



Dignity Health™
Saint Francis Memorial Hospital

MEDICAL STAFF BYLAWS

DECEMBER 7, 2017

**SAINT FRANCIS MEMORIAL HOSPITAL
MEDICAL STAFF BYLAWS
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PREAMBLE:

WHEREAS, Saint Francis Memorial Hospital is a nonprofit, public benefit corporation organized under the laws of the State of California; and

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

WHEREAS, the Medical Staff is responsible for the quality of medical care in the hospital and must accept and discharge this responsibility subject to the ultimate authority of the governing body, and the cooperative efforts of the Medical Staff, the president, and the governing body are necessary to fulfill the hospital's obligations to its patients;

THEREFORE, the practitioners practicing in this hospital hereby organize themselves into a Medical Staff in conformity with these bylaws.

DEFINITIONS: The term

1. Allied Health Professional means an individual, other than a licensed physician, dentist or podiatrist, who exercises independent judgment within the areas of his or her professional competence and the limits established by the governing body, the Medical Staff and the State of California, who is qualified to render direct or indirect medical or psychological care under the supervision or direction of a Medical Staff member possessing privileges to provide such care in the hospital, and who may be eligible to exercise privileges and prerogatives in conformity with the allied health professional Rules and Regulations adopted by the governing body, these bylaws, and the rules and regulations. Allied health professionals are not eligible for Medical Staff membership.
2. Authorized Representative means the individual designated by the hospital and approved by the Medical Executive Committee to provide information to and request information from the National Practitioner Data Bank according to the terms of these bylaws.
3. Chief of Staff means the chief officer of the Medical Staff elected by the members of the Active Medical Staff.
4. Department means that group of practitioners who have privileges in one of the general areas of medicine, surgery, psychiatry and special services (diagnostic radiology, pathology and nuclear medicine, and radiation therapy).
5. Department Chair means the Medical Staff member duly elected in accordance with these bylaws to serve as head of a department.
6. Governing Body means the Board of Trustees of the hospital.
7. Hospital means the Saint Francis Memorial Hospital, and includes all inpatient and outpatient locations and services operated under the auspices of the hospital's license.
8. Investigation means, unless required by law, a process specifically initiated by the Medical Executive Committee to determine the validity, if any, to a concern or complaint raised against a Medical Staff member or individual holding clinical privileges, and does not include activity of the Physician Wellness Committee.
9. Medical Executive Committee means the executive committee of the Medical Staff.
10. Medical Staff means all practitioners in all categories of the Medical Staff who have been granted recognition as members of the Medical Staff pursuant to the terms of these bylaws.
11. Medical Staff Year means the period from July 1 of one year through June 30 of the following year.
12. Member, unless otherwise expressly limited, means any physician (MD or DO), dentist or podiatrist holding a current license to practice within the scope of his/her license who is a member of the Medical Staff.
13. Peer means a practitioner within the same professional discipline.
14. President means the individual appointed by the governing body to act in its behalf in the overall management of the hospital.

15. Practitioner means an individual who is licensed, qualified and permitted by law to provide care and services without direction or supervision within the scope of license and consistent with individually granted clinical privileges.

ARTICLE I. NAME

The name of this organization shall be the "**SAINT FRANCIS MEMORIAL HOSPITAL MEDICAL STAFF.**"

ARTICLE II. DESCRIPTION AND PURPOSES

2.1 Description

- 1) The Medical Staff organization is structured as follows: The members of the Medical Staff are assigned to a staff category depending upon the nature and tenure of practice at the hospital. All new members with the exception of Affiliate Staff appointees are assigned to the provisional staff. Upon satisfactory completion of the provisional period, the members are assigned to one of the staff categories described in Article IV, Categories of the Medical Staff.
- 2) Members are also assigned to departments, depending upon their specialties, as follows: department of medicine, surgery, psychiatry and special services. Each department is organized to perform certain functions on behalf of the department, such as credentials review and peer review.
- 3) There are also Medical Staff committees, which perform staff-wide responsibilities, and which oversee related activities being performed by the departments.
- 4) Overseeing all of this is the Medical Executive Committee, comprised of the elected officials of the Medical Staff, the department chairs for the departments of medicine, surgery, psychiatry and special services, representatives elected at large, and the immediate past chief of staff.

2.2 Purposes

The purpose of this organization shall be:

- 1) to provide a means whereby all patients admitted to or treated in any of the facilities or departments of the hospital, or who receive any of the services of the hospital shall receive high quality medical care;
- 2) to provide a high level of professional performance of all practitioners authorized to practice in the hospital through the appropriate delineation of the clinical privileges that each practitioner may exercise in the hospital and through an ongoing review and evaluation of each practitioner's performance in the hospital;
- 3) to provide an appropriate educational setting that will maintain scientific standards and that will lead to continuous advancement in professional knowledge and skill;
- 4) to initiate and maintain Rules and Regulations for self-government of the Medical Staff;
- 5) to provide a means whereby issues concerning the Medical Staff and the hospital may be discussed by the Medical Staff with the governing body and the president; and
- 6) to provide a framework within which Medical Staff members can act with a reasonable degree of freedom and confidence.

ARTICLE III. MEDICAL STAFF MEMBERSHIP

3.1 Nature of Medical Staff Membership

Membership on the Medical Staff of Saint Francis Memorial Hospital is a privilege which shall be extended only to professionally competent practitioners who continuously meet the qualifications, standards, and requirements set forth in these bylaws. No physician, dentist or podiatrist, including those in a medical administrative position by virtue of a contract with the hospital, shall admit or provide medical or health-related services to patients in the hospital unless the physician is a member of the Medical Staff with approved privileges or has been granted temporary privileges in accordance with the procedures set forth in these bylaws. Appointment to the Medical Staff shall confer only such clinical privileges and prerogatives as have been granted in accordance with these bylaws.

All members of the Medical Staff and allied health professionals will be deemed to be members of the Medical Staff Organized Health Care Arrangement (MSOHCA) with the Hospital under the Healthcare Insurance Portability and Accountability Act (HIPAA). The Hospital will issue a joint notice of privacy practices (JNPP) to its patients. This JNPP will fulfill HIPAA requirements for both the Hospital and MSOHCA members who see patients at the Hospital. When members of the MSOCHA see patients at the Hospital, they must not issue another notice of privacy practices to that patient while the patient is in the Hospital.

MSOHCA member's use of protected health information of the Hospital is restricted to those listed in the JNPP and the JNPP does not fulfill practitioners' obligations when seeing patients outside of the Hospital or in their private offices. Further, MSOHCA members remain responsible for issuing their own notice of privacy practices outside of the Hospital. The Hospital will solicit an acknowledgement of the JNPP from its patients and MSOHCA members must not solicit a separate acknowledgement from patients at the Hospital.

Practitioners remain responsible for obtaining their own acknowledgement of the notice of privacy practices outside of the Hospital.

3.2 Qualifications for Membership

- 1) General Qualifications: Medical Staff membership is limited to practitioners licensed to practice in the State of California who are eligible to participate in federal and state healthcare programs who can adequately document: (1) their background, experience and training and demonstrated current competence; (2) their adherence to the ethics of their profession; (3) their good reputation and adequate physical and mental health; and (4) their ability to work with others, sufficiently to assure the Medical Staff and the governing body that any patient treated by them in the hospital will be given high quality medical care. Only those specialties that are certified by the American Board of Medical Specialties (ABMS), or the American Osteopathic Association (AOA) Board or by the Royal College of Physicians and Surgeons of Canada, or otherwise approved by the Medical Executive Committee will be considered in determining Medical Staff privileges. No practitioner shall be entitled to membership on the Medical Staff or the exercise of particular clinical privileges in the hospital merely by virtue of the fact that he/she is duly licensed to practice in California or any other State, or that he/she is board certified, or that he/she is a member of any professional organization, or that he/she had in the past, or presently has, such privileges in another hospital. Medical Staff membership or clinical privileges shall not be conditioned or determined on the basis of an individual's participation or non-participation in a particular medical group, independent physician association, preferred provider organization, physician hospital organization, hospital-sponsored foundation, or other organization or in contracts with a third party which contracts with this hospital. No practitioner shall be denied membership on the basis of religion, race, color, sex, age, sexual orientation or country of origin.
- 2) Particular Qualifications:
 1. Physicians
 - (a) An applicant for physician membership in the Medical Staff must hold an MD or DO degree and a valid, unsuspended license to practice medicine with no limitations or probation, issued by the Medical Board of California or the Board of Osteopathic Examiners of the State of California.
 - (b) As of January 1, 2011, an applicant for physician membership in the Medical Staff must

be currently Board Certified or an active candidate for certification by a recognized American Board of Medical Specialties (ABMS) or by a recognized American Osteopathic Association (AOA) Board, or by the Royal College of Physicians and Surgeons of Canada, as defined by the applicable board, or otherwise approved by the Medical Executive Committee.

2. Limited License Practitioners.

- (a) Dentists. An applicant for dental membership in the Medical Staff must hold a DDS or DMD degree, and a valid, unsuspended license to practice dentistry with no limitations or probation, issued by the Board of Dental Examiners of California.
- (b) Podiatrists. An applicant for podiatric membership on the Medical Staff must hold a DPM degree and a valid, unsuspended license to practice podiatry with no limitations or probation, issued by the Medical Board of California.

3.3 Conditions and Duration of Appointment

- a) The governing body shall make all appointments, reappointments, and revocation of appointments to the Medical Staff upon recommendation of the Medical Executive Committee as provided in these bylaws.
- b) Initial appointments shall be made for a period of one (1) year. Reappointments shall be for a period of not more than two (2) years.
- c) Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted to that appointee by the governing body in accordance with these bylaws.
- d) Dues may be required as a condition of appointment or reappointment to the Active Staff, Courtesy Staff, Provisional Staff, Affiliate Staff, and Allied Health Professionals by the Medical Executive Committee. Dues so established may be modified or repealed at any regular meeting of the Medical Executive Committee. Annual dues shall be delinquent if not paid by November 1 of the relevant Medical Staff year. Failure to pay dues on or before November 1 of the relevant Medical Staff year shall result in automatic suspension and termination.
- e) Leaves of absence will be granted in accordance with the procedures set forth in Article V, Section 3

3.4 Basic Responsibilities of Medical Staff Membership

The ongoing responsibility of all members of the Medical Staff regardless of staff category or privilege condition include:

- a) abiding by the Medical Staff bylaws and Medical Staff Rules and Regulations and hospital policies consistent with these bylaws applying to the activities of a staff member;
- b) abiding by the lawful ethical principles of the American Medical Association, American Osteopathic Association, American Podiatric Association or the American Dental Association; maintaining the standards and meeting the requirements to warrant at all times full accreditation of the hospital by the Joint Commission on Accreditation of Healthcare Organizations;
- c) refusing to engage in improper inducements for patient referral (including fee splitting);
- d) maintaining board certification status as required in Article II, Section 2.b.
- e) continuously maintaining eligibility to participate in federal and state programs during any term of membership;
- f) to notify the Medical Staff office in writing promptly, and no later than fourteen (14) calendar days, following any action taken, or investigation being commenced, regarding the member's license, Drug Enforcement

Administration registration, staff membership or clinical privileges at another institution, changes in liability insurance coverage, changes in participation in Medicare, Medi-Cal or any other public program, any report filed with the National Practitioner Data Bank, or any other action or change in circumstances that could affect his/her qualifications for Medical Staff membership and/or clinical privileges at the hospital.

- g) continuously inform the Medical Staff leadership of any significant changes in the information required at appointment and reappointment,
- h) providing patients with the quality of care meeting the professional standards of the Medical Staff of this hospital;
- i) discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the member by virtue of Medical Staff membership, including committee assignments;
- j) preparing and completing in timely fashion medical records for all the patients to whom the member provides care in the hospital, assuring that a history and physical examination is completed and documented on all patients within twenty-four (24) hours after admission, or within thirty (30) days prior to admission (the results of which are recorded in the hospital's medical record) by a physician (as defined in section 1861(r) of the Social Security Act (42 U.S.C. § 1395x(r)), an oromaxillofacial surgeon, or other qualified individual in accordance with State law and hospital policy. For those histories and physicals completed within the thirty (30) days prior to admission, an examination for any changes in the patient's condition must be completed and documented in the patient's medical record within twenty-four (24) hours after admission, and it must be updated within twenty-four (24) hours prior to any surgical procedure or other procedure requiring general anesthesia or moderate or deep sedation;

A comprehensive history & physical (H&P) includes the following items: appropriate identification data; medical history, including, chief complaint, history of present illness, current medications and history; relevant past, social and family histories (appropriate to the patient's age); a notation of allergies; an inventory of all major body systems; pertinent lab results; a statement of the conclusions and/or impressions drawn as an assessment or problem list from the admission history and physical exam; the treatment plan and a complete physical examination may be focused depending on the nature of the presenting illness, complexity of intervention and the clinical judgment of the physician.

Elements of a history include: date of admission; chief complaint; history of present illness; past history; family and social history; allergies; past medical and surgical history; medication history and review of systems. Elements of a physical examination include: head/eyes/ears/nose/throat (HEENT); cardiovascular; respiratory; abdominal; neurologic, mental status, plus body systems as appropriate for the clinical problem.

- k) aiding in any Medical Staff approved educational programs for medical interns, resident physicians, staff physicians podiatrists and dentists, nurses and other personnel;
- l) working cooperatively with members, nurses, hospital administration and others so as not to adversely affect patient care;
- m) making appropriate arrangements for the continuous coverage of his or her patients as determined by the Medical Staff;
- n) participating in continuing education programs as determined by the Medical Staff or Medical Executive Committee;
- o) participating in such emergency service coverage or consultation panels as may be determined by the Medical Staff or Medical Executive Committee;

- p) discharging such other staff obligations as may be lawfully established from time to time by the Medical Staff or Medical Executive Committee;
- q) providing information to and/or testifying on behalf of the Medical Staff or an accused practitioner regarding any matter under an investigation pursuant to Article VII, and those which are the subject of a hearing pursuant to Article VIII;
- r) maintaining a professional liability insurance policy with limits at least equal to the minimum amount established by the Medical Executive Committee;
- s) abiding by procedures established by the Dignity Health Bay Area Institutional Review Board when conducting all research/experiments involving human subjects;
- t) agreeing to respect and maintain the confidentiality of all discussions, deliberations, proceedings and activities of the Medical Staff committees and departments which have the responsibility for evaluating and improving the quality of care in the hospital. Such information shall not be disclosed voluntarily to anyone, except to persons authorized to receive it in the conduct of such Medical Staff affairs or as directed by the Medical Executive Committee or by the board of trustees. Any questions regarding whether information is confidential shall be resolved by the chief of staff and president prior to disclosure.
- u) members of the Medical Staff shall provide a valid e-mail address which shall be used as an official communication method for hospital and Medical Staff dissemination of information. Members who do not have an established e-mail address may request a Dignity Health e-mail address by calling the Medical Staff Office.
- v) except in an emergency, members encouraged to participate in the care and treatment of their family members in the same way that is allowed for all patients and their families. Physicians shall not directly administer medical care to their family members, including serving as the admitting, consulting physician or surgeon and writing orders. In accordance with federal and state privacy laws, physicians shall not be permitted to read the medical records of their family members without the written authorization of the patient or as allowed by applicable law. Provision of care and treatment to a family member in violation of this policy will result in an automatic review by the Medical Executive Committee.

The failure by any Medical Staff member to abide by any of the duties specified above shall be grounds for corrective action, including the suspension or termination of privileges and staff membership or for automatic action under Article VII, Section 3, as applicable.

ARTICLE IV. CATEGORIES OF THE MEDICAL STAFF

The Medical Staff shall be divided into the following categories: emeritus, active, courtesy, provisional, burn consulting staff, affiliate and telehealth consultant staff.

4.1 Emeritus Staff

Emeritus staff membership shall be an honorary position for practitioners who are of outstanding reputation and who have retired from active practice. They need not necessarily reside in the community. These practitioners shall be able to attend department, staff and educational meetings.

Emeritus Staff shall not be eligible to admit patients, to attend patients, to hold clinical privileges, to vote, to hold office, or to serve on standing committees. Members of the emeritus staff shall not be subject to reappointment, dues assessment or meeting requirements of any kind.

