practice, have a current, unrestricted DEA registration-and state controlled substance license;

~~ttttttttt)~~c) Have an office located within the geographic service area of the Palomar Health System, as defined by the Board, close enough to fulfill their Medical Staff responsibilities and to provide access for timely and continuous care for their patients in the Hospital;

~~uuuuuuuu)~~d) Have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Hospital as defined in Section 3.2.6 of the Medical Staff Bylaws;

~~vvvvvvvv)~~e) Have never been convicted of Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil monetary penalties for the same;

~~wwwwwwwww)~~f) Have never been, and not currently be, excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care program;

~~xxxxxxxx)~~g) Have never had medical staff appointment, clinical privileges, or status as a participating provider denied, revoked, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct;

~~yyyyyyyyy)~~h) Have never resigned medical staff appointment or relinquished privileges during a medical staff investigation or in exchange for not conducting such an investigation;

~~zzzzzzzz)~~i) Have never been convicted of, or entered 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;

~~aaaaaaaaa)~~j) Agree to fulfill all responsibilities regarding emergency call for their specialty;

~~bbbbbbbbb)~~k) Have coverage arrangements with other members of the Medical Staff for those

times when the individual will be unavailable as defined in Section 3.2.4 (h) of the Medical Staff Bylaws.

1.2. Waiver of Eligibility Criteria

~~cccccccc)~~a) Waivers of eligibility criteria will not be granted routinely. No individual is entitled to a waiver. An application from an individual who does not meet the criteria for appointment or clinical privileges will not be processed unless the Medical Executive Committee and the Board of Directors has determined that a waiver should be granted.

~~ddddddddd)~~b) A request for a waiver will only be considered if the prospective applicant provides information sufficient to satisfy his/her burden of demonstrating that his/her qualifications are equivalent to, or exceed, the criteria in question and that there are exceptional circumstances that warrant a waiver.

~~eeeeeeeee)~~c) ~~The Medical Executive Committee acting in lieu of the~~The Credentials Committee may consider supporting documentation submitted by the prospective applicant, any relevant information from third parties, input from the ~~relevant~~appropriate department chief, and the best interests of the health system and the communities it serves. If the Credentials Committee is the body making a determination regarding a waiver it will forward its recommendation, including the basis for such, to the Medical Executive Committee.

~~fffffffff)~~d) If the recommendation for waiver has come from the Credentials Committee~~,~~ the Medical Executive Committee will review the recommendation of the Credentials Committee and make a recommendation to the Board of Directors regarding whether to grant or deny the request for a waiver and the basis for its recommendation.

~~ggggggggg)~~e) The Board's determination regarding whether to grant a waiver is final. A determination not to grant a waiver is not a "denial" of appointment or clinical privileges and the prospective applicant who requested the waiver is not entitled to a hearing. A determination to grant a waiver in a particular case is not intended to set a precedent for any other individual or group of individuals. A determination to grant a waiver does not mean that appointment will be granted. It simply means that processing of the application can begin.

2. ~~-~~Terms of Appointment

2.1. Appointments to the Medical Staff shall only confer membership as provided by these Bylaws, Rules, and Regulations.

2.2. Appointment and reappointment shall be made by the Board of Directors upon recommendation of the Medical Executive Committee~~.~~ or appropriate Campus Executive Committee. In no case shall the Board of Directors refuse to make a recommended appointment or reappointment without conferring with the Medical Executive Committee stating the reasons for such action.

2.3. Duration of appointment and reappointment including provisional shall not exceed two (2) years. The Medical Staff may establish that all reappointments will terminate based on the renewal date of the California medical license.

3. Application for Appointment

3.1. Doctors of Medicine and Osteopathy and Dentists and Podiatrists shall apply through the Palomar Health System.

Applications to the Medical Staff shall be provided only to those practitioners who meet such minimum objective standards, consistent with these bylaws, as shall be specified by the Board of Directors. Prospective applicants shall have the burden of demonstrating that they meet such standards by completing an application request form specified by the Medical Executive Committee. The provisions of the Medical Staff Rights Manual, Section 5 (Judicial Review Hearing) and Section 6 (Appeal to Board of Directors) shall not apply to a practitioner's failure to receive an application.

3.2. All applications for membership shall be in writing, shall be signed by the applicant, and shall be submitted in a form prescribed by the Board of Directors after consultation with the Medical Executive Committee and the Campus Executive Committees of the Medical ~~Staffs~~Staff of System

Facilities using the application. ~~A Palomar Health application form shall be developed for use at Pomerado Hospital and Palomar Medical Center and may also be used by such other System Facilities, as the Medical Executive Committees or the Medical Staff(s) of such facilities deem appropriate.~~ The application shall require or include:

~~hhhhhhhhh)~~a) Detailed information concerning the applicant's professional qualifications;

~~iiiiiiiii)~~b) The names of at least three (3) persons who have had extensive experience observing (one of which is in the applicant's specialty) and working with the applicant in the past three (3) years and who can provide adequate references pertaining to the applicant's professional competence in at least the following areas:

(1) Patient Care

(2) Medical/Clinical Knowledge

(3) Practice based Learning and Improvement

(4) Interpersonal and Communication Skills

(5) Professionalism

(6) Systems-based Practice

~~jjjjjjjj)~~c) Information as to whether the applicant's membership status and/or clinical privileges have ever been denied, revoked, suspended, reduced, voluntarily relinquished, or not renewed at any other hospital or by national medical societies; whether voluntary or involuntary.

~~kkkkkkkkk)~~d) Information as to whether the applicant has ever resigned or had membership terminated, or been subject to any limitation, reduction or loss of clinical privileges at another hospital whether voluntary or involuntary;

~~lllllll)~~e) Information as to whether the applicant's license to practice has ever been challenged, denied, suspended, revoked or not renewed, whether voluntary or involuntary;

~~mmmmmmmmm)~~f) Information as to whether the applicant's narcotics license has ever been challenged, denied, suspended, revoked, or not renewed, whether voluntary or involuntary;

~~nnnnnnnn)~~g) Information concerning past or pending malpractice litigation or judgment on the applicant or his/her insurance carrier and any prior lapse in malpractice coverage;

~~ooooooooo)~~h) Information about the applicant's current physical and mental health status;

~~ppppppppp)~~i) A signed agreement to guard the privacy of others;

~~qqqqqqqqq)~~j) Such other information as the Medical Executive Committees of the Medical Staffs of the System Facilities using the application deems appropriate.

~~rrrrrrrrr)~~k) The applicant shall also submit current copies of his/her California license, DEA certificate, evidence of compliance with Medical Board of California requirements for continuing medical education, evidence of current malpractice insurance coverage and documentation of current tuberculosis screening in accordance with Palomar Health ~~guidelines.~~ Guidelines.

l) Agreement that the applicant shall notify the hospital, in writing, promptly and no later than fourteen- ~~sssssssss)~~ (14) days from the occurrence of among other things, a receipt of written notice of any adverse action against the applicant under any federal health care program, such as the Medicare/MediCal program, including but not limited to fraud and abuse proceedings or convictions.

The terms, "Hospital" and "all representatives of the Hospital and its Medical Staff," as used herein, are intended to include the Board of Directors and the Administrator and their authorized representatives and all members who have Department, committee, or other responsibilities for collecting and/or evaluating the applicant's credentials and/or acting upon his/her application. The term, "character", is intended to include the applicant's ability to safely perform all of the essential mental and physical functions related to the specific clinical privileges requested.

3.3. By applying for membership on the Medical Staff, each applicant thereby:

~~ttttttttt)~~a)Signifies his/her willingness to appear for interviews with regard to his/her application;

~~uuuuuuuuu)~~b) Authorizes the Medical Staff to consult with members of medical staffs of other hospitals with which the applicant has been associated, and with others who may have information bearing on his/her competence, character, and ethical qualifications;

~~vvvvvvvvv)~~c) Consents to the Medical Staff's inspection of all records and documents that may be material to an evaluation of his/her professional qualifications and competence to carry out the clinical privileges he/she requests, as well as his/her moral and ethical qualifications for membership;

~~wwwwwwwww)~~d) Authorizes the Medical Staff to subject him/her to mandatory non-disciplinary observation requirements pursuant to the hospital's quality management programs and Medical Staff peer review, which requirements shall not be grounds for a hearing pursuant to Section 5.1 of the Medical Staff Rights Manual, Judicial Review Hearing, Grounds for Hearing;

~~xxxxxxxxx)~~c) Releases from any liability all representatives of the Medical Staff for their acts performed in good faith and without malice in connection with evaluating the applicant and his/her credentials;

~~yyyyyyyyy)~~f) Releases from any liability all individuals and organizations who provide information to the Medical Staffs in good faith and without malice concerning the applicant's competence, ethics, character, and other qualifications for membership and clinical privileges, including otherwise privileges or confidential information;

~~zzzzzzzzz)~~g) Authorizes the Medical Staff to release information concerning his/her membership, clinical privileges and performance at the hospital to the Medical Staffs of other System Facilities if he/she is a member at or an applicant to any such medical staff, if such information is relevant to the privileges he/she maintains at such facilities.

~~aaaaaaaaaa)~~h) Agrees that if membership and privileges are granted the member has an ongoing and continuous duty to report to the Medical Staff office within ten days, any and all information that would correct, change, modify or add to any information provided in the application or most recent reappointment application when such information may reflect adversely on current qualifications for membership or privileges.~~-~~

3.4. All applications for membership shall be accompanied by a non-refundable application fee in an amount specified by the Medical Executive Committees of the Medical Staffs and the Board of Directors after consultation with the Medical Staffs using the Palomar Health application to defray part of the cost of processing the application.

3.5. The application form shall include a statement that the applicant has received and read the Bylaws, Rules and Regulations of the Medical Staff and that he/she agrees to be bound by the terms thereof if he/she is granted membership and/or clinical privileges and to be bound by the terms thereof without regard to whether or not he/she is granted membership and/or clinical privileges in all matters relating to consideration of his/her application.

3.6. An applicant shall have the burden of producing accurate and adequate information for a thorough review of the applicant's qualifications and suitability for the requested status or privileges, resolving any reasonable doubt about these matters, and satisfying requests for information. The provision of information containing significant misrepresentation or omissions and/or a failure to sustain the burden of producing information shall result in termination of the processing of the application with no entitlement to a hearing or appeal. To the extent consistent with law, this burden may include submission to a medical or psychological examination, at the applicant's expense, if deemed appropriate by the Medical Executive Committee or appropriate Campus Executive Committee, which may select the examining physician. The applicant may select the examining physician from an outside panel of three physicians chosen by the Medical Executive Committee~~.~~ or appropriate Campus Executive Committee. Any applicant who fails to make an appropriate response to a request by certified, return receipt requested mail, for reasonable information or action within thirty (30) days, shall be deemed to have abandoned his/her request for that status or privilege. Processing of an application shall automatically terminate if all materials requested in the application have not been received within a three~~-~~
~~3.6.~~(3) month period from receipt of the application and there has been no activity on the application. Exceptions may be granted by the Chairperson of the Credentials Committee for the Escondido Campus or the Medical Executive Committee for a valid reason.

3.7. The applicant shall indicate whether he/she is applying to more than one Medical Staff and may also be asked about other System Facilities, as applicable.

3.8. All applications shall be reviewed by the Administrator. Any input on an applicant will be communicated to the Credentials Committee Chairperson or the Medical Executive Committee in a timely manner not to impede the processing of the application.

4. Appointment Process

4.1. Within thirty (30) days of the time that an application is considered complete by the Credentials Coordinator, the Credentials Coordinator will refer it to the Credentials Committee for the Escondido Campus or the Campus Executive Committee for the Poway Campus, as appropriate ~~Department Chairperson,~~ for consideration of privileges. ~~Credentials Committee for consideration of privileges.~~ Once the Credentials Committee or the Campus Executive Committee for the Poway Campus reviews the application and deems it complete, the application may either be forwarded to the appropriate department(s) for consideration of privileges, or forwarded to the ~~Medical~~appropriate Campus Executive Committee if the Credentials Committee has determined that the applicant is not qualified for membership, and there would be no benefit in forwarding the application to any department. The Credentials Committee may make a recommendation on the application. The department~~(s)~~ shall examine the evidence of the character, professional competence, qualifications, and ethical standing of the applicant, and shall determine~~,~~ through information obtained from references, and from other sources available to the department~~(s)~~ whether the applicant has established and meets all of the necessary qualifications for the clinical privileges requested. ~~Every department, in which the applicant seeks clinical privileges, shall provide the specific, written recommendations for delineating the applicant's clinical privileges and these recommendations will be made part of the report that shall be transmitted to the Medical Executive Committee. The department may return the application to the Credentials Committee for review.~~ Every department in which the applicant seeks clinical privileges, shall provide the specific, written recommendations for delineating the applicant's clinical privileges, and these recommendations will be made a part of the report that shall be transmitted to the ~~Medical~~appropriate Campus Executive Committee ~~functioning as a~~. The department may return the application to the Credentials Committee for its review in the event the application raises special or unusual issues on which the department desires the Committee's input.

4.2. If the application is for membership and privileges on the Medical Staff of both Campuses of Palomar Medical Center ~~and Pomerado Hospital~~, then both ~~Medical Staffs~~Campus Executive Committees shall process it in accordance with the joint procedure herein set forth.~~-~~

4.3. At its next regular meeting, after receipt of the application and the report and recommendation of the Campus Department(s) and/or Credentials Committee, the ~~Medical~~Campus Executive Committee shall determine whether to recommend to the ~~Board of Directors~~Medical Executive Committee that the applicant be appointed or rejected for membership. All recommendations to appoint shall specifically recommend the clinical privileges to be granted which may be qualified by probationary conditions relating to such clinical privileges.~~.~~

4.4. When the recommendation of the Campus Executive Committee or the Medical Executive Committee is to defer the application for further consideration, it shall be followed up within ninety (90) days with a subsequent recommendation for membership with specified clinical privileges, or for rejection of membership.~~-~~

4.5. When the recommendation of the Medical Executive Committee is favorable to the applicant, and no outstanding issues are present, the recommendation shall promptly be forwarded to the Board of Directors.~~-~~

~~4.5.~~4.6. When the recommendation of the Medical Executive Committee is ~~averse~~adverse to the applicant, either in respect to membership or clinical privileges requested at Palomar

Health hospitals, the Medical Executive Committee or appropriate Campus Chief of Staff shall promptly so notify the applicant by certified return receipt requested mail. No such adverse recommendation need be forwarded to the Board of Directors until after the applicant has exercised or has been deemed to have waived his/her right to a hearing as provided in the Medical Staff Rights Manual. If the applicant exercises his/her right to a hearing, then the application will be processed in accordance with the Medical Staff Rights Manual.

4.6.4.7. If the application is to both Campuses of the Medical Staffs of more than one hospitalStaff, the recommendations of one of the MedicalCampus Executive Committees shall not be further processed until the other MedicalCampus Executive Committee has made its recommendation. If the recommendations of the MedicalCampus Executive Committees do not agree on the granting of privileges or membership, an ad hoc committee composed of each Campus Chief of Staff and each appropriate Campus Department Chairperson of each Medical StaffCampus shall meet to discuss the differences and shall submit a report to the Medical Executive Committees within ten (10) days from the date the MedicalCampus Executive Committees adopted their recommendations. After considering the report of the ad hoc committee the Medical Executive Committee(s) shall make its recommendation to the Board of Directors.

4.7.4.8. If a hearing panel should occur per Section 4.6 and the recommendation of the Hearing Panel and Medical Executive Committee is favorable to the applicant processing shall be in accordance with Section 4.5 above.

4.8.4.9. If such recommendation continues to be adverse, the appropriate Campus Chief of Staff shall promptly so notify the applicant by certified, return receipt requested mail. The Campus Chief of Staff shall also forward such recommendation and documentation to the Board of Directors only for the purpose of information. The application will continue to be processed in accordance with the Medical Staff Rights Manual.

4.9.4.10. In its next regular meeting after receipt of a favorable recommendation, or after the applicant has been deemed to have waived his/her rights to a hearing or appeal, the Board of Directors shall act in the matter. The Board of Directors may affirm, modify or reverse the recommendation or, in its discretion, may refer the matter back to the Medical Executive Committee for further review and recommendation to be returned within thirty (30) days and in accordance with its instructions. After receipt of such recommendation after referral, the Board of Directors shall take action.

bbbbbbbbbb)a) If the Board of Directors' decision is in accordance with the Medical Executive Committee's recommendation, it is immediately effective and is the final decision in the matter.

ccccccccc)b) If the Board of Directors' decision has the effect of changing the Medical Executive Committee's last recommendation, the matter is referred to a conference as provided for in Section 4.11 that follows. The Board of Directors' action on the matter, after receiving the conference recommendation, is effective as the decision on the matter.

ddddddddddc) If the Board of Directors' decision, after receiving the conference recommendations, is averseadverse to the applicant, and the applicant did not have a prior opportunity to exercise or waive his/her right to a hearing, then the application shall be processed in accordance with the Medical Staff Rights Manual.

4.10.4.11. Within fifteen (15) days after receiving a matter referred to inunder Section 4.9 10(b) above, a conference of two (2) Medical Staff Members and two (2) Board of Directors' Members shall convene to consider the matter and shall submit its recommendations to the Board of Directors. If the applicant is applying to more than one HospitalCampus, then two (2) Medical Staff Members shall be selected, from more than one Hospital. each Campus.

~~4.11.~~4.12. When the Board of Directors' decision is final, it shall send notice of such decision through the Administrator to the Medical Executive Committee, Credentials Committee, and concerned Campus Department Chairperson and by certified, return receipt requested mail to the applicant.

~~4.12.~~4.13. All membership requests and evaluation sheets shall carry the signature of the appropriate Campus Department Chairperson(s), and Officer(s) of the Medical Staff. Written record of all matters considered in each Member's application shall be made a part of the permanent files of the Medical Staff.

5. Reappointment Process~~-~~

5.1. Reappointment of Members shall occur at least every two (2) years and shall coincide with the Member's California medical license cycle. Approximately (6) months prior to the expiration of a Member's current appointment, a reappointment application and supporting documents shall be sent to the Member. Failure to return the reappointment application within 60 (sixty) days of receipt may result in expiration of the appointment. Reassessment shall be conducted by the Department(s) where clinical privileges are maintained. In order to be considered for reappointment by the Department, each Member shall have submitted a completed Medical Staff Biennial Reappointment form which shall include all information necessary to update and evaluate the qualifications of the applicant, including, but not limited to:

~~eeeeeeeeee)~~a) Disclosure of relinquishment of privileges or membership in medical organizations whether voluntary or involuntary;

~~fffffffff)~~b) Disclosure of any previously successful or currently pending challenges to any licensure or registration or the voluntary relinquishment of such licensure or registration;

~~ggggggggg)~~c) Disclosure of any limitation, reduction, or loss of clinical privileges at any hospital or surgery center, whether voluntary or involuntary;

~~hhhhhhhhhh)~~d) Disclosure of involvement in professional liability actions, including final judgments and settlements involving the practitioner;

~~iiiiiiiii)~~e) Completion of an updated clinical privilege checklist(s) along with current copies of California licensure, DEA certificate, evidence of compliance with Medical Board of California requirements for continuing medical education, current status of malpractice insurance coverage, and documentation of a current tuberculosis screening;

The Member shall disclose information about the challenge to or relinquishment of licensure or registration on an ongoing basis as they occur.

5.1.1. The Member agrees to notify the hospital, in writing, promptly and no later than fourteen (14) days from the occurrence of any such change in licensure or registration status, restriction, reduction, or loss of clinical privileges at another hospital, a receipt or written notice of any adverse action against the Member under any federal health care program, such as exclusion from participation in federal health care programs, including but not limited to fraud and abuse convictions.

5.1.2. Failure to respond within thirty (30) days to a request by certified, return receipt requested mail for reassessment information shall be cause for loss of membership and privileges. Such loss will become effective on the first day of the month following expiration of the current reappointment.

5.2. Each recommendation concerning the reappointment of a Member and the clinical privileges to be granted upon reappointment shall be based upon such Member's:

~~jjjjjjjjj)~~a) Professional competence and clinical judgment in the treatment of patients including review of quality of care documentation;~~-~~

~~kkkkkkkkkk)~~b) Ethics and conduct;

~~lllllllll)~~c) Participation in affairs of the Medical Staff;

~~mmmmmmmmmm)~~d) Compliance with the Bylaws, Rules and Regulations;

~~nnnnnnnnn)~~e) Appropriate use of the facilities of the Hospital; and

~~ooooooooo)~~f) Information on the Member's current physical and mental health status.

The biennial reappointment process shall be initiated by the Member in affirming his/her physical and mental competence to carry out his/her responsibility as a Member. Reappointment requests and evaluation sheets shall carry the signature of the appropriate Campus Department Chairperson and Officer(s) of the Medical Staff. Written record of all matters considered in each Member's periodic reappointment appraisal shall be made a part of the permanent files of the Medical Staff. When a question arises as to whether a Member may pose significant risk to the health or safety of patients due to a disability, and when that risk cannot be eliminated by reasonable accommodations, a medical examination may be required by the ~~MEC. The MEC~~appropriate Campus Executive Committee. The Campus Executive Committee shall select three (3) physicians from which the Member shall choose one (1) physician to conduct the physical or psychological evaluation.

Members of the Medical Staff who have had no clinical activity through inpatient admissions or consultations at a Palomar Health hospital during the biennial review period are automatically transferred into the Affiliate category unless they are eligible and wish to transfer into the active with no privileges category as set forth in Section 4.~~5~~2.2 of the Bylaws.~~-~~

In the event that the Member has been involved in the care of an insufficient number of patients to allow evaluation of clinical performance and the Member belongs to the Medical Staff of another Palomar Health facility, then any pertinent information based on organizational improvement activities shall be requested from that facility and considered in the reappointment process.

Once the ~~Medical~~Campus Executive Committee has completed its evaluation, its recommendation shall be processed pursuant to Sections 4.3 through 4.~~12~~13 of this Credentials Policy Manual. Reappointment shall be for a period not to exceed two (2) years, and may be granted subject to such conditions, as the Medical Executive Committee or appropriate Campus Executive Committee deems appropriate, including but not limited to probation, monitoring, consultation or co-admitting. Notwithstanding any other provision in these Bylaws, a Member granted conditional reappointment shall not be entitled to a hearing pursuant to the Medical Staff Rights Manual unless the conditions imposed require the filing of a report pursuant to Business and Professions Code Section 805.

5.3. Conditional Reappointment

In the event the Medical Executive Committee or Campus Executive Committee requires additional information in order to evaluate the application or the applicant, the applicant for reappointment is the subject of an investigation or hearing at the time reappointment is being considered, a conditional reappointment for a period of less than two (2) years may be granted pending the completion of that process.~~-~~

5.4. Failure to File Application for Renewal of Membership

Failure without good cause to timely file a completed application for renewal of membership shall result in the automatic suspension of the member's admitting privileges and expiration of other practice privileges and prerogatives at the end of the current staff membership period.

6. Professional Practice Evaluation

6.1. Purpose

To define, determine, maintain, and evaluate the competency of members of the medical staff

to provide care, treatment, and service in accordance with the credentialing and privileging processes and requirements of the medical staff. The Professional Practice Evaluation process will be defined and performed within the purview of the Medical Staff Peer Review Policy. This policy applies to all members of the medical staff.

6.2. Applicability

Unless otherwise noted, this policy applies to all members of the Medical Staff.

7. Confidentiality of Information

All activities surrounding the professional evaluation of members of the medical staff are considered part of the Medical Staff's quality management program and are therefore considered protected and confidential to the extent permitted by law and regulation.

8. Credential Files

8.1. Insertion of adverse information.

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

8.1.1. Adverse information related to a Member's conduct, performance or competence may be provided to the Medical Staff for possible insertion in the Member's file.

8.1.2. When insertion of adverse information into a Member's credentials file is being considered, the appropriate Campus Department Chairperson, the Campus Chief of Staff, and the involved Member shall review such information. The Member may write a statement to be placed in his/her credentials file.

8.1.3. After such a review a decision will be made by the appropriate Campus Department Chairperson and the Campus Chief of Staff to:

~~ppppppppp)~~a) Not insert the information;

~~qqqqqqqqqq)~~b) Insert the information along with the notation that no further review is warranted; or

~~rrrrrrrrr)~~c) Insert the information along with the notation that a request has been made for an investigation; or

~~sssssssss)~~d) Insert information that refutes the adverse information provided.

8.1.4. This decision as outlined in Section 9.4(e) of the Bylaws shall be reported to the Medical Executive Committee. The Medical Executive Committee when so informed may either ratify or initiate contrary actions to this decision by a majority vote.

9. Credentialing Licensed Independent Practitioners in the Event of a Disaster

To define Palomar Health's policy allowing the provision of care, treatment, or services by volunteers who are licensed independent practitioners when the organization's disaster plan has been implemented, and the immediate needs of patients cannot be met by the organization's staffing capabilities. This is an organization-wide policy. It applies to all settings and services. This policy applies to volunteer practitioners that are required by law and regulation to have a license, certification, or registration to practice their profession.

9.1. Process

Under such circumstances, the organization's Disaster Commander or authorized designee is authorized to implement this policy and grant disaster privileges or permission to treat patients to volunteer physicians, nurses, and other professionals upon receipt of satisfactory evidence that such individuals are currently licensed or otherwise capable of providing services to patients.

A volunteer practitioner must present a valid government issued photo identification issued by a state or federal agency (e.g. driver's license or passport). In addition, the volunteer

practitioner must provide at least one of the following:

~~ttttttttt)~~a) A current hospital picture identification card that clearly identifies the individual's professional designation

~~uuuuuuuuuu)~~b) A current license, certification, or registration

~~vvvvvvvvv)~~c) Primary source verification of licensure, certification or registration

~~wwwwwwwwww)~~d) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organization or group(s).

~~xxxxxxxxxx)~~e) Identification indicating that the individual has been granted authority to render patient care, treatment, or services in disaster circumstances (such as authority having been granted by a federal, state, or municipal entity).

f) Identification by a current member of the organization who possesses personal knowledge regarding the volunteer practitioner's qualifications.

Allied Health Professionals (AHP) defined as a currently licensed physician assistant, nurse midwife, nurse practitioner or nurse anesthetist may be granted disaster privileges to provide services at the request of responsible officials or pursuant to a mutual aid operation plan established and approved under the California Emergency Service Act, only if they are licensed in California and a licensed physician will supervise their practice during the disaster. During a disaster, there is no limit on the number of physician assistants a supervising physician may simultaneously supervise.

As soon as the immediate situation is under control, the organization should obtain primary source verification of the volunteer practitioner's license, certification, or registration. Primary source verification must be completed within 72 hours from the time the volunteer practitioner presented to the organization. In extraordinary circumstances (e.g. no means of communication or a lack of resources), verification may exceed 72 hours, but must be completed as soon as possible.

Primary source is the entity or agency that has the legal authority to issue the credential in question. If the entity or agency has designated another entity or agency to communicate information about the status of a staff member's credential, then the other entity or agency may be considered the primary source.

If the credential is not required by law or regulation in order for the staff member to practice his or her profession, then it is not necessary to obtain verification from the primary source. If the volunteer practitioner is not providing care, treatment, or service for which a license, certification, or registration is required, then primary source verification is not required.

Volunteer practitioners will be identified by a name badge to tag provided by the organization. The badge

/ tag will list the name and professional designation of the volunteer (e.g. John Smith RN) as well as the notation that the individual is a volunteer. The volunteer practitioner will be required to wear the badge / tag on his or her person while performing in that role / capacity.

Volunteer practitioners will be assigned to a member of the organization's staff who possesses similar license, certification, or registration who is a peer in the volunteer's area of practice and experience. The organization's staff member will serve as a mentor and resource for the volunteer practitioner.

The organization's staff member will be responsible for overseeing the professional performance of the volunteer practitioner. This may be accomplished by;

~~yyyyyyyyyy)~~a) Direct observation

~~zzzzzzzzz)~~b) Clinical review of care documented in the patient's medical record.

Volunteer practitioners will cease providing care, treatment, or service if any one of the following criteria is met:

~~aaaaaaaaaa)~~a) Implementation of the emergency management plan ceases.

~~bbbbbbbbbb)~~b) The capability of the organization's staff becomes adequate to meet patient care needs.

~~ccccccccccc)~~c) After 72 hours (or sooner if warranted) a decision is made that the professional practice of the volunteer practitioner does not meet organization standards.

There will be no rights to any hearing or review in the event a physician's or an AHP's disaster privileges are terminated, regardless of the reason for the termination.

1. Collegial Intervention

1.1. This Manual encourages the use of progressive steps by Medical Staff leaders and Hospital administration, beginning with collegial and educational efforts, to address questions relating to an individual's clinical practice, professional conduct, and/or lack of compliance with Medical Staff policies/procedures. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised.

1.2. Collegial efforts may include, but are not limited to, counseling and sharing of comparative data.

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

1.4. The relevant Medical Staff leader(s) will 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 the opportunity to review and respond in writing. The response shall be maintained in that individual's file along with the original documentation.

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

1.6. The appropriate Campus Chief of Staff shall determine whether to direct that a matter be handled in accordance with a Policy or to direct it to the Campus Executive Committee for further determination.

2. Corrective Action Investigation

2.1. Definitions

The following definitions shall apply under this article:

Days refers to calendar days for purpose of determining periods of time.

Medical Disciplinary Cause or Reason means that aspect of a Practitioner's competence or conduct, which is reasonably likely to be detrimental to patient safety or to the delivery of patient care.

Member refers to an applicant, medical staff member or clinical psychologist, as the case may be, who is subject to the provisions set forth in this Manual.

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

2.2. Criteria for Initiation

Any person may provide information to the Medical Staff about the conduct, performance, or competence of its members. A request for investigation or action against a Member may be initiated by ~~the~~a Campus Chief of Staff, the Campus Executive Committee, the Medical Executive Committee, Chief Executive Officer, or Board of Directors when reliable information indicates a Member may have exhibited acts, demeanor, or conduct reasonably likely to be:

~~ddddddddddd)~~d) Detrimental to patient safety or to the delivery of quality patient care within the Hospital,

~~eeeeeeeeeee)~~e) Unethical,

~~fffffffff)~~f) Contrary to Bylaws or Rules and Regulations of the Medical Staff; or

~~ggggggggggg)~~g) Below applicable professional standards

2.3. Initiation

A request for an investigation shall be in writing, submitted to the Campus Chief of Staff from the Campus where the involved Member is assigned and supported by reference to specific activities or alleged conduct. The Campus Chief of Staff will decide whether the request warrants further investigation. If so, the Campus Chief of Staff will submit the request to the ~~Medical~~Campus Executive Committee. The Campus Chief of Staff shall make appropriate recordation of the decision to deny the request or to recommend proceeding with the investigation.-

2.4. Investigation

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

~~iiiiiiiiii)~~b) Upon initiation of the investigation, the Member shall receive Notice that an investigation is being conducted and be advised of the nature of the allegations. The Member shall be given an opportunity to provide information in a manner, and upon such terms, as the investigating body deems appropriate. The individual or body investigating the matter may, but is not obligated to, conduct interviews with persons involved; however, such investigation shall not constitute a Hearing as that term is used in this Manual, nor shall the procedure rules with respect to Hearing or appeals apply.

~~jjjjjjjjjj)~~c) Despite the status of any investigation, the ~~Medical~~Campus Executive Committee, at all times, shall retain authority and discretion to take whatever action maybe warranted by the circumstances, including summary suspension, termination of the investigation, or other action.

2.5. ~~Medical~~Campus Executive Committee Action

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

~~kkkkkkkkkkk)~~a) Determining no corrective action need be taken and, if it is determined that there was insufficient credible evidence for the complaint in the first instance, removing any adverse information from the Member's file.

~~lllllllll)~~b) Deferring action for a reasonable time where circumstances warrant.

~~mmmmmmmmmmm)~~c) Issuing letters of admonition, censure, reprimand, or warning. In the event such letters are issued and placed in the Member's file, the Member may make a written response, which also shall be placed in the Member's file.

~~nnnnnnnnnn)~~d) Recommending probation, reduction, modifications, suspension, or revocation of clinical privileges.

~~ooooooooooo)~~e) Recommending suspension, revocation, limitation, or probation of membership.

~~ppppppppppp)~~f) Taking other actions deemed appropriate under the circumstances.

2.6. Subsequent Action

~~qqqqqqqqqqq)~~a) If corrective action as set forth in Section 5.1 of this Medical Staff Rights Manual is recommended by the ~~Medical~~Campus Executive Committee, the Member shall be given Notice of the recommendation and of the right to request a Judicial Review Hearing ("Hearing") pursuant to Section 5.2. Thereafter, the Hearing shall be conducted as set forth in this Medical Staff Rights Manual.

~~rrrrrrrrrr)~~b) If no timely request for a Hearing is submitted by the Member, the Member shall be deemed to have accepted the recommendation of the ~~Medical~~Campus Executive Committee and to have waived the right to a Hearing or an appeal. So long as the recommendation is supported by substantial evidence, the recommendation of the Campus Executive Committee shall be adopted by the Medical Executive Committee, which shall ~~be adopted by~~submit it to the Board of Directors for its adoption as final action.

2.7. Initiation by Board of Directors

If the ~~Medical~~Campus Executive Committee fails to investigate or take corrective action, contrary to the weight of the evidence, the Board of Directors may direct the ~~Medical~~Campus Executive Committee to initiate investigation or corrective action, but only after consultation with the ~~Medical~~Campus Executive Committee and the Medical Executive Committee. If the Campus Executive Committee and Medical Executive Committee ~~fails~~fail to take action in response to the Board of Directors' direction, the Board of Directors may initiate corrective action after written notice to the Campus Executive Committee and Medical Executive Committee. Such corrective action must comply with the procedures set forth in this Manual.

3. Summary Suspension

3.1. Criteria for Initiation

Whenever a Member's conduct appears to require that immediate action be taken to protect the life, health or safety of any patient, prospective patient or other person, the appropriate Campus Chief of Staff, Campus Executive Committee, Medical Executive Committee, the Chief Executive Officer, the Chief Administrative Officer or the Campus Department Chair in which the Member holds privileges may summarily restrict or suspend the membership or clinical privileges of such Member. The summary suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise stated, such summary suspension shall become effective immediately upon imposition.

3.2. Written Notice of Summary Suspension

The person or body responsible for the summary suspension shall promptly give written notice to the Board of Directors, the Campus Executive Committee, the Medical Executive Committee, and the Chief Executive Officer. The affected Member shall also be provided with prompt written Notice of such suspension. This initial written Notice shall include a statement of facts demonstrating that the action was necessary because failure to do so could reasonably result in imminent danger to the health or safety of an individual. The statement of facts shall also include a summary of one or more particular incidents giving rise to the assessment of imminent danger.

3.3. Continuity of Care

In the event the summary restriction or suspension precludes the Member from continuing to provide necessary care to patient(s) already admitted, or if the Campus Chief of Staff, the Campus Executive Committee, or the Medical Executive Committee determines it is appropriate to transfer the care of patients already admitted by the Member to another member, such patients shall be promptly assigned to another member by the Campus Department Chairperson or Campus Chief of Staff, considering, where feasible, the wishes of the patient in the choice of a substitute member.

