



Guam Memorial Hospital Authority

# MEDICAL STAFF BYLAWS

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**MEDICAL STAFF BYLAWS**  
*GUAM MEMORIAL HOSPITAL AUTHORITY*

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# BYLAWS OF THE MEDICAL STAFF OF GUAM MEMORIAL HOSPITAL AUTHORITY

TAMUNING, GUAM

## PREAMBLE

WHEREAS, the Guam Memorial Hospital Authority is a nonprofit and public corporation organized under the laws of the Territory of Guam; and

WHEREAS, its purpose is to serve as a general hospital providing patient care, and participating in education and research; and

WHEREAS, it is recognized that the Medical Staff strives for quality patient care in the hospital, that the Medical Staff must work with and is subject to the authority of the Board, and that the cooperative efforts of the Medical Staff, Management and the Board are necessary to fulfill the objective of providing quality patient care to its patients;

THEREFORE, the physicians, dentists and podiatrists practicing in this hospital hereby organize themselves into a Medical Staff in conformity within these Bylaws as part of the Guam Memorial Hospital Authority.

These Bylaws are adopted to provide for the organization of the Medical Staff of Guam Memorial Hospital Authority and to establish a framework for self-governance enabling the Medical Staff to discharge its responsibilities. Besides providing the professional and legal structure for Medical Staff operations, these Bylaws govern organized Medical Staff relations with the Board and with applicants to and members of the Medical Staff and those holding or seeking delineated clinical privileges. These Bylaws are not subject to waiver by contract or otherwise between the Guam Memorial Hospital Authority and other parties. These Bylaws constitute a contract between the Medical Staff and the Guam Memorial Hospital Authority and are mutually binding. The bylaws cannot be unilaterally amended by either party

## DEFINITIONS

1. BOARD OF TRUSTEES or BOARD means the Board of Trustees of the Guam Memorial Hospital Authority, who have the overall responsibility for the conduct of the hospital, including the medical staff.
2. CLINICAL PRIVILEGES or PRIVILEGES means the permission granted to a practitioner to render specific diagnostic, therapeutic, medical, dental, or surgical services.
3. EX-OFFICIO means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means without voting rights.
4. FAIR HEARING PLAN means the procedures set forth in Article VIII.
5. HOSPITAL means Guam Memorial Hospital Authority.
6. ALLIED HEALTH PROFESSIONAL means an individual, other than a licensed physician, dentist, or podiatrist who exercises judgment within the areas of his/her professional competence and the limits established by the governing body, the medical staff and statutes governing licensure and certification.
7. MEDICAL EXECUTIVE COMMITTEE means the Executive Committee of the Medical Staff.
8. MEDICAL STAFF or STAFF shall refer to allopathic and osteopathic physicians, dentists and podiatrists who hold unlimited license by the Territory of Guam, and who are granted privileges to practice at Guam Memorial Hospital Authority.
9. PRACTITIONER means, unless otherwise expressly limited, any appropriately licensed physician, dentist, podiatrist, or other state licensed independent practitioner applying for, or exercising, clinical privileges in this hospital.
10. PREROGATIVE means a participatory right granted, by virtue of staff category or otherwise, to a staff member and exercisable subject to the conditions imposed in these bylaws and in other hospital and medical staff policies.
11. ADMINISTRATOR means the individual appointed by the Board to act on its behalf in the overall administrative management of the Hospital.
12. SPECIAL NOTICE means written notification sent by certified mail, return receipt requested, or acknowledged receipt of delivery by a designee of the Administrator.
13. HOUSE PATIENT means a patient who presents to Guam Memorial Hospital who does not have a private practitioner or who does not request and/or is unable to identify an accepting practitioner. For the purposes of the Government Claims Act and for Agent of Hospital Reimbursement, "House Patient" designation is given to the care provided by agents of the hospital. Put here
14. For the purposes of the Government Claims Act, physicians, consultants, or allied health professionals shall be considered Agents of the Hospital if they: (1) provide care to a patient by virtue of being: a) on house call, b) called in consultation by the house call physician to provide additional expertise to a patient, c) called to provide emergency expertise not otherwise available to a patient, d) health professionals of the hospital as delineated in Section 2 of Public Law 24-80; and (2) accept reimbursement through the GMHA's Physician Reimbursement Program at the house patient reimbursement rate.
15. INDEMNIFICATION OF AGENT OF GMHA for the purpose of liability is covered under Public Law 17-29 Section 6500.30 Government Claims Act.

## **ARTICLE I: NAME**

The name of this organization shall be the Medical Staff of the Guam Memorial Hospital Authority.

## **ARTICLE II: PURPOSES AND RESPONSIBILITIES**

### **2.1 PURPOSES**

The purposes of the Staff are to:

- 2.1-1 Be the formal organizational structure through which:
  - 1. The benefits of membership on the staff may be obtained by individual practitioners, and
  - 2. The obligations of staff membership may be fulfilled.
- 2.1-2 Serve as the primary means for accountability to the Board for the appropriateness of the professional performance and ethical conduct of its members and to strive that the pattern of patient care in the hospital is consistently maintained at the level of quality and efficiency achievable by the state of the healing arts and the resources locally available.
- 2.1-3 Provide a means through which the staff may participate in the hospital's policy-making and planning process.
- 2.1-4 Support research and educational activities in the interest of improving patient care, the skills of persons providing health services, and the promotion of the general health of the community.
- 2.1-5 Initiate and maintain self-government for the Medical Staff in accordance with the policies of the Hospital as established by the Board.

### **2.2 RESPONSIBILITIES**

The responsibilities of the staff to be fulfilled through the actions of its officers, departments and committees, include to:

- 2.2-1 Account for the quality and appropriateness of patient care rendered by all practitioners and allied health professionals authorized to practice in the hospital through the following measures:
  - A. A credentials program, including mechanisms for appointment and reappointment, and the matching of clinical privileges to be exercised or of specified services to be performed, with the verified credentials and demonstrated current competence of the applicant, staff member or allied health professional;
  - B. A continuing education process/program, fashioned at least in part on the needs demonstrated through quality improvement programs;
  - C. A utilization management program to allocate inpatient medical and health services based upon patient medical needs;

- D. An organizational structure which allows continuous monitoring of patient care practices;
  - E. Review and evaluation of the quality of patient care through valid and reliable quality improvement programs, such as the development of the Ongoing Practice Performance Evaluation (OPPE) and Focused Practice Performance Evaluation (FPPE) that is established to confirm the staff member's current competency to perform the duties and services granted by the Board.
- 2.2-2 Recommend to the Board action with respect to appointments, reappointments, staff category, department (and service) assignments, clinical privileges, and corrective action.
  - 2.2-3 Account to the Board for the quality, efficiency, and safety of patient care rendered to patients in the Hospital through regular reports and recommendations concerning the implementation, operation and results of quality improvement activities.
  - 2.2-4 Initiate and pursue corrective action with respect to practitioners, when warranted.
  - 2.2-5 Develop, administer and seek compliance with these bylaws, the rules and regulations of the staff, and other patient care related hospital policies.
  - 2.2-6 Assist in identifying community health needs and in setting appropriate institutional goals and implementing programs to meet those needs.
  - 2.2-7 Exercise the authority granted by these Bylaws as necessary to adequately fulfill the foregoing responsibilities

## **ARTICLE III: MEMBERSHIP**

### **3.1 NATURE OF MEMBERSHIP**

Membership on the Medical Staff of Guam Memorial Hospital Authority is a privilege which shall be extended only to professionally competent physicians, dentists, podiatrists, and state licensed independent practitioners who fully meet the qualifications, standards and requirements pursuant to these Bylaws and approved by the Board. All appointees shall be assigned to a specific department (service), but shall be eligible for clinical privileges in other departments as applied for and recommended pursuant to these Bylaws and approved by the Board.

### **3.2 QUALIFICATIONS FOR MEMBERSHIP**

- A. Only physicians with Doctor of Medicine or Doctor of Osteopathy degrees, dentists, oral surgeons, podiatrists, or allied health professionals holding a license (if applicable and legally required and in accordance with individually granted clinical privileges) to practice in Guam, are eligible for membership.
- B. The applicant has clinical delineated privileges that define the scope of patient care services s/he may provide in the hospital.
- C. Such applicants must document their background, experience, training, judgment, individual character and demonstrated competence, physical and mental capabilities, and adherence to the ethics of their profession in order to be eligible to be granted privileges. Continuing Medical Education attendance will be used by the Department in evaluating physicians, podiatrists, oral surgeons, allied health professional staff, and dentists at the time of reappointment or revision of individual clinical privileges.
- D. The applicant must demonstrate ability to work with others with sufficient adequacy to assure the Professional Staff and the Board that any patient treated by him/her in the hospital and the hospital outpatient facilities will be given acceptable professional care.
- E. No individual shall be entitled to membership on the Professional Staff or to the exercise of particular clinical privileges in the hospital merely by virtue of licensure to practice in this or any other state, or of membership in any professional organization, or of privileges at any other health care institution.
- F. In documentation of experience and training, completion of an approved residency is required, unless otherwise specifically delineated by individual departments. The dental staff and allied health professionals shall be exempt from this rule.
- G. In lieu of the requirement of Section F. above, evidence of sufficient clinical experience (as defined by each department) may be submitted, together with documentation of duties and responsibilities.
- H. Must provide or arrange for coverage for all patients; subject to approval of the Department and MEC.
- I. Additional requirements may be set out for individual specialists within their department or division which are necessary and appropriate and in accordance with the specifically granted clinical privileges to those practitioners in their individual specialty.
- J. If the Executive Committee or Board has reason to question the physical and/or mental health status of a practitioner, the practitioner may be required to submit to an evaluation of his/her physical and/or mental health status by a physician or physicians mutually acceptable to the Executive Committee and practitioner (If not mutually agreed, the MEC will assign), as a

prerequisite to further consideration of his/her application for appointment or reappointment, to the exercise of previously granted privileges, or to maintenance of his/her staff appointment.

3.2-2 **Effect of Other Affiliations**

No physician, dentist or podiatrist is entitled to membership on the Staff or to the exercise of particular clinical privileges solely because he/she is licensed to practice in this or in any other state or territory, or because he/she is a member of any professional organization, or is certified by any clinical board, or presently or formerly held staff membership or privileges at another health care facility or in another practice setting.

**3.3 BASIC RESPONSIBILITIES OF MEMBERSHIP**

Each member of the Staff shall:

- 3.3-1 Provide patients with care at the professionally highest level of quality safety and efficiency and with care and compassion.
- 3.3-2 Abide by the Medical Staff bylaws and rules and regulations, and by all other established standards, policies and rules of the hospital;
- 3.3-3 Discharge such staff, department, (service), committee and hospital functions for which he/she is responsible by appointment, election or otherwise;
- 3.3-4 Prepare and complete within the time limitation, the medical and other required records for all patients admitted or in any way provided care in the hospital;
- 3.3-5 Abide by the ethical principles of his/her profession, including but not limited to: refraining from fee splitting or other inducements relating to patient referral; providing for continuous care of his/her patients; refraining from delegating the responsibility for diagnosis or care of hospitalized patients to a practitioner who is not adequately qualified or supervised; seeking consultation whenever necessary;
- 3.3-6 Promptly notify the Administrator of the revocation or suspension of his/her professional license by any state, or of his/her loss of staff membership or privileges at any hospital or other health care institution;
- 3.3-7 Promptly notify the Administrator of any change in health or mental status that would affect his/her ability to practice hospital privileges with reasonable skill and safety;
- 3.3-8 Participate in continuing medical education programs, which may include programs conducted by the hospital.
- 3.3-9 Avoid disruptive behavior and activities that are demeaning or threatening to other staff and/or place the patient at risk.
- 3.3-10 Comply with all hospital requirements to include all hospital required compliance training and adhere to all applicable policies and procedures of the hospital

**3.4 NONDISCRIMINATION**

Staff membership or particular clinical privileges shall not be denied on the basis of any criterion unrelated to the delivery of quality patient care in the hospital.

### **3.5 TERMS AND DURATION OF APPOINTMENT**

#### **3.5-1 Procedure**

Appointments and reappointments shall be made by the Board in accordance with the procedures stated in these Bylaws.

#### **3.5-2 Duration**

Initial appointments shall be no less than one (1) year and may be extended. Reappointments to the medical staff shall be for a period of two years, and is prohibited from any extension beyond this period.

#### **3.5-3 Privileges**

Appointment to the Staff shall confer on the appointee only such privileges specified by the Board in accordance with Article VI.

#### **3.5-4 Duties**

By accepting Staff membership, a member agrees to comply with these Bylaws and Rules and Regulations. The member also agrees to assume and carry out such staff, committee or hospital duties for which the member is responsible by appointment, election, or otherwise including participation in continuing medical education programs sponsored by the Hospital and committee peer review and quality improvement activities. Pursuant to the provisions of Guam law, the records, data and knowledge collected for or by individuals or committees assigned such review function are confidential, shall not be made public records, and shall not be available for court subpoena unless required pursuant to Guam law (6 GCA 412).

### **3.6 INITIAL APPOINTMENTS**

A formal Focused Professional Performance Evaluation (FPPE) will be developed by the applicant and the Chair and presented to the Credentials Committee for their review and approval. If unapproved the Chair will be asked to meet with the Credentials Committee and develop together an acceptable FPPE for the new applicant to present to the MEC for their review, revision and/or approval. The type, length, and the complexity of the review will be dependent upon the applicant's ability to demonstrate activity and current competency at the time of application.

#### **3.6-1 Duration**

All initial appointments to the medical staff regardless of the category of the staff to which the appointment is made and all initial clinical privileges shall be provisional for a period of 12 months from the date of the appointment.

During the term of this provisional appointment, the individual granted the provisional appointment shall be evaluated by the chairperson of the department or departments to which the appointee has been assigned or has privileges, and by the relevant committees of the medical staff and the hospital as to the individual's clinical competence and general behavior and conduct in the hospital. This shall be done according with the Policy on (Re) Appointment and Clinical Privileges which is attached to these Bylaws and incorporated by reference. Provisional clinical privileges shall be adjusted to reflect clinical competence at the end of the provisional period or sooner if warranted. Continued appointment after the provisional period shall be conditioned on an evaluation of the factors to be considered for reappointment set forth in Article V, Section 5.2-2 of these Bylaws.

At the end of this one-year provisional period, the Executive Committee, upon the written recommendation of the President of the Medical Staff and the Chairperson of the department to which the practitioner was assigned, may continue the provisional status of the practitioner's appointment to the Staff up to an additional period of one (1) year.

### 3.6-2 **Conditions**

- A. The method of supervision and review of the performance of a practitioner provisionally appointed to the Staff shall be delineated by the chairperson of the department to which the practitioner is assigned and the President of the Staff. Direct observation, proctoring, chart review, simulation or other oversight will be applied as indicated.
- B. During the provisional period, a member of the Staff shall meet the medical staff meetings requirements set forth in these Bylaws for the Active Staff category and shall have such other prerogatives and be subject to such other restrictions for Active Staff category as are set forth in these Bylaws.
- C. A member of the Staff whose appointment is provisional and does not qualify for advancement to the requested and/or appropriate Staff category and/or who does not meet the qualifications specified for membership of the appropriate Staff category status within two (2) years should be scheduled for a personal interview with the President of the Staff and the chairperson of the appropriate department to discuss the status of this continued interest in maintaining an appointment to the Staff of the Hospital. The President of the Staff shall recommend appointment to the requested and/or appropriate Staff category, or non-appointment to the Staff. A provisional appointee whose appointment is so terminated shall have the rights accorded by these Bylaws, Article VIII.

## 3.7 **LEAVE OF ABSENCE**

- 3.7-1 Persons appointed to the Active Staff may, for good cause be granted leaves of absence by the Board for a definitely stated period of time not to exceed one year. Absence for longer than one year shall constitute voluntary resignation of medical staff appointment and clinical privileges unless an exception is granted by the Board. Absence from Guam for a period exceeding six (6) months shall require a formal request for a leave of absence.
- 3.7-2 Requests for leaves of absence shall be made to the chairperson of the department in which the individual applying for leave has his/her primary clinical privileges, and shall state the beginning and ending dates of the requested leave. The department chairperson shall transmit the request together with his/her recommendation to the Credentials Committee which shall make a report and a recommendation to the Executive Committee. The Executive Committee shall transmit a report and recommendation to the Administrator for action by the Board.
- 3.7-3 At the conclusion of the leave of absence, the individual may be reinstated, upon filing a written statement at least thirty (30) days prior to the date of reinstatement, with the Administrator summarizing his/her professional activities during the leave of absence. The individual shall also provide such other information as may be requested by the hospital at that time.
- 3.7-4 In acting upon the request for reinstatement, the Board may approve reinstatement either to the same or a different staff category, and may recommend limitation or modification of the clinical privileges to be extended the individual upon reinstatement.

## **ARTICLE IV: CATEGORIES OF THE STAFF**

### **4.1 CATEGORIES**

All appointments to the Medical Staff shall be approved by the Board and shall be to one of the following categories of the Staff. All appointees shall be assigned to at least one specific department (service), but shall be eligible for clinical privileges in other departments as applied for and recommended pursuant to these bylaws and approved by the Board

### **4.2 ACTIVE STAFF**

#### **4.2-1 Qualifications**

The Active Staff shall consist of physicians, dentists, podiatrists and allied health professionals, each of whom:

- A. Meets the basic qualifications set forth in Section 3.2 of these Bylaws;
- B. Have been advanced from the Provisional Staff and who attend, admit or are directly involved in the “hands on” care of at least four (4) patients per year at the Hospital.

#### **4.2-2 Prerogatives**

The prerogatives of an active staff member shall be to:

- A. Admit patients to or attend patients in the hospital as follows:
  - 1. A physician member may admit patients according to his/her clinical privileges;
  - 2. A dentist member may admit patients in conformity with the requirements of Section 6.3 of these Bylaws;
  - 3. A podiatrist member may treat patients in collaboration with the admitting physician responsible for the overall aspects of the patient’s care throughout the hospital stay;
- B. Exercise such clinical privileges as are granted by the Board to him/her pursuant to Article VI, and, participate in Emergency Department coverage;
- C. Serve as members of Committee.
- D. Vote on all matters presented at general and special meetings of the Staff, and the department (service), and committees of which he/she is a member, and hold office in the Staff organization, and in the department (service) and committees of which he/she is a member.

