Medical & Dental Bylaws for Socorro General Hospital

Approved by Socorro General Hospital Board of Trustees
January 28, 2025

BYLAWS INDEX

ARTICLE I GOVERNANCE AND ORGANIZATION

[Aug 2024]

MEDICAL STAFF BYLAWS

Article I: Governance and Organization

Section 1 Definitions

The following definitions apply to these Bylaws and its Appendices.

1.1 Advanced Practice Clinicians or APCs

Means certified nurse practitioners, certified registered nurse anesthetists, physician assistants and other Advanced Practice Clinicians who have the ability under applicable law to treat patients independently, or with appropriate supervision as defined by their respective licensing board(s), and who have been recognized by the Boards as being eligible for APC medical staff privileges.

1.2 APC Membership Staff

Means a classification of medical staff membership with limited rights and responsibilities granted by the Board to professionally competent APCs who have privileges at the Hospital and who continuously meet applicable membership and privileging qualifications. APC Membership Staff are not considered Physician Membership Staff and will be entitled to only the membership rights and responsibilities specifically granted to APC Membership Staff in these bylaws and Appendices and in applicable rules, regulations and policies of the Hospital and PHS.

1.3 Appendix A

Means the Organization and Functions Manual.

1.4 Appendix B

Means the Credentials Procedures Manual.

1.5 Appendix C

Means the Investigations, Corrective Actions, Hearings and Appeals Manual.

1.6 Board or the Board (singular)

Means the governing body of Presbyterian Socorro General Hospital.

1.7 Boards or The Boards (plural)

Means the governing bodies of Presbyterian Healthcare Services and Presbyterian Socorro General Hospital.

1.8 Credentialing Authority

Means the Board and the other groups or individuals defined in the Credentials Procedures Manual (Appendix B), the Medical Executive Committee and any designated committees reporting to the Medical Executive Committee and otherwise designated to assist, oversee or participate in credentialing activities such a Credentialing Committee.

1.9 Credentials Procedures Manual

Means Appendix B to these bylaws, which provides details and processes associated with credentialing matters. As an Appendix, the Credentials Procedures Manual can be changed by a vote of the Medical Executive Committee as needed.

1.10 Physician Membership Staff

Means a classification of medical staff membership with the most robust rights and responsibilities granted by the Board to professionally competent physicians (M.D. or D.O.), dentists, oral maxillofacial surgeons, psychologists, and podiatrists who have medical staff privileges at the Hospital and who continuously meet applicable membership and privileging qualifications, standards, and requirements.

1.11 Hospital

Means the medical facility, Presbyterian Socorro General Hospital.

1.12 Hospital Executive

Means the individual charged with management and administrative oversight of the Hospital and individual who shall, among other responsibilities, act as liaison among the Board, medical staff, and other areas of the Hospital.

1.13 Investigations, Corrective Actions, Hearings and Appeal Manual

Means Appendix C to these bylaws, which provides details and processes associated with inquiries, investigations, corrective actions, hearings and appeals.

1.14 Medical Administrative Officer(s)

Means a Practitioner engaged by the Hospital either full or part time in an administratively responsible capacity, whose activities may also include clinical responsibilities such as direct patient care, teaching, or supervision of the patient care activities of other Practitioners under the officer's direction. Such practitioner may include, but not be limited to, the Vice President of Medical Staff Affairs or Chief Medical Officer.

1.15 Medical Executive Committee or MEC

Means a committee, the majority of which shall be members of the Physician Membership Staff, organized and authorized to act pursuant to these bylaws. References to the Medical Executive Committee, sometimes called the MEC, shall include any designee(s) charged with a specific task of the MEC who is acting on the MEC's behalf.

1.16 Medical Staff

Means Physician Membership Staff, Privileged Staff, and APC Membership Staff

1.17 Organization and Functions Manual

Means Appendix A to these bylaws, which provides details and processes regarding the organization and functions of the medical staff. As an Appendix, the Organizations and Functions Manual can be changed by a vote of the Medical Executive Committee as needed.

1.18 Organized Health Care Arrangement or OHCA

Means the mechanism adopted by the Hospital, all members of the Medical Staff and all Practitioners to implement and comply with the Standards for Privacy of Individual Identifiable Health Information promulgated by the US Department Of Health and Human Services pursuant to the Administrative Simplification provisions of Healthcare Information Portability and accountability Act (HIPAA). The Hospital, and all of its medical staff members and Practitioners shall be members of and participate in the OHCA, which functions as a clinically integrated care setting in which patients typically receive health care from more than one healthcare provider.

1.19 PHS Representative

Means the Boards or any of their committees, any committee, group or individual acting as a Credentialing Authority, any member of a review organization defined under state law, including any person acting in an advisory capacity or furnishing counsel or services to such a review organization, any hearing committee, appellate review committee, ad hoc investigation committee, or other committee, group or individual designated to conduct quality review and/or peer review or peer review activities, any member of the MEC, the Medical Administrative Officer of the Hospital or PHS, the Chief Executive Officer, Hospital Executive or president, any medical staff officer, service or division chair, or any other officer, employee or agent of the Hospital, medical staff or PHS who has been delegated responsibility for or requested to assist in:

a. Documenting, investigation, evaluating, or providing information regarding the credentials of any applicant or medical staff member;

b. Acting upon or making recommendations with respect to any application or request for appointment to the medical staff or particular clinical privileges;

c. Acting upon or making recommendations with respect to the competence or professional conduct of an applicant or medical staff member or other practitioner;

d. Gathering, maintaining, or reporting information bearing upon the credentials of an applicant or medical staff member; or

e. Undertaking any quality and/or peer review process or peer review activity.

1.20 PHS

Means Presbyterian Healthcare Services.

1.21 Practitioners

Means physicians (M.D. or D.O), dentists, oral maxillofacial surgeons, psychologists and podiatrists, and Advanced Practice Clinicians who have medical staff membership or exercise privileges at the Hospital.

1.22 Privileged Staff

Means a classification of privileges only, with no medical staff membership granted, to certain physicians (M.D. or D.O), dentists, oral maxillofacial surgeons, psychologists and podiatrists, and Advanced Practice Clinicians who are authorized to exercise privileges at the Hospital and who continuously meet applicable privileging qualifications, standards, and requirements of the Hospital. Privileged Staff will be entitled to exercise only the

membership rights specifically granted in these bylaws and Appendices and in applicable rules, regulations and policies of the Hospital and PHS.

1.23 Peer Review Activities & Professional Review Action

Peer review and professional review are common terms used to describe a broad range of activities related to quality of care and may include committee review, individual chart review and various other forms utilized to evaluate a provider. In addition, both the National Practitioner Data Bank and the New Mexico state regulations assign specific meaning to these terms when applied to practitioners within their jurisdiction. The definitions below are provided to distinguish those processes that may implicate certain Medical Staff regulatory obligations.

Professional Review Action means an investigation and resulting proceeding against a physician on the medical staff that is reportable to the National Practitioner Data Bank under the Health Care Quality Improvement Act of 1986 and its successor statues, and any applicable state reporting requirements, that is related specifically to clinical incompetence or misconduct that adversely affects clinical privileges for greater than thirty (30) calendar days (e.g., denial of appointment and/or reappointment; reduction in clinical privileges) or a resignation, surrender of privileges, or acceptance of privilege reduction either during an investigation or to avoid an investigation that could result in a decision which adversely affects clinical privileges for greater than thirty (30) days.

Peer review activities are those involving the evaluation of the professional judgment, skill or behavior of medical staff members and fall under New Mexico's Review Organization Immunity Act ("ROIA"). ROIA, in turn, involves strict confidentiality of opinions, observations and evaluations on a need-to-know basis. PHS medical staff bylaws provide for both "informal" and "formal" mechanisms to address issues, incidents or patterns of action, inaction or behavior of medical staff members. Peer review activities are generally conducted in a peer review committee setting but can also include individual case reviews, interactions, interviews or other activities that contribute to the evaluation of the professional judgment, skill or behavior or medical staff members. Thus peer review is not limited solely to "peer reviewed cases".

1.24 Third Party

Means any individual, including a medical staff member, organization, association, corporation, partnership, medical staff healthcare entity, or other person or entity from whom information has been requested by the medical staff or PHS Representative or to whom information has been provided by the Hospital or any medical staff member or practitioner.

Section 2 Medical Staff Purpose and Authority

2.1 Purpose

Presbyterian Healthcare Services owns and operates a number of medical facilities in the State of New Mexico, including Central Delivery System. The medical staff of the Hospital is responsible for the quality of medical care at the Hospital, subject to the ultimate authority of its Board. Additional purposes of this medical staff are stated below and explained in more detail in

Appendix A, the Organization and Functions Manual.

a. **Formal Structure and Accountability**

To provide a formal organizational structure of the activities of physicians and other clinical Practitioners who practice at the Hospital in order to carry out and be accountable to the Hospital and the Presbyterian Healthcare Services Boards for the functions delegated to the medical staff. These bylaws, the Organization and Functions Manual, the Credentials Procedures Manual, and the Investigations, Corrective Actions, Hearings and Appeals Manual reflect the current organization and functions of the Medical Staff.

b. **Patient Care**

To provide patients with quality of care commensurate with acceptable standards and available community resources.

c. **Professional Accountability**

To serve as the primary means of accountability to the Board concerning professional performance of Practitioners with regard to the quality and appropriateness of healthcare. This shall be provided through leadership and participation in quality assessment, performance improvement, risk management, case management, utilization review, resource management and other Hospital initiatives to measure and improve performance.

d. **Medical Membership and Privileges**

To provide mechanisms for recommending to the Board the granting of initial and renewed medical staff membership and clinical privileges to qualified and competent Practitioners.

e. **Professional Review and Corrective Action**

To assist the Board by serving as a professional review body in conducting professional review activities, which include without limitation focused professional practice evaluations, ongoing professional practice evaluations, quality assessment, performance improvement, quality and/or peer review, and corrective actions when warranted.

f. **Education**

To provide education that will assist in maintaining patient care standards and encourage continuous advancement in professional knowledge and skills.

g. **Rules and Regulations**

To oversee and adopt rules and regulations for the proper functioning of the medical staff and the integration and coordination of the medical staff with Hospital functions.

h. **Communication**

To provide a means for communication with regard to issues of mutual concern to the medical staff, Hospital management, and the Boards.

i. **Compliance**

To monitor and enforce compliance with these Bylaws, the Organization and Functions Manual, the Credentials Procedures Manual, and the Investigations, Corrective Actions, Hearings and Appeals Manual, the medical staff rules and regulations and other medical staff policies, and Hospital policies, where appropriate, and to maintain compliance of the medical staff with regard to applicable accreditation requirements and federal, state, and local laws and regulations.

2.2 Authority and Delegation

Subject to the authority and approval of the Boards the medical staff will exercise such power as is reasonably necessary to discharge its responsibilities under these bylaws and its Appendices and under the corporate bylaws of the Presbyterian Healthcare Services. When a function is to be carried out by a Practitioner on the Medical Staff or a medical staff committee, the individual or committee through its chair may delegate performance of the function to one or more designees. Similarly, when a Practitioner on the Medical Staff is unavailable or unable to perform an assigned function, one or more of the medical staff officers may perform the function personally or delegate it to another appropriate individual.