3.4. Medical Executive Committee Action

Within seven (7) days after such summary suspension has been imposed, a meeting of the ~~Medical~~Campus Executive Committee shall be convened to review and consider the action. The Member may attend and make a statement concerning the issues under investigation, on such terms and conditions as the ~~Medical~~Campus Executive Committee may impose, although in no event shall any meeting of the ~~Medical~~Campus Executive Committee, with or without the Member, constitute a Hearing as that term is defined in this Manual, nor shall the procedural rules with respect to Hearings or appeals apply. The ~~Medical~~Campus Executive Committee may modify, continue or terminate the summary suspension, and recommend any additional corrective action. The ~~Medical~~Campus Executive Committee shall furnish the Member with written Notice of the decision within two (2) working days of the decision.

3.5. Procedural Rights

Unless the ~~Medical~~Campus Executive Committee promptly terminates the summary suspension, the Member shall be entitled to the procedural rights afforded by Section 5 of this Medical Staff Rights Manual.

3.6. Initiation by Board of Directors

If no one authorized under Section 3.1 is available to summarily restrict or suspend a Member's membership or privileges, the Board of Directors, Chief Executive Officer or the Chief Administrative Officer may immediately suspend a Member's privileges if a failure to suspend those privileges is likely to result in an imminent danger to the health of any person, provided the Board of Directors made reasonable attempts to contact the appropriate Campus Chief of Staff, members of the Campus Executive Committee, the Medical Executive Committee, or the department Chair before the suspension. Such a suspension is subject to the ratification by the Campus Executive Committee or

Medical Executive Committee. If the Campus Executive Committee or Medical Executive Committee does not ratify such a summary suspension within two working days, the summary suspension shall terminate automatically.

4. Automatic Revocation Suspension or Limitation

In the following instances, the Member's admitting and clinical privileges may be revoked, suspended, or limited as described, which action shall be final without a right to hearing or further review, except where the Medical Executive Committee or Campus Executive Committee determines in its sole discretion that a bona fide dispute exists as to whether the circumstances have occurred.

4.1. Licensure

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

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

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

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

4.2. Controlled Substances

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

4.3. Failure to Satisfy Special Appearance Requirement

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

4.4. Conviction of Felony

A Member convicted of a felony that bears on qualification or fitness to practice whether or not appealed, may be a cause for a summary suspension at the discretion of the Medical Executive Committee.

4.5. Bylaws, Rules and Regulations Violations

Suspension of all admitting and clinical privileges, except such clinical privileges as may be deemed necessary by the Campus Executive Committee or Medical Executive Committee to maintain continuity of care for patients already admitted by the Member, shall be imposed by the appropriate Campus Chief of Staff, Campus Executive Committee, Medical Executive Committee, or Board of Directors for the following Bylaws, Rules and Regulations' violations:

~~sssssssssss)~~a) Medical Record Deficiencies: Temporary suspension of a Member's admitting

and clinical privileges, except as provided above will be imposed automatically for failure to complete deficient or delinquent medical records within the time period set forth below, unless the Campus Chief of Staff interceded on his/her behalf.

All medical records shall be completed within fourteen (14) days. Failure to comply with this requirement may result in fines and/or suspension as set forth in the Medical Staff policy, Medical Records/Quality of Care Violations.

A list of suspended Members shall be distributed weekly to the Chief Executive Officer, Chief of Staff, Department Chairpersons, Quality Management Committee Chairperson, and clinical departments within the Hospital.

~~ttttttttttt)~~b) Failure to Provide Emergency Room Consultation: A Member who refuses to provide Emergency Department call panel services, may have his/her admitting and clinical privileges suspended. Emergency Department call panel services shall not apply or encompass the participation by any Member on a separate trauma services call panel, which in all events shall be voluntary. A Member may be disciplined for failure to respond, treat, consult, or follow designated trauma patients, if the Member has volunteered for the trauma services call panel.

~~uuuuuuuuuuu)~~c) Professional Liability Insurance: The admitting and clinical privileges of any Member who fails to provide documentation of professional liability coverage as required by 3.2.6 of the Medical Staff Bylaws shall be automatically suspended. A failure to provide such documentation within three (3) months after the date of this suspension becomes effective shall be deemed to be a voluntary resignation of membership.

~~vvvvvvvvvvv)~~d) Dues and Fines: Any Member required to pay dues or fines and who fails to pay such dues or fines as required by Article IV, after written warning of delinquency, shall have his/her admitting and clinical privileges suspended, and shall remain so suspended until the Member pays the delinquent dues or fines. Failure to pay such dues or fines within three (3) months after this suspension becomes effective shall be deemed to be a voluntary resignation of membership.

~~wwwwwwwwwwww)~~e) Tuberculin Testing Documentation: The admitting and clinical privileges of any Member who fails to provide documentation of TB screening in accordance with Palomar Health guidelines shall be automatically suspended. Failure to provide such documentation within three (3) months after the date this suspension becomes effective shall be deemed to be a voluntary resignation of membership.

4.6. Exclusion from Federal Healthcare Programs

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

5. Judicial Review Hearing

5.1. Grounds for Hearing

Except as otherwise specified in these Bylaws, any one or more of the following actions or recommended actions shall be deemed an actual or potential action and constitute grounds for a Judicial Review Hearing ("Hearing") if such action of recommendation is taken for a Medical Disciplinary Cause or Reason:

~~xxxxxxxxxx)~~a) Denial of Medical Staff membership

~~yyyyyyyyyy)~~b) Denial of Medical Staff reappointment

~~zzzzzzzzzz)~~c) Suspension of Medical Staff membership

~~aaaaaaaaaaa)~~d) Revocation of Medical Staff membership

~~bbbbbbbbbbb)~~e) Denial of requested clinical privileges (excluding temporary privileges unless they are denied for a Medical Disciplinary Cause or Reason)

~~ccccccccccc)~~f) Involuntary reduction of clinical privileges

~~ddddddddddd)~~g) Suspension of clinical privileges

~~eeeeeeeeeee)~~h) Termination of clinical privileges

~~fffffffffff)~~i) Involuntary imposition of significant consultation or proctoring requirements (excluding concurrent or retrospective medical record monitoring and monitoring/proctoring incidental to provisional privileges)

~~ggggggggggg)~~j) Denial of requested advancement in staff membership status or category

5.2. Notice of Hearing

In all cases in which action has been taken or recommended as set forth above, the Member shall be given special Notice of the recommendation or action and of the right to request a Hearing pursuant to Section 5.3 below. The Notice must state:

~~hhhhhhhhhhh)~~a) The action or recommendation taken-

~~iiiiiiiiii)~~b) A brief indication of the reasons for the action or recommendation-

~~jjjjjjjjjj)~~c) That the Member may request a hearing-

~~kkkkkkkkkkk)~~d) That a hearing must be requested within thirty (30) days-

~~lllllllll)~~e) That the Member has the hearing rights set forth in the Medical Staff Rights Manual-

~~mmmmmmmmmmm)~~f) That such action will be reported as required by Business & Professions Code Sections 805 and/or 805.1-

5.3. Request for Hearing-

The Member shall have thirty (30) Days following receipt of Notice of such action or recommendation to request a hearing. The request shall be in writing addressed to the appropriate Campus Chief of Staff. If the Member does not request a hearing within the time and in the manner described, the Member shall be deemed to have waived any right to a Hearing and accepted the action or recommendation involved.

5.4. Time and Place for Hearing-

Upon receipt of a request for Hearing, the appropriate Campus Chief of Staff shall schedule a Hearing and, within fifteen (15) Days give Notice to the Member of the time, place, and date of the hearing. The date of the commencement of the Hearing shall be not be more than sixty (60) days from the date the Campus Chief of Staff received the request for Hearing; provided, however, that when the request is received from a Member who is under summary suspension, the Hearing shall be held as soon as the arrangements may reasonably be made, but not to exceed forty-five (45) days from the date of receipt of the request.-

5.5. Notice of Reason-

Together with the Notice of Hearing, the Campus Chief of Staff shall state clearly and concisely in writing the reasons for the action or recommendation, including the acts or omissions with which the Member is charged, and a list of the charts in question, where applicable. A supplemental Notice may be issued at any time, provided the Member is given sufficient time to respond.-

5.6. Hearing Panel-

When a Hearing is requested, the appropriate Campus Chief of Staff shall appoint a Hearing Panel, which shall be composed of not less than five (5) members of the active Medical Staff, and alternates as appropriate, who have not acted as accusers, investigators, fact finders, or initial decision maker or otherwise have not actively participated in the action or recommendation, and are not in direct economic competition with the Member and who shall gain no direct financial benefit from the outcome. The Hearing Panel shall include, where feasible, an individual practicing the same specialty as the Member. Knowledge of the matter involved shall not preclude a member of the Medical Staff from serving as a member of the Hearing Panel. In the event it is not feasible to appoint a Hearing Panel from the active Medical Staff, the Chief of Staff may appoint members from other staff categories or

practitioners who are not members of the Medical Staff. Such appointment shall include designation of the Chair of the Hearing Panel. The Member shall be entitled to a reasonable opportunity to question and challenge the impartiality of the prospective members of the Hearing Panel. Challenges to the members of the Hearing Panel shall be ruled on by the Hearing Officer. During the Hearing, the Hearing Panel may interrogate the witnesses or call additional witnesses if it deems such action appropriate.

5.7. Hearing Officer

The use of a Hearing Officer to preside at a hearing is mandatory. The appointment of a Hearing Officer shall be by the appropriate Campus Chief of Staff, as a representative of the ~~Medical~~Campus Executive Committee, as follows:

~~nnnnnnnnnnn)~~a) Together with the Notice of Hearing, the Member shall be provided a list of at least three, but no more than five (5) potential Hearing Officers meeting the criteria set forth below.

~~ooooooooooo)~~b) The Member shall have five (5) Days to accept any of the listed potential Hearing Officers, or to propose at least three (3) but no more than five (5) other names of potential Hearing Officers meeting the criteria set forth below.

~~ppppppppppp)~~c) If the Member is represented by counsel, the parties' counsel may meet and confer in an attempt to reach accord in the selection of the Hearing Officer from the two parties' lists.

~~qqqqqqqqqqq)~~d) If the parties are not able to reach agreement on the selection of a Hearing Officer within five (5) working days of receipt of the Member's proposed list, the ~~Hospital's~~Campus Chief of Staff shall select an individual from the composite list.

~~rrrrrrrrrrr)~~e) Unless a Hearing Officer is selected pursuant to stipulation of the parties, the Member shall be entitled a reasonable opportunity to question and challenge the impartiality of the Hearing Officer. Challenges to the impartiality of the Hearing Officer shall be ruled on by the Hearing Officer.

The Hearing Officer shall be an attorney at law qualified to preside over a quasi-judicial hearing, but an attorney regularly utilized by the Hospital, Medical Staff, or Member for legal advice regarding their affairs and activities shall not be eligible to serve. The Hearing Officer shall gain no direct financial benefit from the outcome and must not act as a prosecuting officer or as an advocate. The Hearing Officer shall endeavor to assure that all participants in the Hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The Hearing Officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the Hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure or the admissibility of evidence. If the Hearing Officer determines that either side in a Hearing is not proceeding in an efficient and expeditious manner, the Hearing Officer may take such discretionary action as seems warranted by the circumstances. If requested by the Hearing Panel, the Hearing Officer may participate in its deliberations and serve as a legal adviser to it, but the Hearing Officer shall not be entitled to vote.

5.8. Representation

The Hearing is for the purpose of intra-professional resolution of matters bearing on professional conduct or professional competence. The Medical Staff Member shall have the right to select whether or not to be represented at the Hearing by an attorney. If the Member decides in favor of representation by an attorney~~,~~ then both sides shall be represented. If the member decides against representation by an attorney~~,~~ then neither side shall be represented. If legal representation is not allowed, both sides may be represented at the Hearing by a medical practitioner licensed to practice in the State of California who is also not an attorney at law.

5.9. Personal Presence Mandatory

Under no circumstances shall the Hearing be conducted without the personal presence of the Member unless he/she has waived such appearance or has failed without good cause to appear after appropriate notice. Failure without good cause of the Member to appear personally and proceed in an efficient, orderly, and efficient manner shall be deemed to constitute voluntary acceptance of the action or recommendation involved.

5.10. Continuances shall be granted upon agreement of the parties or by the Hearing Officer on a showing of good cause.

5.11. Discovery

~~sssssssssss)~~a) Each party shall have the right to inspect and copy at its own expense any documentary evidence relevant to the charges which the other party has in its possession or under its control. The failure by either party to comply with reasonable discovery requests at least thirty (30) days prior to the hearing shall constitute good cause for a continuance.

~~ttttttttttt)~~b) The Hearing Officer shall rule on discovery disputes the parties cannot resolve. Discovery may be denied when justified to protect peer review or in the interest of fairness and equity. Further, the right to inspect and copy by either party does not extend to confidential information referring to individually identifiable practitioners other than the Member nor does it create or imply any obligation to modify or create documents in order to satisfy a request for information.

~~uuuuuuuuuuu)~~c) In ruling on discovery disputes, the Hearing Officer may consider: (1) whether the information sought may be introduced to support or defend the charges; (2) the exculpatory or inculpatory nature of the information sought, if any; (3) the burden on the party of producing the requested information; and (4) other discovery requests the party has previously made.

5.12. Pre-Hearing Document Exchange

At the request of either party, the parties must exchange all documents that will be introduced at the Hearing. The documents must be exchanged at least ten (10) days prior to the commencement of the Hearing. A failure to comply with this rule is good cause for the Hearing Officer to grant a continuance. Repeated failures to comply shall be good cause for the Hearing Officer to limit the introduction of any documents not provided to the other side in a timely manner.

5.13. Witness Lists

At the request of either party, the parties shall exchange lists of the individuals, as far as is then reasonably known or anticipated, who are expected to give testimony or evidence at the Hearing. Nothing in the foregoing shall preclude the testimony of additional witnesses whose participation was not reasonably anticipated. The parties shall notify each other as soon as they become aware of the possible participation of such additional witnesses. The failure to provide the name of any witness at least ten (10) days prior to the Hearing date at which the witness is to appear shall constitute good cause for a continuance.

5.14. Procedural Disputes

It shall be the duty of the parties to exercise reasonable diligence in notifying the Hearing Officer of any pending or anticipated procedural disputes as far in advance of a scheduled Hearing session as possible in order that decisions concerning such matters may be made in advance of the Hearing session. Objections to any such decisions may be succinctly made at the Hearing.

5.15. Record of the Hearing

A court reporter shall be present to make a record of the Hearing proceedings. The cost of attendance of the court reporter shall be borne by the Hospital, but the cost of a transcript, if any, shall be borne by the party requesting it. The Hearing Officer may, but shall not be required to, order that oral evidence shall be taken only on oath administered by the court reporter or any person lawfully authorized to administer such oath.

5.16. Rights of the Parties

Within reasonable limitations, both sides at the Hearing may call and examine witnesses for relevant testimony, introduce relevant exhibits or other documents, cross-examine or impeach witnesses who shall have testified orally on any matter relevant to the issues, and otherwise rebut evidence, as long as these rights are exercised in an efficient and expeditious manner. The Member may be called by the ~~Medical~~Campus Executive Committee and examined as if under cross-examination. Both parties shall be provided with all of the information made available to the Hearing Panel. Each party has the right to submit a written closing statement at the close of the Hearing.

5.17. Rules of Evidence

Judicial rules of evidence and procedure relating to the conduct of the Hearing, examination of witnesses, and presentation of evidence shall not apply to a Hearing conducted pursuant to this Medical Staff Rights Manual. Any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the course of serious affairs, regardless of the admissibility of such evidence in a court of law.

5.18. Burden of Presenting Evidence and Proof

The ~~Medical~~Campus Executive Committee shall have the initial duty to present evidence for each case or issue in support of its action or recommendation.

An applicant for membership and/or privileges shall bear the burden of persuading the Hearing Panel, by a preponderance of the evidence, that he/she is qualified for membership and/or the denied privileges.

The applicant must produce information which allows for adequate evaluation and resolution of reasonable doubts concerning his/her current qualifications for membership and privileges. An applicant shall not be permitted to introduce information requested by the Medical Staff but not produced during the application process unless the applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

Except as provided above for applicants, the Medical Executive Committee shall bear the burden of persuading the Hearing Panel, by a preponderance of the evidence, that its action or recommendation is reasonable and warranted.

5.19. Adjournment and Conclusion

The Hearing Officer may adjourn the Hearing and reconvene the same without special notice at such times and intervals as may be reasonable and warranted, with due consideration for reaching an expeditious conclusion to the Hearing. Upon conclusion of the presentation of oral and written evidence, or the receipt of written closing statements, if submitted, the Hearing shall be closed. Thereafter, the Hearing Panel shall conduct its deliberations outside the presence of any person other than the Hearing Officer, if the Hearing Officer is requested by the Hearing Panel to participate in its deliberations. Final adjournment shall be when the Hearing Panel has concluded its deliberations.

5.20. Basis for Decision

The decision of the Hearing Panel shall be based on the evidence introduced at the hearing, including all logical and reasonable inferences from the evidence and the testimony.

5.21. Decision of the Hearing Panel

Within thirty (30) days after final adjournment of the Hearing, the Hearing Panel shall render a written decision. If the Member is currently under summary suspension, however, the time for the decision shall be seven (7) days after final adjournment of the Hearing. The decision shall be delivered to the Campus Executive Committee and the Medical Executive Committee. Copies of the decision shall also be forwarded to the Chief Executive Officer, the Board of Directors and the Member. The decision shall contain a concise statement of the reasons in support of the decision including the findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached. Both parties shall be provided a written explanation of the procedure for appealing the decision. The decision of the Hearing Panel shall be subject only to such rights of appeal to the Board of

Directors as set forth in this Manual.

5.22. Joint Hearing

A ~~joint~~Joint Hearing may be conducted pursuant to Article XVIII of the Medical Staff Bylaws. A ~~joint~~Joint Hearing in accordance with the foregoing shall be deemed to satisfy procedural rights afforded to the Member pursuant to Business & Professions Code ~~Section~~section 809, et. seq.

6. Appeal to Board of Directors

6.1. Time for Appeal

Within ten (10) Days after receipt of the decision of the Hearing Panel, either the Member or the Medical Executive Committee, after consultation with the Campus Executive Committee, may request an appellate review. A written request for such review shall be delivered to the Campus Chief of Staff, the Chief Executive Officer, and the Member. If a request for appellate review is not submitted within such period, the right to an appellate review shall be deemed to have been waived and the action or recommendation shall be affirmed by the Board of Directors as the final action it is supported by substantial evidence following a fair procedure.

6.2. Grounds for Appeal

A written request for appeal shall include an identification of the grounds for appeal, and a clear and concise statement of the facts in support of the appeal. The grounds for appeal from the Hearing shall be:

~~vvvvvvvvvvv)~~a) Substantial non-compliance with the procedures required by this Manual or applicable law which has created demonstrable prejudice; or

~~wwwwwwwwwww)~~b) The decision was not supported by substantial evidence based on the hearing record or such additional information as may be permitted pursuant to 6.4 below.

6.3. Appeal Board

The Board of Directors may act as the Appeal Board or it may appoint an Appeal Board which shall be composed of not more than three (3) members of the Board of Directors. Knowledge of the matter involved shall not preclude any person from serving as a member of the Appeal Board, so long as that person did not take part in a prior hearing on the same matter. The Appeal Board may select an attorney to assist it in the proceeding and during deliberations, but that attorney shall not be entitled to vote with respect to the appeal.

6.4. Appeal Procedures

The proceedings shall be in the nature of an appellate hearing based on the record of hearing before the Hearing Panel, provided that the Appeal Board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the Hearing Panel in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the Hearing. Alternatively, the Appeal Board may remand the matter to the Hearing Panel for the taking of further evidence for decision.

Within seven (7) days after mailing the request for appellate review, the party requesting the appeal shall order the original transcript of the Hearing proceedings for use by the Appeal Board. Failure on the part of the appellant to timely order the original transcript shall be deemed to be an abandonment of the appeal, and the decision of the Hearing Panel shall thereupon become final. The appellant shall cause the original transcript to be delivered to the Appeal Board as soon as it is completed. The initial cost of such original transcript shall be borne by the appellant.

Upon receiving the original transcript, the Appeal Board shall give parties Notice of the date, time~~,~~ and place of the appellate review. The date of the appellate review shall not be less than fifteen (15) Days nor more than forty-five (45) Days from the date of receipt of the original transcript; provided, however, when a request for appellate review is from a Member who is under suspension which is then

in effect, the appellate review shall be held as soon as the arrangements may reasonably be made and not to exceed twenty Days from the date of receipt of the original transcript. The time for appellate review may be extended by the Chair of the Board of Directors for good cause.

Each party shall have the right to submit a written brief, the right to personally appear and make oral argument, and the right to be represented by an attorney or other representative.

At the conclusion of oral argument, the Appeal Board may thereupon, at a time convenient to itself, conduct deliberations in closed session outside the presence of the parties and their counsel or representatives.

6.5. Decision

If the appellate review is conducted by an Appeal Board composed of no more than three members of the Board of Directors, the Appeal Board shall issue its written decision within fifteen (15) Days after conclusion of the appellate hearing. Within fifteen (15) days after receipt of the written decision or within fifteen (15) days after the conclusion of the appellate review by the Board of Directors, the Board of Directors shall render a final decision. The decision shall be in writing and copies thereof shall be delivered to the appropriate Campus Executive Committee and the Medical Executive Committee and to the Member in person or by certified mail within ten (10) days thereafter.

The Board of Directors may affirm, modify, or reverse the decision of the Hearing Panel or it may remand the matter for further review by the Hearing Panel. If the matter is remanded for further review and recommendation, the further review shall be completed within thirty (30) days unless the parties agree otherwise or for good cause as determined by the Chair of the Board.

The Board of Directors shall affirm the decision of the Hearing Panel if it is supported by substantial evidence following a fair procedure. The Board of Directors may, however, exercise its independent judgment in determining whether the Member was afforded a fair hearing. The decision shall specify the reasons for the action taken and provide findings of fact and conclusions articulating the connection between the evidence produced at the Hearing and the appeal, if any, and the decision reached, if such reasons, findings, and conclusions differ from those of the Hearing Panel.

7. Right to One Hearing

Except as otherwise provided in this Manual, no Member shall be entitled to more than one evidentiary hearing and one appellate review on any single matter without regard to whether such subject is the result of action by the Campus Executive Committee or Medical Executive Committee or the Board of Directors, of a combination of acts of such bodies.

8. Contract Physicians

Members under contract with the Hospital in any medical-administrative capacity, in closed departments or departments with exclusive contracts shall be subject to the procedural rights set forth in this Manual only to the extent that the:

xxxxxxxxxxxx)a) Hospital, based on a recommendation by the Medical Executive Committee, proposes contract modifications that result in termination or restrictions of a Member's staff privileges or membership based on a Medical Disciplinary Cause or Reason.

yyyyyyyyyyyy)b) Medical Executive Committee takes action which must be reported under Business & Professions Code Section 805 and/or the Member's membership status or privileges which are independent of the Member's contract are suspended, restricted, or revoked for a Medical Disciplinary Cause or Reason.

Except as provided above, termination or alteration of a contract held between the Hospital or System and Member will be considered an administrative matter and will not be grounds for any of the Hearing procedures set forth in this Manual.

9. Exhaustion of Remedies

If adverse action as described in this Manual is taken or recommended, the Member must exhaust the

remedies afforded by the terms of this Manual before resorting to legal action.

10. Failure to Satisfy Minimum Requirements

Denial or loss or privileges due to failure to meet minimum, generally applicable objective requirements, including but not limited to the requirements set forth in Section 3.2.2 of the Bylaws, shall not be grounds for any of the procedures set forth in this Manual.

11. Reapplication Following Adverse Action

Whenever an applicant is denied appointment or reappointment, or a Member loses membership or some or all privileges for a Medical Disciplinary Cause or Reason, such person shall not be entitled to reapply for membership and/or such privileges for two years, unless the Medical Executive Committee determines, in its sole discretion, that the basis for the denial or termination has been eliminated prior to such time.

CLEAN

Palomar Medical Center
Medical Staff
(Escondido Campus & Poway Campus)

Bylaws

(Includes Credentials Policy Manual
and
Medical Staff Rights Manual)

Rules and Regulations

Approved by:
Palomar Medical Center Escondido Medical Staff on September 25, 2023
Palomar Medical Center Poway Medical Staff on August 29, 2023

Palomar Health Board of Directors
on October 9, 2023

PALOMAR HEALTH

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ARTICLE I: NAME AND REFERENCES

The name of the organization shall be the Palomar Medical Center Medical Staff (the "Medical Staff").

Reference throughout these Bylaws and in Medical Staff rules, regulations, policies, and other documents shall be made to the geographic subdivisions of the Medical Staff comprised of leaders and members at the separate facilities in Escondido (the "Escondido Campus") and Poway (the "Poway Campus"). The separate facilities may be referred to collectively as "Campuses" or individually as "Campus" as the context requires. Unless expressly provided otherwise, the terms, sections, and provisions of these Bylaws shall apply to the Medical Staff without regard to any particular campus.

General references to a campus in these Bylaws and in Medical Staff rules, regulations, policies, and other documents (e.g., the Campus Chief of Staff or the Campus Executive Committee) shall be construed to refer to either the Escondido Campus or the Poway Campus in particular, as the context reasonably requires.

ARTICLE II: PURPOSES

2.1 The purposes of this organization shall be:

2.1.1. To initiate and maintain the bylaws, rules and regulation for the self-governance of the Medical Staff.

2.1.2. To provide a means whereby all Members authorized to practice in the Hospital have the appropriate delineation of clinical privileges that each Member may exercise in the Hospital and assuring ongoing review of each Member's future performance.

2.1.3. To provide a means whereby issues concerning the Medical Staff and the Hospital may be discussed by the Medical Staff with Administration and the Board of Directors.

2.1.4. To provide an appropriate educational setting that shall maintain scientific standards that shall lead to the continuous advancement of professional knowledge and skill.

2.1.5. To provide a framework of self-governance in order to permit the Medical Staff to discharge its responsibilities in matters involving the quality of medical care.

2.1.6. To empower the Medical Executive Committee to impose such sanctions upon a Member that are necessary and appropriate to enforce the bylaws, rules, and regulations to the extent it believes is necessary and appropriate.

2.2 **Effective Date and Automatic Sunset of Bylaws**

These Bylaws shall be effective on the day the governing body of Palomar Medical Center approves the Bylaws pursuant to its authority under California law and the hospital has been issued a single consolidated license to operate the facilities known as Palomar Medical Center Escondido and Palomar Medical Center Poway (the "Effective Date"). Unless duly amended, modified, or withdrawn and superseded by a new set of bylaws in accordance with the provisions of these Bylaws and consistent with California law, these Bylaws shall remain in effect for one (1) year from the original Effective Date. The Medical Executive Committee may, as it deems appropriate, extend the term of these Bylaws by any number of days for a cumulative total of six months.

ARTICLE III: MEMBERSHIP

3.1. **Nature of Membership**

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

3.2. **General Qualifications**

3.2.1 Only Practitioners licensed to practice medicine, dentistry or podiatry in the State of California, who can document their background, experience, training and demonstrated competence, their adherence to the ethics of their profession, their good reputation, their ability to work with others

and their ability to perform the privileges requested shall be admitted to the Medical Staff.

3.2.2 All practitioners who apply for membership shall be certified as a member of the Board of the American Board of Medical Specialties or by the American Osteopathic Association or by the American Board of Foot and Ankle Surgery or by the American Board of Oral and Maxillofacial Surgery, and or another board with equivalent requirements, or shall be actively engaged in the Board application and certification process. Every applicant to the Medical Staff who is not board certified shall sign a statement at the time of application attesting that he/she is qualified and shall attain certification within forty-eight (48) months of appointment to the Medical Staff. Failure to obtain board certification within the permitted period of time shall result in automatic termination of privileges and membership. The Medical Executive Committee, with consultation from the appropriate Campus MEC, may grant an extension at its discretion. Physicians who are in the final months of an approved residency will be eligible to receive an application for membership. However, continued eligibility is contingent upon receipt of documentation that training has been successfully completed and that the applicant is actively engaged in the Board application process.

Any individual who does not attain board certification within forty-eight (48) months or within the time frame permitted by the American Board of Medical Specialties may request a waiver. The individual requesting the waiver bears the burden of demonstrating that his or her qualifications are equivalent to board certification. The Board may grant a waiver in exceptional cases after considering the findings of the Medical Executive Committee, the specific qualification of the individual in question, and the best interest of the hospital and the community it serves. The granting of a waiver in a particular case is not intended to set a precedent for any other individual. No individual is entitled to a waiver or a hearing if the Board determines not to grant a waiver. A determination that an individual is not entitled to a waiver is not a "denial" of appointment or clinical privileges.

3.2.3 Qualifications For Membership
Only physicians, dentists, and podiatrists shall be deemed to possess basic qualifications for membership in the medical staff, and who

a) confirm (1) current licensure, (2) adequate experience, education, and training, (3) current professional competence, (4) good judgment, and (5) current adequate physical and mental health status, so as to demonstrate to the satisfaction of the Medical Staff professional and ethically competence and patients can reasonably expect to receive quality medical care;

b) are determined (1) to adhere to the ethics of their respective professions, (2) to be able to work cooperatively with others so as not to adversely affect patient care, (3) to keep as confidential, as required by law, all information or records received in the physician-patient relationship, and (4) to be willing to participate in and properly discharge those responsibilities as reasonably determined by the Medical Staff;

3.2.4 Basic Responsibilities Of Medical Staff Membership
The ongoing responsibilities of each member of the medical staff include:

a) Providing patients with the quality of care meeting the professional standards of the medical staff of this hospital;

b) Abiding by the medical staff bylaws, Medical Staff rules and regulations, and policies;

c) Discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the member by virtue of Medical Staff membership, including committee assignments;

d) Preparing and completing in timely fashion medical records for all the patients to whom the member provides care in the hospital;

e) Abiding by the lawful ethical principles of the California Medical Association or member's professional association:

(1) Provide for continuous care of his/her patients.

(2) Delegate in their absence the responsibility for diagnosis or care of their patients only to a Member who is qualified to undertake this responsibility.

(3) Seek consultation whenever indicated.

f) Working cooperatively with members, nurses, hospital administration and others so as not to adversely affect patient care;

g) Making appropriate arrangements for coverage of that member's patients as determined by the medical staff or Medical Executive Committee;

h) Refusing to engage in improper inducements for patient referral;

i) Participating in continuing education programs as determined by the Medical Staff or Medical Executive Committee;

j) Participating in such emergency service coverage or consultation panels as may be determined by the Medical Staff or Medical Executive Committee;

k) Discharging such other staff obligations as may be lawfully established from time to time by the Medical Staff or Medical Executive Committee;

l) Providing information to and/or testifying on behalf of the Medical Staff or an accused practitioner regarding any matter under an investigation, and those which are the subject of a hearing;

m) Maintaining Board certification in the primary specialty as specified in 3.2.2; and

n) Serving as a proctor or other peer reviewer, and otherwise participating in Medical Staff peer review as reasonably requested.

3.2.5 Effect of Other Affiliations

No person shall be entitled to membership in the Medical Staff merely because that person holds a certain degree, is licensed to practice in this or in any other state, is a member of any professional organization, is certified by any clinical board, or because such person had, or presently has, staff membership or privileges at another health care facility. Medical Staff membership or clinical privileges shall not be conditioned or determined on the basis of an individual's participation or non-participation in a particular medical group, surgery center or other outpatient service facility, IPA, PPO, PHO, hospital-sponsored foundation, or other organization or in contracts with a third party which contracts with this hospital. Medical Staff membership or clinical privileges shall not be revoked, denied, or otherwise infringed based on the member's professional or business interests.

3.2.6 Every member shall maintain in force professional liability insurance in the amount of $1 million per occurrence and $3 million in the annual aggregate or as from time to time may be jointly determined by the board of directors and the Medical Executive Committee. The Medical Executive Committee, for good cause, shown may waive this requirement with regard to a member as long as such a waiver is not granted or withheld on an arbitrary, discriminatory, or capricious basis. In determining whether an individual exception is appropriate, the following facts may be considered:

a) Whether the member has applied for the requisite insurance;

b) Whether the member has been refused insurance, and if so, the reasons for such refusal; and

c) Whether insurance is reasonably available to the member, and if not, the reasons for its unavailability.

If a Member's insurance is restricted in any manner (such as not covering surgery or obstetrics), the Member must furnish a copy of the policy restriction to the Hospital, and the Member cannot exercise the privileges excluded from the insurance coverage. The Member shall immediately notify the Hospital if coverage lapses for any reason including failure to purchase tail or nose coverage for change in policy or it is expired. Alternative forms of financial security shall be in amounts equal to the required amounts of professional liability insurance, shall cover defense costs and liability, and cannot be used as a substitute for insurance without prior individual approval by the Medical Executive Committee and the Board of Directors.

3.2.7 Acceptance of membership shall constitute an agreement that the Member will abide by these bylaws, rules and regulations and that throughout any period of membership that person will comply with the responsibilities of medical staff membership.

3.2.8 When a Member fails to make an appropriate response to a request sent by certified, return receipt mail, for reasonable information or action within thirty (30) days, it shall be deemed a voluntary resignation of his/her membership and clinical privileges.

3.3. Leave of Absence

3.3.1 Leave Status
At the discretion of the Medical Executive Committee, a Medical Staff member may obtain a voluntary leave of absence from the staff upon submitting a written request to the Medical Executive Committee stating the approximate period of leave desired, which may not exceed two (2) years. During the period of the leave, the member shall not exercise clinical privileges at the hospital, and membership rights and responsibilities shall be inactive.

3.3.2 Termination of Leave
At least thirty (30) days prior to the termination of the leave of absence, or at any earlier time, the Medical Staff member may request reinstatement of privileges by submitting a written notice to that effect to the Medical Executive Committee. The member shall submit a summary of relevant activities during the leave, if the Medical Executive Committee so requests. The Medical Executive Committee shall make a recommendation concerning the reinstatement of the member's privileges and prerogatives, and the procedure provided in Sections 2 and 3 of the Credentials Policy Manual shall be followed.

3.3.3 Failure to Request Reinstatement
Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of membership, privileges, and prerogatives. A request for Medical Staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial membership

3.3.4 Medical Leave of Absence
The Medical Executive Committee shall determine the circumstances under which a particular Medical Staff member shall be granted a leave of absence for the purpose of obtaining treatment for a medical condition or disability. In the discretion of the Medical Executive Committee, unless accompanied by a reportable restriction of privileges, the leave shall be deemed a "medical leave" which is not granted for a medical disciplinary cause or reason.

3.3.5 Military Leave of Absence
Requests for leave of absence to fulfill military service obligations shall be granted upon notice and review by the Medical Executive Committee. Reactivation of membership and clinical privileges previously held shall be granted, notwithstanding the provisions of Sections 3.3.2 and 3.3.3, but may be granted subject to monitoring and/or proctoring as determined by the Medical Executive Committee.

3.4. Non-Eligibility

An applicant who has been denied membership, or whose membership was revoked at any Palomar Health facility (including, but not limited to, Palomar Medical Center Escondido and Palomar Medical Center Poway) within one (1) year prior to the submission of an application to another Palomar Health facility, shall be ineligible for membership on the medical staff of any Palomar Health facility. An applicant who has been denied requested privileges, or had privileges revoked or restricted at any Palomar Health facility shall be ineligible for membership at any Palomar Health facility. Information regarding an issue occurring at any one Palomar Health facility may be shared with other Palomar Health facilities.