#### **4.2-3 Responsibilities**

Each member of the Active Staff shall:

- A. Meet the basic responsibilities set forth in, Section 3.3 of these Bylaws;
- B. Retain responsibility within the area of professional competence required for the care and supervision of each patient in the Hospital for whom he/she is providing services, or arrange a suitable alternative for such care and supervision;
- C. Actively participate in quality improvement and patient safety activities required of the Staff in monitoring new appointees and other members of the same profession, in serving on Emergency Department call rosters except as exempted by the Executive Committee, and in discharging such other staff functions as may from time to time be required;
- D. Satisfy the requirements set forth in Article X of these Bylaws for attendance at meetings of the Staff and of the department (service), and committees of which he/she is a member;

- E. Provide services to house patients and other patients without personal physicians in accordance with the protocol adopted by the Staff delineating responsibilities for services to such patients or at the discretion of his/her assigned department as established by the department rules and regulations. For house patients, physicians are considered agents of the Hospital. On-call is a combined responsibility of administration and medical staff and subject to reasonable negotiations.
- F. Fulfill proctorship requirements in accordance with the Medical Staff Rules and Regulations Section VIII and as determined by each department.

### **4.3 PROVISIONAL STAFF**

#### **4.3-1 Qualifications**

The Provisional Staff shall consist of physicians, dentists and podiatrists in the initial period of appointment who will be considered for advancement to the requested and/or appropriate staff category and who meet the qualifications specified for members of the appropriate Staff Category.

#### **4.3-2 Prerogatives**

The prerogatives of a Provisional Staff member shall be to:

- A. Admit to or attend patients in the Hospital under the same conditions as specified for the requested and/or appropriate staff category;
- B. Exercise such clinical privileges as are granted to him/her pursuant to Article VI of these Bylaws; and
- C. Serve as members of Committees.
- D. Vote on all matters presented at meetings of the department and committees of which he/she is a member, unless otherwise provided by resolution of the Staff, such department, or committee and approved by the Executive Committee and Board. Provisional Staff members shall not be eligible to hold office, nor serve as department/committee chairperson(s) in this Staff organization unless empowered by the Medical Executive Committee.

#### **4.3-3 Responsibilities**

- A. Each member of the Provisional Staff shall be required to discharge the same responsibilities as those specified in Section 4.2-3 of this part. Failure to fulfill those responsibilities shall be grounds for denial of advancement to the appropriate staff status.
- B. Fulfill proctorship requirements in accordance with the Medical Staff Rules and Regulations Section VIII and as determined by the Department.

### **4.4 COURTESY STAFF**

#### **4.4-1 Qualifications**

The Courtesy Staff shall consist of physicians, dentists and podiatrists each of whom:

- A. Meets the basic qualifications set forth in Section 3.2-1 of these Bylaws;
- B. Have been advanced from the Provisional Staff and who attend, admit or are involved in the treatment of at least 4, but not more than 24 non-house patients per year in the Hospital.

#### **4.4-2 Prerogatives**

The prerogatives of a Courtesy Staff member shall be to:

- A. Follow his/her own patients in the Hospital and provide medical consultation upon request for the attending practitioner. This does not divest him/her from the responsibility to provide services to house patients and other patients without personal physicians unless granted by the department for justifiable reasons.
- B. Attend meetings of the Staff and the department (service), of which he/she is a member, and any Staff or Hospital education programs;
- C. Serve as a member of committees; and
- D. Courtesy Staff members shall not be eligible to vote, except when serving as a member of a committee, nor to hold office in this Staff organization.

#### 4.4-3 **Responsibilities**

Each member of the Courtesy Staff shall:

- A. Discharge the basic responsibilities specified in Section 3.3 of these Bylaws; and
- B. Retain responsibility within his/her area professional competence for the care and supervision of each patient in the Hospital for whom he/she is providing services, or arrange a suitable alternative for such care and services; and
- C. Participate in quality improvement and patient safety activities in accordance with departmental rules and regulations; and
- D. Provide services to House Patients and other patients without personal physicians at the direction of the department through the Chairperson, in accordance with the protocol adopted by the Staff delineating responsibilities for services to such patients. For House Patients, physicians are considered Agents of the Hospital; and
- E. Fulfill proctorship requirements in accordance with the Medical Staff Rules and Regulations Section VIII and as determined by each department.

### 4.5 **HONORARY STAFF**

#### 4.5-1 **Qualifications**

Any member of the Staff who retires from the active practice of medicine, dentistry or podiatry, or other physicians, dentists or podiatrists, who are of outstanding reputation, not necessarily residing in the community, may be transferred to Honorary Status upon application to the Department Chairperson and with the approval of that department, the Executive Committee and the Board.

#### 4.5-2 **Prerogatives**

The prerogatives of an Honorary Staff member shall be to:

- A. Attend meetings of the Staff and the department (service), of which he/she is a member, and any Staff or Hospital education programs; and
- B. Serve on standing Staff committees and special committees, as appointed.

#### 4.5-3 **Limitations**

Each member of the Honorary Staff shall not be eligible to hold office, vote, admit patients, chair a department or be Chairperson of a standing or special committee.

### 4.6 **ACTIVE ASSOCIATE STAFF**

#### 4.6-1 **Qualifications**

The Active Associate Staff

- A. Shall consist of those physicians, dentists and podiatrists who maintain active staff membership appointment in another hospital within the United States, its current territories or commonwealths; and
- B. Completed the membership requirements of Guam Memorial Hospital Authority and who fulfill specific departmental requirements; and
- C. Have been recommended by the Medical Executive Committee and approved by the Board of Trustees; and
- D. Attend, admit or are involved in the treatment of at least four (4) patients per medical staff year at the Hospital or as determined by the department; and
- E. The rules and regulations of each department shall specify the membership criteria, scope of privileges, proctorship, meeting requirements and house patient obligations of the Active Associate staff.

4.6-2 **Prerogatives**

The prerogatives of an Active Associate Staff member shall be to:

- A. Follow his/her own patients in the Hospital and provide medical consultation upon request for the attending practitioner;
- B. Attend meetings of the Staff and the department of which s/he is a member and any Staff or Hospital Education programs as determined by the department;
- C. May serve as a member of committees; and
- D. Active Associate Staff Members shall not be eligible to vote, except when serving as members of a committee, or to hold office in his Staff organization.

4.6-3 **Responsibilities**

Each member of the Active Associate Staff shall:

- A. Discharge the basic responsibilities specified in Section 3.3 of these Bylaws;
- B. Retain responsibility within his/her area of professional competence for the care and supervision of each patient in the Hospital for s/he is providing services, or arrange a suitable alternative for such care and services;
- C. Participate in quality improvement activities in accordance with departmental rules and regulations;
- D. Provide services to house patients and other patients without personal physicians in accordance with the protocol adopted by the Staff delineating responsibilities for services to such patients at the discretion of the department. For house patients, physicians are considered agents of the Hospital; and
- E. Fulfill proctorship requirements in accordance with the Medical Staff Rules and Regulations Section VIII and as determined by each department.

**4.7 LIMITATIONS AND PREROGATIVES**

The prerogatives set forth under each staff category are general in nature and may be subject to limitation by special conditions attached to a practitioner's staff appointment, by other sections of these Bylaws, by the Rules and Regulations of the Staff or by policies of the Hospital.

**4.8 WAIVER OF QUALIFICATIONS**

Any qualifications in this Article or any other Article of these Bylaws not required by law or governmental regulation may be waived at the discretion of the Board, upon determination that such waiver will serve the best interests of the patients and of the Hospital.

**4.9 MODIFICATION OF MEMBERSHIP STATUS**

- 4.9-1.1 A staff member may, at any time, request modification of his staff category, department/service assignment, or clinical privileges by submitting a written application to the

Administrator on the prescribed form. Such application shall be processed in substantially the same manner as provided in Section 5.2 for reappointment.

4.9-1.2 Membership will automatically terminate with termination of privileges unless, except for honorary staff members, who must reapply for membership every 2 years

4.9-2 **Prerequisites for Request to Change to Courtesy Staff**

- A. +Staff member who applies for Courtesy Staff membership before or at the time of his/her next reappointment period should meet one or more of the following circumstances under which the application is made:
- B. Planned low utilization of hospital resources of a minimum of four (4) but less than twenty-four (24) non-house and Emergency Medicine Department patient contacts per medical staff year due to anticipated retirement, closure of private practice, for health reasons or special circumstances; or
- C. Actual utilization of hospital resources of a minimum of four (4) but less than twenty-four (24) non-house and Emergency Medicine Department patient contacts for at least one (1) year prior to the application for change of membership status to Courtesy Staff.

4.9-3 A Courtesy Staff member having more than twenty-four (24) non-house patient contacts a year shall assume the responsibilities of an Active member of the Medical Staff.

4.10 **MEDICAL STUDENTS AND POST-GRADUATE TRAINEES**

4.10-1 **General**

Any medical student, resident or fellow at other training programs who have not completed full training in their specialty or who have not otherwise met all minimum experience requirements to qualify for full privileges.

4.10-2 **Qualifications**

All medical students and post-graduate trainees must be in good standing at any accredited training program.

The training program is responsible for verifying the qualifications and credentials of each medical student and post-graduate trainee permitted to function in the hospital.

All post-graduate trainees must receive a temporary training license through Guam Board of Medical Examiners prior to being approved to function in the hospital.

4.10-3 **Approval**

All medical students and post-graduate trainees shall be registered with the Medical Staff office by the Medical Staff member who will be their preceptor. The medical staff office will be informed of the expected duration of their preceptorship in the Hospital.

The training program shall provide:

- a. letter of good standing for the medical student or post-graduate trainee.
- b. for residents/fellows – a delineation of privileges and procedure competencies.
- c. documentation of accreditation.
- d. memorandum of agreement stating the responsibilities of the training program including that malpractice insurance will be covered by the training program

Each attending physician must be approved by his/her department to supervise medical students and post-graduate trainees.

#### 4.10-4 **Preceptor Supervision**

Medical students and post-graduate trainees will be *directly* supervised by a preceptor who has active membership in the Medical Staff, full hospital privileges, and is in good standing with Guam Memorial Hospital.

Direct supervision means the preceptor must be physically present and supervising the medical students and post-graduate trainee during all procedures and surgeries.

Medical students and post-graduate trainees will be permitted to perform procedures, assist in surgery and render other aspects of patient care in the hospital under direct supervision of the preceptor to an extent consistent with the privileges of the preceptor and within the limits of the medical student's and post-graduate trainee's abilities as identified by the sponsoring institution.

Orders and documents created by the medical student and post-graduate trainee must be reviewed and co-signed by the preceptor. The preceptor will be responsible for any completion of medical records after the medical student and post-graduate trainee has left the island.

The care of the patient will be the responsibility of the preceptor. The preceptor, not the medical student and post-graduate trainee, will bill for services.

#### 4.10-.5 **Responsibilities of the Medical Students and Post-Graduate Trainees**

Medical students and post-graduate trainees shall introduce themselves, and their status, to any patient with whom they come into contact. The performance of important tasks related to surgery or invasive procedures (including sensitive examinations) for educational and training purposes performed by medical students and post-graduate trainees will be included on informed consent forms.

Medical students and post-graduate trainees shall not hold appointments to the Medical staff. They will not be required to pay dues. They shall not vote, nor hold office, nor chair committees.

## **ARTICLE V: APPOINTMENT AND REAPPOINTMENT**

### **5.1 APPLICATION FOR INITIAL APPOINTMENT**

#### **5.1-1 Information**

Applications for appointment to the Staff shall be in writing fully completed and shall be submitted on forms approved by the Board upon recommendation of the Credentials Committee via the Medical Executive Committee. Gender, Race, Creed and National Origin are not used in making decisions regarding the granting or denying of clinical privileges. The application shall contain a request for specific clinical privileges desired by the applicant and shall require detailed information concerning the applicant's professional qualifications including:

- A. Documentation of experience and training, completion of an approved residency is required, unless otherwise specifically delineated by individual departments. The dental staff and allied health professionals shall be exempt from this rule.
- B. Written evidence of current Guam license, certificate or other legal credentials required by Guam law.
- C. The names and complete addresses of at least two physicians, dentists, podiatrists or other practitioners, as appropriate, who have had recent extensive experience in observing and working with the applicant and who can provide adequate information pertaining to the applicant's present professional competence and character;
- D. The names and complete addresses of the chairpersons of each department of any and all hospitals or other institutions at which the applicant has worked or trained (i.e., the individuals who served as chairpersons at the time the applicant worked in the particular department). If the number of hospitals the applicant has worked in is great or if a number of years have passed since the applicant worked at a particular hospital, the Credentials Committee and the Board may take into consideration the applicant's good faith effort to produce this information;
- E. Information as to whether the applicant's Staff appointment or clinical privileges have ever been resigned, denied, revoked, suspended, reduced or not renewed at any other hospital or health care facility;
- F. Information as to whether the applicant has ever withdrawn his/her application for appointment, reappointment and clinical privileges before final decision by a hospital's or health care facility's governing board;
- G. Information as to whether the applicant's membership in local, state, territory, or national professional societies or his/her license to practice any profession in any state, territory, or his/her Guam Controlled Substance license (GCSL) or Drug Enforcement Administration (DEA) license has ever been suspended, modified or terminated.
- H. Applicant has up to 180 days to submit GCSL and DEA licenses, or must show just cause in a written statement why DEA or GCSL has not been submitted which will be reviewed by the Chairperson of the Credentials Committee. Failure to comply with the above may result in termination or limitation of hospital privileges.
  1. In accordance with federal and local law, Allied Health Professionals as defined in Article VII, who are not required to hold DEA licenses, are exempt from providing an explanatory letter to the Credentialing Committee and are exempt from obtaining DEA licensure.
- I. Information as to whether the applicant has currently in force professional liability insurance coverage, the name of the insurance company and the amount and classification of such coverage;
- J. Information concerning applicant's malpractice litigation experience;
- K. A consent to the release of information from the applicant's present and past professional liability insurance carriers;

- L. Information on the applicant's physical and mental health;
- M. Information as to whether the applicant has ever been named as a defendant in a criminal action and details about any such instance;
- N. Must submit a police and court clearance. Clearances must be less than three (3) months from the date of hire. Off-island applicant upon selection shall obtain the police/court clearance from the last place of residence.
- O. Copy of Driver's License or Passport and Passport size photo taken within the last year.
- P. The applicant's signature;
- Q. Such other information as the Board may require

5.1-2 **Obligations**

The following undertakings shall be applicable to every medical staff appointee for staff appointment or reappointment as a condition of continued medical staff appointment if granted:

- A. An obligation upon appointment to the Staff to provide continuous care and supervision to all patients within the hospital for whom the individual has responsibility;
- B. An agreement to abide by all bylaws and policies of the Hospital, including all Bylaws, Rules and Regulations of the Staff as shall be in force from time to time during the time he/she is appointed to the Staff;
- C. An agreement to accept committee assignments and such other reasonable duties and responsibilities as shall be assigned to him/her by the Board and the Staff;
- D. An agreement to promptly provide the Hospital current information regarding all questions on the application form at any time, new or updated information that is pertinent to any question on the application form;
- E. A statement that the applicant has received and had an opportunity to read a copy of the Bylaws, Rules and Regulations of the Staff as are in force at the time of his/her application and that he/she has agreed to be bound by the terms thereof in all matters relating to consideration of his/her application without regard to whether or not he/she is granted appointment to the Staff or clinical privileges;
- F. A statement of his/her willingness to appear for personal interviews in regard to his/her application;
- G. A statement that any misrepresentation or misstatement in, or omission from the application whether intentional or not, may constitute cause for automatic and immediate rejection of the application resulting in denial of appointment and clinical privileges. In the event that an appointment has been granted prior to the discovery of such misrepresentation, misstatement or omission, such discovery may result in summary dismissal from the Staff;
- H. A statement that the applicant will:
  1. Refrain from fee splitting or other inducements relating to patient referral;
  2. Refrain from delegating responsibility for diagnoses or care of hospitalized patients to any individual who is not qualified to undertake this responsibility or who is not adequately supervised;
  3. Refrain from deceiving patients as to the identity of an operating surgeon or any other individual providing treatment or services;
  4. Seek consultation whenever necessary;
  5. Abide by generally recognized ethical principles applicable to his/her profession; and
  6. Provide continuous care for his/her patients in the hospital;
  7. Will refrain from abusive and disruptive behavior and demonstrate no discriminatory actions.

Each applicant for Staff appointment and reappointment shall specifically agree to these undertakings as part of his/her application.

5.1-3 **Burden of Providing Information**

The applicant shall have the burden of producing adequate information for a proper evaluation of his/her competence, character, physical and mental health status, ethics and other qualifications, and of resolving any doubts about such qualifications. He/she shall have the burden of providing evidence that all the statements made and information given on the application are factual and true. Until the applicant has provided all information requested by the Hospital, the application will be deemed incomplete and will not be processed.

Applications remaining incomplete for consideration by the Credentials Committee for six (6) months after issuance and not actively being pursued by the applicant shall be considered withdrawn without prejudice and must be resubmitted in their entirety.

5.1-4 **Authorization to Obtain Information**

The individual specifically authorizes the hospital and its authorized representatives to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior or any other matter reasonably having a bearing on the individual's satisfaction of the criteria for initial and continued appointment to the Staff.

This authorization also covers the right to inspect or obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of said third parties that may be relevant to such questions. The individual also specifically authorizes said third parties to release said information to the hospital and its authorized representatives upon request.

5.1-5 **Authorization to Release Information**

Upon specific written authorization to release information, the individual authorizes the hospital and its authorized representatives to release such information to other hospital, health care facilities and their agents, who solicit such information for the purpose of evaluating the applicant's professional qualifications pursuant to the applicant's request for appointment or clinical privileges.

5.1-6 **Submission of Application**

The application for Staff appointment shall be submitted by the applicant to the Administrator or his/her designee. After receiving references and other information or materials deemed pertinent, and after verification of information on the application from the primary source, the Administrator or his/her designee shall determine the application to be complete and transmit the application and all supporting materials to the Chair of the applicable Department for review and development and written description of the proposed Focused Professional Practice Evaluation (FPPE) for the applicant. The Chair will forward the application along with his recommendation and the proposed FPPE to the Credentials Committee for evaluation. It is the responsibility of the applicant to provide that his/her application is complete, including adequate responses from references. An incomplete application will not be processed, and the applicant will be informed in writing.

5.1-7 **Initial Credentials Committee Procedure**

Upon receipt of the completed application for appointment the Credentials Committee shall:

- A. Inform the Chairperson of each department in which the applicant seeks clinical privileges of the pending application, furnish a copy of the application to each chairperson concerned and request recommendations;
- B. Any current Staff appointee shall have the right to appear in person before the Credentials Committee to discuss in private and in confidence any concerns he may have about the applicant.