2.3 Interpretation.

These Bylaws reflect the overarching philosophies and practices set forth in PHS' corporate bylaws. Subject to the authority and approval of the Hospital Boards, these bylaws are written to promote continuity and uniformity. They are to be interpreted, consistent with such philosophies and practices, policies and procedures that are applied to individual Hospitals. These bylaws and Appendices have been written to provide flexibility, where appropriate, for each Hospital, taking into consideration the size of the Hospital and its Medical Staff as well as the types of services offered.

2.4 Digital Communication Preferred

Whenever possible, the default and standard method of communication for all aspects of medical staff governance committees, applications, credentialing and peer review processes shall be electronic.

2.5 Appendices

These bylaws are supplemented by three Appendices: the Organization and Functions Manual (Appendix A), the Credentials Procedures Manual (Appendix B), and the Investigations, Corrective Actions, Hearings and Appeals Manual (Appendix C). These Appendices provide additional detail to the basic fundamental requirements set forth in theses bylaws and may be modified from time to time by the Medical Executive Committee or its designee as set forth more fully in these bylaws and associated Appendices.

Section 3 Medical Staff

3.1 Nature and Classification of Medical Staff

The Hospital has three classifications of Medical Staff:

- Physician Membership Staff
- APC Membership Staff
- Privileged Staff.

The differences in the duties and prerogative of each classification are set forth in these bylaws and associated manuals and policies of the medical staff and Hospital.

a. **Physician Membership Staff.**

Physician Membership on the medical staff of the Hospital is a privilege that shall be extended to professionally competent physicians (M.D. or D.O.), dentists, oral maxillofacial surgeons, psychologists and podiatrists who have medical staff privileges at the Hospital and who continuously meet the membership and privileging qualifications, standards, and requirements set forth in these bylaws and associated manuals and policies of the medical staff and the Hospital. For convenience, these medical staff members may be referred to as Physician Membership Staff;

b. **APC Membership Staff**

APC Membership Staff is a privilege that shall be extended to Advanced Practice Clinicians such as certified nurse Practitioners, certified registered nurse anesthetists, physician assistants and other Advanced Practice Clinicians who have the ability to treat patients independently and/or otherwise continuously meet the qualifications, standards, and requirements set forth in these bylaws and associated manuals and policies of the medical staff and the Hospital. The types of Advanced Practice Clinicians eligible for privileged staff may be modified from time to time based on changes in federal, state laws and regulations or policies and the needs of the Hospital and/or PHS.

c. **Privileged Staff**

Privileged Staff is a privilege that shall be extended to professionally competent Practitioners in the locums and telemedicine category and APCs who do not qualify for APC Membership Staff, all of whom continuously meet the membership qualifications, standards, and requirements set forth in these bylaws and associated manuals and policies of the medical staff and the Hospital.

3.2 Qualifications for Membership

The qualifications for Physician Membership Staff, APC Membership Staff and Privileged Staff are delineated in Article II of these bylaws and the Credentials Procedures Manual (Appendix B).

3.3 Nondiscrimination

The Hospital will not discriminate in granting staff appointment and/or clinical privileges to qualified applicants who meet all other requirements for the provision of patient care on the basis of national origin, race, color, age, sex (including pregnancy, sexual orientation, gender identity, and sex characteristics), religion, disability, or any other basis prohibited by applicable law.

3.4 Conditions and Duration of Appointment

The Board shall make initial appointment and reappointment to the Medical Staff. The Board shall act on appointment and reappointment only after the Medical Staff has had an opportunity to submit a recommendation from the Medical Executive Committee (MEC). Appointment and reappointment to the Medical Staff shall be for twenty-four (24) calendar months unless applicable laws, regulations, and accreditation standards or policies permit a longer, or mandate a shorter, term.

3.5 Qualifying Criteria

Requests for Physician Membership Staff, APC Membership Staff and Privileged Staff will be processed only when the potential applicant meets the current minimum qualifying criteria approved by the Board. Physician Membership Staff, APC Membership Staff and Privileged Staff will be granted and administered as delineated in Article II of these bylaws and Appendix B, the Credentials Procedures Manual.

3.6 Medical Staff Responsibilities

The responsibilities in this section apply to the entire Medical Staff, including Physician Membership Staff, APC Membership Staff and Privileged Staff, unless specifically limited to one classification.

a. Continuous Care

Each Practitioner on the Medical Staff must provide for appropriate, timely, and continuous care of their patients at the level of quality and efficiency generally recognized as appropriate by medical professionals.

b. Quality/Performance Improvement and Peer Review

Each Practitioner on the Medical Staff must participate, as assigned or requested, in quality/performance improvement/peer review activities and in the discharge of other medical staff functions as may be required.

c. Physician or Mental Examination

Whenever the physical or mental condition of a Practitioner on the Medical Staff is believed to put patients or staff safety at risk, the MEC, Credentials Committee, or any committee associated with provider wellness may request the Practitioner to undergo a physical or mental examination by another provider. A Practitioner may refuse to undergo such examination but the Board, MEC or Credentials Committee is entitled to weigh such refusal against the Practitioner when considering whether to grant, deny, suspend or reduce a Practitioner's privileges. Alternatively, a provider may offer to share any relevant test results, medical history, or fitness for duty examinations in lieu of the requested examination. The information provided pursuant to this section will not be construed as a fitness for duty examination for purposes of occupational safety, workers' compensation or similar employment purposes. Additionally, such information will be considered separate and apart from the employment file of any employed provider.

d. Compliance

Each Practitioner on the Medical Staff must abide by the medical staff bylaws, Appendices to these bylaws, and any other rules, regulations, policies, procedures, and standards of the medical staff and Hospital. Additionally, each Practitioner on the Medical Staff must comply with all federal, state, and local laws, rules and regulations applicable to their respective healthcare practices and the Hospital, including but not limited to those related to Medicare and The Joint Commission or other accreditation bodies of the Hospital.

e. **Professional Liability**

Each Practitioner on the Medical Staff must provide evidence of professional liability coverage of a type and in an amount that shall deem the Practitioner a qualified healthcare provider as that term is defined in the New Mexico Medical Malpractice Act or evidence of coverage that they are a person protected pursuant to the New Mexico Tort Claims Act or the Federal Tort Claims Act. Alternatively, each Practitioner must provide evidence of occurrence-based coverage from an A.M. Best rated company in the per occurrence and aggregate amounts most recently approved from time to time by the Board or must provide evidence of equivalent coverage of acceptable self-insurance. In addition, the Medical Staff shall comply with any financial responsibility requirements that apply under the state law to the practice of their profession. Each Practitioner on the Medical Staff shall notify the Hospital Executive or designee within 30 days of any and all malpractice claims filed against the Practitioner.

f. **Release**

Each Practitioner on the Medical Staff agrees to release from any liability to the fullest extent permitted by law, all persons for their conduct in connection with investigating and/or evaluating the quality of care provided by the Practitioner and his/ her credentials.

g. **Medical Records**

Each Practitioner on the Medical Staff shall prepare and complete in timely fashion, according to Medical Staff and Hospital policies, the medical and other required records for all patients to whom the Practitioner provides care in the Hospital, or within its facilities, or clinical services.

h. **Confidential Information**

Each Practitioner on the Medical Staff will use confidential information only as necessary for treatment, payment or healthcare operations in accordance with state and federal laws and regulators, to conduct authorized research activities, or to perform medical staff responsibilities. A practitioner may always review their own medical records using a traditional patient portal tool such as MyChart (as any other patient can) but they cannot utilize their practitioner access in the electronic medical record to view their own medical records or that of friends or family members. For purposes of these bylaws, confidential information means patient information, quality and/or peer review information, and the Hospital's business information designated as confidential by the Hospital or its representatives prior to disclosure.

i. **Competency**

Each Practitioner on the Medical Staff must participate in any type of competency evaluation when determined necessary by the MEC or designee and/or Board in order to properly delineate that member's clinical privileges.

j. **Impairment**

Each Practitioner on the Medical Staff must notify a medical staff officer and/or Hospital Executive (who will then notify the MEC) whenever an impaired practitioner's actions could endanger patients.

k. **Duty to Report Unsafe Treatment**

Each Practitioner on the Medical Staff must report to the MEC all other Practitioners providing unsafe treatment.

l. **Criminal Conduct**

Each Practitioner on the Medical Staff must report to the administrative medical officer or designee any arrests or convictions for misuse of alcohol or drugs, or offenses of moral turpitude.

m. **Medical History and Exam**

Each Practitioner on the Medical Staff shall prepare and complete in timely fashion, according to medical staff and Hospital policies, the medical and other required records for all patients to whom the practitioner provides care in the Hospital, or within its facilities, clinical services, or departments. Specific requirements for medical history and exam are provided in Appendix A, the Organization and Functions Manual.

3.7 Obligated Call.

All Members of the Active and Associate Medical Staff shall be required to serve on consultant panels to the Division of Emergency Medicine ("Obligated Call"), as determined from time to time by the Medical Executive Committee.

a. **Assignment**

The Medical Executive Committee periodically will review and assign Obligated Call requirements as needed, taking into account the call burden for each type of medical specialty, the number of Practitioners participating in each rotation, the number of facilities being served by each Practitioner, applicable community and regional call schedules, available telemedicine support, and any other factor relevant to the Hospital meeting its call needs consistent with current resources.

b. **Regulatory Requirement**

Obligated Call is required to satisfy regulatory requirements of the Hospital's Emergency Department, including the obligation that a Hospital with specialized capabilities and/or a higher level of care (for example, a tertiary care Hospital) must accept a transfer call regardless of origin.

c. **Types of Call**

Obligated Call may be in addition to any call requirements related to inpatient care or imposed by a practitioner's clinical practice or employment agreement. Simultaneous call is permitted consistent with Hospital policy.

d. **Medical Staff Obligation**

In addition to actions authorized in other provisions of these bylaws or its Appendices or the medical staff rules and regulations, the MEC or Credentials Committee will consider compliance with Obligated Call responsibilities when considering Medical Staff reappointment.

e. **Exemptions**

Practitioners of the Active and Associate Medical Staff over the age of 55 with special circumstances may request the Medical Executive Committee to exempt them from some or all of the requirement for Obligated Call. The Medical Executive Committee may grant all or part of the requested exemption provided that current and future community needs can continue to be met consistent with available Hospital resources.

3.8 Physician Membership Staff Rights

The rights in this section apply only to Physician Membership Staff except as further restricted or expanded in each paragraph.

a. **MEC Meeting Request.**

Physician Membership Staff in the active category have the right to meet with the MEC on matters relevant to the responsibilities of the MEC that may affect patient care or safety. In the event such practitioner is unable to resolve a matter of concern after working with their clinical service or division chair or other appropriate medical staff leader(s), that practitioner may, upon written notice to the president of the medical staff two (2) weeks in advance of a regular meeting, meet with the MEC to discuss the issue.

b. **Election Recall.**

Physician Membership Staff member in the active category have the right to initiate a recall election of a medical staff officer by following the procedure outlined in these bylaws regarding removal and resignation from office.

c. **Special Staff Meeting Request**

Physician Membership Staff and/or APC Membership Staff in the active category may initiate a call for a special staff meeting to discuss a matter relevant to the medical staff based on the total number of Physician Membership Staff and APC Membership Staff assigned active staff status at the Hospital.