4.2 Active Staff

The Active Staff shall consist of those practitioners who:

- a) regularly care for or provide consulting services for patients in the hospital;
- b) have satisfactorily completed the Focused Professional Practice Opportunities (proctoring) and have been a member in good standing of the Provisional staff for at least six (6) months;
- c) maintain quality of care in the hospital;
- d) admits patients and exercises such clinical privileges as are granted;
- e) fulfill the basic responsibilities of Medical Staff membership, as provided in Article III, Section 4
- f) shall be eligible to vote and to hold office and serve on Medical Staff Committees;
- g) a minimum of ten (10) admissions, outpatient procedures, or consultations per two year reappointment period or be regularly involved in Medical Staff activities, e.g., participating in medical educational activities, committee activities, peer review and/or proctoring requests. If a member does not have the requisite number of admissions, outpatient procedures, consultations per year, pay dues in a timely manner, or participated in Medical Staff activities, they may be moved to another category.

4.3 Courtesy Staff

The Courtesy Staff shall consist of practitioners who:

- a) have the privilege to occasionally admit or otherwise attend to the care of patients in the hospital but who are not sufficiently active at the hospital to qualify for membership on the active staff;
- b) provide consultative services on an infrequent basis and;
- c) those who desire membership primarily to provide on-call coverage for a colleague who is on the active Medical Staff;
- d) may, as assigned, serve on Medical Staff committees and participate in peer review, but shall not be eligible to hold office or to vote in elections or to vote for bylaws amendments;
- e) maintain a minimum of five (5) admissions, outpatient procedures, or consultations per two year reappointment period. Courtesy or be regularly involved in Medical Staff activities, e.g., participating in medical educational activities, committee activities, peer review and/or proctoring requests. If a member does not have the requisite number of admissions, outpatient procedures, consultations per year, pay dues in a timely manner, or participated in Medical Staff activities, they may be moved to another category.

4.4. Provisional Staff

The Provisional Staff shall consist of those practitioners newly appointed to the Medical Staff. Appointment to the provisional staff will expire twelve months from the date of appointment. Provisional staff appointment may be extended an additional twelve months at the discretion of the department chair.

Provisional staff members shall:

- a) be able to admit patients, to attend patients, to hold clinical privileges, to enter orders for patients, and may serve on Medical Staff committees.
- b) shall not be eligible to vote or hold Medical Staff office.
- c) shall be required to pay annual Medical Staff dues.

The purpose of this provisional category is to provide for a focused professional practice evaluation (FPPE) to include the close observation and evaluation of the clinical competence and ethical and moral conduct of the new staff member who is insufficiently known to the Saint Francis Memorial Hospital Medical Staff. During such provisional staff status, members shall be assigned to a department where their performance will be proctored by the chair of the department [or designee] to determine their eligibility for courtesy or active staff membership.

Except as otherwise determined by the Medical Executive Committee, all appointees to the Medical Staff except Affiliate Staff appointees, and all members granted new clinical privileges, except dermatologists, shall be subject to a period of FPPE

proctoring. Each appointee or recipient of new clinical privileges shall be assigned to a department where performance on an appropriate number of cases as established by the Medical Executive Committee, or the department as designee of the Medical Executive Committee, shall be observed by the chair of the department, or the chair's designee, during the period of proctoring specified in the department's rules and regulations, to determine suitability to continue to exercise the clinical privileges granted in that department.

FPPE proctoring should be accomplished on the first case and thereafter be continued to include a minimum of three (3) cases that satisfactorily represent the scope of the practitioner's provisional privileges. At the discretion of the department chair, proctoring may be continued for all cases or for specific cases or procedures.

Evidence of proctoring from other facilities may be accepted to supplement evaluation provided that the proctor is a member in good standing of the Medical Staff at each facility and the range and level of the proctor's privileges are commensurate at each facility.

The member shall remain subject to such proctoring until the appropriate department chair reviews and approves sufficient reports which describe the cases observed and the evaluation of the applicant's performance.

If, at the conclusion of the provisional staff appointment, the staff member has satisfactorily demonstrated his/her ability to exercise the clinical privileges initially granted and otherwise appears qualified for continued Medical Staff membership, the department chair shall submit a statement to the credentials committee and the Medical Executive Committee that the applicant appears to meet all of the qualifications for unsupervised practice in the departments in which clinical privileges have been granted, has discharged all of the responsibilities of staff membership, and has not exceeded or abused the prerogatives of the category to which the appointment was made. The member shall be eligible to be advanced to the courtesy or active staff upon recommendation of the Medical Executive Committee.

In all other cases in which a satisfactory demonstration has not been made, the appropriate department shall advise the credentials committee and the Medical Executive Committee which shall make its report to the governing body regarding a modification or termination of all Medical Staff privileges.

Whenever clinical privileges are modified or terminated, the staff member shall be advised of his/her rights to due process as defined in the Hearing & Appeal Section of these bylaws.

If at the end of two years there is insufficient clinical activity for appropriate evaluation, the member may be offered affiliate staff membership without clinical privileges or the member may be dropped from the Medical Staff without prejudice.

4.5 Burn Consulting Staff

The burn consulting staff shall consist of those practitioners who:

- (a) meet the general qualifications set forth in Article III, Section 2 of the Medical Staff bylaws,
- (b) are willing and able to promptly come to the hospital when called to render specialized clinical services within the burn center which are otherwise not available within the Medical Staff,
- (c) are members of the active Medical Staff of another hospital, and have satisfactorily completed appointment in the provisional category.
- (d) The burn consulting staff shall not have admitting privileges at Saint Francis Memorial Hospital, or be eligible to vote or hold office, or to be appointed to serve on standing committees of the Medical Staff except as a nonvoting consultant, or be required to pay dues.

4.6 Affiliate Staff

The Affiliate Staff shall:

- (a) consist of physicians who work in the community and who meet the general Medical Staff qualifications for membership as set forth in Article III, who do not admit, consult or treat patients in the hospital.

Affiliate staff members may:

- (a) refer patients for admission and treatment by a privileged members of the Medical Staff,
- (b) order outpatient diagnostic testing and may document relevant clinical information in the medical records of their hospitalized private patients admitted by a privileged physician,
- (c) attend educational meetings and;
- (d) may be appointed to serve on Medical Staff Committees.

Appointment to the Affiliate Staff will expire two years from the date of appointment.

Affiliate staff members shall not be eligible:

- (a) to admit patients,
- (b) to attend patients,
- (c) to hold clinical privileges,
- (d) to enter order for patients,
- (e) to vote, or
- (f) to hold office.

They shall be required to pay annual Medical Staff dues.

4.7 Telehealth Consultant Staff

The telehealth consultant staff shall consist of those practitioners who meet the general qualifications set forth in Article III of the Medical Staff bylaws, and who provide interpretation services via telecommunication systems linking the hospital with a Joint Commission-accredited independently contracted telehealth service. The Medical Staff delegates to the radiologist contractor the responsibility for primary source verification of credentials, with the exception of National Practitioner Data Bank queries, American Medical Association queries, and any other non-delegable access queries restricted to the hospital. The telehealth contractor will provide comprehensive primary source documents for each telehealth applicant applying for appointment and privileges and at the time of reappointment and renewal of privileges.

The telehealth consultant staff shall not have admitting privileges at Saint Francis Memorial Hospital, or be eligible to vote or hold office, or to be appointed to serve on standing committees of the Medical Staff, or be required to pay dues.

4.8 Limitation of Prerogatives

The prerogatives set forth under each membership category are general in nature and may be subject to limitation by special conditions attached to a particular membership, by other sections of these bylaws, and by the Medical Staff rules and regulations.

Regardless of the category of membership in the Medical Staff, unless otherwise required by law, dentists and podiatrists:

- a) shall only have the right to vote on matters within the scope of their licensure. In the event of a dispute over voting rights, that issue shall be determined by the chair of the meeting, subject to final decision by the Medical Executive Committee; and
- b) shall exercise clinical privileges only within the scope of their licensure and as set forth in Article VI, Section 1(f).

4.9 Modification of Membership Category

On its own, upon recommendation of the department committee, or pursuant to request by a member in any category, or upon direction of the board of trustees, the Medical Executive Committee may recommend to the governing body a change in Medical Staff category of that member or any member. Staff category change does not automatically entitle the member to due process as defined in the Hearing and Appeal Section of these bylaws.

ARTICLE V. PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

The basic steps of the appointment and reappointment processes are set forth in Sections 1 through 5 below:

5.1 Application for Appointment

- a) All applications for appointment to the Medical Staff, with the exception of applications for telehealth consultant staff, shall be in writing, shall be signed by the applicant, and shall be submitted on the forms approved by the Medical Executive Committee. An initial application fee is required as a condition of appointment in the amount fixed by the Medical Executive Committee, with the exception of applications for telehealth consultant staff. The applications shall require detailed information concerning the applicant's professional qualifications, shall include the names of at least three of his/her peers who have had extensive experience in observing and working with the applicant and who can provide adequate references pertaining to the applicant's professional competence, quality of care and ethical character. With the exception of applications for telehealth consultant staff, one of the three shall preferably be a member of the active Medical Staff, not professionally associated with the applicant in any way. The applicant may be interviewed by the department chair or committee. The application shall include information as to whether he/she has had any past or pending professional disciplinary action, the applicant's membership status and/or clinical privileges have ever been voluntarily or involuntarily revoked, suspended, reduced or not renewed at any other hospital or institution, local, state, or national professional societies. The application shall also state whether the applicant's license to practice his/her profession in any jurisdiction or DEA registration, has ever been voluntarily or involuntarily suspended, terminated or challenged.

The application shall also include proof that the applicant's California license to practice and DEA license, if any, are current; a record of continuing medical education; a statement that current health status is satisfactory to perform all the duties of his/her practice, and an attestation as to the applicant's purified protein derivative (PPD) status.

The applicant's possession of a current California license shall be confirmed for each applicant. Applicant's record from the National Practitioner Data Bank and the Medical Board of California will be reviewed.

Documented evidence of professional liability coverage in at least the designated minimum amounts must be supplied by each applicant, in addition to any information regarding final judgments or settlements made against the applicant in professional liability cases, and any filed or served cases pending.

The applicant shall also submit a signed Medicare Physician Attestation Statement. Primary source verification is required whenever feasible.

- b) All applications for appointment to the Medical Staff as telehealth consultant staff shall be in writing, shall be signed by the applicant, and shall be submitted by the Joint Commission-accredited independent contracted radiology service. Applicants for telehealth consultant staff shall not be assessed an application fee.

- c) The applicant shall have the burden of producing adequate information for a proper evaluation of his/her competence, character, ethics, and other qualifications and for resolving any doubts about such qualifications. If after ninety (90) days [three months] from the date of the receipt of the initial application by Medical Staff Administration, there is missing information, the applicant shall be notified in writing. The applicant shall be advised that such information must be submitted within thirty (30) days of request or the application shall be considered withdrawn. Furthermore, the application shall be considered withdrawn if: (1) the time from the receipt of the initial application by Medical Staff Administration until the interview process is complete extends beyond eight months; and/or (2) the applicant fails, without good cause, to appear for an interview following request.
- d) The application shall be submitted to the chief of staff in care of Medical Staff Administration. After the references and other materials deemed appropriate have been collected and verified, the completed application and all supporting materials shall be transmitted to the department chair for evaluation. The time from the submission of the completed application to final decision by the board of trustees shall take no longer than six (6) months.
- e) By applying for appointment to the Medical Staff, each applicant thereby:
 - 1) signifies his/her willingness to appear for interviews in regard to his/her application and/or to undergo any examination required by the Medical Executive Committee to assess fitness to exercise requested clinical privileges;
 - 2) authorizes the hospital to consult with members of the Medical Staff at other hospitals with which the applicant has been associated and with others who may have information bearing on his/her competence, character, and ethical qualifications;
 - 3) consents to the hospital's inspection of all records and documents that may be material to an evaluation of his/her professional qualifications, his/her moral and ethical qualifications for membership and competence to carry out any clinical privileges requested as well as his/her moral and ethical qualifications for membership.
 - 4) releases from any liability all individuals and organizations which provide information to the hospital in good faith and without malice concerning the applicant's competence, ethics, character and other qualifications for staff membership and clinical privileges, including otherwise privileged or confidential information; and
 - 5) consents to the disclosure, as required by law, to other hospital, medical associations, licensing boards, and other similar organizations of any information regarding his/her professional or ethical standing that the hospital or Medical Staff may have, and releases the Medical Staff and the hospital, its trustees, officers, employees and agents for so doing to the fullest extent permitted by law.
- f) The application form shall include a statement that the applicant has received and read the bylaws, Rules and Regulations of the Medical Staff and agrees to abide by applicable hospital policies consistent with the Medical Staff bylaws if he/she is granted membership and/or clinical privileges and agrees to be bound by the terms thereof in all matters relating to consideration of his/her application.
- g) The applicant seeking clinical privileges shall pledge to provide for continuous quality care for his/her patients.

5.2 APPOINTMENT PROCESS

- a) Within sixty (60) days after receipt of the Medical Staff application for membership and all necessary documentation, the department chair shall make a report of his/her review to the credentials committee, including his/her recommendation that the practitioner be appointed to the provisional Medical Staff, that he/she be rejected for Medical Staff membership, or that the application be deferred for further consideration.

All recommendations for appointment must also specifically recommend the clinical privileges to be granted pursuant to Article VI, Clinical Privileges, Section 1(d). Where appropriate, recommendations for clinical privileges may be qualified by probationary conditions.

- b) The credentials committee shall evaluate all matters deemed relevant to a recommendation, including information concerning the applicant's provision of services within the scope of privileges granted, and shall transmit to the Medical Executive Committee a written report and recommendation as to appointment and, if appointment is recommended, as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached. The credentials committee may also request that the Medical Executive Committee defer action on the application.
- c) When, in the opinion of the governing body, there has been a delay of over sixty (60) days on the part of the Medical Staff, the governing body may act on an individual's appointment status without awaiting a staff recommendation. Prior to taking such action, the governing body must notify the staff of its intent, allowing the staff an action date to complete its responsibility.
- d) At its next regular meeting after receipt of the application and recommendations of the clinical department chair and report and recommendations from the credentials committee, the Medical Executive Committee shall determine whether to recommend to the governing body that the practitioner be appointed to the Medical Staff, that he/she be rejected for Medical Staff membership, or that his/her application be deferred for further consideration. When the recommendation is to defer the application for further consideration, it must be acted on within sixty (60) days with a subsequent recommendation for appointment or rejection of staff membership. When the recommendation is favorable to the practitioner, the chief of staff shall forward it promptly to the governing body for consideration at its next regular meeting.
If the Medical Executive Committee's recommendation is adverse to the applicant, the chief of staff, shall give the applicant written notice of the adverse recommendation and of the applicant's right to request a hearing in the manner specified in Article VIII, and the applicant shall be entitled to the procedural rights provided therein. For the purpose of this Section 2(d), an "adverse recommendation" by the Medical Executive Committee is a denial of membership or a denial of requested clinical privileges. The governing body shall be informed of, but not take action on, the pending adverse recommendation until the applicant has exhausted or waived his/her procedural rights.
- e) The governing body, at its next regular meeting after receipt of the final report and recommendation of the Medical Executive Committee on any initial application for membership, shall consider such report and recommendation and shall either accept the recommendation of the Medical Executive Committee or refer it back for further consideration, stating the reasons for such action and setting a time by which the Medical Executive Committee shall report back to the governing body. After receipt of such further report, the governing body shall take final action thereon. If the governing body does not concur with the Medical Executive Committee's recommendation relative to Medical Staff appointment, reappointment, or termination of appointment, and the granting or curtailment of clinical privileges, the governing body shall appoint a combined committee of the Medical Staff and the governing body to review the recommendation and report back to the governing body within a specified time before the governing body renders a final decision.
- f) If delegated by the governing body, the executive committee of the governing body may act on its behalf to approve Medical Staff recommendations for initial membership and clinical privileges, provided that the applicant has submitted a complete application and the Medical Executive Committee recommendation is favorable and without limitations. The following situations must be evaluated on a case-by-case basis, but will generally require review by the full governing body: there is a current challenge or a previously successful challenge to licensure or DEA registration; the applicant has received an involuntary termination of Medical Staff membership at another organization; the applicant has received involuntary limitation, reduction, denial or loss of clinical privileges; or the applicant has had either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.
- g) If the governing body has specified a time period for Medical Executive Committee action under Section 2(c) and has not received a Medical Executive Committee recommendation within such time period, it may, after notifying the Medical Executive Committee, take action on its own initiative. If such action is favorable to the

applicant, it shall become effective as the final decision of the governing body. If the action is one set forth in Article VIII, Section 2(b), the president shall give the applicant written notice of the adverse action and of the applicant's right to request a hearing in the manner specified in Article VIII, and the applicant shall be entitled to the procedural rights provided therein.

- h) After the governing body has taken the final action on any application for membership on the Medical Staff, the chief of staff shall notify the applicant in writing of the action taken within ten (10) days after such action has been taken.

A decision and notice to appoint or reappoint shall include, if applicable: (1) the staff category to which the applicant is appointed; (2) the department to which he/she is assigned; (3) the clinical privileges granted; and (4) if any special conditions attach to the appointment.

If the recommendation of the governing body is one of those set forth in Article VIII, Section 2(b), the chief of staff shall give the applicant written notice of the adverse recommendation and of the applicant's right to request a hearing in the manner specified in Article VIII, and the applicant shall be entitled to the procedural rights provided therein.

- i) Reapplication after Adverse Appointment Decision: An applicant who has received a final adverse decision regarding appointment or reappointment shall not be eligible to reapply to the Medical Staff for a period of three (3) years. Final adverse decision means the final decision of the governing body. Following the three-year period, any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as may be required to demonstrate that the basis for the earlier adverse action no longer exists.

5.3. REAPPOINTMENT PROCESS

- a) At least every two (2) years the credentials committee and the Medical Executive Committee shall review all pertinent information available on each practitioner scheduled for periodic appraisal for the purpose of determining its recommendations for reappointments to the Medical Staff and if privileged for the granting of clinical privileges for the ensuing period and shall submit its recommendations in writing to the governing body. If non-reappointment or a change in clinical privileges is recommended, the reasons for such recommendation shall be stated or documented.

An Active Category member will maintain a minimum of ten (10) admissions, outpatient procedures, or consultations per two year reappointment period or be regularly involved in Medical Staff activities, e.g., participating in medical educational activities, committee activities, peer review and/or proctoring requests. If a member does not have the requisite number of admissions, outpatient procedures, consultations per year, pay dues in a timely manner, or participated in Medical Staff activities, they may be moved to another category.

A Courtesy Category member will maintain a minimum of five (5) admissions, outpatient procedures, or consultations per two year reappointment period. Courtesy or be regularly involved in Medical Staff activities, e.g., participating in medical educational activities, committee activities, peer review and/or proctoring requests. If a member does not have the requisite number of admissions, outpatient procedures, consultations per year, pay dues in a timely manner, or participated in Medical Staff activities, they may be moved to another category.

- b) Each recommendation concerning the reappointment of a Medical Staff member and the clinical privileges to be granted upon reappointment if any shall be based upon each member's professional competence and clinical judgment in the treatment of his/her patients, ethics and conduct, results of quality assessment and improvement activities, current health status, primary source verification of current licensure, board certification status, reports from the National Practitioner Data Bank, attendance at Medical Staff meetings if privileged and participation in staff activities, compliance with the Medical Staff bylaws, rules and regulations,

and if privileged use of the hospital's facilities for his/her patients as that use relates to the appropriate staff status category.

In addition, consideration will be made of relations to other practitioners, hospital personnel and patients and the ability to work cooperatively with others so as not to adversely affect patient care. Peer recommendations are part of the basis for the development of recommendations for continued membership on the Medical Staff and/or for the delineation of individual clinical privileges.

- c) Each practitioner subject to reappointment appraisal must submit proof of current licensure, DEA registration if applicable, continuing medical education, professional liability coverage in at least the designated minimum amounts, completed clinical privileges request forms, if applicable, any reasonable evidence of current ability to perform privileges that may be requested, and a statement concerning current health status. The practitioner shall supply any information regarding final judgments or settlements made against the practitioner in professional liability cases, and any filed cases pending. The practitioner shall supply any information regarding voluntary or involuntary (1) relinquishment of or challenges to licensure or DEA registration; (2) termination of Medical Staff membership; and (3) limitation, reduction or loss of clinical privileges. The practitioner shall also submit an attestation statement as to their PPD status. Thereafter, the procedure provided in Section 2 of this Article V relating to recommendations on application for initial appointment shall be followed.
- d) A Medical Staff member who seeks a demotion in Medical Staff status or modification of clinical privileges may submit a written request at any time to the Medical Executive Committee, except that such application may not be filed within one (1) year of the time a similar request has been denied. Advancement to the active staff may only be granted at the time of reappointment.
- e) Failure without good cause to timely file a completed application for reappointment shall result in the automatic suspension of the member's admitting privileges and expiration of other practice privileges and prerogatives at the end of the current staff appointment. The member shall be deemed to have resigned membership in the Medical Staff. In the event membership terminates for the reasons set forth herein, the procedures set forth in Article VIII shall not apply.
- F) Leave of Absence: At the discretion of the Medical Executive Committee, a Medical Staff member may obtain a voluntary leave of absence from the staff upon submitting a written request to the Medical Executive Committee stating the approximate period of leave desired up to one (1) year. Leaves of absence may be continued after one (1) year upon request to the Medical Executive Committee, which may not exceed one (1) additional year.

During the period of the leave and until reinstated the member shall not exercise clinical privileges at the hospital, and membership rights and responsibilities shall be inactive, but the obligation to pay dues, if any, shall continue unless waived by the Medical Executive Committee.

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

Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of membership, privileges, and prerogatives. A member whose membership is automatically terminated shall be entitled to the procedural rights provided in Article VIII for the sole purpose of determining whether the failure to request reinstatement was unintentional or

excusable, or otherwise. A request for Medical Staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

The Medical Executive Committee may authorize/place a member on a leave of absence if it determines that circumstances warrant such action.

5.4 Duration of Appointment and Reappointment

Initial appointments to the provisional Medical Staff shall be for a period of one (1) year. Initial appointments to the Affiliate Staff shall be for a period of two (2) years. Reappointments shall be for a period of up to two (2) years.

5.5. Administrative Positions

Individuals in administrative positions who desire Medical Staff membership or clinical privileges are subject to the same procedures as all other applicants for membership or privileges.

ARTICLE VI. CLINICAL PRIVILEGES

The basic steps for processing requests for privileges are described in Sections 1 through 6 below.

6.1 Clinical Privileges

- a) Every practitioner at this hospital by virtue of Medical Staff membership or otherwise, shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted to him/her by the governing body except as provided in Sections 2 and 3 of this Article VI. Medical Staff privileges may be granted, continued, modified or terminated by the governing body of this hospital only upon recommendation of the Medical Staff, only for reasons directly related to quality of patient care and other provisions of the Medical Staff bylaws, and only following the procedures outlined in these bylaws.
- b) Every initial application for staff appointment must contain a request for specific clinical privileges desired by the applicant. Clinical privileges to be granted shall be determined in conjunction with the determination of Medical Staff membership and in accordance with the procedures set forth in Article V herein. Requested clinical privileges that are infrequently performed may be denied, subject to review or have proctoring requirements assigned.

Eligible non-Medical Staff practitioners and Medical Staff members who desire increased or additional clinical privileges may make an application for privileges or increased additional privileges to the Medical Executive Committee. Such application shall be subject to the procedures set forth in Article V, Section 2, of these bylaws. If a Medical Staff member requesting a modification of clinical privileges or department assignment fails to timely furnish the information necessary to evaluate the request, the application shall automatically lapse, and the applicant shall not be entitled to a hearing as set forth in Article VIII.

- c) Requests for clinical privileges shall be evaluated on the basis of the applicant's education, training, experience, demonstrated professional competence and judgment, patient care, references, board certification status, the ability of the hospital to provide adequate facilities and supportive services for the applicant and his/her patients, the need for additional practitioners with the applicant's skills and training, current professional liability insurance, geographic location of the applicant, health status which affects clinical performance, and other quality assessment and improvement activities which the Medical Staff deems appropriate. Privilege determinations may also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a member exercises clinical privileges. The applicant shall have the burden of establishing his/her qualifications and competency for the clinical privileges requested.

- d) Applicants may be required to meet with the appropriate department committee. Proposed delineation of privileges shall be recommended to the Medical Executive Committee by the applicable department.
- e) Except as otherwise specifically determined by the Medical Executive Committee, all initial appointees to the Medical Staff and members granted new clinical privileges shall be subject to a period of proctoring.
- f) Privileges granted to dentists and podiatrists shall be based on their training, experience and demonstrated competence and judgment. The scope and extent of surgical procedures that each dentist or podiatrist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by dentists or podiatrists shall be monitored by the chair of the department of surgery. All dental and podiatry patients shall receive the same basic medical appraisal as patients admitted to other surgical services. A physician member of the Medical Staff shall record a history and physical examination and be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization. Dentists and podiatrists shall record an examination of their findings in their sphere of specialization. Admission and discharge of patient shall be with the approval of the physician member of the staff in addition to the dentist or podiatrist.

6.2. Temporary Privileges

- a) Practitioners who are not members of the Medical Staff may be granted temporary privileges to fulfill an important patient need.
- b) To consult on a patient who is under the care of an attending Medical Staff member or assist a Medical Staff member in surgery or to provide professional education.
- c) Temporary privileges may be granted to a practitioner for a period not to exceed 120 days, subject to the temporary privileges request/application.
- d) Temporary privileges may be granted when there is a clean, completed Medical Staff application for staff privileges and the Department Chair feels that he/she has received reliable and substantive information regarding the applicant's current professional competence, ethical character, and ability to work well with others so as not to adversely affect patient care following the Credentials Committee and is awaiting review and approval by the Medical Executive Committee and the Governing Body. In such instances, when Board approval is anticipated temporary privileges may extend until the date of the acceptance or rejection of the application, but in any event shall the temporary privileges last for more than 120 days.

All persons requesting or receiving temporary privileges shall be bound by the bylaws, Rules and Regulations of the Medical Staff. Temporary privileges may be granted to physicians licensed in a state other than California for the sole purpose of conducting professional education to the extent permitted by law as outlined in the California Business and Professions Code Section 2060. There shall be evidence of current medical malpractice insurance, and verification of licensure and current competence. The applicant's record from the National Practitioner Data Bank and the Medical Board of California will be requested and reviewed.

Special requirements of supervision and reporting may be imposed by the responsible department chair on any practitioner granted temporary privileges. Temporary privileges shall be immediately terminated by the chief of staff or department chair upon notice of any failure by the practitioner to comply with such special conditions.

If temporary privileges are denied, terminated or revoked for a medical disciplinary cause or reason, the practitioner is afforded procedural rights pursuant to Article VIII, Hearing & Appeal procedures of these bylaws.

6.3 Locum Tenens Privileges

Locum tenens privileges may be granted to a practitioner to cover the practice of a current member of the Medical Staff, provided that the procedure described in Article V, Section 1 has been completed. Such person may attend only patients of the member(s) for whom that person is providing coverage, for a period not to exceed four (4) months or four (4) separate periods of time within a calendar year after which they must apply for Medical Staff membership and privileges. Prior to the granting of such locum tenens temporary privileges, there shall be evidence of current medical malpractice insurance and verification of licensure and current competence. The applicant's record from the National Practitioner Data Bank and the Medical Board of California will be requested and reviewed.

6.4 Modification of Clinical Privileges or Department Assignment

On its own, upon recommendation of the department, or pursuant to a request under Article V, Section 3(a), the Medical Executive Committee may recommend a change in the clinical privileges or department assignment of a member. The Medical Executive Committee may also recommend that the granting of additional privileges to a current Medical Staff member be made subject to monitoring in accordance with procedures similar to those outlined in Article VI, Section 1(e).

6.5 Proctors/Intervention

The chair of a department may request a member of the Active or Courtesy staff be assigned from the department to act as a proctor of medical care and/or procedures performed by another member of the Medical Staff, an applicant for admission to the Medical Staff, or a practitioner granted temporary or emergency privileges pursuant to Sections 2 and 3 of this Article VI.

As a condition of membership of the Active or Courtesy staff, it shall be the obligation of practitioners to serve as a proctor upon such request. A proctor, in performing his/her duties as such, is acting on behalf of the hospital, and shall be governed by these bylaws in all respects.

6.6 Emergency and Disaster Privileges

a) Emergency Privileges

For the purpose of this section, an "emergency" is defined as an unexpected or sudden event that significantly disrupts the hospital's ability to provide care, or the environment of care itself, or that results in a sudden, significantly changed or increased demand for the hospital's services, or a condition in which serious or permanent harm would result to a patient or in which the life of the patient is in immediate danger and any delay in administering treatment would add to that danger.

In the case of emergency, any practitioner, to the degree permitted by his/her license and regardless of service or staff status or lack of it, shall be permitted and assisted to do everything possible to save the life of a patient, using every facility of the hospital necessary, including the calling for any consultation necessary or desirable.

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

In the event of an officially declared "emergency" or "disaster," whether it is local, state or national, refer to the Hospital's Emergency Management and Disaster Manual for the process of granting privileges.

b) Disaster Privileges

For the purpose of this section, a “disaster” is defined as an emergency that, due to its complexity, scope, or duration, threatens the hospital’s capabilities and requires outside assistance to sustain patient care, safety, or security functions.

In the case of a disaster, temporary clinical privileges may be granted by the president [or designee], or by the chief of staff or by a department chair [or designee], to volunteer licensed independent practitioners only after the hospital emergency operations plan has been activated in response to a disaster and the hospital is unable to meet immediate patient needs.

In the case of a disaster, volunteer practitioners are eligible to function upon presentation of his/her valid government issued photo identification and at least one of the following:

- 1) A current license to practice;
- 2) A current picture identification card from a known healthcare facility that clearly identifies professional designation;
- 3) Primary source verification of licensure;
- 4) Identification that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System For Advance Registration Of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization;
- 5) Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances;
- 6) Confirmation by a current member of the Medical Staff with personal knowledge of the volunteer’ practitioner’s ability to act as a licensed independent practitioner during a disaster.

Primary source verification of licensure shall occur as soon as the immediate disaster situation is under control, or within 72 hours from the time the volunteer licensed independent practitioner is granted disaster privileges.

The Medical Staff oversees the performance of each volunteer licensed independent practitioner who has been granted disaster privileges by direct observation when possible or by medical record review.

When a disaster continues beyond 72 hours, the hospital determines, within 72 hours of the arrival of the volunteer licensed independent practitioner, if granted disaster privileges should continue.

6.7 Dissemination of Privileges List

Documentation of current privileges (granted, modified, or rescinded) shall be disseminated to the hospital admissions/registration office and such other scheduling and health information services personnel as necessary to maintain an up-to-date listing of privileges for purposes of scheduling and monitoring to assure that practitioners are appropriately privileged to perform all services rendered.

ARTICLE VII. CORRECTIVE ACTION

7.1 Procedure

- a) When reliable information indicates a practitioner has exhibited demeanor or conduct reasonably likely to be (1) detrimental to patient safety or to the delivery of quality patient care within the hospital; (2) unethical; (3) contrary to the Medical Staff bylaws, rules and regulations; or (4) below applicable

professional standards, a request for an investigation or action against such member may be initiated by any officer of the Medical Staff, by any department chair, by the chair of any standing committee of the Medical Staff, by the president, or by the governing body. All requests for corrective action shall be in writing to the Medical Executive Committee and shall specifically set forth the information as to the actions, demeanor, or conduct giving rise to such request.