5.1-8 **Department Procedure**

Each department in which the applicant seeks clinical privileges shall provide the Credentials Committee with specific written recommendations for approving or disapproving the application and for delineating the applicant's clinical privileges.

These recommendations shall be made a part of the Credentials Committee's report. As part of the process of making this recommendation, the department has the right to meet with the applicant to discuss any aspect of his/her application, his/her qualifications and his/her requested clinical privileges.

5.1-9 **Subsequent Credentials Committee Procedure**

- A. The Credentials Committee shall examine the evidence of the character, physical and mental health status, professional competence, qualifications, prior behavior and ethical standing of the applicant and shall determine, through information contained in references given by the applicant and from a query of the National Practitioner Data Bank and other sources available to the Committee, including an appraisal from the chairperson of each clinical department in which privileges are being sought, whether the applicant has established and meets all the necessary qualifications for the staff category and clinical privileges requested by him/her.
- B. As part of this process, the Credentials Committee may require a physical and mental examination of the applicant by a physician or physicians mutually acceptable to the Committee and the applicant and shall require that the results be made available for the Committee's consideration.
- C. If, after considering the recommendations of the clinical departments concerned, the Credentials Committee's recommendation for appointment is favorable, the Credentials Committee shall recommend provisional department assignment and provisional clinical privileges.
- D. As part of the process of making its recommendation, the Credentials Committee shall have the right to require the applicant to meet with the Committee to discuss any aspect of his/her application, his/her qualifications, and his/her clinical privileges.

5.1-10 **Credentials Committee Action**

- A. Not later than ninety (90) days from its receipt of the completed application, the Credentials Committee shall make a written report and recommendation with respect to the applicant to the Executive Committee.  
The Executive Committee shall make a written report and recommendation with respect to the applicant to the Board, through the Administrator. This report and recommendation shall be forwarded to the Board along with the original report and recommendation of the Credentials Committee.
- B. If the recommendation of the Credentials Committee is delayed longer than ninety (90) days, the Chairperson of the Credentials Committee shall send a letter to the applicant, with a copy to the Executive Committee through the Administrator explaining the delay.
- C. The Credentials Committee shall transmit to the Executive Committee the complete application and its recommendation that the applicant be appointed to the Staff, that the application be deferred for further consideration, or that the applicant be rejected for Staff appointment.

5.1-11 **Medical Executive Committee Action**

- A. When the recommendation of the Executive Committee is favorable to the applicant, the Administrator shall promptly forward it, together with all supporting documentation, to the Board. After final Board decision, the applicant will be notified promptly in writing. All recommendations to appoint must also specifically recommend the clinical privileges to be granted, which may be qualified by any probationary conditions relating to such

clinical privileges. Practitioner privilege information will also be made available to internal and external persons or entities via the GMHA website.

- B. When the recommendation of the Executive Committee is to defer the application for further consideration it must be followed up within thirty (30) days by a subsequent recommendation to the Board for appointment to the Staff with specified clinical privileges, or for rejection of the application for Staff appointment.
- C. When the recommendation of the Executive Committee is adverse to the applicant in respect to either appointment to the Staff or clinical privileges requested, it shall be forwarded to the Administrator who shall promptly notify the applicant in writing, return receipt requested. The Administrator shall then hold the application until verification of receipt has arrived, at which time all supporting documentation is forwarded to the Board.

#### 5.1-12 **Reapplication after Adverse Appointment Decision**

An applicant who has received a final adverse decision regarding initial appointment shall not be eligible to reapply to the Staff for a period of 6 (six) months from the time of the final adverse decision. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as the staff or the Board may require to demonstrate that the reasons for the earlier adverse action no longer exist.

## 5.2 **REAPPOINTMENT PROCESS**

Membership on the Staff and delineation of clinical privileges shall be reviewed biennially for each member of the Staff.

#### 5.2-1 **Application**

Each current appointee who wishes to be reappointed to the Staff shall be responsible for completing the reappointment application form approved by the Board.

The appointment application shall be submitted to the Administrator or his/her designee at least 120 days prior to the expiration of the appointee's then current appointment. Failure to submit an application by that time will result in automatic expiration of the appointee's appointment and clinical privileges at the end of the then current medical staff year. Reappointment, if granted, shall be for a period not to exceed two years.

#### 5.2-2 **Factors to be considered**

Each recommendation concerning reappointment of a person currently appointed to the Staff or a change in Staff category, where applicable, shall be based upon such appointee's:

- A. Ethical behavior, clinical competence and clinical judgment in the treatment of patients;
- B. Attendance at Staff meetings and participation in Staff duties;
- C. Compliance with the hospital policies and with the Medical Staff Bylaws and Rules and Regulations;
- D. Behavior in the Hospital, his/her cooperation with medical and hospital personnel relating to patient care or the orderly operation of this hospital, and his/her general attitude toward patients, the hospital and its personnel;
- E. Use of the hospital's facilities for his patients;
- F. Physical and mental health;
- G. Capacity to satisfactorily treat patients as indicated by the results of the hospital's quality improvement activities or other reasonable indicators of continuing qualifications, such as FPPE and OPPE. When insufficient practitioner-specific data is available, the medical staff obtains and evaluates peer recommendations from practitioners. Peer recommendations are obtained from practitioners in the same professional discipline with personal knowledge of the providers ability to practice.

- H. Satisfactory completion of such continuing education requirements as may be imposed by law, this hospital or applicable accreditation agencies;
- I. Satisfactory response from a query of the National Practitioner Data Bank; and
- J. Other relevant findings from the hospital's quality improvement activities, such as corrective actions, cause for Focused Professional Practice Evaluation (FPPE) undertaken and their results.

5.2-3 **Department Procedure**

- A. No later than ninety days prior to the end of the current appointment period, the Administrator shall send a list of those appointees desiring reappointment to the Credentials Committee.
- B. The Credentials Committee shall then in turn transmit to the Chairperson of each department a current list of all appointees who have clinical privileges in that department, together with the clinical privileges each then holds, accompanied by copies of their applications.
- C. No later than fifteen days after he/she receives the application, the Chairperson shall transmit to the Credentials Committee the list of individuals recommended for reappointment in the same medical staff category with the same clinical privileges they then hold. In addition, the Chairperson shall submit individual recommendations and the reasons therefore, for any changes recommended in staff category, in clinical privileges, or for non-reappointment both for those who applied for changes and those who did not.
- D. Recommendations for increase or decrease of clinical privileges shall be based upon:
  - 1. relevant recent training;
  - 2. observation of patient care provided;
  - 3. review of the records of patients treated in this or other hospitals;
  - 4. results of the hospital's and medical staff quality improvement activities; and
  - 5. other reasonable indicators of the individual's continuing qualifications for the privileges in question

5.2-4 **Credentials Committee Action**

- A. The Credentials Committee, after receiving recommendations from each department, shall review all pertinent information available including all information provided from other committees of the Staff and from hospital management, and from any for cause FPPE or OPPE for the purpose of determining its recommendations for Staff reappointment, for change in Staff category, and for the granting of clinical privileges for the ensuing appointment period.
- B. The Credentials Committee may require that a person currently seeking reappointment procure a physical and/or mental examination by a physician or physicians mutually acceptable to the person and the Credentials Committee either as part of the reapplication process or during the appointment period to aid it in determining whether clinical privileges should be granted or continued and make results available for the Credentials Committee's consideration.

Failure of the person seeking reappointment to procure such an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall constitute a voluntary relinquishment of all medical staff and clinical privileges until such time as the Credentials Committee has received the examination results and has had a reasonable opportunity to evaluate them and make a recommendation thereon.
- C. The Credentials Committee shall prepare a list of persons currently holding appointment who are recommended for reappointment without change in staff category and clinical privileges.

Recommendations for non-reappointment and for changes in category or privileges, with supporting data and reasons attached, shall be handled individually.

5.2-5 **Final Processing and Board Action**

The Credentials Committee shall transmit its report and recommendations to the Executive Committee in time for the Board to consider reappointments at its final scheduled meeting in each reappointment cycle. Where non-reappointment, non-promotion of an eligible current appointee, or a further limitation in clinical privileges is recommended, the reason for such recommendation shall be stated, documented and included in the report.

This report shall not be transmitted to the Board until the affected staff appointee has exercised or has been deemed to have waived his/her right to a hearing as provided in Article VIII of these Bylaws.

5.2-6 **Meeting with Affected Individual**

If, during the processing of a particular individual's reappointment, it becomes apparent to the Credentials Committee or its chairperson that the Committee is considering a recommendation that would deny reappointment, deny a requested change in staff category or clinical privileges, or reduce clinical privileges, the chairperson of the Credentials Committee shall notify the individual of the general tenor of the possible recommendation and ask him/her if he/she desires to meet with the committee prior to any final recommendation by the committee.

At such meeting, the affected individual shall be informed of the general nature of the evidence supporting the action contemplated and shall be invited to discuss, explain or refute it. This interview shall not constitute a hearing and none of the procedural rules provided in these Bylaws with respect to hearing shall apply nor shall minutes of the discussion in the meeting be kept. However, the committee shall indicate as part of its report to the Board whether such a meeting occurred.

5.2-7 **Procedure Thereafter**

Any recommendation by the Credentials Committee denying reappointment, denying a requested change in staff category or clinical privileges or recommending reduction of existing clinical privileges shall entitle the affected individual to the procedural rights provided in Article VIII of these Bylaws. The Administrator shall then promptly notify the individual of the recommendation by special notice.

The recommendation shall not be forwarded to the Board until the individual has exercised or has been deemed to have waived his/her right to a hearing as provided in Article VIII of these Bylaws, after which the Board shall be given the committee's final recommendation and shall act on it. If for any reason the application for reappointment has not been finally acted on by the Board prior to the end of the appointment year, the then current appointment and clinical privileges shall continue until final action on the application is taken by the Board.

## ARTICLE VI: CLINICAL PRIVILEGES

### 6.1 EXERCISE OF PRIVILEGES

All Staff appointees including Allied Health Professionals providing direct clinical services at the Hospital by virtue of Staff membership or otherwise shall, in connection with such practice and except as provided in Section 6.5 and 6.6, be entitled to exercise only those clinical privileges or provide patient care services as are specifically granted by the Board pursuant to the provisions of these Bylaws and Rules and Regulations.

### 6.2 DELINEATION OF PRIVILEGES

#### 6.2-1 Requests

Each application for appointment and reappointment to the staff shall contain a request for the clinical privileges desired by the applicant on the form prescribed by the Executive Committee and approved by the Board.

#### 6.2-2 Basis for Privileges Determination

Each individual who has been given an appointment to the Staff of the Hospital shall be entitled to exercise only those clinical privileges granted by the Board. The clinical privileges recommended to the Board shall be based upon the hospital's desire to perform the privilege, the presence of the resources needed to safely carry out the privilege, the applicant's education, training, experience, demonstrated current competence and judgment, references and other relevant information, including an appraisal by the chairperson of the clinical department in which such privileges are sought.

Such recommendations shall be forwarded to the Credentials Committee and thereafter processed as a part of the application for Staff appointment or reappointment.

#### 6.2-3 Procedure

All requests for clinical privileges shall be processed during initial appointment or during reappointment pursuant to the procedures outlined in Article V, or pursuant to the procedures outlined in this Article.

#### 6.2-4 Change in Clinical Privileges

Whenever, during the term of his/her appointment to the Staff, an individual desires to change his/her clinical privileges, the application shall be transmitted to the Department Chair for their review and will then submit the request to the Credentials Committee and from here the MEC for action.

If the request is to increase privilege(s), the application shall state in detail the specific additional clinical privileges desired and the applicant's relevant training and experience, which justify increased privileges. The hospital will perform a query of the National Practitioners Data Bank (NPDB) on any practitioner requesting a new privilege. The Chair will provide written verification of the training, education and current competency of the member to perform the requested privileges. The Chair will confirm with Administrator that the hospital has the intent and the resources to safely provide this service.

Thereafter, it will be processed in the same manner as an application for initial clinical privileges if the request is made during the term of appointment, or as a part of the reappointment application if the request is made at that time. The recommendation for such increased privileges may carry with it such requirements for supervision or consultation for such period of time as are deemed necessary.

## **6.3 CLINICAL PRIVILEGES FOR DENTISTS**

### **6.3-1 General Dentists**

Dentists shall not have admitting privileges. Request for clinical privileges for dentists shall be processed in the manner specified in Section 6.2. Surgical procedures performed by dentists shall be under the overall supervision of the Chairperson of the Department of Surgery. A medical history and physical examination of the patient shall be made and recorded by a physician who holds an active appointment to the Staff, and who shall be responsible for medical care of the patient throughout the period of hospitalization.

### **6.3-2 Oral Surgeons**

Oral Surgeons with clinical and admitting privileges shall perform a complete admission history and physical examination and assess the medical risks of the procedure on the patient if they are deemed qualified to do so by the Credentials Committee.

"Oral surgeons" shall be interpreted to refer to licensed dentists who have successfully completed a post-graduate program in oral surgery accredited by a nationally recognized accrediting body approved by the United States Office of Education.

### **6.3-3 Scope of Privileges**

The dentist shall be responsible for the dental care of the patient, including the dental history and dental physical examination as well as all appropriate elements of the patient's record.

Dentists may write orders within the scope of their privileges and in compliance with the Medical Staff Bylaws, and Rules and Regulations.

## **6.4 CLINICAL PRIVILEGES FOR PODIATRISTS**

### **6.4-1 General**

Requests for clinical privileges for podiatrists shall be processed in a manner specified in Section 6.2. Surgical procedures performed by podiatrists shall be under the overall supervision of the Chairperson of the Department of Surgery. A medical history and physical examination of the patient shall be made and recorded by a physician who holds an appointment to the Staff, and who shall be responsible for the medical care of the patient throughout the period of hospitalization.

### **6.4-2 Scope of Privileges**

The podiatrist shall be responsible for the podiatric care of the patient, including the podiatric history and podiatric physical examination as well as all appropriate elements of the patient's record. Podiatrists may write orders within the scope of their privileges and in compliance with the Medical Staff Bylaws, Rules and Regulations.

## **6.5 TEMPORARY PRIVILEGES**

### **6.5-1 Circumstances**

#### **A. Pendency of Application**

Temporary Privileges are granted by the Hospital only in the following circumstances:

When necessary to fulfill important patient care needs, the Hospital Administrator may, upon the basis of verified licensure and training, query of the NPDB, and Medicare sanction list, and reasonable information of current competence of the applicant, and upon recommendation of the applicable clinical department chairperson and the President of the Medical Staff, grant temporary admitting and clinical privileges to an applicant for a

specific time period, not to exceed ninety (90) days while the applicant's credentials are being further reviewed for medical staff membership and delineated clinical privileges.

In exercising such privileges, the applicant shall act under the supervision of the chairperson or his designee of the department in which he/she has requested primary privileges.

The following are non-exclusive examples of such situations to fulfill important patient care need:

1. When the only physician privileged to perform a highly specialized service becomes ill, disabled, or is otherwise unable to perform this service, a qualified physician may be brought in and given temporary privileges to provide this service while his or her credentials are being reviewed for medical staff membership and delineated clinical privileges.
2. A recently recruited applicant whose specialized training is needed to perform necessary procedures may be given temporary privileges while his or her credentials are being processed.

Primary source verification (documented phone call or fax information) of licensure and current competence [at least from the residency director (for recent post-graduate) and/or department chairperson of one (1) current hospital affiliation] is required prior to the granting of temporary privileges.

In exercising such privileges, the applicant shall act under the supervision of the chairperson or his designee of the department in which he/she has requested primary privileges.

**B. Care of Specific Patients**

Temporary admitting and clinical privileges for care of a specific patient or patients may be granted by the Hospital Administrator with the concurrence of the chairperson of the department concerned, Chairperson of the Credentials Committee and the President of the Staff to a physician who is not an applicant for appointment in the same manner and upon the same conditions as set forth in this Section. Such privileges shall be restricted to the specific patients for which they are granted and are subject to query of the NPDP and Medicare sanction list.

**6.5-2 Conditions**

- A. A complete application with no admission involuntary reduction, limitation, loss, or denial of clinical privileges at any previous institution verified by the NPDB.
- B. Temporary privileges shall be granted only when the information available reasonably supports a favorable determination regarding the requesting practitioner's qualifications, ability and judgment to exercise the privileges requested. Special requirements of supervision and reporting may be imposed by the department chairperson concerned on any individual granted temporary clinical privileges.
- C. Before temporary privileges are granted the practitioner must acknowledge in writing that he/she has received and read the Medical Staff Bylaws and Staff Rules and Regulations, and that he/she agrees to be bound by the terms thereof in all matters relating to his/her temporary privileges.

**6.5-3 Termination**

On the discovery of any information, or the occurrence of any event of a professionally questionable nature, pertinent to a practitioner's qualifications or ability to exercise any or all of the temporary privileges granted, the Administrator may after consultation with the department chairperson responsible for supervision, and the President of the Staff, terminate any or all of such practitioner's temporary privileges.

Where the life or well-being of a patient is determined to be endangered by continued treatment by the practitioner, the termination may be effected by any person entitled to impose summary suspensions under Article VIII of these Bylaws. In the event of any such termination, the practitioner's patient then in the hospital shall be assigned to another practitioner by the department chairperson responsible for supervision.

The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner. The terminated practitioner shall confer with the substitute practitioner to the extent necessary to safeguard the patient.

6.5-4 **Rights of the Practitioner**

A practitioner shall not be entitled to the procedural rights afforded by Article VIII of these Bylaws because of his/her inability to obtain temporary privileges or because of any termination or suspension of temporary privileges.

6.5-5 **Locum Tenens**

The Administrator may grant an individual serving as a locum tenens for a person holding an appointment to the Staff temporary admitting and clinical privileges to attend patients of that appointee for a period not to exceed thirty (30) days without applying for appointment to the Staff.

The Administrator may grant an extension of locum tenens privileges for thirty (30) days, a total not to exceed sixty (90) days.

This shall be done in the same manner and upon the same conditions as set forth in Section 6.5 of this Part, provided that the Administrator shall first obtain such individual's signed acknowledgement that he/she has received and had an opportunity to read copies of the Medical Staff Bylaws, and Staff Rules and Regulations, which are then in force and that he/she agrees to be bound by the terms thereof in all matters relating to his/her temporary clinical privileges. The individual serving as a locum tenens must also complete a request for clinical privileges form.