The minimum number required to request a special staff meeting at a PHS hospital is:

Percentage of Combined Physician Membership Staff and APC Membership Staff at a PHS Hospital Required to Request a Special Meeting	Total Number of Physician Membership Staff and APC Membership Staff Assigned to Active Staff at Hospital
50%	Less than 40 Active Staff
25%	Between 40 and 200 Active Staff
10%	Over 200 Active Staff

The MEC shall schedule a special staff meeting for the specific purposes addressed by the petitioners. No business other than that detailed in the petition may be transacted.

d. **Rule or Policy Review**

Active staff members of the Physician Membership Staff or APC Membership Staff may challenge any rule or policy established by the MEC. In the event that a rule, regulation or policy is thought to be inappropriate, any Physician Membership Staff or APC Membership Staff in the active category may submit a petition signed by three members of the active category or ten percent, whichever is larger. Upon presentation of such a petition, the adoption procedure outlined elsewhere in these bylaws will be followed.

e. **Division Meeting Request**

Active staff members of the Physician Membership Staff or APC Membership Staff may call for a division meeting in a Hospital that has divisions by presenting a petition signed by 10 percent of like members of the division. Upon presentation of such a petition the division chief will schedule a division meeting.

f. **Limitations**

Topics excluded from meetings requested by Physician Membership Staff or APC Membership Staff include issues involving individual quality or peer review information, informal and formal investigations of professional performance or conduct, denial of requests for appointment or clinical privileges, or any other matter relating to individual membership or privileges. Article III of these bylaws (Investigations, Corrective Action, Hearing and Appeal Manual) provides recourse in these matters.

g. **Appeals**

Physician Membership Staff have a right to a hearing/appeal pursuant to the conditions and procedures described in Article III of these bylaws and Appendix C, Investigations, Corrective Actions, Hearings and Appeals Manual.

3.9 Staff Dues

If a Medical Staff requires dues, they shall be paid annually in an amount recommended by the MEC and approved by Physician Membership Staff members in the active category. Failure of a Medical Staff member to pay dues shall be considered a voluntary withdrawal from the medical staff. The MEC may pass policies from time to time which exempt from dues payment certain categories of membership or members holding specified leadership positions.

3.10 Immunity and Indemnification

Practitioners on the Medical Staff are entitled to the applicable immunity provisions of state and federal law for the credentialing, quality and/or peer review and performance improvement work they perform on behalf of the Hospital and Medical Staff. Additionally, the Hospital shall indemnify members of the medical staff in accordance with these bylaws and any the provisions in Appendix A, Organization and Functions Manual.

Section 4 Officers of the Medical Staff and MEC At-Large Members

4.1 Designation of Officers of the Medical Staff and MEC at-large members

The officers shall be President of the Medical Staff, President Elect, and Immediate Past President. The officers will have the duties and responsibilities described in Appendix A, the organization and Functions Manual.

4.2 Qualifications of Officers and MEC at-large members

a. General Qualifying Criteria for MEC Officers and At-Large Members

Officers and MEC at-large members must be Physician Membership Staff or APC Membership Staff in good standing of the active category for the number of years designated in the job description and be actively involved in patient care in the Hospital or a Hospital clinic. Additionally, they must (i) have previously served in a significant leadership position on a medical staff (e.g. clinical service or division chair, committee chair), (ii) indicate a willingness and ability to serve, (iii) have no pending adverse recommendations concerning medical staff appointment or clinical privileges, (iv) have demonstrated an ability to work well with others, (v) be in compliance with the professional conduct policies of the Hospital, and (vi) have excellent administrative and communication skills. Participation in medical staff leadership training and/or willingness to participate in such training during their term of office is desirable and the Hospital will pay for approved training.

b. Additional Requirements for President and President-Elect

Qualifications for the positions of President of the Medical Staff and President Elect also include the degree of MD, DO, DDS, DMD, DPM. MEC.

c. Additional Requirements for MEC At-Large Members

Consistent with the MEC's role to identify and implement programs to meet healthcare needs throughout the community, each PHS Hospital MEC may have one or more at-large member. To the extent possible for those PHS Hospitals comprised of more than one hospital campus or remote provider-based departments or clinics, at least one MEC at large member should have their primary practice at such remote campus, department or clinic. For example, Presbyterian Hospital should have an MEC at-large whose primary practice is at Rust Medical Center.

d. Determining Eligibility Based on Qualifying Criteria

The medical staff nominating committee will have discretion to determine if a staff member wishing to run for MEC meets the qualifying criteria.

e. No Dual Positions

Officers and MEC at-large members may not simultaneously hold a position as a Board member, officer, or section or division chief on another Hospital's medical staff or in a facility that is directly competing with the Hospital. Noncompliance with this requirement will result in the officer being removed from office unless the Board determines that allowing the officer to maintain their position is in the best interest of the Hospital.

f. **No Financial Conflict**

Each medical staff officer shall disclose in writing to the medical staff any ownership or financial interest that may conflict with, or have the appearance of conflicting with, the interests of the medical staff or Hospital. Medical staff leadership will deal with conflict-of-interest issues per the Medical Staff Conflict of Interest policy.

4.3 Election of Officers and MEC at-large members

a. **Nomination Committee**

The nomination committee shall offer at least one nominee for each available position. Nominations must be announced, and the names of the nominees distributed to all members of the active medical staff at least 30 days prior to the election.

b. **Nomination by Petition**

A petition signed by the number of members of the active staff specified below may add nominations to the ballot. The medical staff must submit such a petition to the president of the medical staff at least thirty days prior to the election for the nominee(s) to be placed on the ballot. The nominating committee must determine if the candidate is qualified in accordance with these bylaws before they can be placed on the ballot.

Percentage of Combined Physician Membership Staff and APC Membership Staff at a PHS Hospital Required to Add Names to Nomination Ballot	Total Number of Physician Membership Staff and APC Membership Staff Assigned to Active Staff at Hospital
50%	Less than 40 Active Staff
25%	Between 40 and 200 Active Staff
10%	Over 200 Active Staff

c. **Timing**

Officers and MEC at-large members shall be elected at least one month prior to the expiration of the term of the current officers.

d. **Voting**

Physician Membership Staff and APC Membership Staff in the active category shall be eligible to vote. The MEC will determine the mechanisms by which votes may be cast. The mechanisms that may be considered include written mail ballots and electronic voting via computer, fax, or other technology for transmitting the member's voting choices. No proxy voting will be permissible. The nominee(s) who receives the greatest number of votes will be elected. In the event of a tie vote, the Medical Staff Affairs Office will make arrangements for a repeat vote(s) until one candidate receives a greater number of votes. Specifically for Presbyterian Hospital in Albuquerque, one MEC at-large member will be elected by the Physician Membership Staff and APC Membership Staff in the active category who practice at Rust Medical Center and the other will be

elected by the Physician Membership Staff and APC Membership Staff in the active category practicing in Albuquerque.

4.4 Term of Office

All officers and MEC at-large members serve a term of two (2) years. They shall take office in the month of January. An individual may be reelected for two successive terms.

4.5 Vacancies of Office

The MEC shall fill vacancies of office during the medical staff year, except the office of the president of the medical staff. If there is a vacancy in the office of the president of the medical staff, the president elect shall serve the remainder of the term and an election to fill the vacated position of president elect will occur.

4.6 Removal and Resignation from Office

a. Removal by Medical Staff

The medical staff may remove any officer or MEC at-large member if at least ten percent of the active medical staff sign a petition advocating for such action. The petition must be followed by an affirmative vote by two thirds (2/3) of those active staff members casting ballot votes.

b. Removal by Board

Automatic removal shall be for failure to meet those responsibilities assigned within these bylaws, failure to comply with policies and procedures of the medical staff, for conduct or statements that damage the Hospital, its goals, or programs, or an automatic or precautionary suspension of clinical privileges that lasts more than thirty days. The Board will determine if the member has failed in their responsibilities after consulting with the joint conference committee.

c. Resignation

Any elected officer or MEC at-large member may resign at any time by giving written notice to the MEC. Such resignation takes effect on the date of receipt, when a successor is elected, or any later time specified therein.

Section 5 Medical Staff Organization

5.1 Clinical Services of the Medical Staff

To the extent the Hospital provides general and specialty Hospital services, the medical staff shall be organized as a departmentalized staff according to clinical services and divisions in order to facilitate medical staff activities. Where services and Practitioners are limited in scope and number, such functions will be assigned to the MEC. A list of clinical services organized by the medical staff and formally recognized by the MEC is listed in the medical staff rules and regulations. The MEC, with approval of the Board, may designate new medical staff clinical services or divisions or dissolve current clinical services or divisions as it determines will best promote the medical staff needs for promoting performance improvement, patient safety, and effective credentialing and privileging.

5.2 Assignment to Clinical Service

The MEC will, after consideration of the recommendations of the chair of the appropriate clinical service, recommend clinical service assignments for all members in accordance with their qualifications. Each member will be assigned to one primary clinical service. Clinical privileges are independent of clinical service assignment.

5.3 Term and Qualifications of Clinical Service Chairs

Each clinical service chair shall serve a term of two (2) years commencing on January 1 and may be elected to serve successive terms. All chairs must be members of the active medical staff have relevant clinical privileges and be certified by an appropriate specialty Board or have affirmatively established comparable competence through the credentialing process.

5.4 Selection

Clinical service chairs and vice chairs shall be elected by majority vote of the active members of the clinical service. Each clinical service shall establish procedures for identifying and electing candidates and these procedures must be ratified by the MEC.

5.5 Removal and Replacement.

a. **Initiated by Clinical Service**

Clinical service chairs may be removed from office by the MEC if two-thirds (2/3) of the voting members of the clinical service recommend such action.

b. **Initiated by MEC**

The MEC may remove a chair on its own by a two-thirds vote if the chair suffers an involuntary loss or significant limitation of practice privileges or the MEC determines that the chair has failed to demonstrate to the satisfaction of the MEC that they are effectively carrying out the responsibilities of the position.

c. **Replacement.**

If a clinical service chair is removed through this process, a new election will be held according to established clinical service procedures

5.6 Responsibilities.

Clinical service chairs shall carry out the responsibilities assigned in Appendix A of these bylaws, the Organization and Functions Manual.

Section 6 MEC and Other Committees

6.1 Designation and Substitution

There shall be a MEC and such other standing and ad hoc committees as established by the MEC and enumerated in Article I of the bylaws and also Appendix A, the Organization and Functions Manual, Appendix B, the Credentials Procedures Manual, and Appendix C, the Investigations, Corrective Actions, Hearings and Appeals Manual. Meetings of these committees will be either regular or special. Those functions requiring participation of rather than direct oversight by the medical staff may be discharged by medical staff representation on such Hospital committees as are established to perform such functions. The president of the medical staff may appoint ad hoc committees as necessary to address time-limited or specialized tasks.