3.5. Quality Improvement

The Hospital has an ongoing quality improvement program. Part of the program is to observe Members' performance both in and outside the Hospital. By accepting membership, a Practitioner agrees to

participate in this program including any requirement for attendance to discuss quality, monitoring, or other observation initiated by the Member's respective department or the Quality Management Committee. The Member understands that such attendance and/or monitoring is necessary for an effective quality assessment program and shall not be grounds for a hearing pursuant to The Medical Staff Rights Manual. If requested by the Chief of Staff or the department chairman to attend a meeting to discuss quality, by notice of the time and place of the meeting using certified, return receipt requested mail, failure by a Member to attend such a meeting may result in automatic suspension of clinical privileges by the Chief of Staff as outlined in the Medical Staff Rights Manual 4.3. The advance notice to attend should include a statement of the suspected deviation from the standard of care and should state that attendance is mandatory.

3.6. Harassment Prohibited

Harassment by a Medical Staff member against any individual (e.g., against another Medical Staff member, hospital employee, or patient, on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex or sexual orientation is prohibited under law.

"Sexual harassment" is unwelcome verbal or physical conduct of a sexual or gender-based nature which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and visual harassment (such as the display of derogatory cartoons, drawings, or posters).

Sexual harassment includes unwelcome advances, requests for sexual favors, and any other verbal, visual, or physical conduct of a sexual nature when (1) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion, or other aspects of employment; or (2) this conduct substantially interferes with the individual's employment or creates and/or perpetuates an intimidating, hostile, or offensive work environment. Sexual harassment also includes conduct which indicates that employment and/or employment benefits are conditioned upon acquiescence in sexual activities.

All allegations of sexual harassment shall be promptly investigated within a reasonable time frame by the Medical Staff and, if confirmed, will result in appropriate corrective action.

3.7. Nondiscrimination

No aspect of Medical Staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, religion, ancestry, national origin, disability, physical or mental impairment, marital status, or sexual orientation that does not pose a threat to the quality of patient care.

ARTICLE IV: MEMBERSHIP CATEGORIES

Palomar Medical Center and its Campuses at Escondido and Poway operate under a consolidated license and are part of Palomar Health ("System"). Among the purposes of the System is to maintain high professional standards among its patient care facilities and to strive to provide efficient patient care and support services. In keeping with the foregoing, cooperative credentialing is hereby authorized, in accordance with the guidelines set forth in these bylaws. Each Medical Staff member shall be assigned to a Medical Staff category based upon the qualifications defined in the Bylaws. The members of each Medical Staff category shall have the prerogatives and carry out the duties defined in the Bylaws and Rules and Regulations. Action may be initiated to change the Medical Staff category or terminate the membership of any member who fails to meet the qualifications or fulfill the duties described in the Bylaws or Rules and Regulations. Changes in Medical Staff category shall not be grounds for a hearing unless they adversely affect the member's privileges.

All Medical Staff members shall be assigned to one or both Campuses that comprise Palomar Medical Center, depending on the requests of the member, their department assignment, and the privileges they are granted. Members' privileges at one or both of the separate Palomar Medical Center hospitals prior to the Effective Date, including any restrictions, limitations, or other conditions, shall transfer automatically upon the Effective Date and be assigned to one or both Campuses as appropriate. Unless otherwise specified in these Bylaws or Rules and Regulations, Campus assignment does not create, modify, waive, or terminate any duties, obligations, rights, and entitlements that are generally applicable to all Medical Staff members by virtue of their membership on the

Medical Staff.

4.1. Provisional

All Members shall serve a minimum of one (1) year and a maximum of two (2) years on a provisional basis prior to advancement. All Members shall be assigned to a Campus Department, where the Campus Department Chairperson or his/her designee shall observe his/her performance and clinical competence. Provisional Members are eligible to serve on Medical Staff and Department committees and shall be eligible to vote on committee matters, but they may not hold office. Provisional Members shall not be eligible to vote on general medical staff and Department matters. Provisional category Members assigned to the Escondido Campus, except those intending to become consulting and affiliate categories, shall be required to attend meetings of their Campus Department, unless waived (preferably in advance) by the Escondido Campus Executive Committee and the appropriate Campus Department. This meeting requirement shall have no application at the Poway Campus.

If, at the end of the provisional time, an individual has satisfied the provisional requirements, as determined by the appropriate committee(s) and Department(s) he/she shall be recommended to the Board of Directors for appropriate advancement, if applicable. If, at the end of the provisional time, an individual has not satisfied the provisional requirements, his/her provisional membership shall automatically terminate, and the Member shall be given written notice of such termination and of his/her entitlement to procedural rights specified in the Medical Staff Rights Manual, as applicable.

Members in the Provisional category have the same obligations to provide Emergency Room coverage as Active members.

Dues shall be assessed newly appointed provisional Members, if applicable, on a prorated basis, beginning with the quarter of initial appointment. Any provisional Member who does not pay dues within forty (40) days of the dues notice, shall have his/her clinical privileges suspended, and shall remain so suspended until the Member pays the delinquent dues or until the parameters in Section 4.5(d) of the Medical Staff Rights Manual are met. Provisional category Members shall not be required to serve on a Trauma Services consultation panel. In the event a Member who fails to satisfy the provisional requirements is not otherwise barred from reapplying, such Member may reapply. If a Member fails to meet all Provisional requirements by the end of the second consecutive provisional appointment, the membership shall be terminated.

4.2. Active

4.2.1 Active With Clinical Activity

This category shall consist of Members who regularly admit, or who are regularly involved in the care of patients in the Hospital. Members who attend more than twenty-five (25) patients at a specific Campus during their two (2) year reassessment-reappointment period shall be eligible for active staff membership on the Medical Staff and assignment to that particular Campus. Counting toward the twenty-five (25) patients requirement shall not be cumulative across the Campuses; Members must instead satisfy this requirement at one Campus to be eligible for assignment to that Campus. Such Members must be located close enough to the Campus(es) to which they are assigned to provide continuous care to their patients, and shall assume all functions and responsibilities of the active staff membership, including emergency room coverage, according to the rules and regulations. Active membership does not require a Member to serve on a Trauma Services consultation panel. These Members shall be appointed to a specific department at their assigned Campus(es), shall be eligible to vote, to hold office, to serve on standing committees of the Medical Staff and departments, and shall be required to attend departmental meetings and meetings of the Medical Staff designated as mandatory by the Medical Executive Committee or a Campus Executive Committee, unless waived (preferable in advance) by the Medical Executive Committee, the appropriate Campus Executive Committee, and/or the approved department. Annual dues shall be assessed. Should the Member have no clinical activity at a Palomar Health facility during their two-year reassessment-reappointment period they will automatically be transferred to Active Without Clinical Activity unless that Member has maintained Active or equivalent status at a non-Palomar Health facility, in which

case the Member will be automatically transferred to Courtesy status. Nothing herein restricts, affects, modifies, or supersedes department or committee rules concerning scheduling, response times for ER calls, or other similar requirements.

4.2.2 Active Without Clinical Activity

This category shall consist of Members who are regularly involved in Medical Staff functions as determined by the Medical Staff. These Members shall request "refer and follow" privileges if privileged in Family Practice or Internal Medicine. Members in this category are:

a) Appointed to a specific department at one or both Campuses,
b) Eligible to vote,
c) Allowed to be a departmental officer,
d) Eligible to serve on standing committees of the Medical Staff and departments, and
e) Required to attend departmental meetings and meetings of the Medical Staff designated as mandatory by the Medical Executive Committee or Campus Executive Committee unless waived (preferably in advance) by the Medical Executive Committee, the Campus Executive Committee, and/or the approved department.

Annual dues will be assessed.

"Refer and follow" shall apply only to Members privileged in either Family Practice or Internal Medicine. This allows the Member to perform outpatient preadmission, history and physicals, order non-invasive outpatient diagnostic tests and services; visit patients in the hospital, review medical records, consult with attending physicians; and observe diagnostic or surgical procedures with the approval of the attending physician or surgeon.

4.3. Consulting

The Consulting category shall consist of Members who are recognized specialists who have an appointment equivalent to active category at another hospital where they are required to participate in patient care assessment or other quality care review. These physicians shall consult only at the request of a Member of the Medical Staff. The consulting member's role shall be to evaluate patients, and make recommendations for therapy. This category precludes any procedural privileges except when the procedural privileges are not available from a member of the Medical Staff of that facility. The Chief of Staff or Department Chairman will be required to confirm that monitoring has been completed. Such consulting category Members shall submit a completed application. Initial appointment to this category shall be provisional for one year. A review will be conducted at the end of the first year. Consulting members shall have no admitting privileges, shall not be eligible to vote or hold office in the Medical Staff, and shall not be required, but shall be encouraged to attend department meetings. Annual dues shall be assessed.

4.4. Courtesy

The courtesy category shall consist of Members who only occasionally attend patients at the Hospital. In order to allow for assessment of a member's performance, the Member shall have an appointment equivalent to active category status on the medical staff of another hospital in San Diego County, or at a hospital or surgery center approved by the Medical Executive Committee, where they are required to participate in patient care assessment, and other quality care reviews. A Courtesy category Member is to attend and/or consult upon no more than twenty-five (25) individual patients during a two (2) year assessment-reappointment period. Should a Courtesy Category Member wish to admit and/or consult upon more than twenty-five (25) individual patients in such a time period, they shall apply for Active Category status. Should a Member be on the Active staff of another Palomar Health facility, they may exceed the twenty-five (25) individual patient admit and/or consultation limitation on the Courtesy staff while they maintain their Active staff membership at another Palomar Health facility. Courtesy category Members shall be appointed to a specific Department where attendance, while encouraged is not required unless specifically requested by the Department Chairperson. Courtesy category Members shall not be eligible to vote or to hold office. Courtesy category Members shall not automatically be eligible to serve on the emergency room backup panel but may be required, at the discretion of the Chief of Staff or

Department Chairperson, to be on emergency room call. Courtesy category Members may voluntarily serve but also may be required, at the discretion of the Chief of Staff or department chairperson, to serve on standing committees of the Medical Staff or department committees. When assigned to committee responsibility, courtesy category Members shall have the right to vote in that committee. Annual dues shall be assessed. Should a Member have no clinical activity at a Palomar Health facility during their two-year reassessment-reappointment period, they will be required to transfer to the appropriate category.

4.5. Affiliate

The Affiliate category shall consist of members who meet any one of the following categories:

a) Only admit or regularly attend patients at a Palomar Health distinct part skilled nursing/rehabilitation service;

b) Only act in a surgery assist capacity;

c) Desire no active involvement with the Medical Staff but request "refer and follow" privileges; or

d) Only desire an affiliation with the hospital without any clinical privileges but appear likely to provide a distinct service to the hospital, Medical Staff, and patients. This category shall mainly be comprised of family practitioners that have had no clinical activity through inpatient admissions to Palomar Medical Center, at either of its campuses, during the biennial review period. Practitioners in other specialties may be assigned to this category if they have not had any clinical activity, inpatient admissions, or consultations, during the biennial reassessment period.

Appointment to this category shall be for a period of two (2) years. Affiliate Members shall not be required to live or practice in the Hospital's service area and shall not be required to provide emergency department coverage. Affiliate category members shall not be eligible to vote or hold office and shall not be required, but shall be encouraged to attend departmental and Medical Staff meetings designated as mandatory by the Medical Executive Committee. Annual dues shall be assessed.

4.6. Retired

The retired category shall consist of members who have been in the active category for a minimum of five (5) years and who have retired from practice but wish to maintain affiliation. Such members shall not have admitting or clinical privileges, shall not be eligible to vote, to hold office, or serve on standing committees of the Medical Staff. Meeting attendance shall not be required. Retired category members may avail themselves to all educational and social activities. Annual dues shall not be assessed.

4.7. Administrative

The administrative category shall consist of members who only serve in an administrative capacity at a Palomar Health facility. They shall have no admitting privileges, shall not be eligible to vote or to hold office in the Medical Staff, shall not be required to attend meetings, and shall not represent the Medical Staff at meetings. Annual dues will be assessed.

4.8. Medical Staff Categories Grid

	PROVISIONAL	ACTIVE	CONSULTING	COURTESY	AFFILIATE	RETIRED	ADMINISTRATIVE
PREROGATIVES							
Admits, consults and refers inpatients and outpatients	Yes[3]	Yes[3]	Yes (consults only) [8]	Yes[5]	Yes[7]	No	No
Eligible for clinical privileges			Yes				
Vote	No[2]	Yes	No	No[2]	No	No	No
Hold office	No	Yes	No	No	No	No	No
Serve as Committee Chair	Yes[9]	Yes	No	Yes[9]	No	No	No

Serve on Committees	Yes	Yes	Yes	Yes	No	No	No
RESPONSIBILITIES							
Medical staff functions	Yes	Yes	Yes	Yes	No	No	No
Consulting	Yes	Yes	Yes	Yes	No	No	No
ER call	Yes	Yes	No	Yes[6]	No	No	No
Attend Meetings	Yes	Yes	No[4]	No[4]	No[4]	No	No
Pay App/Reapplication Fee	Yes	Yes	Yes	Yes	Yes	No	No
Pay Dues	Yes	Yes	Yes	Yes	Yes	No	Yes
ADDITIONAL PARTICULAR QUALIFICATIONS							
Must first complete provisional	N/A	Yes	Yes	Yes	Yes	No	No
Malpractice Insurance	Yes	Yes	Yes	Yes	Yes	No	No
File application and apply for reappointment	Yes	Yes	Yes	Yes	Yes	No	No

1. Provisional members serve a minimum of 1 year and a maximum of 2 years.
2. May vote on committee matters but are not eligible to vote on general Medical Staff and Departmental matters.
3. Includes members with clinical activity and without clinical activity that have only "refer and follow" privileges.
4. Consulting, courtesy, and affiliate category members are encouraged but not required to attend meetings.
5. Courtesy category members are to attend and/or consult on no more than 25 individual patients during a 2 year reappointment period. If they are a member on the active staff of another Palomar Health facility they may exceed the 25 patient limitation as long as they maintain active category status at another Palomar Health facility.
6. May be required at the discretion of the Chief of Staff or Department Chairperson.
7. Only admit or attend patients at a Palomar Health distinct part skilled nursing facility, act in a surgery assist capacity, may have "refer and follow" privileges.
8. Except when the procedural privileges are not available from a Member of the Medical Staff (Bylaws 4.3)
9. Provisional and Courtesy Members may serve as Committee Chairs as needed.

ARTICLE V: CLINICAL PRIVILEGES

5.1. Clinical Privileges Overview

5.1.1 Members shall exercise only those clinical privileges specifically granted by the Board of Directors following recommendation by the Department and the Medical Executive Committee. Privileges shall be granted specific to the Campus(es) to which a member has applied and is eligible or consistent with the Palomar Medical Center hospital(s) at which the Member held privileges prior to the Effective Date.

5.1.2 Initial application for membership shall contain a request for the specific clinical privileges desired by the applicant and the Campus(es) where such privileges will be exercised, except for categories Affiliate (unless requesting surgery assist or refer and follow privileges) (Section 4.5), and Administrative (Section 4.7). The evaluation of such requests shall be based on the applicant's education, training, experience, demonstrated competence, references and other relevant information, including an appraisal by the Chairperson of the Campus Department in which privileges are sought. The applicant shall have the burden of establishing his/her qualifications and competence in the clinical privileges he/she requests. Clinical privileges shall be delineated for every applicant and shall not be stated in general, broad terms.

5.1.3 Applicants who wish to request privileges in a specialty other than the specialty in which they maintain board certification may submit their request for such privileges in writing along with documentation of his/her qualifications and competence in support of the request. The appropriate Campus Department and the Campus Executive Committee will review the request for a waiver of eligibility criteria in accordance with Section 1.2 of the Credentials Policy Manual and determine if the applicant should be permitted to apply for these privileges outside of their recognized specialty. A determination that the applicant is not eligible to request such privileges is not a "denial" of clinical privileges and the applicant is not entitled to a hearing. The waiver is in the sole discretion of the Campus Executive Committee and the Department.

5.1.4 Periodic re-determination of clinical privileges and the increase or curtailment of same may be based upon the direct observation of care provided, review of the records of patients treated in the Hospital or other hospitals, review of the Member's participation in the delivery of medical care and any documentation of additional training and/or experience.

5.1.5 Requests for additional clinical privileges, modification of clinical privileges, changes in medical staff status, including new procedures, shall be submitted in writing. The applicant's relevant training and/or experience shall be stated. When not previously established, monitoring requirements will be developed by the appropriate Department. Such requests shall be processed in the same manner as initial applications.

5.2. **Temporary**

5.2.1 Applicants

Following the receipt of a completed application and initial review by the Department Chairperson or the Credentials Committee, where applicable, the Chief Administrative Officer, with the written concurrence of the Chief of Staff and the appropriate Department Chairperson may grant temporary clinical privileges pending processing of the application in accordance with the Medical Staff Procedure for Temporary Privileges. Such temporary privileges shall be time-limited and shall not exceed ninety (90) days, subject to renewal of up to an additional thirty (30) days during the pendency of an application. Temporary privileges shall in no circumstances exceed a total of 120 days in a two- year reappointment cycle. In such instances, the applicant shall be under the supervision of the appropriate Department Chairperson or designee. Special requirements of supervision and reporting may be required by the appropriate Department Chairperson. Temporary clinical privileges shall be immediately terminated by the Chief Administrative Officer, with the concurrence of the Chief of Staff or appropriate Department Chairperson upon notice of any failure by the applicant to comply with such special requirements.

5.2.2 Locum Tenens

Following receipt of a fully completed application and supporting documentation and initial review by the Department Chairperson or Credentials Committee, where applicable, the Chief Administrative Officer, with the written concurrence of the Chief of Staff, and appropriate Department Chairperson, may grant temporary clinical privileges to a person serving as locum tenens for a current member of the Medical Staff. Such privileges shall be granted for a period not to exceed ninety (90) days in a calendar year or one hundred twenty (120) days in a two-year period. The locum tenens physician must apply for the appropriate category of staff membership if a longer period of coverage is requested.

5.2.3 Non-Applicants

The Chief Administrative Officer may grant temporary privileges for an important care need, with the written concurrence of the appropriate Department Chairperson and the Chief of Staff. The following criteria must be met and documented in order to grant temporary privileges to meet an important care need:

a) The individual must have a current license to practice in California.

b) The individual must meet the qualifications for membership as specified in Section 3.2 of these bylaws

c) The individual must have current competence to perform the privileges requested. Evidence of current competence can be demonstrated by meeting the following:

d) Evidence of recent relevant (past 2 years) education, training or experience in the area of privileges being requested, or verification that the individual maintains an active affiliation at a hospital where they are required to participate in patient care assessment and other quality care reviews and where they maintain the same privileges as the temporary privileges being sought.

e) Additional criteria (if any) for the specific privileges requested

Non-Applicant temporary privileges shall in no circumstance exceed one hundred twenty (120) days in a two-year period.

5.2.4 Criteria for "Cross-Specialty" Privileges Within the Hospital

Any request for clinical privileges that are either new to the Hospital or that overlap more than one Department shall initially be reviewed by the appropriate Departments, in order to establish the need for, and appropriateness of, the new procedure or services. The Medical Executive Committee shall facilitate the establishment of hospital-wide credentialing criteria for new or trans-specialty procedures, with the input of all appropriate Departments, with a mechanism designed to ensure that quality patient care is provided for by all individuals with such clinical privileges. In establishing the criteria for such clinical privileges, the Medical Executive Committee may establish an ad-hoc committee with representation from all appropriate Departments.

5.2.5 Termination

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

5.3. Emergency

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

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

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

5.4. Telemedicine Privileges

a) Telemedicine is the exchange of medical information from one site to another via electronic communications for the purpose of improving patient care, treatment, and services. The Board shall determine the clinical services, if any, to be provided through telemedicine after considering the recommendations of the appropriate Department Chairperson and the Medical Executive Committee.

b) This section applies only to those Practitioners appointed to the Medical Staff who will have total or shared responsibility for the care of a patient at the Hospital through the use of a telemedicine link.

"Total or shared responsibility" is evidenced by the Practitioner having the authority to write medical orders and direct a patient's care, treatment, or services. This section shall not pertain to Practitioners who are providing either official or preliminary readings of images, tracings, or specimens through a telemedicine link. Those Practitioners shall be credentialed in a manner that ensures that the medical services are provided safely and effectively.

c) In processing a request for telemedicine privileges pursuant to this section, the Hospital will credential and grant privileges to the Practitioners in the same manner as any other applicant.

5.5. Lapse of Application

If a medical staff member requesting a modification of clinical privileges or reappointment fails to furnish within 90 days after request being made, the information reasonably necessary to evaluate the request, the application shall automatically lapse, and the applicant shall not be entitled to a hearing under these bylaws.

ARTICLE VI: ALLIED HEALTH PROFESSIONALS

6.1. General Qualifications

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

6.2. Board of Directors' Action

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

6.2. Application Procedure

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

6.4. Specifications of Services

Allied Health Professionals shall be individually authorized and assigned to an appropriate Department of one or both Campuses, and shall carry out their services under the supervision of the appropriate Department, or the appropriate attending staff Member assigned this responsibility, and are subject to Department policies and procedures.

6.4.1 Prerogatives
The authorized scope of services for each Allied Health Professional member shall be determined by the Interdisciplinary Practice Committee and the appropriate Medical Staff Department and, in any event, shall not exceed the Allied Health Professional's training, experience, scope of licensure and demonstrated competence.

6.4.2 Limitation of Prerogatives
Allied Health Professionals shall not be eligible to admit patients to the Hospital or Skilled Nursing Facility, nor shall they be eligible for appointment for membership on the Medical Staff, except as may otherwise be required by law. Nothing herein shall create any vested rights in any Allied Health Professional to receive or to maintain any services in a District Facility. The authorization of Allied Health Professional Staff to render care in a District Facility may, at any time and for any reason, be terminated by the appropriate Department Chairperson or the Chief of Staff, the Allied Health Professional's supervising Practitioner, or the Board of Directors. The peer review rights and procedures required under the Business and Professions Code section 809 *et seq.* as further delineated in the Medical Staff Rights Manual shall not apply to Allied Health

Professionals, unless otherwise required by law, except to psychologists when an adverse action is taken which required the filing of a report under Business and Professions Code 805.

6.5. Hearing Rights

6.5.1 Hearing and Appeal Rights

a) Any Allied Health Professional shall have the right to challenge any action that would constitute grounds for a hearing under these Bylaws by filing a written grievance with the Interdisciplinary Practice Committee (IPC) within fifteen (15) days of such action. On receipt of such a grievance, the IPC or its designee shall conduct an investigation that shall afford the AHP an opportunity for an interview concerning the grievance. Any such interview shall not constitute a "hearing," as that term is defined in Section 5 of the Medical Staff Rights Manual, and the procedural rules applicable to such hearings shall not apply. Before the interview, the AHP shall be informed of the general nature and circumstances giving rise to the action, and that AHP may present information relevant at the interview. A record of the interview shall be made. The IPC, or its designee, shall make a recommendation to the Medical Executive Committee based on the interview and all other information available to it. The IPC shall give the AHP written notice of its recommendation to the Medical Executive Committee.

b) The AHP shall have the right to file a written appeal with the Medical Executive Committee within thirty (30) days of receiving notice of the IPC's recommendation. The proceeding by the Medical Executive Committee shall be to review the record of the IPC's interview with the AHP and other information available to the IPC. At its discretion, the Medical Executive Committee may request the IPC or its designee, and the AHP to appear before it to provide information. Within thirty (30) days of meeting to review the AHP's appeal, the Medical Executive Committee shall issue a final decision, which shall be submitted to the Board of Directors for final approval.

6.6. Qualifications Generally

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

ARTICLE VII: MEDICAL STAFF AND CAMPUS OFFICERS

7.05. Officers of the Medical Staff

The Medical Staff shall not have any officers while these Bylaws are in effect and until such time as a new, permanent set of Medical Staff bylaws be adopted and provides for the selection of officers.

All references to the Chief of Staff or any other Medical Staff officer in these Bylaws and in Medical Staff regulations, policies, and other documents shall be construed to refer to the Medical Executive Committee, which shall hold all authority and responsibility to govern the Medical Staff in a manner consistent with these Bylaws.

7.1. Officers of Each Campus

7.1.1 Identification

Each Campus may have the following Campus Officers: the Campus Chief of Staff, Campus Chief of Staff-Elect, Campus Immediate Past Chief of Staff, Campus Secretary-Treasurer, and the Campus Organized Medical Staff Section Representative (who shall work cooperatively with the counterpart OMSS representative from the other Campus to represent the Medical Staff before the California Medical Association's Organized Medical Staff Section).

7.1.2 Eligibility Criteria

Campus Officers shall be Members of the active category of the Medical Staff assigned to the Campus over which they preside and shall remain Members in good standing during their term of office. Failure to maintain such status shall create a vacancy in the office involved. In addition, Campus Officers must satisfy the following criteria initially and continuously to be eligible to serve.

To be eligible for office, candidates must:

a) Have no pending adverse recommendations concerning medical staff appointment or clinical privileges;

b) Not presently be serving as a medical staff officer, Board member or department chairperson at a non-Palomar Health hospital and shall not so serve during their term of office;

c) Be willing to faithfully discharge the duties and responsibilities of the position; and

d) Have demonstrated an ability to work well with others.

7.1.3 Terms of Elected Office

Except as otherwise provided in this paragraph, each Campus Officer shall serve the longer of the effective period of these Bylaws or the remainder of their term as an elected officer of the separate medical staff at the Poway and Escondido hospitals prior to the merger of the medical staffs. If these Bylaws are repealed and superseded with a new set of bylaws before the end of a Campus Officer's term, unless otherwise provided in the new set of bylaws, the Campus Officer shall complete the term under the new set of bylaws for the Medical Staff. Each Campus Officer shall serve in each office until the end of his or her term, or until a successor is elected, unless he/she shall resign or be removed from office.

7.1.4 Recall of Officers

A Campus Officer may be recalled from office for any valid cause, including but not limited to, failure to comply with applicable policies, Bylaws, and Rules and Regulations; failure to perform the duties of the position held; conduct detrimental to the interests of the Medical Staff; an infirmity that renders the individual incapable of fulfilling the duties of his or her office or serious acts of moral turpitude. Except as otherwise provided, recall of a Campus Officer may be initiated by the Medical Executive Committee, or shall be initiated by a petition signed by at least one-third of the voting members of the Campus from which the Campus Officer serves. Recall shall be considered at a special meeting called for that purpose. At least ten (10) days prior to the initiation of any removal action, the individual shall be given notice of the date of the meeting at which such action is to be considered. The individual shall be afforded an opportunity to speak to the appropriate Campus of the Medical Staff present at a special meeting. If a mail ballot is used the individual will be afforded the opportunity to speak to the Medical Executive Committee or the Board prior to the vote on removal. Recall shall require a two-thirds (2/3) vote of the voting Members who actually cast votes at the special meeting in person or by mail ballot.

7.1.5 Vacancies in Campus Office

Vacancies in office occur upon the death or disability, resignation, or removal of the officer or such officer's loss of membership. Vacancies shall be filled by appointment by the Medical Executive Committee, unless otherwise provided herein. If there is a vacancy in the office of Campus Chief of Staff, the Campus Chief of Staff- Elect serves out the remaining term, and the Medical Executive Committee shall promptly nominate an eligible Member to serve as Campus Chief of Staff - Elect, who shall assume the office upon ratification by the appropriate Campus Officers.

7.2. Duties of Campus Officers

7.2.1 Campus Chief of Staff

Campus Chiefs of Staff shall serve as the chief officer of the Campus over which they preside. He/she shall receive a stipend for this service that shall be of an amount determined by the Medical Executive Committee. The duties of the Campus Chiefs of Staff shall include but not be limited to:

a) Enforcing the bylaws, rules and regulations of the Medical Staff as applied to their Campus, implementing sanctions where indicated, and promoting compliance with the procedural safeguards where corrective action has been requested or initiated.

b) Calling, presiding at, and being responsible for the agenda of all meetings of the Campus.

c) Serving as Chair of the Campus Executive Committee and serving as a member of the Joint Conference Committee. Serving as a nonvoting member of all other committees of the Campus unless his/her membership on a particular committee is required by these bylaws.

d) In coordination with and by delegation of the Medical Executive Committee, interacting with the Chief Administrative Officer and the Board of Directors in all matters of mutual concern between his/her Campus and the Hospital.

e) Appointing members for all standing and special liaison, multi-disciplinary, or Campus committees, except where otherwise provided by these bylaws, and except where otherwise indicated, designating the chairpersons of these committees.

f) In coordination with and by delegation of the Medical Executive Committee, representing the views and policies of the Campus to the Board of Directors and to the Chief Administrative Officer.

g) In coordination with and by delegation of the Medical Executive Committee, being a spokesperson for the Campus in external professional and public relations.

h) Serving on liaison committees with the Board of Directors and administration, as well as outside licensing or accreditation agencies.

i) Performing such other functions as may be assigned to them by these Bylaws, the Medical Staff, or by the Medical Executive Committee.

j) The Campus Chief of Staff or his/her designee may coordinate with administration in the annual evaluation of physician administrative positions, such as vice president of medical affairs or chief medical officer, if in existence

k) Recommending to the Medical Executive Committee, who shall certify to the Board, that applicants recommended by the Campus Executive Committee for appointment, advancement, or reappointment to the Medical Staff and assigned to their Campus, or to receive authorization to provide patient care services as allied health professionals , have satisfied all requirements specified by the Medical Staff and the Board.

7.2.2 Campus Chief of Staff-Elect

The Campus Chief of Staff-Elect shall assume all duties and authority of the Campus Chief of Staff in the absence of the Campus Chief of Staff. The Campus Chief of Staff-Elect shall be a member of the Campus Executive Committee, and any other committees as specified by the Campus Executive Committee. He/she shall chair the Campus Credentials Committee and the Bylaws Committee or the equivalent subcommittee of the Campus Executive Committee. He/she shall perform such other duties as the Campus Chief of Staff may assign, or as may be delegated by these Bylaws or by the Medical Executive Committee. The Campus Chief of Staff-Elect shall receive a stipend for their services that shall be of an amount determined by the Medical Executive Committee.

7.2.3 Immediate Past Campus Chief of Staff

The Immediate Past Campus Chief of Staff's role shall be advisory in nature. He/she shall be a member of the Medical Executive Committee and any other Committee as specified by the Medical Executive Committee.

7.2.4 Campus Secretary-Treasurer

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

a) Attend meetings of the Campus, Medical Staff, and Campus Executive Committee and ensure minutes are maintained.

b) Be the custodian of all records and papers belonging to his/her Campus.

c) Cause to be collected all dues and assessments from Members assigned to the Campus and deposit such funds into the account of the Medical Staff to be segregated for each Campus, make payments, and generally manage the fiscal affairs of the Campus, subject to oversight of the Medical Executive Committee.

7.2.5 Organized Medical Staff Section (OMSS) Representative

The Organized Medical Staff Section Representative shall:

a) Be a member of the American Medical Association, the California Medical Association, and the San Diego County Medical Society.

b) Attend meetings of the Campus Medical Executive Committee.

c) Working cooperatively with the counterpart Campus OMSS member, serve as the representative to the Medical Staff Section of the American Medical Association, California Medical Association, and the San Diego County Medical Society.

d) Report to the Campus Medical Executive Committee after attending meetings of the American Medical Association, California Medical Association, and the San Diego County Medical Society.

e) From time to time the Campus Medical Executive Committee shall establish appropriate compensation for the OMSS representative for expenses incurred to fulfill the duties of the position.

7.2.6 Chain of Command

a) Campus Chief of Staff

b) Campus Chief of Staff-Elect

c) Immediate Past Campus Chief of Staff

d) Chairperson, Campus Department of Surgery

e) Chairperson, Campus Department of Medicine

f) Chairperson, Campus Department of Obstetrics and Gynecology

7.2.7 References to Officers

Any references to a chief of staff, chief of staff - elect, immediate past chief of staff, and secretary-treasurer in existing Medical Staff bylaws, rules, regulations, and policies shall be construed to refer to the corresponding Campus Officer for the appropriate Campus, as dictated by the context.

ARTICLE VIII: COMMITTEES OF THE MEDICAL STAFF AND THE CAMPUSES

8.1. Designation

The Committees described in this article shall be the standing committees of the Medical Staff, including Campus-specific committees where so specified. Special or ad hoc committees may be created by the Medical Executive Committee or a Campus Executive Committee to perform specified tasks.

Appointment and removal of committee members are subject to consultation with and approval by the Medical Executive Committee in the case of Medical Staff Committees or Campus Executive Committee in the case of Campus Committees. All committees of the Medical Staff shall be responsible to the Medical Executive Committee, but Campus Committees shall be preliminarily responsible to the appropriate Campus Executive Committee. Nothing in these Bylaws or any Medical Staff rules, regulations, or policies shall limit or nullify the authority of the Medical Executive Committee as the ultimate governing body of the Medical Staff.

8.2. General Provisions

8.2.1 Appointment of Committee Members

Unless otherwise specified in these Bylaws, committees of the Medical Staff and Campus committees shall be composed of all those members of the equivalent or corresponding committees of the medical staffs who were seated on the day immediately prior to the effective date of the single consolidated license for Palomar Medical Center, which resulted in the consolidation of the medical staffs into this Medical Staff. To the extent any seat on a committee was vacant on such day, such seat shall remain vacant on the corresponding or equivalent Medical Staff or Campus committee and may be filled pursuant to these Bylaws.

8.2.2 Terms

Unless removed from their committee position as provided in these Bylaws, and except as provided below in this section, committee members shall serve the longer of the effective period of these Bylaws or the remainder of their term as a committee member on the separate medical staff at the Poway and Escondido hospitals prior to the merger of the medical staffs. If these Bylaws are repealed and superseded with a new set of bylaws before the end of the committee member's term, unless otherwise provided in the new set of bylaws, the committee member shall complete the term under the new set of bylaws for the Medical Staff or the member's successor is appointed, unless the member shall be removed from the committee. Members of the Campus Executive Committee shall attend at least 50% of the scheduled meetings of such committees at their campus annually, unless excused by the committee.

Notwithstanding the foregoing, any appointments of committee members that are made prior to but will not commence until after the Effective Date shall be carried out as originally planned, including installing new committee members and replacing old committee members. Such committee appointments shall carry terms consistent with this section.

8.2.3 Removal

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

8.2.4 Vacancies

Unless otherwise specifically provided in these Bylaws, the Medical Executive Committee shall appoint a successor to fill any vacancies on a Medical Staff committee and the appropriate Campus Executive Committee shall appoint a successor to fill any vacancies in a Campus committee.

8.3. Medical Executive Committee of the Medical Staff

8.3.1 Composition (4 total) and Authority to Act

a) Campus Chief of Staff from each Campus (2); and

b) Campus Chief of Staff – Elect from each Campus (2).

The Medical Executive Committee is the exclusive governing body vested with authority to act on behalf of and for the benefit of the Medical Staff. The Medical Executive Committee shall operate and act by majority vote of its members. Tiebreakers shall be determined in the following order:

1. If the Medical Executive Committee is acting upon a formal recommendation as recognized in these Bylaws (e.g., a recommendation on a privileging application) from a Campus officer or a Campus Executive Committee, or any campus department or campus committee, such recommendation shall be adopted as the decision of the Medical Executive Committee in the event of a tie vote in the Medical Executive Committee.
2. If the Medical Executive Committee is acting upon an issue that exclusively affects one Campus, the Medical Executive Committee shall adopt the position of the affected Campus Executive

Committee in the event of a tie vote in the Medical Executive Committee.

Notwithstanding any provision in these Bylaws, the Medical Executive Committee may delegate its authority to any one or more of its individual members or to any committee, department, or Campus Officer as the Medical Executive Committee deems proper. The Medical Executive Committee reserves the right to modify, terminate, or rescind any delegation of authority.