- A. Locum tenens membership to the Medical Staff may be granted to an individual who is substituting for a Medical Staff member while the staff member is on leave or vacation. Locum tenens membership may also be granted to an individual who will temporarily be filling a shortage or vacancy in a patient service department.
- B. Application for temporary membership in order to occupy a Locum Tenens position may be made to the Medical Staff Office.  
Locum Tenens appointments may be granted by the Hospital Administrator upon recommendation of the appropriate Department Chairperson, Credentials Committee Chairperson and the President of the Medical Staff limited to ninety (90) days.
- C. All candidates applying for Locum Tenens position shall have and present a valid and current license to practice medicine, dentistry or podiatry in the territory of Guam. The appropriate Medical Staff member for whom the Locum Tenens candidate will be substituting or the department chairperson shall send a letter to the President of the Medical Staff stating that the candidate is qualified to assume the staff member's work. Applicants for Locum Tenens shall possess comparable qualifications required for permanent membership on the staff, or as established by the department within which such privileges are set. It shall be responsibility of a Medical Staff member(s) to supervise the work of the Locum Tenens physician and provide consultations in difficult cases.
- D. Basic primary verification shall be obtained from the (1) National Practitioners Data Bank, (2) Medicare sanction list, (3) at least one of the current United States state license and the Guam medical license, (4) health status and (5) current clinical competence and judgment to exercise the privileges requested from the most recent hospital or clinical affiliation. Telephone verification of relevant training and experience (most recent hospital or clinical affiliation) and health status in terms of his/her ability to practice in the area in which

privileges are sought shall be done and documented accordingly by the appropriate Department Chairperson.

Before Locum Tenens privileges are granted, the practitioner must acknowledge in writing that s/he has received, or has been given access to, and read the Medical Staff Bylaws and Rules and Regulations and that s/he agrees to be bound by the terms thereof in all matters relating to his/her Locum Tenens.

Continued primary verification shall be completed on the other requirements for Medical Staff membership.

- E. Any unfavorable determination of an applicant will be grounds for denial of Locum Tenens privileges as recommended by the appropriate department chairperson, Chairman of the Credentials Committee, Associate Administrator of Medical Services or the President of the Medical Staff. The applicant shall not be entitled to the procedural rights afforded by Article VIII of these Bylaws because of inability to obtain Locum Tenens privileges.
- F. Practitioners granted locum tenens status will be assigned a proctor/mentor, and that individual will complete a Focused Professional Practice Evaluation (FPPE) regarding the practitioner at the mid-point of the locum tenens assignment.

#### 6.5-6 **Visiting Consultants**

##### A. Qualifications

- 1. Consultants who are of outstanding reputation may be granted consultation and clinical privileges by the Hospital Administrator with consultation of the requesting Clinical Medical Department Chairperson, Credentials Committee Chairperson, and President of the Medical Staff, and must be sponsored by the Department chairperson; and
- 2. The Consultant Appointment is not to exceed fifteen (15) days and is without admitting privileges; and
- 3. The Consultant is not presently seeking Medical Staff membership; and
- 4. The consultant physician should function in areas of patient care, teaching or research which are not otherwise readily available and/or has specialized skills needed infrequently at GMHA.

##### B. Prerogatives

- 1. See patients as a consultant upon the request of the primary physician.
- 2. Provide clinical instruction.
- 3. Exercise clinical privileges as delineated by the Chairperson of the respective Department, but not as attending, admitting or discharge physician.
- 4. Privileges are not renewable and must have a lapse time of no less than 30 days from the last expiration date for future consideration.
- 5. Attend Committee and Department meetings as the guest of the Chairperson. Does not vote or hold offices.

##### C. Responsibilities

- 1. Submit documents to the Medical Staff Office for review of background information and references in a curriculum vitae or resume form, and provide additional information, if requested by the department chairperson or the Hospital Administrator.
- 2. Submit current license(s) from any of the states or territories of the United States, including appropriate Guam license, certificate of exemption or other authorization from the Commission on Licensure. If hands on care is allowed primary source verification of licensure, training, education and current competency must be provided. Also NPDB and Medicare sanction review.
- 3. The Clinical Medical Department Chairperson will be held responsible for consultant's action(s) in the Hospital.

4. Agree to abide by the Medical Staff Bylaws and Rules and Regulations, Hospital Policies, and Federal and Guam laws.
5. Is not expected to accept committee and other assignments, accept Consultation Schedule assignment, attend patient(s), attend meetings or pay dues. The appointee may not vote and does not hold office (except with the concurrence of the member and the MEC).
6. If privileges are granted for telemedicine beyond image and tissue reports then the member is required to undergo training to assure that they know how to operate the equipment and also be formally privileged to provide the service.

## **6.6 EMERGENCY CLINICAL PRIVILEGES**

### **6.6-1 Definition**

For the purpose of this section, an "emergency" is defined as a condition which could result in serious or permanent harm to a patient, or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that harm or danger.

### **6.6-2 Conditions**

- A. In an emergency involving a particular patient, a physician who is not currently appointed to the Staff may be permitted by the Hospital Administrator to exercise clinical privileges to act in such emergency using all necessary facilities of the Hospital, including calling for any consultation necessary or desirable.
- B. Similarly, in an emergency involving a particular patient, a physician currently appointed to the Staff may be permitted by the Hospital to act in such emergency by exercising clinical privileges not specifically assigned to him/her.
- C. When the emergency situation no longer exists, such physician must request the temporary privileges necessary to continue to treat the patient. In the event such temporary privileges are denied or he does not request such privileges, the patient shall be assigned by the President of the Staff or his/her designee to an appropriate person currently appointed to the Staff. The wishes of the patient shall be considered in the selection of a substitute physician.

## **6.7 EMERGENCY CLINICAL PRIVILEGES FOR A MEDICAL DISASTER BY THE HOSPITAL ADMINISTRATOR:**

Temporary emergency clinical privileges may be granted to a practitioner (allied health professional or physician) actively practicing in Guam or currently licensed in any state or territory of the United States upon declaration by the Governor of Guam of "A State of Emergency".

Disaster privileges are granted only when the Emergency Management Plan has been activated and the Hospital is unable to meet immediate patient needs.

The following may grant temporary disaster privileges to licensed independent practitioners.

- 1) The Associate Administrator of Medical Services
- 2) The Chair of the Credentials Committee
- 3) The Chairperson of the Board or
- 4) Any department chairperson in a department requiring emergency providers

These privileges may be granted following:

- 1) Completion of the Disaster Privileges Form
- 2) Presentation of a valid government-issued photo identification issued by a state or federal agency (such as driver's license or passport)
- 3) At least one of the following:

- a) A current hospital identification card with professional designation identified
- b) A current license to practice
- c) A primary source of verification of license
- d) Identification that the individual is a member of a Defense Health Administrator (DHA), Virtual Medical Center (VMC) Disaster Medical Assistance Team (DMAT), Medical Reserve Corps (MRC) unit
- e) Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment and/or services in disaster circumstances (with such authority having been granted by a federal, state, or municipal entity), or
- f) Confirmation by a licensed practitioner currently privileged by the hospital or by a medical staff member who possesses personal knowledge regarding the clinical provider's ability to act as a licensed practitioner during a disaster.

These providers will wear a temporary identification badge that readily identifies them as having Disaster Privileges. As soon as the immediate situation is under control, the Associate Administrator of Medical Services will contact the Medical Staff Office to advise that Disaster Privileges have been granted and will forward the original Disaster Privileges forms. The Medical Staff Office will then verify each practitioner's information with primary source verification of licensure completed as soon as possible, but at least within seventy-two (72) hours before the provider has been granted disaster privileges. If for any reason, the primary source verification of licensure cannot be completed within seventy-two hours, the Medical Staff Office will document the following:

- 1) Why the primary source verification could not be performed
- 2) Evidence of a demonstrated ability to continue to provide adequate care, treatment and services
- 3) Evidence of the attempt to perform primary source verification as soon as possible. Primary source verification of licensure is not required if the licensed independent practitioner has not provided care, or services under the disaster privileges.

The Medical Staff will oversee the professional practice of the providers through direct observation, mentoring, or medical record review and make a decision within seventy-two hours as to whether or not to continue the disaster privileges initially granted. When the hospital has determined that the emergency management plan is no longer needed, all disaster privileges will immediately terminate.

## **6.8 TELEMEDICINE PRIVILEGES**

### **A. DEFINITION OF TELEMEDICINE PRIVILEGES**

"Telemedicine Privileges" means the authorization granted by the Board of Trustees to a Practitioner not residing on Guam to render a diagnosis of a patient at the Hospital through the use of electronic communication or other communications technologies. The Practitioner licensed on Guam will be an active member and may provide direct patient care. In the event of a Public Health Emergency declared by the President of the United States or a State of Emergency declared by the Governor of Guam, as permitted by law and regulation, providers with telemedicine privileges may render patient care, and may write orders independently, within the scopes of their consultation.

### **B. REQUIRED DOCUMENTATION**

Any Practitioner who wishes to be considered for Telemedicine Privileges will provide the following documentation to the Medical Staff Office (MSO) or its designee:

1. Signed consent and release/authorization form;
2. Current Guam license to practice medicine, unless exempted by Guam Law from that requirement;
3. Curriculum Vitae;
4. Current copy of DEA and state controlled substance certificate, if applicable;
5. Evidence of no exclusion from any federal health care program;
6. Evidence of medical staff appointment and clinical privileges in good standing at another hospital/organization.

a. If the telemedicine practitioner is a member of a group of a medical institution, such as an accredited hospital or medical educational institution, the published practitioner directory will be acceptable evidence of the practitioners' appointment and clinical privileges in good standing; and,

7. Such additional information as may be requested by the Hospital.

#### C. REQUIRED VERIFICATIONS

The following verifications will be completed by the Medical Staff Office (MSO) or its designee:

1. Query to the National Practitioner Data Bank;
2. Query to determine that the Practitioner has not been excluded from any federal health care program;
3. Verification of the Practitioner's medical staff status at the Practitioner's primary Joint Commission accredited or equivalent hospital/organization;
4. Verification of the Practitioner's medical license(s) in the Practitioner's primary state and the state in which telemedicine services will be provided (when applicable);
5. Verification of the Practitioner's current DEA status (when applicable); and
6. Verification of the Practitioner's current board status (when applicable).

#### D. ACTIONS TO BE TAKEN

1. The Medical Executive Committee, in consultation with the Chief Executive Officer, will determine the specific services to be provided at the Hospital via telemedicine; and will make such recommendation to the Board of Trustees.
2. The Medical Executive Committee will make a recommendation to the Board of Trustees regarding whether the Practitioner's request for Telemedicine Privileges should be granted. The decision of the Board of Trustees will be final.

#### E. ANNUAL REVIEW

All Practitioners who have been granted Telemedicine Privileges will be reviewed, and all information regarding such Practitioners will be re-verified, on an annual basis.

#### F. OBLIGATION TO REPORT

A Practitioner who has been granted Telemedicine Privileges will immediately report to the Chief Executive Officer the loss or suspension of any license, certificate or authorization described above. Such loss or suspension will result in the immediate and automatic relinquishment of any and all Telemedicine Privileges with no right to a hearing or an appeal as outlined in these Bylaws. If telemedicine services are being provided at the Hospital through a contracted group, it will be the responsibility of the contracted group to notify the Medical Staff Office (MSO) or its designee of any Practitioner who requires Telemedicine Privileges and of any Practitioner who no longer needs to maintain Telemedicine Privileges.

#### G. PROVISION OF DIRECT PATIENT CARE

If any Practitioner who has been granted Telemedicine Privileges intends to direct patient care or to provide "hands-on" patient care, such Practitioner will be required to apply for an active Medical Staff membership and clinical privileges at the Hospital prior to the provision of any such direct patient care.

## **ARTICLE VII: ALLIED HEALTH PROFESSIONALS**

### **7.1 GENERAL**

#### **7.1-1 Qualifications**

Any non-physician provider, such as a Certified Registered Nurse Midwife (CRNM), Certified Registered Nurse Anesthetist (CRNA), Physician's Assistant (PA-C) and Nurse Practitioner (NP) who possesses a license, certificate or other legal credentials, if any, required by Guam law to provide patient care services in a hospital setting, as approved by the respective Guam licensing board may apply for hospital appointment as an Allied Health Professional. Certified Registered Nurse Anesthetists (CRNA) are classified as Licensed Independent Practitioners in the Territory of Guam.

#### **7.1-2 Responsibilities**

Allied Health Professionals must practice within the scope of their license and scope of practice agreement as well as the privileges granted them by the Board. They must:

- A. Provide care to at least four hospital patients per year at the generally recognized professional level of quality and efficiency
- B. Abide by the relevant sections of the Medical Staff bylaws and by all other lawful standards, policies and rules of Guam Memorial Hospital Authority;
- C. Discharge such staff, department (service), committee and hospital functions for which he/she is responsible by staff category assignment, appointment, election, or otherwise;
- D. Prepare and complete in a timely fashion any documentation relevant to patient care provided; and
- E. Abide by the ethical and moral principles of the relevant profession.
- F. Participate in the Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) process thru evaluation by their respective department and/or sponsoring physician.

#### **7.1-3 Prerogatives**

Allied Health Professionals may:

- A. Those AHP's who by law require supervision may provide services upon direct order and under the supervision and direction of the Guam Memorial Hospital Medical Staff. AHP's who by law may practice independently may provide services under their scope of practice without additional supervision.
- B. Provide specified patient care services upon direct order and under the supervision and direction of the Guam Memorial Hospital Medical Staff.
- C. Write orders but not beyond the scope of the Allied Health Professional's license, certificate or other credentials;
- D. Serve on staff, department (service), and hospital committees as requested;
- E. Attend meetings of department (service), and committees, as requested;
- F. Exercise such other prerogatives as shall be, by resolution or written policy, duly adopted by any of the medical staff departments or committees and approved by the Medical Executive Committee and the Board to be accorded to the Allied Health Professionals.

### **7.2 APPOINTMENT AND REAPPOINTMENT**

#### **7.2-1 Application**

An Allied Health Professional making initial application shall submit a written application on a prescribed form to the Medical Staff Office.

- A. The applicant accepts the obligation of providing all information requested in support of the application.
- B. The applicant authorizes Guam Memorial Hospital Authority to consult with appointees of medical staffs, hospital administrations, and other professional contacts with whom the applicant has been previously associated.
- C. The applicant consents to the Hospital's inspection of all records and documents such as school diplomas, state and territory licenses, and certificates of membership in professional societies and organizations.
- D. The applicant consents to the Hospital's query of the National Practitioner Data Bank.

7.2-2 **Content of Application**

The application shall include, at a minimum, the following information:

- A. Professional education and training;
- B. Professional experience;
- C. Other professional qualifications;
- D. Written evidence of current Guam license, certificate or other legal credentials, required by Guam law;
- E. Letters of reference from at least three practitioners who are knowledgeable about the applicant's professional competence and ethical character. The letters of reference must also include the (6) ACGME competencies just as the medical staff peer letter must.
- F. Any instance in which the applicant has been subject to legal action based upon an allegation of medical malpractice, including a summary of the allegation, the names of the person or persons making such allegation, and the disposition of the allegation against the Allied Health Professional;
- G. Any instance in which the Allied Health Professional's license, certificate or other legal credential, has ever been suspended or challenged by a state or territory licensing board in any jurisdiction;
- H. Whether the applicant has ever been refused admission, renewal or suffered suspension, or reduction of practice privileges at any other institution;
- I. A specific request for particular hospital assignments and delineated practice privileges;
- J. A disclosure of malpractice insurance coverage status;
- K. Information relating to the applicant's current physical and mental health;
- L. Information relating to the candidate's adherence to professional ethical principles".
- M. Applicants must submit a police and court clearance. Clearances must be less than three (3) months from date of application. Off-island applicant shall obtain the police and court clearances from the last place of residence.
- N. Agreement to abide by those regulations imposed on the hospital by regulatory agencies and laws.

**7.3 ACTION ON INITIAL APPOINTMENT**

7.3-1 **Department Action**

Upon receipt of an application from an Allied Health Professional, the Supervisor of the Medical Staff Office shall review the application for completeness.

An incomplete application shall be returned to the applicant for completion and resubmission.

Upon determining that an application is complete, the Medical Staff Office shall transmit the completed application to the chairperson of the appropriate clinical department in which the applicant seeks practice privileges. The chairperson of the clinical department shall forward recommendations to the Credentials Committee.

### 7.3-2 **Credentials Committee Review**

Upon receipt of a completed application, the Credentials Committee shall expeditiously proceed to:

- A. Review and investigate the character, health, qualifications and professional competence of the applicant;
- B. Review the results of the query of the National Practitioner Data Bank;
- C. Verify the accuracy of the information contained in the application; and
- D. Request a written opinion from the chairperson of the appropriate clinical department in which the applicant is seeking privileges indicating whether the applicant should be granted the privileges requested, and the scope of the privileges to be granted.

### 7.3-3 **Credentials Committee Action**

Unless the applicant consents to a longer period of time, within ninety days of receipt of the completed application, the Credentials Committee shall make a written report of its review to the Medical Executive Committee. Such report shall include a recommendation that the applicant be:

- A. Appointed as an Allied Health Professional;
- B. Deferred for further consideration; or
- C. Rejected.

The report of the Credentials Committee shall include specific recommendations for delineating the applicant's privileges.

## 7.4 **EXECUTIVE COMMITTEE ACTION ON INITIAL APPOINTMENT**

### 7.4-1 **Executive Committee Action**

At the next regular Medical Executive Committee meeting after the Credentials Committee forwards its report to the Medical Executive Committee, the Medical Executive Committee will consider the report of the Credentials Committee and determine the recommendation to be made to the Board.

- A. If the recommendation of the Medical Executive Committee is that the applicant should be appointed, the Medical Executive Committee shall also specifically recommend the privileges to be granted.
- B. If the recommendation of the Medical Executive Committee is to defer action on the application for further consideration, the Medical Executive Committee communicates this information to the applicant. It must specify the specific procedures and time limits that will be used to make a subsequent recommendation on its acceptance, rejection, or limitation of the applicant's privileges.
- C. If the Medical Executive Committee's recommendation is that the applicant should be rejected or that the practice privileges granted to the applicant should be less than requested by the applicant, the Administrator shall promptly notify the applicant by certified mail, or return receipt requested, of the Medical Executive Committee's recommendation. No such adverse recommendation shall be transmitted to the Board until the applicant has exercised or has been deemed to waive his or her rights for departmental review under Section 10 of this Article.

## 7.5 **TERM OF APPOINTMENT**

### 7.5-1 **Board Action**

The Board shall grant all Allied Health Professional appointments and clinical privileges. The initial appointment shall be made provisional for a twelve-month period. Thereafter, the member shall be subject to reappointment as set forth in Section 6 of this Part.

7.5-2 **Assignment of Sponsor**

All Allied Health Professionals shall be assigned to a department. Those AHP's who by law require supervision will be supervised by one or more sponsoring practitioners assigned to the AHP. AHP's who by law may practice independently may provide services within their scope of practice without additional supervision and thus do not require the assignment or sponsorship of another medical staff member.

7.5-3 **Suspension of Privileges**

Notwithstanding the provisions of this Section 7.5, the privileges of any Allied Health Professional may be suspended or revoked at any time pursuant to Sections 7.8 and 7.9 of this Part, and the applicable provisions of the governing documents of Guam Memorial Hospital Authority.

**7.6 REAPPRAISAL AND REAPPOINTMENT**

7.6-1 **Term**

Reappointments by the Board shall be hospital and Unit specific and be for a maximum of two years, based upon a recommendation of the Board's Joint Advisory Committee.

7.6-2 **Application**

A. At least one hundred twenty days prior to the expiration of the term of appointment, the Medical Staff Office shall begin review of all pertinent information available for the purpose of making a recommendation on the Allied Health Professional's reappointment and for the granting of privileges during the term of such appointment.

The Medical Staff Office will obtain in writing and forward to the Department Chair for review:

1. Any change from the information provided in the initial application
2. Any change in the privileges;
3. The basis for any request for a change in privileges;
4. The extent of the Allied Health Professional's continuing education efforts since the last appointment or reappointment;
5. The Allied Health Professional's malpractice insurance coverage status.

B. The Department Chair will review the application and forward it to the Credentials Committee with his recommendation.

7.6-3 **Review of Application**

Simultaneously, the Credentials Committee will obtain, at a minimum, the following information from the appropriate Department Chairperson:

- A. A peer evaluation of the Allied Health Professional's performance, judgment, and, when appropriate, technical skill;
- B. Whether the Allied Health Professional has any physical or mental impairments that interfere with his/her ability;
- C. Whether the member maintains timely, accurate and complete records;
- D. Performance patterns as demonstrated by reviews and evaluations; In the absence of insufficient internal quality data, the Chair will submit a letter of recommendation containing the six ACGME competencies.
- E. The Allied Health Professional's ability to work with members of the Medical Staff and with Guam Memorial Hospital Authority personnel;
- F. Quality improvement and risk management information; and

G. Any other relevant factors.

7.6-4 **CREDENTIALS COMMITTEE ACTION**

After determining that the Allied Health Professional has a satisfactory response from the National Practitioner Data Bank, the Credentials Committee shall transmit its recommendations in writing to the Medical Executive Committee.

7.6-5 **MEDICAL EXECUTIVE COMMITTEE ACTION**

At least thirty days prior to the expiration of the appointment, the Medical Executive Committee shall make written recommendations to the Board of Trustees concerning the reappointment, non-reappointment, and/or revision of privileges of each Allied Health Professional then scheduled for periodic appraisal.

In each step above, when non-reappointment or a change in the practice privilege is recommended, the reason for such recommendation shall be stated and documented.

Changes in privileges at reappointment time are for a provisional period as with initial appointment and privilege delineation.

**7.7 PROVISIONAL PERIOD**

Allied Health Professionals will serve in a provisional status for a minimum of twelve months to allow sufficient time for evaluation. During this provisional period their professional competence, ethical and moral conduct shall be observed by the appropriate Department Chairperson or designee.

At the end of the twelve-month provisional period, the appropriate Department Chairperson will submit a written report to the Medical Executive Committee via the Credentials Committee indicating whether the Allied Health Professional is recommended for full appointment or whether the provisional period should be extended, indicating the recommended period of time.

**7.8 SUMMARY SUSPENSION**

7.8-1 **Procedure**

The Administrator, at any time believing that it is in the best interest of patient care, may summarily suspend all or a portion of the practice privileges of an Allied Health Professional on the recommendation or with a concurrence of:

- A. The Chairperson of a Department of the Staff or;
- B. The President of the Staff or;
- C. The Board.

7.8-2 **Notification**

The Administrator shall notify the Allied Health Professional, Department Chairperson, and Medical Executive Committee of such summary suspension.

**7.9 AUTOMATIC SUSPENSION**

7.9-1 **License**

Any Allied Health Professional whose license or certificate is revoked or suspended shall automatically have all privileges at Guam Memorial Hospital Authority revoked.

7.9-2 **Medical Records**

An automatic suspension of all clinical privileges shall be imposed for failure to complete medical records as detailed in Medical Staff Rules and Regulations, and shall remain in effect until the incomplete medical records are completed.

## **7.10 DEPARTMENT REVIEW**

Allied Health Professional shall be entitled to the same Fair Hearing Plan as other Medical Staff Members as set forth in Article VIII of these Bylaws.

### **7.10-1 Grievance Procedure**

- A. When any Allied Health Professional receives written notice from the Department Chairperson, Medical Executive Committee, or Administrator that will adversely affect that appointment or re-appointment and delineation of privileges, his or her hospital's status or exercise of privileges, that individual shall be entitled to file an appeal. Such grievance shall be filed with the Chairperson of the Department to which the Allied Health Professional has applied or been assigned and in which he/she has applied for or has exercised privileges. This must be submitted within fifteen days of receiving notice.
- B. Upon receipt of such an appeal, the Department Chairperson shall appoint a Committee to review the proposed action. The Department Committee shall include if available, one or more Allied Health Professionals having the same or similar license or certification as the affected Allied Health Professional.
- C. The Committee shall initiate an investigation and the Allied Health Professional shall be afforded the opportunity for an interview before the Departmental Committee within 45 days of receipt of the appeal. At the interview, the Allied Health Professional may provide information relevant to the circumstances giving rise as to the proposed action.
- D. A record of the findings and recommendations of such review shall be made to the Medical Executive Committee.
- E. The decision of the Medical Executive Committee shall be final.

## **7.11 ALLIED HEALTH PROFESSIONALS' RELEASE FROM LIABILITY**

All Allied Health Professionals agree to release and give full immunity from civil liability and to execute any requested releases, in the same manner and to the same extent as is provided in the appropriate sections of Article XIII of these Bylaws.

# ARTICLE VIII: CORRECTIVE ACTION AND FAIR HEARING PLAN

## 8.1 ROUTINE CORRECTIVE ACTION

### 8.1-1 Criteria for Initiation

Whenever the activities or professional conduct of any Staff member are believed to be detrimental to patient safety or to the delivery of quality patient care, or believed to be disruptive to hospital operations, or are believed to be in violation of these Bylaws, Staff Rules and Regulations, department rules, or other hospital policies, corrective action against such staff member may be initiated by any officer of the Staff, by the chairperson of any department or standing committee of the Staff, by the Administrator or by the Board. Initiation of corrective action pursuant to Section 8.1 of this Part does not preclude imposition of summary suspension as provided for in Section 8.2 of this Part. Any persons with concerns should notify any of these authorized individuals mentioned above.

### 8.1-2 Requests and Notices

All requests for corrective action shall be in writing, submitted to the Medical Executive Committee, and supported by reference to the specific conduct or activities which constitute grounds for the request. The President of the Staff shall promptly notify the Administrator in writing of all requests for corrective action received by the committee and shall continue to keep the Administrator fully informed of all action taken in connection therewith.

### 8.1-3 Investigation

The Medical Executive Committee shall either reject the request and report the reasons for its decision to the Administrator, or forward the request either to the chairperson of the department in which the questioned activities or conduct occurred, or to an impartial ad hoc committee appointed by the Executive Committee, to conduct the investigation.

Alternatively, the Executive Committee may itself conduct the investigation. The staff member who is under investigation may be invited to appear before the investigating committee.

Any such appearance shall be informal in nature and shall not constitute a hearing. Within thirty days after the receipt of the request, the investigating committee if other than the Medical Executive Committee itself, shall forward a written report of the investigation to the Medical Executive Committee.

### 8.1-4 Executive Committee Action

Within thirty days following such report, the Medical Executive Committee shall take action. Such action may include, without limitation:

- A. Rejecting the request for corrective action;
- B. Issuing a warning, a letter of admonition, or letter of reprimand;
- C. Recommending documentation of physical and mental health status by a physician(s) acceptable to the Medical Executive Committee;
- D. Recommending terms of probation or requirements of consultation; or as required additional medical education for recognized deficiency;
- E. Recommending reduction, suspension or revocation of clinical privileges;
- F. Recommending reduction of staff category or limitation of any staff prerogatives directly related to patient care; and
- G. Recommending suspension or revocation of staff appointment.

8.1-5 **Board Option**

When the Medical Executive Committee, after the review of a report of investigation or after the review of a summary suspension imposed pursuant to Section 8.2-1, determines that corrective action be taken, the Medical Executive Committee shall report such determination to the Administrator and to the Board.

Within sixty days after the report from the Medical Executive Committee, the Board shall take action.

8.1-6 **Procedural Rights**

Any adverse action by the Board pursuant to Sections 8.1-4 D, E, F, or G, or any combination of such actions or action by the Board pursuant to Section 8.1 shall entitle the staff member to the procedural rights as provided in the Fair Hearing Plan for Medical Staff Members, which is appended to and made a part of these Bylaws.

**8.2 SUMMARY SUSPENSION**

8.2-1 **Criteria for Initiation**

Whenever a staff member willfully disregards or grossly violates these Bylaws, Staff Rules and Regulations, or other hospital policies, or whenever his/her conduct requires that immediate action be taken to protect the life of any patient or to reduce the substantial likelihood of immediate injury or damage to the health or safety of any patient, employee or other person present in the hospital, or whenever the conduct of the staff member disrupts the operations of any department or unit of the hospital, the President of the Staff, a chairperson of the respective department or the Medical Executive Committee, shall have the authority to suspend summarily the staff appointment, or all or any portion of the clinical privileges, of such staff member.

Such summary suspension shall become effective immediately upon imposition, and the President shall promptly give written notice to the Medical Executive Committee and the Administrator of such action.

8.2-2 **Executive Committee Action**

Within fifteen days after such summary suspension, the Medical Executive Committee shall meet and may recommend modification, continuation or termination of the terms of the summary suspension.

8.2-3 **Procedural Rights**

Unless the Medical Executive Committee recommends immediate termination of the suspension and cessation of all further corrective action, the staff member shall be entitled to the procedural rights as provided in the Fair Hearing Plan of the Medical Staff, which is appended to and made a part of these Bylaws. The terms of the summary suspension as sustained or modified by the Medical Executive Committee shall remain in effect pending a final decision by the Board.

**8.3 AUTOMATIC SUSPENSION**

8.3-1 **License**

If a staff member's license to practice his/her profession in the Territory of Guam is revoked or suspended, such staff member shall immediately and automatically be suspended from practicing in the Hospital.

8.3-2 **Drug Enforcement Administration (DEA) Number**

A staff member whose DEA license is revoked or suspended or voluntarily relinquished shall immediately and automatically be divested of his/her right to prescribe medications covered by such number. A staff member who has his/her DEA license revoked, or suspended, or voluntarily relinquished, shall, in writing, inform the department chairperson, or President of the Staff, or the Medical Executive Committee of the facts surrounding this action.

8.3-3 **Failure to Satisfy Special Appearance Requirement**

A staff member who fails to satisfy the requirements of Section 10.6-3 of these Bylaws shall immediately and automatically be suspended from exercising all or such portion of his/her clinical privileges in accordance with the provision of said Section 10.6-3.

8.3-4 **Conviction of a Felony**

Upon conviction of a felony of a staff member in any court of the United States, either federal, state, or territory, the member's staff appointment is automatically revoked. Revocation pursuant to this section of the Bylaws does not preclude the staff member from subsequently reapplying for staff appointment. *(As used in this paragraph, the term "conviction" shall include a finding or verdict of guilt, a plea of guilty, or a plea of nolo contendere in a criminal proceeding, regardless of whether the adjudication of guilt or sentence is withheld or not entered thereon.)*

8.3-5 **Medical Records**

An automatic suspension of all clinical privileges shall be imposed for failure to complete medical records as detailed in Medical Staff Rules and Regulations, and shall remain in effect until the incomplete medical records are complete.

**8.4 NOTIFICATION**

Once a decision to suspend a practitioner's privileges is made, all reasonable efforts shall be made to notify the practitioner by the Hospital Administrator or his designee.

**8.5 CONTINUITY OF PATIENT CARE**

Upon imposition of summary suspension or the occurrence of an automatic suspension, the President of the Staff with the concurrence of the chairperson of the department to which the suspended staff member is assigned shall provide for alternative coverage for the suspended staff member's patients in the Hospital. The wishes of the patient will be considered, where feasible, in choosing a substitute practitioner. The suspended staff member shall confer with the substitute practitioner to the extent necessary to safeguard the patient.

**8.6 FAIR HEARING PLAN**

The Fair Hearing Plan for Medical Staff Members appended to and made a part of these Bylaws shall govern the procedure for hearings, special hearings, and appellate reviews.

**8.7 NATIONAL PRACTITIONER DATA BANK**

8.7-1 **Requirements**

Title IV of Public Law 99-660, the Healthcare Quality Improvement Act of 1986, as amended requires the Hospital to report to and request information from the National Practitioner Data Bank as follows:

- A. Report to the Guam Commission on Licensure, within fifteen (15) days, an adverse professional review action taken against a physician or dentist;

- B. Report to the Guam Board of Licensure, within fifteen (15) days, a voluntary surrender of a practitioner's membership or privileges if the physician, dentist or podiatrist was under investigation for professional competence or conduct concerns;
- C. Report revisions to professional review actions noted in A. and B. of this section; and
- D. Query the National Practitioner Data Bank on initial application and each two years for physicians, dentists, podiatrists and allied health professionals who maintain clinical privileges at the Hospital.
- E. Comply with the Current National Practitioner Data Bank Guidebook, and all pertinent National Practitioner Data Bank updates.

## **ARTICLE IX: STRUCTURE OF THE STAFF**

### **9.1 MEDICAL STAFF YEAR**

For the purpose of these Bylaws the medical staff year commences on the first day of October and ends on the thirtieth day of September of each year.

### **9.2 QUALIFICATIONS OF OFFICERS**

To be eligible for nomination to an office the candidate must be an Active member of any of the Medical Staff in good standing.

### **9.3 ELECTION OF OFFICERS**

#### **9.3-1 Nominations**

- A. Eligible nominations for Medical Staff Officers shall be obtained by any of the following methods:
  - 1. Nominations from the Medical Staff.
  - 2. Nominations from the Medical Executive Committee.
- B. The above Nomination methods must be presented at the general staff meeting 3 months prior to the election.

#### **9.3-2 Election**

Officers shall be elected at the July Quarterly Meeting of the Medical Staff election year. Voting shall be by secret ballot, and voting by proxy shall not be permitted. If members are unable to attend this meeting, they may cast their vote in the Medical Staff Office in person or via email 30 days before the election or until 3 days after the meeting. A nominee shall be elected upon receiving a majority of the votes cast by Provisional and Active Staff members. If no candidate for the office receives a majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes.

### **9.4 TERM OF OFFICE**

Elected officers shall hold an office for a period of two years and no more than four consecutive years.

### **9.5 DUTIES OF OFFICERS**

#### **9.5-1 President**

The President of the Staff shall:

- A. Act as the chief medical officer of the Hospital, in coordination and cooperation with the Administrator in matters of mutual concern involving the Hospital;
- B. Call, preside at and be responsible for the agenda of all general meetings of the Staff;
- C. Make recommendations for appointment of committee chairmen and members, in accordance with the provisions of these Bylaws, to all standing and special Staff committees except the Executive Committee;
- D. Serve as Chair of the Executive Committee; serve as a member of the Joint Conference Committee;
- E. Serve as *ex-officio* member of all medical staff committees other than the Executive Committee; with vote;
- F. Represent the view, policies, needs and grievances of the Staff and report on the medical activities of the Staff to the Board and to the Administrator; attend the Board Joint

Advisory Committee and Board of Trustees meetings; and serve as a voting member of the QA/I Steering Council.

- G. Provide day-to-day liaison on medical matters the Administrator and the Board; and
- H. Receive and interpret the policies of the Board to the Staff and report to the Board on the performance and maintenance of quality with respect to the delegated responsibility of the Staff to provide medical care.

9.5-2 **Vice-President**

The Vice-President shall:

- A. Serve on the Medical Executive Committee; serve as a member of the Joint Conference Committee;
- B. In the temporary absence of the President, assume all the duties and have the authority of the President;
- C. Perform such additional duties and responsibilities as may be delegated by the President, the Medical Executive Committee or the Board.

9.5-3 **Secretary**

The Secretary of Staff shall:

- A. Serve on the Medical Executive Committee; serve as a member of the Joint Conference Committee;
- B. Cause to be kept accurate and complete minutes of all Medical Executive Committee and Staff meetings;
- C. Call Staff meetings on order of the President and record attendance; and
- D. Attend to all correspondence and perform such other duties as ordinarily pertain to this office.
- E. Assume the duties and responsibilities of the President and Vice-President of the Staff in their absence.

9.5-4 **Immediate Past President**

The Immediate Past President shall:

- A. Serve on the Medical Executive Committee; and
- B. Serve as a voting member of the Board's Quality Assessment/Improvement Steering Council; and
- C. Perform such additional or special duties as shall be assigned by the President, the Medical Executive Committee, or the Board

**9.6 ABSENCE OF MEDICAL STAFF OFFICERS**

In the event that the President of the Staff, Vice-President of the Staff and Secretary of the Staff are absent at the same time, the Immediate Past President shall assume all the duties of the President of the Staff. If s/he is not available, the Chairman of the Credentials Committee will then assume those duties.

**9.7 REMOVAL OF OFFICERS**

- 9.7-1 An officer shall be removed from office by a majority (50%+1) of a minimum of two-thirds of the Active and Provisional Staff eligible to vote in favor of removal, and provided that the Medical Executive Committee concurs. Grounds for removal shall include, but not be limited to, mental and/or physical impairment and inability to perform the duties and responsibilities of the office.

9.7-2 Action directed towards removing an officer may be initiated by the Medical Executive Committee or by a petition seeking removal of an officer, signed by not less than twenty-five percent (25%) of the Active and Provisional Staff with voting rights and filed with the Medical Executive Committee, in care of the President or the Vice-President if the action is directed towards the President. The officer shall be afforded the opportunity to speak on his/her behalf prior to the taking of any vote on his/her removal.