6.2 MEC Membership

a. Composition

The MEC shall be a standing committee consisting of the following voting members: the officers of the medical staff, the chairs of any separate credentials and clinical performance committees, Vice President of Medical Staff Affairs or the chief medical officer, the chairs of any clinical services and, where size of medical staff permits, two active medical staff members elected at-large. For PHS of Albuquerque, one of the at-large members will be elected by the active Physician Membership Staff and APC Membership practicing at Rust Medical Center. Ex-officio members without a vote will be the chair of the medical staff practice committee and the immediate past president of the medical staff unless the Hospital's MEC determines that the size of its medical staff necessitates that these ex-officio members be voting members. Additionally, the Hospital Executive(s), the chief nursing officer and a Board member will be ex-officio members without a vote. The chair will be the president of the medical staff. No individual may hold two seats on the MEC. A majority of the voting members of the committee must be doctors of medicine or osteopathy.

b. Removal from MEC

An officer, MEC At-Large Member, or clinical service chair who is removed from their position will automatically lose their membership on the MEC. When the chair of either the credentials or performance improvement committees or clinical service chair resigns or is removed from these positions, their replacement will serve on the MEC. Other members of the MEC may be removed by a two-thirds (2/3) affirmative vote of MEC members. When a member of the MEC who was elected at-large resigns, is removed, or in the case of president-elect is required to fulfill the role of president, the MEC will arrange for an at-large election for a replacement to serve out the remainder of the

vacated term. Such an election will follow procedures established by the MEC and must take place within sixty (60) days of the removal of an MEC member.

6.3 MEC Duties

The duties of the MEC, as delegated by the medical staff, shall be to:

a. Serve as the decision-making body of the medical staff in accordance with the medical staff bylaws and provide oversight for all medical staff functions;

b. Coordinate the implementation of policies adopted by the Board;

c. Submit recommendations to the Board concerning all matters relating to appointment, reappointment, staff category, clinical service/division assignments, clinical privileges, and corrective action;

d. Report to the Board and to the staff for the overall quality and efficiency of professional patient care services provided by individuals with clinical privileges and coordinate the participation of the medical staff in organizational performance improvement activities;

e. Take reasonable steps to encourage professionally ethical conduct and competent clinical performance on the part of staff members including collegial and educational efforts and investigations, when warranted;

f. Make recommendations to the Board on medical administrative and Hospital management matters;

g. Keep the medical staff up-to-date concerning the licensure and accreditation status of the Hospital;

h. Participate in identifying community health needs and in setting Hospital goals and implementing programs to meet those needs;

i. Review and act on reports from medical staff committees, clinical services, divisions and other assigned activity groups;

j. Formulate and recommend to the Board medical staff rules, policies, and procedures;

k. Request evaluations of Practitioners privileged through the medical staff process when there is question about an applicant or member’s ability to perform privileges requested or currently granted;

l. Make recommendations concerning the structure of the medical staff, the mechanism by which medical staff membership or privileges may be terminated, and the mechanisms for fair hearing procedures;

m. Consult with administration on the quality, timeliness, and appropriateness of contracts for patient care services provided to the Hospital by entities outside the Hospital;

n. Oversee that portion of the corporate compliance plan that pertains to the medical staff;

o. Hold medical staff leaders, committees, and clinical services accountable for fulfilling their duties and responsibilities;

p. Make recommendations to the medical staff for changes or amendments to the medical staff bylaws;

q. Generally act for the organized medical staff between meetings of the organized medical staff within the scope of its responsibilities as defined by the organized medical staff;

r. Notify the medical staff of actions taken and decisions; and

s. Determine minimum Obligated Call requirements for each specialty based the call burden for each type of medical specialty, the number of medical staff members participating in each rotation, the number of facilities being served by each medical staff member, applicable community and regional call schedules, available telemedicine support, and any other factor relevant to the Hospital meeting its call needs consistent with current resources.

6.4 Meetings

The MEC shall meet at least 10 times per year and more often as needed to perform its assigned functions. Permanent records of its proceedings and actions shall be maintained.

Section 7 Medical Staff Meetings

7.1 Annual and Others

An annual meeting and other general meetings, if any, of the medical staff shall be held at a time determined by the MEC. Notice of the meeting shall be given to all medical staff members via appropriate media and posted conspicuously.

7.2 Types of Meetings

The members present in person or via electronic means and voting at a meeting of the medical staff is the action of the group. Action may be taken without a meeting of the medical staff by presentation of the question to each member eligible to vote, in person, via telephone, web or other electronic meeting mechanism and/or by standard or electronic mail or Internet, and their vote recorded in accordance with procedures approved by the MEC. Such vote shall be binding so long as the question that is voted on receives a majority of the votes cast. Where feasible, documents to be voted on will be distributed prior to the meeting.

7.3 Special Meetings of the Medical Staff

a. Initiation

The president of the medical staff may call a special meeting of the medical staff at any time. Such request or resolution shall state the purpose of the meeting. The president of the medical staff shall designate the time and place of any special meeting. Special meetings may be attended in person or via electronic means.

b. Notice

Written or electronic notice stating the time, place, and purposes of any special meeting of the medical staff shall be conspicuously posted and shall be sent to each member of the medical staff at least three (3) business days before the date of such meeting. No business shall be transacted at any special meeting, except that stated in the notice of such meeting.

7.4 Regular Meetings of Medical Staff Committees, Clinical Services and Divisions

Regular meetings of committees, clinical services and divisions shall be held at scheduled times as determined by the Chair. Notices of the scheduled meetings shall be sent electronically. Meeting attendance may be in person or via electronic means.

7.5 Special Meetings of Committees, Divisions and Clinical Services

A special meeting of any committee, clinical service or division may be called by the chair thereof or by the president of the medical staff. Meeting attendance may be in person or via electronic means.

7.6 Quorum, Attendance, Minutes, Procedures and Actions of Committees

Quorum, attendance, minutes, procedures, and other requirements for various types of meetings are set forth in Appendix A, the Organizations and Functions Manual.

7.7 Investigations, Corrective Action, Hearings and Appeals

Initiation and procedures for meetings that could result in corrective action or adverse recommendations for privileges or medical staff membership, including hearings and appeals, are addressed in Article III of these bylaws and Appendix C, Investigations, Corrective Action, Hearings and Appeals Manual and meetings related thereto are governed thereby.

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Section 8 Conflict Resolution and Direct Input to Board

8.1 Conflict Resolution Requested by MEC

In the event the Board acts in a manner contrary to a recommendation by the MEC, the matter may (at the request of the MEC) be submitted to a joint conference committee composed of the officers of the medical staff and an equal number of members of the Board for review and recommendation to the full the Board. The committee will submit its recommendation to the Board within thirty (30) days of its meeting.

8.2 Direct Input Between Board and MEC

The chair of the Board or the president of the medical staff may call for a joint conference as described above at any time and for any reason in order to seek direct input from the medical staff leaders, clarify any issue, or relay information directly to medical staff leaders.

Section 9 Bylaws Review, Revision, Adoption, and Amendment

9.1 Medical Staff Responsibility

a. Bylaws

The medical staff shall have the responsibility to formulate, review at least biennially, and recommend to the Board any medical staff bylaws and amendments. The medical staff can exercise this responsibility through its elected and appointed leaders or through direct vote of its

membership when required. Amendments to the bylaws shall be effective when approved by the Board.

b. **Rules, Regulations, Policies, Procedures, and Protocols**

The medical staff shall have oversight responsibilities for the formulation, review, and adoption of rules, regulations, policies, procedures, and related protocols as well as any amendments thereto as needed. Amendments and adoption of rules, regulations, policies, procedures, and related protocols shall be effective when approved by the MEC, appropriate committee or other designee.

c. **Standard**

Such responsibility shall be exercised in good faith and in a reasonable, responsible and timely manner.

9.2 Methods of Adoption and Amendment

a. **To Bylaws**

Proposed amendments to these bylaws may be originated by the MEC or by a petition signed by ten percent (10%) of the members of the active category. Each active member of the medical staff will be eligible to vote on the proposed amendment via printed or secure electronic ballot in a manner determined by the MEC. All active members of the medical staff shall receive at least thirty (30) days advance notice of the proposed changes. To be adopted, the amendment must receive majority approval by those members eligible to vote and voting. An affirmative vote will be counted by returning the ballot marked "yes." Amendments so adopted shall be effective when approved by the Board.

b. **To Medical Staff Rules, Regulations and Policies**

Proposed rules, regulations, policies, procedures and protocols and any amendments thereto may be originated by the MEC in reliance on the authority delegated to the MEC by the organized medical staff. The MEC shall vote on the proposed language changes at a regular meeting, or at a special meeting called for such purpose, unless the MEC has delegated approval to an appropriate committee. Following an affirmative vote by the MEC, rules, regulations and policies may be adopted, amended or repealed, in whole or in part and such changes shall be effective when approved by the MEC. For those rules, regulations, policies, procedures and protocols, or any amendments thereto which have been delegated by the MEC to an appropriate committee, such documents will be effective when reported to the MEC. Board will be notified of material substantive changes to the rules, regulations and policies.

c. **Direct Requests to Board**

The organized medical staff itself may recommend directly to the Board any bylaws, rule, regulation, or policy and subsequent amendment by submitting a petition signed by twenty percent (20%) of the members of the active category. Upon presentation of such petition, the adoption process outlined for bylaws adoption and amendment will be followed.

d. **Technical Amendments or Clarification.**

The MEC may adopt such amendments to these bylaws, rules, regulations, and policies that are, in the committee's judgment, technical or legal modifications or clarifications. Such modifications may include, but need not be limited to, reorganization or renumbering, punctuation, spelling, or other errors of grammar or expression. Such amendments need not be approved by the entire Board but must be approved by the Hospital Executive as a representative of the Board.

e. **No Unilateral Amendment.**

Neither the organized medical staff nor the Board may unilaterally amend the medical staff bylaws, rules or regulations.

Section 10 Organized Health Care Arrangement: HIPAA Compliance

The Hospital, all membership of the medical staff, and other Practitioners at the Hospital are considered members of, and shall participate in, the Hospital's Organized Health Care Arrangement ("OHCA") formed for the purpose of implementing and complying with the Standards for Privacy of Individually Identifiable Health Information promulgated by the U.S. Department of Health and Human Services pursuant to the Administrative Simplification provisions of HIPAA.

Section 11 Confidentiality of Information

11.1 Information to be Kept Confidential

To the fullest extent permitted by law, the following shall be kept confidential:

i. Information submitted, collected, or prepared by the Hospital, any PHS Representative or Third Party for the purposes of assessing, reviewing, evaluating, monitoring, or improving the quality and efficiency of healthcare provided including recommendations made and actions taken;

ii. Evaluations of current clinical competence and qualifications for staff appointment/affiliation and/or clinical privileges or specified services**;**

iii. Contributions to teaching or clinical research; and

iv. Determinations that healthcare services were indicated or performed in compliance with an applicable standard of care.