8.3.2 Duties

The duties of the Medical Executive Committee as delegated by the Medical Staff shall include, but not be limited to, the following below. Such delegated authority may be removed by two-thirds vote of those Members of the Medical Staff voting.

a) Representing and acting on behalf of the Medical Staff in the intervals between meetings of the Medical Staff, subject to such limitations as may be imposed by these bylaws.

b) Coordinating and implementing the professional and organizational activities and policies of the Medical Staff.

c) Receiving and acting upon reports and recommendations from Departments, committees, and assigned activity groups of the Medical Staff.

d) Recommending action to the Board of Directors on matters of a medical-administrative nature.

e) Establishing the structure of the Medical Staff, the mechanism to review credentials and delineate individual clinical privileges, the organization of quality management activities and mechanisms of the Medical Staff, termination of membership and fair hearing procedures, as well as other matters relevant to the operation of an organized Medical Staff, including a cooperative working relationship with other District Facilities, as to each of these obligations.

f) Evaluating the medical care rendered to patients in the Hospital.

g) Participating in the development of policies, practices, and planning of the Medical Staff and Hospital.

h) Reviewing the qualifications, credentials, performance and professional competence and character of applicants and Members. Making recommendations to the Board of Directors regarding appointment, reappointment, assignment to Departments, clinical privileges, and corrective action.

i) Taking reasonable steps to promote ethical and competent clinical performance on the part of the Members including the initiation of and participation in corrective or review measures when warranted.

j) Designating such committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the Medical Staff and approving or rejecting recommendations from those committees.

k) Reporting to the Medical Staff at meetings of the Medical Staff.

l) Assisting in the obtaining and maintaining of accreditation.

m) Developing and maintaining methods for the protection and care of patients and others in the event of internal or external disaster.

n) Appointing such special or ad hoc committees as may seem necessary or appropriate to assist the Medical Executive Committee in carrying out its functions and those of the Medical Staff.

o) Reviewing the quality and appropriateness of services provided by contract physicians.

p) Undertaking the functions of the Credentials Committee for any Campus without such committee, including the following activities: review and evaluate the credentials of all applicants to be assigned to the relevant Campus and Allied Health Professional Staff after receiving applications; investigate, review, and recommend on matters referred by the Campus Chief of Staff or Campus Department Chairpersons regarding the conduct, professional character, or competence of any applicant to the relevant Campus or Allied Health Professional Staff; review any such referral in regard to re-application at the time of reappointment to the Medical Staff or the Allied Health Professional Staff; and charge the

creation of an Interdisciplinary Practice Committee, to perform functions consistent with the requirements of law and regulation and to receive reports from same.

q) Making Medical Staff recommendations to the Board of Directors for its approval, pertaining to at least the following:
   (1) The Medical Staff structure
   (2) The mechanism used to review credentials and to delineate individual clinical privileges.
   (3) Appointment and Reappointment of Medical Staff Members, and restricting, reducing, suspending, terminating and revoking Medical Staff membership.
   (4) Granting, modifying, restricting, reducing, suspending, terminating, and revoking clinical privileges, and assignments to Departments.
   (5) The participation of the Medical Staff in organization performance improvement activities.
   (6) The mechanism by which Medical Staff membership may be terminated.
   (7) The mechanism for fair hearing procedures.

r) Developing and approving Medical Staff policies and procedures. The Medical Executive Committee will communicate such policies and procedures to the Medical Staff. Any Members, responsible committee, or department may also formulate and propose policies and procedures to the Medical Executive Committee.

8.3.3 Conflict Management.

In the event of conflict between the Medical Executive Committee and the Medical Staff (as represented by a petition signed by at least 20% of the voting members of the Medical Staff on issues affecting both Campuses, or by at least 20% of the voting members of a Campus on issues affecting only that Campus), the Medical Executive Committee or its designee(s) (including representatives from a Campus on issues affecting only that Campus) shall convene a meeting as soon as possible with the petitioners' representative(s) to identify the conflict. The foregoing petition shall include a designation of up to (five) members of the voting Medical Staff who shall serve as the petitioners' representative(s). The Medical Executive Committee or its designee(s) and the petitioners' representative(s) shall gather and exchange information relevant to the conflict and shall work in good faith to resolve differences in a manner that respects the positions of the Medical Staff, the leadership responsibilities of the Medical Executive Committee, and the safety and quality of patient care at the hospital. At all times, the parties will ensure the safety and quality of patient care. Resolution at this level requires a majority vote of the Medical Executive Committee after recommendation from its designee(s), if any. Unresolved differences shall be submitted to the Board of Directors for final resolution.

8.3.4 Meetings

The Medical Executive Committee shall usually meet at least semiannually. It shall maintain a record of its proceedings and actions. Nothing herein shall prevent the Medical Executive Committee from functioning or discharging its duties via remote meetings or via email or similar electronic communications.

8.4 Campus Executive Committees

8.4.1 Composition. There shall be a Campus Executive Committee at each Campus of the Medical Staff, which shall be comprised of all members seated on the medical executive committee of the medical staff at that Campus on the day immediately prior to the effective date of the single consolidated license for Palomar Medical Center, which resulted in the consolidation of the medical staffs into this Medical Staff. To the extent any seat on the medical executive committee was vacant on such day, such seat shall remain vacant on the Campus Executive Committee. For purposes of illustration only, each Campus Executive Committee may consist of the following seats:

a) Campus officers of the Campus (Campus Chief of Staff, Campus Chief of Staff – Elect, and Campus Immediate Past Chief of Staff);

b) Campus Department Chairpersons;

c) Chair, Campus Quality Management Committee;

d) The Chief Executive Officer of Palomar Health or his/her designee shall attend as a non-voting ex-officio member. He/she may not attend executive sessions of this committee, unless requested to do so by the Campus Chief of Staff, with approval of the Campus Executive Committee;

e) For the Escondido Campus only, the Medical Director of the Trauma program, as a non-voting member;

f) Chair, Campus Medical Staff Peer Review Committee (MSPRC), as a non-voting member; and

g) At-large members elected by the Campus, who are subject to removal by unanimous vote of the remaining Campus Executive Committee members.

8.4.2 Duties

The duties of the Campus Executive Committee are delegated from and derivative of the authority and duties of the Medical Executive Committee of the Medical Staff. The Medical Executive Committee may, at its discretion, revoke or modify these duties at any time as it deems appropriate.

a) Representing and acting on behalf of the Campus in the intervals between meetings of the Campus, subject to such limitations as may be imposed by these bylaws.

b) Coordinating and implementing the professional and organizational activities and policies of the Campus.

c) Receiving and acting upon reports and recommendations from Campus Departments, committees, and assigned activity groups of the Campus.

d) Recommending action to the Medical Executive Committee on matters of a medical-administrative nature.

e) Establishing the structure of the Campus, the mechanism to review credentials and delineate individual clinical privileges, the organization of quality management activities and mechanisms of the Campus, termination of membership and fair hearing procedures, as well as other matters relevant to the operation of an organized Medical Staff, including a cooperative working relationship with other District Facilities, as to each of these obligations.

f) Evaluating the medical care rendered to patients in the Hospital.

g) Participating in the development of policies, practices, and planning of the Campus and Hospital.

h) Reviewing the qualifications, credentials, performance and professional competence and character of applicants and Members at the Campus. Making recommendations to the Medical Executive Committee regarding appointment, reappointment, assignment to a Campus or Campus Departments, clinical privileges, and corrective action.

i) Taking reasonable steps to promote ethical and competent clinical performance on the part of the Members including the initiation of and participation in corrective or review measures when warranted.

j) Designating such Campus committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the Medical Staff and approving or rejecting recommendations from those Campus committees.

k) Reporting meetings of the Medical Staff for that Campus.

l) Assisting in the obtaining and maintaining of accreditation.

m) Developing and maintaining methods for the protection and care of patients and others in the event of internal or external disaster.

n) Appointing such special or ad hoc Campus committees as may seem necessary or appropriate to assist the Campus Executive Committee in carrying out its functions and those of the Medical Staff.

o) Reviewing the quality and appropriateness of services provided by contract physicians at the Campus.

p) For the Poway Campus only, undertaking the functions of the Credentials Committee, including the following activities: review and evaluate the credentials of all applicants to the Medical Staff and Allied Health Professional Staff at the Poway Campus after receiving applications; investigate, review, and recommend on matters referred by the Campus Chief of Staff, the Medical Executive Committee, or Campus Department Chairpersons regarding the conduct, professional character, or competence of any applicant to either the Medical Staff or Allied Health Professional Staff at the Poway Campus; review any such referral in regard to re-application at the time of reappointment to the Medical Staff or the Allied Health Professional Staff at the Poway Campus; and charge the creation of an Interdisciplinary Practice Committee, to perform functions consistent with the requirements of law and regulation and to receive reports from same.

q) Making Medical Staff recommendations to the Medical Executive Committee for its approval, pertaining to at least the following:

(1) The Medical Staff structure

(2) The mechanism used to review credentials and to delineate individual clinical privileges.

(3) Appointment and Reappointment of Medical Staff Members, and restricting, reducing, suspending, terminating and revoking Medical Staff membership.

(4) Granting, modifying, restricting, reducing, suspending, terminating, and revoking clinical privileges, and assignments to Departments.

(5) The participation of the Medical Staff in organization performance improvement activities.

(6) The mechanism by which Medical Staff membership may be terminated.

(7) The mechanism for fair hearing procedures.

r) Developing and approving Medical Staff policies and procedures for the Campus. The Campus Executive Committee will communicate such policies and procedures to the Medical Executive Committee and the Medical Staff at its Campus. Any Members, responsible committee, or department may also formulate and propose policies and procedures to the Campus Executive Committee.

8.4.3 Meetings

The Campus Executive Committee shall usually meet monthly but not less than nine (9) times per year. It shall maintain a record of its proceedings and actions.

8.5 Campus Credentials Committee for the Escondido Campus

8.5.1 Composition

There shall be a Campus Credentials Committee for the Escondido Campus, which shall consist of the Campus Chief of Staff - Elect as Chairperson, the Campus Chief of Staff, the Campus Immediate Past Chief of Staff, the Chair of the Campus Interdisciplinary Practice Committee; Campus Department Chairpersons, may be invited to participate as members of the Credentials Committee from time to time.

8.5.2 Duties

The Campus Credential Committee for the Escondido Campus shall:

a) Review and evaluate the credentials of all applicants to the Medical Staff and Allied Health Professional Staff at the Escondido Campus after receiving applications.

a) Submit timely recommendations to the Medical Executive Committee and/or Campus Departments.

b) Investigate, review, and report on matters referred by the Campus Chief of Staff, the Medical Executive Committee, the Campus Executive Committee, or Campus Departments regarding conduct, professional character, or competence of any applicant.

c) Charge the creation of an Interdisciplinary Practice Committee to perform functions consistent with the requirements of law and regulation and to receive reports from same.

8.5.3 Meetings

The Campus Credentials Committee for the Escondido Campus shall meet as necessary, usually quarterly. It shall maintain a record of its proceedings and report its activities and recommendations to the Campus Executive Committee.

8.6 Quality Management Committee

There shall be a Quality Management Committee of the Medical Staff. The composition, responsibilities, meeting and reporting requirements and functions (blood usage, drug usage, pharmacy and therapeutics, nutrition, medical records timeliness and pertinence, surgical case review, special care unit review, utilization review, Palomar Health skilled nursing facilities, and infection control) are specified in the Palomar Health System Performance Improvement Plan, the pertinent provisions of which are incorporated herein by this reference.

8.7 Campus Critical Care Committee

There shall be a Campus Critical Care Committee at each Campus of the Medical Staff. The composition, responsibilities, meeting, and reporting requirements of the Campus Critical Care Committee are as specified in the Critical Care Committee Plan present in Attachment 2 of the Palomar Health Performance Improvement Plan, the pertinent provisions of which are incorporated herein by this reference.

8.8 Physician Well Being Committee of the Medical Staff

8.8.1 Composition

There shall be a Physician Well Being Committee of the Medical Staff to serve both Campuses, which shall be comprised of no less than five (5) active members of the Medical Staffs, each serving a two (2) year term, a majority of which, including the chair, shall be physicians. Insofar as possible, members of this committee shall not serve as active participants on other peer review or quality assessment and improvement committees while serving on this committee.

8.8.2 Duties

The Physician Well Being Committee may receive reports related to the health, well-being, or impairment of Medical Staff members and, as it deems appropriate, may investigate such reports. With respect to matters involving individual Medical Staff members, the committee may, on a voluntary basis, provide such advice, counseling, or referrals as may seem appropriate. Such activities shall be confidential; however, in the event information received by the committee clearly demonstrates that the health or known impairment of a Medical Staff member poses an unreasonable risk of harm to hospitalized patients, that information may be referred for corrective action. The committee shall also consider general matters related to the health and well-being of the Medical Staff and, with the approval of the Medical Executive Committee, develop educational programs or related activities.

8.8.3 Meetings

The Physician Well Being Committee may meet as often as necessary, but at least twice a year. It shall maintain a record of its proceedings, as it deems advisable, but shall report on its activities as needed to the Medical Executive Committee.

8.9 Biomedical Ethics Committee of the Medical Staff

8.9.1 Composition

The Biomedical Ethics Committee shall be a combined committee of the two Campuses of the Medical Staff. The Committee shall consist of three (3) physician representatives from each Campus and other members, as the Medical Executive Committee may deem appropriate. It may include lay representatives, social services, clergy, ethicists, attorneys, nursing staff, administrators (or their designees), and representatives from the Board of Directors as non-voting members. Physician members will be appointed by the Medical Executive Committee, including a chairperson. A subcommittee of the committee shall be formed at each Campus composed of the three (3) representatives for the respective Campus.

8.9.2 Duties

The Biomedical Ethics Committee shall participate in the development of guidelines for consideration of cases having bio-ethical implications; development and implementation of

procedures for the review of such cases; development and/or review of institutional policies regarding the care and treatment of such cases; retrospective review of cases for the evaluation of bio-ethical policies; consultation with concerned parties to facilitate communication and aid in conflict resolution; and education of the hospital staff on bio-ethical matters.

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

8.10 Education/ Library Committee

8.10.1 Composition
The Education/Library Committee is a joint committee for both Campuses and shall be composed of broad physician representation. The following ancillary representatives shall serve as non-voting members: The Director of Organizational Learning, the Tumor Registrar and a representative from the Department of Pharmacy, all of which are district positions.

8.10.2 Duties
a) Coordinating all continuing medical education activities including recording of attendance at educational meetings.
b) Assuring that any deficiencies in patient care as revealed by peer review and disease audits are made subjects of educational sessions.
c) Prioritizing hospital sponsored continuing education.
d) Reviewing library policies and procedures, establishing priorities in the selection of new texts, online and digital educational content and selecting or reviewing journal subscriptions.
e) Evaluating effectiveness of the library in meeting the informational and educational needs of users.

8.11 Long Term Care Committee of the Poway Campus

8.11.1 Composition
The Long Term Care Committee of the Poway Campus serves that Campus, in which the Medical Director of the Palomar Health Skilled Nursing Facility (SNF) shall serve as the Chair. At least three (3) physician representatives shall be appointed from the Poway Campus Departments of Medicine and Surgery by the Campus Chief of Staff. Non-voting members shall include the SNF Administrator, the Director of Nursing, the Director of Staff Development, the UR Coordinator, the Director of Environmental Services, EP&S Committee Chairperson, Infection Surveillance Nurse, Director of Health Information Services, a Pharmacist, and the Director of Quality Management.

8.11.2 Duties
The duties of the Long Term Care Committee of the Poway Campus shall include:
a) Advisory review and revision of administrative policies and procedures.
b) Coordinating the functioning of the facility, including equipment purchases and operating policies.
c) Performing utilization review activities for the facility. In this capacity, the Committee or a subcommittee of it, shall function as the UR subcommittee for the facility.
d) Review results of current improvement activities, including ongoing measurements and focus studies, to prioritize opportunities for improvement.

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

8.12 Infection Surveillance Committee

There shall be an Infection Surveillance Committee of the Medical Staff. The composition, responsibilities, meeting, and reporting requirements of this committee are as specified in the Infection Prevention and Control Committee section of *Patient Safety Plan, Performance Improvement* (Lucidoc ID 11234), and pertinent provisions of which are incorporated herein by this reference.

8.13 Pharmacy and Therapeutics Committee

There shall be a Pharmacy and Therapeutics Committee of the Medical Staff. The composition, responsibilities, meeting, and reporting requirements of this committee are as specified in the Pharmacy and Therapeutics Committee section of *Patient Safety Plan, Performance Improvement* (Lucidoc ID 11234), and pertinent provisions of which are incorporated herein by this reference.

8.14 Utilization Review Committee

There shall be a Utilization Review Committee of the Medical Staff. The composition, responsibilities, meeting, and reporting requirements of this committee are as specified in *Patient Safety Plan, Performance Improvement* (Lucidoc ID 11234), and pertinent provisions of which are incorporated herein by this reference.

8.15 Interdisciplinary Practice Committee

8.15.1 Composition

There shall be a Interdisciplinary Practice Committee at each Campus of the Medical Staff. The Campus Interdisciplinary Practice Committee (IPC) shall have an equal number of Medical Staff members and nursing staff members. It shall include the Chief Nurse Executive or his/her designee for the appropriate Campus. In addition, representatives of the categories of Allied Health Professionals granted privileges for the Campus should serve as consultants on an as-needed basis, and shall participate in the committee proceedings when invited.

8.15.2 Duties

a) Standardized Procedures

(1) The IPC shall develop and review standardized procedures that apply to Advanced Practice Nurses; identify functions that are appropriate for standardized procedures; initiate such procedures; and review and approve standardized procedures.

(2) Standardized procedures can be approved only after consultation with the Department involved, and by affirmative vote of (i) the administrative representatives, (ii) a majority of physician members, and (iii) a majority of nurse members.

b) Credentialing Allied Health Professionals

(1) The IPC shall recommend policies and procedures for expanded role privileges for assessing, planning, and directing the patients' diagnostic and therapeutic care.

(2) The IPC shall participate in AHP peer review and quality improvement. It may initiate corrective action, when indicated, against AHPs in accordance with the Medical Staff Bylaws that govern AHPs

(3) The IPC shall serve as a liaison between the AHPs and the Medical Staff.

8.15.3 Meetings

The IPC shall meet as often as necessary, but at least quarterly. It shall maintain a record of its proceedings and report its activities and recommendations to the Campus Executive Committee.

8.16 Joint Conference Committee of the Medical Staff

8.16.1 Purpose

The purpose of the Joint Conference Committee is two-fold:

a) To facilitate communication amongst the Board, Administration of Palomar Health Medical Center, and the Medical Staff involving medical staff issues such as credentialing, quality improvement, corrective action, and bylaws amendments.

b) To address and confer in good faith to resolve medical staff disputes including but not

limited to those set forth in Section 2282.5 of the Business and Professions Code.

8.16.2 Composition
The Joint Conference Committee shall be a joint committee of with Members from both Campuses consisting of the following: Three Board members selected by the Board; the Chief Executive Officer of Palomar Health; the Chief Medical Officer; the Campus Chiefs of Staff from both Campuses, Campus Chiefs of Staff-Elect from both Campuses; and the Campus Immediate Past Chiefs of Staff from both Campuses; an At Large member of Medical Staff selected by members of the Joint Conference Committee to represent the Medical Staff. The chairperson shall alternate between the Campus Chiefs of Staff for each successive convening of the Joint Conference Committee.

8.16.3 Meetings
The Joint Conference Committee shall meet as often as necessary (usually on a quarterly basis). It shall maintain a record of its proceedings, as it deems advisable and report to the Medical Executive Committee.

8.16 Campus Operating Room Committee

8.16.1 Composition
There shall be a Campus Operating Room Committee at each Campus of the Medical Staff. The Operating Room Committee shall function as a multi-disciplinary committee with physician and other voting representatives from the following departments, service areas, and committees, to the extent applicable for a given Campus: Campus Departments of Anesthesia (two members), OB/GYN, Surgery (including a general surgeon, orthopedic surgeon, and ophthalmologist), Orthopedic Surgery/Rehabilitation, Urology, Trauma; Cardiac Catheterization, Interventional Radiology, GI Endoscopy and Bronchoscopy procedural areas; the Chair of the Campus Robotics Committee, the Director of Surgery Procedure Services or his/her designee, and the Chief Nursing Officer or his/her designee. The Chairperson will be selected from the membership by majority vote.

8.16.2 Duties
The duties of the Campus Operating Room Committee shall include:

a) To recommend guidelines for the efficient and safe functioning of the Perioperative Platform.
b) Promotion of a coordinated, multi-disciplinary approach to overseeing the functioning of the Perioperative Platform.
c) Establishment of OR Scheduling Guidelines with responsibility for application of and revision of the Scheduling Guidelines.
d) The Committee shall serve as a forum for the discussion of problems that are multi-disciplinary in nature. Meetings will allow for exchange of ideas and information among Anesthesiologists, Surgeons, Proceduralists and the OR Staff.
e) The Committee shall review volume reports of the OR activity, as appropriate.

8.16.3 Meetings
The Campus Operating Room Committee shall meet as determined by the Committee, but at least quarterly. It shall maintain a record of its proceedings and shall report its activities and recommendations to the Medical Executive Committee.

8.17 Robotics Committee of the Escondido Campus

8.17.1 Composition
The Robotics Committee of the Escondido Campus is comprised of at least one representative from each of the subspecialties that utilize the DaVinci Robot(s) at the Escondido Campus. The Director of Perioperative Services and other administrative support personnel shall be included as non-voting members as determined by the Chairperson. The Chairperson shall be selected by the Escondido Campus Chief of Staff.

8.17.2 Duties

The duties of the Robotics Committee of the Escondido Campus shall include:

a) To recommend guidelines for the efficient and safe functioning of the Robotic Surgery Program.

b) Promotion of a coordinated, multi-disciplinary approach to overseeing the functioning of the Robotic Surgery Program.

c) Establishment of OR Scheduling Guidelines with responsibility for application of and revision of the Scheduling Guidelines.

d) Serve as a forum for the discussion of problems that are multi-disciplinary in nature. Meetings will allow for exchange of ideas and information among Anesthesiologists, Surgeons and the OR Staff.

e) Review volume reports of the OR activity, as appropriate.

f) Work with administration, surgeons and marketing to promote the growth and development of the Robotic Surgery Program.

g) Ensure financial viability of the Robotic Surgery Program.

8.17.3 Meetings

The Robotics Committee of the Escondido Campus shall meet as determined by the Committee, but at least quarterly. It shall maintain a record of its proceedings and shall report its activities and recommendations to the Operating Room Committee.

8.18 Campus Medical Staff Peer Review Committee (MSPRC)

There shall be a Campus Medical Staff Peer Review Committee at each Campus of the Medical Staff. The composition, responsibilities, meeting, and reporting requirements of this committee are specified in the Palomar Health Medical Staff Peer Review Committee Manual, pertinent provisions of which are incorporated herein by this reference.

ARTICLE IX: CLINICAL DEPARTMENTS

9.1. Organization

Each Campus of the Medical Staff shall be divided into clinical departments. Each Campus Department shall be organized as a separate component and shall have a chairperson selected and entrusted with the authority, duties and responsibilities specified in 9.4. When appropriate, the Medical Executive Committee may recommend to the Medical Staff the creation, elimination, modification, or combination of departments.

9.2. Campus Departments

The current Campus Departments for each Campus (unless otherwise specified) are:

a) Anesthesiology
b) Emergency Medicine
c) Family Medicine (for Escondido Campus only)
d) Medicine
e) Obstetrics and Gynecology (for Escondido Campus only)
f) Gynecology (for Poway Campus only)
g) Orthopedic Surgery and Rehabilitation (for Escondido Campus only)
h) Pathology
i) Pediatrics
j) Psychiatry
k) Radiology
l) Surgery
m) Trauma (for Escondido Campus only)
n) Urology (for Escondido Campus only)

9.3. Membership

Department assignments from the prior medical staffs at Palomar Medical Center Escondido and Palomar Medical Center Poway shall be preserved for the Campus Departments at each Campus. The Medical Executive Committee, following the recommendation of the appropriate Campus Department, shall recommend initial Department assignments for all new members of the Medical Staff. Representatives from the Hospital Administration may be invited to attend departmental meetings, and when so present, shall not be entitled to vote.

Each Member will be assigned to the Department in which he/she does the majority of his/her work. The Member shall hold voting rights only in that Department, with the exception of the Department of Trauma. Members may be granted privileges by additional Departments (except contract departments, unless approved by these departments) at the Member's request and with the approval of the other Department(s). Members with privileges in other Departments shall be subject to all the rules of such Department and to the jurisdiction of the Department Chairperson. The Member is encouraged to attend meetings held each year by his/her assigned Department. The Department Chairperson may require the attendance of any Member or Physician with privileges in the Department at a specific Department meeting for review of particular cases or for the purpose of continuing medical education.

Each member must also comply with all requirements of Departmental membership, including Emergency Department consultation panel service pursuant to applicable rules and regulations, for each Department for which he/she is a Member. Only Department Members shall be entitled to vote on departmental matters and hold departmental office. Members may be granted privileges in other departments without membership, but shall not be required to attend departmental meetings or serve on the Emergency Department consultation panel of those departments.

9.4. Campus Department Chairperson

The Campus Department Chairperson shall be an active category Member and shall have served as Chairperson- Elect for the previous one (1) or two (2) years, as determined by Department rules and regulations, except in Departments, which do not provide for a Chair-Elect in their rules and regulations. The Department Chairperson shall be certified by the appropriate specialty board, unless it shall be affirmatively established, through the privilege delineation process, that the Department Chairperson possesses comparable competence. The Department Chairperson or Chairperson-Elect shall be elected by the voting members of each Department at least thirty (30) days prior to the annual staff meeting. Terms of office shall be for at least one (1) or two (2) years as determined by Departmental rules and regulations.

Unless removed as provided in these Bylaws, and except as provided below in this section, Campus Department Chairpersons shall serve the longer of the effective period of these Bylaws or the remainder of their term as a Department Chairperson on the separate medical staff at the Poway and Escondido hospitals prior to the merger of the medical staffs. If these Bylaws are repealed and superseded with a new set of bylaws before the end of the Department Chairperson's term, unless otherwise provided in the new set of bylaws, the Department Chairperson shall complete the term under the new set of bylaws for the Medical Staff or the member's successor is appointed.

Notwithstanding the foregoing, any Member who is a Department Chair-Elect from the separate medical staffs at the Poway and Escondido hosptials prior to the merger of the medical staffs prior to the Effective Date of these Bylaws shall assume the Department Chairperson position and replace the outgoing chairperson at the appropriate Campus Department as originally planned. Such Department Chairperson shall serve their term consistent with this section.

The roles and responsibilities of the Campus Department Chairperson shall include:

a) Clinically related activities of the department.
b) Administratively related activities of the department, unless otherwise provided by the hospital.
c) Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges.
d) Recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care

provided in the department.

e) Recommending clinical privileges for each member of the department.

f) Assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the hospital.

g) The integration of the department or service into the primary functions of the hospital.

h) The coordination and integration of interdepartmental and intradepartmental services.

i) The development and implementation of policies and procedures that guide and support the provision of care, treatment, and services.

j) The recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services.

k) The determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services.

l) The continuous assessment and improvement of the quality of care, treatment, and services.

m) The maintenance of quality control programs, as appropriate.

n) The orientation and continuing education of all persons in the department or service.

o) Recommending space and other resources needed by the department service.

9.4.1 Compensation of Campus Department Chairs

Campus Department Chairs should be compensated for their work spent representing and leading the medical staff. Such compensation shall come from the Medical Staff bank account, for which the medical staff has sole responsibility. The payment to individual physicians should be in the amount determined by the Medical Executive Committee. If the hospital provides any funds specifically earmarked for such compensation, those funds should be requested and accounted for in the Medical Staff Services Department budget for hospital approval. Payment to each physician shall be contingent upon each physician's proper performance of those duties.

9.4.2 Removal

Removal of department chairs and vice-chairs from office may occur by a two- thirds vote of the department members eligible to vote on department matters with approval of the Medical Executive Committee.

9.5. Campus Department Functions

Campus Departments shall:

a) Establish criteria relevant to the care provided in the Department, consistent with the policies of the Medical Staff and the Board of Directors for granting privileges and monitoring as described in the Department rules and regulations.

b) Participate in the evaluation of the medical care provided by Members of the Department.

c) Review minutes and requests of Department committees and forward recommendations to the Campus Executive Committee.

d) Review Department Rules and Regulations annually. The Medical Executive Committee and the Board of Directors must approve revisions.

e) Provide education.

f) Provide the Emergency Department with a panel of physicians to do consultation admit patients to the Hospital, and to see outpatient referrals only when the ED coverage system in place fails to provide adequate coverage for patients that present to the Emergency Department. Failure to participate according to these Bylaws when necessary may result in suspension in the case of a physician failing to provide Emergency Department consultation services or corrective action in the case of a physician failing to provide requested outpatient follow-up.

g) Provide the Campus Department of Trauma Services with a panel of physicians to do consultations and provide continuing care of designated trauma patients (trauma services consultation panel) meeting the criteria of the County of San Diego; provided, however, participation on such panel shall be voluntary for any provisional or active category Member and therefore, no Department shall

be compelled to provide a trauma services consultation panel.

h) Recommend, when appropriate, annual exemptions from department attendance requirements.

9.6. Committees

Campus Departments may create committees and/or subsections when necessary to accomplish the goals and required functions of the Department.

9.7. Creation of New Campus Departments

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

ARTICLE X: CONFIDENTIALITY, IMMUNITY FROM LIABILITY AND RELEASES

10.1. Authorizations and Conditions

By applying for or exercising clinical privileges within the hospital, an applicant:

10.1.1 Authorizes representatives of the hospital and the medical staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the applicant's professional ability and qualifications;

10.1.2 Authorizes persons and organizations to provide information concerning such practitioners to the medical staff;

10.1.3 Agrees to be bound by the provisions of this Article and to waive all legal claims against any representative of the Medical Staff or the hospital who would be immune from liability under Section 10.3 of this Article; and

10.1.4 Acknowledges that the provisions of this Article are express conditions to an application for Medical Staff membership, the continuation of such membership, and to the exercise of clinical privileges at this hospital.

10.2. Confidentiality of Information

10.2.1 General

Records and proceedings of all medical staff committees having the responsibility of evaluation and improvement of quality of care rendered at Palomar Health, including, but not limited to, meetings of the Medical Staff meeting as a committee of the whole, meetings of departments and divisions or subsections, meetings of committees, and meetings of special or ad hoc committees created by the Medical Executive Committee or by departments and including information regarding any member or applicant to this medical staff, shall to the fullest extent permitted by law, be confidential.

10.2.2 Breach of Confidentiality

As effective peer review and consideration of the qualifications of medical staff members and applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of medical staff departments, divisions, or committees, except in conjunction with other hospital, professional society, or licensing authority, is outside appropriate standards of conduct of this medical staff, violates the medical staff bylaws, and will be deemed disruptive to the operations of the hospital. If it is determined that such a breach has occurred, the Medical Executive Committee may undertake such corrective action as it deems appropriate.

10.3. Immunity from Liability

10.3.1 For Action Taken

Each representative of the Medical Staff and hospital shall be immune, to the fullest extend provided by law, from liability to an applicant or member for damages or other relief for any action taken or statements or recommendations made within the scope of duties exercised as a

representative of the Medical Staff or hospital.

10.3.2 For Providing Information
Each representative of the Medical Staff and hospital and all third parties shall be immune, to the fullest extent provided by law, from liability to an applicant or member for damages or other relief by reason of providing information to a representative of the Medical Staff or hospital concerning such 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 Palomar Health.

10.4. Activities and Information Covered

The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health care facilities or organization's activities concerning, but not limited to:

10.4.1 application for membership, renewal of membership, or clinical privileges;

10.4.2 corrective action;

10.4.3 hearings and appellate reviews;

10.4.4 utilization reviews;

10.4.5 other department, or division, committee, or medical staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and

10.4.6 queries and reports concerning the National Practitioner Data Bank, peer review organization, the Medical Board of California, and similar queries and reports.

10.5. Releases

Each applicant or member shall, upon request of the Medical Staff or Palomar Health, execute general and specific releases in accordance with the express provisions and general intent of this Article. Execution of such release shall not be deemed a prerequisite to the effectiveness of this Article.

10.6. Indemnification

To the extent allowed by law, Palomar Health shall indemnify, defend and hold harmless the Medical Staff and its individual members from and against losses and expenses (including attorneys' fees, judgments, settlements, and all other costs, direct or indirect) incurred or suffered by reason of or based upon any threatened, pending or completed action, suit, proceeding, investigation, or other dispute relating or pertaining to any alleged act or failure to act within the scope of peer review or quality assessment activities including, but not limited to (1) as a member of or witness for a medical staff department, service, committee or hearing panel, (2) as a member of or witness for the hospital board or ay hospital task force, group, or committee, and (3) as a person providing information to any medical staff or hospital group, officer, board member or employee for the purpose of adding in the evaluation of the qualifications, fitness or character of a medical staff member or applicant. The Medical Staff or Member may seek indemnification for such losses and expenses under this bylaws provision, statutory and case law, and any available liability insurance or otherwise as the Medical Staff or Member sees fit, and concurrently or in such sequence as the Medical Staff or Member may choose. Payment of any losses or expenses by the Medical Staff or Member is not a condition precedent to Palomar Health's indemnification obligations hereunder.

10.7. Placenta Disposition

The Medical Executive Committee will develop a policy regarding disposition of placentas.

ARTICLE XI: MEDICAL STAFF MEETINGS

11.1. Regular Meetings

11.1.1 Regular meetings shall be held annually. Active and provisional Members are encouraged to attend all meetings and shall be required to attend any meetings designated by the Medical Executive Committee as mandatory. Representatives from the Hospital may be invited to attend and when so present, shall not be entitled to vote.

11.1.2 The annual meeting shall be held within thirty (30) days of the end of the Medical Staff year.

11.2. Special Meetings

11.2.1 The Medical Executive Committee may call a special meeting of the Medical Staff and Campus Chiefs of Staff may call a special meeting of the Campus Medical Staff at any time. In addition, the Medical Executive Committee and the Campus Chiefs of Staff shall call a special meeting of the Medical Staff or Campus, respectively, within thirty (30) days after receipt of a written request for same signed by not less than one-fourth (1/4) of the voting Members of the Medical Staff or Members of the Campus, as appropriate, and stating the purpose for such a meeting. The Medical Executive Committee or the Campus Chiefs of Staff shall designate the time and place of any special meeting.

11.2.2 Written or oral notice stating the place, day, and hour of any special meeting shall be given, either personally or by mail or FAX, to each active and provisional category Member not less than seven (7) nor more than thirty (30) days before the date of such meeting, by or at the direction of the Medical Executive Committee or Campus Chief of Staff. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

11.2.3 Active and provisional Members are encouraged to attend all special meetings and shall be required to attend any meetings designated by the Medical Executive Committee or the Campus Chief of Staff as mandatory. Representatives from the hospital may be invited to attend and, when so present, shall not be entitled to vote. Failure to attend a majority of these meetings may result in a recommendation for sanctions by the Medical Executive Committee as described in the Medical Staff Rights Manual.

11.2.4 A Member of the Medical Staff may arrange for a proxy vote at special meetings if the Member is unable to attend. In order for the proxy to be valid, the Member must so inform the Medical Executive Committee or Campus Chief of Staff at least one (1) week in advance of the meeting in writing as to why he/she is unable to attend and to designate the individual who hold his/her proxy vote.