- A. The petition shall be presented at the next meeting of the Committee, which shall verify the signatures and the requisite number.
- B. If the petition complies with this section, the Committee shall instruct that a ballot to each Active and Provisional member of the Medical Staff be mailed or delivered. These ballots shall be returnable to the President not more than 20 days from the date of such mailing or delivery.
- C. The ballot shall be in the following form: "Shall Dr. \_\_\_\_\_ be recalled as \_\_\_\_\_ of the Medical Staff? Yes \_\_\_ No \_\_\_. Vote, and return this ballot to the Medical Staff Office on or before\_\_\_\_\_."
- D. The President shall present the ballots at the next Medical Executive Committee meeting following the date of the recall election and they shall be counted by a teller appointed by the Medical Executive Committee.  
If an officer is recalled, he/she will be relieved of his/her duties as of the date of such Medical Executive Committee meeting and a successor shall be appointed as provided in Section 9.9 concerning vacancies.

## **9.8 REVIEW OF RESPONSIBILITIES**

Prior to taking office, all newly elected staff officers shall meet with the Administrator of Guam Memorial Hospital Authority or designee to be orientated to the responsibilities of the office which may include the review of the Medical Staff Bylaws, Rules and Regulations and JCAHO standards.

## **9.9 VACANCIES IN OFFICE**

If there is a vacancy in the office of the President prior to the expiration of the President's term, the Vice-President shall assume the duties and authority of the President for the remainder of the unexpired term. If there is a vacancy in any other office, the Medical Executive Committee shall appoint another Active Staff member to serve out the remainder of the unexpired term. Appointed Officers may not ascend to the office of Acting President unless elected by the Medical Staff at the next regular general staff meeting. Nominations should be made available to the Medical Staff as soon as possible.

## **ARTICLE X: MEETINGS**

### **10.1 GENERAL STAFF MEETINGS**

#### **10.1-1 Regular Meeting**

The Staff shall hold a regular meeting in October, January, April and July of each year. During a Medical Staff election year, the election of officers will be held in July. In the event of natural disaster or holiday, the meeting will be rescheduled within thirty days.

#### **10.1-2 Order of Business and Agenda**

The order of business at a regular meeting shall be determined by the President and shall include:

- A. Minutes of the last meeting;
- B. Old and new business;
- C. Reports from committees;
- D. Election of officers, when required by these Bylaws;
- E. Announcements by staff officers and staff departments; and
- F. Any other business deemed appropriate.

#### **10.1-3 Minutes and Attendance**

The proceedings of general staff meetings shall be recorded, including attendance and votes taken. The minutes shall be signed by the presiding officer and filed in the Medical Staff Office. Attendance at general staff meetings shall be limited to members of the Staff, the Administration of the Hospital, the Board of Trustees, and others invited by the President and/or the Administrator of the Hospital.

### **10.2 SPECIAL GENERAL STAFF MEETINGS**

#### **10.2-1 Special Meetings**

Special meetings of the Staff may be called at any time by the Board, the President of the Staff, the Medical Executive Committee, or shall be called by the President of the Staff within fifteen days after receipt of a written request of at least twenty-five percent of the members of the Active Staff, and shall be held at the time and place designated in the meeting notice. No business shall be transacted at any special meeting except that stated in the meeting notice.

#### **10.2-2 Notice of Meetings**

Typed or printed notice stating the place, day and hour of any special meeting of the Staff shall be delivered to each member of the Active and Provisional Staffs not less than seven days nor more than nine days before the date of such meeting by or at the direction of the President.

The notice of the meeting shall be deemed delivered when sent by electronic media, courier, or United States mail addressed to each staff member at his/her address as it appears on the records of Guam Memorial Hospital Authority. Sufficient notice may be supplemented, but not replaced by other methods. The attendance of a member of the Staff shall constitute a waiver of notice of such meeting.

#### **10.2-3 Agenda**

The Agenda at special meetings shall be:

- A. Reading of the notice calling the meeting;
- B. Transaction of business for which the meeting was called; and
- C. Adjournment.

10.2-4 **Minutes and Attendance**

The proceedings of special general staff meetings shall be recorded, including attendance and votes taken. The minutes shall be signed by the presiding officer and filed in the Medical Staff Office. Attendance at special general staff meetings shall be limited to members of the Staff, the Administration of the Hospital, the Board, and others invited by the President and/or the Administrator of the Hospital.

**10.3 QUORUM**

Fifteen (15%) percent of those members, who are eligible to vote and have signed in, shall constitute a quorum for any regular or special meeting of the Staff. A quorum once having been found, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the meeting. The exception would be for items not on the agenda unless approved by a quorum present.

**10.4 DEPARTMENT AND COMMITTEE MEETINGS**

10.4-1 **Department Meetings**

Members of each department shall meet as a department quarterly, but no less frequently than three meetings yearly. A time shall be set by the chairperson of the department to review and evaluate the clinical work of the department. The agenda for the meeting and its general conduct shall be set by the chairperson.

10.4-2 **Committee Meetings**

The agenda, general conduct and time for the following committees shall be set by the chairperson.

- A. The following shall meet more frequently than quarterly:
  - 1. Medical Executive Committee
  - 2. Clinical Departments' Multidisciplinary Working Committees
  - 3. Special Care Committee
  - 4. Credentials Committee
- B. The following committee shall meet at least Quarterly but no less than three meetings yearly:
  - 1. Continuing Education (CE) Committee
- C. Unless otherwise indicated, all other Committee listed in Section XII, Committees of the Staff, shall meet as needed, but no less frequently than three meetings yearly.

10.4-3 **Special Department and Committee Meetings**

A special meeting of any committee or department may be called by or at the request of the chairperson, by the President or by a petition signed by no less than one-fourth of the members of the department or committee.

In the event that it is necessary for a committee or department to act on a question without being able to meet, the voting members may be presented with the question, in person or by mail or other verifiable means, and their vote returned to the chairperson of the department or committee. Such a vote shall be binding so long as the question is voted on by a majority of the department or committee eligible to vote.

#### 10.4-4 **Quorum**

- A. The presence of fifteen (15%) percent of the total membership of the department or committee eligible to vote at any regular or special meeting (but no fewer than one medical staff member) shall constitute a quorum for all actions.
- B. When a Medical Staff Committee has a multidisciplinary composition, a quorum shall consist of fifteen (15%) percent of the total membership of the committee.
- C. Once a quorum has been established, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the meeting.

#### 10.4-5 **Minutes**

Minutes of each meeting of each department and committee shall be prepared and shall include a record of the attendance of members, of the recommendations made and of the votes taken on each matter.

The minutes shall be signed by the presiding officer and copies thereof shall be promptly forwarded to the Medical Executive Committee, the Administrator, and to committees as specified elsewhere in these Bylaws. All minutes shall be maintained by the Medical Staff Office.

### **10.5 PROVISIONS COMMON TO ALL DEPARTMENT AND COMMITTEE MEETINGS**

#### 10.5-1 **Notice of Meetings**

Notice of regular meetings of the medical staff and regular meetings of departments and committees shall be distributed at least five days before such meetings. The attendance of any individual at any meeting shall constitute a waiver of that individual's notice of said meeting.

#### 10.5-2 **Rules of Order**

Wherever they do not conflict with these Bylaws, the currently revised Robert's Rules of Order shall govern all meetings and elections.

#### 10.5-3 **Voting**

Any individual who, by virtue of position, attends a meeting in more than one capacity shall be entitled to only one vote.

### **10.6 ATTENDANCE REQUIREMENTS**

10.6-1 **Each Active and Provisional Staff** appointee shall be required to attend meetings in each medical staff year:

- A. At least fifty percent of all the regular Quarterly General Medical Staff and departmental meetings; and
- B. At least fifty percent of the collective total of meetings of the department's Multi-Disciplinary Working committees and committees to which s/he is assigned annually by the President of the Medical Staff or by the Department Chairperson.

10.6-2 Staff Members with **Locum tenens** or **Temporary Privileges** and **Active Associate members** shall attend departmental and departmental Multi-Disciplinary Working Subcommittee meetings as determined by the department.

10.6-3 **Visiting Consultants, Honorary and Courtesy Staff** members may attend meetings.

10.6-4 **Absence from Meetings**

- A. Failure to meet the attendance requirements of Section 10.6-1 shall be grounds for any corrective action specified in Article VIII and, in addition, removal from such department or committee unless the Executive Committee finds that the submitted reasons for absences are valid. Reinstatement of a staff member whose membership has been revoked because of absence from meetings shall be made only on application, and any such application shall be processed in the same manner as an application for initial appointment.
- B. Failure to meet attendance requirements may be grounds for recommendation for reappointment for one year and such application at the end of the one-year reappointment shall be processed in the same manner as an application for initial appointment relative to being assessed an application fee.
- C. Repeated failure to meet attendance requirements after a one-year reappointment for failure to meet attendance requirements shall be grounds for recommendation for six months reappointment and such application at the end of the six months reappointment shall be processed in the same manner as an application for initial appointment.
- D. Medical Staff who are members of the United States Armed Forces in a reserve capacity shall be exempt from routine meeting attendance requirements when those activities occur during periods when they are in a drill status, active recall, on orders, or involved in military operations in an official capacity. Members are to submit proof of membership in the armed forces. Medical Staff members may not be required to document activities of a classified nature.

# ARTICLE XI: CLINICAL DEPARTMENTS

## 11.1 DEFINITION

All members of the Staff shall hold membership in a clinical department. A clinical department is defined as consisting of at least five Active and Provisional members who practice the same specialty, choose to be identified as a department, have a chairperson, hold regular meetings, have appropriate Rules and Regulations for the department (which shall be reviewed by the department every two years), and are designated a department by the Medical Executive Committee and the Board. Those specialty or sub-specialty areas not meeting all of these criteria will be services within a department.

## 11.2 DEPARTMENTS

### 11.2-1 List of Departments

The following clinical departments are established.

- A. Medicine
- B. Surgery
- C. Obstetrics and Gynecology
- D. Pediatrics
- E. Family/General Practice
- F. Emergency Medicine
- G. Anesthesiology
- H. Radiology

### 11.2-2 Hospital Service Departments

Hospital Clinical Services are established with the recommendation of the Medical Executive Committee and as approved by the Board of Trustees. Each Hospital Clinical Service shall be directed by a member of an appropriate Clinical Department.

In the absence of the Clinical Services Director or his/her designee, the Hospital Administrator, in consultation with the President of the Medical Staff, will appoint an acting Director.

### 11.2-3 Additional Departments

Other departments and clinical services may be established at the recommendation of the Medical Executive Committee or Hospital Administrator with the approval of the Board.

## 11.3 CONTRACT DEPARTMENTS/SERVICES

Contracted Staff member, group or department will be governed by all rules and regulations of Staff and departmental membership. When a department/service has a contractual arrangement with the Hospital, the following requirements shall be met:

### 11.3-1 Staff Privileges

Privileges must be obtained by all practitioners who are under contractual agreements for patient care services.

- a. If the practitioner is a member of a group of a medical institution, such as an accredited hospital or medical educational institution, the published practitioner directory will be acceptable evidence of the practitioners' appointment and clinical privileges in good standing.

### 11.3-2 Termination of Staff Membership and Privileges

Staff membership and privileges of physicians in a contract department/service shall not be terminated without the same due process provisions provided for other members of the Staff.

## 11.4 ASSIGNMENT TO DEPARTMENTS

Each member of the Staff shall be granted membership in at least one department, by the Staff and the Board, and may be granted clinical privileges and attendant responsibilities in one or more department.

Responsibility for determining qualifications belongs within the department(s) recommending the granting in these clinical privileges. The exercise of clinical privileges within any department shall be subject to the Rules and Regulations of that department.

## 11.5 FUNCTIONS OF DEPARTMENTS

The primary responsibility delegated to each department is to implement and conduct specific monitoring and evaluation activities that contribute to the preservation and improvement of the quality and appropriateness of patient care provided in the department. To carry out this responsibility, each department shall:

- 11.5-1 Participates in retrospective, concurrent, and prospective activities for the purpose of monitoring and evaluating the quality and appropriateness patient care within the department. Each department shall review all clinical work performed under its jurisdiction;
- 11.5-2 Recommend to the Credentials Committee written criteria for the assignment of clinical privileges within the department (service). Such criteria shall be consistent with and subject to the Bylaws, policies, and Rules and Regulations of the Staff and Hospital.
- 11.5.3 Conduct or participate in programs by selecting cases for presentation at its meetings that will contribute to the continuing education of the members of the department. Such presentations should include cases involving deaths or complications, quality improvement clinical monitors, appropriateness and safety of patient care, and such other cases believed to be important, such as those involving patients currently in the Hospital with unsolved clinical problems.
- 11.5-4 Monitor, on a continuing and concurrent basis, adherence to:
  - A. Staff and hospital policies and procedures;
  - B. Requirements for alternate coverage for consultation;
  - C. Sound principles of clinical practice;
  - D. Fire and other regulations designed to promote patient safety.
- 11.5-5 Coordinate the patient care provided by the department's members with nursing and ancillary patient care services and with the administrative support services;
- 11.5-6 Submit copies of minutes to the Executive Committee. Such minutes will reflect:
  - A. Findings of the department's monitoring and evaluation activities, actions taken thereon, and the results of such actions;
  - B. Recommendations for maintaining and improving the quality of care provided in the department and the Hospital; and

C. Such other matters as may be requested from time to time by the Executive Committee.

11.5-7 Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it.

11.5-8 Report to the Medical Executive Committee after each meeting detailing its analysis of patient care and to the Credentials Committee whenever further investigation and appropriate action involving any individual member of the department is indicated.

## **11.6 DEPARTMENT ORGANIZATION**

### **11.6-1 Department Chairperson**

Each department of the Staff shall have a Chairperson who shall be responsible for supervising the professional work of its members and shall be responsible for the programs and activities conducted by the department.

Department Chairpersons shall be responsible for monitoring standards of care within the department consistent with the standards of the Hospital, including surveillance of professional performance, Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE).

The Department Chairperson shall be responsible to the Executive Committee for the performance of his/her duties within the department.

Periodically, the Department Chairperson shall confer with the administrative staff and the nursing staff of the Hospital regarding the functioning of the Department, quality and safety of services, orientation, assessment and maintenance of the surveillance of quality improvement programs, professional performance, OPPE and FPPE.

The additional specific duties for each Department Chairperson shall be delineated in the Rules and Regulations for that department.

### **11.6-2 Qualifications of Department Chairpersons**

The Department Chairperson shall be an Active member of the Staff and is certified by an appropriate specialty board or affirmatively establishes, through the privilege delineation process, that he/she has comparable competence. Additional qualifications must be specified by the individual Staff departments in their Rules and Regulations. These individuals must be members in good standing of the Staff during the tenure of their office.

### **11.6-3 Selection of Department Chairpersons/Vice Chairpersons**

A. The Chairpersons/Vice Chairpersons of the following departments shall be elected on odd-numbered years: Family/General Practice, Obstetrics and Gynecology, Surgery, and Anesthesiology.

B. The Chairpersons/Vice Chairpersons of the following departments shall be elected on even-numbered years: Medicine, Pediatrics and Emergency Medicine.

C. The Chairpersons or Vice-Chairpersons shall be elected by a simple majority of the members of the department who are eligible to vote.

### **11.6-4 Term of Office**

Department Chairpersons/Vice Chairpersons shall serve a term of two (2) staff years and until a successor is elected. A department chairperson/vice chairperson shall be eligible to serve two consecutive terms, or a total of four (4) years.

### **11.6-5 Removal from Office**

Removal of a Chairperson or Vice-Chairperson during the term of office shall require a two-thirds vote of all Active and Provisional Staff appointees in the department through secret ballot or as determined by the Department.

11.6-6 **Absence of Department Chair or Vice-Chair**

In the absence of the Department Chair, the Department Vice-Chair, or his/her designee, the President of the Medical Staff will temporarily appoint an acting Chairperson.

## ARTICLE XII: COMMITTEES OF THE STAFF

### 12.1 DESIGNATION, STRUCTURE AND FUNCTION

There shall be such standing and special committees of the staff as may from time to time be necessary and desirable to perform the functions of the staff required by these Bylaws, the Quality Assessment and Improvement Process or necessarily incidental thereto.

#### 12.1-1 Key Committees

The following shall be standing committees of the Staff:

- A. Medical Executive Committee
- B. Joint Conference Committee
- C. Credentials Committee
- D. Clinical Departments' Multidisciplinary Working Committees
- E. Departments' Medical Staff Peer Review Subcommittees
- F. Infection Control Committee
- G. Bylaws Committee
- H. Special Care Committee
- I. Continuing Education (CE) Committee
- J. Institutional Review Board
- K. Tumor Board/Oncology Committee
- L. Pharmacy & Therapeutics Committee
- M. Tissue & Transfusion Committee
- N. Clinical Emergency Preparedness Team Committee

#### 12.1-2 Chairpersons

- A. All medical staff committee and clinical departments' Multidisciplinary Working Subcommittee chairpersons, unless otherwise provided for in these Bylaws, will be appointed by the President of the Medical Staff subject to the approval of the Medical Executive Committee.  
All chairpersons shall be selected from among persons appointed to the Active Staff. After serving an initial term of one year, a chairperson may be reappointed by the President of the Medical Staff or the department chairperson, as appropriate, for a maximum of three additional yearly terms.
- B. Co-Chairpersons of the Multidisciplinary Subcommittees shall be the appropriate nurse director and shall be appointed by the Assistant Administrator of Nursing Services. The term of office for the co-chairperson shall be for an indefinite period.
- C. The Chairpersons of all medical staff committees shall have the responsibility of ensuring that committee meetings are held and conducted in accordance with these bylaws.
- D. The Chairman identified in Bylaws 12.1-1 as being members of the Medical Executive Committee are expected to attend all MEC meetings. If a Chairman is not available for the MEC meeting, he/she may designate a representative to attend as proxy.
- E. If the Chairman of a committee has 2 consecutive unexcused absences from meetings of the committee of which he/she is Chairman, then it will be the responsibility of the MEC Chairman to speak with the Chairman of that committee and reschedule the meeting immediately. If the Chairman of a committee has 2 consecutive unexcused absences from meetings of the MEC, then it will be the responsibility of the MEC Chairman to counsel the Chairman of that committee.
- F. If the Chairman of a committee has 3 consecutive unexcused absences from meetings either of the committee of which he/she is Chair or of the MEC, then it will be the responsibility of the MEC Chairman to appoint a new Chairman of the committee.

- G. It will be the responsibility of the MEC Chairman to report to the Board of Trustees any committee which does not meet 3 consecutive times as scheduled by the Bylaws, regardless of the reason for not meeting.

#### 12.1-3 **Members**

- A. Medical staff members of each committee and subcommittee, except as otherwise provided for in these Bylaws, shall be appointed yearly by the President of the Staff, not more than ten (10) days after the end of the medical staff year, with no limitation in the number of terms they may serve. All appointed medical staff members may be removed and vacancies filled by the President of the Staff at his/her discretion.
- B. All appointed non-physician staff (sub) committee members may be removed and vacancies filled by the appropriate Hospital Administrative staff. Non-physician staff (sub) committee members or their respective designees, unless otherwise designated as ex-officio, shall be members, with vote, on all multidisciplinary (sub) committees.
- C. Members of committees may designate a member of the medical staff to act as a proxy member in their absence. The proxy will have voting rights in accordance with these bylaws.
- D. The Chairman identified in Bylaws 12.1-1 as being members of the Medical Executive Committee are expected to attend all MEC meetings. If a Chairman is not available for the MEC meeting, he/she may designate a representative to attend as proxy.
- E. If the Chairman of a committee has 2 consecutive unexcused absences from meetings of the committee of which he/she is Chairman, then it will be the responsibility of the MEC Chairman to speak with the Chairman of that committee and reschedule the meeting immediately. If the Chairman of a committee has 2 consecutive unexcused absences from meetings of the MEC, then it will be the responsibility of the MEC Chairman to counsel the Chairman of that committee.
- F. If the Chairman of a committee has 3 consecutive unexcused absences from meetings either of the committee of which he/she is Chair or of the MEC, then it will be the responsibility of the MEC Chairman to appoint a new Chairman of the committee.
- G. It will be the responsibility of the MEC Chairman to report to the Board of Trustees any committee which does not meet 3 consecutive times as scheduled by the Bylaws, regardless of the reason for not meeting.

#### 12.1-4 **Conflict of Interest**

In any instance where a member of a (sub) committee has a conflict of interest in any matter involving another staff appointee that comes before the (sub) committee, or in any instance where a member of a (sub)committee brought the complaint against that appointee, that member shall not participate in the discussion or voting on the matter and shall absent himself/herself from the meeting during that time, although he/she may be asked and answer any questions concerning the matter before leaving.

## 12.2 **MEDICAL EXECUTIVE COMMITTEE**

#### 12.2-1 **Composition**

The Medical Executive Committee shall consist of the officers of the Staff, the chairpersons of each clinical department, the Associate Administrator Medical Services, and those key committee chairpersons as indicated in Section 12.1-1 and clinical service directors as determined by the Medical Executive Committee. The Associate Administrator of Medical Services (Medical Director) shall serve as ex-officio member, without vote. The President of the Staff shall serve as Chairperson of the Medical Executive Committee.

#### 12.2-2 **Duties**

The Medical Executive Committee will be responsible for taking leadership in the hospital's quality, performance improvement and patient safety activities.

The duties of the Executive Committee shall be to:

- A. Represent and to act on behalf of the Staff in all matters, without requirement of subsequent approval by the Staff, between meetings of the Staff, subject only to any limitations imposed by these Bylaws;
- B. Coordinate the activities and general policies of the various departments;
- C. Receive and act upon those committee reports as specified in these Bylaws, and to make recommendations concerning them to the Administrator and the Board;
- D. Implement policies of the Staff that are not the responsibility of the departments;
- E. Provide liaison among Medical Staff, the Administrator, and the Board;
- F. Keep the Staff abreast of applicable accreditation and regulatory requirements affecting the hospital;
- G. Enforce hospital and Medical Staff rules in the best interest of patient care and of the Hospital on the part of all persons who hold appointment to the Staff;
- H. Recommend initial and reappointments to the Credentials Committee, the MEC, and the Board.  
Refer situations involving questions of the clinical competence, patient care and treatment, case management or inappropriate behavior of any Staff appointees to the Credentials Committee for appropriate action in accordance with Article V: Appointment and Reappointment and Article VI: Clinical Privileges;
- I. Be responsible to the Board for implementation of the hospital's quality improvement plan as it affects the Staff;
- J. Review the Bylaws, Rules and Regulations of the Staff and associated documents and recommend such changes thereto as may be necessary or desirable;
- K. Determine minimum continuing education requirements for appointees to the Staff.
- L. Coordinate development of and approve the mission and the strategies of the hospital.

#### 12.2-3 **Meetings, Reports and Recommendations**

The Executive Committee shall meet at least once each month or more often if necessary to transact pending business.

The Secretary will maintain reports of all meetings, which reports shall include the minutes of the various committees and departments of the Staff.

Copies of all minutes and reports of the Executive Committee shall be transmitted to the Administrator routinely as prepared, and important actions of the Executive Committee shall be reported to the Staff as a part of the Executive Committee's report at each regular general staff meeting.

Recommendations of the Executive Committee shall be transmitted to the Board with a copy to the Administrator.

The Chairperson of the Executive Committee, his/her representative and such members of his/her committee as may be necessary shall be available to meet with the Board or its applicable committee on all recommendations that the Executive Committee may make.

Between meetings of the Executive Committee, an ad hoc committee composed of the officers of the Staff and the chairperson of the MEC shall be empowered to act in situations of urgent or confidential concern where not prohibited by these Bylaws

## **12.3 JOINT CONFERENCE COMMITTEE**

### **12.3-1 Composition**

The Committee shall be comprised of three members of the Medical Staff: The President, Vice-President and the Secretary

### **12.3-2 Function**

The Medical Staff will notify the Board Chair of their desire to meet. The Board Chair will then assign three Board members to meet with the physicians. The Joint Conference Committee shall be convened to provide a forum for the Medical Staff and Board of Trustees to discuss areas of mutual concern that are related to hospital policy and practice. These meetings shall be informational and be an additional avenue for communication between the Medical Staff and the Board of Trustees.

### **12.3-3 Meetings, Reports and Recommendations**

The committee shall meet as often as necessary. The committee shall maintain a permanent record of its proceedings and actions, and shall report its recommendations to the Board.

## **12.4 CREDENTIALS COMMITTEE**

### **12.4-1 Composition**

The Credentials Committee shall be composed of a minimum of six Active members of the Staff representing all clinical departments, the Chairperson of the Special Care Committee or his/her designee and the Administrator.

### **12.4-2 Functions**

The duties and responsibilities of the Credentials Committee shall be to:

- A. Investigate and evaluate the credentials, qualifications, behavior, and competence of each applicant for appointment and periodic reappointment to the Staff;
- B. Review and approve the planned components of the department's FPPE and its outcomes and triggers. It will also approve or reject the initial proposed FPPEs for all department applicants as well as focused FPPEs based upon cause.
- C. Prior to granting a privilege, the Credentials Committee must determine if the resources necessary to support the requested privileges are currently available or available within a specific time frame
- D. Recommend acceptance or rejection of an applicant. A recommendation for acceptance shall include a clear delineation of clinical privileges;
- E. Review and recommend requests for change of category of membership or privileges;
- F. Investigate any breach of ethics which is reported to it;
- G. Investigate all reports of suspected practitioner impairment and to function in accordance with guidelines established by the Committee;
- H. Review National Practitioner Data Bank reports.

### **12.4-3 Meetings, Reports and Recommendations**

The Credentials Committee shall meet as often as necessary to accomplish its duties but no less than three meeting a year and shall maintain a permanent record of its proceedings and actions, and shall report its recommendations to the Executive Committee, the Administrator, and the Board. The chairperson of the Credentials Committee, the chairperson's representative or such members of the committee as are deemed necessary shall be available to meet with the Board or its applicable committee on all recommendations that the Credentials Committee may make.

## **12.5 CLINICAL DEPARTMENTS' MULTIDISCIPLINARY WORKING COMMITTEES**

### **12.5-1 Composition**

The Clinical Departments' Multidisciplinary Working Committees shall consist of the Chairperson or Vice-Chairperson of the appropriate department, the Associate Administrator of Medical Services, the assigned head nurse as Co-Chairperson, the assigned physicians, representatives from Administration, Pharmacy, Laboratory, Social Service, and others asked to participate, as needed.

### **12.5-2 Duties**

The duties of the Clinical Departments' Multidisciplinary Working Committees shall be:

- A. Initiate and/or serve on assigned and approved quality assessment and improvement process and/or control activities.
- B. Report the results of all activity to the appropriate department chairperson and/or clinical department.
- C. See duties responsibilities listed under Bylaws section 11.5 FUNCTIONS OF THE DEPARTMENT.

## **12.6 MEDICAL STAFF PEER REVIEW SUBCOMMITTEES**

### **12.6-1 Composition**

The Medical Staff Peer Review Subcommittee shall consist of the Department Chairperson, assigned physicians, and Associate Administrator Medical Services.

### **12.6-2 Duties**

The duties of the Medical Staff Peer Review Subcommittees shall be:

- A. Conduct peer review on individual cases;
- B. Utilize findings to evaluate practitioners;
- C. Assist the clinical director in recommending appointment, reappointment and clinical privileges for practitioners to the Credentials Committee;
- D. Recommend and/or conduct education as needed;
- E. Initiate and/or serve on special task forces as necessary; and
- F. Report the results of all activity to the appropriate department chairperson and/or clinical department.

## **12.7 INFECTION CONTROL COMMITTEE**

### **12.7-1 Composition**

The Infection Control Committee shall be a multi-disciplinary committee of the Hospital and shall consist of one Staff appointee from each of the major clinical departments of Medicine, Surgery, Obstetrics and Gynecology, Family Practice, Emergency Medicine and Pediatrics. The Committee shall also include at least one Pathologist, and representatives from Nursing, Housekeeping, Operating Room, Labor and Delivery, Pharmacy, Infection Control and Hospital Management appointed by the Administrator. The Chairperson shall be a physician whose credentials document knowledge of and special interest or experience in infection control.

### **12.7-2 Duties**

The Infection Control Committee shall be responsible for the surveillance of inadvertent hospital infection potentials, the review and analysis of actual infections, the review and

approval all policies and procedures related to the infection surveillance, prevention, and control activities in all departments/services in accordance with established standards, the promotion of a preventive and corrective program designed to minimize infection hazards, report the summary of all activity to the Medical Executive Committee and Quality Assessment & Improvement Steering Council and the supervision of infection control in all phases of the Hospital's activities.

12.7-3 **Meetings, Reports and Recommendations**

The Infection Control Committee shall meet not less than quarterly, shall maintain a permanent record of its findings, proceedings and actions, and shall make a report thereof after each meeting to the Medical Executive Committee, the Hospital Administrator, the Assistant Administrator of Nursing Services and the Quality Management Department Director.

**12.8 BYLAWS COMMITTEE**

12.8-1 **Composition**

The Bylaws Committee shall be composed of at least four (4) Active Staff appointees. The Chairman shall not be the chairman of a department.

12.8-2 **Duties**

The Bylaws Committee shall review the Bylaws of the Staff and associated documents and recommend amendments thereto to the Medical Executive Committee. This review shall include, but not be limited to, the Staff Rules and Regulations, and policies and procedures of the Staff. In addition, the committee shall receive and consider all recommendations for changes in these Bylaws by the Board, any committee or department of the Staff, the Administrator, and any individual appointed to the Staff.

12.8-3 **Meetings, Reports and Recommendations**

The Bylaws Committee shall meet as often as necessary, but not less than annually, to fulfill its duties, shall maintain a permanent record of its activities, and shall report its recommendations to the Executive Committee.

**12.9 SPECIAL CARE COMMITTEE**

12.9-1 **Composition**

The Special Care Committee shall consist of at least one representative with Admit or Consult ICU/CCU privileges from each of the clinical departments listed in Section 11.2-1, Internal Medicine (Cardiologist, Nephrologist), Surgery(Operating Room Medical Director), Pediatric(Neonatologist, PICU Medical Director), OB/GYN, Emergency Medicine, Anesthesiology, Radiology, the ICU/CCU Medical Director, the Medical Director of Respiratory Therapy, the Medical Director of Hemodialysis, the Hospital Medical Director, the Assistant Administrator Nursing Services, ICU/CCU Unit Supervisor, Hemodialysis Unit Supervisor, and the Chief of Respiratory Therapy/Cardiopulmonary.

12.9-2 **Duties**

The duties of the Special Care Committee shall be to:

- A. Develop and recommend approval of policies relating to medical, nursing, and ancillary care of patients in ICU/CCU, Hemodialysis, and Medical-Telemetry;
- B. Develop and recommend criteria for non-core privileges for ICU/CCU, Hemodialysis; and
- C. Recommend methods for training physicians, nurses, and ancillary personnel on specialized care of patients.
- D. Responsible for Quality Assessment and Performance Improvement (QAPI) Program for ICU/CCU, Hemodialysis, Medical Telemetry

12.9-3 **Meetings, Reports and Recommendations**

The Special Care Committee shall meet monthly, but not less than ten (10) meetings per year shall be held, shall make a permanent record of its findings, proceedings and actions, and shall make a report thereof to the Executive Committee.

**12.10 CONTINUING EDUCATION (CE) COMMITTEE**

12.10-1 **Composition**

The CE Committee shall consist of three or more representatives of the active staff, a representative from the medical staff office, a representative from the education department and may also include members from other departments of the hospital such as nursing, allied health, compliance, and risk management.

12.10-2 **Duties**

The CE Committee shall recommend purchases or deletion of medical resources, materials, equipment including internet service access and/or subscriptions for the medical staff and patient education.

The CE Committee will maintain CME accreditation under the ACCME. The CE committee will assign hospital departments to present CE activities on a regular schedule based on the ACGME core competencies.

The CE Committee will develop educational activities relevant to the community and hospital needs. The CE Committee will review mandatory training for medical staff members.

12.10-3 **Meetings, Reports and Recommendations**

The CE Committee shall meet at least quarterly, shall maintain a permanent record of its findings, proceedings and actions, and shall make a report thereof to the Medical Executive Committee.

**12.11 INSTITUTIONAL REVIEW BOARD**

12.11-1 **Composition**

The Institutional Review Board shall be a Hospital Committee and shall consist of appointees from the departments of Surgery and Medicine, Chief Pathologist, physician with oversight responsibility for research at the Hospital, Pastoral Care Coordinator, a representative from the University of Guam Research Council, and the Administrator.

12.11-2 **Duties**

The Institutional Review Board shall review, approve, and monitor all aspects of research. The additional specific duties for the Institutional Review Board shall be delineated in the Rules and Regulations of the Institutional Review Board.

12.11-3 **Meetings, Reports and Recommendations**

The Institutional Review Board shall meet as often as necessary, but not less than semiannually, shall maintain a permanent record of its findings, proceedings and actions, and shall make a report thereof to the Executive Committee and the Administrator.

## **12.12 ONCOLOGY/TUMOR BOARD COMMITTEE**

### **12.12-1 Composition**

The Oncology/Tumor Board Committee shall consist of at least one Active Medical Staff representative from Pathology, Radiology/Nuclear Medicine, Oncology/Internal Medicine, Surgery, and Obstetrics & Gynecology. The Committee shall also include a representative from the Social Services Department and the Nursing Services Department.

If an invasive neoplasm occurs in a specialty not represented on the Oncology/Tumor Board Committee (i.e., Orthopedics), a member of that specialty will be requested by the Chairperson to be present at the committee meeting.

### **12.12-2 Duties**

The duties of the Oncology/Tumor Board Committee shall be to:

- A. Provide consultation, at the request of the attending physician, for the diagnosis, staging and treatment of cancer cases. The attending physician must be present during the meeting.
- B. Monitor and promote quality and appropriateness of diagnostic and treatment activities in the hospital setting.
- C. Conduct reviews of all cancer cases diagnosed or treated in the hospital. This will initially consist of the review of a list of diagnosed cancer cases which is provided on a monthly basis by the Pathology Department. The Chairperson or Committee will decide if any cases merit further study. This may consist of chart review, or the Chairperson may request the attending physician to present the case. Periodic review of cases in selected sites may be performed.

### **12.12-3 Meetings, Reports and Recommendations**

The Oncology/Tumor Board Committee shall meet as needed, but not less than quarterly, at the discretion of the Chairperson; shall maintain a permanent record of the cases reviewed to include the site discussed and official recommendations for treatment or further diagnosis(es); and shall make the pertinent report thereof after each meeting to the Medical Executive Committee and appropriate Social Service representative.

## **12.13 PHARMACY AND THERAPEUTICS COMMITTEE**

### **12.13-1 Composition**

The Pharmacy and Therapeutics Committee shall consist of a representative from the medical staff clinical departments of Emergency Medicine, Family/General Practice, Medicine, Obstetrics/Gynecology, Pediatrics and Surgery. The Committee shall also include the Chief Pharmacist and representatives from Administration, Nursing and Nursing Education.

The Chairperson shall be a physician appointed by the President of the Medical Staff. The Co-Chair shall be the Chief Pharmacist appointed by the Hospital Administrator.

### **12.13-2 Duties**

The Committee shall have the following responsibilities in the improvement of the quality of medical care:

- A. Maintain a hospital formulary.
- B. Create policies and procedures for the safe selection, procurement, distribution and administration of medications.
- C. Approve the use of medications in clinical trials, and hospital participation in studies of investigational medications.
- D. Approve antidotes and other medications to be kept in emergency areas.
- E. Review the use of medications. Review adverse drug events, near misses, and pharmacy interventions
- F. Participate in the continuing education of the professional staff (physicians, nurses, pharmacists and other health-care practitioners).

12.13-3 **Meetings, Reports and Recommendations**

The Pharmacy and Therapeutics Committee shall meet as often as necessary to transact its business, but at least quarterly, shall maintain a permanent record of its findings, proceedings and actions, and shall make a report thereof after each meeting to the medical staff departments, the Special Care Committee and the Medical Executive Committee.

**12.14 TISSUE & TRANFUSION COMMITTEE**

12.14-1 **Composition**

The Tissue & Transfusion Committee shall consist of at least one (1) Surgeon, one (1) Obstetrician/Gynecologist, one (1) Family Practitioner, one (1) Hematologist/ Oncologist, one (1) Radiation Oncologist, two (2) Pathologist, one (1) Internal Medicine, one (1) Nursing Supervisor, one (1) from Medical Laboratory Department, one (1) Administrator/ Designee.

12.14-2 **Duties**

The duties of the Tissue & Transfusion Committee Shall:

**Tissue Review Functions**

1. Systematically measure processes involving operative and other invasive procedures on a continuing basis including, at least, the following.
  - a. Selecting appropriate procedures.
  - b. Preparing the patient for the procedure,
  - c. Performing the procedure and monitoring the patient, and
  - d. Providing post procedure care.
 

Conduct reviews to document that post procedure monitoring includes pathological findings, when appropriate, 91% to 100% of the time.
2. Be responsible for policies, procedures, guidelines, reporting requirements, and continuing medical education of Tumor Board cases.

**Blood Utilization Review Functions:**

The Tissue & Transfusion Committee shall:

1. Measure the use of blood and blood components in a systematic and continuing manner which include, at least, the following processes:
  - a. Ordering
  - b. Distributing, handling and dispensing,
  - c. Administration, and
  - d. Monitoring the blood and blood components effects on patients.
2. Determine and use appropriate statistically valid sample size bases on the following the following guidelines;
  - a. If the average number of cases per quarter is more than 600, at least 5% of cases are reviewed; and

- b. If the average number of cases per quarter is fewer than 600, at least 30 cases are reviewed.

#### 12.14-3 Meetings, Reports and Recommendations

1. The Tissue & Transfusion Committee Shall Meet as often as necessary at the discretion of the Chairperson, but at least monthly. It shall maintain a record of its proceedings and shall report on its activities and recommendations to the Medical Executive Committee.
2. The Committee's findings, conclusions, recommendation and actions taken to improve the hospital-wide performance relating to tissue and blood and blood components shall be communicated to appropriate medical staff members.
3. When the findings of the assessment processes are relevant to an individual's performance, there is documentation that 100% of such cases are reviewed. If steps are taken for further review, final recommendations and any actions and follow-up are documented.

### 12.15 SPECIAL COMMITTEES

Special committees shall be created and their members and chairpersons shall be appointed by the President of the Staff. Such committees shall confine their activities to the purpose for which they were appointed, and shall report to the Executive Committee.

### 12.16 CLINICAL EMERGENCY PREPAREDNESS TEAM COMMITTEE

#### 12.16-1 Composition

- a. The Clinical Emergency Preparedness Committee shall consist of a multi-disciplinary team consisting of members from the Active/Provisional Medical Staff that could be from each of the following defined medical staff specialties: Critical Care (includes Intensive Care and Hemodialysis), Emergency Medicine, Internal Medicine, Radiology, Infectious Disease, Pediatrics, Anesthesia, Surgery, Special Services and OB/GYN.
- b. It may also include members from defined clinical, Nursing and Ancillary Specialties: Critical Care, Clinical Pharmacists, Chief of Pharmacy, representative from the Environment of Care Committee, Infectious Disease, Clinical Social Worker and Nursing Leadership.
- c. Depending on the clinical emergency, specific members may be chosen by the Associate Administrator of Medical Services (AAMS), Associate Administrator of Clinical Services (AACS), and activated by the Chief Executive Officer (CEO) of GMHA.
- d. The Clinical Emergency Preparedness Committee will be under the Medical Executive Committee with the chairperson nominated by the MEC, and appointed by the MEC president. The chair will be eligible for a stipend and the ability to bill for administrative hours as outlined in the GMH Pandemic plan.

#### 12.16-2 Duties

The Clinical Emergency Preparedness Committee shall:

- a. Provide leadership as the clinical arm while working closely with the Operations Environment of Care committee and executive leadership, including the administratively appointed Emergency Medical Director, to enhance organization for the purposes of combating a hospital-wide clinical emergency.
- b. Be an active committee, as pursuant with GMHA Medical Staff Bylaws, if there is a clinical emergency. It will be deactivated only by the CEO under the direct guidance and recommendations from the AAMS, AACS, and the MEC president.

### 12.16-3 Objectives:

To focus on the clinical provision of safe hospital-wide care when clinical emergencies arise that will involve hospital-wide measures and services. To assure that the hospital has clinical protocols and policies, if applicable, that have been vetted and implemented to aid in the specific clinical emergency. Each protocol or policy, may have the following, if applicable:

- a. Be based on an accurate description of individual and aggregate hospital-wide needs and requirements
- b. Be based on the specialized qualifications and competencies of the clinical staff
- c. Be consistent with nationally recognized evidence-based standards and guidelines established by the professional clinical specialty organizations, i.e. Centers of Disease Control (CDC) and World Health Organization (WHO) and the Local Guam Department of Public Health and Social Services (DPHSS)
- d. Address issues related to the existing pandemic clinical plans to include and incorporate all hospital-wide areas needed for proper response
- e. Work within the parameters of the medical executive committee, hospital leadership, and subsequently the Board of Trustees
- f. To work in collaboration and report to the MEC on all clinically based issues.
- g. To work in collaboration with the Environment of Care Committee to assure input from all appropriate hospital direct care and specialty caregivers into unit-based plans. This input will then provide oversight and assurance that relevant information is incorporated into the hospital-wide plan.
- h. To monitor data related to patient safety and outcomes and make appropriate modification recommendations as needed.
- i. To assure that at least an annual review of the plan is performed and submitted, as part of the hospital's quality management processes, to the CEO or designee for its review and completion of any necessary revisions.

### 12.16-4 Roles and Responsibilities of Membership:

- a. Leadership:
  - i. The chairperson of the Committee will be nominated by the MEC and appointed by the MEC president from the Active or Provisional Medical Staff membership.
  - ii. There may be a need for a vice chairperson of the Committee who will also come from the active or provisional medical staff, but again must be appointed by the MEC president based on their discretion.
- b. Responsibilities of the membership in this Committee:
  - i. Be responsible for inter-disciplinary protocols including but not limited to developing, implementing, monitoring, evaluating, and modifying as needed.
  - ii. Establish and agree to a working charter
  - iii. Term of committee membership: As pursuant to the GMHA policies
  - iv. All members are expected to attend all meetings and follow up on action items. Please notify chair if unable to attend.
  - v. Consistent attendance (two or more unexcused absences will result in follow up. Unexcused absences can be made up by reading the minutes of missed meetings.)
  - vi. Commitment to participation
  - vii. Follow through with action items
  - viii. Communication with colleagues hospital wide to assure input
  - ix. Meeting minutes will be made available hospital wide.
  - x. For issues requiring additional discussion or if potential impasse arises, the committee may form smaller groups to address issues and bring back for recommendations to the larger committee.

c. Responsibilities of the Chairperson of Committee:

- i. Lead the Committee in the meetings, or make appropriate accommodations if unable to lead the meetings.
- ii. To be in active communication with the executive hospital leadership and attend meetings as designated for this purpose as called upon the hospital executive leadership
- iii. To be available for questions from the Board of Trustees.

12.16-5 Meetings, Reports and Recommendations:

- a. Meeting dates frequency and times will be discretionary per the Chairperson of Committee with direct oversight from the MEC president, AAMS, AACS, and CEO.
- b. Meetings may be conducted either in-person, virtually or possibility mixture of both per the Chairperson of Committee discretion.
- c. The Committee has authority – to gather data, to make recommendations, to pause, to clarify or negotiate, to act, to implement, and give oversight for clinical protocols per the said clinical emergency of which the Committee has been activated by the CEO.
- d. Signature page is attached for all protocols and policies of the Committee in the order of: Clinical Emergency Preparedness, Medical Director, Medical Executive Chairman, Nursing Management, Incident Commander, and if applicable Associate Executive, whether it be from Fiscal or Operations, AAMS or AACS, and CEO (or designated authority).

## **ARTICLE XIII: CONFIDENTIALITY, IMMUNITY AND RELEASE**

### **13.1 SPECIAL DEFINITIONS**

For the purposes of this Article the following definitions shall apply:

- 13.1-1 **INFORMATION** means all acts, communications, records of proceedings, minutes, order records, reports, memoranda, statements, recommendations, data and other disclosures whether in written, recorded, computerized or oral form, relating to any of the subject matter specified in Section 12.5-2 of this Part.
- 13.1-2 **MALICE** means the dissemination of a known falsehood, or of information with a reckless disregard for whether it is true or false, or the absence of a reasonable belief that an action, statement or recommendation is warranted by the facts.
- 13.1-3 **PRACTITIONER** means a staff member or applicant.
- 13.1-4 **REPRESENTATIVE** means a board, any director, a committee, or chief executive officer or hospital administrator or other health care institution or designee; a Medical Staff entity, an organization of health practitioners, a Peer Review organization, a state or local board of medical or professional quality assurance, and any member, officer, department or committee thereof; and any individual authorized by any of the foregoing to perform specific information gathering or disseminating function.
- 13.1-5 **THIRD PARTIES** means both individuals and organizations providing information to any representative.

### **13.2 AUTHORIZATIONS AND CONDITIONS**

By applying for, exercising, clinical privileges within this Hospital, a practitioner:

- 13.2-1 Authorizes representatives of the Hospital and the Staff to solicit, provide, and act upon information bearing on his/her professional ability and qualifications.
- 13.2-2 Authorizes third parties and their representatives to provide information, including otherwise privileged or confidential information, concerning such health practitioner to the Hospital and its Medical Staff; and
- 13.2-3 Agrees to be bound by the provisions of this Article and to waive all legal claims against any representative who acts in accordance with the provisions of this Article; and
- 13.2-4 Acknowledges that the provisions of this Article are expressed conditions to the application for, or acceptance of, Staff membership, or to the exercise of clinical privileges at this Hospital, or to the application for or acceptance of approval and exercise of practice privileges at this Hospital.

### **13.3 CONFIDENTIALITY OF INFORMATION**

Information with respect to any practitioner submitted, collected or prepared by a representative of this or any other healthcare facility, organization or medical staff, shall be to the fullest extent permitted by law, confidential and shall not be disseminated to anyone other than a representative or used in any way except as provided herein or except as otherwise required by law.

Such information shall be for the purpose of achieving and improving quality patient care, reducing morbidity and mortality, or contributing to clinical research. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall become a part of the Medical Staff department or committee files and shall not become a part of any particular patient's file or of the general Hospital records.

#### **13.4 BREACH OF CONFIDENTIALITY**

Inasmuch as effective peer review and consideration of the qualifications of Medical Staff members and applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of Medical Staff departments, services, sections, or committees, except in conjunction with another hospital, professional society, licensing authority or as provided in 6 GCA §413(g), is outside appropriate standards of conduct for this Medical Staff and will be deemed disruptive to the operations of the Hospital. If it is determined that such a breach has occurred, the Medical Executive Committee may undertake such corrective action as it deems appropriate, including the loss or suspension of clinical privileges and membership on medical staff.

#### **13.5 IMMUNITY AND LIABILITY**

##### **13.5-1 For Action Taken**

No representative of the Hospital or Staff shall be liable in any judicial proceeding for damages or other relief for any action taken or statement or recommendation made within the scope of his/her duties as a representative, if such representative acts in good faith and without malice. Regardless of any provisions of Guam law to the contrary, truth shall be an absolute defense for a representative in all circumstances.

#### **13.6 ACTIVITIES AND INFORMATION COVERED**

##### **13.6-1 Activities**

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

- A. Applicants for appointment and clinical privileges;
- B. Periodic reappraisals for reappointment and clinical privileges;
- C. Corrective action;
- D. Hearings and appellate reviews;
- E. Patient care monitoring and evaluation;
- F. Utilization reviews; and
- G. Other hospital department (service), committee activities related to monitoring and maintaining quality patient care and appropriate professional conduct.

##### **13.6-2 Information**

The acts, communications, reports, recommendations, disclosures, and other information referred to in this Article may relate to a practitioner's professional qualifications, clinical ability, judgment, character, physical and mental health, professional ethics, ability to work cooperatively with others or any other matter that might directly or indirectly affect patient care or the efficient functioning of an institution or organization.

### **13.7 CUMULATIVE EFFECT**

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

## **ARTICLE XIV: ETHICS AND ETHICAL RELATIONSHIPS**

### **14.1 PROFESSIONAL CODES APPLY**

The Principles of Medical Ethics of the American Medical Association, Code of Ethics of the American Osteopathic Association or Code of Ethics of the American Dental Association, shall govern the professional conduct of all members of the Staff. Furthermore, it is understood that any Staff member who violates the provisions of any of the articles of the code of ethics enumerated shall be liable to reduction or loss of privileges through the procedures outlined.

### **14.2 SHARING OF FEES PROHIBITED**

Each member of the Staff shall pledge not to receive from, or pay to another physician, either directly or indirectly, any part of a fee received for professional services, except in cases where a partnership or an employee relationship exists.

### **14.3 MEDICAL AND PEER REVIEW COMMITTEE RECORDS AND REPORTS**

Patient charts and records are privileged and confidential and are to be used only for the purpose for which they are intended.

Records, data and knowledge selected by Staff departments and committees to review professional practices in the Hospital for the purpose of reducing morbidity and improving the care provided to patients, are privileged and confidential and are to be used only for the purpose for which they are intended.

The use of such information by Staff members for any purpose other than those related to official Staff and Hospital activities shall be grounds for discipline by the Staff and may include expulsion from the Staff.

## **ARTICLE XV: GENERAL PROVISIONS**

### **15.1 STAFF RULES AND REGULATIONS**

Staff Rules and Regulations as may be necessary to implement more specifically the general principles of conduct found in these bylaws shall be adopted in accordance with this Article. Rules and regulations shall set standards of practice that are to be required of each individual exercising clinical privileges in the Hospital, and shall act as an aid to evaluating performance under, and compliance with, these standards. Rules and regulations shall have the same force and effect as the Bylaws. Staff Rules and Regulations shall be reviewed by the Bylaws Committee every two (2) years.

#### **15.1-1 Adoption and Amendment**

The Medical Executive Committee may propose changes to the Rules and Regulations for the entire Medical Staff to be voted on at the next regular general staff meeting. The Executive Committee shall provide or cause to provide copies of the proposed amendments, additions or repeals to all members of the Staff seven (7) days before the general staff meeting. Changes in the Rules and Regulations shall become effective only when approved by the Board.

### **15.2 DEPARTMENT RULES AND REGULATIONS**

Subject to the approval of the Executive Committee and the Board, each department (and service) shall formulate its own rules and regulations for the conduct of its affairs and the discharge of its responsibilities. Such rules and regulations shall be consistent with these Bylaws, the general Rules and Regulations of the Staff, and policies of the Hospital. Department Rules and Regulations shall be reviewed by the department every two (2) years. A permanent file of current department (and service) rules and regulations shall be maintained by the Administrator.

The Bylaws Committee and the MEC should review the departmental rules and regulations to be certain they do not contradict the Bylaws or medical staff rules and regulations.

### **15.3 FORMS**

Application forms and any other prescribed forms required by the Bylaws for use in connection with Staff appointments, reappointments, delineation of privileges, corrective action, notices, recommendations, reports, and other matters shall be adopted by the Board after considering the recommendation of the Executive Committee.

### **15.4 HEADINGS**

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

### **15.5 TRANSMITTAL OF REPORTS**

Reports and other information which these Bylaws require the Staff to transmit to the Board shall be deemed so transmitted when delivered, unless otherwise specified, to the Board of Trustees Secretary via the Administrator.

## **ARTICLE XVI: AMENDMENT**

### **16.1 STAFF RESPONSIBILITY AND AUTHORITY**

The Medical Staff will have the primary responsibility and delegated authority to formulate, adopt, amend, and periodically review its Bylaws. Such responsibility and authority will be exercised in a reasonable, timely and responsible manner reflecting the interests of providing quality patient care and of maintaining a harmony of purpose and effort by and between the Administration, Medical Staff, Board of Trustees and community.

### **16.2 AMENDMENT PROCEDURES**

16.2.1. Bylaw amendments shall be reviewed and recommended by the Bylaws Committee and the Medical Executive Committee (“MEC”) prior to being submitted for vote by the Staff. Proposals to amend the Bylaws may also be submitted to the MEC by written petition of any member of the Staff or the Board of Trustees. The Staff shall receive notice of the proposed changes at least 21 days prior to required action on the proposed amendments. Voting on the amendment will commence at the next regularly scheduled Quarterly or Special Staff Meeting and will conclude at 5 p.m. the following day. Votes may be submitted either in person or via electronic ballot. Amendments shall require an affirmative vote of a majority of the ballots cast. The amendment will be effective on approval by the Board. Neither the Medical Staff nor the Board may unilaterally amend the Bylaws.

16.2.2. In the event of a documented need for an urgent amendment of the Medical Staff Bylaws to comply with law or regulation or accreditation standards, the Medical Executive Committee may provisionally adopt, and the Board of Trustees may provisionally approve the amendment without prior notification of the voting members of the Medical Staff. In such cases, the voting members of the Medical Staff shall be immediately notified by the Medical Executive Committee of the amendment within ten (10) days after the Board of Trustees has approved the amendment. The voting members of the Medical Staff shall have an additional twenty (20) days within which to review the amendment and provide written comment to the Medical Executive Committee. If there are no comments opposing the provisional amendment, then the provisional amendment shall become final. If there are comments opposing the provisional amendment, then a Joint Conference Committee will be convened consisting of representatives of the Hospital Administration, the Board of Trustees and the Medical Staff to review and consider the comments, and, if warranted in the opinion of the Joint Conference Committee, a revised amendment shall be submitted to the Board as provided in Section 16.3.

16.2.3. The Medical Executive Committee shall have the power to adopt such amendments to the Bylaws as are, in its judgment, technical modifications or clarifications, reorganization or renumbering of existing Bylaws, or amendments made necessary because of punctuation, spelling, or other errors of grammar or expression, or inaccurate cross-references. Such amendments shall be effective immediately, and shall be permanent if not disapproved by the Board of Trustees within ninety (90) days after adoption by the Medical Executive Committee. The action to amend may be taken by motion and acted upon in the same manner as any other motion before the Medical Executive Committee. Such approved amendments shall be communicated in writing to the Medical Staff at the next regularly scheduled Quarterly or Special Staff Meeting, or sooner if deemed necessary by the Medical Executive Committee or the Board of Trustees.

### **16.3 BOARD ACTION**

16.3.1. All amendments to the Bylaws will become effective on approval by the Board of Trustees.

16.3.2. In the event the Board of Trustees votes against approval of the amendment a Joint Conference Committee will be convened to resolve the conflict between the Medical Staff and the Board. The Committee will consist of representatives of the Hospital Administration, the Board and the Medical Staff.

### **16.4 NOTICES TO THE STAFF**

All amendments to the Bylaws should be communicated to the Members of the Medical Staff immediately upon approval by the Board of Trustees.

### **16.5 REVIEW OF THE BYLAWS**

Periodic review of the Bylaws should be conducted by the Medical Staff at least every two years.

## **ARTICLE XVII: ADOPTION**

These Bylaws are adopted and made effective upon approval of a majority vote of the Medical Staff of Guam Memorial Hospital Authority and the Board, superseding and replacing any and all previous Medical Staff Bylaws, and henceforth all activities and actions of the Medical Staff and of each individual exercising clinical privileges in the hospital shall be taken under and pursuant to the requirements of these Bylaws.