11.2 Duty of Nondisclosure

This information will not be disseminated to anyone other than an employee or representative of the Hospital, PHS Representatives, or Third Parties engaged in official, authorized activities for which the information is needed.

11.3 Consequences of Improper Disclosure

Each practitioner expressly acknowledges that violations of confidentiality provided here are grounds for immediate and permanent revocation of staff appointment/affiliation and/or clinical privileges or specified services.

Section 12 Privileges Claimed

The Boards, the Hospital, medical staff, PHS, and their committees and representatives which conduct quality and peer review processes hereby constitute themselves as Professional Review Bodies as defined in Health Care Quality Improvement Act (HCQIA) and review organization(s) under the New Mexico Review Organization Immunity Act (ROIA). As such, they hereby claim all privileges and immunities afforded by said state and federal statutes. Any action taken by a HCQIA Professional Review Body pursuant to these Medical Staff Bylaws shall be in the reasonable belief that it is in furtherance of quality health care (including the provision of care in a manner that is not disruptive to the delivery of quality medical care at the Hospital) only after a reasonable effort has been made to obtain the true facts of the matter, after adequate notice and hearing procedures are afforded to any Applicant or Medical Staff Member, and only in the reasonable belief that the action is warranted by the facts known after a reasonable effort has been made to obtain the facts. Any action taken by a ROIA review organization shall be without malice and based on the reasonable belief that the action is warranted by facts known after reasonable efforts to ascertain the facts.

Section 13 Immunity from Liability

13.1 For Official Actions

The Hospital, PHS, and PHS Representatives shall not be liable to an applicant, medical staff member or practitioner for damages or other relief for any decision, opinion, action, statement, or recommendation made within the scope of their duties as an official representative of the Hospital, PHS, or medical staff.

13.2 For Good Faith Disclosures

The Hospital, PHS, and PHS Representatives shall not be liable for providing in good faith information, opinion, counsel, or services to a representative or to any healthcare facility, regulatory entity or organization of health professionals concerning said applicant, medical staff member or practitioner.

13.3 Additional Protections

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

13.4 Consent and Release

By applying for and/or accepting appointment to the medical staff and by applying for, and accepting and/or exercising clinical privileges within the Hospital, each applicant, medical staff member, and practitioner extends absolute immunity to, and releases from all claims, damages, and liability whatsoever, the Hospital, PHS, and PHS Representatives for any actions taken or statements, disclosures, and recommendations made in compliance with these bylaws, the Appendices, medical staff and PHS policies and protocols.

Section 14 Indemnity

Subject to applicable law, the Hospital shall indemnify medical staff members and Practitioners against actual and necessary expenses, costs, and liabilities incurred in connection with the defense of any pending or threatened action, suit or proceeding to which the medical staff member or practitioner is made a party by reason of having acted in an official capacity in good faith on behalf of the Hospital, medical staff or PHS. However, no individual shall be entitled to such indemnification if the acts giving rise to the liability constituted willful misconduct, breach of a fiduciary duty, self-dealing, malice or bad faith.

Section 15 Covered Activities

The confidentiality and immunity provided applies to all acts, communications, reports, recommendations, information obtained, or disclosures performed or made in connection with this the Hospital, PHS, and Third Party healthcare facility or organization's peer-related covered activities concerning, but not limited to those set forth in Appendix A, Organization and Functions Manual.

Section 16 Conflicts of Interest

A member of the medical staff or other practitioner requested to perform a Board designated medical staff responsibility (such as credentialing, quality and/or peer review or corrective action) may have a conflict of interest that could impact their ability to render an unbiased opinion. The Hospital will address such potential conflicts as set forth in Appendix A, the Organization and Functions Manual.

Section 17 Completion of History and Physical Examinations

17.1 Obligation

In accordance with medical staff and hospital policies, each practitioner shall prepare and timely complete a history and physical for all hospital patients to whom the practitioner provides care.

17.2 Initial Requirement

A medical history and physical examination be completed no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician, an oral maxillofacial surgeon, or other qualified licensed individual in accordance with State law and Hospital policy.

17.3 Updated Requirement

If the initial history and physical is prepared within 30 days prior to admission or registration, an updated examination of the patient, including any changes in the patient's condition, must be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician, an oral maxillofacial surgeon, or other qualified licensed individual in accordance with State law and Hospital policy.

17.4 Required Content

The content of complete and focused history and physical examinations is delineated more specifically in the medical staff rules and regulations, which may be modified from time to time to reflect current regulatory and accreditation requirements. Additionally, to the extent initial and updated regulatory requirements as outlined above should change, this section will be deemed to have been amended accordingly.

Article II: Medical Staff Categories and Credentialing Process

Section 1 Basic Steps for Credentialing

The following sections provide the basic steps for credentialing. The details associated with the basic steps in this section are contained in a more expansive form in Appendix B, the Credentials Procedures Manual.

Section 2 Medical Staff Credentials Committee

2.1 Purpose

The Credentials Committee oversees and carries out functions delegated to the Medical Staff by the Board, including credentialing and recredentialing, privileging and re-privileging, appointment and reappointment to the medical staff, and ongoing and focused professional evaluations.

2.2 Composition and Appointment

To the extent the Hospital utilizes a credentials committee and has designated clinical services or service divisions, the medical staff credentials committee shall consist of at least four (4) other members of the active medical staff who are experienced leaders that are not clinical service chairs. The president of the medical staff will appoint the chair and other members. The chair will be appointed after consultation with the Director of Medical Staff Affairs and ratified by the MEC. Hospitals without service divisions or those lacking sufficient numbers of service divisions to enable the MEC to have a separate credentials committee will utilize the MEC as its credentials committee.

2.3 Meetings and Voting

The medical staff credentials committee shall meet monthly or otherwise as necessary to accomplish their functions and shall maintain a record of their findings, proceedings, and actions. The credentials committee will make timely written reports to the MEC and governing Board.

2.4 Responsibilities

The credentials committee has duties as delegated by the governing Board and the MEC. The committee's duties are set forth in expanded form in the Credentials Procedure Manual, including oversight of provider evaluation using electronic means. The committee's duties which may be removed or modified by amending the Hospital bylaws, the Credentials Procedure Manual, medical staff rules and regulations and other policies, as applicable.

Section 3 Medical Staff Categories

This section outlines the basic categories of the Medical Staff with their general qualifications, prerogatives, and responsibilities. More details associated with the different medical staff categories are contained in Appendix B, the Credentials Procedures Manual.

3.1 The Active Category

To be eligible for active staff category, a medical staff member first must have been credentialed as associate medical staff at the Hospital and involved in a sufficient number of annual patient encounters to demonstrate clinical competence and otherwise meet the requirements for medical staff membership and privileges as set forth in the bylaws and the Credentials Procedures Manual.

3.2 The Associate Category

The associate staff category is reserved for medical staff members who do not meet the eligibility requirements for active category or who choose not to pursue active status but who demonstrate clinical competence and otherwise meet the requirements for medical staff membership and privileges as set forth in the Credentials Procedures Manual.

3.3 The Affiliate Category

The affiliate staff category is reserved for medical staff members who maintain a clinical practice in the Hospital service area and wish to be able to follow the course of their patients who are admitted to the Hospital.

3.4 Locums, Telemedicine and House Staff Privileges Only Category

This privileges only category is reserved for practitioners serving short locum tenens positions, telemedicine practitioners, house staff such as residents moonlighting the hospital, and others deemed appropriate by the MEC and Board for privileges.

3.5 FPPE – Training Category

This category is restricted to practitioners on the medical staff of the Hospital or another hospital within PHS who are seeking, or providing, the requisite training necessary for a practitioner to expand their delineation of privileges and be granted new privileges.

3.6 The Honorary Category

The honorary staff category is reserved for medical staff members who have retired from active Hospital practice.

3.7 Advance Practice Clinicians Category

This category is restricted to advance practice clinicians (APCs).

Section 4 Qualifications for Membership and/or Privileges

This section provides basic information with respect to membership and privileges qualifications. More details associated with membership qualifications and privileges are contained in Appendix B, the Credentials Procedures Manual.

4.1 Service Needs

The applicant is requesting privileges for a needed service the Board has determined appropriate for performance at the Hospital as documented under a Board-approved medical staff development plan.

4.2 Applicant's Burden

Individuals seeking appointment shall have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, character, ethics, and other qualifications, and of resolving any doubts. No practitioner shall be entitled to membership on the medical staff or to privileges merely by virtue of licensure, employment, membership in any professional organization, or privileges at any other healthcare organization.

4.3 Eligibility

To be eligible to apply for initial appointment, or reappointment, to the medical staff and/or clinical privileges, an individual must submit the appropriate application form approved by the Hospital demonstrating continuous satisfaction of all threshold criteria for appointment (or reappointment) and the requested clinical privileges as well as all other factors for consideration outlined in Appendix B, the Credentials Procedures Manual and other relevant Hospital policies. Such factors include, but are not limited to, appropriate education, training, experience, current clinical competence, professional conduct, licensure, and ability to safely and competently perform the clinical privileges requested.

Section 5 Initial Appointment Procedure

This section provides basic information with respect to initial appointment procedures. More details associated with initial appointment procedures are included in Appendix B, the Credentials Procedures Manual.

5.1 Application

Application packets will include a complete set of the medical staff bylaws or reference to an electronic source for this information. This package will enumerate the eligibility requirements for medical staff membership and/or privileges and a list of expectations of performance for individuals granted medical staff membership or privileges (if such expectations have been adopted by the medical staff).

5.2 Applicant's Burden

The burden is on the applicant to provide all required information. It is the applicant's responsibility to ensure that the medical staff office receives all required supporting documents verifying information on the application and to provide sufficient evidence, as required in the sole discretion of the Hospital, that the applicant meets the requirements for medical staff membership and/or the privileges requested.

5.3 Threshold Requirements Determination

Upon a determination that all applicable threshold requirements are met, the application will be accepted for further processing. In the event it is determined that the threshold requirements are not met and cannot be met with the provision of additional information, the potential applicant will be notified that they are ineligible to apply for membership or privileges on the medical staff, the application will not be processed, and the applicant will not be eligible for a fair hearing.

5.4 Primary Source Verification

Applications that meet all applicable threshold requirements will be verified by the medical staff office or designee. Verification will include current licensure, education, relevant training, and current competence from the primary source whenever feasible, or from a credentials verification organization (CVO). When all verification has been obtained, the application will be considered eligible for evaluation.

5.5 Evaluation for Completed, Verified Applications

Credentialing will be conducted according to process outlined in these bylaws and procedures set forth in Appendix B, the Credentials Procedures Manual. All initial completed, verified applications for membership and/or privileges will be designated Track 1, Track 2 or Track 3 and processed accordingly before being sent to the governing Board for final decision.

5.6 Applicant Notice

If the Credentialing Authority makes an adverse recommendation concerning an applicant, the applicant will be sent a special notice, stating the reason for the adverse recommendation. The applicant will then be entitled to the procedural rights provided in Article III of these bylaws (Investigation, Corrective Action, Hearing and Appeal Plan), with the Board taking final action in accordance with Article III. Notice of the Board's final decision shall be given, through the Hospital Executive to the MEC and to the chair of each clinical service concerned. The applicant shall receive written notice of appointment and special notice of any adverse final decisions in a timely manner.