- b) If the request for corrective action is made by the department or chair of the department in which a practitioner has privileges, and that request is made after a review by an ad hoc committee of that department, the Medical Executive Committee may immediately take action upon the request pursuant to subsection (e), provided that the review by the department included notice to the practitioner of the nature of the information giving rise to the investigation review and request, identified any specific charts or records on which the department's review was based, and afforded the practitioner an opportunity to appear before the department committee and be heard, and that following such a review the department prepared a written report of its review and submitted that report with its request for corrective action to the Medical Executive Committee.
- c) If a request for corrective action under subparagraph (a) of this section is not preceded by a department review and report meeting the requirements of subparagraph (b), upon receipt of a request for correction action the Medical Executive Committee may conduct its own investigation with respect to that request or may assign the task to the chair of the department in which the practitioner has privileges. If the Medical Executive Committee decides to investigate the matter itself, it shall promptly appoint an ad hoc committee of not less than three (3) persons to investigate the matter.

During the course of such investigation, the practitioner as to whom corrective action has been requested shall have an opportunity for an interview with the department investigating committee or the ad hoc committee appointed by the Medical Executive Committee, as the case may be. At such interview, the practitioner shall be informed of the general nature of the charges against him/her and shall be invited to discuss, explain or refute them. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these bylaws with respect to hearings shall apply. A written record of the interview shall be made and shall be included in the final report of the investigation.

- d) Within forty-five (45) days following the receipt of a request for corrective action, or thirty (30) days following receipt of a written report from a department following the department's review of a request for corrective action, whichever first occurs, the Medical Executive Committee shall take action upon the request. If the action could involve a reduction or suspension of clinical privileges, or a suspension or expulsion from the Medical Staff, and the review or investigation was conducted by the department or an ad hoc committee of the Medical Executive Committee, the practitioner shall be permitted to make an appearance before the Medical Executive Committee prior to its taking action on such request. This appearance shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these bylaws with respect to hearings shall apply thereto. A written record of such appearance shall be made by the Medical Executive Committee.
- e) The action of the Medical Executive Committee on a request for corrective action may be to adopt, reject or modify the request for corrective action, to issue a warning, a letter of admonition, or a letter of reprimand, to impose terms of probation, suspension or revocation of clinical privileges, to recommend that an already imposed summary suspension of clinical privileges be terminated, modified or maintained, or to recommend that the practitioner's staff membership be suspended or revoked, or any combination thereof. Regardless of the status of any investigation, the Medical Executive Committee may recommend or take any action warranted by the circumstances.
- f) Any recommendation by the Medical Executive Committee for reduction, suspension, or revocation of clinical privileges, or for suspension or expulsion from the Medical Staff shall entitle the affected practitioner to the procedural rights provided in Article VIII of these bylaws.

- g) The chair of the Medical Executive Committee shall promptly notify the governing body in writing of all requests for corrective action received by the Medical Executive Committee and shall continue to keep the governing body fully informed of all actions taken in connection therewith.
- h) In the event reliable information indicates that a practitioner has acted in a way, or exhibited demeanor or conduct, which might justify corrective action pursuant to this section, notwithstanding the provisions of this section, the Medical Executive Committee or chair of the department in which the practitioner has privileges may take action short of the "corrective action" contemplated in paragraphs (a)-(g), which action may include required monitoring or supervision of a practitioner without a concurrent reduction or restriction of staff privileges. Such action shall be taken pursuant to procedures established by the Medical Executive Committee or the department, as the case may be.
- l) If the Medical Executive Committee fails to investigate or take disciplinary action, contrary to the weight of the evidence, the board of trustees may direct the Medical Executive Committee to initiate an investigation or disciplinary action, but only after consultation with the Medical Executive Committee.

If the Medical Executive Committee fails to take action in response to that board of trustee's direction, the board of trustees may initiate corrective action, but this corrective action must comply with Articles VII and VIII of these Medical Staff bylaws.

7.2 Summary Suspension

- a) Whenever a practitioner's conduct requires immediate action to be taken to reduce a substantial likelihood of imminent impairment of the health or safety of any patient, prospective patient, employee, or other person present in the hospital, the chief of staff, the Medical Executive Committee, the department chair or designee in which the member holds privileges, or the president shall have the authority to summarily suspend the Medical Staff membership status or all or any portion of the clinical privileges of such practitioner. Such summary suspension shall become effective immediately upon imposition, and the person or body responsible therefore shall promptly give written notice of the suspension to the practitioner, governing body, Medical Executive Committee and president.
- b) If a Medical Staff investigation has not already been conducted, a practitioner whose clinical privileges have been summarily suspended shall be entitled to request an ad hoc investigative committee of the appropriate department to investigate the matter, hold an informal hearing and make a recommendation to the Medical Executive Committee within a reasonable period of time but, in any event, within five (5) working days of the summary suspension, and shall be informed of this right in writing.
- c) The Medical Executive Committee shall consider the recommendation of the ad hoc committee and, if it deems necessary, shall make its own investigation or hold its own informal hearing. The Medical Executive Committee shall make a decision on the summary suspension within ten (10) calendar days of the receipt of the ad hoc committee recommendation. If the summary suspension is upheld or if the Medical Executive Committee fails to terminate the summary suspension within the time period provided for its decision, the practitioner shall be entitled to the procedural rights provided by Article VIII. The practitioner's failure without good cause to attend any Medical Executive Committee meeting on request shall constitute a waiver of his/her rights under Article VII and Article VIII.

7.3 Automatic Suspension or Limitation

In the following instances, the member's privileges or membership shall be suspended or limited as described:

7.3.1 Licensure

- 1) **Revocation, Suspension, or Expiration:** Whenever a practitioner's license or other legal credential authorizing practice in this state is revoked, suspended, or expired without an application pending for renewal, Medical Staff membership and privileges shall be automatically revoked as of the date such action becomes effective.
- 2) **Restriction:** Whenever a member's license or other legal credential authorizing practice in this state is limited or restricted by the applicable licensing or certifying authority, any privileges which are within the scope of such limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.
- 3) **Probation:** Whenever a member is placed on probation by the applicable licensing or certifying authority, his or her membership status and privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

7.3.2 DEA Certificate

- 1) **Revocation, Suspension, and Expiration:** Whenever a privileged member's DEA certificate is revoked, limited, suspended, or expired, the member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate as of the date such action becomes effective and throughout its term.
- 2) **Probation:** Whenever a privileged member's DEA certificate is subject to probation, the member's right to prescribe such medications shall automatically become subject to the same terms of the probation as of the date such action becomes effective and throughout its term.

7.3.3 Board Certification

Failure of members initially appointed after January 1, 2011 to maintain board certification shall require the member to reacquire certification within two (2) years of certification expiration.

Failure to recertify within two (2) years shall result in the automatic suspension of the member's admitting privileges and expiration of other practice privileges and prerogatives at the end of the current staff appointment, unless otherwise excepted by the Medical Executive Committee.

7.3.4 Failure to Satisfy Special Appearance Requirement

A member who fails to appear and satisfy the requirements of Article XIII, Section 6 shall automatically be suspended from exercising all or such portion of privileges as that Section specifies.

7.3.4 Medical Records

Medical Staff members are required to complete medical records within fourteen (14) days of a patient's discharge. Failure to timely complete medical records shall result in an automatic suspension after notice is given.

Such suspension shall apply to the Medical Staff member's right to admit, treat, or provide services to new patients in the hospital, but shall not affect the right to continue to care for a patient the Medical Staff member has already admitted or is treating or has been scheduled for surgery. The suspension shall continue until the medical records are completed.

7.3.5 Professional Liability Insurance

Failure to maintain professional liability insurance as required by these bylaws shall result in the automatic suspension of a member's privileges. Failure to maintain professional liability insurance for certain procedures shall result in the automatic suspension of privileges to perform those procedures. The suspension shall be effective until appropriate coverage is reinstated, including coverage of any acts or potential liabilities that may have occurred or arisen during the period of any lapse in coverage.

7.3.6 Physician Attestation Statement

Any practitioner failing to submit a Medicare Physician Attestation Statement shall be automatically suspended and shall remain so suspended until the statement is submitted.

7.3.7 Automatic Termination

- 1) Failure to pay dues on or before November 1 of the relevant Medical Staff year or failure to pay other assessments within thirty (30) days after written warning of delinquency, a practitioner's Medical Staff membership and privileges shall be automatically terminated.
- 2) If a practitioner accumulates more than sixty (60) cumulative suspension days, his or her membership (or the affected privileges, if the suspension is a partial suspension) shall be automatically terminated. Thereafter, reinstatement to the Medical Staff shall require application and compliance with the appointment procedures applicable to applicants.

7.3.8 Medical Executive Committee Deliberation and Procedural Rights

- 1) As soon as practicable after action is taken or warranted as described in Section 3(a-c), the Medical Executive Committee shall convene to review and consider the facts and may recommend such further corrective action as it may deem appropriate following the procedure generally set forth commencing at Article VII. There is no need for the Medical Executive Committee to act on automatic suspensions for failures to complete medical records [Section 3(d)], maintain professional liability insurance [Section 3(e)], or submit a Physician Attestation Statement [Section 3(f)]. The Medical Executive Committee review and any subsequent hearings and reviews shall not address the propriety of the licensure or DEA action, but instead shall address what action should be taken by the hospital.
- 2) Practitioners whose privileges are automatically suspended and/or who have been deemed to have automatically resigned their Medical Staff membership shall be entitled to a hearing only if the suspension is reportable to the Medical Board of California or the Federal National Practitioner Data Bank.

7.3.9 Notice of Automatic Suspension and Transfer of Patients

Written notice of an automatic suspension shall be given to the suspended individual, and regular notice of the suspension shall be given to the Medical Executive Committee, president, and governing body, but such notice shall not be required for the suspension to become effective. Patients affected by an automatic suspension shall be assigned to another member by the department chair or chief of staff. The wishes of the patient and affected practitioner shall be considered, where feasible, in choosing a substitute member.

7.3.10 Medical Staff Policy

Failure to comply with any policy applicable to the Medical Staff shall result in the automatic suspension of clinical privileges until compliance has been completed.

7.3.11 Health Surveillance

Each member of the Medical/Allied Health Staff* (except members of the Telehealth Consultant Staff) must document annual PPD testing and, if PPD testing is positive, must provide documentation of annual tuberculosis screening. In addition, each member shall obtain, or provide documentation of, annual influenza vaccination or documentation of declination. Members are required to meet any future federal or state mandated infection prevention testing or vaccinations.

Failure to comply with this requirement within thirty (30) days following receipt of written Notice from the Chief of Staff shall result in an automatic suspension of the member's clinical privileges and Medical Staff prerogatives. If a member's privileges and prerogatives remain suspended under this section for ninety (90) days, the member shall be deemed to have voluntarily resigned from the Medical Staff without prejudice.

ARTICLE VIII. HEARING & APPEAL PROCEDURES

IMMUNITY FROM LIABILITY: Any report, information, or accusation filed, or any action recommended under this section, shall be deemed a privileged communication. Each member of the Medical Staff or applicant to the Medical Staff waives any right of personal redress against the Medical Staff, the judicial review committee, the governing body, or any member thereof, for disciplinary action taken under this Article VIII.

8.1 Definitions

- a) Body whose decision prompted the hearing refers to the committee or body which, pursuant to the Medical Staff bylaws, made the report or recommendation which resulted in a hearing being requested.
- b) Notice as used in this Article shall be a written communication delivered in person or sent by certified mail to the most recent known address, return receipt requested. The notice shall be deemed to have been served when delivered in person or when return receipt has been received.
- c) Person who requested the hearing refers to the applicant or Medical Staff member, as the case may be, who has requested a hearing pursuant to Section 2 (Request for Hearing) of this Article.

8.2 Request for Hearing

- a) Notice of Decision: In all cases in which the body or committee which, under these bylaws has the authority to, and pursuant to this authority, has recommended or taken any of the actions constituting grounds for hearing as hereinafter set forth in subsection (b) of Section 2 of this Article, the applicant or Medical Staff member, as the case may be, shall promptly be given notice of that action, and informed that such action, if adopted, shall be taken and reported to the Medical Board of California and/or the National Practitioner Data Bank if required. Furthermore, if the action is reportable, the applicant or Medical Staff member shall be informed of the reasons for the proposed action including the acts or omissions which the member is charged, his/her right to request a hearing and that such hearing must be requested within thirty (30) days, and a summary of the rights granted in the hearing pursuant to the Medical Staff bylaws. A request for hearing shall be by written notice to the president. If the applicant or member does not request a hearing within the time and manner hereinabove set forth, he/she shall be deemed to have accepted the action involved and waived his/her right to a hearing, and it shall become effective immediately.
- b) Grounds for Hearing: Any one or more of the following actions shall constitute grounds for a hearing only, if the action, or recommendation, would be reportable to the Medical Board of California or to the National Practitioner Data Bank:

- 1) denial of Medical Staff membership;
 - 2) denial of requested advancement in Medical Staff membership except when due to extension of provisional staff membership/proctoring or movement from provisional to courtesy staff;
 - 3) denial of Medical Staff reappointment;
 - 4) demotion to lower staff category;
 - 5) suspension of Medical Staff membership;
 - 6) expulsion from Medical Staff membership;
 - 7) denial of requested privileges;
 - 8) reduction in privileges;
 - 9) suspension of privileges;
 - 10) termination of privileges;
 - 11) involuntary imposition of significant consultation or monitoring requirements (excluding monitoring incidental to provisional status or granting of new procedures).
- c) Time and Place for Hearing: Upon receipt of a request for hearing, the president shall deliver such request to the Medical Executive Committee. The Medical Executive Committee shall, within thirty (30) days after the date of such request, schedule and arrange for a hearing.

The Medical Executive Committee shall give notice to the applicant or member of the time, place, and date of the hearing. The date of the commencement of the hearing shall be not less than thirty (30) days, nor more than sixty (60) days from the date of receipt of the request by the president for a hearing; provided, however, that when the request is received from a member who is under suspension which is then in effect, the hearing shall be held as soon as the arrangements may reasonably be made, but not to exceed forty-five (45) days from the date of receipt of the request for hearing by the president.

d) Prehearing Procedure

- 1) If either side to the hearing requests in writing a list of witnesses, within fifteen (15) days of such request, each party shall furnish to the other a written list of the names and addresses of the individuals, so far as is reasonably known or anticipated, who are anticipated to give testimony or evidence in support of that party at the hearing. The member shall have the right to inspect and copy documents or other evidence upon which the charges are based, as well as all other evidence relevant to the charges. The member shall also have the right to receive at least thirty (30) days prior to the hearing a copy of the evidence forming the basis of the charges which is reasonably necessary to enable the member to prepare a defense, including all evidence which was considered by the Medical Executive Committee in determining whether to proceed with the adverse action, and any exculpatory evidence in the possession of the hospital or Medical Staff. The member and the Medical Executive Committee shall have the right to receive all evidence which will be made available to the judicial review committee.
- 2) The Medical Executive Committee shall have the right to inspect and copy at its expense any documents or other evidence relevant to the charges which the member possesses or controls as soon as practicable after receiving the request.
- 3) The failure by either party to provide access to this information at least thirty (30) days before the hearing shall constitute good cause for a continuance. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable members, other than the member under review.

- 4) The hearing officer shall consider and rule upon any request for access to information and may impose any safeguards the protection of the peer review process and justice requires. In so doing, the hearing officer shall consider;
 - a. whether the information sought may be introduced to support or defend the charges;
 - b. the exculpatory or inculpatory nature of the information sought, if any;
 - c. the burden imposed on the party in possession of the information sought, if access is granted; and
 - d. any previous requests for access to information submitted or resisted by the parties to the same proceeding.
- 5) The member shall be entitled to a reasonable opportunity to question and challenge the impartiality of judicial review committee members and the hearing officer. Challenges to the impartiality of any judicial review committee member or the hearing officer shall be ruled on by the hearing officer.
- 6) It shall be the duty of the member and the Medical Executive Committee or its designee to exercise reasonable diligence in notifying the chair of the judicial review committee of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any prehearing decisions may be succinctly made at the hearing.
- e) **Judicial Review Committee:** If a hearing is requested, within fifteen (15) days of such request, the Medical Executive Committee shall recommend a judicial review committee which shall be composed of not less than three (3) members of the active Medical Staff who shall gain no direct financial benefit from the outcome, and who shall not have actively participated in the consideration of the matter involved at any previous level. The Medical Executive Committee shall promptly notify the governing body of its action. The governing body shall be deemed to approve the selection unless it provides written notice to the Medical Executive Committee stating the reasons for its objection within five (5) days. Knowledge of the matter involved shall not preclude a member of the active Medical Staff from serving as a member of the judicial review committee. If it is not possible or practicable to appoint all or any members of a judicial review committee from the active Medical Staff, the Medical Executive Committee may recommend to such a committee qualified practitioners from the courtesy Medical Staff or from practitioners outside the Medical Staff, none of whom shall have previously participated in the consideration of the issues under review. Membership on a judicial review committee shall consist of one member who shall have the same healing arts licensure as the accused, and where feasible, include an individual practicing the same specialty as the member.
- f) **Failure to Appear:** Failure without good cause of the person requesting the hearing to appear and proceed at such a hearing shall be deemed to constitute voluntary acceptance of the recommendations of actions involved which shall become final and effective immediately.
- g) **Postponements and Extensions:** Postponements and extensions of time beyond the time expressly permitted in these bylaws may be requested and shall be permitted for up to ninety (90) days by the judicial review committee, or by the chair acting on behalf of the committee, on a showing of good cause. If, after ninety (90) days, the party requesting postponement of the hearing has not requested that a new hearing date be set, the matter shall be considered closed and no further action shall be taken.

- h) Decision of the Judicial Review Committee: Within thirty (30) days after final adjournment of the hearing (provided that in the event the member is currently under suspension this time shall be ten (10) days), the judicial review committee shall render a decision which shall be accompanied by a report in writing which shall be delivered to the body whose decision prompted the hearing. The report shall contain a concise statement of the reasons justifying the decision made by the judicial review committee. At the same time, a copy of this report and decision shall be delivered in person or by certified mail to the person who requested the hearing.
- i) Appeal: The decision of the judicial review committee shall be considered final, subject only to the right of appeal as provided in Section 4 of this Article.
- j) Adverse Action: If action described in Section 2(h) adverse to the person requesting the hearing is taken or recommended, the applicant or member must exhaust the remedies afforded by these bylaws before resorting to legal action challenging the decision, the procedures used to arrive at the decision, or asserting any claim against the hospital or participants in the decision process.

8.3 Hearing Procedure

- a) Personal Presence Mandatory: Under no circumstances shall the hearing be conducted without the personal presence of the person requesting the hearing unless he/she has waived such appearance or has failed without good cause to appear after appropriate notice.
- b) Representation: The member requesting the hearing shall be entitled to representation by legal counsel in any phase of the hearing, should he/she so choose, and shall receive notice of the right to obtain representation by an attorney at law. In the absence of legal counsel, the member shall be entitled to be accompanied by and represented at the hearing only by a practitioner licensed to practice in the State of California who is not also an attorney at law, and the Medical Executive Committee shall appoint a representative who is not an attorney to present its action or recommendation, the materials in support thereof, examine witnesses, and respond to appropriate questions. The Medical Executive Committee shall not be represented by an attorney at law if the member is not so represented.
- c) The Presiding Officer: The presiding officer at the hearing shall be the hearing officer or, if none has been appointed, the chair of the judicial review committee. The presiding officer shall act to insure that all participants in the hearing have a reasonable opportunity to be heard, to present all oral and documentary evidence, and that decorum is maintained. He/she shall be entitled to determine the order or procedure during the hearing. He/she shall have the authority and discretion, in accordance with these bylaws, to make all rulings on questions which arise during the course of the hearing and to the admissibility of evidence.
- d) The Hearing Officer: The Medical Executive Committee shall appoint a hearing officer to preside at the hearing. The hearing officer may be an attorney at law qualified to preside over a quasi-judicial hearing, but attorneys from a firm regularly utilized by the hospital, the Medical Staff or the involved Medical Staff member or applicant for membership, for legal advice regarding their affairs and activities shall not be eligible to serve as hearing officer. The hearing officer shall gain no direct financial benefit from the outcome and must not act as a prosecuting officer or as an advocate. The hearing officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The hearing officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure or the admissibility of evidence. If the hearing officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the hearing officer may take such

discretionary action as seems warranted by the circumstances. If requested by the judicial review committee, the hearing officer may participate in the deliberations of such committee and be a legal advisor to it, but the hearing officer shall not be entitled to vote.

- e) Record of Hearing: The judicial review committee shall maintain a record of the hearing by one of the following methods: A shorthand reporter to make a record of the hearing, a recording, or minutes of the proceedings. The cost of such shorthand reporter shall be borne by the party requesting same. The judicial review committee may, but shall not be required to, order that oral evidence shall be taken only on oath or affirmation administered by any person designated by such body and entitled to notarize documents in the State of California.
- f) Rights of Both Sides: At a hearing, both sides shall have the following rights: to call and examine witnesses, to introduce exhibits, to cross-examine any witness on any matter relevant to the issues, to impeach any witness, and to rebut any evidence.

If the applicant or member of the Medical Staff does not testify on his/her own behalf, he/she may be called and examined as if under cross-examination.

- g) Admissibility of Evidence: The hearing shall not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant evidence shall be admitted by the presiding officer if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Each party shall have this right to submit a memorandum of points and authorities, and the judicial review committee may request a memorandum to be filed following the close of the hearing. The judicial review committee may interrogate the witnesses or call additional witnesses if it deems it appropriate.
- h) Official Notice: The presiding officer shall have the discretion to take official notice of any matters either technical or scientific relating to the issues under consideration which could have been judicially noticed by the courts of this State. Participants in the hearing shall be informed of the matters to be officially noticed and they shall be noted in the record of the hearing. The person requesting the hearing shall have the opportunity to request that a matter be officially noticed or to refute the noticed matters by evidence or by written or oral presentation of authority. Reasonable or additional time shall be granted, if requested, to present written rebuttal of any evidence admitted on official notice.
- i) Basis of Decision: The decision of the judicial review committee shall be based on the evidence presented at the hearing. This evidence may consist of the following:
 - 1) oral testimony of witnesses;
 - 2) briefs, or memorandum of points and authorities presented in connection with the hearing;
 - 3) any material contained in the Medical Staff's credentials files regarding the person who requested the hearing;
 - 4) any and all applications, references, and accompanying documents;
 - 5) all officially noticed matters; or
 - 6) any other evidence deemed admissible under Section 3(g) of this Article.

- j) **Burden of Proof:** In all other cases specified in Section 2(b) of this Article, it shall be incumbent on the body or committee whose action prompted the hearing to initially come forward with evidence in support of its action or decision.
 - 1) At the hearing the Medical Executive Committee shall have the initial duty to present evidence for each case or issue in support of its action or recommendation. The member shall be obligated to present evidence in response.
 - 2) An applicant shall bear the burden of persuading the judicial review committee, by a preponderance of the evidence, of the applicant's qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning the applicant's current qualifications for membership and privileges. An applicant shall not be permitted to introduce information requested by the Medical Staff but not produced during the application process unless the applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.
 - 3) Except as provided above for applicants, throughout the hearing, the Medical Executive Committee shall bear the burden of persuading the judicial review committee, by a preponderance of the evidence, that its action or recommendation is reasonable and warranted.
- k) **Adjournment and Conclusion:** The presiding officer may adjourn the hearing and reconvene the same at the convenience of the participants without special notice. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The judicial review committee shall thereupon, within the time specified in Section 2(h) of this Article, outside of the presence of any other person, conduct its deliberations and render a decision and accompanying report as provided therein.
- l) **Ruling:** In all cases in which a hearing is conducted under this Article, after all the evidence has been submitted by both sides, the judicial review committee shall rule against the person who requested the hearing unless it finds that the decision made by the committee or body which prompted the hearing is not sustained by the evidence.

8.4 Appeal to the Board of Trustees

- a) **Time for Appeal:** Within ten (10) days after receipt of the decision of the judicial review committee, either the person who requested the hearing or the body whose decision prompted the hearing may request an appellate review by the governing body. Said request shall be delivered to the president in writing and delivered either in person or by certified mail. If such appellate review is not requested within such period, both sides shall be deemed to have accepted the action involved and it shall thereupon become final and shall be effective immediately. The written request of appeal shall also include a brief statement as to the reasons for appeal.
- b) **Grounds for Appeal:** The grounds for appeal from the hearing shall be:
 - 1. substantial non-compliance with the procedures required by these bylaws or applicable law which has created demonstrable prejudice; or
 - 2. the decision was not supported by substantial evidence based upon the hearing record or such additional information as may be permitted pursuant to Section 4.d of this Article.
- c) **Time, Place & Notice of Appellate Review:** In the event of any appeal to the governing body as set forth in the preceding subsection, the governing body shall, within ten (10) days after receipt of such notice of appeal, schedule and arrange for an appellate review. The governing body shall cause the applicant or member to be given notice of time, place, and date of the appellate review.

The date of the appellate review shall be not less than six (6) days nor more than thirty (30) days from the date of receipt of the request for appellate review, provided, however, that when a request for appellate review is from a member who is under suspension which is then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made and not to exceed thirty (30) days from the date of receipt of the request for appellate review. The time for appellate review may be extended by the chair of the governing body for good cause.

- d) Nature of Appellate Review: The proceedings by the governing body shall be in the nature of an appellate hearing based upon the record of the hearing before the judicial review committee, provided that the governing body may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the judicial review committee hearing.

Each party shall have the right to present a written statement in support of his/her position on appeal, and the governing body shall allow each party or representative to personally appear and make oral argument.

At the conclusion of oral argument, if allowed, the governing body may thereupon at a time convenient to itself conduct deliberations outside the presence of the appellant and respondent and their representatives. The governing body may affirm, modify, or reverse the decision of the judicial review committee or, in its discretion, refer the matter for further review and recommendation.

- e) Final Decision: Within thirty (30) days after the conclusion of the proceedings before the governing body, the governing body shall render a final decision in writing and shall deliver copies thereof to the applicant or member of the Medical Staff and to the Medical Executive Committee in person or by certified mail. Both the member and the Medical Executive Committee shall be provided a written explanation of the procedure for appealing the decision.
- f) Further Review: Except where the matter is referred for further review and recommendation in accordance with Section 4(d), the final decision of the governing body following the appeal procedures set forth in this Article shall be effective immediately and shall not be subject to further review. Provided, however, if the matter is referred back to the judicial review committee for further review and recommendation, said committee shall promptly conduct its review and make its recommendations to the governing body in accordance with the instruction given by the governing body. This further review process and the report back to the governing body shall in no event exceed thirty (30) days in duration except as the parties may otherwise stipulate.
- g) Right to One Hearing Only: Except as otherwise provided in this Article, no applicant or member shall be entitled as a matter of right to more than one hearing before the governing body on any single matter which may be the subject of an appeal without regard to whether such subject is the result of action by the Medical Executive Committee or the governing body, or a combination of acts of such bodies.

8.5 National Practitioner Data Bank Reporting

The authorized representative shall report an adverse action to the National Practitioner Data Bank only upon its adoption as final action and only using the description set forth in the final action as adopted by the board of trustees. The authorized representative shall report any and all revisions of an adverse action, including, but not limited to, any expiration of the final action consistent with the terms of that final action.

ARTICLE IX. CONFIDENTIALITY OF INFORMATION

9.1 Confidential Information

All Medical Staff, department, Medical Executive Committee, standing committee, ad hoc committee, judicial review committee, and governing body minutes, files and records and related oral or written information relating to the evaluation and improvement of the quality of patient care provided in the hospital or the qualifications of any member of or applicant for admission to the Medical Staff (collectively "Confidential Information") shall be confidential and shall be maintained as such to the fullest extent permitted by law. Confidential Information in written form shall be kept in a file or other repository, access to which is limited to authorized personnel. No one shall disclose or disseminate any Confidential Information, whether oral or written, except as is expressly required by law, authorized pursuant to these bylaws or official policies of the Medical Staff or hospital from time to time in effect, or in the absence of an official policy only with the approval of the governing body, the Medical Executive Committee, or the president.

9.2 Access to Records

Access to Confidential Information shall be strictly limited to those persons who are officers of the Medical Staff, chairs of departments, members of committees or of the governing body, the president, designated employees of the hospital with the specific responsibility for maintaining Confidential Information, and legal counsel to the hospital or Medical Staff, and, in each case, access to Confidential Information shall be limited to those who have a need to know such Confidential Information for the sole purpose of discharging their responsibilities to the hospital or under these bylaws. All persons having access to Confidential Information shall keep such Confidential Information confidential in accordance with the provisions of Section I of this Article.

Violation of Section 9.2 is grounds for corrective action under Article VII of these Bylaws or for the removal of a member from any committee or officer position, which removal shall be determined by the Medical Executive Committee and shall not entitle the affected member to the hearing rights under Article VIII of the Medical Staff Bylaws.

9.3 Disclosure of Confidential Information with Consent

A member of the Medical Staff may give his/her consent in writing to the disclosure of Confidential Information contained in the credentials file of such member to another hospital, the Medical Staff of another hospital, a professional licensing board, a medical school or underwriting committee; provided, however, that no Confidential Information shall be so disclosed if such disclosure would violate any limitation on the use of such Confidential Information imposed by the person furnishing such Confidential Information or the terms on which such Confidential Information was solicited or received; and further provided, that any disclosure of Confidential Information except as permitted by Section 2 of this Article shall require the approval of the chief of staff and the chairman of the relevant department. Information contained in the credentials file of any member may be disclosed with the member's consent, or to any Medical Staff or professional licensing board, as required by law.

9.4 Compliance; Corrective Action

Each member of the Medical Staff may be required to sign a confidentiality agreement in the form approved by the Medical Executive Committee as may be necessary or appropriate to ensure compliance with the foregoing provisions of this Article. Any member of the Medical Staff who discloses Confidential Information in violation of the foregoing provisions of this Article shall be subject to corrective action in accordance with Article VII of these bylaws.

9.5 Applicant Access to File

In connection with a request for clinical privileges or an application for changed or additional clinical privileges, or in preparation for any interview or hearing as provided for in Articles VII or VIII of these bylaws, a Medical Staff member or an applicant for membership on the Medical Staff shall be granted access to his/her own credentials file, subject to the following provisions:

- a) A timely written request for access shall be given by the member to the chief of staff;
- b) The member may review, and receive a copy of, only those documents provided by or addressed personally to the member. A summary of all other information shall be provided to the member, in writing, by the officer of the Medical Staff designated to do so by the chief of staff, within a reasonable period of time, as determined by the Medical Executive Committee.
- c) The review by the member shall take place in Medical Staff administration, during regular business hours, with a Medical Staff officer [or designee] present.
- d) A member shall have the right to add to his/her own credentials file a written statement responding to or supplementing any information contained in the file.

9.6 Indemnification

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

ARTICLE X. OFFICERS

10.1 Officers of the Medical Staff

The officers of the Medical Staff shall be:

- a) the Chief of Staff; and
- b) the Vice-Chief of Staff

10.2 Qualifications of Officers

Officers must be members of the active staff at the time of nomination and election and must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved. Officers must have served at least one (1) year as a department chair, Medical Staff committee chair or member of the Medical Executive or Quality Assessment/ Improvement Committees, within the past five (5) years. The chief of staff must be either a doctor of medicine or osteopathy.

10.3 Election of Officers

- a) Officers shall be elected by a secret ballot to be mailed to all members of the active staff at least twenty (20) days prior to start of the Medical Staff year. The ballot shall contain the names of those nominated by the nominating committee and by petition unless a nominee does not qualify for election under these bylaws. Only those ballots received at the hospital not later than five (5) days before the start of the Medical Staff year shall be counted. The candidate or candidates receiving the highest number of votes cast shall be elected. The ballots shall be canvassed by the Medical Executive Committee.
- b) The nominating committee shall consist of the chief of staff, the two most immediate past chiefs of staff who are still members of the active staff, plus the chairs of the departments of medicine, surgery, and psychiatry, and special services. The most immediate past chief of staff shall act as chair. This committee shall nominate one or more candidates for each of the two offices and this slate shall be announced at the quarterly Medical Staff meeting in April.
- c) Nominations may also be made by petition signed by at least ten (10) members of the active staff and filed with the secretary of the Medical Staff not more than fourteen (14) days following the April quarterly Medical Staff meeting.

10.4 Term of Office

Officers shall serve a two (2) year term commencing on the first day of the Medical Staff year, or until a successor has been elected or qualified. Officers may be elected for additional terms.

10.5 Removal of an Officer

Any officer whose election is subject to these bylaws may be removed from office for valid cause, including, but not limited to, gross neglect or malfeasance in office, serious acts of moral turpitude, or failure to carry out the duties as defined in Section 7 of this Article. Such removal shall be by petition of twenty-five percent (25%) of the active members and a subsequent two-thirds majority vote of all active staff members who actually cast votes and shall be effective immediately. The Medical Executive Committee may relieve an officer by a two-thirds majority vote due to grave and serious circumstances leading to the inability to fulfill the duties of said office. This act shall be in effect until sustained or overturned by vote of active members.

10.6 Vacancies in Office

Vacancies in office occur upon the death or disability, resignation, or removal of the officer, or such officer's loss of membership in the Medical Staff. If there is a vacancy in the office of chief of staff, the then vice-chief of staff shall serve out that remaining term as chief of staff and shall immediately appoint an ad hoc committee to decide promptly on nominees for the office of vice-chief of staff. Such nominees shall be reported to the Medical Executive Committee and to the Medical Staff. A special election to fill the position shall occur at the next regular staff meeting. If there is a vacancy in the office of vice-chief of staff, that office need not be filled by election, but the Medical Executive Committee shall appoint an interim officer to fill this office until the next regular election.

10.7 Duties of Officers

- a) Chief of Staff: The chief of staff shall serve as the chief administrative officer of the Medical Staff. He/she shall:
 - 1) serve as an ex-officio member of the governing body;
 - 2) act in coordination and cooperation with the president and governing body in all matters of mutual concern within the hospital;

- 3) call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;
- 4) serve as chair of the Medical Executive Committee;
- 5) serve as an ex-officio member of all other Medical Staff committees without vote, unless his/her membership in a particular committee is required by these bylaws;
- 6) be responsible for the enforcement of Medical Staff bylaws, rules & regulations, for the implementation of sanctions where these are indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner;
- 7) report the activities of the Medical Staff and represent the views, policies, needs and grievances of the Medical Staff to the governing body and to the president;
- 8) receive and interpret to the Medical Staff the policies of the governing body and report to the governing body on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care; and
- 9) be the spokesperson for the Medical Staff in its external professional and public relations.

b) Vice-Chief of Staff:

- 1) In the absence of the chief of staff, the vice-chief of staff shall assume all the duties and have the authority of the chief of staff.
- 2) He/she shall be responsible for collecting and disbursing Medical Staff funds and shall report quarterly to the Medical Executive Committee the amount of money received, deposited, and expended, and shall perform such other duties as ordinarily pertain to his/her office.
- 3) He/she shall
 - a. serve as chair of the Medical Staff quality assessment and improvement committee;
 - b. shall report committee activities to the Medical Executive Committee including by not limited to. performance improvement activities;
 - c. key quality and safety indicators; regulatory activities; and
 - d. proposed solutions to unmet quality standards.
- 4) He/she shall perform such other duties as ordinarily pertain to his/her office or as assigned by the Medical Executive Committee.

ARTICLE XI. DEPARTMENTS

11.1 Organization

Each practitioner on the Medical Staff shall be assigned to a specific department. The departments shall be medicine, surgery, psychiatry, and special services. Each department shall be organized as a separate part of the Medical Staff and shall have a chair who shall monitor the clinical work within the department.

11.2 Assignment to Departments

a) Clinical Departments

1) Department of Medicine (includes, but not limited to the following specialties):

- | | | | |
|----|-------------------------|----|--------------------|
| a) | Ambulatory Care | i) | Internal Medicine |
| b) | Cardiology | j) | Nephrology |
| c) | Dermatology | k) | Neurology |
| d) | Emergency Medicine | l) | Oncology |
| e) | Gastroenterology | m) | Pediatrics |
| f) | General/Family Practice | n) | Physical Medicine |
| g) | Geriatrics | o) | Pulmonary Medicine |
| h) | Hematology | p) | Other |

2) Department of Surgery (includes, but not limited to the following specialties):

- | | | | |
|----|---------------------|----|----------------------------|
| a) | Anesthesiology | h) | Orthopedic Surgery |
| b) | Dental Surgery | i) | Plastic Surgery |
| c) | Otolaryngology | j) | Podiatric Surgery |
| d) | Surgery | k) | Thoracic Surgery |
| e) | General Surgery | l) | Urologic Surgery |
| f) | Gynecologic Surgery | m) | Vascular Surgery |
| g) | Neurosurgery | n) | Other Surgical Specialties |
| h) | Ophthalmology | | |

3) Department of Psychiatry

4) Department of Special Services (to include):

- | | |
|----|--|
| a) | Section of Diagnostic Radiology & Nuclear Medicine |
| b) | Section of Pathology |
| c) | Section of Radiation Oncology |

Additional departments may be organized as necessary to meet the needs of the Medical Staff.

11.3 General/Family Practice

- Each general/family practitioner shall be assigned to the department of medicine for purposes of participating in the required functions of the Medical Staff, for holding office, and for fulfilling all of the other obligations which go with Medical Staff membership.
- General/family practitioners may have clinical privileges in one or more departments in accordance with their education, training, experience and demonstrated competence. They shall be subject to all of the rules of such departments and to the jurisdiction of each department chair involved.

11.4 Qualifications and Tenure of Clinical Department Chairs

- Each chair shall be a member of the active Medical Staff and must remain a member in good standing during his/her term of office. He/she shall be qualified by training, experience, and demonstrated ability in at least one of the clinical areas covered by the department. Department chairs must be certified by an appropriate specialty board or must demonstrate comparable competence.
- Each chair shall be elected for a three (3) year term, as provided in Section 5 below. Chairs may be elected for additional terms.

- c) Any department chair may be removed from office for valid cause, including, but not limited to, gross neglect or malfeasance in office, serious acts of moral turpitude, or failure to carry out the duties as defined in Section 7 of this Article. Removal of a chair during his/her term of office may be initiated by petition of twenty-five percent (25%) of the active department members and a subsequent two-thirds majority vote of all active staff members of the department who actually cast votes. The Medical Executive Committee may relieve a department chair by a two-thirds majority vote due to grave and serious circumstances leading to the inability to fulfill the duties of the chair. This act shall be in effect until sustained or overturned by vote of active department members.

11.5 Election of Clinical Department Chairs

- a) Chairs shall be elected by secret ballot to be mailed to all active staff members of the department at least twenty (20) days prior to the departmental meeting held in the month of May in an election year. The ballot shall contain the names of those nominated by the nominating committee and by petition unless a nominee does not qualify for election under these bylaws. The candidate receiving the highest number of properly identified ballots cast shall be elected. Only those ballots received at the hospital not later than five (5) days prior to the May departmental meeting shall be counted. The ballots shall be canvassed by the Medical Executive Committee. No nominee shall be present for the counting of the ballots. In the event of a tie, the ballots shall be recast, using the same time frame as described above, with the election result announced in June.
- b) The nominating committee shall consist of five (5) members of the active staff from the department concerned and shall be appointed by the chief of staff. The chief of staff shall be an ex-officio member of the committee without power to vote. The committee shall nominate one or more candidates for the office of chair from the active staff members of the department. This slate shall be announced to members of the department at the departmental meeting in March.
- c) Nominations may also be made by petition signed by at least five (5) members of the active staff of the department filed with the vice-chief of staff of the Medical Staff not more than five (5) days following the March departmental meeting.

11.6 Clinical Department Vice-Chairs

One or more vice-chairs, who shall serve in the absence of the chair, shall be appointed by the elected chair of each department. Each vice-chair shall be a member of the active staff of the department concerned and must remain a member in good standing during his/her term of office.

11.7 Functions of Clinical Department Chairs

Each chair shall have the following authority, duties and responsibilities, and the vice chair, in the absence of the chair, shall assume all of them and shall otherwise perform such duties as may be assigned. These roles and responsibilities include at least the following:

- a) act as presiding officer at departmental meetings;
- b) report to the Medical Executive Committee and to the chief of staff regarding all clinically and administratively related activities within the department;
- c) continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges;
- d) recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the department;

- (e) recommending clinical privileges for each member of the department;
- (f) assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization;
- (g) integration of the department or service into the primary functions of the organization;
- (h) coordination and integration of interdepartmental and intradepartmental services;
- (i) development and implementation of policies and procedures that guide and support the provision of care, treatment and services;
- (j) recommendations for a sufficient number of qualified and competent persons to provide care, treatment and services;
- (k) determination of the qualification and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment and services;
- (l) continuous assessment and improvement of the quality of care, treatment and services;
- (m) maintenance of quality control programs, as appropriate;
- (n) orientation and continuing education of all persons in the department;
- (o) endeavor to enforce the Medical Staff bylaws, rules, policies and regulations within the department;
- (p) assist in the preparation of such annual reports, including budgetary planning, pertaining to the department as may be required by the Medical Executive Committee;
- (q) perform such other duties commensurate with the office as may from time to time be reasonably requested by the chief of staff or the Medical Executive Committee.

11.8 Functions of Clinical Departments

- a) Each clinical department shall recommend criteria to the credentials committee, consistent with the policies of the Medical Staff and of the governing body, for the granting of clinical privileges in the department. The criteria are designed to assure the Medical Staff and the board of trustees that patients will receive quality care. Each clinical department shall establish its own Rules and Regulations subject to approval by the Medical Executive Committee and shall have a maximum degree of autonomy over the affairs of the department, provided that the Medical Executive Committee shall have the ultimate authority over departmental and interdepartmental affairs which affect the Medical Staff and the hospital as a whole.
- b) Each department shall conduct case review for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the department. Such reviews shall include a consideration of selected deaths, unimproved patients, patients with infections, complications, errors in diagnosis and treatment, and such other instances as are considered to be important, such as patients currently in the hospital with unsolved clinical problems. The departments shall select educational cases or topics for presentation at department meetings. The department of surgery shall also conduct a comprehensive tissue review for justification of all surgery performed whether tissue was removed or not, and for the acceptability of the procedure chosen. Specific consideration shall be given to the agreement or disagreement of the preoperative and pathological diagnoses.
- c) The departments of medicine, surgery, psychiatry and special services shall meet at least quarterly to review and analyze on a peer-group basis the clinical work of the department.

- d) There shall be minutes maintained for all departmental meetings and for all department committee meetings.
- e) Reports shall be regularly submitted to the Medical Executive Committee detailing the departmental analysis of patient care.
- f) Clinical Interdisciplinary Conferences may be organized under the auspices of the care evaluation committees. These multidisciplinary conferences will focus on the goal of improved patient care and safety. They are intended to provide non-punitive opportunities to learn from complications and errors, to offer suggestions for alternate and/or improved behavior and judgment based on previous experiences, and to prevent repetition of errors leading to complication. The educational proceedings are kept confidential and protected under Article IX, Section 1 of these bylaws.

11.9 Department of Medicine

The department of medicine shall have the committees listed below, and additional committees may be appointed by the department chair as the need arises. A record shall be kept of all meetings of the committees. Committee members shall be members of the active and courtesy staffs, shall be appointed by the department chair for a term of one year, and may be reappointed. Committee chairs shall be active staff members.

- a) **Medical Care Evaluation Committee:** Members of this committee shall be members of the active staff and a representative of the Psychiatry Department. There shall be a minimum of nine (9) members, including the chair and vice-chair of the department. The chair of the department shall act as committee chair and be a voting member of this committee. The committee shall meet as needed but at least quarterly.

It shall be the duty of this committee to conduct an ongoing review of the quality of medical care and psychiatric care administered in the hospital. The committee shall act as the executive committee of the department of medicine and shall, as part of its duties:

- 1) determine the proctorship requirements for practitioners in the department in accordance with the department rules and regulations;
- 2) conduct patient care/medical record reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the department of Medicine and within the department of Psychiatry. The committee shall routinely collect information about important aspects of patient care provided in the department, periodically assess this information, and develop objective criteria for use in evaluating patient care. Patient care reviews shall include all clinical work performed under the jurisdiction of the department, regardless of whether the practitioner whose work is subject to such review is a member of that department;
- 3) review indications and performance of invasive or non-invasive procedures performed by department members;
- 4) review risk management issues involving department members and take appropriate actions to address these issues;
- 5) review and evaluate departmental adherence to: 1) policies and procedures; and 2) sound principles of clinical practice;
- 6) formulate recommendations for department of Medicine Rules and Regulations reasonably necessary for the proper discharge of its

responsibilities subject to the approval by the Medical Executive Committee; and

- 7) conduct, participate and make recommendations regarding continuing medical education programs pertinent to departmental clinical practice.

- b) Additional committees may be appointed by the department chair as the need arises and are referenced in the Medical Staff rules and regulations.

11.10 Department of Surgery

The department of surgery shall have the committees listed below, and additional committees may be appointed by the department chair as the need arises. A record shall be kept of all meetings of the committees. Committee members shall be members of the active and courtesy staffs, shall be appointed by the department chair for a term of one year, and may be reappointed. Committee chairs shall be active staff members.

- a) Surgical Care Evaluation Committee: This committee shall be the executive committee of the department of Surgery and shall include a representative of the Special Services Department. The chair of the department of surgery shall act as chair and shall be a voting member of the committee. This committee shall meet as often as necessary but at least quarterly. The committee shall:
 - 1) determine the proctorship requirements for practitioners in the department in accordance with the department rules and regulations;
 - 2) conduct patient care/medical record reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the department of Surgery and the department of Special Services. The committee shall routinely collect information about important aspects of patient care provided in the department, periodically assess this information, and develop objective criteria for use in evaluating patient care. Patient care reviews shall include all clinical work performed under the jurisdiction of the department, regardless of whether the practitioner whose work is subject to such review is a member of that department;
 - 3) review indications and performance of invasive or non-invasive procedures performed by department members;
 - 4) review risk management issues involving department members and take appropriate actions to address these issues;
 - 5) review cases in which tissue expected/none received; normal tissue removed (abnormal expected); and opposed diagnosis (differing pre- and postoperative/pathologic diagnosis);
 - 6) review and evaluate departmental adherence to: (1) policies and procedures; and (2) sound principles of clinical practice;
 - 7) formulate recommendations for department Rules and Regulations reasonably necessary for the proper discharge of its responsibilities subject to the approval by the Medical Executive Committee; and
 - 8) conduct, participate and make recommendations regarding continuing medical education programs pertinent to departmental clinical practice.
- b) Additional committees may be appointed by the department chair as the need arises and are referenced in the Medical Staff rules and regulations.

11.11 Department of Psychiatry

The department of psychiatry shall have the committees listed below, and additional committees may be appointed by the department chair as the need arises.

A record shall be kept of all meetings of the committees. Committee members shall be members of the active and courtesy staffs, shall be appointed by the department chair for a term of one year, and may be reappointed. Committee chairs shall be active staff members.

- a) Psychiatric Committee: This committee shall be the executive committee of the department of psychiatry and shall also serve as the department meeting. The chair of the department shall act as chair and shall be a voting member of the committee. All clinically active members of the department shall be appointed to the committee. This committee shall meet as often as necessary, but at least quarterly. The committee shall:
 - 1) determine the proctorship requirements for practitioners in the department in accordance with the department rules and regulations;
 - 2) conduct patient care/medical record reviews in the Medical Care Evaluation Committee for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the department. Patient care reviews shall include all clinical work performed under the jurisdiction of the department, regardless of whether the practitioner whose work is subject to such review is a member of that department;
 - 3) review risk management issues involving department members and take appropriate actions to address these issues;
 - 4) review and evaluate departmental adherence to: 1) policies and procedures; and 2) sound principles of clinical practice;
 - 5) formulate recommendations for department Rules and Regulations reasonably necessary for the proper discharge of its responsibilities subject to the approval by the Medical Executive Committee; and
 - 6) conduct, participate and make recommendations regarding continuing medical education programs pertinent to departmental clinical practice.
- b) Additional committees may be appointed by the department chair as the need arises and are referenced in the Medical Staff rules and regulations.

11.12 Department of Special Services

The department of special services shall be made up of members of the Medical Staff who are members of the sections of diagnostic radiology and nuclear medicine, pathology, and radiation oncology. Each of these three sections shall meet as often as needed. A representative of the Special Services Department shall participate on the Surgical Care Evaluation Committee for the purpose of participating in patient care/medical record reviews to analyze and evaluate the quality and appropriateness of care and treatment provided to patients.

- a) Section of Diagnostic Radiology and Nuclear Medicine

For purposes of organization, the section of diagnostic radiology & nuclear medicine is divided into two disciplines:

1) Diagnostic Radiology

This section shall be directed by a radiologist certified by the American Board of Radiology who shall be responsible for the use of all imaging equipment. He/she will supervise and instruct the radiology technicians. All fluoroscopic procedures (except for radiation oncology simulation fluoroscopy), ultrasound and contrast media studies shall be under the guidance of the radiologist although certain procedures shall be specifically performed by other qualified specialists. Ultrasound procedures performed by cardiologists and neurologists will be supervised by the appropriate committees.

A board certified radiologist shall supervise and interpret all imaging studies performed in the radiology and surgery departments. He/she shall submit a signed report for inclusion in the patient's medical record. He/she shall be responsible for all records of the department and shall insure compliance with State and Federal regulations governing radiation sources. He/she shall be available to the Medical Staff for conferences, lectures, staff committee assignments, and other professional functions, as required.

2) Nuclear Medicine

The nuclear medicine service shall provide full-scale radioactive isotope scanning services both for diagnosis and treatment. A qualified radiologist shall supervise and direct the technicians in this service and it shall be staffed appropriately. The radiologist shall insure that proper radiation safety principles and practices are observed. The radiologist shall interpret all nuclear medicine procedures and shall submit a signed report for inclusion in the patient's medical record.

b) Section of Pathology:

This section shall be directed by a pathologist who is certified by the American Board of Pathology. The pathologist shall direct the hospital clinical laboratory which is licensed by the State of California and operates under the laws and regulations related to clinical laboratories.

For purposes of organization, the section of pathology is divided into two major disciplines:

1) Anatomic Pathology - to include: surgical pathology, necropsy pathology, cytopathology;

The anatomic pathology service shall be concerned with the gross and histologic examination of tissues and certain secretions and fluids from the body. Any tissue, regardless of its source within the hospital, must be submitted to the pathologist. All specimens examined by the pathologist shall be logged within the department and a written report of the findings of the examination shall be reported to the attending physician. The original of this report shall be filed within the patient's clinical records. A copy of the report shall be transmitted to the attending physician and a copy shall be filed within the department. A cross index of patient name, tissue, and tissue diagnosis shall be maintained.

2) Clinical Pathology - to include: clinical biochemistry, hematology, immunohematology, bacteriology (parasitology, virology, mycology)

The clinical laboratory shall be organized to provide a full-scale, full-time routine laboratory service. The pathologist is responsible for the procurement and training of the medical technologists and their

performance, as well as that of other laboratory personnel. He/she shall determine the methodology by which laboratory tests are performed. He/she shall be responsible for the quality control program.

The pathologist shall be available to all members of the Medical Staff for consultation with respect to the various scientific disciplines. He/she shall be available for Medical Staff conferences, lectures, and such other teaching or Medical Staff assignments as may be requested.

c) Section of Radiation Oncology:

This section shall be directed by a radiation oncologist certified by the American Board of Radiology (Radiation Oncology), who shall be responsible for the use of all therapeutic radiation sources. He/she will supervise and instruct the radiation oncology technologists. All simulation fluoroscopic procedures shall be under the guidance of the radiation oncologist. A qualified radiation oncologist shall approve all films taken in the section. He/she shall be responsible for all records of the section and shall insure compliance with State and Federal regulations governing radiation sources. He/she shall be available to the Medical Staff for conferences, lectures, staff committee assignments, and other professional functions, as required.

d) Additional committees may be appointed by the department chair as the need arises and are referenced in the Medical Staff rules and regulations.

ARTICLE XII. GENERAL STAFF COMMITTEES

12.1 Medical Executive Committee

(a) The Medical Executive Committee shall consist of thirteen (13) members of the active Medical Staff:

1. the Chief of Staff, who shall serve as the committee chair;
2. the Vice-Chief of Staff;
3. the immediate past Chief of Staff;
4. the chair of the department of medicine;
5. the chair of the department of surgery;
6. the chair of the department of psychiatry;
7. the chair of the department of special services;
8. two (2) elected members-at-large;
9. the medical director of the hospitalist program;
10. the medical director of the Intensivist program;
11. the medical director of the Emergency Room; and
12. a primary care physician.

The Medical Executive Committee may also include other practitioners and/or individuals as determined by the Medical Staff when amending these bylaws. The Medical Executive Committee shall hold meetings at least quarterly.

The members-at-large shall be elected for a two-year term pursuant to the procedures for election of officers as set forth in Article X and must be members of the active staff. Members-at-large may be elected for additional terms. Removal of a member-at-large, the immediate past chief of staff, or the filling of vacancies of offices shall be governed by the procedures outlined for the vice-chief of staff in Article X.

Members-at-large on the Medical Executive Committee are not precluded membership on the governing body but are precluded from running for any other Medical Staff office represented on the

Medical Executive Committee while serving as a member-at-large on the Medical Executive Committee.

Officers, department chairs, and the immediate past chief of staff serve on the Medical Executive Committee by virtue of having been elected to their respective positions. Accordingly, officers are selected, elected and removed from the Medical Executive Committee by Article X, Sections 3(b), (c) (selection), Article X, Section 3(a) (election) and Article X, Section 5 (removal).

Department chairs are selected, elected and removed from the Medical Executive Committee by Article XI, Sections 5(b), (c) (selection), Article XI, Section 5 (election), and Article XI, Section 4(c) (removal). The immediate past chief of staff was selected and elected pursuant to Article X, Sections 3(b), (c) (selection) and Article X, Section 3(a) (election). The immediate past chief of staff may be removed pursuant to Article XI, Section 1(a) above.

b) Duties: The Medical Staff delegates to the Medical Executive Committee broad authority to oversee the operations of the Medical Staff. With the assistance of the chief of staff, and without limiting this broad delegation of authority, the Medical Executive Committee shall perform in good faith the duties listed below.

- 1) to adopt Rules and Regulations as may be necessary pursuant to Article XVI of these bylaws;
- 2) to represent and to act on behalf of the Medical Staff at intervals between Medical Staff meetings, subject to such limitations as may be imposed by these bylaws;
- 3) to coordinate the activities and general policies of the various departments;
- 4) to receive and act upon department and committee reports and reports of other assigned activity groups;
- 5) to participate in the development and implementation of policies of the Medical Staff and the hospital;
- 6) to provide liaison between the Medical Staff and the president and the governing body;
- 7) to recommend action to the president on matters of a medico-administrative nature;
- 8) to make recommendations to the president on relevant hospital management matters;
- 9) to make recommendations to the governing body regarding the organized Medical Staff's structure;
- 10) to fulfill the Medical Staff's accountability to the governing body for the medical care rendered to patients in the hospital;
- 11) to ensure that the Medical Staff be kept abreast of the accreditation program and informed of the accreditation status of the hospital and to participate in the implementation of the accreditation program, identifying areas of suspected non-compliance and making recommendations to the Medical Staff and the governing body for appropriate action;
- 12) to provide for the preparation of all educational programs, either directly or through delegation to the continuing education/library committee or other suitable agent and to prioritize and assure that hospital-sponsored educational programs incorporate

- the recommendations and results of Medical Staff quality assessment and improvement activities;
- 13) to review the credentials of all applicants and to make recommendations to the governing body for staff membership, assignment to departments, and delineation of clinical privileges and the process for review of same;
 - 14) to review periodically all information available regarding the performance and clinical competence of staff members and other practitioners with clinical privileges and to make recommendations to the governing body for reappointments and renewal or changes in clinical privileges and the process for review of same;
 - 15) to take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all members of the Medical Staff, including the initiation of and/or participation in Medical Staff corrective review or evaluation measures and/or recommendations regarding membership or privileges termination when warranted;
 - 16) on the recommendation of the Committee to Assign Committees, department chairs or chief of staff, to appoint committee members and chairs to all standing, special and multidisciplinary Medical Staff committees, making an effort to honor staff members' preferences as much as possible;
 - 17) to approve the removal of a committee chair from his/her position on the recommendation of the chief of staff;
 - 18) to approve the hospital's designated authorized representative for National Practitioner Data Bank purposes;
 - 19) to make recommendations to the board of trustees concerning quality of care issues related to exclusive arrangements for physician and/or other professional services, prior to any decision being made, in the following circumstances: 1) the decision is whether to execute an exclusive contract in a previously open department or service; 2) the decision is whether to modify an exclusive contract in a particular department or service; or 3) the decision is whether to terminate an exclusive contract in a particular department or service, except in the instance in which a termination is automatic;
 - 20) to make recommendations to the board of trustees concerning additions to or changes in the scope of clinical services offered by the hospital;
 - 21) to participate in organization performance-improvement activities;
 - 22) appointing such special or ad hoc committees as may seem necessary or appropriate to assist the Medical Executive Committee in carrying out its functions and those of the Medical Staff; and
 - 23) to ensure that practitioners who become excluded from Medicare/Medi-Cal or other public programs while holding clinical privileges at the hospital are prohibited from furnishing, directing or prescribing items or services to any such patients at the hospital or its outpatient facilities;
 - 24) to review the quality and appropriateness of services provided by contract physicians;

- 25) to review the job descriptions (e.g. qualifications, responsibilities, and reporting relationship) of medical directorships in the hospital both to assure their adequacy for Medical Staff purposes, and to avoid a conflict of duties between the medical director and any Medical Staff leader;
- 26) to participate in the interview and review of candidates for positions of medical director in the hospital, and forward a recommendation to the hospital administration concerning Medical Staff affirmation of the candidate's competence and appropriate privileges for the medical directorship position;
- 27) to review the performance of the hospital's medical directors prior to hospital renewal of the medical director contract and transmit the results of that review to the hospital administration for consideration;
- 28) to take such other action as may reasonably be deemed necessary in the best interests of the Medical Staff and the hospital.

The authority delegated pursuant to this Section may be removed by amendment of these bylaws.

12.2 Bylaws Committee

- a) This committee shall be composed of the two (2) immediate past chiefs of staff who are still members of the active staff, and the four (4) department chairs. The immediate past chief shall act as chair. This committee shall meet as often as needed, but at least annually. The duties of this committee shall be:
 - 1) to review the Medical Staff's bylaws, general Medical Staff's Rules and Regulations and policies and procedures at the discretion of the Medical Executive Committee but at least biannually; and
 - 2) to make recommendations for any necessary changes in the bylaws, Rules and Regulations and policies and procedures to the Medical Executive Committee for subsequent recommendation to the governing body.

12.3 Standing Committees

All standing committees shall meet as often as necessary but at least three (3) times per year or as otherwise specified and shall submit a written report of their meetings to the Medical Executive Committee prior to its next regular scheduled meeting. Only physician members have voting privileges, unless otherwise specifically stated.

Unless otherwise specified, committee members shall be appointed for a term of one (1) year, and shall serve until the end of this period or until the member's successor is appointed, unless the member shall sooner resign or be removed from the committee. Effort will be made to replace no more than fifty (50) percent of committee members in any one year so as to maintain continuity. Physicians sharing the same office shall be precluded from serving on the same standing committee except as specifically approved by the Medical Executive Committee. Unless otherwise specified, the chair and members of all committees shall be appointed by and may be removed by the chief of staff, subject to consultation with and approval by the Medical Executive Committee. Medical Staff committees shall be responsible to the Medical Executive Committee.

The standing committees are described in the Medical Staff rules and regulations.

12.4 Special Committees

Special committees shall be appointed by the Medical Executive Committee on recommendation of the chief of staff and shall be appointed from time to time as may be required to properly carry out the duties of the Medical Staff. Chairs of such committees shall be appointed by the chief of staff. Such committees shall confine their work to the purpose for which they

are appointed and shall report to the Medical Executive Committee. They shall not have the power of action unless such is specifically granted by the motion that created the committee.

ARTICLE XIII. MEETINGS

13.1 Regular Meetings

Regular meetings of the Quarterly Medical Staff shall ordinarily be held on the fourth Tuesday in the months of January, April, July and October.

13.2 Department Meetings

The departments of medicine, surgery, psychiatry and special services shall meet separately at least quarterly to review and analyze on a peer-group basis the clinical work of the department.

13.3 Special Meetings

Special meetings may be called at any time by the chief of staff, the Medical Executive Committee, the governing body, or any twenty-five (25) members of the active Medical Staff. The person(s) calling or requesting the meeting shall state the purpose of such meeting in writing. The meeting shall be scheduled by the Medical Executive Committee within thirty (30) days after receipt of such request.

No later than five (5) days prior to the meeting, the Medical Executive Committee shall mail or deliver to the members of the staff a notice which includes the stated purpose of the meeting. No business shall be transacted at such special meeting except as stated in the notice calling the meeting. Notice of such special meeting shall be posted on the bulletin board in the doctors' lounge at least forty-eight (48) hours prior to the meeting.

13.4 Attendance at Medical Staff Meetings

Medical Staff members are encouraged to attend department, committee and Medical Staff meetings, however, there are no specific meeting attendance requirements.

13.5 Medical Staff Committee Quorum

One-third of the total voting membership, as specified and defined in the Medical Staff Rules & Regulations for each committee, shall constitute a quorum.

13.6 Special Appearance

A committee, at its discretion, may require the appearance of a practitioner. If possible, the chair of the meeting should give the practitioner at least ten (10) days' advance written notice of the time and place of the meeting. In addition, whenever an appearance is requested because of an apparent or suspected deviation from standard clinical practice, the notice shall include a statement of the issue involved and that the practitioner's appearance is mandatory.

Failure of a practitioner to appear at any meeting with respect to which he or she was given notice shall result in an automatic suspension of the practitioner's privileges for two (2) weeks, or such period as the Medical Executive Committee deems appropriate. A committee chair or Medical Staff officer may also require a practitioner to respond to a formal communication or participate in a discussion. Failure to cooperate with such request within fifteen (15) days of written notice shall result in an automatic suspension of the practitioner's privileges for two (2) weeks, or such period as the Medical Executive Committee deems appropriate.

ARTICLE XIV. ALLIED HEALTH PROFESSIONALS

Allied Health Professionals are not eligible for Medical Staff membership. However, they may be granted practice privileges to perform certain functions under supervision of a physician member of the Medical Staff based on their individual training, experience, and demonstrated competence. Applications to perform such privileges must be processed and specific privileges granted by the governing body in the same manner as for members of the Medical Staff. Each allied health professional applying to provide in-hospital services shall have a sponsoring physician who is a member of the Medical Staff. It shall be the responsibility of the sponsoring physician to submit a sponsoring physician's statement.

An initial application fee and annual dues shall be required as a condition of appointment or reappointment as an allied health professional in the amount fixed by the Medical Executive Committee.

Allied health professionals shall be required to provide documented evidence of professional liability coverage in accordance with the minimum requirement designated for the Medical Staff.

Allied health professionals shall not have admitting or voting privileges. With the exception of clinical psychologists, they shall not have the hearing and appeal rights granted to staff applicants and members. The president, the chief of staff, or the chair of the sponsoring department [or their designee] may terminate the right of any allied health professional to practice in the hospital. In this event, the individual may request a hearing as provided in Section 1(b) below.

14.1 Procedural Rights of Allied Health Professionals

a) Clinical Psychologists/certain other AHP's

Clinical psychologists, and any other category of AHP for which an action requires a report to the Medical Board of California under Section 805 of the Business and Professions Code, are entitled to the rights provided in Article VIII of these bylaws.

b) Allied Health Professionals

An allied health professional shall have a right to challenge any action that would constitute grounds for a hearing under Article VIII, Section 2(b) of the Medical Staff's bylaws by filing a written grievance with the chief of the applicable department within fifteen (15) days of notice of such action. Upon receipt of such a grievance request, the department chair will review the matter and afford the affected allied health professional the opportunity for an interview. The interview will be either with the chair of the department or before an ad hoc committee of no less than three (3) individuals designated by the chair and whose members did not participate in the action under review. The reviewing individual or body, as appropriate and reasonably attainable, shall include at least one (1) allied health professional holding the same or similar license or certificate as the affected allied health professional. Such allied health professional will also be appointed by the chair of the department. Before the interview, the allied health professional shall be informed that the general circumstances giving rise to the adverse action being contested and, at the interview, may present information relevant thereto. A record of the interview shall be made.