11.3. Quorum

Fifty percent (50%) of the total membership of the active Members eligible to vote shall constitute a quorum for meetings of the Medical Staff. Fifty percent (50%) of the total membership of the active Members eligible to vote and assigned to a Campus shall constitute a quorum for meetings of that Campus.

11.4. Attendance Requirements

Each active and provisional category Member, except those intending to become consulting or affiliate shall be encouraged to attend the regular meeting and shall be encouraged to attend a majority of all other meetings in each year. Notwithstanding the foregoing, the Medical Executive Committee or Campus Chiefs of Staff may designate any meeting of the Medical Staff or a Campus, respectively, as a mandatory meeting if attendance at such meeting is deemed essential to the accomplishment of the Medical Staff's or Campus's responsibilities and functions. The Medical Executive Committee or Campus Chief of Staff shall have given notice of any such meeting at least thirty (30) days in advance. A Member who is compelled to be absent from any annual or other mandatory meeting, shall promptly submit to the Medical Executive Committee or Campus Chief of Staff, either prior to or not more than three (3) days after the meeting, in writing, his/her reason for such absence. Failure to attend a mandatory meeting, or to receive an excused absence, may result in sanctions as described in Section 12.7.1, which may include the Member being assessed a fine in the amount of $250 per unexcused absence. Any information deemed important by a Campus Chief of Staff, which is disseminated at any Campus meeting, may be distributed to Members not in attendance at such meeting. Members shall be notified of any fine authorized herein by certified, return receipt requested mail. Failure to pay such fine within thirty (30) days of the date of the notice may result in sanctions as described in the Medical Staff Rights Manual.

11.4.1 Attendance Requirements

Attendance via web conferencing or electronic means (if available) may be accepted. Each member of the temporary, consulting, or courtesy staff and members of the provisional staff who

qualify under criteria applicable to courtesy or consulting members shall be required to attend such meetings as may be determined by the Medical Executive Committee.

11.5. **Agenda**

11.5.1 The agenda of the annual meeting of the Medical Staff shall include such items as call to order, introduction of guests, approval of minutes of the previous meeting and of any special meetings, unfinished business, communications, reports of standing and special committees, Campus Treasurers' Reports, new business, approval of granting, renewing or terminating contracts held between Members and Palomar Health, and election of officers.

11.5.2 The agenda of the special meetings shall be reading of the notice calling the meeting, transaction of business for which the meeting was called, and adjournment. No formal action may be taken at any general or special meeting on any item, which has not been specifically described in a notice of the meeting provided thirty (30) days before the meeting.

ARTICLE XII: CAMPUS COMMITTEE AND CAMPUS DEPARTMENT MEETINGS

12.1. **Regular Meetings**

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

12.2. **Special Meetings**

A special meeting of any committee or Department may be called by, or at the request of, the appropriate Chairperson, the Campus Chief of Staff, or by one-third (1/3) of the committee or Department's voting Members. At least two (2) members are required to make the request.

12.3. **Notice of Meeting**

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

12.4. **Manner of Action**

A quorum shall consist of those voting Members present. The action of the majority of Members present shall be the action of a committee, or Department with the exception of the Medical Executive Committee, which shall require that fifty percent (50%) of the voting membership be present in order to act. Action may be taken without a meeting by unanimous consent, in writing, signed by each voting Member.

12.5. **Rights of Nonvoting Members**

Persons serving under these bylaws as nonvoting Members of a committee or Department shall have all rights and privileges of regular Members, except that they shall not be counted in determining the existence of a quorum or allowed to vote.

12.6. **Minutes**

Minutes of each regular and special meeting of a campus committee or Campus Department shall be prepared and shall include a record of the attendance of Members and the action taken on each matter. The minutes shall be signed by the presiding officer and forwarded to the appropriate Campus Executive Committee. Each campus committee and Campus Department shall maintain a permanent file of the minutes of each meeting. Minutes of all Medical Staff meetings shall be maintained in Medical Staff Services and shall be maintained as a permanent confidential record. In this regard, meeting minutes shall not be removed from Medical Staff Services except for distribution at a meeting for review and approval purposes, or for regulatory review.

12.7. **Attendance Requirements**

Each Member is encouraged to attend meetings of each campus committee or Campus Department of which he/she may be a Member. The Chairperson of any committee or Department may designate certain meetings of the committee or Department as mandatory.

12.7.1 Provisional Members at Escondido Campus

Except as provided in Section 4.1 of these Bylaws, each active or provisional Member assigned to the Escondido Campus shall be required to attend twenty-five percent (25%) of Campus Department meetings, and fifty percent (50%) of any specified Medical Staff committee of which he/she may be a Member. Campus Departments at the Escondido Campus may, with the approval of the Campus Executive Committee, increase meeting attendance requirements up to fifty percent (50%) of Department meetings. The failure to meet the attendance requirement during the Medical Staff year shall be grounds for sanctions as stated below to the same effect as provided in Section 4.5 of the Medical Staff Rights Manual. Campus Committee and Campus Department Chairpersons shall report all such failures to the Campus Executive Committee for action. The Campus Departments may, with the approval of the Campus Executive Committee, exempt Members of the Department from attendance for reasons, which justify such exemption. These exemptions would need to be re-approved annually if appropriate. Nothing herein shall be deemed to restrict the discretion of the Medical Executive Committee to impose corrective action.

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

12.7.2 Members at Poway Campus

No such Committee Chairperson or Department Chairperson shall mandate attendance at more than fifty percent (50%) of all meetings of a committee or Department. Failure to attend mandatory meetings, or to receive an excused absence from the Campus Committee, Campus Department Chairperson or the Campus Executive Committee shall result in the Member being assessed a fine of $250.00 per unexcused absence. Any information deemed important by the Committee Chairperson or Department Chairperson which is disseminated at any meeting, shall be distributed to Members not in attendance at such meeting.

12.7.3 Mandatory Attendance of Certain Members

A Member, whose patient's clinical course is scheduled for discussion at a regular Department meeting, shall be so notified and shall be expected to attend such meeting. If such Member is not otherwise required to attend the regularly scheduled Campus Department meeting, the Campus Chief of Staff shall give the Member advance written notice of the time and place of the meeting at which his/her attendance is expected. Whenever apparent or suspected deviation from standard clinical practice is involved, the notice to the Member shall so state, shall be given by certified, return receipt requested mail, and shall include a statement that his/her attendance at the meeting at which the alleged deviation is to be discussed is mandatory. Failure by a Member to attend such meeting may result in limited suspension of clinical privileges by the Campus Chief of Staff.

12.8. Conduct of Meetings

Unless otherwise specified, meetings shall be conducted according to Robert's Rules of Order or Sturgis Standard Code of Parliamentary Procedure. Technical or non-substantive departures from such rules shall not invalidate action taken at such a meeting.

12.9. Executive Session

Executive session is a meeting of a Medical Staff committee, department, or of the Medical Staff as a whole which only voting Medical Staff members may attend, unless others are expressly requested to attend by the Chair. Executive session may be called by the presiding member at the request of any Medical Staff committee member and the session shall be called by the Chair pursuant to a duly adopted motion. Executive session may be called to discuss peer review issues, personnel issues, or any other sensitive issues requiring confidentiality.

ARTICLE XIII: MEDICAL STAFF YEAR

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

ARTICLE XIV: DUES AND FINES

14.1 Annual dues shall be assessed to Members in an amount to be determined by the Medical Executive Committee, considering any recommendation from a Campus Executive Committee, and approved at the annual meeting. Such dues shall be due and payable no later than May 1 of each year. Any Member not paying dues on or before the above date shall receive by certified, return receipt requested mail, a notice of delinquency advising the Member of his/her obligation to pay dues. Any Member who does not pay the delinquent dues shall have his/her clinical privileges suspended, and shall remain so suspended until the member pays the delinquent dues or until the parameters of Section 4.5 of the Medical Staff Rights Manual are met.

14.2 Fines for failure to comply with the requirements, as specified in 12.7.1 shall be considered delinquent if not paid within three (3) months of the date of the notice, to the Member, imposing the fine. Delinquent payments shall result in automatic suspension of the member's clinical privileges.

14.3 Failure to pay either delinquent dues pursuant to this Article or delinquent fines pursuant to this Article, for three (3) months after the suspension becomes effective shall be deemed a voluntary resignation as specified in the Medical Staff Rights Manual.

14.4 The Medical Staff dues shall be utilized for the purposes of the Medical Staff as deemed appropriate by the Medical Executive Committee. If the Medical Staff desires, a budget shall be submitted at the Annual Medical Staff Meeting, and may include stipends for officers of the Medical Staff including Chairpersons of departments or other committee Chairpersons as from time to time may be established.

14.5 A Member may petition for a waiver of dues by submitting reasons to the Medical Executive Committee, who, with the concurrence of the appropriate Campus Chief of Staff, may waive payment.

14.6 Hospital-Provided Funds Deposited to the Medical Staff Fund
Any funds authorized by Palomar Health to the Medical Staff shall be deposited into the Medical Staff account. The Medical Staff shall have the financial ability to solely administer the funds. Any funds authorized by Palomar Health to the Medical Staff shall be under the sole discretion of the Medical Staff.

14.7 Allocation and Maintenance of Medical Staff Funds

All dues and other funds for use of the Medical Staff, including any funds of the separate medical staffs of Palomar Medical Center Escondido and Palomar Medical Center Poway prior to the Effective Date, shall be segregated and subject to the control and direction of the Campus Executive Committee for the campus from which the funds came or are collected, subject to oversight of the Medical Executive Committee.

ARTICLE XV: ADOPTION/AMENDMENTS OF BYLAWS

15.1. **Bylaws**

Adoption of amendments to or repeal and complete replacement of the Bylaws of this Medical Staff may be made at either a regular or special meeting, or by mail ballot. A two-thirds (2/3) majority of returned votes, which must represent a quorum of all active Members eligible to vote shall be required for the change. Changes shall become effective when approved by the Palomar Health Board of Directors, which approval shall not be unreasonably withheld.

15.1.1 Procedure for Amendments to the Bylaws
Upon request of (1) the Medical Executive Committee or a Campus Chief of Staff with the approval of the Medical Executive Committee, or (2) upon timely written petition signed by at least 20% of the members of the Medical Staff entitled to vote, consideration shall be given to the amendment of these bylaws. Repeal and replacement of these Bylaws shall be recommended only by the Medical Executive Committee in consultation with the Campus Executive

Committees. Such actions shall be taken at a regular or special meeting of the Medical Staff, provided (1) written notice of the proposed change was sent to all Members at least thirty (30) days prior to the regular or special meeting, and (2) such notice includes the exact wording of the existing bylaw language, if any, and the proposed change(s). Notwithstanding the foregoing, repeal and replacement of these Bylaws require written notice of such proposed change no less than forty-five (45) days prior to the regular or special meeting and distribution of the new proposed bylaws to replace these Bylaws.

15.2. Rules and Regulations

15.2.1 Except as otherwise provided in this subsection, a new rule or regulation of the Medical Staff, a new rule or regulation of a Medical Staff or Campus committee or department, and any amendment thereof shall be adopted if a simple majority of the Medical Staff, committee, or department, respectively, approves. Proposals to change a committee or department rule or regulation may be submitted in writing by any chair of such committee or department.

15.2.2 Changes to committee and department rules or regulations shall become effective upon final approval by the appropriate Campus Executive Committee and the Medical Executive Committee. Changes to Medical Staff-wide rules and regulations after approval of the Campus Executive Committee and Medical Executive Committee shall become effective upon final approval by the Palomar Medical Center Board of Directors, which approval shall not be unreasonably withheld.

15.3. Mandated Amendments

In the event any amendment to the Bylaws, rules, or regulations is required based on any provision of state or federal statute or regulation, such amendment may be provisionally adopted by the Medical Executive Committee and presented to the Board of Directors. The Medical Staff has the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the Medical Staff and the Medical Executive Committee, the provisional amendment stands. If there is a conflict over the provisional amendment, the process resolving the conflict between the Medical Staff and the Medical Executive Committee is implemented. If necessary, a revised amendment is then submitted to the Board for action. Notwithstanding any other provision of this article, such amendment shall become effective upon approval by the Board, and shall be distributed to Members as soon as reasonably possible.

15.4. Effect of the Bylaws

These Bylaws may not be unilaterally amended or repealed by the medical staff or board of directors.

No medical staff governing document and no hospital corporate bylaws or other hospital governing document shall include any provision purporting to allow unilateral amendment of the medical staff bylaws or other medical staff governing document. Hospital corporate bylaws, policy, rules, or other hospital requirements that conflict with medical staff bylaw provisions, rules, regulations and/or policies and procedures, shall not be given effect and shall not be applied to the medical staff or its individual members.

15.5. Successor in Interest

These bylaws, and privileges of individual members of the medical staff accorded under these bylaws, will be binding upon the medical staff, and the board of directors of any successor in interest in this hospital, except where hospital medical staffs are being combined.

ARTICLE XVI: CONTRACT PHYSICIANS

16.1 All contract physicians shall have Medical Staff membership and shall undergo the same individual evaluation and appointment and reappointment process as the other Members. Upon termination of a contract, membership shall continue unaltered, unless otherwise provided for in the contract. If termination is for a medical disciplinary cause or reason, the Medical Staff Rights Manual may apply.

16.2 The Board of Directors with input from the Medical Staff shall make an annual determination with respect to the quality and availability of contract physician services to the patients at the Hospital in such

areas as emergency medicine, anesthesiology, pathology, radiology, hospitalists, and any other physician services for which the Hospital may choose to contract. Evaluation shall include use of a Medical Staff questionnaire approved by the Medical Executive Committee, criteria for which will be developed and revised as needed, for the Departments of Emergency Medicine, Anesthesiology, Pathology, Hospitalists, and Radiology.

The Medical Executive Committee, with input from the appropriate Campus Executive Committee(s), will prepare a recommendation regarding contract renewal annually based on the questionnaire evaluation and review of quality improvement functions of the services and departments. The recommendation of the Medical Staff will be presented to the Board of Directors who has the responsibility and duty to make the final decision and arrangement with respect to contract services.

16.3 Medical Staff Role in Exclusive Contracting
The Medical Staff shall review and make recommendations to the board regarding quality of care issues related to exclusive arrangements for physician and/or professional services, and as soon as an issue arises, prior to any decision being made by the board, in the following situations:

a) The decision to execute an exclusive contract;

b) The decision to renew or modify an exclusive contract; or

c) The decision to terminate an exclusive contract.

16.4 The Medical Staff shall review and make recommendations to the Board of Directors regarding the selection, performance evaluation, and any change in retention or replacement of physicians with whom the hospital has a contract. Prior to any decision being made, the Board of Directors shall be required to review and approve the recommendations of the Medical Staff regarding these contracts, which approval shall not be unreasonably withheld.

ARTICLE XVII: INDEPENDENT LEGAL COUNSEL

The Medical Staff has the right to retain and be represented by independent legal counsel at any time at the expense of the Medical Staff. Such independent legal counsel shall be retained under terms and circumstances authorized by the Medical Executive Committee, including assignment to represent only one Campus.

ARTICLE XVIII: SYSTEMWIDE AFFILIATION AND COOPERATION

This hospital is part of a system. Palomar Health (the System) strives to maintain professional standards among its patient care facilities and to provide efficient patient care and support services. In keeping with the foregoing, cooperative credentialing, peer review, corrective action, and procedural rights are hereby authorized in accordance with the guidelines set forth in these Bylaws.

18.1. Credentialing

The Medical Staff may develop in conjunction with other facilities or entities in the System, a cooperative appointment and reappointment process that includes, but is not limited to, a single application form, cooperative investigation of background information, sharing of information about the applicant, and cooperative processing of the applications. Any such process should be developed cooperatively among the participating facilities and entities in the System, and shall be subject to approval by each Hospital's Medical Executive Committee and the Board of Directors prior to implementation.

18.2. Peer Review

The Medical Staff may assist other facilities or entities in the System in peer review activities. This may include, without limitation, relying on information in other System facilities' credentials and peer review files, and utilizing the other System facilities' medical or professional staff resources to conduct or assist in conducting peer review activities.

18.3. Corrective Action

18.3.1 Notice of Investigations/Joint Investigations

a) The Campus Chief of Staff may notify the Chief of Staff or other leader in a similar position of any other System facilities whenever a request for investigation has been

received.

b) The Medical Executive Committee or appropriate Campus Executive Committee may authorize a coordinated investigation and may appoint other Medical Staff members of other System facilities to assist in the coordinated investigation.

c) The Medical Executive Committee or relevant Campus Chief of Staff is authorized to disclose to the peer review body (or an authorized representative of that body) of another System facility information from Hospital and Medical Staff records to assist in the other System facility's independent or joint investigation of any Member (as that term is defined in Section 2.1 of the Medical Staff Rights Manual).

d) The results of any joint investigation shall be reported to the Medical Executive Committee and appropriate Campus Executive Committee of each System facility that participated in the joint investigation for its independent determination of what, if any, corrective action should be taken.

18.3.2 Notice of Actions

a) The Medical Executive Committee or appropriate Campus Chief of Staff (or the Chief Administrative Officer at the request of the Campus Chief of Staff) shall inform the Chief of Staff or equivalent leader at any other System facility where the practitioner is known to hold privileges whenever any of the following actions have been taken:

(1) Summary suspension or restriction of clinical privileges for a medical disciplinary cause or reason. The action or basis for such action shall be promptly reported after the imposition of the summary suspension or restriction.

(2) Any corrective action set forth in Section 5.1 of the Medical Staff Rights manual. The action and basis for action shall be promptly reported after such action or recommendation is taken.

b) The effect of such action on the Member's privileges at another System facility shall be determined by the Medical Staff Bylaws of that other System facility.

c) The Medical Executive Committee or appropriate Campus Chief of Staff is authorized to disclose to another System facility's peer review body information from the Hospital and Medical Staff records regarding the Member and/or action taken.

18.3.3 Effect of Actions Taken by Other System Facilities

Whenever the appropriate Campus Chief of Staff or Medical Executive Committee receives information about an action taken at another System facility and involving a Member holding privileges at the hospital, that Campus Chief of Staff or Medical Executive Committee shall, if time permits, independently assess the facts and circumstances to ascertain whether to take comparable action. However, when the Member was summarily suspended or restricted at another System facility, the appropriate Campus Chief of Staff, Campus Chief of Staff- Elect or the Chief Administrative Officer (if neither the Campus Chief or Chief-Elect is available) is authorized to immediately impose a comparable suspension or restriction at this hospital, subject to review by the Medical Executive Committee or appropriate Campus Executive Committee in accordance with the provisions of the Medical Staff Rights Manual. The facility may share the information regarding the nature of the summary suspension or restriction with other System facilities at such time that the other System facility initiates its own investigation.

18.4. Joint Hearings

A joint Hearing may be conducted if the Executive Committees of more than one System facility give notice of substantially similar actions or recommendations to the Member. The Medical Executive Committees, the Chiefs of Staff and the Chief Executive Officers will coordinate their efforts to assure the joint Hearing is conducted pursuant to the provisions of the Medical Staff Rights Manual. With regard to the composition of the joint Hearing Panel, each Chief of Staff shall appoint two members. The Chiefs of Staff shall jointly select an additional member who shall serve as the Chairperson of the Hearing Panel.

The decision of the joint Hearing Panel shall be delivered in accordance with Section 5.21 of the Medical

Staff Rights Manual provided, however, each Medical Executive Committee shall be furnished with a copy of the recommendations and report.

Notwithstanding the foregoing, if a Member can demonstrate to the Medical Executive Committee (in the case of a Hearing based on the recommendation of the Medical Executive Committee) or the Board of Directors (in the case of a Hearing based on the recommendation of the Board of Directors), prior to the initiation of a joint Hearing, that the benefits of quasi-judicial economy and efficiency are outweighed by particular burdens or unfairness unique to the Member's particular circumstances, the Medical Executive Committee or the Board of Directors may, in its sole discretion, order that a separate Hearing be conducted solely with respect to privileges at this Hospital, in accordance with this Medical Staff Rights Manual. Examples of such unique burdens or unfairness would include but not be limited to unavailability of witnesses or documents at the joint Hearing. The mere fact that the outcome would affect privileges at more than one Hospital would not ordinarily be deemed sufficient to preclude a joint Hearing.

ARTICLE XIX: HISTORY AND PHYSICAL POLICY

It is the responsibility of the Member to assure that a medical history and appropriate physical examination (H&P) is performed on patients being admitted for inpatient care as well as prior to operative and complex invasive procedures and OB admissions for vaginal deliveries in either an inpatient or outpatient setting.

Patients requiring an H&P will receive a full H&P, focused H&P, or an update note as set forth in these rules and regulations. The minimum required content of each H&P is noted below:

a) Full H&P

A full H&P is defined as a documentation that contains the following data elements and may be fulfilled by a consultation of it includes all the elements:

(1) A chief complaint
(2) History of present illness
(3) Allergies
(4) Current Medications
(5) Past medical and surgical history
(6) Relevant past psycho-social and family history (appropriate to the patient's age)
(7) Pertinent review of systems
(8) A full physical examination
(9) A statement on the conclusions or impressions drawn from the history and physical examination
(10) A statement on the course of action planned for the patient for that episode of care
(11) Signature with date /time
(12) Code status

b) Focused H&P

A focused H&P is defined as an H&P that contains the following data elements:

(1) Chief complaint
(2) History of present illness
(3) Allergies
(4) Current Medications
(5) Relevant past medical and surgical history pertinent to the operative or invasive procedure being performed.
(6) Relevant past psycho-social history pertinent to the operative or invasive procedure being performed.
(7) Focused review of systems.
(8) A focused physical examination of those body systems pertinent to the operative or invasive procedure performed including an appropriate assessment of the patients cardio-respiratory status
(9) A statement on the conclusions or impressions drawn from the history and physical examination

(10) A statement on the course of action planned for the patient for that episode of care

(11) Signature with date/time

(12) Code status

c) Update Note

An update note is defined as a statement entered into the patient's medical record that the H&P was reviewed and that;

(1) There are no significant changes to the findings contained in the H&P since the time it was performed, or

(2) There are significant changes and such changes are subsequently documented in the patient's medical record.

The update note must be performed by the individual performing the procedure.

The requirement as to which type of H&P must be performed, and associated time frames are noted in the following table:

PATIENT TYPE	H&P REQUIREMENTS
Inpatient Admission	A full H&P is required. The H&P must be completed no more than 30 days prior to admission or within 24 hours after admission. If the H&P is performed within 30 days prior to admission, an update note must be entered into the record within 24 hours after admission.
Inpatient Surgical Procedure	A full H&P is required. If the surgery is performed more than 24 hours after admission, then the admission H&P is considered the surgical procedure H&P as well. No update is needed since the physician progress notes constitute an "updating" of the patient's condition. If surgery is to be performed within the first 24 hours of admission, but an admission H&P has not been done, then an H&P must be completed on the day of surgery prior to the start of the procedure. In an emergent situation, the H&P should be completed as soon as possible after surgery. If surgery is to be performed within the first 24 hours of admission, and an H&P was performed prior to admission, then an update note must be entered into the record on the day of surgery prior to the start of the procedure. In an emergent situation, the update note should be completed as soon as possible after surgery.
Outpatient Surgical Procedure	A full or focused H&P is required. The H&P must be completed no more than 30 days prior to surgery or on the day of surgery prior to the start of the procedure. If the H&P was performed within 30 days prior to surgery, an update note must be entered into the record on the day of surgery prior to the start of the procedure.
Outpatient Complex Invasive Procedure	A full or focused H&P is required. The H&P must be completed no more than 30 days prior to admission or within 24 hours after admission. If the H&P is performed within 30 days prior to admission, an update note must be entered into the record within 24 hours after admission prior to the start of the procedure.

19.1. Oral and Maxillofacial Surgeons

Oral and Maxillofacial Surgeons may perform an H&P if they possess the clinical privileges to do so in order to assess the medical, surgical, and/or anesthetic risks of the proposed operative and/or other procedure.

19.2. Dentists and Podiatrists

Doctors of dentistry or podiatry are responsible for that part of the patient's history and physical examination that relate, respectively, to dentistry and podiatry whether or not they are granted clinical privileges to take a complete history and perform a complete examination. Doctors of dentistry or podiatry may perform a complete H&P if they possess the clinical privileges to do so. If the Dentist or

Podiatrist does not possess such privileges, then a qualified Physician must perform the H&P.

19.3. **Licensed Dependent Practitioners**

If an Allied Health Professional (e.g. physician assistant, nurse practitioner, etc.) is granted privileges to perform part or all of an H&P, the findings and conclusions are co-signed by the supervising Physician the same day.

1. Admission of Patients

1.1 The Hospital shall admit patients for care and treatment except for those patients with critical burns.

1.2 Only Members, as per these bylaws, may admit a patient to the Hospital. No patient shall be admitted to the Hospital without a provisional diagnosis. In the case of an emergency, the provisional diagnosis shall be recorded as soon as possible.

1.3 A Member, designated as the attending physician, shall be responsible for the medical care, the accuracy of medical records, necessary special instruction, and transmitting reports of the condition of the patient to relatives of the patient. Whenever consultations are requested or required, physician-to-physician contact is required. In accepting the consultation, the physician agrees that he/she will see the patient within 24 hours or as requested by the attending physician. A short progress note containing the impression and plan shall be entered into the electronic health record at the time of consultation followed by a full consult note dictation, unless the full consult note is entered into the record at the time of the consult. Referral or transfer of patient responsibility to another attending physician or surgeon shall be with the consent of the referral physician and the accepting physician. This may be either temporary for a specific procedure, a period of time, or for the remainder of the hospitalization. Orders on the chart must clearly reflect this transfer of responsibility. For trauma patients, the Trauma Surgeon or Trauma Neurosurgeon will remain the attending physician until the patient is transferred out of the ICU with specific written orders transferring care to an accepting physician as appropriate. The consultant shall be responsible for transmitting reports of the condition of the patient to the referring physician and/or family as may be appropriate. It is the responsibility of all caregivers involved in a patient's care to communicate regarding treatment and services.

1.4 In any emergency in which it appears the patient will have to be admitted to the hospital, the member shall first contact the admitting department or bed control coordinator to ascertain whether there is an available bed.

1.5 Any patient without an assigned physician shall be provided with a physician from the E.D. on-call roster

1.6 Each member must assure timely (no more than thirty minute response time) adequate professional care of his/her patients in the hospital by being available, or having available through his/her office, an eligible alternative Member with whom prior arrangements have been made and who has at least equivalent clinical privileges at the Hospital. Failure of an attending Member, to fulfill these requirements may result in loss of clinical privileges.

1.7 The admitting Member shall be held responsible for giving such information as may be necessary to assure the protection of the patient from self-harm and to assure the protection of others whenever his/her patient might be a source of danger from any cause whatever.

1.7.1 Any patient known or suspected to be suicidal shall have consultation with a Member who specializes in psychiatry.

1.8 Pathology specimens will not be processed or interpreted, or radiological examinations/procedures performed unless they are accompanied by the appropriate clinical information.

1.9 Time requirements for physicians seeing an admitted patient will be designated in the policy: *Medical Staff Time Requirements for Seeing a Patient after Admission*.

2. Consultation Policies

2.1 Any individual with clinical privileges at this Hospital may be requested to provide consultation within his or her area of expertise. Consultations should be dictated and include all information appropriate to the consultation.

2.2 If a nurse employed by the Hospital has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, that nurse shall notify the nursing supervisor who, in turn, may refer the matter to the nursing director. The nursing director may discuss the matter with the attending physician, or may bring the matter to the attention of the department chairperson in which the member in question has clinical privileges. Thereafter, the

Department Chair may request a consultation after discussion with the attending Medical Staff Member. In the absence of the Chairperson, the appropriate Campus Chief of Staff shall be notified.

2.3 In circumstances of grave urgency, or where consultation is required by these Rules and Regulations or imposed by the Medical Executive Committee, the Board, or the appropriate Campus Chief of Staff, the appropriate Department Chair shall at all times have the right to call in a consultant or consultants.

2.4 Required consultations:

2.4.1 Consultations shall be required in all non-emergency cases whenever requested by the patient or the patient's representative if the patient is incompetent.

2.4.2 Consultations are also required in all cases which in the judgment of the attending Medical Staff Member fulfill the below criteria:

a) The diagnosis is obscure after ordinary diagnostic procedures have been completed;

b) There is doubt as to the best therapeutic measures to be used;

c) Unusually complicated situations are present that may require specific skills of other practitioners, or

d) The patient exhibits severe symptoms of mental illness or psychosis.

2.5 Psychiatric consultation and treatment shall be requested for, and offered to all patients who have engaged in self-destructive behavior (e.g. attempted suicide, chemical overdose). If psychiatric care is recommended, evidence that such care has at least been offered and/or appropriate referral made must be documented in the patient's medical record.

2.6 Whenever a consultation (medical or surgical) is requested prior to surgery, the anesthesiologist shall ascertain that an adequate notation of the consultation, including relevant findings and reasons, appears in the patient's medical record. If it does not so appear, surgery and anesthesia shall not proceed.

2.7 Each consultation report shall be completed in a timely manner and shall contain a written opinion and recommendations by the consultant that reflect, when appropriate, an actual examination of the patient and the patient's medical record.

2.8 Where non-emergency operative procedures are involved, the consultant's report must be recorded in the patient's medical record prior to the surgical procedure. The consultation report shall contain the date and time of the consultation, an opinion based on the relevant findings and reasons, and the signature of the consultant.

2.9 The consultation policy for the ICU and IMC units is defined in *Consultations to ICU Patients, Medical Staff* (Lucidoc ID 10362).

3. Discharge of Patients

3.1 The patient shall be discharged only on a written order of the Member, or their designee or by verbal order if dictated to a registered nurse and signed by the Member at the earliest opportunity. It is the responsibility of the Member to assure that a history and physical is entered into the record.

3.2 The physician of record or their alternate must prepare a discharge summary. This summary shall include admission diagnosis, discharge diagnosis, as well as pertinent history, physical findings, laboratory abnormalities, a brief description of the patient's course, major diagnosis or diagnoses relevant to the admission, procedures performed, condition on discharge, and instructions given to the patient or his/her family regarding diet, activity, medications, code status, and follow up date.

3.3 All deaths require a full discharge summary.

3.4 The Discharge Summary must be completed within 24 hours prior to or at the time of transfer to a skilled nursing facility or other acute care facility.

4. Medical Records and Protected Health Information

4.1 All medical records shall be completed within fourteen (14) days after discharge as stated in the Medical Staff Rights Manual.

4.2 All records are the property of the Hospital. X-rays and charts, or copies thereof shall be released from the Hospital only as provided by law. In cases of readmission of the patient, all previous records shall be

made available to the attending physician. Unauthorized removal of medical records from the Hospital is grounds for suspension.

4.3 Pertinent progress notes shall be recorded at the time of observation sufficient to permit continuity of care and transferability. Where possible, each of the patient's clinical problems should be clearly identified in the progress notes, and correlated with specific orders as well as the results of tests and treatment. Patients shall be seen and progress notes shall be written at least daily, with the exception of the skilled nursing patients. In lieu of daily physician visits, daily visits may be made and progress notes written, by an approved Allied Health Professional (nurse practitioner or physician's assistant) with appropriate privileges, subject to any specific requirements set forth in the applicable department's rules and regulations. The department requirements should be based upon any applicable state or federal regulations. The progress note done by the Allied Health Professional must be co-signed by the supervising physicians the same day.

4.3.1 Patients shall be seen and progress notes written in accordance with the level of care and policies of the extended care unit.

4.3.2 Other than members, only the individuals referenced in *Medical Record - Entries, Content and Completeness* (Lucidoc ID 15287) may initiate entries in the physician progress notes.

4.4 All orders and progress notes shall be dated and timed in writing. Orders and progress notes from Allied Health Professionals have to be countersigned by the responsible attending Physician the same day in accordance with the Allied Health Professional admission and co-signature requirements (see Appendix A.) Relevant verbal orders can be accepted by a licensed nurse, registered pharmacist, registered physical, occupational, or speech therapist, registered dietician or any qualified respiratory therapy personnel, or other specialist allowed by law if such specialist has been approved for the same by the Medical Executive Committee or the appropriate Campus Executive Committee and the Board of Directors. All verbal orders shall be signed by the person to whom dictated with the name of the Physician and his/her own name.

4.5 The Member shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current. The record shall include identification data, complaints, history and physical examination, special reports and other consultations, clinical history and radiology reports, provisional diagnoses, medical or surgical treatment, operative reports, pathological findings, progress notes, final diagnosis, condition on discharge, summary for discharge note, clinical resume and autopsy report when performed.

4.5.1 A complete history and physical examination shall be dictated within 24 hours of admission and signed within fourteen (14) days following discharge. The report shall reflect a comprehensive current physical assessment by a Medical Staff Member or appropriate Allied Health Professional who has been approved to perform histories and physicals.

4.6 If a complete history has been recorded and a physical examination performed prior to the patient's admission to the Hospital, either a dictated copy through the hospital or a reasonable durable, legible copy of these reports may be used in the patient's hospital medical record in lieu of the admission history and physical examination, described in Section 1.4 of these Rules and Regulations. To be acceptable, outside records should be in a form approved by the Medical Executive Committee or the appropriate Campus Executive Committee and should be compatible with current hospital medical records system as determined by the Medical Executive Committee or the appropriate Campus Executive Committee. The history and physical examination cannot be performed more than thirty (30) days prior for the same medical condition. An interval admission note that includes all additions to the history and subsequent changes in physical findings must always be recorded within twenty-four hours of admission. Prenatal records shall be accepted for thirty (30) days before the expected date of confinement. An interval admission note is required.

4.7 Record of an adequate history and physical examination must be part of the patient's chart before they may be transferred to the operating room and the performance of surgery. When the history and physical examination are not recorded before a surgical procedure or any potentially hazardous diagnostic procedure, the procedure shall be cancelled unless the attending practitioner states in writing that an emergency situation exists, or that such delay would be detrimental to the patient. However, in these rare instances, a late chart note will be placed in the chart and the history and physical examination shall be

recorded within twenty-four (24) hours of admission. A brief note must be entered to indicate the nature of the problem.

4.8 Operative reports shall include a detailed account of the findings at surgery, as well as the details of the surgical technique. Operative reports shall be performed immediately upon completion of the operative or other high risk procedure for outpatients, as well as for inpatients. An operative report (brief) with all the required elements as outlined in the electronic health record (EHR) template must be entered directly into the electronic medical record within 30 minutes after the patient reaches the Recovery Room when the full operative report is dictated via transcription. If the full operative report is generated electronically and immediately available, no brief operative report is required.

4.9 Symbols and abbreviations may be used only when they have been approved by the Medical Staff. There shall be available in Medical Staff Services, an explanatory legend of those symbols and abbreviations used. Unapproved abbreviations as determined by the Medical staff and by outside agencies such as the Joint Commission shall not be used in the Medical Record.

4.10 For purposes of complying with the Health Insurance Portability and Accountability Act Standards for Individually Identifiable Health Information, 45 C.F.R. Parts 160 and 164 ("Privacy Standards) and Hospital Policies and Procedures relating to compliance with the Privacy Standards, such medical records shall be part of the "Designated Record Set".