Section 6 Reappointment Procedure

This section provides basic information with respect to reappointment procedures. More details associated with reappointment procedures are included in Appendix B, the Credentials Procedures Manual.

6.1 Criteria and Process

It is the policy of the Hospital to approve for reappointment and/or renewal of privileges only those Practitioners who meet the criteria for initial appointment. The practitioner seeking reappointment will complete an application for reappointment updating all requested information and agreeing to abide by the bylaws as well as all rules, regulations, policies, procedures, manuals, protocols and other responsibilities of appointment. The Credentialing Authority will verify, review, and evaluate the

reappointment application pursuant to the requirements stated in these bylaws and the Credentials Procedures Manual.

6.2 Loss of Eligibility

In the event a practitioner finds no need to utilize the facilities or resources of the Hospital for purposes of patient care through either admission, performance of a procedure, consultation, or referral, during any appointment period they may not be eligible for reappointment or continued privileges. Such practitioner may apply as a new applicant at any time subsequent to the expiration of current appointment or privileges.

Section 7 Clinical Privileges

This section provides basic information with respect to reappointment procedures. More details associated with reappointment procedures are included in Appendix B, the Credentials Procedures Manual.

7.1 Exercise of privileges

A practitioner providing clinical services at the Hospital may exercise only those privileges granted to them by the Board or emergency or disaster privileges as described herein.

7.2 Requests

When applicable, each application for appointment or reappointment to the medical staff must contain a request for the specific clinical privileges the applicant desires. Specific requests must also be submitted for temporary privileges and for modifications of privileges in the interim between reappointments and/or granting of privileges.

7.3 Basis for Privileges Determination

Requests for clinical privileges will be considered only when accompanied by evidence of education, training, experience, and demonstrated current competence as specified by the Hospital in its Board approved criteria for clinical privileges or otherwise as authorized in the Credentialing Procedures Manual.

Section 8 Reapplication, Resignation, and Appeals

This section provides basic information with respect to application, resignation, leaves of absence and appeals. More details associated with these topics are included in Appendix B, the Credentials Procedures Manual.

8.1 Reapplication after adverse credentials decision

Practitioners who have a final adverse credentials decision or have resigned or withdrawn a pending application or reapplication to avoid such a decision are prohibited from reapplying to the medical staff or seeking privileges for three (3) years.

8.2 Request for Modification

A staff appointee, either in connection with reappointment or at any other time, may request modification of clinical service assignment or clinical privileges by submitting a written request to the medical staff office. A modification request must be on the prescribed form and must contain all pertinent information supportive of the request. All requests for additional clinical privileges must be accompanied by information demonstrating additional education, training, and current clinical competence in the specific privileges requested. A modification application is processed in the same manner as a reappointment. A practitioner who determines that they no longer exercise, or wish to restrict or limit the exercise of, particular privileges that they have been granted shall send written notice, through the medical staff office, to the credentials committee, and MEC. A copy of this notice shall be included in the practitioner's credentials file. A staff appointee may request a change in staff category only at the time of reappointment.

8.3 Resignation of staff appointment or privileges

Resignations by staff appointees shall be accepted as provided in Appendix B, the Credentials Procedures Manual, and shall be upon the terms stated therein.

8.4 Exhaustion of administrative remedies

Every practitioner agrees that they will exhaust all the administrative remedies afforded in the various sections of the bylaws and its appendices, including without limitation, the Investigation, Corrective Action, Hearings and Appeals Plan before initiating legal action against the Hospital or its agents.

8.5 Reporting requirements

The Hospital Executive or their designee shall be responsible for assuring that the Hospital satisfies its obligations under the Health Care Quality Improvement Act of 1986 and its successor statutes and any State reporting requirements, if applicable. Actions that must be reported include any negative professional review action against a physician related to clinical incompetence or misconduct that leads to a denial of appointment and/or reappointment; reduction in clinical privileges for greater than thirty (30) calendar days; resignation, surrender of privileges, or acceptance of privilege reduction either during an investigation or to avoid an investigation.

Section 9 Leave of Absence

Required and voluntary leaves of absence from the medical staff are authorized upon the terms and conditions outlined in Appendix B, the Credentials Procedures Manual, which provides details associated with the procedure and effect of leave requests, as well as the process for reinstatement.

Section 10 Practitioners Providing Contracted Services

10.1 Contracted Services Practitioners

Practitioners who are under contract with the Hospital to provide healthcare services onsite or through telemedicine technology will be permitted to do so only after being granted privileges at the Hospital in accordance with the bylaws and Appendix B, the Credentials Procedures Manual.

10.2 Qualifications and Corrective Action

Contracted services Practitioners must meet the same qualifications, must be processed in the same manner, and must fulfill all the obligations of their appointment category as any other applicant or staff appointee and will be subject to the same quality and/or peer review and corrective action requirements.

10.3 Effect of contract or employment expiration or termination

The effect of expiration or other termination of a contract upon a practitioner's staff appointment and clinical privileges will be governed solely by the terms of the practitioner's contract with the Hospital. If the contract or the employment agreement is silent on the matter, then contract expiration or other termination alone will not affect the practitioner's staff appointment status or clinical privileges as long as the practitioner continues to meet eligibility requirements.

Section 11 Medical Administrative Officers Appointment and Privileges

Each Medical Administrative Officer must achieve and maintain medical staff membership, appointment, and clinical privileges appropriate to their clinical responsibilities, if any. Removal from office or an adverse change in appointment status, including appeals rights, are governed by these bylaws with associated details in Appendix B, the Credentials Procedures Manual.

Article III: Investigations, Corrective Actions, Hearings and Appeals Plan

Section 11. Nature of Investigation and Corrective Action

11.1 Progressive Approach

These bylaws encourage medical staff leaders and Hospital management to use a progressive approach that takes into account the facts and circumstances of each individual situation,

. Actions to address questions relating to a practitioner's clinical practice and/or professional conduct may vary from collegial and educational efforts to termination of medical staff privileges and medical staff membership at the Hospital. Different rights, responsibilities, and procedures for the initiation, investigation, recommendation, review, implementation, and appeals apply to the various approaches set forth in these bylaws and in Appendix C, the Investigations, Corrective Actions, Hearings and Appeals Manual.

11.2 General Scope and Grounds

Some level of inquiry and corrective action is appropriate if the practice of a practitioner falls below the standards of clinical practice of the Hospital, disrupts the orderly operations of the Hospital, including the inability to work cooperatively with others, or fails to meet the requirements of the bylaws, Appendices, rules, regulations, or policies of the medical staff or Hospital or applicable law or accreditation standards. Investigations and corrective action may be initiated based on conduct arising in the practitioner's private practice or otherwise outside of the Hospital so long as such conduct has a nexus to the quality of care being provided to Hospital patients or the conduct of the practitioner at the Hospital.

11.3 Reporting

The facts and circumstances of each individual situation will determine whether any mandated reporting is required to applicable federal and/or state authorities. Accordingly, not all practitioner inquiries will be considered "professional review actions," "professional review activity," "adverse actions," or actions "adversely affecting" or which could "adversely affect" a practitioner so as to mandate reporting under applicable federal and state statutes and regulations.

11.4 Basic Fundamental Steps

These bylaws provide the basic fundamental steps related to investigation and corrective action and are supplemented in more detail by Appendix C to these bylaws, the Investigations, Corrective Actions, Hearings and Appeals Manual.

Section 12 Collegial Intervention

12.1 Goal

The goal of collegial intervention is to help the individual voluntarily respond to resolve questions that have been raised.

12.2 Performance Improvement Activities

All collegial intervention efforts by medical staff leaders and Hospital management shall be considered confidential and part of the Hospital's performance improvement and professional quality and/or peer review activities. Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate medical staff leaders and Hospital management. When any observations arise suggesting opportunities for a practitioner to improve, the matter should be referred for quality and/or peer review in accordance with the quality and/or peer review and performance improvement policies adopted by the medical staff and Hospital.

12.3 Types of Collegial Intervention

Collegial intervention efforts may include but are not limited to the following:

a. Educating and advising colleagues of all applicable policies, including those related to appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;

b. Following up on any questions or concerns raised about the clinical practice and/or conduct of privileged Practitioners and recommending such steps as proctoring, monitoring, consultation, and letters of guidance;

c. Sharing summary comparative quality, utilization, and other relevant information to assist individuals to conform their practices to appropriate norms; and

d. Taking notice of, reviewing, or mirroring all or part of any quality improvement actions taken in a practitioner's clinical practice or independent private practice, or by a practitioner's employer, a Hospital vendor or supplier, or otherwise outside of the Hospital as long as there is a nexus to the quality of care being provided to Hospital patients or the conduct of the practitioner at the Hospital.

12.4 Reporting

Collegial interventions are intended to be in the nature of quality improvement activities and will not be considered "professional review actions," "professional review activity," "adverse actions," or actions "adversely affecting" or which could "adversely affect" a practitioner so as to mandate reporting under applicable federal and state statutes and regulations unless the Hospital determines otherwise based on the specific facts and circumstances of a particular instance.

12.5 Limits of Collegial Intervention

Collegial intervention is not appropriate if it appears that the practitioner's performance places patients in danger or compromises the quality of care, or in cases where it appears that patients may be placed in harm's way while collegial interventions are undertaken.

Section 13 Automatic Withdrawal

13.1 Automatic Withdrawal, Restriction or Suspension

In certain instances, the practitioner's privileges and/or membership will be automatically terminated, or limited as described, and the action shall be final without a right to hearing.