A written report of the findings and recommendations shall be made by the reviewing chair or ad hoc committee and forwarded to the Medical Executive Committee which shall act thereon.

- 1) After the interview, if the recommendation of the department continues to be adverse to the allied health professional he/she may request an opportunity to provide further information to the Medical Executive Committee prior to its decision on the matter. Should the allied health professional wish to do so, he/she may present to the Medical Executive Committee written arguments relevant to the determination being contested. There is no right for the allied health professional to personally appear before the Medical Executive Committee unless permitted by the committee on such terms and conditions as it will establish. After considering the allied health professional's arguments, if any, the Medical Executive Committee shall make a final written decision on the matter. The action of the Medical Executive Committee shall be final, subject only to review and final decision by the governing body. Any allied health professional wishing to contest the Medical Executive Committee's decision may make an appeal to the governing body. The decision of the governing body shall be binding and there shall be no further appeal.

- 2) The procedural rights afforded by this Section 1 are the exclusive procedural rights afforded to allied health professionals unless otherwise required by law.

14.2 Automatic Termination

Notwithstanding the provisions of Bylaws Section 1, above, an allied health professional's privileges shall automatically terminate, without the review provided in Section 1 above or any other section of the bylaws, upon failure of the allied health professional to meet any appointment standard. If the allied health professional's supervising physician is no longer willing or able to provide any required supervision, the allied health professional's ability to practice shall be automatically suspended. The allied health professional shall have thirty (30) days to obtain a qualified supervising physician, and, if he/she does, the ability to practice will be reinstated. Failure to re-obtain the required supervising physician within thirty (30) days will result in the automatic termination of allied health professional's status.

None of the actions provided for under this Section 2 shall entitle the allied health professional to the hearing rights under Article VIII of the Medical Staff's bylaws.

ARTICLE XV. GENERAL PROVISIONS

15.1 Effect and Obligations of Medical Staff Documents

The Medical Staff's Bylaws, Rules and Regulations, policies and procedures, governing body's bylaws, and medical center's policies are all compatible with each other and compliant with law and regulation. The Medical Staff complies with and enforces the Medical Staff's Bylaws, Rules and Regulations and policies and procedures by taking action or by recommending action to the governing body as appropriate and as provided for in its organizational documents. The governing body upholds the Medical Staff's Bylaws, Rules and Regulations, and policies and procedures which it has approved.

15.2 Conflict Management

In the event of a conflict between the Medical Executive Committee and the Medical Staff regarding proposals to adopt or amend the Medical Staff's Rules and Regulations, Medical Staff's policies and procedures, or other issue of significance to the Medical Staff, the following process shall be followed:

- a) Identification of Conflict and Representatives

A conflict between the Medical Executive Committee and the Medical Staff shall be identified by a written petition signed by at least twenty-five percent (25%) of the Active Medical Staff. The foregoing petition shall include a designation of up to five (5) members of the voting Medical Staff who shall serve as petitioner's representatives. The Medical Executive Committee shall be represented by an equal number of Medical Executive Committee members, each of whom will be appointed by the chief of staff.

- b) Conflict Resolution

Once a conflict and representatives have been identified, the chief of staff shall schedule a meeting for the Medical Executive Committee's and petitioner's representative(s). At that meeting, the Medical Executive Committee's and the petitioner's representatives shall exchange information relevant to the conflict and shall work in good faith to resolve differences in a manner that respects the positions of the Medical Staff, the leadership responsibilities of the Medical Executive Committee, and the safety and quality of patient care at the hospital. Resolution at this level requires a majority vote of the Medical Executive Committee's representatives and a majority vote of the petitioner's representatives. In the event the matter is not resolved at this level, the matter, including any information exchanged in relation thereto, shall be forwarded to the governing body, who shall decide

the matter at its next regularly scheduled meeting, or as soon as possible thereafter. The governing body shall determine the method of communication.

15.3 Communication with the Governing Body

Nothing in this Article is intended, nor will it be construed to prevent direct communication by the Medical Staff to the governing body on any Bylaw, Rule and Regulation, policy and procedure, or issue of significance to the Medical Staff, regardless of the manner in which it is adopted. However, the governing body shall establish the method for any such communication.

ARTICLE XVI. ADOPTION AND AMENDMENT OF RULES & REGULATIONS AND POLICIES AND PROCEDURES

16.1 Overview and Relation to Bylaws

These bylaws describe the fundamental principles of Medical Staff self-governance and accountability to the governing body. Accordingly, the key standards for Medical Staff membership, appointment, reappointment, and privileging are set out in these bylaws.

Additional provisions including, but not limited to, detailed procedures for implementing these Medical Staff standards may be set out in the Medical Staff's or department's rules and regulations, or in the Medical Staff's policies and procedures adopted or approved as described below. Applicants and members of the Medical Staff shall be governed by such Rules and Regulations and policies and procedures as are properly initiated and adopted.

If there is a conflict between the Medical Staff's bylaws and Medical Staff's Rules and Regulations and/or Medical Staff's policies and procedures, the Medical Staff's bylaws shall prevail. If there is a conflict between the Medical Staff's Rules and Regulations and the Medical Staff's policies and procedures, the Medical Staff's Rules and Regulations shall prevail.

16.2 Delegation of Authority

The Medical Staff shall initiate and adopt such Rules and Regulations as it may deem necessary and shall periodically review and revise its Rules and Regulations to comply with current Medical Staff practice. By this Section, the Medical Staff delegates to the Medical Executive Committee the authority to initiate, adopt and/or amend such Medical Staff Rules and Regulations and policies and procedures it deems necessary for the proper conduct of the Medical Staff's work. Pursuant to bylaw Article XII, Section 2, the Medical Staff's bylaws committee shall review the Medical Staff's Rules and Regulations and policies and procedures to ensure they comply with current Medical Staff practice biannually and may not delegate that responsibility and/or authority to any other entity.

16.3 Process for Adoption or Amendment of General Medical Staff Rules and Regulations

Proposals for the adoption or amendment of the general Medical Staff rules and regulations, including additions, deletions, or modifications thereto, may be developed by the bylaws committee, the Medical Executive Committee, or by a petition stating the exact language of the proposed amendment which is signed by at least twenty-five percent (25%) of the Medical Staff members entitled to vote on bylaw amendments and submitted to the Medical Executive Committee. Any such proposal must contain the specific language proposed for adoption.

Except as provided in Section 5 below, the Medical Executive Committee shall communicate the text of any such proposed rule and regulation to the Medical Staff at least twenty-one (21) calendar days prior to voting on adoption, together with instructions explaining how interested members may communicate comments to the Medical Executive Committee and the deadline for submitting comments, provided that a comment period of at least fourteen (14) days shall be afforded. All submitted comments shall be summarized and provided to the Medical Executive Committee prior to Medical Executive Committee action on the proposed rule and regulation. The procedure for communicating

the rule and regulation and submitting and summarizing comments regarding any such rule and regulation, shall be determined by the Medical Executive Committee.

16.4 Mechanism for Adoption or Amendment

Following the notice and comment period, a Medical Staff rule and regulation may be adopted, amended or repealed by the following combined actions:

a) By the Medical Executive Committee

- 1) The affirmative vote of a majority of the Medical Executive Committee members present at a meeting; or
- 2) If the Medical Executive Committee does not approve a proposal submitted by petition of the Medical Staff, it shall notify the petitioner's representatives. The Medical Executive Committee and the petitioner's representatives each has the option of invoking or waiving the Conflict Management Process of Article XVI, Section 2 within thirty (30) days. If the Conflict Management Process is not invoked within thirty (30) days, the right to the process shall be deemed waived. If the Conflict Management Process is invoked, a majority vote of the Medical Executive Committee's representatives and a majority vote of the petitioner's representatives; or
- 3) If the Conflict Management Process is invoked, but differences remain unresolved, by the decision of the governing body; or
- 4) If the Conflict Management Process is waived, the Medical Staff's proposed rule and regulation shall be forwarded to the governing body for action. The Medical Executive Committee may forward comments to the governing body regarding the reasons it declined to approve the proposed rule and regulation.

b) By the Governing Body

A proposed rule and regulation shall become effective only after approval by the governing body, whose approval shall not be withheld unreasonably. The governing body shall take action on changes proposed to the Rules and Regulations within one hundred and twenty (120) days of receipt of a request for such change from the Medical Staff. If approval is withheld, the reasons for doing so shall be specified by the governing body in writing, and shall be forwarded to the chief of staff, the Medical Executive Committee, and the bylaws committee. If the governing body fails to take any action within one hundred and twenty (120) days, the proposed rule and regulation shall be deemed automatically approved. Once approved by the governing body, all Medical Staff members shall be provided with copies of the revised rule and regulation.

16.5 Urgent Amendment to Rules and Regulations

In the event that urgent action is required to comply with law or regulation, the Medical Executive Committee is authorized to provisionally adopt a rule or regulation and forward it to the governing body for approval and immediate implementation, subject to the following. If the Medical Staff did not receive prior notice of the proposed rule (as described in Section 3 above) the Medical Staff shall be notified of the provisionally-adopted and approved rule and regulations, and may, by petition signed by at least twenty-five percent (25%) of the voting members of the Medical Staff require the rule and regulation to be submitted for possible recall; provided, however, the approved rule and regulation shall remain effective until such time as a superseding rule and regulation meeting the requirements of the law or regulation that precipitated the initial urgency has been approved pursuant to any applicable provision of this Section. In the event that a petition seeking to recall the rule and regulation is presented, the Conflict Management Process set forth in Article XVI, Section 2 shall be followed.

16.6 Process for Adoption or Amendment of General Medical Staff Policies and Procedures

Proposals for the adoption or amendment of the general Medical Staff policies and procedures, including additions, deletions, or modifications thereto, may be developed by the bylaws committee, the Medical Executive Committee, or by a petition stating the exact language of the proposed amendment which is signed by at least twenty-five percent (25%) of the Medical Staff members entitled to vote on bylaw amendments and submitted to the Medical Executive Committee. Any such proposal must contain the specific language proposed for adoption.

16.7 Mechanism for Adoption or Amendment

A Medical Staff Policy and Procedure may be adopted, amended or repealed by the following combined actions:

a) By the Medical Executive Committee

- 1) The affirmative vote of a majority of the Medical Executive Committee members present at a meeting; or
- 2) If the Medical Executive Committee does not approve a proposal submitted by petition of the Medical Staff, it shall notify the petitioner's representatives. The Medical Executive Committee and the petitioner's representatives each has the option of invoking or waiving the Conflict Management Process of Article XVI, Section 2 within thirty (30) days. If the Conflict Management Process is not invoked within thirty (30) days, the right to the process shall be deemed waived. If the Conflict Management Process is invoked, a majority vote of the Medical Executive Committee's representatives and a majority vote of the petitioner's representatives; or
- 3) If the Conflict Management Process is invoked, but differences remain unresolved, by the decision of the governing body; or
- 4) If the Conflict Management Process is waived, the Medical Staff's proposed policy and procedure shall be forwarded to the governing body for action. The Medical Executive Committee may forward comments to the governing body regarding the reasons it declined to approve the proposed policy and procedure.

b) By the Governing Body

A proposed policy and procedure shall become effective only after approval by the governing body, whose approval shall not be withheld unreasonably. The governing body shall take action on changes proposed to a policy and procedure within one hundred and twenty (120) days of receipt of

a request for such change from the Medical Staff. If approval is withheld, the reasons for doing so shall be specified by the governing body in writing, and shall be forwarded to the chief of staff, the Medical Executive Committee, and the bylaws committee. If the governing body fails to take any action within one hundred and twenty (120) days, the proposed policy and procedure shall be deemed automatically approved. Once approved by the governing body, all Medical Staff members shall be provided with copies of the revised policy and procedure.

16.8 Current Medical Staff Rules and Regulations, Medical Staff Policies and Procedures, and Clinical Service Rules and Regulations

All Medical Staff rules and regulations, Medical Staff policies and procedures, and clinical service Rules and Regulations that are in effect immediately preceding the adoption of these bylaws, and that are not inconsistent with these bylaws, shall be considered as Rules and Regulations and policies and procedures adopted in accordance with these bylaws and shall continue in effect until amended pursuant to these bylaws.

ARTICLE XVII. ADOPTION AND AMENDMENT OF BYLAWS

17.1 Medical Staff Responsibility and Authority

The Medical Staff shall have the initial responsibility and authority to formulate, adopt, and recommend Medical Staff bylaws and amendments thereto, which shall be effective when approved by the governing body as described in Section 3 below. The Medical Staff shall exercise such responsibility and authority in good faith and in a reasonable, timely, and responsible manner, reflecting the interests of providing patient care of the generally recognized levels of quality and efficiency, and maintaining a harmony of purpose and effort with the governing body and the community. The Medical Staff's bylaws committee (established pursuant to bylaw Article XII, Section 2) shall review the bylaws biannually and may not delegate this responsibility and/or authority to any other entity. Unilateral amendment of these bylaws by the Medical Staff, Medical Executive Committee or the governing body is not permitted.

17.2 Process for Adoption or Amendment of Bylaws

Proposals for the adoption or amendment of the bylaws, including additions, deletions, or modifications thereto, may be developed by the bylaws committee, the Medical Executive Committee, or by a petition stating the exact language of the proposed amendment which is signed by at least twenty-five percent (25%) of the Medical Staff members entitled to vote on bylaw amendments and submitted to the Medical Executive Committee. Amendments developed by the bylaws committee, Medical Executive Committee, or by petition, shall be submitted to the Medical Staff for a vote as provided in Section 3 below.

17.3 Mechanism for Adoption or Amendment

The Medical Staff bylaws may be adopted, amended, or repealed by the following combined actions:

- a) By vote of the Active Medical Staff the bylaws may be amended by:
 - (1) an electronic or mailed written ballot;
 - (2) a written ballot at any regular Medical Staff meeting; or
 - (3) at a special Medical Staff meeting called for this specific purpose.

A two-thirds (2/3) majority vote of the active Medical Staff members voting shall be required for adoption of any proposed bylaw amendment. Wording of the proposed change(s) and instructions regarding the procedure for voting must be mailed or delivered (electronically or otherwise) to all members of the active Medical Staff at least five (5) days prior to the official vote. The procedure for distributing, returning, and counting ballots shall be determined by the Medical Executive Committee.

- b) By vote of the Governing Body

Changes approved by the Medical Staff shall become effective only after approval by the governing body, whose approval shall not be withheld unreasonably. The governing body shall take action on such proposed bylaws changes within one hundred and twenty (120) days of receipt of a request for such change from the Medical Staff. If approval is withheld, the reasons for doing so shall be specified by the governing body in writing, and shall be forwarded to the Chief of Staff, the Medical Executive Committee, and the bylaws committee. If the governing body fails to take any action within one hundred and twenty (120) days, the bylaws shall be deemed automatically approved. Once approved by the governing body, all Medical Staff members shall be provided with copies of the revised bylaw provisions.

17.4 Technical and Editorial Corrections

The Medical Executive Committee shall have the power to adopt technical corrections to the bylaws such as reorganizing or renumbering of the bylaws, or to correct punctuation, spelling, and other errors of grammar, expression, or inaccurate cross-references. Substantive amendments are not permitted by this Section. Corrections may be effected by motion and acted upon in the same manner as any other motion before the Medical Executive Committee. After approval, such corrections shall be communicated in writing to the Medical Staff and to the governing body. Such corrections are effective upon adoption by the Medical Executive Committee provided, however, they may be rescinded by vote of the Medical Staff or the governing body within ninety (90) consecutive days after adoption by the Medical Executive Committee.

Approved by the Medical Staff:

November 16, 2017

Approved by the Board of Trustees:

December 7, 2017

Previous Approvals:

02/2007; 5/2008; 8/2010; 4/2014; 5/2015

End.