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

4.11 Medical Staff obligations with respect to confidentiality of patient Protected Health Information include the following:

4.11.1 Generally: Medical Staff shall to the best of their ability and consistent with professional standards, respect and maintain the confidentiality of all "Protected Health Information" (which includes any electronic or paper-based Protected Health Information) (as defined below) with respect to all Hospital patients and to comply with the terms and conditions of the (i) Confidentiality of Medical Information Act of 1981, California Civil Code Section 56 et seq. (General Patient Medical Records); (ii) California Welfare & Institutions Code §5328.6 and §5328.7 (Mental Health Records); and (iii) 42 U.S.C. §§290dd-2; 42 C.F.R.., Part 2, §2.31 (Alcohol and Drug Abuse Records); (iv) Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Regulations promulgated there under (42 U.S.C. Sections 1320d-2 and 1320d-4; 45 C.F.R. Subtitle A, Subchapter C, parts 160-164), as amended from time to time, and all Hospital Policies and Procedures relating to confidentiality and protection of patient information.

4.11.2 Definition of Protected Health Information: For purposes of these rules and regulations, patient "Protected Health Information" or "PHI" shall include without limitation, all information regarding a patient's (1) Medical treatment and condition; (2) Psychiatric and Mental Health; and (3) Substance abuse and chemical dependency, which a Medical Staff member may receive in the course of treating Hospital patients consulting with other Medical Staff or as a participant in Health Care Operations of the Hospital, and which is defined as "identifiable pursuant to the Hospital's applicable policies and procedures.

4.12 The duties with respect to confidentiality of Protected Health Information are as follows:

4.12.1 General Duty: Physicians have the duty to keep all information about Hospital patients confidential and to treat such information with the utmost discretion. No Hospital Patient Protected Health Information may be accessed by a Medical Staff member, in any manner,

including, without limitation; (i) direct medical record access; (ii) access by electronic means; or (iii) access by querying persons involved in a patients care, unless the member is one of the patient's direct healthcare provider and requires such Protected Health Information for purposes of diagnosis or treatment of the patient; requires such Protected Health Information for official peer review purposes or to participate in Hospital Health Care Operations; or is otherwise authorized by the patient or appropriate representative, or permitted to be used or disclosed under applicable federal and state laws and regulations, as amended from time to time, and applicable Hospital policies and procedures.

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

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

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

4.12.5 Any violation of these Sections 4.11 and 4.12, or any Hospital Policy and Procedure regarding the protection of Hospital patients' Protected Health Information, shall be considered unprofessional conduct and shall be referred to the appropriate peer review body.

5. Medications

Medical Staff requirements, policies, and procedures related to medication use at Palomar Health are delineated in the policies and procedures of the Department of Pharmacy the pertinent provisions of which are incorporated herein by this reference.

6. Patient Death

6.1 In the event of a patient death, the deceased shall be pronounced dead by the attending Member or his/her designee.

6.2 The Medical Staff will attempt to secure autopsies in all cases of unusual deaths and of medico-legal and educational interest. Clinical situations in which autopsy shall be requested will be defined by the Medical Staff procedure.

7. Informed Consent

7.1 It is the treating member's responsibility to obtain informed consent for all surgical or other procedures, other than simple, common, or routine procedures, which do not entail significant risks. Examples of such procedures are venipuncture, arterial blood gas puncture, and routine injections of medications. The Member's responsibility to obtain informed consent cannot be delegated to personnel of the Hospital.

7.2 In order to give informed consent, the patient is to be informed of:

a) Name of Procedure

b) The nature of the treatment.

c) Risks, possible complications and expected benefits or effects from such treatment including potential problems related to recuperation.

d) Alternatives to the procedures and their risks and benefits, including the possible results of non-treatment.

e) Likelihood of success.

f) The name of the physician or other practitioner who has primary responsibility for the patient's care.

g) The identity and professional status of individuals responsible for authorizing and performing procedures or treatment.

h) Any professional relationship to another health care provider or institution that might suggest a conflict of interest.

i) When indicated, any limits on the confidentiality of information learned from or about the patient.

j) Any business relationship between individuals treating the patient or between the organization and any other health care, service, or educational institutions involved in the patient's care, or other potentially conflicting interests, including but not limited to financial or research related matters.

k) In addition, patient should be given an opportunity to ask questions about the information presented by the physician.

7.3 An informed consent is the verbal exchange of information between physician and patient, and this shall be documented in the physician's progress notes, history and physical, or x-ray report in the medical record and should include all procedures contemplated other than simple, common, or routine procedures described in section 7.1.

7.4 Informed consent shall be obtained prior to any pre-procedure medication, which might render the patient incapable of giving consent.

7.5 A procedure for which informed consent is required may not be performed unless the consent has been obtained except in the emergency as described in Section 7.8 below.

7.6 When consent cannot be obtained from the patient, consent should be obtained, whenever possible, from a competent "adult." For purpose of this rule, "competency" is defined as the ability to understand the nature and consequences of the medical procedure to which one is asked to consent. For purposes of these rules, an "adult" is:

a) A person who has reached the age of 18, or

b) A minor who has entered into a valid marriage (whether or not the marriage was terminated by dissolution), who was on active duty with the armed forces of the United States or who has been declared emancipated pursuant to Civil Code Section 64.

7.7 In the event the patient is not a competent adult who is able to give valid informed consent, informed consent must be obtained from an appropriate surrogate decision maker except in an emergency as described in 7.8 below. If the patient is a minor, the surrogate is a court appointed guardian, if one exists, or if none exists, then the parents. If the patient is an incompetent adult the surrogate is:

a) The attorney in fact appointed pursuant to a durable power of attorney for health care or if none, then;

b) A court appointed guardian or conservator who has been granted to make medical decisions, or if none, then

c) The patient's closest available relative; generally the patient's spouse will be the closest available relative, followed by a child or a parent, and then a brother or a sister. However, individual cases may vary depending upon which of the relatives is in the best position to know and articulate the patient's wishes. If no immediate family member can reasonably be located or contacted, other relatives may act as surrogate. In unusual circumstances, "significant others" or close friends may be acceptable as surrogate decision makers; however, before relying on such persons, the Administrator and Chief of Staff (or their respective designees) shall be consulted to determine whether judicial proceedings should be instigated.

7.8 In the event a patient requiring a surgical or other procedure is incompetent to give informed consent by age or physical or mental status, and no surrogate decision maker as described in Section 7.7 is

reasonably available to consent on the patient's behalf, the treating physician shall make a determination whether an emergency exists. A progress note shall be written documenting:

a) The immediate need for the procedure and why the procedure is necessary.

b) The nature and circumstances of the emergency, and

c) The unavailability of any surrogate decision maker.

For the purpose of this rule, an emergency is defined as a situation in the hospital, whether or not it occurs in the emergency department, requiring immediate services for alleviation of severe pain. Or immediate diagnosis and treatment of unforeseen medical conditions, which if not immediately diagnosed and treated can reasonably be expected to lead to serious disability or death. In these cases, if it is reasonable to assume that the patient would have consented to the treatment if he/she were capable of doing so, treatment may proceed. If the patient is a minor and the parents are not available to give consent, the same documentation is required by the treating physician.

If the physician has obtained a consultation, the consulting physician should also document his/her findings and opinion in the patient's medical record.

7.9 Consent via Telephone: Informed consent should be obtained by telephone only if the person having legal capacity to consent for the patient is not otherwise available. The physician must, in so far as possible, provide the patient's legal representative with information regarding risks, benefits, alternatives and consequences of refusing treatment, and any potentially conflicting interests the physician may have, such as research or financial interests. Hospital personnel will verify that consent for treatment has been given by the patient's legal representative by being a third party on the phone.

7.10 Consent via E-Mail.

7.11 Consent via Facsimile.

7.12 In all cases dealing with informed consent, the Member shall refer to the hospital's procedure on who may give consent to medical treatment and the Member shall comply with hospital administrative requirements for documenting consent (see *Consent or Informed Consent for Surgery or Special Procedures*, Lucidoc ID 17201).

8. Authority to Act

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

9. Division of Fees

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

10. Disclosure of Interest

All nominees for election or appointment to office of the Medical Staff, Department Chairpersonships, or the Medical Executive Committee shall, within thirty (30) days prior to the date of election or appointment, disclose, in writing, to the Medical Executive Committee those personal, professional or financial affiliations or relationships of which they are reasonably aware which could foreseeable result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff.

11. Confidentiality

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

11.1 The records of the Medical Staff and its committees responsible for the evaluation and improvement of the quality of patient care as rendered in the hospital shall be maintained as confidential.

11.2 Access to such records shall be limited to Medical Staff members who are duly appointed officers or serve on committees of the Medical Staff or of the Medical Staffs of other System Facilities for the sole purpose of discharging Medical Staff responsibilities and subject to the requirement that confidentiality be maintained.

11.3 Information which is disclosed to the Board of Directors or its appointed representatives, in order that the Board of Directors may discharge its lawful obligations and responsibilities, shall be maintained by that body as confidential.

11.4 Information contained in the credentials file of any Member may be disclosed with the Member's consent to any Medical Staff, Hospital, Professional Licensing Board, or medical school. However any disclosure outside of the Medical Staff, except with the Member's consent, or to the Medical Staffs of other System Facilities as authorized in the Medical Staff Bylaws and Rules and Regulations, shall require the authorization of the appropriate Campus Chief of Staff. If such were to occur then the Member will be alerted prior to the disclosure.

12. Emergency Department Consultation

12.1 All active category Members, and all provisional category Members, who have completed their respective department requirements, shall participate on the Emergency Department call panel for the Campus to which they are assigned. When so requested by either the Campus Department Chairperson or the Campus Chief of Staff, a courtesy Member may be required to serve on the Emergency Department call panel.

12.2 Participation on a separate trauma services call panel, if present, will be voluntary. For those Members who volunteer to serve on the trauma service call panel, if present, call schedules may be combined with the Emergency Department call panel. Nothing contained herein shall prevent any Member from receiving compensation for his participation on either a dedicated call schedule or the trauma services call panel.

12.3 Notwithstanding 13.1, any Member sixty (60) years of age or older (or any Member who is from age fifty-five (55) to fifty-nine (59), and who has completed twenty (20) years of service on ER Call at Palomar Health), shall upon the Member's request, be excused from participation on the panel.

12.4 Unless a shorter period is specified to comply with a Department rule or trauma designation, or other contractual or legal mandate, the Member shall be able to respond by phone to the Emergency Department approximately fifteen (15) minutes from the initial attempt to contact the Member. The member shall only be required to come to the Emergency Department if specifically requested. If so requested, the Member must be present in the Emergency Department within thirty (30) minutes from the time of phone contact.

12.5 The Member shall respond and evaluate the patient in the Emergency Department and be responsible for the disposition of the patient (i.e., transfer, inpatient care, discharge). The Member should determine if hospitalization is required for the appropriate care of complaints or medical problems within his/her area of specialty or expertise. If a transfer is necessary but cannot be accomplished within six (6) hours of the time of the request for consultation, the Member shall admit the patient to the appropriate inpatient unit of the hospital.

12.6 Patients presenting to the Emergency Department who have an established Practitioner-patient relationship will be referred to that Practitioner or his/her on-call coverage. Any patient who has no prior existing relationship with a Member and who requires follow-up care will be referred to an appropriate facility or to the appropriate primary care or specialty Practitioner who is on call for the Emergency Department when the patient presented. A patient referred for follow-up care shall receive an offer to be seen at least once.

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

12.8 If the Practitioner-patient relationship does exist, the Practitioner or his/her on-call coverage is obligated to care for the patient. If a Practitioner-patient relationship does not exist or has been ended, the physician who is on call on the Emergency Department roster is obligated to care for the patient. If a patient, who has been sent a letter of discharge, presents to the Emergency Department within thirty (30) days of receipt of the letter and an alternative Practitioner cannot be found, the original Practitioner is obligated to care for the patient. Failure to carry out a Practitioner's obligation can result in suspension of privileges. (Sending a copy of certified letter of discharge to the Medical Records Department for inclusion in the patient's chart is encouraged).

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

12.10 7:00 a.m. shall be the official time for changing the on-call schedule in the Emergency Department. The Member on-call for the twenty-four (24) hour period starting at 7:00 a.m., in the required specialty, shall be responsible for the patient referred from the Emergency Department according to the time the consult is requested.

13. Monitoring Procedure

13.1 General Policy

In accordance with TJC Standards and with the accepted standard of care, all new Medical Staff appointees shall undergo a period of focused professional practice evaluation (FPPE). Specific monitoring requirements shall be established by each Department and shall be a part of the applicable specialty specific checklist. Monitoring guidelines as set forth in this section refer to monitoring for newly appointed Members and when new procedural privileges have been granted.

13.2 Documentation of Monitoring

Monitoring reports will be completed and returned to Medical Staff Services. Monitoring reports are considered confidential and should be routed in sealed envelopes. Such reports should be completed and returned to Medical Staff Services within 2 weeks after monitoring has occurred.

13.2.1 Responsibility for Reporting

The monitored Member is ultimately responsible for seeing that appropriate monitoring reports are completed and filed on his/her behalf. The monitored Member is responsible for obtaining monitoring. A list of Members who are eligible to carry out retrospective monitoring shall be kept in Medical Staff Services. Participating as a monitor is an obligation of membership on the Medical Staff.

13.2.2 Access to Reports

Monitoring reports are considered confidential. The physician who was monitored will not have access to these except under certain, legally specific circumstances. In the event additional monitoring is recommended, a separate written communication should be sent to the Member from the Department Chairperson to advise the Member of the questions or problems contained in the monitoring reports. The reason (s) why additional monitoring or other recommendations have been made should also be stated.

13.3 Qualifications for Monitors

Medical Staff Members, with the exception of consulting, or associate, may serve as monitors provided they have satisfactorily completed monitoring, and provided they have been granted full privileges for the procedure or admission to be monitored. A department may develop more specific qualifications for monitors.

13.4 Responsibilities of Monitors

13.4.1 Concurrent Monitoring

The monitor must be present for the major portion of the surgical procedure. He/she may or may not serve as the assistant surgeon. The monitor has the option of talking to or examining the patient pre and postoperatively (pre and post procedure), but he/she is expected to inform the monitored physician in advance as a courtesy.

13.4.2 Filing of Monitoring Reports

These reports shall be completed and returned to Medical Staff Services within two (2) weeks of notification of the requirement to perform such monitoring (concurrent and retrospective).

13.5 Assignment of Monitors

As a general policy, more than one individual should serve as a monitor for procedural monitoring. For the retrospective/admission monitoring, one Member may serve as the monitor for the basic number of admissions. Monitoring shall be accomplished in accordance with Departmental Rules and Regulations and policies.

13.6 Completion of Monitoring

When the required number of monitoring reports have been submitted to Medical Staff Services, the reports will be sent to the appropriate Campus Department(s) for review. If the appropriate number of monitoring reports have been submitted, the Campus Department Chair shall determine that monitoring is complete. The Member shall be informed of such recommendation by a letter from the Campus Department Chairperson. Notification of completion of monitoring shall also be sent to the appropriate Nursing Unit Directors.

13.6.1 All required monitoring must be satisfactorily completed in order for a provisional Member to be considered eligible for advancement to either active or courtesy category. Individual Departments may permit advancement to courtesy category without completion of monitoring but such advancement does not negate the need to complete monitoring.

13.6.2 As a general rule, Members should not be assigned to serve on the Emergency Department consultant panel until all required monitoring has been satisfactorily completed.

14. Compliance with Policies and Procedures

All Practitioners shall comply with all reasonable Medical Staff policies and procedures, including relevant Palomar Health policies and procedures which have be reviewed and ratified by the Medical Executive Committee.

15. Requirements for Establishing Clinical Privileges for New Procedures

15.1 Purpose

To establish a process to determine whether sufficient space, equipment, staffing, and financial resources are in place or available within a specified period of time to support each requested privilege.

To assure that the organization consistently determines the resources needed for each requested privilege.

Requests for clinical privileges to perform a significant procedure or service not currently being performed at a Palomar Health facility (or a significant new technique to perform an existing procedure ("new procedure") will not be processed until:

a) A determination has been made that the procedure will be offered by the hospital, and

b) Criteria to be eligible to request those clinical privileges has been established.

15.2 Policy

Prior to the establishment of a clinical privilege, the medical staff and the organization will ensure the following:

a) That criterion have been developed defining current competence for practitioners who may request the privilege (see below).

b) That the setting in which the privilege may or may not be performed has been determined.

c) That the privilege is within the scope of services provided by the organization.

d) That appropriate policies - where necessary - have been developed to support the privilege

e) That the organization has the appropriate equipment and supplies to support the privilege.

f) That the organization has an adequate number of qualified staff to support the privilege.

g) That financial resources necessary to support the privilege have been committed.

15.3 New Privileges

If it is recommended that the new procedure be offered, the appropriate Campus Department and/or Credentials Committee (or oin the Poway Campus, the Campus Executive Committee) shall conduct research and consult with experts, including those on the Medical Staff or those outside the hospital, and review guidelines published by professional organizations and develop recommendations regarding: a) the minimum education, training, and experience necessary to perform the new procedure, and b) the extent of monitoring and supervision that should occur if the privileges are granted. The Campus Department and/or the Credentials Committee may also develop criteria and/or indications for when the new procedure is appropriate.

For new privileges added after January 1, 2007, a new privilege information form must be completed by the individual or department(s) that is requesting the privilege. The form will be reviewed by the originating department(s) and a recommendation made to the Medical Executive Committee on whether

or not to establish the privilege. The Medical Executive Committee will review the recommendation and the privilege information form and make a final determination as to whether or not the privilege will be established. If established, the privilege may be requested and granted under processes otherwise codified by the Medical Staff.

15.4 Existing Privileges

The Medical Staff Office will facilitate a review of existing privileges against the requirements of this policy by each department. This will be accomplished by reviewing each department's privilege list and will include a determination by the organization that there continues to be sufficient space, equipment, staffing and financial resources in place to support the privileges. If a privilege no longer meets the requirements set forth in this policy, the department(s) will remove the privilege from availability and inform applicable practitioners and the Medical Executive Committee of this action.

1. General

Except as otherwise specified herein, no person (including persons engaged by the hospital in administratively responsible positions) shall exercise clinical privileges in the hospital unless and until that person applies for and obtains membership on the medical staff and is granted privileges as set forth in these bylaws, or, with respect to allied health practitioners, has been granted a service authorization or privileges under applicable medical staff policies. By applying to the medical staff for initial membership or renewal of membership (or, in the case of members of the honorary staff, by accepting membership in that category), the applicant acknowledges responsibility to first review these bylaws and medical staff rules, regulations and policies, and agrees that throughout any period of membership that person will comply with the responsibilities of medical staff membership and with the bylaws, rules and regulations and policies of the medical staff as they exist and as they may be modified from time to time. Membership on the medical staff shall confer on the member only such clinical privileges as have been granted in accordance with these bylaws.

All privileges possessed by members on the medical staffs of the Poway Campus and Escondido Campus prior to the effective date of the single consolidated license that resulted in the merger of the medical staffs into this Medical Staff shall be transferred to privileges for Members of this Medical Staff, including any restrictions, limitations, and conditions. All investigations, peer review actions, and related actions affecting members' privileges likewise shall be transferred and remain active under this Medical Staff.

1.1. Eligibility Criteria for Appointment

To be eligible to apply for initial appointment or reappointment to the medical staff, physicians, oral surgeons, dentists, and podiatrists must:

a) Have a current, unrestricted license to practice in this state and have never had a license to practice revoked or suspended by any state licensing agency;

b) Where applicable to their practice, have a current, unrestricted DEA registration-and state controlled substance license;

c) Have an office located within the geographic service area of the Palomar Health System, as defined by the Board, close enough to fulfill their Medical Staff responsibilities and to provide access for timely and continuous care for their patients in the Hospital;

d) Have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Hospital as defined in Section 3.2.6 of the Medical Staff Bylaws;

e) Have never been convicted of Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil monetary penalties for the same;

f) Have never been, and not currently be, excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care program;

g) Have never had medical staff appointment, clinical privileges, or status as a participating provider denied, revoked, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct;

h) Have never resigned medical staff appointment or relinquished privileges during a medical staff investigation or in exchange for not conducting such an investigation;

i) Have never been convicted of, or entered 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;

j) Agree to fulfill all responsibilities regarding emergency call for their specialty;

k) Have coverage arrangements with other members of the Medical Staff for those times when the individual will be unavailable as defined in Section 3.2.4 (h) of the Medical Staff Bylaws.

1.2. Waiver of Eligibility Criteria

a) Waivers of eligibility criteria will not be granted routinely. No individual is entitled to a waiver.

An application from an individual who does not meet the criteria for appointment or clinical privileges will not be processed unless the Medical Executive Committee and the Board of Directors has determined that a waiver should be granted.

b) A request for a waiver will only be considered if the prospective applicant provides information sufficient to satisfy his/her burden of demonstrating that his/her qualifications are equivalent to, or exceed, the criteria in question and that there are exceptional circumstances that warrant a waiver.

c) The Credentials Committee may consider supporting documentation submitted by the prospective applicant, any relevant information from third parties, input from the appropriate department chief, and the best interests of the health system and the communities it serves. If the Credentials Committee is the body making a determination regarding a waiver it will forward its recommendation, including the basis for such, to the Medical Executive Committee.

d) If the recommendation for waiver has come from the Credentials Committee the Medical Executive Committee will review the recommendation of the Credentials Committee and make a recommendation to the Board of Directors regarding whether to grant or deny the request for a waiver and the basis for its recommendation.

e) The Board's determination regarding whether to grant a waiver is final. A determination not to grant a waiver is not a "denial" of appointment or clinical privileges and the prospective applicant who requested the waiver is not entitled to a hearing. A determination to grant a waiver in a particular case is not intended to set a precedent for any other individual or group of individuals. A determination to grant a waiver does not mean that appointment will be granted. It simply means that processing of the application can begin.

2. Terms of Appointment

2.1. Appointments to the Medical Staff shall only confer membership as provided by these Bylaws, Rules, and Regulations.

2.2. Appointment and reappointment shall be made by the Board of Directors upon recommendation of the Medical Executive Committee or appropriate Campus Executive Committee. In no case shall the Board of Directors refuse to make a recommended appointment or reappointment without conferring with the Medical Executive Committee stating the reasons for such action.

2.3. Duration of appointment and reappointment including provisional shall not exceed two (2) years. The Medical Staff may establish that all reappointments will terminate based on the renewal date of the California medical license.

3. Application for Appointment

3.1. Doctors of Medicine and Osteopathy and Dentists and Podiatrists shall apply through the Palomar Health System.

Applications to the Medical Staff shall be provided only to those practitioners who meet such minimum objective standards, consistent with these bylaws, as shall be specified by the Board of Directors. Prospective applicants shall have the burden of demonstrating that they meet such standards by completing an application request form specified by the Medical Executive Committee. The provisions of the Medical Staff Rights Manual, Section 5 (Judicial Review Hearing) and Section 6 (Appeal to Board of Directors) shall not apply to a practitioner's failure to receive an application.

3.2. All applications for membership shall be in writing, shall be signed by the applicant, and shall be submitted in a form prescribed by the Board of Directors after consultation with the Medical Executive Committee and the Campus Executive Committees of the Medical Staff of System Facilities using the application. The application shall require or include:

a) Detailed information concerning the applicant's professional qualifications;

b) The names of at least three (3) persons who have had extensive experience observing (one of which is in the applicant's specialty) and working with the applicant in the past three (3) years and who can provide adequate references pertaining to the applicant's professional competence in at least the following areas:

(1) Patient Care

(2) Medical/Clinical Knowledge
(3) Practice based Learning and Improvement
(4) Interpersonal and Communication Skills
(5) Professionalism
(6) Systems-based Practice

c) Information as to whether the applicant's membership status and/or clinical privileges have ever been denied, revoked, suspended, reduced, voluntarily relinquished, or not renewed at any other hospital or by national medical societies; whether voluntary or involuntary.

d) Information as to whether the applicant has ever resigned or had membership terminated, or been subject to any limitation, reduction or loss of clinical privileges at another hospital whether voluntary or involuntary;

e) Information as to whether the applicant's license to practice has ever been challenged, denied, suspended, revoked or not renewed, whether voluntary or involuntary;

f) Information as to whether the applicant's narcotics license has ever been challenged, denied, suspended, revoked, or not renewed, whether voluntary or involuntary;

g) Information concerning past or pending malpractice litigation or judgment on the applicant or his/her insurance carrier and any prior lapse in malpractice coverage;

h) Information about the applicant's current physical and mental health status;

i) A signed agreement to guard the privacy of others;

j) Such other information as the Medical Executive Committees of the Medical Staffs of the System Facilities using the application deems appropriate.

k) The applicant shall also submit current copies of his/her California license, DEA certificate, evidence of compliance with Medical Board of California requirements for continuing medical education, evidence of current malpractice insurance coverage and documentation of current tuberculosis screening in accordance with Palomar Health Guidelines.

l) Agreement that the applicant shall notify the hospital, in writing, promptly and no later than fourteen (14) days from the occurrence of among other things, a receipt of written notice of any adverse action against the applicant under any federal health care program, such as the Medicare/MediCal program, including but not limited to fraud and abuse proceedings or convictions.

The terms, "Hospital" and "all representatives of the Hospital and its Medical Staff," as used herein, are intended to include the Board of Directors and the Administrator and their authorized representatives and all members who have Department, committee, or other responsibilities for collecting and/or evaluating the applicant's credentials and/or acting upon his/her application. The term, "character", is intended to include the applicant's ability to safely perform all of the essential mental and physical functions related to the specific clinical privileges requested.

3.3. By applying for membership on the Medical Staff, each applicant thereby:

a) Signifies his/her willingness to appear for interviews with regard to his/her application;

b) Authorizes the Medical Staff to consult with members of medical staffs of other hospitals with which the applicant has been associated, and with others who may have information bearing on his/her competence, character, and ethical qualifications;

c) Consents to the Medical Staff's inspection of all records and documents that may be material to an evaluation of his/her professional qualifications and competence to carry out the clinical privileges he/she requests, as well as his/her moral and ethical qualifications for membership;

d) Authorizes the Medical Staff to subject him/her to mandatory non-disciplinary observation requirements pursuant to the hospital's quality management programs and Medical Staff peer review, which requirements shall not be grounds for a hearing pursuant to Section 5.1 of the Medical Staff Rights Manual, Judicial Review Hearing, Grounds for Hearing;

e) Releases from any liability all representatives of the Medical Staff for their acts performed in good faith and without malice in connection with evaluating the applicant and his/her credentials;

f) Releases from any liability all individuals and organizations who provide information to the Medical Staffs in good faith and without malice concerning the applicant's competence, ethics, character, and other qualifications for membership and clinical privileges, including otherwise privileges or confidential information;

g) Authorizes the Medical Staff to release information concerning his/her membership, clinical privileges and performance at the hospital to the Medical Staffs of other System Facilities if he/she is a member at or an applicant to any such medical staff, if such information is relevant to the privileges he/she maintains at such facilities.

h) Agrees that if membership and privileges are granted the member has an ongoing and continuous duty to report to the Medical Staff office within ten days, any and all information that would correct, change, modify or add to any information provided in the application or most recent reappointment application when such information may reflect adversely on current qualifications for membership or privileges.

3.4. All applications for membership shall be accompanied by a non-refundable application fee in an amount specified by the Medical Executive Committees of the Medical Staffs and the Board of Directors after consultation with the Medical Staffs using the Palomar Health application to defray part of the cost of processing the application.

3.5. The application form shall include a statement that the applicant has received and read the Bylaws, Rules and Regulations of the Medical Staff and that he/she agrees to be bound by the terms thereof if he/she is granted membership and/or clinical privileges and to be bound by the terms thereof without regard to whether or not he/she is granted membership and/or clinical privileges in all matters relating to consideration of his/her application.

3.6. An applicant shall have the burden of producing accurate and adequate information for a thorough review of the applicant's qualifications and suitability for the requested status or privileges, resolving any reasonable doubt about these matters, and satisfying requests for information. The provision of information containing significant misrepresentation or omissions and/or a failure to sustain the burden of producing information shall result in termination of the processing of the application with no entitlement to a hearing or appeal. To the extent consistent with law, this burden may include submission to a medical or psychological examination, at the applicant's expense, if deemed appropriate by the Medical Executive Committee or appropriate Campus Executive Committee, which may select the examining physician. The applicant may select the examining physician from an outside panel of three physicians chosen by the Medical Executive Committee or appropriate Campus Executive Committee. Any applicant who fails to make an appropriate response to a request by certified, return receipt requested mail, for reasonable information or action within thirty (30) days, shall be deemed to have abandoned his/her request for that status or privilege. Processing of an application shall automatically terminate if all materials requested in the application have not been received within a three (3) month period from receipt of the application and there has been no activity on the application. Exceptions may be granted by the Chairperson of the Credentials Committee for the Escondido Campus or the Medical Executive Committee for a valid reason.

3.7. The applicant shall indicate whether he/she is applying to more than one Medical Staff and may also be asked about other System Facilities, as applicable.

3.8. All applications shall be reviewed by the Administrator. Any input on an applicant will be communicated to the Credentials Committee Chairperson or the Medical Executive Committee in a timely manner not to impede the processing of the application.

4. Appointment Process

4.1. Within thirty (30) days of the time that an application is considered complete by the Credentials Coordinator, the Credentials Coordinator will refer it to the Credentials Committee for the Escondido Campus or the Campus Executive Committee for the Poway Campus, as appropriate, for consideration of privileges. Once the Credentials Committee or the Campus Executive Committee for the Poway Campus reviews the application and deems it complete, the application may either be forwarded to the

appropriate department(s) for consideration of privileges, or forwarded to the appropriate Campus Executive Committee if the Credentials Committee has determined that the applicant is not qualified for membership, and there would be no benefit in forwarding the application to any department. The Credentials Committee may make a recommendation on the application. The department shall examine the evidence of the character, professional competence, qualifications, and ethical standing of the applicant, and shall determine through information obtained from references, and from other sources available to the department whether the applicant has established and meets all of the necessary qualifications for the clinical privileges requested. Every department in which the applicant seeks clinical privileges, shall provide the specific, written recommendations for delineating the applicant's clinical privileges, and these recommendations will be made a part of the report that shall be transmitted to the appropriate Campus Executive Committee. The department may return the application to the Credentials Committee for its review in the event the application raises special or unusual issues on which the department desires the Committee's input.

4.2. If the application is for membership and privileges on the Medical Staff of both Campuses of Palomar Medical Center, then both Campus Executive Committees shall process it in accordance with the joint procedure herein set forth.

4.3. At its next regular meeting, after receipt of the application and the report and recommendation of the Campus Department(s) and/or Credentials Committee, the Campus Executive Committee shall determine whether to recommend to the Medical Executive Committee that the applicant be appointed or rejected for membership. All recommendations to appoint shall specifically recommend the clinical privileges to be granted which may be qualified by probationary conditions relating to such clinical privileges.

4.4. When the recommendation of the Campus Executive Committee or the Medical Executive Committee is to defer the application for further consideration, it shall be followed up within ninety (90) days with a subsequent recommendation for membership with specified clinical privileges, or for rejection of membership.

4.5. When the recommendation of the Medical Executive Committee is favorable to the applicant, and no outstanding issues are present, the recommendation shall promptly be forwarded to the Board of Directors.

4.6. When the recommendation of the Medical Executive Committee is adverse to the applicant, either in respect to membership or clinical privileges requested at Palomar Health hospitals, the Medical Executive Committee or appropriate Campus Chief of Staff shall promptly so notify the applicant by certified return receipt requested mail. No such adverse recommendation need be forwarded to the Board of Directors until after the applicant has exercised or has been deemed to have waived his/her right to a hearing as provided in the Medical Staff Rights Manual. If the applicant exercises his/her right to a hearing then the application will be processed in accordance with the Medical Staff Rights Manual.

4.7. If the application is to both Campuses of the Medical Staff, the recommendations of one of the Campus Executive Committees shall not be further processed until the other Campus Executive Committee has made its recommendation. If the recommendations of the Campus Executive Committees do not agree on the granting of privileges or membership, an ad hoc committee composed of each Campus Chief of Staff and each appropriate Campus Department Chairperson of each Campus shall meet to discuss the differences and shall submit a report to the Medical Executive Committees within ten (10) days from the date the Campus Executive Committees adopted their recommendations. After considering the report of the ad hoc committee the Medical Executive Committee shall make its recommendation to the Board of Directors.

4.8. If a hearing panel should occur per Section 4.6 and the recommendation of the Hearing Panel and Medical Executive Committee is favorable to the applicant processing shall be in accordance with Section 4.5 above.

4.9. If such recommendation continues to be adverse, the appropriate Campus Chief of Staff shall promptly so notify the applicant by certified, return receipt requested mail. The Campus Chief of Staff shall also forward such recommendation and documentation to the Board of Directors only for the purpose of information. The application will continue to be processed in accordance with the Medical Staff Rights

Manual.

4.10. In its next regular meeting after receipt of a favorable recommendation, or after the applicant has been deemed to have waived his/her rights to a hearing or appeal, the Board of Directors shall act in the matter. The Board of Directors may affirm, modify or reverse the recommendation or, in its discretion, may refer the matter back to the Medical Executive Committee for further review and recommendation to be returned within thirty (30) days and in accordance with its instructions. After receipt of such recommendation after referral, the Board of Directors shall take action.

a) If the Board of Directors' decision is in accordance with the Medical Executive Committee's recommendation, it is immediately effective and is the final decision in the matter.

b) If the Board of Directors' decision has the effect of changing the Medical Executive Committee's last recommendation, the matter is referred to a conference as provided for in Section 4.11 that follows. The Board of Directors' action on the matter, after receiving the conference recommendation, is effective as the decision on the matter.

c) If the Board of Directors' decision, after receiving the conference recommendations, is adverse to the applicant, and the applicant did not have a prior opportunity to exercise or waive his/her right to a hearing, then the application shall be processed in accordance with the Medical Staff Rights Manual.

4.11. Within fifteen (15) days after receiving a matter referred to under Section 4.10(b) above, a conference of two (2) Medical Staff Members and two (2) Board of Directors' Members shall convene to consider the matter and shall submit its recommendations to the Board of Directors. If the applicant is applying to more than one Campus, then two (2) Medical Staff Members shall be selected from each Campus.

4.12. When the Board of Directors' decision is final, it shall send notice of such decision through the Administrator to the Medical Executive Committee, Credentials Committee, and concerned Campus Department Chairperson and by certified, return receipt requested mail to the applicant.

4.13. All membership requests and evaluation sheets shall carry the signature of the appropriate Campus Department Chairperson(s), and Officer(s) of the Medical Staff. Written record of all matters considered in each Member's application shall be made a part of the permanent files of the Medical Staff.

5. Reappointment Process

5.1. Reappointment of Members shall occur at least every two (2) years and shall coincide with the Member's California medical license cycle. Approximately (6) months prior to the expiration of a Member's current appointment, a reappointment application and supporting documents shall be sent to the Member. Failure to return the reappointment application within 60 (sixty) days of receipt may result in expiration of the appointment. Reassessment shall be conducted by the Department(s) where clinical privileges are maintained. In order to be considered for reappointment by the Department, each Member shall have submitted a completed Medical Staff Biennial Reappointment form which shall include all information necessary to update and evaluate the qualifications of the applicant, including, but not limited to:

a) Disclosure of relinquishment of privileges or membership in medical organizations whether voluntary or involuntary;

b) Disclosure of any previously successful or currently pending challenges to any licensure or registration or the voluntary relinquishment of such licensure or registration;

c) Disclosure of any limitation, reduction, or loss of clinical privileges at any hospital or surgery center, whether voluntary or involuntary;

d) Disclosure of involvement in professional liability actions, including final judgments and settlements involving the practitioner;

e) Completion of an updated clinical privilege checklist(s) along with current copies of California licensure, DEA certificate, evidence of compliance with Medical Board of California requirements for continuing medical education, current status of malpractice insurance coverage, and documentation of a current tuberculosis screening;

The Member shall disclose information about the challenge to or relinquishment of licensure or registration on an ongoing basis as they occur.