13.2 Grounds for Automatic Withdrawal

a. **Revocation and suspension of license to practice:**

Whenever a practitioner's license or other legal credential authorizing practice in this state is revoked, suspended, expired, or voluntarily relinquished, medical staff membership and clinical privileges shall be automatically terminated at the Hospital as of the date such action becomes effective.

b. **Restriction of license:**

Whenever a practitioner's license or other legal credential authorizing practice in this state is limited or restricted by an applicable licensing or certifying authority, any clinical privileges that the practitioner has been granted at this Hospital that 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.

c. **Probation related to license:**

Whenever a practitioner is placed on probation by the applicable licensing or certifying authority, their membership status 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.

d. **Medicare, Medicaid, Tricare (a managed-care program that replaced the former Civilian Health and Medical Program of the Uniformed Services), or other federal programs:**

Whenever a practitioner is sanctioned or barred from Medicare, Medicaid, Tricare, or other federal programs, such medical staff membership and clinical privileges shall be automatically terminated as of the date such action becomes effective.

e. **Excluded List:**

Any practitioner listed on the United States Department of Health and Human Services Office of the Inspector General's List of Excluded Individuals/Entities will have such medical practitioner's medical staff appointment and privileges automatically terminated as of the date of inclusion on such list.

f. **Controlled substances/DEA certificate revoked, limited, suspended or expired**:

Whenever a practitioner's United States Drug Enforcement Agency (DEA) certificate or New Mexico Controlled Substance Registration is revoked, limited, or suspended or expires, the practitioner will 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.

g. **Controlled substances/DEA certificate subject to probation**:

Whenever a practitioner's DEA certificate or New Mexico Controlled Substance Registration is subject to probation, the practitioner'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.

h. **Professional liability insurance**:

Failure of a practitioner to maintain professional liability insurance in the amount required by the medical staff and Board policies and sufficient to cover the clinical privileges granted shall result in immediate automatic suspension of a practitioner's clinical privileges. If within 30 calendar days of the suspension the practitioner does not provide evidence of required professional liability insurance (including tail or nose coverage for any period during which insurance was not maintained) or evidence of coverage as a protected person under the New Mexico Tort Claims Act or Federal Tort Claims Act for work at a PHS facility, the practitioner shall not be considered for reinstatement and shall have their medical staff appointment and clinical privileges automatically terminated. The practitioner must notify the medical staff office immediately of any change in professional liability insurance carrier or coverage.

i. **Medical Staff dues/special assessments**:

Failure to promptly pay medical staff dues or any special assessment, as applicable, shall result in an automatic suspension of a practitioner's medical staff appointment and privileges. If within 60 calendar days after written warning of the delinquency the practitioner still has not paid, the practitioner shall not be considered for reinstatement and shall have their medical staff appointment and clinical privileges automatically terminated.

j. **Felony/misdemeanor conviction**:

A practitioner who has been convicted of or pled "guilty" or "no contest" or its equivalent to a felony or to a misdemeanor involving a charge of immoral action in any jurisdiction shall have their medical staff appointment and clinical privileges automatically terminated effective immediately upon such conviction or plea regardless of whether an appeal is filed. If such practitioner reapplies for appointment and privileges, the MEC will consider the felony/misdemeanor and may impose corrective action as deemed necessary.

k. **Failure to satisfy the special appearance requirement**:

A practitioner who fails without good cause to appear at a meeting where their special appearance is required in accordance with these bylaws or its Appendices shall have all clinical privileges automatically suspended with the exception of emergencies and imminent deliveries. These privileges will be reinstated automatically if such appearance occurs within 30 calendar days of the initially scheduled appearance. If the practitioner fails to comply with the special appearance requirement within such time period, the practitioner's medical staff appointment and clinical privileges will be automatically terminated.

l. **Failure to participate in an evaluation**:

A practitioner who fails to participate in an evaluation of their qualifications for medical staff membership or privileges as required under these bylaws or its

Appendices (whether an evaluation of physical or mental health or of clinical management skills) shall have all clinical privileges automatically suspended. These privileges will be reinstated automatically when the practitioner complies with the requirement for an evaluation if such compliance occurs within 30 calendar days of the automatic suspension. If the practitioner fails to comply with 30 calendar days, the practitioner's medical staff appointment and clinical privileges will be automatically terminated.

m. **Failure to become Board certified or failure to maintain Board certification**:

A practitioner who fails to become Board certified or maintain Board certification in compliance with medical staff credentialing policies will have their medical staff appointment and clinical privileges automatically terminated as of the date the practitioner ceases to be eligible for Board certification unless an exception is granted by the Board upon recommendation from the MEC.

n. **Failure to Execute Release and/or Provide Documents**:

A practitioner who fails to execute a general or specific release and/or provide documents when requested by the president of the medical staff or designee to evaluate the competency and credentialing/privileging qualifications of the practitioner shall have their medical staff appointment and clinical privileges automatically terminated. If the release is executed and/or documents provided within 30 calendar days of notice of the automatic withdrawal, the practitioner will be reinstated automatically on the date such document(s) is provided. If still not provided, the practitioner will have their medical staff appointment and clinical privileges automatically terminated as of that date and must reapply for staff membership and privileges.

o. **Failure to Participate in Obligated Call**:

A practitioner who fails to satisfy the member's Obligated Call requirements for the second time, after receiving a warning for an initial failure to satisfy Obligated Call, shall have their medical staff membership and clinical privileges automatically terminated and must reapply for staff membership and privileges.

p. **Improper Review of Electronic Medical Records**:

A practitioner who accesses or reviews their own or a family member's electronic medical records for the second time, after receiving a prior warning, shall have their medical staff membership and/or clinical privileges automatically terminated and must reapply for staff membership and privileges.

13.3 Notice

Notice of withdrawal shall be given to the affected practitioner. However, such notice shall not be required for the automatic withdrawal to become effective.

13.4 Bona Fide Dispute

Within ten days of the date of notice, the affected practitioner shall have the right to present written evidence to negate the grounds of automatic withdrawal. If the President

of the Medical Staff or Hospital Executive, or their respective designees, determine that the written evidence submitted negates such grounds for automatic withdrawal, the automatic withdrawal will be considered void from the beginning. The practitioner will be notified in writing of the decision.

13.5 No Hearing or Reporting

The automatic withdrawals, restrictions and suspensions in this section are based on actions or inactions of practitioner with respect to basic administrative requirements for Hospital appointment and clinical privileges (for example, licensure and Board certification) and without regard to a finding of clinical competence or professional conduct. As such, automatic withdrawal, restriction and suspensions in this section do not afford the practitioner hearing or appellate rights. Unless the Hospital determines otherwise based on the specific facts and circumstances of a particular instance, the automatic withdrawal, restriction and suspension in this section is not intended to be a "professional review action," a "professional review activity," an "adverse action," an action "adversely affecting" or which could "adversely affect" a practitioner, or a voluntary surrender of privileges while "under investigation," "in return for not conducting an investigation," or "to avoid" other actions or sanctions so as to mandate reporting under applicable federal and state statutes and regulations.

Section 14 MEC-Directed Investigation [Professional Review Action Procedures]

14.1 Request for Investigation

A MEC-Directed Investigation will be initiated by a request for an investigation submitted by a medical staff officer, chair of the credentials or medical staff practice committee, clinical service chair, Hospital Executive, CMO or Hospital Board chair to the MEC. The request must be supported by references to the specific activities or conduct that is of concern. If the MEC initiates the request, it shall appropriately document its reasons.

14.2 Initiation of Investigation

If the MEC decides that an investigation is warranted, it shall direct an investigation to be undertaken as a precursor to a professional review action. The MEC's decision to investigate will be reflected in a written resolution of the MEC, which shall document the initiation of a professional review action.

14.3 Investigative Process

a. The MEC may conduct the investigation itself or may assign the task to an appropriate standing or ad hoc committee of the medical staff in which a majority of voting members are doctors of medicine or osteopathy.

b. If the investigation is delegated to a committee other than the MEC, such committee shall proceed with the investigation promptly and forward a written report of its findings, conclusions, and recommendations to the MEC as soon as feasible.

c. The committee conducting the investigation shall have the authority to review all documents it considers relevant, to interview individuals, to consider appropriate clinical literature and practice guidelines, and consider the use of an external consultant in accordance with Hospital guidelines. Documents that are subject to review include, without limitation, relevant documents related to any collegial intervention and automatic withdrawal.

d. The investigating body may also require the practitioner under review to undergo a physical and/or mental examination and may access the results of such exams.

e. The investigating body shall notify the practitioner in question that the investigation is being conducted and permit the practitioner an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate.

f. The investigating process is considered an administrative matter and not an adversarial proceeding. The meeting between the practitioner in question and the investigating body (and meetings with any other individuals the investigating body chooses to interview) shall not constitute a "hearing" as that term is used in the hearing and appeals sections of these bylaws. The procedural rules with respect to hearings or appeals shall not apply to these meetings either. The individual being investigated shall not have the right to be represented by legal counsel before the investigating body.

g. During the status of any investigation, the MEC shall retain the authority and discretion to take whatever action may be warranted by the circumstances, including suspension, termination of the investigative process, or other action.

14.4 MEC Action Following Investigation

As soon as feasible after the conclusion of the investigation, whether conducted by the MEC itself or conducted by an appropriate standing or ad hoc committee, the MEC shall take action that may include, without limitation, the following recommendations:

a. Determination that no corrective action is warranted,

b. Deferral of action for a reasonable time when circumstances warrant;

c. Issuance of letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude appropriate committee, division chief or clinical service chairs from issuing informal written or oral warnings during ongoing quality and/or peer review processes irrespective of any investigation. In the event such letters are issued, the affected practitioner may make a written response, which shall be placed in the practitioner’s file;

d. Imposition of terms of probation or special limitation upon continued medical staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring/proctoring;

e. Denial, restriction, modification, reduction, suspension, revocation, or probation of clinical privileges;

f. Reductions of membership status or limitation of any prerogatives directly related to the member's delivery of patient care;

g. Suspension, revocation, or probation of medical staff membership; or

h. Other actions deemed appropriate under the circumstances.

14.5 Notice to Practitioner

If the MEC recommends any termination or restriction of the practitioner's membership or clinical privileges, the affected practitioner will be given written notice of the proposed action, including information about any rights for hearing and appeal.

14.6 Board Action – Final Decision Following Investigation

All recommendations of the MEC will be forwarded to the Board for decision. However**,** if the MEC recommends any termination or restriction of the practitioner's membership or privileges, and the practitioner has requested a hearing on the recommendation and proposed adverse action following the practitioner's receipt of notice thereof, the final decision shall be determined as set forth in these bylaws and in Appendix C, Corrective Actions, Hearings and Appeals Manual.

Section 15 Corrective Action – Precautionary Restriction or Suspension

15.1 Criteria for Initiation

A precautionary restriction or suspension may be imposed when:

a. The medical staff feels that immediate action must be taken to protect the life or well-being of a patient(s);

b. When a practitioner's actions present a substantial risk of imminent harm to the life or well-being of patients, employees, other staff, or the member themselves;

c. When medical staff leaders and/or the Hospital Executive determines that there is a need to carefully consider any event, concern, or issue that, if confirmed, has the potential to affect patient or employee safety or the effective operation of the institution; or

d. When all or a portion of practitioner's clinical privileges at another Hospital have been suspended or restricted.

15.2 Action

Under such circumstances the president of the medical staff or president elect if the president is absent, or their designee, and the Hospital Executive, or designee, may restrict or suspend the medical staff membership or clinical privileges of such practitioner as a precaution. The precautionary suspension is not a complete professional review action in and of itself, and it shall not imply any final finding regarding the circumstances that caused the suspension.

15.3 Precautionary Restriction or Suspension Process

a. Unless otherwise stated, such precautionary restriction or suspension shall become effective immediately upon imposition and the person or body responsible shall promptly give written notice to the practitioner, the MEC, the Hospital Executive, and the Board.

b. The restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein.

c. Unless otherwise indicated by the terms of the precautionary restriction or suspension, the practitioner's patients shall be promptly assigned to another medical staff member by the president of the medical staff or designee, considering, where feasible, the wishes of the affected practitioner and the patient in the choice of a substitute practitioner.