5.1.1. The Member agrees to notify the hospital, in writing, promptly and no later than fourteen (14) days from the occurrence of any such change in licensure or registration status, restriction, reduction, or loss of clinical privileges at another hospital, a receipt or written notice of any adverse action against the Member under any federal health care program, such as exclusion from participation in federal health care programs, including but not limited to fraud and abuse convictions.

5.1.2. Failure to respond within thirty (30) days to a request by certified, return receipt requested mail for reassessment information shall be cause for loss of membership and privileges. Such loss will become effective on the first day of the month following expiration of the current reappointment.

5.2. Each recommendation concerning the reappointment of a Member and the clinical privileges to be granted upon reappointment shall be based upon such Member's:

a) Professional competence and clinical judgment in the treatment of patients including review of quality of care documentation;

b) Ethics and conduct;

c) Participation in affairs of the Medical Staff;

d) Compliance with the Bylaws, Rules and Regulations;

e) Appropriate use of the facilities of the Hospital; and

f) Information on the Member's current physical and mental health status.

The biennial reappointment process shall be initiated by the Member in affirming his/her physical and mental competence to carry out his/her responsibility as a Member. Reappointment requests and evaluation sheets shall carry the signature of the appropriate Campus Department Chairperson and Officer(s) of the Medical Staff. Written record of all matters considered in each Member's periodic reappointment appraisal shall be made a part of the permanent files of the Medical Staff. When a question arises as to whether a Member may pose significant risk to the health or safety of patients due to a disability, and when that risk cannot be eliminated by reasonable accommodations, a medical examination may be required by the appropriate Campus Executive Committee. The Campus Executive Committee shall select three (3) physicians from which the Member shall choose one (1) physician to conduct the physical or psychological evaluation.

Members of the Medical Staff who have had no clinical activity through inpatient admissions or consultations at a Palomar Health hospital during the biennial review period are automatically transferred into the Affiliate category unless they are eligible and wish to transfer into the active with no privileges category as set forth in Section 4.2.2 of the Bylaws.

In the event that the Member has been involved in the care of an insufficient number of patients to allow evaluation of clinical performance and the Member belongs to the Medical Staff of another Palomar Health facility, then any pertinent information based on organizational improvement activities shall be requested from that facility and considered in the reappointment process.

Once the Campus Executive Committee has completed its evaluation, its recommendation shall be processed pursuant to Sections 4.3 through 4.13 of this Credentials Policy Manual. Reappointment shall be for a period not to exceed two (2) years, and may be granted subject to such conditions, as the Medical Executive Committee or appropriate Campus Executive Committee deems appropriate, including but not limited to probation, monitoring, consultation or co-admitting. Notwithstanding any other provision in these Bylaws, a Member granted conditional reappointment shall not be entitled to a hearing pursuant to the Medical Staff Rights Manual unless the conditions imposed require the filing of a report pursuant to Business and Professions Code Section 805.

5.3. Conditional Reappointment

In the event the Medical Executive Committee or Campus Executive Committee requires additional information in order to evaluate the application or the applicant, the applicant for reappointment is the subject of an investigation or hearing at the time reappointment is being considered, a conditional reappointment for a period of less than two (2) years may be granted pending the completion of that process.

5.4. Failure to File Application for Renewal of Membership

Failure without good cause to timely file a completed application for renewal of membership shall result

in the automatic suspension of the member's admitting privileges and expiration of other practice privileges and prerogatives at the end of the current staff membership period.

6. Professional Practice Evaluation

6.1. Purpose

To define, determine, maintain, and evaluate the competency of members of the medical staff to provide care, treatment, and service in accordance with the credentialing and privileging processes and requirements of the medical staff. The Professional Practice Evaluation process will be defined and performed within the purview of the Medical Staff Peer Review Policy. This policy applies to all members of the medical staff.

6.2. Applicability

Unless otherwise noted, this policy applies to all members of the Medical Staff.

7. Confidentiality of Information

All activities surrounding the professional evaluation of members of the medical staff are considered part of the Medical Staff's quality management program and are therefore considered protected and confidential to the extent permitted by law and regulation.

8. Credential Files

8.1. Insertion of adverse information.

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

8.1.1. Adverse information related to a Member's conduct, performance or competence may be provided to the Medical Staff for possible insertion in the Member's file.

8.1.2. When insertion of adverse information into a Member's credentials file is being considered, the appropriate Campus Department Chairperson, the Campus Chief of Staff, and the involved Member shall review such information. The Member may write a statement to be placed in his/her credentials file.

8.1.3. After such a review a decision will be made by the appropriate Campus Department Chairperson and the Campus Chief of Staff to:

a) Not insert the information;

b) Insert the information along with the notation that no further review is warranted; or

c) Insert the information along with the notation that a request has been made for an investigation; or

d) Insert information that refutes the adverse information provided.

8.1.4. This decision as outlined in Section 9.4(e) of the Bylaws shall be reported to the Medical Executive Committee. The Medical Executive Committee when so informed may either ratify or initiate contrary actions to this decision by a majority vote.

9. Credentialing Licensed Independent Practitioners in the Event of a Disaster

To define Palomar Health's policy allowing the provision of care, treatment, or services by volunteers who are licensed independent practitioners when the organization's disaster plan has been implemented, and the immediate needs of patients cannot be met by the organization's staffing capabilities. This is an organization-wide policy. It applies to all settings and services. This policy applies to volunteer practitioners that are required by law and regulation to have a license, certification, or registration to practice their profession.

9.1. Process

Under such circumstances, the organization's Disaster Commander or authorized designee is authorized to implement this policy and grant disaster privileges or permission to treat patients to volunteer physicians, nurses, and other professionals upon receipt of satisfactory evidence that such individuals are currently licensed or otherwise capable of providing services to patients.

A volunteer practitioner must present a valid government issued photo identification issued by a state or federal agency (e.g. driver's license or passport). In addition, the volunteer practitioner must provide at

least one of the following:

a) A current hospital picture identification card that clearly identifies the individual's professional designation

b) A current license, certification, or registration

c) Primary source verification of licensure, certification or registration

d) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organization or group(s).

e) Identification indicating that the individual has been granted authority to render patient care, treatment, or services in disaster circumstances (such as authority having been granted by a federal, state, or municipal entity).

f) Identification by a current member of the organization who possesses personal knowledge regarding the volunteer practitioner's qualifications.

Allied Health Professionals (AHP) defined as a currently licensed physician assistant, nurse midwife, nurse practitioner or nurse anesthetist may be granted disaster privileges to provide services at the request of responsible officials or pursuant to a mutual aid operation plan established and approved under the California Emergency Service Act, only if they are licensed in California and a licensed physician will supervise their practice during the disaster. During a disaster, there is no limit on the number of physician assistants a supervising physician may simultaneously supervise.

As soon as the immediate situation is under control, the organization should obtain primary source verification of the volunteer practitioner's license, certification, or registration. Primary source verification must be completed within 72 hours from the time the volunteer practitioner presented to the organization. In extraordinary circumstances (e.g. no means of communication or a lack of resources), verification may exceed 72 hours, but must be completed as soon as possible.

Primary source is the entity or agency that has the legal authority to issue the credential in question. If the entity or agency has designated another entity or agency to communicate information about the status of a staff member's credential, then the other entity or agency may be considered the primary source.

If the credential is not required by law or regulation in order for the staff member to practice his or her profession, then it is not necessary to obtain verification from the primary source. If the volunteer practitioner is not providing care, treatment, or service for which a license, certification, or registration is required, then primary source verification is not required.

Volunteer practitioners will be identified by a name badge to tag provided by the organization. The badge / tag will list the name and professional designation of the volunteer (e.g. John Smith RN) as well as the notation that the individual is a volunteer. The volunteer practitioner will be required to wear the badge / tag on his or her person while performing in that role / capacity. Volunteer practitioners will be assigned to a member of the organization's staff who possesses similar license, certification, or registration who is a peer in the volunteer's area of practice and experience. The organization's staff member will serve as a mentor and resource for the volunteer practitioner.

The organization's staff member will be responsible for overseeing the professional performance of the volunteer practitioner. This may be accomplished by;

a) Direct observation

b) Clinical review of care documented in the patient's medical record.

Volunteer practitioners will cease providing care, treatment, or service if any one of the following criteria is met:

a) Implementation of the emergency management plan ceases.

b) The capability of the organization's staff becomes adequate to meet patient care needs.

c) After 72 hours (or sooner if warranted) a decision is made that the professional practice of the volunteer practitioner does not meet organization standards.

There will be no rights to any hearing or review in the event a physician's or an AHP's disaster privileges are terminated, regardless of the reason for the termination.

1. Collegial Intervention

1.1. This Manual encourages the use of progressive steps by Medical Staff leaders and Hospital administration, beginning with collegial and educational efforts, to address questions relating to an individual's clinical practice, professional conduct, and/or lack of compliance with Medical Staff policies/procedures. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised.

1.2. Collegial efforts may include, but are not limited to, counseling and sharing of comparative data.

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

1.4. The relevant Medical Staff leader(s) will 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 the opportunity to review and respond in writing. The response shall be maintained in that individual's file along with the original documentation.

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

1.6. The appropriate Campus Chief of Staff shall determine whether to direct that a matter be handled in accordance with a Policy or to direct it to the Campus Executive Committee for further determination.

2. Corrective Action Investigation

2.1. Definitions

The following definitions shall apply under this article:

Days refers to calendar days for purpose of determining periods of time.

Medical Disciplinary Cause or Reason means that aspect of a Practitioner's competence or conduct, which is reasonably likely to be detrimental to patient safety or to the delivery of patient care.

Member refers to an applicant, medical staff member or clinical psychologist, as the case may be, who is subject to the provisions set forth in this Manual.

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

2.2. Criteria for Initiation

Any person may provide information to the Medical Staff about the conduct, performance, or competence of its members. A request for investigation or action against a Member may be initiated by a Campus Chief of Staff, the Campus Executive Committee, the Medical Executive Committee, Chief Executive Officer, or Board of Directors when reliable information indicates a Member may have exhibited acts, demeanor, or conduct reasonably likely to be:

d) Detrimental to patient safety or to the delivery of quality patient care within the Hospital,

e) Unethical,

f) Contrary to Bylaws or Rules and Regulations of the Medical Staff; or

g) Below applicable professional standards

2.3. Initiation

A request for an investigation shall be in writing, submitted to the Campus Chief of Staff from the Campus where the involved Member is assigned and supported by reference to specific activities or alleged conduct. The Campus Chief of Staff will decide whether the request warrants further investigation. If so, the Campus Chief of Staff will submit the request to the Campus Executive Committee. The Campus Chief of Staff shall make appropriate recordation of the decision to deny the request or to recommend proceeding with the investigation.

2.4. Investigation

a) If the Campus Executive Committee concludes an investigation is warranted, it shall direct an

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

b) Upon initiation of the investigation, the Member shall receive Notice that an investigation is being conducted and be advised of the nature of the allegations. The Member shall be given an opportunity to provide information in a manner, and upon such terms, as the investigating body deems appropriate. The individual or body investigating the matter may, but is not obligated to, conduct interviews with persons involved; however, such investigation shall not constitute a Hearing as that term is used in this Manual, nor shall the procedure rules with respect to Hearing or appeals apply.

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

2.5. Campus Executive Committee Action

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

a) Determining no corrective action need be taken and, if it is determined that there was insufficient credible evidence for the complaint in the first instance, removing any adverse information from the Member's file.

b) Deferring action for a reasonable time where circumstances warrant.

c) Issuing letters of admonition, censure, reprimand, or warning. In the event such letters are issued and placed in the Member's file, the Member may make a written response, which also shall be placed in the Member's file.

d) Recommending probation, reduction, modifications, suspension, or revocation of clinical privileges.

e) Recommending suspension, revocation, limitation, or probation of membership.

f) Taking other actions deemed appropriate under the circumstances.

2.6. Subsequent Action

a) If corrective action as set forth in Section 5.1 of this Medical Staff Rights Manual is recommended by the Campus Executive Committee, the Member shall be given Notice of the recommendation and of the right to request a Judicial Review Hearing ("Hearing") pursuant to Section 5.2. Thereafter, the Hearing shall be conducted as set forth in this Medical Staff Rights Manual.

b) If no timely request for a Hearing is submitted by the Member, the Member shall be deemed to have accepted the recommendation of the Campus Executive Committee and to have waived the right to a Hearing or an appeal. So long as the recommendation is supported by substantial evidence, the recommendation of the Campus Executive Committee shall be adopted by the Medical Executive Committee, which shall submit it to the Board of Directors for its adoption as final action.

2.7. Initiation by Board of Directors

If the Campus Executive Committee fails to investigate or take corrective action, contrary to the weight of the evidence, the Board of Directors may direct the Campus Executive Committee to initiate investigation or corrective action, but only after consultation with the Campus Executive Committee and the Medical Executive Committee. If the Campus Executive Committee and Medical Executive Committee fail to take action in response to the Board of Directors' direction, the Board of Directors may initiate corrective action after written notice to the Campus Executive Committee and Medical Executive Committee. Such corrective action must comply with the procedures set forth in this Manual.

3. Summary Suspension

3.1. Criteria for Initiation

Whenever a Member's conduct appears to require that immediate action be taken to protect the life, health or safety of any patient, prospective patient or other person, the appropriate Campus Chief of Staff, Campus Executive Committee, Medical Executive Committee, the Chief Executive Officer, the Chief Administrative Officer or the Campus Department Chair in which the Member holds privileges may summarily restrict or suspend the membership or clinical privileges of such Member. The summary suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise stated, such summary suspension shall become effective immediately upon imposition.

3.2. Written Notice of Summary Suspension

The person or body responsible for the summary suspension shall promptly give written notice to the Board of Directors, the Campus Executive Committee, the Medical Executive Committee, and the Chief Executive Officer. The affected Member shall also be provided with prompt written Notice of such suspension. This initial written Notice shall include a statement of facts demonstrating that the action was necessary because failure to do so could reasonably result in imminent danger to the health or safety of an individual. The statement of facts shall also include a summary of one or more particular incidents giving rise to the assessment of imminent danger.

3.3. Continuity of Care

In the event the summary restriction or suspension precludes the Member from continuing to provide necessary care to patient(s) already admitted, or if the Campus Chief of Staff, the Campus Executive Committee, or the Medical Executive Committee determines it is appropriate to transfer the care of patients already admitted by the Member to another member, such patients shall be promptly assigned to another member by the Campus Department Chairperson or Campus Chief of Staff, considering, where feasible, the wishes of the patient in the choice of a substitute member.

3.4. Medical Executive Committee Action

Within seven (7) days after such summary suspension has been imposed, a meeting of the Campus Executive Committee shall be convened to review and consider the action. The Member may attend and make a statement concerning the issues under investigation, on such terms and conditions as the Campus Executive Committee may impose, although in no event shall any meeting of the Campus Executive Committee, with or without the Member, constitute a Hearing as that term is defined in this Manual, nor shall the procedural rules with respect to Hearings or appeals apply. The Campus Executive Committee may modify, continue or terminate the summary suspension, and recommend any additional corrective action. The Campus Executive Committee shall furnish the Member with written Notice of the decision within two (2) working days of the decision.

3.5. Procedural Rights

Unless the Campus Executive Committee promptly terminates the summary suspension, the Member shall be entitled to the procedural rights afforded by Section 5 of this Medical Staff Rights Manual.

3.6. Initiation by Board of Directors

If no one authorized under Section 3.1 is available to summarily restrict or suspend a Member's membership or privileges, the Board of Directors, Chief Executive Officer or the Chief Administrative Officer may immediately suspend a Member's privileges if a failure to suspend those privileges is likely to result in an imminent danger to the health of any person, provided the Board of Directors made reasonable attempts to contact the appropriate Campus Chief of Staff, members of the Campus Executive Committee, the Medical Executive Committee, or the department Chair before the suspension. Such a suspension is subject to the ratification by the Campus Executive Committee or Medical Executive Committee. If the Campus Executive Committee or Medical Executive Committee does not ratify such a summary suspension within two working days, the summary suspension shall terminate automatically.

4. Automatic Revocation Suspension or Limitation

In the following instances, the Member's admitting and clinical privileges may be revoked, suspended, or limited as described, which action shall be final without a right to hearing or further review, except where the Medical Executive Committee or Campus Executive Committee determines in its sole discretion that a bona fide dispute exists as to whether the circumstances have occurred.

4.1. Licensure

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

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

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

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

4.2. Controlled Substances

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

4.3. Failure to Satisfy Special Appearance Requirement

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

4.4. Conviction of Felony

A Member convicted of a felony that bears on qualification or fitness to practice whether or not appealed, may be a cause for a summary suspension at the discretion of the Medical Executive Committee.

4.5. Bylaws, Rules and Regulations Violations

Suspension of all admitting and clinical privileges, except such clinical privileges as may be deemed necessary by the Campus Executive Committee or Medical Executive Committee to maintain continuity of care for patients already admitted by the Member, shall be imposed by the appropriate Campus Chief of Staff, Campus Executive Committee, Medical Executive Committee, or Board of Directors for the following Bylaws, Rules and Regulations' violations:

a) Medical Record Deficiencies: Temporary suspension of a Member's admitting and clinical privileges, except as provided above will be imposed automatically for failure to complete deficient or delinquent medical records within the time period set forth below, unless the Campus Chief of Staff interceded on his/her behalf.

   All medical records shall be completed within fourteen (14) days. Failure to comply with this requirement may result in fines and/or suspension as set forth in the Medical Staff policy, Medical Records/Quality of Care Violations.

   A list of suspended Members shall be distributed weekly to the Chief Executive Officer, Chief of Staff, Department Chairpersons, Quality Management Committee Chairperson, and clinical departments within the Hospital.

b) Failure to Provide Emergency Room Consultation: A Member who refuses to provide Emergency

Department call panel services, may have his/her admitting and clinical privileges suspended. Emergency Department call panel services shall not apply or encompass the participation by any Member on a separate trauma services call panel, which in all events shall be voluntary. A Member may be disciplined for failure to respond, treat, consult, or follow designated trauma patients, if the Member has volunteered for the trauma services call panel.

c) Professional Liability Insurance: The admitting and clinical privileges of any Member who fails to provide documentation of professional liability coverage as required by 3.2.6 of the Medical Staff Bylaws shall be automatically suspended. A failure to provide such documentation within three (3) months after the date of this suspension becomes effective shall be deemed to be a voluntary resignation of membership.

d) Dues and Fines: Any Member required to pay dues or fines and who fails to pay such dues or fines as required by Article IV, after written warning of delinquency, shall have his/her admitting and clinical privileges suspended, and shall remain so suspended until the Member pays the delinquent dues or fines. Failure to pay such dues or fines within three (3) months after this suspension becomes effective shall be deemed to be a voluntary resignation of membership.

e) Tuberculin Testing Documentation: The admitting and clinical privileges of any Member who fails to provide documentation of TB screening in accordance with Palomar Health guidelines shall be automatically suspended. Failure to provide such documentation within three (3) months after the date this suspension becomes effective shall be deemed to be a voluntary resignation of membership.

4.6. Exclusion from Federal Healthcare Programs

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

5. Judicial Review Hearing

5.1. Grounds for Hearing

Except as otherwise specified in these Bylaws, any one or more of the following actions or recommended actions shall be deemed an actual or potential action and constitute grounds for a Judicial Review Hearing ("Hearing") if such action of recommendation is taken for a Medical Disciplinary Cause or Reason:

a) Denial of Medical Staff membership

b) Denial of Medical Staff reappointment

c) Suspension of Medical Staff membership

d) Revocation of Medical Staff membership

e) Denial of requested clinical privileges (excluding temporary privileges unless they are denied for a Medical Disciplinary Cause or Reason)

f) Involuntary reduction of clinical privileges

g) Suspension of clinical privileges

h) Termination of clinical privileges

i) Involuntary imposition of significant consultation or proctoring requirements (excluding concurrent or retrospective medical record monitoring and monitoring/proctoring incidental to provisional privileges)

j) Denial of requested advancement in staff membership status or category

5.2. Notice of Hearing

In all cases in which action has been taken or recommended as set forth above, the Member shall be given special Notice of the recommendation or action and of the right to request a Hearing pursuant to Section 5.3 below. The Notice must state:

a) The action or recommendation taken

b) A brief indication of the reasons for the action or recommendation

c) That the Member may request a hearing

d) That a hearing must be requested within thirty (30) days

e) That the Member has the hearing rights set forth in the Medical Staff Rights Manual

f) That such action will be reported as required by Business & Professions Code Sections 805 and/or 805.1

5.3. Request for Hearing

The Member shall have thirty (30) Days following receipt of Notice of such action or recommendation to request a hearing. The request shall be in writing addressed to the appropriate Campus Chief of Staff. If the Member does not request a hearing within the time and in the manner described, the Member shall be deemed to have waived any right to a Hearing and accepted the action or recommendation involved.

5.4. Time and Place for Hearing

Upon receipt of a request for Hearing, the appropriate Campus Chief of Staff shall schedule a Hearing and, within fifteen (15) Days give Notice to the Member of the time, place, and date of the hearing. The date of the commencement of the Hearing shall be not be more than sixty (60) days from the date the Campus Chief of Staff received the request for Hearing; provided, however, that when the request is received from a Member who is under summary suspension, the Hearing shall be held as soon as the arrangements may reasonably be made, but not to exceed forty-five (45) days from the date of receipt of the request.

5.5. Notice of Reason

Together with the Notice of Hearing, the Campus Chief of Staff shall state clearly and concisely in writing the reasons for the action or recommendation, including the acts or omissions with which the Member is charged, and a list of the charts in question, where applicable. A supplemental Notice may be issued at any time, provided the Member is given sufficient time to respond.

5.6. Hearing Panel

When a Hearing is requested, the appropriate Campus Chief of Staff shall appoint a Hearing Panel, which shall be composed of not less than five (5) members of the active Medical Staff, and alternates as appropriate, who have not acted as accusers, investigators, fact finders, or initial decision maker or otherwise have not actively participated in the action or recommendation, and are not in direct economic competition with the Member and who shall gain no direct financial benefit from the outcome. The Hearing Panel shall include, where feasible, an individual practicing the same specialty as the Member. Knowledge of the matter involved shall not preclude a member of the Medical Staff from serving as a member of the Hearing Panel. In the event it is not feasible to appoint a Hearing Panel from the active Medical Staff, the Chief of Staff may appoint members from other staff categories or practitioners who are not members of the Medical Staff. Such appointment shall include designation of the Chair of the Hearing Panel. The Member shall be entitled to a reasonable opportunity to question and challenge the impartiality of the prospective members of the Hearing Panel. Challenges to the members of the Hearing Panel shall be ruled on by the Hearing Officer. During the Hearing, the Hearing Panel may interrogate the witnesses or call additional witnesses if it deems such action appropriate.

5.7. Hearing Officer

The use of a Hearing Officer to preside at a hearing is mandatory. The appointment of a Hearing Officer shall be by the appropriate Campus Chief of Staff, as a representative of the Campus Executive Committee, as follows:

a) Together with the Notice of Hearing, the Member shall be provided a list of at least three, but no more than five (5) potential Hearing Officers meeting the criteria set forth below.

b) The Member shall have five (5) Days to accept any of the listed potential Hearing Officers, or to propose at least three (3) but no more than five (5) other names of potential Hearing Officers meeting the criteria set forth below.

c) If the Member is represented by counsel, the parties' counsel may meet and confer in an attempt to reach accord in the selection of the Hearing Officer from the two parties' lists.

d) If the parties are not able to reach agreement on the selection of a Hearing Officer within five (5) working days of receipt of the Member's proposed list, the Campus Chief of Staff shall select an individual from the composite list.

e) Unless a Hearing Officer is selected pursuant to stipulation of the parties, the Member shall be entitled a reasonable opportunity to question and challenge the impartiality of the Hearing Officer. Challenges to the impartiality of the Hearing Officer shall be ruled on by the Hearing Officer.

The Hearing Officer shall be an attorney at law qualified to preside over a quasi-judicial hearing, but an attorney regularly utilized by the Hospital, Medical Staff, or Member for legal advice regarding their affairs and activities shall not be eligible to serve. The Hearing Officer shall gain no direct financial benefit from the outcome and must not act as a prosecuting officer or as an advocate. The Hearing Officer shall endeavor to assure that all participants in the Hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The Hearing Officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the Hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure or the admissibility of evidence. If the Hearing Officer determines that either side in a Hearing is not proceeding in an efficient and expeditious manner, the Hearing Officer may take such discretionary action as seems warranted by the circumstances. If requested by the Hearing Panel, the Hearing Officer may participate in its deliberations and serve as a legal adviser to it, but the Hearing Officer shall not be entitled to vote.

5.8. Representation

The Hearing is for the purpose of intra-professional resolution of matters bearing on professional conduct or professional competence. The Medical Staff Member shall have the right to select whether or not to be represented at the Hearing by an attorney. If the Member decides in favor of representation by an attorney then both sides shall be represented. If the member decides against representation by an attorney then neither side shall be represented. If legal representation is not allowed, both sides may be represented at the Hearing by a medical practitioner licensed to practice in the State of California who is also not an attorney at law.

5.9. Personal Presence Mandatory

Under no circumstances shall the Hearing be conducted without the personal presence of the Member unless he/she has waived such appearance or has failed without good cause to appear after appropriate notice. Failure without good cause of the Member to appear personally and proceed in an efficient, orderly, and efficient manner shall be deemed to constitute voluntary acceptance of the action or recommendation involved.

5.10. Continuances shall be granted upon agreement of the parties or by the Hearing Officer on a showing of good cause.

5.11. Discovery

a) Each party shall have the right to inspect and copy at its own expense any documentary evidence relevant to the charges which the other party has in its possession or under its control. The failure by either party to comply with reasonable discovery requests at least thirty (30) days prior to the hearing shall constitute good cause for a continuance.

b) The Hearing Officer shall rule on discovery disputes the parties cannot resolve. Discovery may be denied when justified to protect peer review or in the interest of fairness and equity. Further, the right to inspect and copy by either party does not extend to confidential information referring to individually identifiable practitioners other than the Member nor does it create or imply any obligation to modify or create documents in order to satisfy a request for information.

c) In ruling on discovery disputes, the Hearing Officer may consider: (1) whether the information sought may be introduced to support or defend the charges; (2) the exculpatory or inculpatory nature of the information sought, if any; (3) the burden on the party of producing the requested information; and (4) other discovery requests the party has previously made.

5.12. Pre-Hearing Document Exchange

At the request of either party, the parties must exchange all documents that will be introduced at the

Hearing. The documents must be exchanged at least ten (10) days prior to the commencement of the Hearing. A failure to comply with this rule is good cause for the Hearing Officer to grant a continuance. Repeated failures to comply shall be good cause for the Hearing Officer to limit the introduction of any documents not provided to the other side in a timely manner.

5.13. Witness Lists

At the request of either party, the parties shall exchange lists of the individuals, as far as is then reasonably known or anticipated, who are expected to give testimony or evidence at the Hearing. Nothing in the foregoing shall preclude the testimony of additional witnesses whose participation was not reasonably anticipated. The parties shall notify each other as soon as they become aware of the possible participation of such additional witnesses. The failure to provide the name of any witness at least ten (10) days prior to the Hearing date at which the witness is to appear shall constitute good cause for a continuance.

5.14. Procedural Disputes

It shall be the duty of the parties to exercise reasonable diligence in notifying the Hearing Officer of any pending or anticipated procedural disputes as far in advance of a scheduled Hearing session as possible in order that decisions concerning such matters may be made in advance of the Hearing session. Objections to any such decisions may be succinctly made at the Hearing.

5.15. Record of the Hearing

A court reporter shall be present to make a record of the Hearing proceedings. The cost of attendance of the court reporter shall be borne by the Hospital, but the cost of a transcript, if any, shall be borne by the party requesting it. The Hearing Officer may, but shall not be required to, order that oral evidence shall be taken only on oath administered by the court reporter or any person lawfully authorized to administer such oath.

5.16. Rights of the Parties

Within reasonable limitations, both sides at the Hearing may call and examine witnesses for relevant testimony, introduce relevant exhibits or other documents, cross-examine or impeach witnesses who shall have testified orally on any matter relevant to the issues, and otherwise rebut evidence, as long as these rights are exercised in an efficient and expeditious manner. The Member may be called by the Campus Executive Committee and examined as if under cross-examination. Both parties shall be provided with all of the information made available to the Hearing Panel. Each party has the right to submit a written closing statement at the close of the Hearing.

5.17. Rules of Evidence

Judicial rules of evidence and procedure relating to the conduct of the Hearing, examination of witnesses, and presentation of evidence shall not apply to a Hearing conducted pursuant to this Medical Staff Rights Manual. Any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the course of serious affairs, regardless of the admissibility of such evidence in a court of law.

5.18. Burden of Presenting Evidence and Proof

The Campus Executive Committee shall have the initial duty to present evidence for each case or issue in support of its action or recommendation.

An applicant for membership and/or privileges shall bear the burden of persuading the Hearing Panel, by a preponderance of the evidence, that he/she is qualified for membership and/or the denied privileges. The applicant must produce information which allows for adequate evaluation and resolution of reasonable doubts concerning his/her current qualifications for membership and privileges. An applicant shall not be permitted to introduce information requested by the Medical Staff but not produced during the application process unless the applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

Except as provided above for applicants, the Medical Executive Committee shall bear the burden of persuading the Hearing Panel, by a preponderance of the evidence, that its action or recommendation is reasonable and warranted.

5.19. Adjournment and Conclusion

The Hearing Officer may adjourn the Hearing and reconvene the same without special notice at such times and intervals as may be reasonable and warranted, with due consideration for reaching an expeditious conclusion to the Hearing. Upon conclusion of the presentation of oral and written evidence, or the receipt of written closing statements, if submitted, the Hearing shall be closed. Thereafter, the Hearing Panel shall conduct its deliberations outside the presence of any person other than the Hearing Officer, if the Hearing Officer is requested by the Hearing Panel to participate in its deliberations. Final adjournment shall be when the Hearing Panel has concluded its deliberations.

5.20. Basis for Decision

The decision of the Hearing Panel shall be based on the evidence introduced at the hearing, including all logical and reasonable inferences from the evidence and the testimony.

5.21. Decision of the Hearing Panel

Within thirty (30) days after final adjournment of the Hearing, the Hearing Panel shall render a written decision. If the Member is currently under summary suspension, however, the time for the decision shall be seven (7) days after final adjournment of the Hearing. The decision shall be delivered to the Campus Executive Committee and the Medical Executive Committee. Copies of the decision shall also be forwarded to the Chief Executive Officer, the Board of Directors and the Member. The decision shall contain a concise statement of the reasons in support of the decision including the findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached. Both parties shall be provided a written explanation of the procedure for appealing the decision. The decision of the Hearing Panel shall be subject only to such rights of appeal to the Board of Directors as set forth in this Manual.

5.22. Joint Hearing

A Joint Hearing may be conducted pursuant to Article XVIII of the Medical Staff Bylaws. A Joint Hearing in accordance with the foregoing shall be deemed to satisfy procedural rights afforded to the Member pursuant to Business & Professions Code section 809, et. seq.

6. Appeal to Board of Directors

6.1. Time for Appeal

Within ten (10) Days after receipt of the decision of the Hearing Panel, either the Member or the Medical Executive Committee, after consultation with the Campus Executive Committee, may request an appellate review. A written request for such review shall be delivered to the Campus Chief of Staff, the Chief Executive Officer, and the Member. If a request for appellate review is not submitted within such period, the right to an appellate review shall be deemed to have been waived and the action or recommendation shall be affirmed by the Board of Directors as the final action it is supported by substantial evidence following a fair procedure.

6.2. Grounds for Appeal

A written request for appeal shall include an identification of the grounds for appeal, and a clear and concise statement of the facts in support of the appeal. The grounds for appeal from the Hearing shall be:

a) Substantial non-compliance with the procedures required by this Manual or applicable law which has created demonstrable prejudice; or

b) The decision was not supported by substantial evidence based on the hearing record or such additional information as may be permitted pursuant to 6.4 below.

6.3. Appeal Board

The Board of Directors may act as the Appeal Board or it may appoint an Appeal Board which shall be composed of not more than three (3) members of the Board of Directors. Knowledge of the matter involved shall not preclude any person from serving as a member of the Appeal Board, so long as that person did not take part in a prior hearing on the same matter. The Appeal Board may select an attorney to assist it in the proceeding and during deliberations, but that attorney shall not be entitled to vote with respect to the appeal.

6.4. Appeal Procedures

The proceedings shall be in the nature of an appellate hearing based on the record of hearing before the Hearing Panel, provided that the Appeal Board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the Hearing Panel in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the Hearing. Alternatively, the Appeal Board may remand the matter to the Hearing Panel for the taking of further evidence for decision.

Within seven (7) days after mailing the request for appellate review, the party requesting the appeal shall order the original transcript of the Hearing proceedings for use by the Appeal Board. Failure on the part of the appellant to timely order the original transcript shall be deemed to be an abandonment of the appeal, and the decision of the Hearing Panel shall thereupon become final. The appellant shall cause the original transcript to be delivered to the Appeal Board as soon as it is completed. The initial cost of such original transcript shall be borne by the appellant.

Upon receiving the original transcript, the Appeal Board shall give parties Notice of the date, time and place of the appellate review. The date of the appellate review shall not be less than fifteen (15) Days nor more than forty-five (45) Days from the date of receipt of the original transcript; provided, however, when a request for appellate review is from a Member who is under suspension which is then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made and not to exceed twenty Days from the date of receipt of the original transcript. The time for appellate review may be extended by the Chair of the Board of Directors for good cause.

Each party shall have the right to submit a written brief, the right to personally appear and make oral argument, and the right to be represented by an attorney or other representative.

At the conclusion of oral argument, the Appeal Board may thereupon, at a time convenient to itself, conduct deliberations in closed session outside the presence of the parties and their counsel or representatives.

6.5. Decision

If the appellate review is conducted by an Appeal Board composed of no more than three members of the Board of Directors, the Appeal Board shall issue its written decision within fifteen (15) Days after conclusion of the appellate hearing. Within fifteen (15) days after receipt of the written decision or within fifteen (15) days after the conclusion of the appellate review by the Board of Directors, the Board of Directors shall render a final decision. The decision shall be in writing and copies thereof shall be delivered to the appropriate Campus Executive Committee and the Medical Executive Committee and to the Member in person or by certified mail within ten (10) days thereafter.

The Board of Directors may affirm, modify, or reverse the decision of the Hearing Panel or it may remand the matter for further review by the Hearing Panel. If the matter is remanded for further review and recommendation, the further review shall be completed within thirty (30) days unless the parties agree otherwise or for good cause as determined by the Chair of the Board.

The Board of Directors shall affirm the decision of the Hearing Panel if it is supported by substantial evidence following a fair procedure. The Board of Directors may, however, exercise its independent judgment in determining whether the Member was afforded a fair hearing. The decision shall specify the reasons for the action taken and provide findings of fact and conclusions articulating the connection between the evidence produced at the Hearing and the appeal, if any, and the decision reached, if such reasons, findings, and conclusions differ from those of the Hearing Panel.

7. Right to One Hearing

Except as otherwise provided in this Manual, no Member shall be entitled to more than one evidentiary hearing and one appellate review on any single matter without regard to whether such subject is the result of action by the Campus Executive Committee or Medical Executive Committee or the Board of Directors, of a combination of acts of such bodies.

8. Contract Physicians

Members under contract with the Hospital in any medical-administrative capacity, in closed departments or departments with exclusive contracts shall be subject to the procedural rights set forth in this Manual only to the extent the:

a) Hospital, based on a recommendation by the Medical Executive Committee, proposes contract modifications that result in termination or restrictions of a Member's staff privileges or membership based on a Medical Disciplinary Cause or Reason.

b) Medical Executive Committee takes action which must be reported under Business & Professions Code Section 805 and/or the Member's membership status or privileges which are independent of the Member's contract are suspended, restricted, or revoked for a Medical Disciplinary Cause or Reason.

Except as provided above, termination or alteration of a contract held between the Hospital or System and Member will be considered an administrative matter and will not be grounds for any of the Hearing procedures set forth in this Manual.

9. Exhaustion of Remedies

If adverse action as described in this Manual is taken or recommended, the Member must exhaust the remedies afforded by the terms of this Manual before resorting to legal action.

10. Failure to Satisfy Minimum Requirements

Denial or loss or privileges due to failure to meet minimum, generally applicable objective requirements, including but not limited to the requirements set forth in Section 3.2.2 of the Bylaws, shall not be grounds for any of the procedures set forth in this Manual.

11. Reapplication Following Adverse Action

Whenever an applicant is denied appointment or reappointment, or a Member loses membership or some or all privileges for a Medical Disciplinary Cause or Reason, such person shall not be entitled to reapply for membership and/or such privileges for two years, unless the Medical Executive Committee determines, in its sole discretion, that the basis for the denial or termination has been eliminated prior to such time.

ADDENDUM C

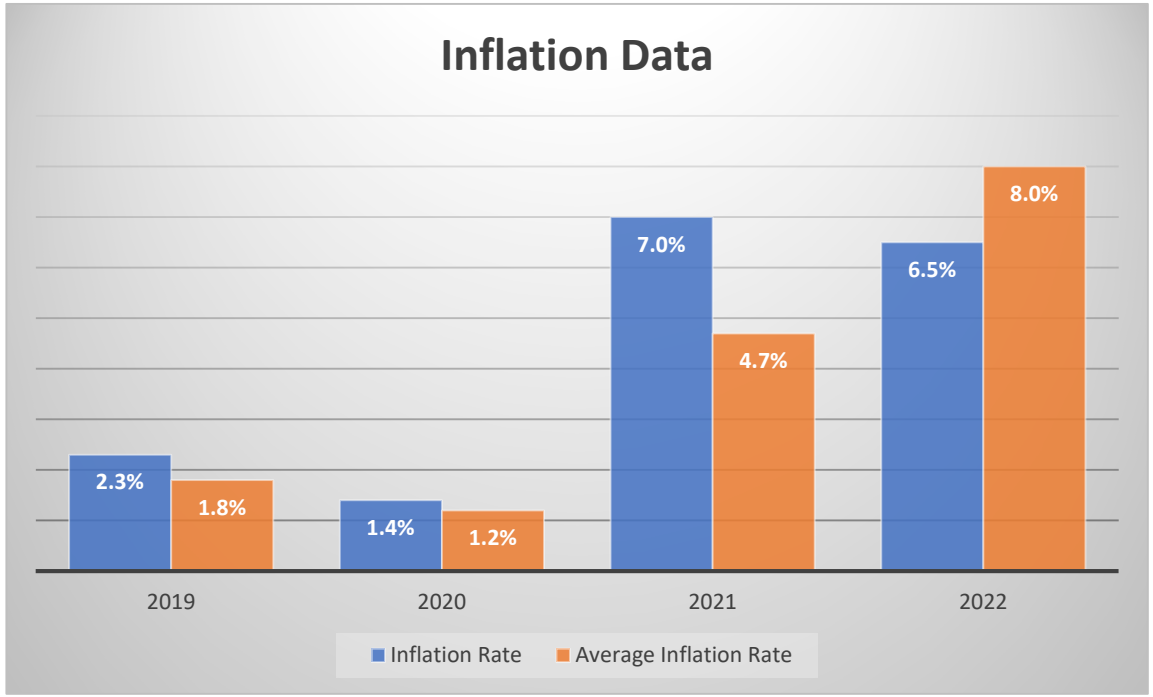
Palomar Health: Executive Compensation

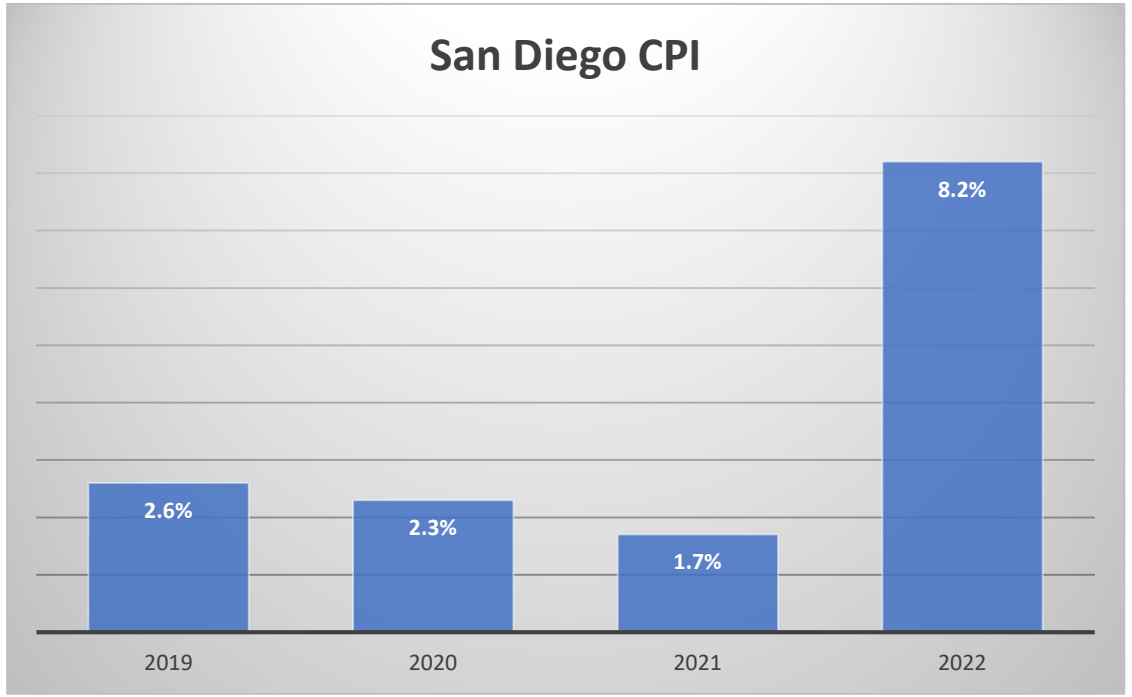
Executive Compensation

Entity	CEO Name	Years	Compensation	Entity Type
Cedars-Sinai Medical Center	Thomas M. Priselac	2022	$5,159,849[1]	Non-Profit
Sharp Healthcare	Christopher D. Howard	2021	$2,070,064[2]	Non-Profit
Scripps Health	Christopher van Gorder	2021	$2,442,197[2]	Non-Profit
Washington Township Hospital District	Kimberly Hartz	2021	$1,013,327[3]	Non-Profit
El Camino Hospital	Dan Woods	2019	$890,000[4]	Non-Profit
UCSF Health	Suresh Gunasekaran	2022	$1,850,000[5]	Non-Profit
UCSF Health	Mark Laret (Emeritus)	2021	$2,294,237	Non-Profit
Marin General Hospital	David Klein MD	2021	$1,287,288[1]	Non-Profit
USC Health System	Rodney B. Hanners	2021	$1,578,726	Non-Profit
Long Beach Memorial Care	Barry S. Arbuckle	2021	$4,120,677[1]	Non-Profit
Stanford Health Care 227	David Entwistle	2021	$4,360,713[2]	Non-Profit
John Muir Health	Calvin Knigh	2021	$4,227,689[1]	Non-Profit
Huntington Medical Foundation	Lori Morgan	2021	$1,988,040[1]	Non-Profit
UC Davis	David Lubarsky	2021	$1,081,142[6]	Non-Profit
UC Irvine	Chad Lefteris	2021	$1,245,594[6]	Non-Profit
Palomar Health	**Diane Hansen**	**2021**	**$1,407,391**	**Non-Profit**
UC San Diego Health System	Patricia Maysent	2021	$1,462,487[6]	Non-Profit
UCLA	Johnese Spisso	2021	$2,170,312[6]	Non-Profit

1. 2021 Form 990
2. 2020 Form 990
3. GovSalaries
4. Forestieri, Kevin, Pay raises for El Camino executives, Mountain View Voice, Aug. 18, 2018.
5. Meeting Minutes, January 18, 2022
6. Transparent California

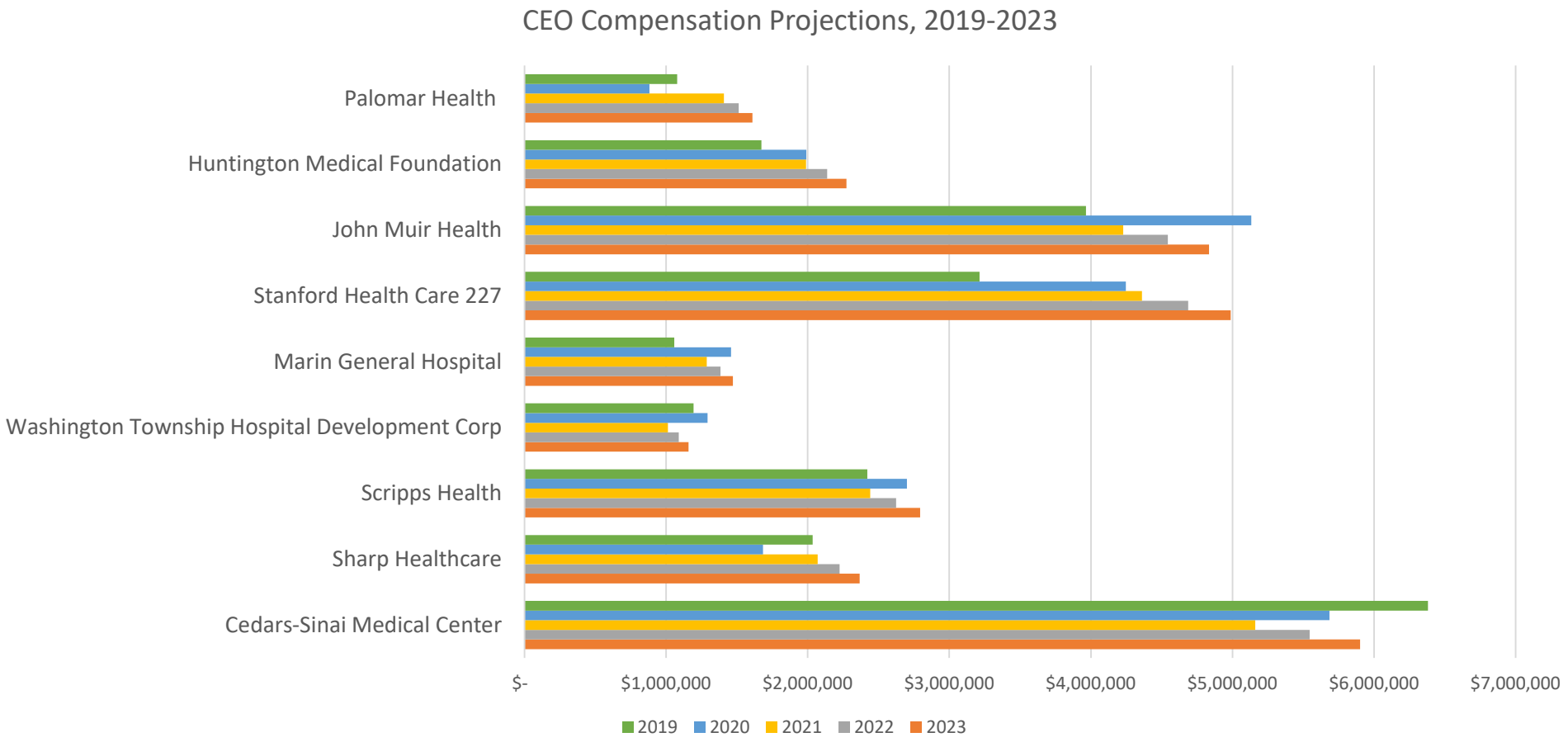
Inflation Rates





[Current US Inflation Rates: 2000-2023 (usinflationcalculator.com)]
[Consumer Price Index, San Diego Area — July 2023 : Western Information Office : U.S. Bureau of Labor Statistics (bls.gov)]

CEO Compensation Projections



[CPI Inflation Calculator (bls.gov)]

RESOLUTION NO. 10.09.23(01)-16

RESOLUTION OF THE BOARD OF DIRECTORS OF PALOMAR HEALTH PROPOSING AND CONSENTING TO AMENDMENT TO CEO EMPLOYMENT AGREEMENT

WHEREAS, the Board of Directors of Palomar Health has reviewed that certain Employment Agreement, made and entered into by and between Diane Hansen and Palomar Health, effective September 10, 2020, and as amended thereafter;

WHEREAS, the Board of Directors, consistent with the duly-adopted CEO Compensation Policy, appointed an Ad Hoc CEO Compensation Committee;

WHEREAS, the Ad Hoc CEO Compensation Committee recommends that certain amendments be offered to Diane Hansen to be made to the Employment Agreement;

NOW, THEREFORE, IT IS HEREBY RESOLVED that the Board:

(1) Orders the Chief Legal Officer to prepare an amendment to the Employment Agreement with the following substantive revisions:

a. Base Salary will be set to _____;
b. Base Salary will be paid according to a schedule determined by the Chief Legal Officer, with the full amount paid no later than January 1, 2027;
c. Variable compensation maximum is amended to be __%;
d. Long Term Disability insurance will be provided on terms as set forth below in (3);
d. Paid Time Off not used will be paid on an annual basis;
e. Notice of Termination Without Cause require 6-months advance notice;
f. No further market surveys related to compensation occur until at least 2027;
g. The above changes are proposed without prejudice to any other terms of the Employment Agreement, except where such terms conflict with the provisions of this Resolution, in which case this Resolution, if accepted, will control; and
h. No other substantive changes be made or proposed.

(2) Orders the Chief Legal Officer, to take all necessary steps in execution of the above-identified proposed amendment, including to propose any further non-substantive changes to effect the same;

(3) Further orders the Chief Legal Officer to take all necessary steps to acquire Long Term Disability insurance, with the Chief Executive Officer as the beneficiary, with benefits and term at competitive market levels, to be determined by the Chief Legal Officer in consultation with the Chair, with the Chair empowered to execute such insurance at competitive market levels.

(4) Consents to the above-identified proposed amendment to the Employment Agreement, and authorizes its signature be attached to the Amendment to Employment Agreement, through the Chair;

(5) Authorizes that such amendment be offered to Diane Hansen for her approval, such approval to be indicated by a signature on the Amendment to Employment Agreement.

(6) Sets forth on its calendar annual meetings to extend the Employment Agreement for additional 12-month periods;

(7) Pursuant to that certain Resolution of March 14, 2022, amending the Employment Agreement, finds that Diane Hansen scored __/5 on her Annual Performance Review.

PASSED AND ADOPTED by the Board of Directors of Palomar Health held on October 9, 2023, by the following vote:

AYES:

NAYS:

ABSENT:

ABSTAINING:

DATED: October 9, 2023

APPROVED:	***ATTESTED***:
Linda Greer, RN, Chairperson Board of Directors Palomar Health	Terry Corrales, RN, Secretary Board of Directors Palomar Health

ADDENDUM D

PALOMAR HEALTH
Reimagining Healthcare

Memorandum

To: Board of Directors

From: Linda Greer, R.N., Chair Board Quality Review Committee

Date: October 9, 2023

Re: Wednesday, September 26, 2023 Board Quality Review Committee – Meeting Summary

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Board Committee Member Attendance: Directors: Greer, Corrales and Barry. Medical Staff: Goldsworthy

Action Items:

Approval of Board Quality Review Committee July 26, 2023, Meeting Minutes

- The BQRC meeting minutes from July 26, 2023, were approved.

Approval of Contracted Services; San Diego Urology, South Coast Perfusion, Specialty Care Intra Operative Monitoring, UHS Surgical Services, San Diego Blood Bank, Becton Dickinson and Company, Boston Scientific Labsystem Pro Recording Equipment, and Boston Scientific Micropace Evercare

- The contracted services were approved.

STANDING ITEMS:

Medical Executive Committee (MEC)/Quality Management Committee (QMC) Update

- Mark Goldsworthy, MD, shared an update with the committee.

NEW BUSINESS:

Center of Excellence – Cardiovascular Services Annual Report

- Thomas McGuire, District Director of Interventional Radiology and Cardiology, shared an update with the committee.

Bariatric Surgical Services Annual Report

- Karen Hana, MD, Medical Director & Brian Cohen, Sr. Director of Service Lines, shared an update with the committee.

Management of the Medical Record

- Kim Jackson, Director of Health Information Services, shared an update with the committee.

Medical Staff: Utilization Review Annual Report

- Frank Martin, MD, Physician Advisor, shared an update with the committee.

Medical Staff: Anesthesia Services Annual Report

- Graham Davis, DO, Chairman, Department of Anesthesia, shared an update with the committee.

PALOMAR HEALTH
Reimagining Healthcare

Memorandum

Service Excellence (Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Annual Report

- Omar Khawaja, MD, Chief Medical Officer, Mel Russell, Chief Nurse Executive, and Suz Fisher, Patient Experience District Director, shared an update with the committee.

Memorandum

PALOMAR HEALTH
Reimagining Healthcare

To: Board of Directors

From: Mike Pacheco, Chair, Board Strategic and Facilities Planning Committee

Date: October 9, 2023

Re: Board Strategic and Facilities Planning Committee
September 26, 2023, Meeting Summary

BOARD MEMBER ATTENDANCE: Directors Pacheco, Barry & Griffith

INFORMATION ITEMS

- **Service Line Update – Palomar Behavioral Health Institute:** Following a request by the Committee that the practice of reviewing various service lines throughout the year be reinstated, a presentation was made to the Committee that provided a status update on the Palomar Behavioral Health Institute.
- **Construction Project Update[1]:** Reviewed a presentation providing updates on the status of projects across the District.

ACTION ITEM

- **Minutes, Tuesday, May 30, 2023, Meeting:** Reviewed and approved the draft minutes from the Tuesday, May 20, 2023, Board Strategic & Facilities Planning Committee meeting.

[1] *Attached*

Strategic & Facilities Planning Committee

Diane Hansen, Chief Executive Officer |

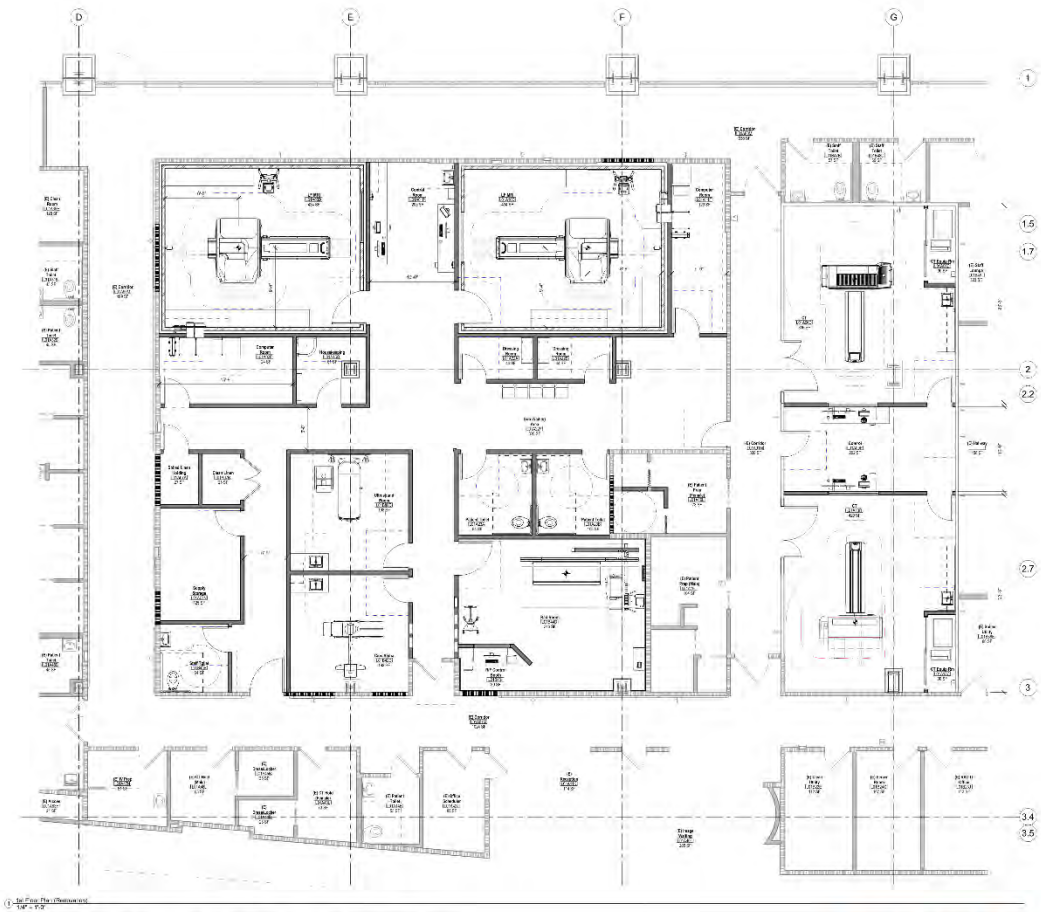
Michael Mills, VP Facilities/Construction Mgt |
September 26, 2023

PALOMAR HEALTH
Reimagining Healthcare

Poway – Projects in Progress

Poway – Projects in Progress

- POP Imaging Suite — Design revised per JV partner



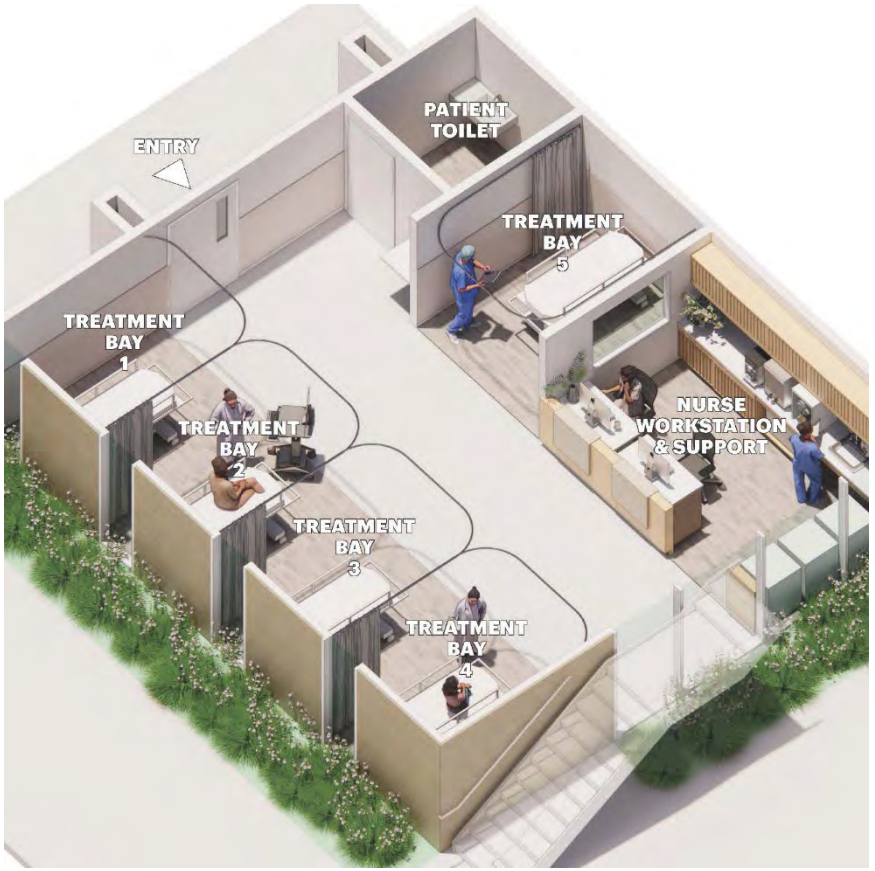
Scale: 1/4" = 1'-0"
Date: 08.02.2023

Imaging Suite Build-Out
15611 Pomerado Rd. Poway, CA 92064

PALOMAR HEALTH | MA Architects, Inc. Planning - Architecture - Interiors

Poway – Projects in Progress

- ED Multi-station treatment room—Completion 9/2024



Poway – Projects in Progress

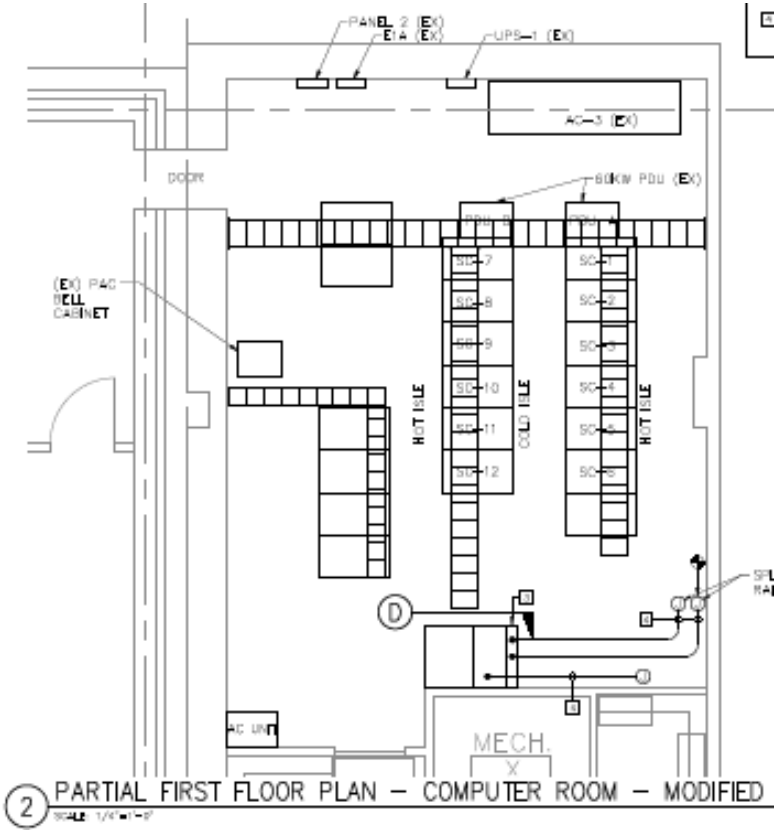
- Main Lobby Expansion — Finalizing Air Balancing

Poway – Projects in Progress

- 5th floor – Convert Birthing Center to ICU
  - Completion 12/2025

Poway – Projects in Progress

- Data Center UPS — Completion 12/2023



Poway – Projects in Progress

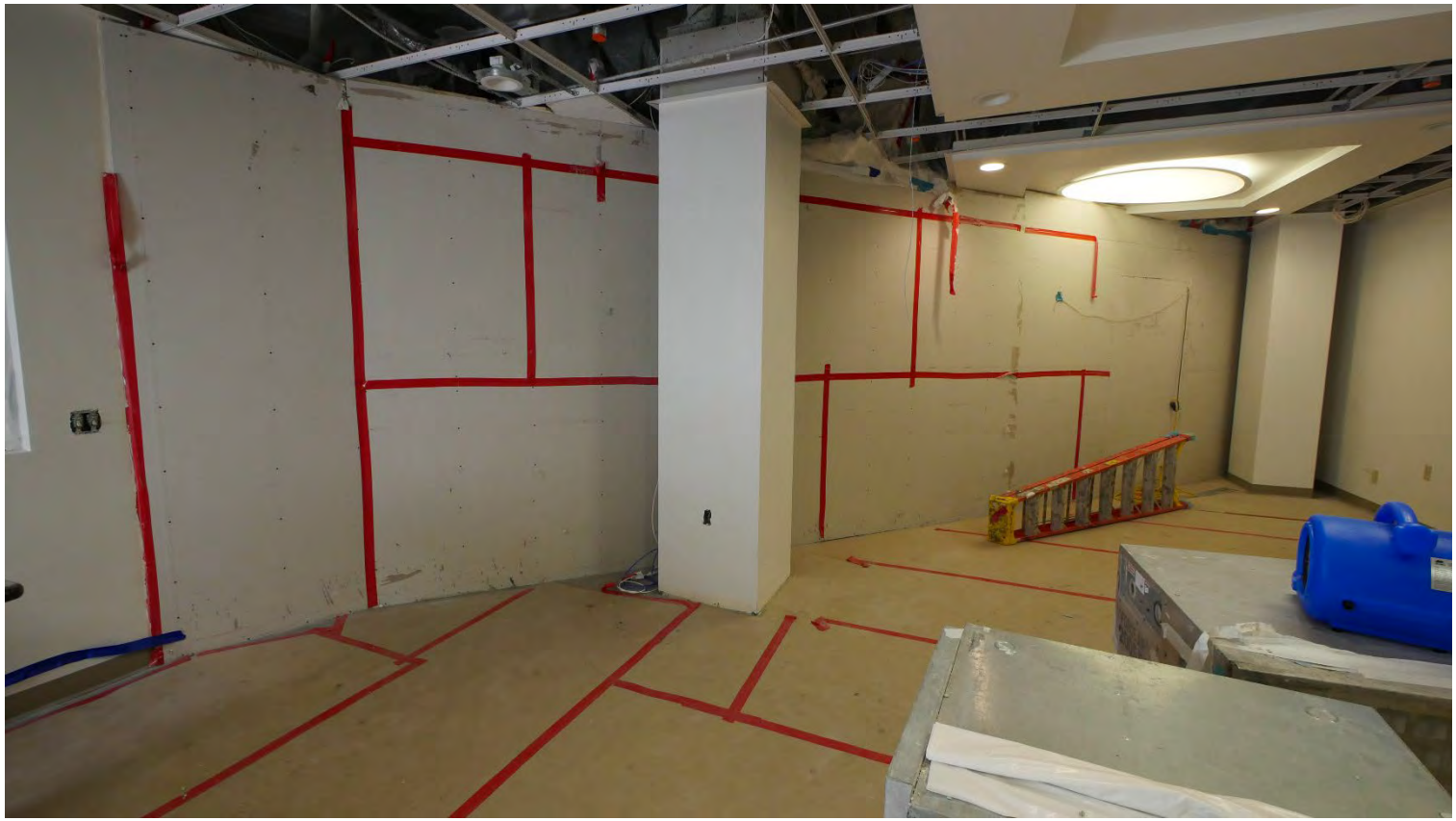
- Nurse Call Replacement — Completion 4/2024

Poway – Projects in Progress

Chiller Replacement — Completion 12/2023

Poway – Projects in Progress

- ED Lobby Expansion
  - Completion Phase I – 10/2023
  - Completion Phase II & III – 4/2024



Poway – Projects in Progress

- POP Elevator Expansion — Completion 2/2024

Poway – Projects in Progress

- UPS Building — Completion 12/2023
  - Future site to support new imaging equipment
  - Main supply cut over 11/2023

Poway – Projects in Progress

- Cafeteria refresh
  - Design Review with HCAI on 9/20/2023

Escondido – Projects in Progress

Escondido – Projects in Progress

- Palomar Health Outpatient Center III
  - Renovating 1st floor ASC for JV Partner
  - Completion 1/2024

Escondido – Projects in Progress

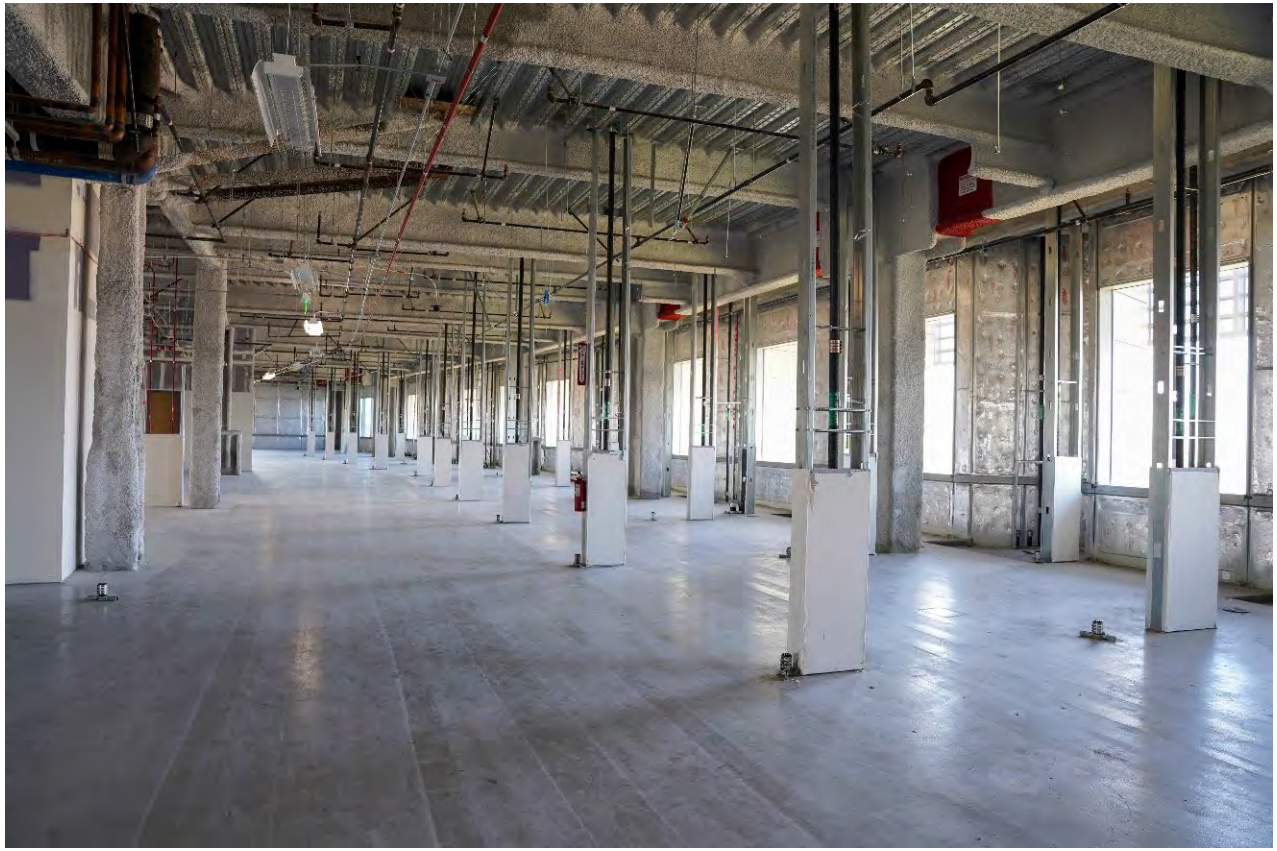
- Palomar Health Outpatient Center II
  - Currently reviewing spacial needs and usage

Escondido – Projects in Progress

- PMCE 9th floor Build Out — 24 Med Surge Tele
  - Phase I—12/2023 & Phase II—7/2024

Escondido – Projects in Progress

- PMCE 10th & 11th floor Build Out—Completion 9/2025
  - Evaluating RFQ for General Contractors
  - Drafting RFP



Escondido – Projects in Progress

- LINAC #2 — Completion 12/2023