15.4 MEC Action Following Precautionary Restriction or Suspension

a. As soon as feasible and within 14 calendar days after such precautionary suspension has been imposed, the MEC shall meet to review and consider the action and if necessary, begin the investigation process as noted above.

b. The practitioner will be given the opportunity to address the MEC concerning the action, on such terms and conditions as the MEC may impose, although in no event shall any meeting of the MEC, with or without the practitioner, constitute a "hearing" as defined in this hearing and appeal plan, nor shall any procedural rules with respect to hearing and appeal apply.

c. The MEC may modify, continue, or terminate the precautionary restriction or suspension, but in any event, it shall furnish the practitioner with notice of its decision.

15.5 Procedural Rights

Unless the MEC promptly terminates the precautionary restriction or suspension prior to or immediately after reviewing the results of any investigation described above, the practitioner shall be entitled to the procedural rights afforded by this hearing and appeal plan once the restrictions or suspension last more than 14 calendar days. Notice of the practitioner's hearing and appeal rights will be included in the initial notification of actions.

Section 16 Notice and Hearing Rights

This section only applies to those practitioners whom the hospital is required to report to the National Practitioner Data Bank or other professional state licensing boards.

16.1 Right to Request Hearing

A practitioner shall be entitled to request a hearing whenever an unfavorable recommendation with regard to clinical competence or professional conduct has been made by the MEC prior to final determination by the Board in the following actions:

a. Denial of medical staff appointment or reappointment;

b. Revocation of medical staff appointment;

c. Denial or restriction of requested clinical privileges;

d. Involuntary reduction or revocation of clinical privileges;

e. Application of a mandatory concurring consultation requirement, or an increase in the stringency of a pre-existing mandatory concurring consultation requirement, when such requirement only applies to an individual medical staff member and is imposed for more than fourteen (14) calendar days; or

f. Suspension of staff appointment or clinical privileges, but only if such suspension is for more than fourteen (14) calendar days and is not caused by the member's failure to complete medical records or any other reason unrelated to clinical competence or professional conduct.

16.2 No Right to Request Hearing

A practitioner shall not be entitled to request a hearing in the following actions unless such action results in adverse report to the New Mexico Medical Board or to the National Practitioner Data Bank:

a. Issuance of a letter of guidance, warning, or reprimand;

b. Imposition of a requirement for proctoring (i.e., observation of the practitioner's performance by a peer in order to provide information to a medical staff quality and/or peer review committee) with no restriction on privileges;

c. Failure to process a request for a privilege when the applicant/member does not meet the eligibility criteria to hold that privilege;

d. Conducting an investigation into any matter, including a MEC-Directed Investigation, or the appointment of an ad hoc investigation committee;

e. Requirement to appear for a special meeting under the provisions of these bylaws;

f. Automatic withdrawal or voluntary resignation of appointment or privileges;

g. Imposition of a precautionary suspension or administrative time out that does not exceed 14 calendar days;

h. Denial of a request for leave of absence, or for an extension of a leave;

i. Determination that an application is incomplete or untimely;

j. Determination that an application will not be processed due to misstatement or omission;

k. Decision not to expedite an application;

l. Termination or limitation of temporary privileges unless for demonstrated incompetence or unprofessional conduct;

m. Determination that an applicant for membership does not meet the requisite qualifications/criteria for membership;

n. Ineligibility to request membership or privileges or continue privileges because a relevant specialty is closed under a medical staff development plan or covered under an exclusive provider agreement;

o. Imposition of supervision pending completion of an investigation to determine whether corrective action is warranted;

p. Termination of any contract with or employment by Hospital;

q. Proctoring, monitoring, and any other performance monitoring requirements imposed in order to fulfill any Joint Commission standards on focused professional practice evaluation;

r. Any recommendation voluntarily accepted by the practitioner;

s. Expiration of membership and privileges as a result of failure to submit an application for reappointment within the allowable time period;

t. Change in assigned staff category;

u. Refusal of the Credentialing Authority or MEC to consider a request for appointment, reappointment, or privileges within three years of a final adverse decision regarding such request;

v. Removal or limitations of emergency department call obligations;

w. Any requirement to complete an educational assessment;

x. Retrospective chart review;

y. Any requirement to complete a health and/or psychiatric/psychological assessment required under these bylaws;

z. Grant of conditional appointment or appointment for a limited duration; or

aa. Appointment or reappointment for duration of less than 24 months; or

bb. Any other action that is not based on an assessment of clinical competence or conduct.

16.3 Notice of Recommendation

When a precautionary suspension lasts more than fourteen (14) calendar days or when a recommendation is made, which entitles a practitioner to request a hearing prior to a final decision of the Board, the affected practitioner shall promptly (but no longer than five (5) calendar days) be given written notice by the Hospital Executive that includes:

a. A statement that a professional review action has been proposed to be taken against the practitioner, along with a statement of the recommendation made and the general reasons for it (Statement of Reasons);

b. Notice that the individual shall have thirty (30) calendar days following the date of the receipt of such notice within which to request a hearing on the recommendation; and

c. A summary of hearing rights as included in Appendix C, Investigations, Corrective Actions, Hearing, and Appeal Manual.

16.4 Request for Hearing

The affected practitioner shall have thirty (30) calendar days following the date of the receipt of such notice within which to request the hearing. The request shall be made in writing to the Hospital Executive or PHS Representative designated in the Notice of Recommendation.

16.5 Forfeiture of Hearing

In the event the affected practitioner does not request a hearing within the time and in the manner required, the practitioner shall forfeit their right to hearing and be deemed to have waived the right to object to such recommendations and instead be deemed to have accepted the recommendations made, which shall become effective immediately upon final Board action.

16.6 Notice of Hearing and Statement of Reasons

If the affected practitioner requests a hearing within the time and manner required, the Hospital Executive or designee shall schedule the hearing and shall give written notice to the practitioner who requested the hearing. The notice shall include:

a. The time, place and date of the hearing, which shall be no sooner than 30 calendar days after the date of the notice of hearing unless an earlier hearing date has been agreed upon in writing signed by the affected practitioner and the Hospital Executive or designee;

b. A proposed list of witnesses (as known at that time) who will give testimony or evidence in support of the MEC (or the Board) at the hearing;

c. The names of the hearing panel members and presiding officer or hearing officer, if known; and

d. A statement of the specific reasons for the recommendation as well as the list of patient records and/or information supporting the recommendation.

16.7 Hearing Procedures

The hearing process and procedures are addressed in more detail in Appendix C, Investigations, Corrective Actions, Hearing and Appeal Procedure Manual. The issues presented at the hearing will be decided by either a hearing panel or a hearing officer as provided therein.

16.8 Role and Decision of Hearing Panel or Hearing Officer

The hearing panel or hearing officer will hear evidence and arguments related to the recommendation(s) on appeal and determine whether the facts presented warrant the recommendation(s) made as it relates to the furtherance of quality health care.

16.9 Deliberations and Recommendation of the Hearing Panel

Within thirty (30) calendar days after final adjournment of the hearing, the hearing panel shall conduct its deliberations and shall render a recommendation. The recommendation shall contain a concise statement of the reasons for the recommendation. Its recommendation may be to accept, reject, or accept with modification the original recommendations that were addressed on appeal.

16.10 Disposition of Hearing Panel Report.

The hearing panel shall deliver its report and recommendation to the Hospital executive who shall forward it, along with all supporting documentation, to the Board for further action. The Hospital administrator shall also send a copy of the report and recommendation, certified mail, return receipt requested, to the individual who requested the hearing, and to the MEC for information and comment.

Section 17 Appeal to the Hospital Board

17.1 Right to Appeal – Grounds and Procedures

Either party may appeal the hearing panel's decision to the Board solely based on the grounds described below and in accordance with the procedures described in Appendix C, the Investigations, Corrective Actions, Hearings and Appeals Manual. The grounds for appeal shall be limited to the following:

a. There was substantial failure to comply with the medical staff bylaws prior to or during the hearing so as to deny a fair hearing; or

b. The recommendation of the hearing panel was made arbitrarily, capriciously or with prejudice; or

c. The recommendation of the hearing panel was not supported by substantial evidence based upon the hearing record.

17.2 Notice of Appeal; Forfeiture of Appeal

Within ten (10) business days of receipt of the hearing panel's report and recommendation, the appealing party shall deliver to the Hospital Executive or designee a written request for appellate review to the Hospital Executive or designee. Methods of delivery are limited to personal delivery or certified mail, return receipt requested. The notice of appeal shall include a brief statement of the reasons for appeal and the specific facts or circumstances which justify further review. If such appellate review is not requested within ten (10) business days, such party shall be deemed to have accepted the recommendation involved, and the hearing panel's report and recommendation shall be forwarded to the Board.

17.3 Nature of Appellate Review

If a party requests a hearing within the time and manner required, an appellate review will occur in accordance with theses bylaws and Appendix C, the Investigations, Corrective Actions, Hearings, and Appeals Manual.

a. Board Review Panel

The chair of the Board shall appoint a review panel composed of at least three (3) members of the Board to consider the information upon which the recommendation before the Board was made. Members of this review panel may not be direct competitors of the practitioner under review and should not have participated in any formal investigation or hearing process leading to the recommendation for corrective action that is under consideration.

b. Deliberations and Recommendations

Within ten (10) business days after final adjournment of the hearing, the Board Review Panel shall conduct its deliberations and render a recommendation. The recommendation shall contain a concise statement of the reasons for the recommendation. Its recommendation may be to accept, reject, or accept with modification the original recommendations that were addressed on appeal.

17.4 Board Review Panel Report

The Board Review Panel shall deliver its report and recommendation, with any supporting documentation, to Board for final action and shall also send a copy of the report and recommendation, certified mail, return receipt requested, to the parties.

17.5 Final Decision of the Hospital Board

a. Decision

Within sixty (60) calendar days after receiving the Board review panel's recommendation, the Board shall render a final decision. The Board's decision may accept, reject, or accept or reject with modification the original recommendations made by the MEC, the hearing panel, or the Board review panel based on the Board's ultimate legal responsibility to grant appointment and clinical privileges.

b. Notice

The parties shall be informed of the Board's decision in writing, including specific reasons for its action, with copies sent to the chairs of the Credentials Committee and MEC, in person or by certified mail, return receipt requested.

17.6 Right to One Appeal Only

No applicant or medical staff member shall be entitled as a matter of right to more than one (1) hearing or appellate review on any single matter which may be the subject of an appeal. In the event that the Board ultimately determines to deny, in whole or in part, medical staff appointment or reappointment and/or clinical privileges to an applicant, or to revoke or terminate , in whole or in part, the medical staff appointment and/or clinical privileges of a current member, that individual may not reapply for medical staff appointment or for those clinical privileges at this Hospital from the date of the final Board decision, unless the Board advises otherwise.

ADOPTION

These Bylaws shall be adopted by a majority vote of the total membership of the Active Staff eligible to vote at any regular meeting of the Medical Staff or by an electronic or mail vote of the Medical Staff. They shall replace any previous Bylaws and shall become effective when approved by the Board of the Hospital.

Adopted by the Medical Staff of Socorro General Hospital:

12/18/2024
Date

President of the SGH Medical Staff

Approved by the Board of Socorro General Hospital:

January 28, 2025
Date

SGH BOARD CHAIR

Approved by MS:
Approved by SGH BOT Chair
Approved by SGH BOT: