CHA Hollywood Presbyterian Medical Center

Medical Staff Bylaws

Approved
March 31, 2019

CHA HOLLYWOOD PRESBYTERIAN MEDICAL CENTER
MEDICAL STAFF BYLAWS

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PREAMBLE

WHEREAS, CHA HOLLYWOOD PRESBYTERIAN MEDICAL CENTER is a limited partnership organized under the laws of the state of California; and

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

WHEREAS, although the Governing Board must act to protect the quality of medical care and the competency of the Medical Staff, and the Medical Staff is accountable to the Governing Board for the quality of medical care treatment and services to patients, the Medical Staff is self-governing as to the professional work performed in the medical center, with responsibility for establishing the criteria and standards for Medical Staff membership and privileges, for enforcing those criteria and standards, overseeing and managing, performance improvement, utilization review and other Medical staff activities, including but not limited to periodic meetings of the Medical Staff, its committees and departments, reviewing and analyzing patient medical records, and describing the standards and procedures for selecting and removing officers.

WHEREAS, notwithstanding any language to the contrary in these Bylaws, the Governing Board will give great weight to the actions and recommendations of the Medical Staff, shall not assume a duty or responsibility of the Medical Staff precipitously, unreasonably or in bad faith, and only shall assume such duty or responsibility after giving great weight to the Medical Staff's actions or recommendations and implementing the dispute resolution processes in these Bylaws; provided, further the Governing Board also must reasonably and in good faith believe that the Medical Staff has failed to fulfill a substantive duty or responsibility in matters pertaining to the quality of patient care.

WHEREAS, only duly qualified physicians, dentists, and podiatrists are eligible for Medical Staff membership, privileges and prerogatives; and

WHEREAS, the medical center is governed by a Governing Board and all phases of the conduct of the medical center is the legal and moral responsibility of the Governing Board;

THEREFORE, the physicians, dentists, and podiatrists practicing in this medical center hereby organize themselves into a Medical Staff in conformity with these Bylaws.

DEFINITIONS

ACTIVE STAFF shall mean both Active members of the Medical Staff.

ADMINISTRATION shall mean Chief Executive Officer or any officer of the medical center to whom the Chief Executive Officer delegates authority to act on his behalf.

ALLIED HEALTH PROFESSIONAL (AHP) means an individual, other than a licensed physician, dentist, or podiatrist, who exercises independent judgment within the areas of his professional competence and the limits established by the Governing Body, the Medical Staff, and the applicable State Practice Acts, who is qualified to render direct or indirect medical, dental, or podiatric care under the supervision or direction of a Medical Staff Member possessing privileges to provide such care in the Medical center; and who may be eligible to exercise practice privileges and prerogatives in conformity with the rules adopted by the Governing Body, these Bylaws, and the Medical Staff Rules and Regulations. AHPs are not eligible for Medical Staff membership.

CHIEF EXECUTIVE OFFICER (CEO) means the individual appointed by the Governing Board to act on its behalf in the overall management of the medical center.

CLINICAL PRIVILEGES or PRIVILEGES means the permission granted to a Medical Staff member to render specific diagnostic, therapeutic, medical, dental, podiatric, or surgical services and includes unrestricted access to those medical center resources (including equipment, facilities, and personnel) which are necessary to exercise those privileges effectively.

CONFIDENTIAL COMMUNICATION means any statements made by verbally or written, including all electronic communication, or by gesture which are prohibited from disclosure as specified in the Bylaws or by contract.

EMERGENCY SERVICES OR E.R. means Emergency Room.

EX-OFFICIO means a person who serves as a member of a body, department or committee by virtue of an office or position held.

EXECUTIVE COMMITTEE means Medical Executive Committee.

GOOD STANDING means a Medical Staff member not currently (or in the past seven years) suspended or subject to corrective action by any Medical Staff, Governing Body, or licensing agency.

GOVERNING BODY shall mean the Governing Board of the Medical Center, or any special or standing committee of the Governing Board charged with responsibility for oversight of quality improvement and/or medical staff functions.

INVESTIGATION means a process specifically instigated by the Medical Executive Committee to determine the validity, if any, to a concern or complaint raised against a medical staff member or individual with clinical privileges.

LIMITED DATA SET means that portion of a medical record which remains following exclusion of certain identifiers as specified in section 45 CFR 164.514(e) of the Health Insurance Portability and Accountability Act of 1996.

MEDICAL CENTER means CHA HOLLYWOOD PRESBYTERIAN MEDICAL CENTER, including The Chalet.

MEDICAL DISCIPLINARY CAUSE OR REASON means the same as those terms are defined in Business & Professional Code Section 805.

MEDICAL STAFF or STAFF means the formal organization of all licensed physicians, dentists, and podiatrists who have privileges at the medical center.

MEDICAL STAFF YEAR means the period from January 1 to December 31.

MEDICO-ADMINISTRATIVE describes a practitioner, employed by or otherwise serving the medical center on a full or part-time basis, whose duties include certain responsibilities which are both administrative and clinical in nature. Clinical responsibilities are defined as those involving professional capability as a practitioner such as to require the exercise of clinical judgment with respect to patient care, and include the supervision of professional activities or practitioners under his direction.

PHYSICIAN means an individual with an M.D. or D.O. degree who is fully licensed to practice medicine in all its phases.

PRACTICE PRIVILEGES means the permission granted to an Allied Health Professional to participate in the provision of certain patient care services.

PRACTITIONER means, unless otherwise expressly limited, any physician, dentist, or podiatrist applying for Medical Staff membership or a Medical Staff member exercising clinical privileges in this medical center.

PRESIDENT means the President or Chief of the Medical Staff.

TELEMEDICINE means the use of electronic communication or other communication technologies to provide or support clinical care at a distance. Diagnosis and treatment of a patient may be performed via telemedicine link.

TELEMEDICINE PRACTITIONER means any appropriately licensed and credentialed practitioner who prescribes, renders a diagnosis or otherwise provides clinical treatment to a patient who has expressly applied for and been granted telemedicine privileges.

TREAT means to admit, consult, or provide medical/surgical care to patients, inpatient or outpatient, excluding patients referred to and treated by Emergency Room physicians.

Whenever there is reference to “he”, “his” or “him” it shall be understood that these terms also mean, “she”, “hers”, or “her”.

Whenever there is reference to “Chairman”, it shall be understood the terms also means “Chairperson”.

ARTICLE I:
NAME

The name of this organization shall be the Medical Staff of CHA HOLLYWOOD PRESBYTERIAN MEDICAL CENTER.

ARTICLE II:
PURPOSE

These bylaws are adopted in order to provide for the organization of the medical staff of CHA Hollywood Presbyterian Medical Center and to provide a framework for self-government in order to permit the medical staff to discharge its responsibilities in matters involving the quality of medical care, and to govern the orderly resolution of those purposes. These bylaws provide the professional and legal structure for medical staff operations, organized medical staff relations with the governing board, Chief Executive Officer and relations with applicants to and members of the medical staff.

The Purposes of this organization are to work with the support of the medical center Governing Board:

A. Patient Care

To provide that all patients admitted to or treated in the facilities, departments, or services of the medical center shall receive the optimal quality of care in the community within the medical center's means and circumstances.

B. Professional Performance

To provide a high level of professional performance of all practitioners and allied health professionals authorized to practice in the medical center through the appropriate delineation of the clinical privileges or practice privileges that each practitioner and allied health professional may exercise in the medical center and through an ongoing review and evaluation of each practitioner and allied health professional's performance in the medical center;

C. Continuing Medical Education

To provide an appropriate educational setting that will maintain scientific standards and that will lead to continuous advancement in professional knowledge and skill of both medical and allied health personnel;

D. Administrative Liaison

To provide means whereby issues concerning the Medical Staff and the medical center may be discussed and resolved by the Medical Staff with the Governing Board and the Administration;

E. Medical Institutes

To maintain appropriate affiliations with medical schools for the teaching of medical students, residents, and health science personnel.

F. Ethics

To provide and improve professional and ethical standards and foster goodwill and understanding among the members of the Medical staff.

ARTICLE III
MEDICAL STAFF MEMBERSHIP

3.1 Nature of Medical Staff Membership

Membership on the Medical Staff of CHA Hollywood Presbyterian Medical Center is a privilege and shall be extended only to professionally competent practitioners who continuously meet the qualifications, standards, and requirements set forth in these Bylaws, without regard to race, religion, national origin, sex, age, sexual preference, or handicap except as it may impair their ability to practice medicine, dentistry, or podiatry. Appointment to and membership on the Medical Staff shall confer on the appointee or member only such clinical privileges and prerogatives as have been granted by the Governing Board upon recommendation of the Medical Staff in accordance with these Bylaws. No practitioner shall admit or provide services to patients in the medical center unless he is a member of the Medical Staff or has been granted temporary privileges in accordance with the procedure set forth in these Bylaws.

3.2 Qualifications for Membership

1. Only physicians, dentists, and podiatrists with a valid license to practice in the State of California who can document their background, experience, and training; who have no physical or mental impairment to hinder their clinical practice; and who can demonstrate competence and judgment, their adherence to the ethics of their profession, their professional participation in continuing medical education activities, their good reputation, and their ability to work with others, with sufficient adequacy to assure the Medical Staff and the Governing Board that any patient treated by them in the medical center will be given a high quality of medical care. No physician, dentist, or podiatrist shall be entitled to membership on the Medical Staff or to the exercise of particular clinical privileges in the medical center merely by virtue of the fact that he is duly licensed to practice medicine, dentistry, or podiatry in this or in any other state, or that he is a member of any professional organization, or that he had in the past, or presently has, such privileges at another medical center. Such physicians, dentists, and podiatrists shall be actively practicing within geographic boundaries such that they are able to respond within the time

frames prescribed by the Medical Staff, to insure that all patients admitted to or treated in the medical center shall receive continuous, timely patient care.

Acceptance of membership on the Medical Staff shall constitute the staff member's agreement that he will strictly abide by the Medical Staff Bylaws, Rules & Regulations, ethical principles of this profession and "The Guiding Principles for Physician Hospital Relationships" of the California Medical Association, the Code of Ethics of the American Dental Association, or American Podiatry Association Code or Ethics, whichever is applicable; and specifically that he will refrain from fee splitting or other inducements relating to patient referral, provide for the continuous care of his patients, refrain from delegating the responsibility for diagnosis or care of hospitalized patients to a practitioner who is not qualified or licensed to undertake this responsibility and who is not adequately supervised, and seek consultation whenever necessary. In addition, his acceptance of membership on the Medical Staff shall constitute his agreement to participate in Joint Commission on Accreditation of Healthcare Organization surveys and particularly, in final critique sessions.

2. All members of the Medical Staff shall carry malpractice liability insurance in the amounts of one (1) million dollars per liability claim and three (3) million dollars per aggregate, per calendar year. If a physician obtains "claims made" as distinguished from "occurrence" insurance, he shall obtain "tail" coverage to provide coverage if he should leave the medical center Medical Staff. Particulars are to be spelled out in General Rules and Regulations of the Medical Staff.

3. Each applicant shall be required to present written evidence of participation in continuing medical education as required by the applicable State of California licensing agency.

4. Great weight shall be given to board certification in considering the qualifications of applicants.**(Approved 01/25/17)**

5. No aspect of medical staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, national origin, sexual orientation or physical or mental impairment that does not pose a threat to the quality of patient care.

3.3 Limited License Practitioners (Approved 10/22/14)

3.3-1 Dentists and Podiatrists

Dentists and Podiatrists with a license, certificate, or other legal credential required by California State Law may be eligible to provide specified services within the medical center, subject to terms and conditions described in the Surgery Department Rules and Regulations. A dentist or podiatrist shall be assigned to the Surgery Department and shall not be permitted to admit his own patients except as otherwise provided in these Bylaws. Dentists and podiatrists

shall be entitled to the rights and prerogatives of membership in accordance with their staff category.

3.3-1 (a) Dentists

The admission of a dental patient shall be a dual responsibility of the dentist and a physician member of the Medical Staff, as outlined in the Department Rules and Regulations. Dentists shall be assigned to the Department of Surgery and shall not be permitted to admit his own patients except as otherwise provided in the Department of Surgery Rules & Regulations.

3.3-1 (b) Podiatrists

The admission of a podiatric patient shall be a dual responsibility of the podiatrist and a physician member of the Medical Staff, as outlined in the Departmental Rules and Regulations. Podiatrists shall be assigned to the Department of Surgery and shall be subject to the Department Policies and Procedures and Rules and Regulations.

3.4

Responsibilities of the Medical Staff Members

Each member of the Medical Staff shall:

1. Provide his patients with care at the generally recognized professional level of quality and efficiency established by the Medical Staff;

2. Abide by the Medical Staff Bylaws, Rules and Regulations and by all other lawful Standards, Policies, and Rules of the medical center approved by the Medical Staff;

3. Discharge such personal, Medical Staff, Department, Committee, and medical center functions, including but not limited to, peer review, patient care monitoring and evaluation, professional review organizations, utilization review, and emergency services, for which he is responsible by staff category assignment, appointment, election or otherwise, or for which he is responsible by his utilization of Allied Health Professionals, or his exercise of privileges or rights in the medical center;

4. Prepare and complete in timely fashion, the medical and other required records for all patients he admits or in any way provides care to in the medical center;

5. Abide by the highest ethical standards of his profession;

6. Aid in the education programs for the medical students, graduate trainees, practitioners, nurses, and other personnel.

7. Notify the Medical Staff Office, within fourteen (14) days, regarding any adverse action, investigation, focus review, or outside review by any health facility, health care organization or licensing agency which may or will affect licensure, membership or privileges, any court action, or any insurance claim or loss of insurance.

8. As requested by the Medical Executive Committee, submit Limited Data Sets of office medical records, to authorize submission of same from other health care facilities, and to enter into or facilitate the Medical Staff's entry into an agreement governing such information in accordance with the Health Insurance Portability and Accountability Act of 1996.

9. Upon the request of the Medical Executive Committee, undergo physical or mental evaluation by a professional designated by the Medical Executive Committee, at the practitioner's expense.

10. Work cooperatively with members, nurses, hospital administration and others so as not to adversely affect patient care.

11. Make appropriate arrangements for coverage of that member's patients as determined by the medical staff.

12. Refuse to engage in improper inducements for patient referral or improper division of fees.

13. Discharge such other staff obligations as may be lawfully established from time to time by the Medical Staff or Medical Executive Committee.

14. Provide information to and/or testifying on behalf of the medical staff or an accused practitioner regarding any matter under an investigation pursuant to paragraph 9.3, and those which are the subject of a hearing pursuant to Article X.

15. Complete a brief written admitting note and a dictated history and physical (H&P) examination on all patients within 24 hours of admission. All history and physicals performed by other than the attending physician must be reviewed for completeness, corrected, and signed, when necessary, by the attending physician.

A. History and Physical Basic Requirements.

1. A history and physical examination ("H&P") report shall be dictated or handwritten and include all pertinent positive and negative findings resulting from an inventory of systems.

2. A "full" H&P is required for all patients admitted for inpatient care, with the exception of obstetric patients admitted for vaginal deliveries. It should address the following:
   (a) A chief complaint.

(b) Details of the present illness.
(c) Past medical and surgical history.
(d) Relevant Past Psycho-Social History (appropriate to the patient's age)
(e) Family history
(f) Allergies
(g) Current medications
(h) A physical examination inventoried by body systems. Unless relevant to the chief complaint or necessary to establish diagnosis, a pelvic and/or rectal exam need not be performed.
(i) A statement on the conclusions or impressions drawn from the history and physical examination.
(j) A statement on the course of action planned for the patient for that episode of care.

3. A short form H&P may be used for outpatient cases and for obstetric patients admitted for vaginal deliveries. It should address the following:
   (a) A chief complaint.
   (b) Details of the present illness.
   (c) Past medical and surgical history pertinent to the operative or invasive procedure being performed.
   (d) Allergies
   (e) A relevant physical examination of those body systems pertinent to the operative or invasive procedure performed, but including at a minimum an appropriate assessment of the patient's cardiorespiratory status.
   (f) A statement on the conclusions or impressions drawn from the history and physical examination.
   (g) A statement on the course of action planned for the patient for that episode of care.

4. An interval H&P may be used to update a full H&P in the following circumstances:
   (a) There are no significant changes to the findings contained in the full or abbreviated H&P since the time such H&P was performed, or
   (b) There are significant changes and document what those changes are.

5. Time Frames for Completion of H&P Report
   (a) The H&P for each patient shall be completed and placed on the record up to 24 hours prior to the admission or registration, but not more than 30 days, and no later than 24 hours after the patient's admission or registration, unless the patient will be taken to surgery requiring anesthesia services before that time, in which case the H&P report must be placed in the patient's chart before the patient is taken

to surgery. If it is impossible to have a dictated H&P report prepared and placed in the chart prior to surgery (e.g., it is a life-threatening emergency), the physician shall include a handwritten report in the record.

(b) An updated examination of the patient, including any changes in the patient's condition, be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination are completed within 30 days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician (as defined in section 1861® of the Act), an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

(c) If the patient is readmitted to the Hospital within 30 days of a previous discharge for the same or a related condition, an interval H&P must be completed and documented in a note stating the reason for readmission. Any changes in the H&P report may be written in lieu of a complete H&P report. The interval H&P must be placed in the chart within 24 hours of the admission. A copy of the original H&P report shall be placed in the patient's medical record.

6. Who May Prepare the H&P

(a) The H&P report shall be prepared by the patient's Attending Physician, unless he or she delegates this responsibility to another Practitioner or Allied Health Professional or he or she is required by the Hospital Medical Staff Bylaws or Rules to delegate or share this responsibility with another Practitioner.

(b) If a licensed dependent practitioner (e.g., a nurse practitioner or physician assistant) is granted privileges to perform part or all of an H&P, the findings, conclusions, and assessment of risk must be confirmed or endorsed by a qualified Physician.

(c) Use of an H&P provided by a Licensed Independent Practitioner (LIP) who is not a member of the hospital's Medical Staff is permissible provided that the H&P is reviewed by a LIP with staff privileges following an assessment to confirm the information and findings. The Medical Staff member must sign and date the outside H&P as well as the note on his or her assessment.

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

(e) Doctors of dentistry or podiatry are responsible for that part of the patient's history and physical examination that relate, respectively, to dentistry and podiatry.

3.5 Behavior/Conduct

All members of the Medical Staff are expected to conduct themselves at all times while on Hospital premises in a courteous, professional, respectful, collegial, and cooperative manner. This applies to interactions and communications with or relating to Medical Staff colleagues, Allied Health Professional Staff ("AHP"), nursing and technical personnel, other care-givers, other Hospital personnel, patients, patients' family members and friends, visitors, and others. Such conduct is necessary to promote high quality patient care and to maintain a safe work environment. Behaviors that undermine a culture of safety are discriminatory, or harassing behavior, as defined below, will not be tolerated.

A. "Behaviors that undermine a culture of safety is behavior manifested through personal interaction with practitioners, Hospital personnel, patients, family members, or others, which interferes, or could reasonably be expected, to interfere with high quality patient care or the orderly administration of the Hospital or the Medical Staff; or creates a hostile work environment; or is directed at a specific person or persons, causes substantial emotional distress and serves no legitimate purpose.

B. "Discrimination" is conduct directed against any individual (e.g., against another Medical Staff member, AHP, Hospital employee, patient or others) that deprives the individual of full and equal accommodations, advantages, facilities, privileges, or services, based on the individual's race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex, gender, or sexual orientation.

C. "Sexual Harassment" is unwelcome verbal or physical conduct of a sexual nature which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and visual harassment (such as the display of derogatory cartoons, drawings, or posters). Sexual harassment includes unwelcome advances, requests for sexual favors, and any other verbal, visual, or physical conduct of a sexual nature when (1) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion, or other aspects of employment; or (2) this conduct substantially interferes with the individual's employment or creates an intimidating, hostile, or offensive work environment. Sexual harassment also includes conduct which indicates that employment and/or employment benefits are conditioned upon acquiescence in sexual activities.

Allegations of unacceptable behavior/conduct shall be investigated by the medical staff and if it involves hospital employees hospital administration will investigate as well. If allegations are confirmed appropriate corrective action shall be taken which may include reprimand up to termination of medical staff membership and/or privileges.

3.6 Condition and Duration of Appointment

3.6-1 Appointment and Reappointment

Initial appointments and reappointments to the Medical Staff shall be approved by the Governing Board. The Governing Board shall act on appointments, reappointments, or revocation of appointments only after there has been a recommendation from the Medical Staff as provided in these Bylaws; provided that in the event of unwarranted delay on the part of the Medical Staff, the Governing Board, in consultation with the Medical Executive Committee, may act as set forth in Article IX of these Bylaws without such recommendation on the basis of documented evidence of the applicant's or staff member's professional and ethical qualifications obtained from reliable sources which need not be limited to the Medical Staff of CHA Hollywood Presbyterian Medical Center. In such instances, the Governing Board shall notify the Medical Staff of its intent, specifying an action date by which the Medical Staff may make a recommendation for appointment or reappointment.

3.6-2 Duration of Appointment **(Approved 10/22/14)**

3.6-2 (a) All new staff members shall be appointed to the provisional staff and subjected to a period of formal observation and review, not to exceed twenty-four (24) months. A review of the provisional member can be requested anytime. A provisional member must remain in the provisional category for a minimum of twelve (12) months

3.6-1 (b) Reappointments to any staff category other than provisional shall be for a period not to exceed twenty-four months

ARTICLE IV
CATEGORIES OF THE MEDICAL STAFF

4.1 Categories

The Medical Staff shall be divided into Provisional, Active, Affiliate, Courtesy, Medico Administrative Physicians, Honorary and Emeritus Staff categories. Except as limited below, all members of the Medical Staff shall be entitled to the specific procedural rights provided in Articles IX and X of these Bylaws.

4.2 The Provisional Staff

a) The Provisional Staff shall consist of new appointees to the Medical Staff who meet the basic qualifications for membership. They shall be assigned to a specific Department, where their performance shall be observed by the Chairman or his designee, as described in Section 8.9 of these Bylaws, to determine their eligibility for Active or Courtesy Medical Staff membership and the exercise of the clinical privileges provisionally granted to them.

b) The purpose of observation shall be to evaluate the member's (1) proficiency in the exercise of clinical privileges initially granted and (2) overall eligibility for continued staff membership and advancement within staff categories. Observation of provisional staff members shall follow whatever frequency and format each department deems appropriate in order to adequately evaluate the provisional staff member including, but not limited to, concurrent or retrospective chart review, mandatory consultation, and/or direct observation. Appropriate records shall be maintained. The results of the observation shall be communicated by the department chair to the credentials committee.**(Approved 10/22/14)**

c) Provisional Staff members shall have no vote nor shall they be eligible for elective office.

d) If their performance is satisfactory, including completion of proctoring requirements, the provisional staff member is eligible to be advanced to Active or Courtesy Category after one full year as a member of the Provisional Staff.

e) For those appointees who are active candidates for board certification, completion of board certification will be considered in the evaluation of satisfactory performance.

4.2-1 Action at Conclusion of Provisional Staff Status **(Approved 10/22/14)**

a) If the provisional staff member has satisfactorily demonstrated the ability to exercise the clinical privileges initially granted and otherwise appears qualified for continued medical staff membership, the member shall be eligible for placement in the Active or Courtesy staff, upon recommendation of the department chair and the Medical Executive Committee, and the Governing Board.

b) In all other cases, the appropriate department shall advise the Credentials Committee which shall make its report to the Medical Executive Committee which, in turn, shall make its recommendation to the Governing Board regarding a modification or termination of clinical privileges or termination of medical staff membership

c) As set forth in Section 8.9, during the initial twelve (12) months of Provisional status, the member did not admit sufficient patients, or perform sufficient number of procedures on which an evaluation of his performance may be made, or his performance does not warrant promotion to Active or Courtesy staff membership, the provisional membership shall be extended for a period not to exceed one additional year.

d) If the performance of the member during the Provisional period is unsatisfactory, then his staff appointment shall be terminated. Failure to advance a Provisional appointee to the Active or Courtesy staff membership may be deemed a termination of his staff appointment. A Provisional appointee whose membership is so terminated shall have the rights accorded by these Bylaws to a member of the Medical Staff who has failed to be reappointed.

4. 3 The Active Staff **(Approved 10/22/14/Revised 9/2016)**

a) The Active Staff shall meet all basic qualifications for membership and

b) Are involved in twenty four (24) patients per two year reappointment period.

Eligibility for Active Staff Status shall be determined at the time of reappointment or at the request of a physician.

b) At the time of reappointment, when an Active Staff member no longer meets the requirements for Active Staff Status they shall be reappointed to the category for which they qualify.

c) When an Active Staff member reaches the age of sixty-five (65) and has been a member of the Active Staff for at least 10 cumulative years, the Active Staff member shall not be required to pay dues.

4.4 The Courtesy Staff

Courtesy Staff members:

a) May use medical center facilities according to availability of beds.

b) May not vote or hold elective office

c) Must pay annual medical staff dues membership. They are not required to attend meetings unless serving on a committee.

d) Shall be appointed, reappraised, and reappointed in accordance with the processes specified in Article VII.

e) It shall be the obligation of members of the Courtesy staff serving on standing Committees, to participate, when so requested, in peer review activities, including monitoring of Provisional Staff members, Performance Improvement monitoring and evaluation activities, and any other required review activities.

f) Courtesy Staff shall also consist of exclusive telemedicine physicians and full-time academic physicians from an affiliating institution who may be individually approved by the applicable section and clinical department upon the request of a staff physician to assist the resident-in-training on a recurring basis. The individuals requesting this privilege would be reviewed by the applicable section and clinical department to confirm the academic affiliation.

4.5 The Honorary and Emeritus Staff

4.5-1 Honorary Staff

a) The Honorary Staff shall consist of practitioners who are not active in the medical center or who are honored for outstanding reputation not necessarily resident in the community as determined by the Medical Executive Committee.

b) An Honorary Staff member is not eligible to vote, hold office, or serve on standing Medical Staff Committees and may not admit or treat patients. Attendance at meetings or payment of dues is not required.

c) An Honorary Staff member once appointed to this category and approved by the Medical Executive Committee and Governing Board, is considered to be appointed for life and is not subject to the reappraisal and reappointment process specified in Article VII.

4.5-2 Emeritus Staff

a) The Emeritus status may be granted to physicians who have been on the Active Staff of the medical center for at least fifteen (15) years and have retired from active medical practice. They may not admit patients to the medical center.

b) It will be the privilege of members of the Emeritus Staff to attend Medical Staff Meetings and use the medical center facilities, except for admission and treatment of patients. They shall not be required to pay dues. They may not hold office or vote. They will not be required to attend meetings.

c) An Emeritus Staff member, once appointed to this category and approved by the Medical Executive Committee and Governing Board, is considered to be appointed for life and is not subject to the reappraisal and reappointment process specified in Article VII.

4.6 The Affiliate Staff

The Affiliate Staff shall consist of physicians who meet the qualifications set forth in Article III, Section 2, of these Bylaws, and who are not requesting privileges. All members of the Affiliate Physician Staff shall be assigned to the appropriate department and will not be authorized to provide any patient-care services. Membership qualifications will include current licensure and insurance. Members in this category shall abide by and be subjected to the ethical conduct and practices as outlined for all physicians within the body of these bylaws; specifically Article III, inclusive.

Affiliate Physician Staff members shall not be eligible to hold a Medical Staff Office or to vote on matters before the Medical Staff. Affiliate Physician Staff members may attend Medical Staff committees and conferences however; they do not have voting privileges. Members within this category will be required to pay annual medical staff dues.

4.7 Medico Administrative Physicians

1. Physicians engaged by the medical center by contractual arrangement to provide medical services and consultative medical service to the Medical Staff both within the medical center full-time or on a part-time basis, and who have some administrative duties, shall be required to make application, be processed for appointment and reappointment, and maintain membership on the Medical Staff as are all other members of the Medical Staff.

2. The Chief Executive Officer shall at the request of the Medical Executive Committee be required to submit contracts (excluding remuneration) of practitioners providing contractual medical services in the medical center to the Medical Executive Committee to ensure strict compliance with these Bylaws and assure quality medical care.

3. Those physicians who have a partial or exclusive contractual arrangement with the medical center may serve on Committees and may hold office of the Medical Staff in accordance with the Medical Staff Bylaws. When an issue represents a conflict of interest, those physicians shall abstain from definitive action or voting regarding these matters. All questions of dispute shall be presented to the Medical Executive Committee for deliberation and recommendation.

4. Members of the Medical Staff engaged in such a Medico-Administrative capacity shall not have their Medical Staff membership terminated except in accordance with the terms and provisions of these Bylaws.

4.8 **Temporary** Non-Clinical **Staff (Approved 10/22/14)**

a) The temporary non-clinical staff shall consist of physicians, dentists and podiatrists who do not have clinical privileges at the Hospital but are important resource individuals for Medical Staff, including, but not limited to, peer review activities and quality assessment/improvement activities. Such persons shall be qualified to perform the functions for which they are made temporary members of the staff.

b) Temporary non-clinical staff members shall be entitled to attend all meetings of committees to which they have been appointed for the limited purpose of carrying out the functions for which they were temporarily appointed to the Medical Staff. They shall have no privileges to perform clinical services in the Hospital. They may not admit patients to the Hospital or hold office in the Medical Staff organization. They may, however, serve on designated committees without vote. They may attend Medical Staff meetings outside of their committees, upon invitation.

ARTICLE V
ALLIED HEALTH PROFESSIONALS

5.1 Qualifications

Allied Health Professionals (AHPs) holding licenses, certificates or such other legal credentials, as required by California Law, which authorizes the AHPs to provide certain professional services, are not eligible for Medical Staff membership and are not entitled to the rights and privileges granted in these Bylaws in Article IX and Article X. AHPs are entitled to the Grievance Procedure set forth in Article V, Section 4.

AHPs are eligible for practice privileges in this Medical center only if they:

a) Hold a license, certificate or other legal credential in a category of AHPs which the Governing Board has identified as eligible to apply for practice privileges.

b) Document their experience, background, training, and demonstrated ability with sufficient adequacy to demonstrate that any patient treated by them will receive care of the generally recognized professional level of quality.

c) Are determined, on the basis of documented references, to adhere strictly to the lawful ethics of their respective profession; to work cooperatively with others in the medical center setting; and to be willing to commit to and regularly assist the medical center in fulfilling its obligations related to patient care, within the areas of their professional competence and credentials.

5.2 Procedure for Granting Practice Privileges to Allied Health Professionals (AHPs)

The Medical Executive Committee shall establish a Committee on Interdisciplinary Practice which shall be accountable to the Medical Executive Committee who shall report its activities to the Governing Board. The Committee shall include, as a minimum, the President of the Medical Staff or his designee, Chief Nursing Officer, an equal number of physicians appointed by the Medical Executive Committee of the Medical Staff, and registered nurses appointed by the Chief Nursing Officer. Licensed or Certified health professionals who are not members of the Medical Staff shall also be represented on the Committee.

The Committee on Interdisciplinary Practice shall review and approve credentials of Allied Health Professionals, assuring that their experience and training qualify them to provide professional care and that professional liability coverage is current. Policies, procedures, and protocols developed by the Committee on Interdisciplinary Practice will delineate the qualifications, status, clinical duties, and responsibilities of their practice. Recommendations for approval of practice privileges for each non-physician Allied Health Professional will be made to the appropriate Medical Staff Department. The Department may limit, but not extend, the practice privileges of these professionals after quality of care review. Recommendations will then be forwarded through the Medical Executive Committee to the Governing Board for their action.

Allied Health Professionals, except Clinical Psychologists and Optometrists, shall practice under the supervision of a designated member of the Medical Staff and will be subject to reappraisal at least every twenty-four (24) months as are all other practitioners.

Loss of Supervisor
In the event that a supervised Allied Health Professional loses their supervisor, their membership and privileges shall be automatically be suspended. Failure to obtain coverage within four (4) months shall be deemed a voluntary resignation from the Allied Health Professional Staff and there will be no right to a hearing and appeal process.

5.3 Participation in Medical Staff Activities

Allied Health Professionals (AHPs) may and will be encouraged to attend clinical Medical Staff meetings that will enhance their understanding of the particular problems that bear on their practice. They shall serve on committees as assigned and shall participate in all appropriate performance improvement monitoring and evaluation activities when so requested.

5.4 AHP Grievance Procedure

Nothing in these Bylaws shall be interpreted to entitle an AHP [other than clinical psychologists] to the procedural or fair hearing and appeal rights set forth in Articles IX and X. An AHP shall have the right, however, to challenge any action that would constitute grounds for a hearing under Article X by filing a written grievance with the Medical Executive Committee within fifteen (15) days of receiving notice of such proposed action. Within forty-five (45) calendar days of the receipt of such a grievance, the medical executive committee shall conduct an investigation that affords the affected AHP an opportunity for an interview before the committee concerning the

grievance. The interview shall not constitute a "hearing" as set forth in Article X, and shall not be conducted according to the procedural rules applicable with respect to hearings. Before the interview, the AHP shall be informed of the general nature and circumstances giving rise to the proposed action, and at the interview, the AHP may present information relevant thereto. A record of the interview shall be made, and a decision on the action shall be made by the medical executive committee. The affected AHP shall be notified of the action of the medical executive committee in writing, with a copy to the governing body, within ten (10) days of the decision. Within thirty (30) days of the notice of the date of the decision, the affected AHP may submit a written notice of appeal to the governing body. Such notice shall be hand-delivered or sent by certified mail to the chief executive officer. The governing body, or a delegated committee thereof, shall consider the appeal based on a review of the record from the earlier grievance process, and based on written submissions by the parties. The governing body shall give great weight to the recommendations and actions of the medical executive committee. The decision of the governing body shall be hand-delivered or sent by certified mail to the affected AHP and the medical executive committee. If the affected AHP does not submit a timely notice of appeal, the decision of the Medical Executive Committee shall be final.

ARTICLE VI
GRADUATE MEDICAL EDUCATION: INTERNS, RESIDENTS, AND FELLOWS

6.1 Definitions

The terms "interns," "residents" and "fellows" (hereinafter collectively referred to as "residents") as used in these Bylaws, refer to persons who are currently enrolled in a graduate medical education program approved by the MEC and the Governing Board and who, as part of their educational program, will provide patient care services at the hospital subject to supervision and direction as provided in approved training protocols. Residents shall not be considered independent practitioners, shall not be eligible for clinical privileges, nor Medical Staff membership, and shall not be entitled to any of the rights, privileges, or the hearing or appeal rights under these Bylaws.

6.2 Qualifications

Residents may only render patient care services at the hospital pursuant to and limited by the following:

a) In compliance with applicable provisions of the hospital licensing laws of this state;

b) Pursuant to a written affiliation agreement between the hospital and the sponsoring medical school, training program or nonaffiliated program (hereinafter collectively referred to as "medical school") that includes written descriptions of the roles, responsibilities and patient care activities of the participants in the medical school's programs. Such agreement

shall identify the individual or entity responsible for providing professional liability insurance coverage for residents in the amount of $1 million/$3 million with an approved carrier.

c) In compliance with policies established by the MEC, in conjunction with the medical school, regarding the scope of the resident's authority (including but not limited to who may write orders, the circumstances under which they may do so, and the entries, if any, that must be counter-signed), direction and supervision, mechanisms and responsibilities for effective communication between the medical staff, hospital and medical school (including but not limited to quality of care, treatment, services and educational needs), and other conditions imposed by this hospital or Medical Staff.

6.3 Responsibilities

While functioning at this hospital, residents shall abide by all provisions of the Medical Staff Bylaws, Rules and Regulations, and hospital and Medical Staff policies, and shall be subject to limitation or termination of their ability to function at the hospital at any time at the discretion of the Chief Executive Officer, the President of the Medical Staff, or the Medical Director. Residents may perform only those services set forth in the training protocols developed by the applicable medical school to the extent that such services do not exceed or conflict with the Rules and Regulations or hospital policies and to the extent approved by the Medical Staff and Governing Board. Residents shall be responsible and accountable at all times to a member of the Medical Staff. Residents shall be required to attend Medical Staff meetings when invited or as required, and may be appointed to Medical Staff Committees, but shall not have voting rights.

6.4

As defined above, residents are distinguished from practitioners who, though currently enrolled in a graduate medical education program, provide patient care services independently at the hospital (e.g., moonlighting or locum tenens coverage) and not as part of their educational program. Such practitioners who provide independent services must meet the qualifications for Medical Staff membership and privileges as provided in these Bylaws, and shall be credentialed in accordance with Articles VII and VIII.

ARTICLE VII
PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

7.1 Application for Appointment

When a practitioner requests an application form he shall be given a copy of these Bylaws, Rules and Regulations, general and Departmental Rules; and have access to a copy of the Medical Center Corporate Bylaws and summaries of other medical center and staff policies relating to clinical practice in the medical center.

7.1-1 All applications for appointment to the Medical Staff shall be in writing shall be signed by the applicant and shall be submitted on a form prescribed by the Medical Executive Committee and approved by the Governing Board. Such form shall request detailed information concerning the applicant's professional qualifications, education, training, experience and current competence, including the names of at least three professional references (with one, if possible being on the Medical Staff) who are in the same professional discipline as the applicant, have had the opportunity of observing and working with the applicant, and who can provide adequate references pertaining to the applicant's current competence, character, ethics, any effects of health status on professional practice, and interpersonal relationships. The application also shall require information as to whether the applicant's membership status and/or clinical privileges have ever been voluntarily or involuntarily revoked, suspended, reduced, or not renewed at any other medical center or institution, and as to whether there has been any previously successful or currently pending challenges to any licensure or registration or the voluntarily relinquishment of such licensure or registration; and whether his license to practice any profession in any jurisdiction has ever been suspended or ever been terminated. In addition, the application will also request information (1) as to whether the applicant's narcotic license has ever been suspended or ever been revoked; and (2) any adverse malpractice experience including a consent for the release of information from his past malpractice insurance carriers, Medical Board of California, and current insurance carriers, as required. Such application form shall require a statement from the applicant regarding his physical and mental health.

7-1-2 The applicant shall have the burden of producing adequate information required for a proper evaluation of his competence, character, professional interpersonal relationships, ethics, and other qualifications and for resolving any doubts about such qualifications.

7.1-3 Every application for Staff appointment must also contain the following documentation to be supplied by the applicant:

a) Request for membership in specific Department and for specific clinical privileges.

b) Current/valid California State License to Practice.

c) Current/valid DEA Certificate (not mandatory for pathologists nor teleradiologists).

d) Certificate evidencing current insurance coverage for professional liability for at least one (1) million per claim and three (3) million per aggregate, per calendar year.

e) Relevant training and experience demonstrating current competence, and ability to perform the privileges requested, including documentation of continuing medical education pertinent to the scope of privileges

requested for the preceding two years as required by State law or regulatory agencies.

f) A valid picture ID issued by a state, federal or regulatory agency. This document shall be used when conducting a face-to-face verification of the applicant and shall be recorded in the credentials file. A notarized copy of a valid picture ID issued by a state, federal or regulatory agency. document will be accepted in the event that the applicant is unable to physical be present for a face-to-face verification process.

7.1-4 The applicant shall deliver a completed application to the Medical Staff Office or designated centralized verification organization or regional credentialing office**,** which shall, in a timely fashion, seek to collect or verify the references, training, licensure, and other qualification evidence submitted. The applicant shall be promptly notified of any problems in obtaining the information required, and it shall then be the applicant's obligation to obtain the required information. If an applicant fails to either provide the required information within sixty (60) days or to submit a response explaining the need for additional time despite reasonable efforts to obtain the required information, the application shall be deemed voluntarily withdrawn. An applicant whose application is not completed within six (6) months after it was received shall automatically be deemed withdrawn, unless the delay is excused by the Credentials Committee upon a determination that there was good cause for the delay. An application that is deemed withdrawn may, thereafter, be reconsidered only if all information therein which may change over time including, but not limited to, medical center reports and personal references, have been resubmitted by the applicant. When collection and verification is accomplished, the Medical Staff Office shall transmit the application and all supporting material to the Chairman of each Department in which the applicant seeks privileges and later to the Credentials Committee.

7.1-5 By applying for appointment to the Medical Staff, each applicant thereby signifies his acceptance to appear for interviews in regard to his application. The applicant also authorizes the medical center and its appropriate representatives to consult with members of medical staffs of other medical centers and others with whom the applicant has been associated and who may have information bearing on the historical elements itemized in these Bylaws. This includes the inspection of all records and documents that may be material to an evaluation of his professional qualifications and competence to carry out the clinical privileges the applicant requests, as well as his moral and ethical qualifications for Staff membership. As requested by the Medical Executive Committee, department, or credentials committee, the applicant agrees to provide Limited Data Sets of his office medical records, and to authorize other hospitals/facilities to provide the Medical Executive Committee with Limited Data Sets of medical records to assist in the evaluation. Such factors as physical, mental, and emotional stability shall be considered in the appraisal. Upon request of the Medical Executive Committee, the applicant shall undergo a physical and/or mental evaluation by a professional designated by the Medical Executive Committee, at the applicant’s cost. The applicant releases from liability, to the fullest extent permitted by law, all representatives of the medical center and its Medical Staff for their acts performed in connection with evaluating the applicant and his credentials, and releases from any

liability to the fullest extent permitted by law, all individuals and organizations who provide information to the medical center concerning the applicant's qualification for Staff appointment and clinical privileges, including otherwise privileged or confidential information, as detailed in these Bylaws.

7.1-6 The application form shall include a statement that the applicant has received and read the Bylaws and Rules & Rules Regulations approved by the Medical Staff, Confidentiality Agreement and Attestation Agreement and current medical center policies that apply to his activities as a Medical Staff member and that he agrees to abide by the terms thereof if he is granted membership to the Medical Staff and/or clinical privileges. He further agrees to abide by the terms thereof without regard to whether or not he is granted membership and/or clinical privileges in all matters relating to consideration of his application.

7.1-7 The applicant agrees that if an adverse ruling is made with respect to his staff membership, staff status, or clinical privileges at any time, regardless of whether he be an applicant or a Medical Staff member, he shall exhaust the intra-organizational remedies afforded by these Bylaws before resorting to formal legal action challenging the decision, the procedures used to arrive at it, or asserting any claims against the medical center or participants in the decision process, and that the exclusive procedure for obtaining judicial review shall be petitioned for Writ of Mandate pursuant to Part 3, Title 1, Chapter 1 of the California Code of Civil Procedure, with all costs and attorney's fees to be paid by the losing party.

7.1-8 The application shall also include a signed acknowledgment to the effect that should the applicant for appointment or reappointment withhold or modify significant facts or information, which, in the opinion of the Medical Executive Committee, would have adversely affected the appointment or reappointment, then the Medical Executive Committee, upon discovery of it, may at its discretion recommend to the Governing Board to declare the appointment or reappointment void, as if it did not take place, or the Medical Executive Committee may take other corrective steps as it may deem appropriate.

7.1-9 The applicant agrees to notify the Medical Staff Office, within ten (10) business days, regarding any adverse action, investigation, focus review, or outside review by any health facility, health care organization or licensing agency which may or will affect licensure, membership or privileges, any court action, or any insurance claim or loss of insurance. Failure to submit such notice, along with related documents, shall constitute grounds for *non-approval* of application.

7.1-10 The applicant consents to the disclosure to other hospitals, medical associations, licensing boards, and to other similar organizations as required by law, any information regarding the applicant’s professional or ethical standing that the hospital or medical staff may have, and releases the medical staff and hospital from liability for so doing to the fullest extent permitted by law.

7.1-11 The applicant agrees to provide for continuous quality care for patients.

7.1-12 The applicant pledges to maintain an ethical practice, including refraining from illegal inducements for patient referral, seeking consultation whenever necessary, refraining from failing to disclose to patients when another surgeon will be performing the surgery, and refraining from delegating patient care responsibility to non-qualified or inadequately supervised practitioners.

7.1-13 Any division of professional fees by members of the medical staff is forbidden and any such division of fees shall be cause for exclusion or expulsion from the medical staff.

7.2 Appointment Process

7.2-1 The Department Chairman shall consider the applicant's verified credentials, qualifications, competence, and physical and mental health status. The Department Chair may elect to consult with his Department or a committee of the Department regarding an application. Following completion of evaluation, the Department Chairman shall make recommendations as to the Staff appointment and clinical privileges. In evaluating the applicant's eligibility for Medical Staff membership, consideration shall also be given to the ability of the medical center to provide adequate facilities and supportive services for the applicant and his patients. All initial appointments to the Medical Staff shall be to the Provisional category.

7.2-2 The Credentials Committee shall examine the evidence of the character, professional competence, qualifications, and ethical standing of the applicant and shall determine, through information contained in references given by the applicant and from other sources available to the Committee whether the applicant has established and meets all of the necessary qualifications for the category of Staff membership and the clinical privileges requested by him. The Credentials Committee and/or the Department may require a personal interview with the applicant. Unexplained or unexcused failure to appear for scheduled interviews with the Credentials Committee and/or a Department on two occasions shall result in automatic termination of the application process. Every Department in which the applicant seeks clinical privileges shall provide specific written recommendations for delineating the applicant's clinical privileges. After receipt of the completed application with supporting documents and any personal interviews, the Credentials Committee shall transmit to the Medical Executive Committee a recommendation that the applicant be either provisionally appointed to the Medical Staff or rejected for Medical Staff membership, or that the application be deferred for further consideration, not to exceed ninety (90) days. Notwithstanding the foregoing, if applicant meets all of the criteria for expedited credentialing, as set forth in Section 7.2-6, the Chair of the Credentials Committee may elect to review the application and submit a recommendation to the Medical Executive Committee on behalf of the Credentials Committee. No applicant, including one who meets all of the criteria, has the right to have an application reviewed through the expedited credentialing process or the right to procedures in Article X to challenge a decision not to use the expedited credentialing process.

7.2-3 At its next regular meeting after receipt of the application and the report and recommendation of the Credentials Committee, the Medical Executive Committee shall determine whether to recommend to the Governing Board that the applicant be provisionally appointed to the Medical Staff, that he be rejected for Medical Staff membership, or that his application be deferred for further consideration. All recommendations to appoint must also specifically recommend the clinical privileges to be granted, which may be qualified by additional probationary conditions relating to such clinical privileges.

7.2-4 When, in the opinion of the Governing Board, there has been an unwarranted delay on the part of the Medical Staff in forwarding any such recommendations for appointment, reappointment or clinical privileges, the Governing Board shall notify the Medical Executive Committee of the Governing Board's concerns. The Medical Executive Committee then shall have sixty (60) days to either (1) forward the application to the Governing Board with its recommendation, or (2) submit to the Governing Board an explanation for the reason for not submitting a recommendation. The Governing Board will give great weight to the recommendation and/or explanation from the Medical Executive Committee. However, if the Governing Board disagrees with the recommendation and/or explanation, the matter shall be referred to the Ad Hoc Dispute Resolution Committee. After giving great weight to the Medical Executive Committee in the Ad Hoc Dispute Resolution Committee, the Governing Board then may exercise it final authority on such matters; provided however, if it is a matter pertaining to quality of care, the Governing Board shall act only if it determines that the Medical Staff has failed to fulfill a substantive duty or responsibility in regard to the matter. If the Governing Board determines that the Medical Staff has failed to fulfill a substantive duty or responsibility in regard to the matter, the Governing Board then may act on the individual's appointment, reappointment or clinical privilege status without the Medical Executive Committee's recommendations, requiring the same information and applying the same standards as required by these Bylaws and as usually imposed by the Medical Staff. If the Governing Board's recommendation is favorable, it shall become effective as the final decision of the Governing Board. If the recommendation is ground for a hearing under Article X of these bylaws, the Chief Executive Officer shall give the practitioner notice of the tentative adverse recommendation and of the practitioner's right to request a hearing. The practitioner shall be entitled to the procedural rights set forth in Article X, conducted in accordance with Section 10.3-5 (Hearings Prompted by Governing Board Action) before any final adverse action is taken.

7.2-5 When the recommendation of the Medical Executive Committee is to defer the application for further consideration, it must be followed up within ninety (90) days with a subsequent recommendation for appointment with specific clinical privileges, or for rejection of Staff membership.

7.2-6 When the recommendation of the Medical Executive Committee is favorable to the applicant, the President of the Medical Staff shall promptly forward it, together with all supporting documentation, to the Governing Board. The recommendation to the Governing Board shall indicate whether the application is eligible for the expedited process of consideration by a committee of the Governing Board composed of at least two (2) members, based on criteria

for delegation provided by the Governing Board. Such eligibility criteria shall include at least applications which are: (1) complete; (2) without adverse recommendations or recommendations with limitation; (3) without a current challenge or previously successful challenge to licensure or registration; (4) without involuntary termination of medical staff membership at another organization; (5) without involuntary limitation, reduction, denial or loss of clinical privileges; (6) without final adverse judgment in a professional liability action.

7.2-7 When the recommendation of the Medical Executive Committee is adverse to the applicant either in respect to appointment or clinical privileges, the Chief Executive Officer shall promptly notify the applicant by certified mail, return receipt requested. No such adverse recommendation need be forwarded to the Governing Board until after the applicant has exercised or has been deemed to have waived any right to a hearing he may possess as provided in these Bylaws. Such an applicant shall have a right to a hearing pursuant to Articles IX and X of these Bylaws if the recommendation of the Medical Executive Committee is to reject his application for Medical Staff membership because of a medical disciplinary cause or reason.

7.2-8 If the aggrieved applicant has requested a hearing as provided in these Bylaws, and if the hearing has resulted in a decision, either at the hearing or appellate level, which is favorable to the applicant, the applicant shall be processed in accordance with these Bylaws, following final action by the Governing Board.

7.2-9 At its next regular meeting after receipt of a favorable recommendation, the Governing Board shall act in the matter. The Governing Board shall adopt, reject or modify a favorable recommendation of the Medical Executive Committee, or shall refer the recommendation back to the Medical Executive Committee for further consideration, stating the reasons for the referral, and setting a time limit within which the Medical Executive Committee shall respond. If the Governing Board decision is adverse to the practitioner, the Chief Executive Officer shall promptly notify him of such adverse decision by certified mail, return receipt requested, and he or she shall be entitled to the procedural rights as provided in Article X of these bylaws. Any hearing pursuant to such adverse Board decision shall be conducted in accordance with Section 10.3-5 (Hearings Prompted by Governing Board Action). Such adverse decision shall be held in abeyance until the applicant has exercised or has been deemed to have waived his rights as so stated in these Bylaws. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before.

7.2-10 When an applicant is denied Medical Staff membership, any 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.

7.2-11 Whenever the Governing Board's decision is final, it shall send notice of such decision through the Chief Executive Officer by certified mail, return receipt requested, to the applicant.

7.2-12 Guidelines for Time of Processing

Applications shall be acted on in a timely manner by all persons and committees. While special or unusual circumstances, such as the need for additional information or scheduled meeting dates, may constitute good cause and warrant exceptions, the following time periods provide a guideline for routine processing of applications:

a) evaluation, review, and verification of application and all supporting documents by the medical staff office: 60 days from receipt of all necessary documentation;

b) review and recommendation by Credentials Committee: 60 days after receipt of all necessary documentation from the medical staff office;

c) review and recommendation by department(s): 60 days after receipt of all necessary documentation by credentials committee and all necessary documentation from the department(s);

d) review and recommendation by Medical Executive Committee: 60 days after receipt of all necessary documentation from the credentials committee; and

e) final action by the Governing Board: 60 days after receipt of all necessary documentation from the medical executive committee, except when the hearing and appeal rights of these Bylaws apply.

7.3 Reappointment Process

7-.3-1 Reappointment Schedule

Reappointment shall be determined according to the last Governing Board approval date. In no case shall reappraisal and reappointment be greater than two (2) years from the previous reappraisal and reappointment.

7.3-2 Application for Reappointment

a) At least one hundred fifty (150) days prior to the expiration of a practitioner/AHP current appointment to the Medical Staff, a reappointment application will be sent to each Medical Staff member scheduled for reappraisal. Such member who desires reappointment shall submit:

1) A completed, signed reappointment application.

2) Specific request for the clinical privileges sought on reappointment, with any basis for change.

3) Request for change in Staff category or departmental assignment.

4) Information regarding malpractice insurance coverage (expiration date and amount of coverage) in compliance with these Bylaws.

5) Full disclosure of any malpractice judgments or settlements since last reappointment and any pending or current malpractice proceedings.

6) Full disclosure of professional sanctions pertaining to any medical license(s), drug enforcement certificate, privileges or staff membership at any other health care institution or organization; and any changes thereto since last review voluntary or involuntary.

7) Certification of any continuing medical education pertinent to the scope of privileges requested for the preceding two years as required by State law or regulatory agencies.

8) A signed acknowledgment to the effect that should the applicant for reappointment withhold or modify significant facts or information, which, in the opinion of the Medical Executive Committee, would have adversely affected the reappointment, then the Medical Executive Committee upon discovery of it, may at its discretion recommend to the Governing Board to declare the reappointment void, as if it did not take place, or the Medical Executive Committee may take other corrective steps as it may deem appropriate.

9) Courtesy Staff members may be required to submit verification of their good standing, compliance with peer review requirements, and compliance with Medical Staff Rules and Regulations from another medical center where they are a member of the Active Staff.

10) A signed Confidentiality Statement.

11) A statement regarding his physical and mental health. As determined by the Medical Executive Committee, the reapplicant may be required to undergo a physical or mental evaluation or clinical assessment by a professional/organization designated by the Medical Executive Committee, at the reapplicant's expense.

b) A second notice will be sent via email or text message if the reappointment materials are not received within the thirty (30) days. If the Practitioner/AHP does not return the completed application within thirty (30) days following the second notice, a third and final notice will be sent by certified mail and the Department Chair will be notified at this time to contact the reapplicant.

c) Failure without good cause to provide all information required for an application to be deemed complete within sixty (60) days of the request for such information shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of membership at the expiration of the current term. A practitioner whose membership is so terminated shall not be entitled to the procedural rights provided in these Bylaws. A member so terminated may submit the necessary material and the application shall be treated as if it were a new application.

d) The applicant agrees that if an adverse ruling is made with respect to this staff membership, staff status, or clinical privileges at any time, regardless of whether he be an applicant or a Medical Staff member, he shall exhaust the intra organizational remedies afforded by these Bylaws before resorting to formal legal action challenging the decision, the procedures used to arrive at it, or asserting any claims against the medical center or participants in the decision process, and that the exclusive procedure for obtaining judicial review shall be petitioned for Writ of Mandate pursuant to Part 3, Title 1, Chapter 1 of the California Code of Civil Procedure, with all costs and attorney's fees to be paid by the losing party.

7.3-3 Reappointment Procedure

The time frames for processing reappointment shall be as set forth in Section 7.2-12 of these Bylaws.

a) When a member of the Medical Staff is scheduled for biennial review, the Chairman of the Department, with his Department or a Committee thereof, shall review the application for the reappointment of the member and specifically concern itself with evaluation of the current professional competence, clinical judgment of the member, his participation in departmental activities relative to quality of patient care, and if available, relevant practitioner-specific data compared to aggregate date and performance measurement data, including morbidity and mortality data. The Department Chair then shall make a recommendation to the Credentials Committee specifically with regard to clinical privileges. When recommendation is for reduction in clinical privileges, the reason for such recommendation shall be stated and documented.

b) The extent of his participation in patient care, admission of patients, and consultation shall also be considered.

c) Prior to the meeting of the Medical Executive Committee, the Credentials Committee shall review the Departmental recommendation for reappointment of a member and shall also consider: his compliance with the Medical Staff Bylaws and Rules and Regulations, attendance at Medical Staff meetings, timely completion of records, his ethics and conduct, his

cooperation with medical center personnel, his relation with other practitioners, and his general attitude towards patients, the medical center, and the public.

The Credentials Committee shall also consider the applicant's physical and mental health; the recommendations of the Department Chairman concerning the findings of monitoring and evaluation activities; and his fulfillment of continuing medical education requirements. The Credentials Committee shall transmit its recommendation, in writing, to the Medical Executive Committee. Where non-reappointment or a reduction in clinical privileges is recommended, the reason for such recommendation shall be stated and documented. A written record of all matters considered in each practitioner's periodic reappointment appraisal will be made a part of each practitioner's permanent Medical Staff file of the medical center. Notwithstanding the foregoing, if applicant meets all of the criteria for expedited credentialing, as set forth in Section 7.2-6, the Chair of the Credentials Committee may elect to review the application and submit a recommendation to the Medical Executive Committee on behalf of the Credentials Committee. No applicant, including one who meets all of the criteria, has the right to have an application reviewed through the expedited credentialing process or the right to the procedures in Article X to challenge a decision not to use the expedited credentialing process.

d) The Medical Executive Committee meeting shall make written recommendation to the Governing Board, through the Chief Executive Officer concerning the reappointment, including the clinical privileges for the ensuing period. Where non-reappointment or a change in clinical privileges is recommended, the reasons for such recommendation shall be stated and documented. The recommendation to the Governing Board shall indicate whether the application is eligible for the expedited process of consideration by a committee of the Governing Board composed of at least two (2) members, based on criteria for delegation provided by the Governing Board. Such eligibility criteria shall include at least applications which are: (1) complete; (2) without adverse recommendations or recommendations with limitation; (3) without a current challenge or previously successful challenge to licensure or registration; (4) without involuntary termination of medical staff membership at another organization; (5) without involuntary limitation, reduction, denial or loss or clinical privileges; (6) without final adverse judgment in a professional liability action.

e) Governing Board Action.

1. In the event the Governing Board determines there has been an unwarranted delay on the part of the Medical Staff to forward a recommendation for reappointment, the Governing Board shall follow the procedure specified for applicants, as set forth in Sections 7.2-4.

2. At its next meeting after receipt of a favorable recommendation, the Governing Board shall act on the matter in accordance with the procedure specified in Section 7.2-9.

7.3-4 Leave of Absence and Reappointment **(Approved 10/22/14)**

Any member of the Medical Staff may request in writing a leave of absence for a period not to exceed one year. During the period of the leave, he shall not exercise 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

a) A leave of absence is intended to provide a mechanism by which a practitioner may temporarily leave the area and/or active practice without undergoing a full credentialing process upon returning to practice. A leave of absence will not be approved for members remaining in active practice in the area or remaining on the medical staff of another area hospital

b) At least ninety (90) days prior to the termination of the leave of absence, or at any earlier time, the medical staff member may request reinstatement of his privileges by submitting a written request to the Medical Staff Services Office. The staff member submits a written summary of his relevant activities during the leave, and other information as requested. The reappointment application is processed according to Article VII, Section 7.3 The Credentials Committee may recommend re-institution of proctoring and/or observation for any or all requested clinical privileges.

c) Failure, without good cause, to request reinstatement or to provide requested information will be considered a voluntary resignation from the medical staff and result in automatic termination of membership and privileges. The practitioner whose membership is automatically terminated is not entitled to the procedural rights provided in Article X. 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.

7.3-5 Military Leave of Absence: **(Approved 10/22/14)**

If the medical staff member requests a leave of absence to fulfill military obligations, and if there are fewer than 24 months until the expiration of his current appointment, the medical staff member shall be asked to complete a reappointment application so that he may be granted a full two year leave of absence. If the medical staff member has not completed his military obligation at the end of the current appointment, the Medical Executive Committee may recommend to the governing body that the member be reappointed for medical staff membership only up to another 24 months. 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 his privileges by submitting a reappointment application to the Medical Staff Services Office. If the duration of the leave of absence is more than 24 months, the medical staff member shall be reappointed to the Provisional Staff and his request for clinical privileges shall be subject to the usual and customary proctoring and observation process.

7.3-6 Medical Leave Of Absence **(Approved 10/22/14)**

a) A Medical Staff member may obtain a medical leave of absence from the Medical Staff by submitting written notice to the Medical Executive Committee stating the approximate time period of the leave, which may not exceed one year. During that period of leave, the member's clinical privileges, prerogatives and responsibilities shall be suspended.

A Medical Staff member may be placed on a medical leave of absence by the chairman of the clinical Department to which he/she is assigned or by the Chief of Staff. This placement of medical leave of absence will be made after conferring with the involved physician that they are, in fact, on a medical leave of absence but have not previously requested a stated leave as such. The physician will be notified via a certified letter from the Chief of Staff that they are being placed on a voluntary medical leave of absence. This notification will include the information listed below regarding Reinstatement of Medical Leave.

During the duration of the medical leave of absence, the Medical Staff member may be reappointed to the Medical Staff pending final verification of health status as required in Section 7.3-2 of these Medical Staff Bylaws

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

b) Reinstatement Of Medical Leave: **(Approved 10/22/14)**

The Medical Staff member on medical leave of absence shall request reinstatement of his/her privileges and prerogatives in writing to the Medical Executive Committee with a letter from the physician's attending physician confirming that the physician is able to resume Medical Staff obligations and if any limitations are applicable. The Medical Executive Committee may request the physician to submit to a third party objective physical assessment for current health status. The Chief of Staff, with ratification by the Medical Executive Committee, shall recommend whether to approve the member's request for reinstatement of privileges, prerogatives and, thereafter, the procedures followed. Failure to submit to a requested physical examination by a third party physician shall automatically extend the leave of absence, but for no more than one year period as provided for in this Section.

7.3-7 Conditional Reappointment

Whenever any of the procedures authorized by these Bylaws shall have been initiated against any member of the Medical Staff who otherwise would have been a candidate for reappointment pursuant to these Bylaws, reappointment made shall be conditional in nature and the practitioner's right to continued Medical Staff membership shall be contingent upon the outcome of the procedures authorized within these Bylaws.

ARTICLE VIII- CLINICAL PRIVILEGES

8.1 Definition and Restrictions

8.1-1 The clinical privileges pertain directly to the clinical aspects of patient care and have no relationship to the membership category.

8.1-2 Every practitioner practicing at this medical center by virtue of Medical Staff membership or otherwise, including the provision of telemedicine services, shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted to him by the Governing Board, except as provided in these Bylaws.

8.2 Request and Basis for Clinical Privileges

8.2-1 Every initial application for Medical Staff appointment, except Affiliate Category, must contain a request for the specific clinical privileges desired by the applicant. The evaluation of such request shall be done by the clinical Department in which the privileges are sought based upon the applicant's education, training, experience, demonstrated current competence, physical and mental health status, references, relevant practitioner-specific data compared to aggregate data (when available), performance measurement data including morbidity and mortality data (when available) and other relevant information. The applicant shall have the burden of establishing his qualifications and competency in the clinical privileges he requests.

8.2-2 Periodic re-determination of clinical privileges and the increase or curtailment of same shall be based upon professional performance, including clinical and technical skills and information from the Hospital’s performance improvement activities (when such information is available), direct observation of care provided, and review of other records of the Medical Staff which document the evaluation of the member's participation in the delivery of medical care.

8.2-3 A Practitioner who only seeks telemedicine privileges shall be credentialed in the same manner as any other applicant for membership and privileges

8.3 Modification of Privileges

8.3-1 Promotion, modification and addition of privileges may be initiated by written application from the applicant to the Chairman of the Department; the Department shall forward

such information with a recommendation to the Medical Executive Committee for action. All requests for additional privileges must be accompanied by supporting documentation, as determined necessary by the department and/or the Medical Executive Committee. Additional privileges may be granted subject to proctoring in accordance with the procedures set forth in Section 8.9.

8.4 Clinical Privileges for Dentists and Podiatrists

8.4-1 Surgical procedures performed by dentists and podiatrists shall be under the overall supervision of the Chairman of the Department of Surgery or his designee. All dental and podiatric patients shall be co admitted by a physician member of the Medical Staff and receive the same basic medical appraisal as patients admitted to other surgical services. The co admitting physician member of the Medical Staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization and shall determine the risk and effect of the proposed surgical procedure on the total health status of the patient.

8.5 Practice Privileges for Allied Health Professionals (AHPs)

8.5-1 Requests by Allied Health Professionals (AHPs) to perform specified patient care services shall be submitted and processed in a parallel manner to that provided in Section 7.2. As such, procedures may be modified or more particularly specified in the Rules and Regulations of the Department to which the AHP is assigned. An AHP may, subject to any licensure requirements or other legal limitations, and consistent with the privileges granted, exercise independent judgment within the areas of his professional competence, and may participate directly in the medical management of the patients under the supervision or direction of a practitioner who has been accorded privileges to provide such care and who has ultimate responsibility for the patient's care.

8.5-2 The Rules and Regulations of the Department to which the AHP is assigned shall include separate sections delineating the practice privileges of the AHP.

8.6 Clinical Privileges for Emergency Department Physicians, Hospitalists and Intensivists

While the Emergency Department Physicians shall have no admitting or consulting privileges on inpatients, except for emergency as defined in the Bylaws, the Hospitalists and Intensivists shall have full privileges to admit, consult and perform procedures on inpatients.

8.7 Temporary Clinical Privileges (Approved 10/22/14)

Temporary clinical privileges are allowed under two circumstances only: to address a patient care need and to permit patient care to be provided while an application is pending. Each circumstance has different criteria for granting privileges. Temporary privileges for applicants may be granted for no more than 120 days

8.7-1 Pending Application for Medical Staff Membership:

Temporary clinical privileges may be granted to an applicant while that person's application for medical staff membership and privileges is completed, has been reviewed by the department chair and the credentials chair, raises no concerns, and is awaiting review and approval of the medical executive committee or the governing board provided that the application process has been completed in accordance with these Bylaws, and that the applicant has no current or previously successful challenge to professional licensure or registration, no involuntary termination of medical staff membership at any other organization, and no involuntary limitation, reduction, denial or loss of clinical privileges.

Temporary privileges may be granted for an initial period of thirty (30) days, with subsequent renewals; however, the total period of temporary privileges shall not exceed one hundred and twenty (120) days. In exercising such privileges, the applicant shall act under the supervision of the Chairman, or the Chairman's designee, of the Department to which he is assigned, in accordance with the condition specified in these Bylaws.

Note: Applicant for new privileges includes an individual applying for clinical privileges at the hospital for the first time; an individual currently holding clinical privileges who is requesting one or more additional privileges; and an individual who is in the reappointment/reprivileging process and is requesting one or more additional privileges.

8.7-2 Patient Care Needs – To Fulfill and Important Patient Care, Treatment, and Service Need:

a) **Care of Specific Patient:**
Temporary clinical privileges may be granted where good cause exists, but not more than three (3) times during a calendar year, provide care to a specific patient that cannot be met by members who already have privileges. In such circumstances and, upon receipt of a written request for specific temporary privileges, ***an appropriately licensed practitioner of documented current competence*** who is not an applicant for membership may be granted temporary privileges for the care of the occasional patient. Such privileges shall be exercised in accordance with the conditions specified in these Bylaws. In circumstances where a third request is approved, the Medical Staff Office will then send an application to the physician informing the physician that the next time the need for temporary privileges arises, the physician must submit an application.

b**) Locum Tenens (Approved 10/22/14)**

Upon receipt of a written request for specific temporary privileges, temporary clinical privileges may be granted to a physician, dentist, or podiatrist serving as a locum tenens for a current member of the medical staff in the same specialty to meet the care needs of that member's patients in that member's absence, provided that the application

process has been completed in accordance with these Bylaws. Such person may attend only patients of the member(s) for whom that person is providing coverage, for a period not to exceed thirty (30) days, unless the medical executive committee recommends a longer period for good cause.

Locum Tenens privileges will only be considered when the physician member documents that the member's covering physician is not available, and all other physician members in the same specialty are not available, or it is an emergency. Covering physicians are expected to cover on weekends, holidays, conferences, and other non-urgent scheduling issues.

(c) **Other Important Patent Care Needs (Approved 10/22/14)**

Temporary clinical privileges may be granted to allow a physician, dentist, or podiatrist to fulfill an important patient care treatment or service need provided that the procedure described in these Bylaws has been completed.

8.7-3 Temporary Membership and Temporary Privileges Not Co-Extensive (Approved 10/22/14)

Temporary members of the Medical Staff who are granted temporary membership for purposes of serving on standing or ad hoc committees for investigation proceedings are not, by virtue of such membership, granted temporary clinical privileges.

8.7-4 Conditions

a) Pendency of Application: At a minimum, to grant temporary privileges for new applicants there is verification of the following:
- a valid California License by the applicable licensing agency;
- relevant training/experience,
- current competence,
- ability to perform the privileges requested,
- valid narcotic certificate;
- results and evaluation of the National Practitioner Data Bank query,
- valid liability coverage (malpractice insurance); and
- a favorable determination regarding the requesting practitioner's qualifications, ability, and judgment to exercise the privileges requested from the Department and Credentials Committee,

b) Temporary privileges during the pendency of an application will not be considered under the following circumstances:

- if a complete application is not received by the Medical Staff Office,

- if there are any previous successful challenges to the applicant's licensure or registration or if any such challenge is pending,
- the applicant has been subject to involuntary termination of medical staff membership at another organization, or

- the applicant has been subject to involuntary limitation, reduction, denial, or loss of clinical privileges at another organization.

Specific requirement for Focused Professional Practice Evaluation (FPPE)/Proctoring of a practitioner granted temporary privileges shall be defined by the applicable Chairman of the Department. Before temporary privileges are granted, the practitioner must acknowledge in writing that he has received or been given access to, and read the Medical Staff Bylaws, Rules and Regulations and that he agrees to be bound by the terms thereof in all matters relating to his temporary privileges.

8.7-5 Termination

On the discovery of any information or the occurrence of any event of a nature which raises a question about a practitioner's professional qualifications or ability to exercise any or all of the temporary privileges granted, the Chief Executive Officer or the President of the Medical Staff may, after consultation with the Department Chairman responsible for supervision, terminate any or all of such practitioner's temporary privileges, provided that where the life of a patient is determined to be endangered by continued treatment by the practitioner, the termination may be effected by any person entitled to impose summary suspensions as provided in these Bylaws.

8.8 Emergency and Disaster Privileges

8.8-1 Emergency Privileges: For the purpose of this Section, an emergency is defined as a condition in which serious or permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger. In the case of an emergency, any medical center practitioner to the degree permitted by his license and regardless of Department, Medical Staff status, or clinical privileges, shall be permitted to do, and shall be assisted by medical center personnel in doing, everything possible to save a patient from serious harm. The member would defer to the department chair when the emergency no longer exists. When an emergency situation no longer exists, such practitioner must request the privileges necessary to continue to treat the patient. In the event the privileges are either not requested or denied, the patient shall be assigned to an appropriate member of the Staff.

8.8-2 Disaster Privileges:

a) In the event of a disaster where the disaster plan has been activated and the hospital is unable to handle the immediate patient needs, the President of the Medical Staff, or in the absence of the President of the Medical Staff, the President-Elect, may grant disaster

privileges. In the Absence of the President of the Medical Staff and President-Elect and Department Chair(s), the Chief Executive Officer or the CEO's designee may grant the disaster privileges consistent with this subsection. The grant of privileges under this subsection shall be on a case-by-case basis at the sole discretion of the individual authorized to grant such privileges. An initial grant of disaster privileges is reviewed by a person authorized to grant disaster privileges within 72 hours to determine whether the disaster privileges should be continued.

b) The verification process of the credentials and privileges of individuals who receive disaster privileges under this subsection shall be developed in advance of a disaster situation. This process shall begin as soon as the immediate disaster situation is under control, and shall meet the following requirements in order to fulfill important patient care needs:

1. The medical staff identifies in writing the individual(s) responsible for granting disaster privileges.

2. The medical staff describes in writing, the responsibilities of the individual(s) responsible for granting disaster privileges

3. The medical staff describes in writing, a mechanism to manage the activities of individuals who receive disaster privileges. There is a mechanism to allow staff to readily identify these individuals.

4. The medical staff addresses the verification process as a high priority. The medical staff has a mechanism to ensure that the verification process of the credentials and privileges of individuals who receive disaster privileges begins as soon as the immediate situation is under control. This privileging process is identical to the process established under the medical staff bylaws for granting temporary privileges to fulfill an important patient care need.

5. Those authorized under subsection (a) may grant disaster privileges upon presentation of a valid picture ID issued by a state, federal or regulatory agency and at least one of the following:

    i. A current picture hospital ID card clearly identifying professional designation.

    ii. A current license to practice.

    iii. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT) or MRC, ESAR-VHP, or other recognized state or federal organizations or groups.

    iv. Identification indicating that the individual has been granted authority by federal, state, or municipal entity to render patient care in disaster circumstances.

v. Identification by current hospital or medical staff member(s) with personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during a disaster.

c) Current professional licensure of those providing care under disaster privileges is verified from the primary source as soon as the immediate situation is under control and completed within 72 hours, unless extraordinary circumstances prohibit verification, in which case the following is documented:

1. The reasons verification could not be performed within 72 hours.

2. Evidence of demonstrated ability to continue to provide adequate care, treatment and services.

3. An attempt to rectify the situation as soon as possible.

(d) Members of the medical staff shall oversee those granted disaster privileges.

8.9 Proctoring

8.9-1 Except as otherwise determined by the Medical Executive Committee with the approval of the Governing Board, all initial appointees to the Medical Staff and all members requesting new clinical privileges shall be subject to a period of 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 each Department, shall be proctored as specified in the Department Rules and Regulations, to determine suitability to continue to exercise the clinical privileges granted in that Department. Proctoring may include direct observation, concurrent chart review or retrospective chart review, as specified in the Department Rules and Regulations. The exercise of clinical privileges in any other Department shall also be subject to proctoring by that Department's designated Proctors. Proctoring will start at the time temporary privileges are granted. The member shall remain subject to such proctoring until the Medical Executive Committee has been furnished with and has approved:

a) A report signed by the Chairman of the Department, or designee to which the member is assigned, describing the types and number of cases observed and the evaluation of the applicant's performance, a statement that the applicant meets all the qualifications for unsupervised practice in that Department, has discharged all the responsibilities of staff membership, and has not exceeded or abused the prerogatives of the category to which the appointment has been made; and,

b) A report signed by the Chairmen of other Departments, or designee in which the appointee may exercise clinical privileges, describing the types and number of cases observed and the evaluation of the applicant's performance and a statement that the member

has satisfactorily demonstrated the ability to exercise the clinical privileges initially granted by those Departments.

8.9-2 The Proctor shall be charged with the duty of executing directives of the Medical Executive Committee and the Governing Board and thus shall be protected from liability while acting without compensation as an agent of the medical center. Any member of the medical staff who has completed their proctoring may be assigned as a proctor. A maximum of 50% of proctoring requirements may be met by acceptable written reports from Joint Commission accredited outside hospital physicians. **(Approved 9/28/16)**

8.9-3 Medical Staff Advancement The failure to complete proctoring for any specific clinical privileges shall not, of itself, preclude advancement in medical staff category of any member. If such advancement is granted absent such certification, continued proctorship on the uncertified procedure shall continue for the specified time period. **(Approved 10/22/14)**

8.10 Medical Staff Privileges and Exclusive Contracts

Privileges can be reduced or terminated as a result of a decision to close or continue closure of a Department or Section pursuant to an exclusive contract, or to transfer an existing exclusive contract, only following review by the Medical Executive Committee of the related quality of care issues pursuant to Section 8.11 and a recommendation of appropriateness of the closure, continued closure or transfer as set forth below. The Governing Board's decision shall be given only after careful and full consideration to the Medical Staff recommendations.

8.10-1 The Medical Executive Committee shall determine the need to change to an exclusive contract to be appropriate where:

a) A failure to provide full coverage of a needed service cannot be remedied by less extreme measures, such as mandated call schedules; or

b) Irreconcilable differences within an existing Department or Section adversely affecting quality of care have not been resolved by less extreme measures; or

c) Demonstrable efficiencies would result, producing significant improvement in the ability of the Medical Staff to dispense quality care, which have not been accomplished through less extreme measures.

A determination to close a Department or Section pursuant to an exclusive contract must be based upon the preponderance of the evidence following notice and opportunity for comment.

8.10-2 The Medical Executive Committee shall determine the transfer of an existing exclusive contract to be appropriate only when:

a) Continued closure of the Department or Section pursuant to an existing contract is found appropriate pursuant to 8.10-1.a) through c) above, and

b) Quality of care is maintained or improved by the transfer.

8.10-3 The Medical Staff member(s) whose privileges may be adversely affected by the Medical Staff's determination of appropriateness of the closure or continued closure of a department or Section pursuant to an exclusive contract, or transfer of an exclusive contract, are not entitled to the hearing and appeals process as set forth in Article X of these Bylaws unless it is determined that the action is reportable pursuant to either Business and Professions Code Section 805 or the National Practitioner Data Bank.

8.10-4 Except as specified in this Section, the termination of privileges following the decision determined to be appropriate by the Medical Staff to close a Department or Section pursuant to an exclusive contract or to transfer an exclusive contract shall not be subject to the procedural rights set forth in Article X.

8.11 Medical Executive Committee Role in Exclusive Contracting

The Medical Executive Committee shall review and make recommendations to the Board regarding quality of care issues related to exclusive arrangements for professional physician services, prior to any decision being made, in the following situations:

a) the decision to execute an exclusive contract in a previously open department or service;

b) the decision to renew or modify an exclusive contract (other than the financial terms) in a particular department or service; or

c) the decision to terminate an exclusive contract in a particular department or service.

ARTICLE IX
PEER REVIEW & CORRECTIVE ACTION

9.1 Criteria for Initiation

Any person may provide information to the Medical Staff about the conduct, performance, or competence of its members. When reliable information indicates a member may have exhibited acts, demeanor, or conduct reasonably likely to be (1) detrimental to patient safety or to the delivery of quality patient care within the medical center; (2) unethical; (3) contrary to the Medical Staff Bylaws, and Rules and Regulations; or (4) disruptive of medical staff or hospital operations, a request for an investigation or action against such member may be initiated by the

President of the Medical Staff, a Department Chairman, Chief Executive Officer, Medical Executive Committee or the Governing Board.

9.2 Peer Review

9.2-1 Role of Medical Staff in Organization-wide Quality Improvement Activities

a) Members of the medical staff are expected to actively and cooperatively participate in a variety of peer review activities to measure, assess and improve performance of their peers in the hospital.

b) The goals of the peer review processes are to prevent, detect and resolve problems and potential problems through routine collegial monitoring, education and counseling. However, when necessary, remedial measures, including formal investigation and discipline, must be implemented and monitored for effectiveness.

c) Peers in the departments and committees are responsible for carrying out delegated review and quality improvement functions as described in the Medical Staff Peer Review Policy in a manner that is consistent, timely, defensible, balanced, useful and ongoing. The term "peers" generally requires that a majority of the peer reviewers be members holding the same license as the practitioner being reviewed, including, where practical, at least one member practicing the same specialty as the member being reviewed. D.O.s and M.D.s shall be deemed to hold the "same licensure" for purposes of participating in peer review activities.

d) The department and committees may be assisted by the Chief Medical Office as requested by President of the Medical Staff and the Department and/or Committee Chairman.

9.2-2 Informal Remedial Activities

The medical staff officers, departments, department chairs and committees may counsel, educate, issue letters of warning or censure, or institute retrospective or concurrent monitoring (so long as the practitioner is only required to provide reasonable notice of admissions and procedures and respond to the monitor's questions if asked) in the course of carrying out their duties without initiating formal corrective action. Comments, suggestions and warnings may be issued orally or in writing. The practitioner shall be given an opportunity to respond in kind and may be given an opportunity to meet with the officer, department, department chair or committee. Any informal actions, monitoring or counseling shall be documented in the member's file. Medical Executive Committee approval is not required for such actions, although the actions shall be reported to the

Medical Executive Committee. The actions shall not constitute a restriction of privileges or grounds for any formal hearing or appeal rights under Article X (Hearing and Appellate Review).

9.3 Initiation

A request for an investigation must be in writing, submitted to the Medical Executive Committee, and supported by reference to specific activities or conduct alleged. If the Medical Executive Committee initiates the request, it shall make an appropriate recording of the reasons.

9.4 Investigation

If the Medical Executive Committee concludes that an investigation is warranted, it shall direct an investigation to be undertaken. The Medical Executive Committee may conduct the investigation itself, or may assign the task to an appropriate Medical Staff Officer, Medical Staff Department, or Standing or Ad Hoc Committee of the Medical Staff. If the investigation is delegated to an officer or Committee other than the Medical Executive Committee, such Officer or Committee shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the Medical Executive Committee as soon as practicable. The report may include recommendations for appropriate corrective action. The member shall be notified by the Medical Executive Committee that an investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The individual or body investigating the matter may, but is not obligated to, conduct interviews with persons involved; however, such investigation shall not constitute a "hearing" as that term is used elsewhere, nor shall the procedural rules with respect to hearing or appeals apply. Despite the status of any investigation, at all times the Medical Executive Committee shall retain authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension, termination of the investigative process, or other action.

9.5 Medical Executive Committee Action

As soon as practicable after the conclusion of the investigation, the Medical Executive Committee shall take action which may include, without limitation:

1. Determining no corrective action be taken and, if the Medical Executive Committee determines there was no credible evidence for the complaint in the first instance, removing any adverse information from the member's file;

2. Deferring action for a reasonable time where circumstances warrant;

3. Issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude Department Chairmen from issuing informal written or oral

warnings outside of the mechanism for corrective action. In the event such letters are issued, the affected member may make a written response which shall be placed in the member's file;

4. Recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of clinical privileges, including, without limitation, requirements for co admissions or mandatory consultation.

5. Recommending reduction, modification, suspension, or revocation of clinical privileges;

6. Recommending reductions of membership status or limitation of any prerogatives directly related to the member's delivery of patient care;

7. Recommending suspension, revocation or probation of Medical Staff membership; and

8. Taking other actions deemed appropriate under the circumstances.

9.6 Subsequent Action

If the Medical Executive Committee determines that no corrective action is required or only a letter of warning, admonition, reprimand or censure should be issued, the decision shall be transmitted to the Governing Board before notice is given to the practitioner. The Governing Board may affirm, reject or modify the action. The Governing Board shall give great weight to the Medical Executive Committee's decision and initiate further action only if the failure to act is contrary to the weight of the evidence that is before it, and then only after it has consulted with the Medical Executive Committee and the Medical Executive Committee still has not acted in accordance with the Governing Board's recommendation. The Medical Executive Committee's decision shall become final if the Governing Board affirms it.

If the Medical Executive Committee recommends an action (other than summary suspension or restriction of clinical privileges) that is a ground for a hearing under Section 10.3, the Governing Board shall be informed of the recommendation before notice is given to the practitioner. If the Governing Board has not notified the Medical Executive Committee of its objection to the recommendation within ten (10) business days of its receipt from the Medical Executive Committee, the practitioner shall be given notice of the adverse recommendation and of the right to request a hearing in accordance with these Bylaws. If the Governing Board determines that the action recommended by the Medical Executive Committee is contrary to the weight of the evidence, and is excessive, the Governing Board shall request the Medical Executive Committee to reconsider its recommended action. If the Governing Board determines that the action recommended by the Medical Executive Committee is contrary to the weight of the evidence and is too lenient, the Governing Board may initiate alternative or more stringent corrective action, after consulting with the Medical Executive Committee, and proceed in accordance with Articles IX and X of these Bylaws pursuant to the procedure for an action

initiated by the Governing Board. If the Governing Board initiates alternative or more stringent corrective action, the recommendation of the Medical Executive Committee shall be held in abeyance until the recommendation of the Governing Body has become final or until the affected practitioner exercises his or her right to a hearing and appeal in accordance with Article X.

9.6.1 Governing Board Affirms It

So long as the recommendation of the Medical Executive Committee is supported by substantial evidence it shall be adopted by the Governing Board as final action unless the member requests a hearing, in which case the final decision shall be determined as set forth in Article X of these Bylaws. If the Medical Executive Committee recommends an action (other than summary suspension or restriction of clinical privileges) that is a ground for a hearing under Section 10.3-1, the Governing Board shall be informed of the recommendation before notice is given to the practitioner. If the Governing Board has not notified the Medical Executive Committee of its objection to the recommendation within ten (10) business days of its receipt from the Medical Executive Committee, the practitioner shall be given notice of the adverse recommendation and of the right to request a hearing in accordance with Section 10.3 If the Governing Board determines that the action recommended by the Medical Executive Committee is contrary to the weight of the evidence, and is excessive, the Governing Board shall request the Medical Executive Committee to reconsider its recommended action. If the Governing Board determines that the action recommended by the Medical Executive Committee is contrary to the weight of the evidence and is too lenient, the Governing Board may initiate alternative or more stringent corrective action, after consulting with the Medical Executive Committee, and proceed in accordance with Articles IX and X of these Bylaws pursuant to the procedure for an action initiated by the Governing Board. If the Governing Board initiates alternative or more stringent corrective action, the recommendation of the Medical Executive Committee shall be held in abeyance until the recommendation of the Governing Body has become final or until the affected practitioner exercises his or her right to a hearing and appeal in accordance with Article X.

9.6.2 Criteria for Initiation

Whenever a member's conduct appears to require that immediate action be taken to protect the life or well-being of patient(s) or to reduce a substantial and imminent likelihood of significant impairment of the life, health, or safety of any patient, prospective patient, or other person, the President of the Medical Staff, the Medical Executive Committee, the Chairman of the Department or designee in which the member holds privileges, or the Chief Executive Officer, may summarily restrict or suspend the Medical Staff membership or clinical privileges of such member. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition, and the person or body responsible shall promptly give written notice to the member, the Governing Board, the Medical Executive Committee, the Chief Executive Officer, and the Chairman of the member's Department. The summary restriction shall remain in effect until resolved as set forth herein. Unless otherwise indicated by the terms of the summary restriction or suspension, the member's patients shall be promptly assigned to another member by the Department Chairman or by the President of the Medical Staff, considering where feasible, the wishes of the patient in the choice of a substitute member.

9.7 Summary Restriction of Suspension

9.7-1 Criteria for Initiation

Where the failure to take action may result in an imminent danger to the health of any individual, the President of the Medical Staff, the Medical Executive Committee, or the Chairman of the Department or designee in which the member holds privileges, or the Chief Executive Officer after consultation with the President of the Medical Staff, may summarily restrict or suspend the Medical Staff membership or clinical privileges of such member. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition, and the person or body responsible shall promptly give written notice to the member, the Governing Board, the Medical Executive Committee, the Chief Executive Officer, and the Chairman of the member's Department. The summary restriction shall remain in effect until resolved as set forth herein. Unless otherwise indicated by the terms of the summary restriction or suspension, the member's patients shall be promptly assigned to another member by the Department Chairman or by the President of the Medical Staff, considering where feasible, the wishes of the patient in the choice of a substitute member.

9.7-2 Medical Executive Committee Action

Within one week after such summary restriction or suspension has been imposed, a meeting of the Medical Executive Committee shall be convened to review and consider the action. Upon request, the member may attend and make a statement concerning the issues under investigation, on such terms and conditions as the Medical Executive Committee may impose, although in no event shall any meeting of the Medical Executive Committee, with or without the member, constitute a "hearing" within the meaning of Article X, nor shall any procedural rules apply. The member's failure without good cause to attend any Medical Executive Committee meeting upon request shall constitute a waiver of his or her rights under Article X. The Medical Executive Committee may modify, continue, or terminate the summary restriction or suspension, but in any event it shall furnish the member with notice of its decision.

9.7-3 Procedural Rights

Unless the Medical Executive Committee promptly terminates the summary restriction or suspension, the member shall be entitled to the procedural rights afforded by Article IX of these Bylaws.

9.7-4 Initiation by Governing Board

If no one authorized under Section 9.7-1 to take a summary action is available to summarily restrict or suspend the member's membership or clinical privileges, the Governing Board may immediately suspend a member's privileges if a failure to summarily suspend those privileges is likely to result in an imminent danger to the health of any individual, provided that the Governing

Board made reasonable attempts to contact the President of the Medical Staff, members of the Medical Executive Committee, and the Chairman of the Department before the suspension.

If the President of the Medical Staff, members of the Medical Executive Committee, and the Chairman of the Department in which the member holds privileges are not available and no one authorized under Section 7.7-1 to take a summary action is available to summarily restrict or suspend the member's membership or clinical privileges, the Governing Board may immediately suspend a member's privileges if a failure to summarily suspend those privileges is likely to result in an imminent danger to the health of any patient, prospective patient, or other person, provided that the Governing Board made reasonable attempts to contact the President of the Medical Staff, members of the Medical Executive Committee, and the Chairman of the Department before the suspension.

Such a suspension is subject to ratification by the Medical Executive Committee. If the Medical Executive Committee does not ratify such a summary suspension within two working days, excluding weekends and holidays, the summary suspension shall terminate automatically.

9.8 Automatic Suspension or Revocation

The following shall result in the automatic suspension and possible automatic resignation or termination of Medical Staff membership and/or clinical privileges and shall not entitle the affected practitioner to the hearing, fair review or appeal rights specified in these Bylaws, unless otherwise expressly provided.

9.8-1 License

a) **Revocation or Expiration**: Whenever a practitioner's license authorizing him to practice in this State is revoked or has expired, his Medical Staff membership, prerogatives, and clinical privileges shall be immediately and automatically suspended.

b) **Restriction:** Whenever a practitioner's license authorizing him to practice in this State is limited or restricted by the applicable licensing authority, those clinical privileges which he has been granted the right to perform that are within the scope of said limitation or restriction shall be immediately and automatically terminated.

c) **Suspension**: Whenever a practitioner's license authorizing him to practice in this State is suspended, without stay, his staff membership and clinical privileges shall be automatically terminated.

d) **Probation:** Whenever a practitioner is placed on probation by the applicable licensing authority, his applicable membership status, prerogatives, privileges, and responsibilities, if any, shall automatically become subject to the terms of that probation effective upon and for at least the term of that probation.

9.8-2 Drug Enforcement Administration Certificate

a) **Revocation or Expiration**: Whenever a practitioner's DEA Certificate is revoked or has expired, he shall immediately and automatically be divested of his right to prescribe medications covered by the Certificate.

b) **Suspension**: Whenever a practitioner's DEA Certificate is suspended, he shall be divested, at a minimum, of his right to prescribe medications covered by the Certificate, effective upon, and for at least the term of, that suspension.

c) **Probation**: Whenever a practitioner's DEA Certificate is subject to an order of probation, his right to prescribe medications covered by the Certificate shall automatically become subject to the terms of that probation, effective upon, and for at least the term of, that probation.

9.8-3 Failure to Satisfy Special Appearance Requirement

A staff member who fails to appear (without good cause acceptable to the Committee) at any meeting with respect to which he was given notice requiring a special appearance and notice of intent to effect the provisions of this Section may immediately and automatically be suspended from exercising all or such portion of his clinical privilege in accordance with the provisions set forth elsewhere until the special appearance requirement is satisfied by attendance at a subsequent meeting of the forum requiring the special appearance.

9.8-4 Medical Executive Committee Deliberation On Matters Involving License, Drug Enforcement Administration, Failure to Satisfy Special Appearance, Conviction of a Felony, and Over Utilization

As soon as practicable after action is taken on matters involving license, drug enforcement administration, failure to satisfy special appearance, conviction of a felony, or over utilization,, the Medical Executive Committee shall convene to review and consider the facts upon which such action was predicated. The Medical Executive Committee may then recommend such further corrective action as may be appropriate based upon information disclosed or otherwise made available.

9.8-5 Conviction of a Felony

After a conviction of a felony, or plea of guilty or no contest or equivalent, of a staff member in any court in the United States, Federal or State, the member's staff membership and privileges are automatically suspended. Such suspension shall become effective immediately, regardless of whether an appeal is filed, and the provisions of Section 8.7.3 shall apply. Such suspension shall remain in effect unless reinstatement is approved by the Medical Executive Committee and Governing Body. If reinstatement is not approved within 6 months, the member shall be deemed

to have voluntarily resigned his medical staff membership and clinical privileges. Such suspension and any subsequent resignation does not afford review, hearing or appeal rights.

9.8-6 Medical Records

Members of the Medical Staff are required to complete medical records within fourteen (14) days of the patient's discharge, to dictate operative reports within the time frame specified in the General Rules and Regulations, and to sign the required Attestation Statement. A limited suspension in the form of withdrawal of admitting and other related privileges until medical records are completed, operative reports are dictated, or Attestation Statement signed shall be imposed by the CEO, or his designee, after notice of delinquency for failure to complete medical records, dictate operative reports, or sign the Attestation Statement within the specified time periods. For the purpose of this Section, "privileges" means voluntary on call service for the Emergency Room, scheduling surgery, assisting in surgery, consulting on medical center cases, and providing professional services within the medical center. Members whose privileges have been suspended for delinquent records may continue to care for patients in the medical center at time of suspension, but may admit patients only in life threatening situations. The suspension shall continue until lifted by the Medical Staff President and CEO. Suspensions for failure to complete medical records will be reported as required, pursuant to Section 805 of the California Business and Professions Code.

If a practitioner continues to remain on suspension for ***thirty (30) consecutive days*** for delinquent medical records it will result in an automatic voluntary resignation of membership and privileges. Unless the Medical Executive Committee finds that the continued failure is excused by good cause, the practitioner will be considered to have resigned from the Medical Staff and will be required to submit an initial application, non-refundable application processing fees, and be processed as an initial applicant before membership and privileges may be granted.

Suspensions of fifty (50) ***cumulative days*** during a twelve (12) month period it will result in a voluntary resignation of membership and privileges.

9.8-7 Malpractice Insurance

At the time of appointment and reappointment, each applicant or member must provide information on any professional liability claims filed against him or her, any malpractice claims reported to his or her insurance carrier, any letters of intent to sue he or she received, any claims pending, any judgment entered against him or her, and any settlement made where there was a monetary payment. In addition, the applicant or member must state whether he or she was denied professional liability insurance, had his or her policy canceled, had limitations placed on his or her scope of practice, or has been notified of any intent to deny, cancel, or limit coverage.

Each member of the Medical Staff shall report any reduction, restriction, cancellation, or termination of the required professional liability insurance or change in insurance carrier as soon

as reasonably possible to the Credentials Committee and Chief Executive Officer, through a notice sent to the Medical Staff Office.

For failure to maintain the required amount of professional liability insurance, a practitioner's membership and clinical privileges shall be automatically suspended and shall remain so suspended until the practitioner provides evidence to the Medical Executive Committee that he has secured professional liability coverage in the amount required. If the practitioner has the required amount of coverage but it does not include all of the privileges granted, the clinical privileges not sufficiently covered shall be automatically suspended and remain so suspended until the practitioner provides evidence to the Medical Executive Committee that he has secured the required coverage for such privileges. A failure to provide evidence of coverage within four (4) months after the date the automatic suspension became effective shall be deemed to be a voluntary resignation of the practitioner's Medical Staff membership and the failure to provide evidence of coverage for particular clinical privileges within the four (4) months after the automatic suspension of those privileges shall be deemed a voluntary resignation of those privileges.

9.8-8 Attestation Forms

Members of the Medical Staff are required to complete attestation forms as required by law. A limited suspension in the form of withdrawal of admitting and other related privileges until attestation forms are complete shall be imposed by the CEO, or his designee, after notice of delinquency for failure to complete attestation forms within such period. For the purpose of this Section, "related privileges" means voluntary on call service for the Emergency Room, scheduling surgery, assisting in surgery, consulting on medical center cases and providing professional services within the medical center. Members whose privileges have been suspended for failure to complete attestation forms may continue to care for patients in the medical center at the time of suspension, but may admit patients only in life threatening situations. The suspension shall continue until lifted by the CEO.

Failure to complete the attestation forms within four (4) months after the date a suspension became effective, pursuant to this Section, shall be deemed to be a voluntary resignation of the practitioner's Medical Staff membership.

Three (3) such suspensions of admitting privileges within any twelve (12) month period shall be deemed a voluntary resignation from the Medical Staff shall result in a deemed resignation of membership and privileges unless the Medical Executive Committee finds that the continue failure was excused for good cause..

9.8-9 Failure to Pay Dues

For failure to timely pay dues, as provided in Article 12.4-1 of these Bylaws, a practitioner's Medical Staff membership and clinical privileges, shall be deemed to be voluntarily forfeited.

9.8-10 Exclusion from Participation in Federal Health Care Programs

Whenever a member is excluded from participation in any federal health care program, medical staff membership and clinical privileges shall be automatically revoked as of the date such action becomes effective.

9.8-11 Final Action by another Peer Review Body

Upon notification of a final action (review able under California Code of Civil Procedure Section 1094.5) by another peer review body (as that term is defined in California Business and Professions Code Section 805, hereinafter referred to as "B&P 805") based on a medical disciplinary cause or reason (as defined in B&P 805), the member's staff membership and clinical privileges shall be subject to same consequences as imposed by the other peer review body. The consequences shall remain in effect unless the member's request for termination or modification of the consequences has been approved by the Governing Board following a recommendation by the Medical Executive Committee following receipt and review of such information and documents as may be requested by the Medical Executive Committee or Governing Board.

9.8-12 Coverage

If a member ceases to have coverage by another practitioner, the member's clinical privileges will be suspended until the member obtains coverage. Failure to obtain coverage within four (4) months shall be deemed a voluntary resignation from the Medical Staff.

9.8-13 Reapplication

Except as otherwise specified in these Bylaws, a revocation or voluntary resignation pursuant to this Section 7.8 of the Bylaws does not preclude the practitioner from subsequently applying as an initial applicant for Medical Staff appointment.

9.8-14 Continuity of Patient Care

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

ARTICLE X - HEARING AND APPELLATE REVIEW

10.1 Entitlement to Hearing and Appellate Review

10.1-1 By Practitioner

a) Adverse Medical Executive Committee Recommendation

When any staff member or applicant receives notice of an adverse recommendation or adverse action of the Medical Executive Committee, which constitutes grounds for a hearing as provided in Section 10.3 below, or when any applicant for Medical Staff privileges receives notice that there is a recommendation to reject his application for medical disciplinary reasons, as provided in Section 10.3-1of this Article, he shall be entitled upon timely written request, to a hearing by an ad hoc hearing committee (Judicial Review Committee) of the Medical Staff. If the recommendation or adverse action of the Medical Executive Committee following such hearing is still adverse to the staff member, he shall then be entitled, upon timely written request, to an appellate review by the Governing Board before a final decision is rendered.

b) Adverse Board Decision

A Medical Staff member or applicant, who receives notice of an adverse action or recommendation of the Governing Board which constitutes grounds for a hearing as provided in Section 10.3 below, shall be entitled, under this Article, to request a hearing by a Judicial Review Committee, as provided in this Article. of an adverse decision taken by the Governing Board that is either:

c) Contrary to a favorable recommendation by the Medical Executive Committee, or

d) On the Board's own initiative without benefit of a prior recommendation by the Medical Executive Committee.

If such hearing does not result in a favorable recommendation, he shall then be entitled, upon timely written request, to an appellate review by the Board before the decision is considered as final and the matter closed. Judicial Review Committee participants are disqualified from participation in any Board appellate review.

10.1-2 By Medical Executive Committee Body Whose Decision Prompted the Hearing.

After receipt of a decision of a Judicial Review Committee, the Medical Executive Committee body whose decision prompted the hearing may request an appellate review.

10.1-3 Procedure and Process

All hearings and appellate reviews shall be in accordance with the procedure and safeguards set forth herein.

10.1-4 Exceptions

The denial, termination, or reduction of temporary privileges except for medical disciplinary cause or reason, or any other actions, except for those specified herein shall not give rise to any right to a hearing or appellate review.

10.2 Exhaustion of Remedies

If adverse action is taken or recommended, the remedies afforded by these Bylaws must be exhausted before resorting to legal action.

10.3 The Hearing

10.3-1 Grounds for Hearing

Except as otherwise provided in these bylaws, or other than in compliance with a policy decision of the hospital (e.g., closing a service or physical plant changes), the taking or recommending of any one or more of the following recommendations or actions, if based on medical disciplinary cause or reason, shall entitle the affected practitioner to a hearing:

a. denial of initial appointment to the Medical Staff.

b. denial of Medical Staff reappointment.

c. suspension of Medical Staff membership or clinical privileges for thirty (30) days or more in any twelve (12) month period.

d. termination of Medical Staff membership.

e. denial or termination of clinical privileges, including temporary privileges.

f. involuntary reduction in clinical privileges for a cumulative total of thirty (30) days or more in a twelve (12) month period;

g. Summary suspension of clinical privileges for more than fourteen (14) consecutive days.

h. significant consultation/proctoring or co-admitting requirements which restrict the practitioner’s exercise of clinical privileges, other than in

compliance with the routine processes set forth in the Medical Staff Bylaws, rules and regulations or departmental rules and regulations.

10.3-2 When Deemed Adverse

a. A recommendation or action taken by the Medical Executive Committee.

b. An action taken by the Governing Board contrary to a recommendation by the Medical Executive Committee.

c. An action taken by the Governing Board on its own initiative without benefit of a prior recommendation by the Medical Executive Committee.

10.3-3 Notice of Adverse Recommendation or Action

A practitioner, against whom adverse action has been taken by the Medical Executive Committee pursuant to Section 10.3-1 C.2.a, shall promptly be given written notice of such action by the President of the Medical Staff. A practitioner, against whom adverse action has been taken by the Governing Board pursuant to Section 10.3-1 C.2.b or C.2.c, shall promptly be given written notice of such action by the CEO. Each written notice shall indicate the recommendation or final proposed action, that the action will be reported pursuant to Section 805 of the California Business and Professions Code, that the practitioner may request a hearing in accordance with these Bylaws, that such a hearing must be requested within forty-five (45) days, and a summary of the practitioner's rights at a hearing.

10.3-4 Request for Hearing

A practitioner shall have forty-five (45) days following his receipt of a notice to file a written request for a hearing. Such request shall be deemed to have been made when delivered to the Medical Executive Committee in person or when sent by registered mail to the Medical Executive Committee, properly addressed and postage prepaid.

10.3-5 Waiver by Failure to Request a Hearing

a) A practitioner who fails to request a hearing within the time and in the manner specified waives any right to such hearing and to any appellate review to which he might otherwise have been entitled.

b) The failure of a practitioner to request a hearing shall constitute acceptance of that action which shall thereupon become effective as the final decision.

c) The Medical Executive Committee shall promptly send notice to the practitioner who fails to request a hearing within the time and within the manner specified, informing him of each action taken and shall notify the Governing Board of each action.

10.3-6 Hearings Prompted by Governing Board Action

If the hearing is based upon an adverse action by the Governing Board, the Chair of the Governing Board or such person as the Chair shall appoint, shall fulfill the functions assigned in this Section to the Medical Executive Committee.

10.3-7 Notice of Time and Place of Hearing

Upon receipt of a timely request for hearing, the Medical Executive Committee shall schedule a hearing and, within thirty (30) days, give written notice to the member of the time, place and date of the hearing. Unless extended by the Judicial Review committee, the date of the commencement of the hearing shall be not less than thirty (30) days from the date of the notice from the Medical Executive Committee of the time, place, and date of the hearing nor more than sixty (60) days after receipt of the request from a member for a hearing; provided, however, that when the request is received from a member who is under summary suspension the hearing shall be held as soon as the arrangements may reasonably be made, but not to exceed forty-five (45) days from the date of receipt of the request. However, a member under summary suspension is entitled to at least thirty (30) days notice prior to hearing if he so requests.

10.3-8 Notice of Charges

Together with the notice of hearing, the Medical Executive Committee shall state clearly and concisely in writing the reasons for the adverse action taken or recommended, including the acts or omissions with which the member is charged and a list of the charts in question, where applicable. The Notice of Charges may be amended by the body whose recommendation or action prompted the hearing at any time until the matter is submitted to the Judicial Review Committee for decision; provided that, whenever the charges are amended, the practitioner shall be granted a reasonable opportunity to respond to any new charges.

10.3-9 Appointment of Judicial Review Committee

A hearing occasioned by a Medical Executive Committee recommendation or a Governing Board' recommendation shall be conducted by a Judicial Review Committee appointed by the President of the Medical Staff on behalf of the Medical Executive Committee. A hearing occasioned by a Governing Board recommendation shall be conducted by a Judicial Review Committee appointed by the Governing Board Chair or his designee. In either case, the Judicial Review Committee shall be and composed of at least five (5) members of the Active medical staff who shall gain no direct financial benefit from the outcome; who have not acted as accuser, investigator, fact finder, or initial decision maker; and who otherwise have not actively participated in the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude a member of the Medical Staff from serving as a member of the Judicial Review Committee. In the event that it is not feasible to appoint a Judicial Review

Committee from the Active Medical Staff, the Medical Executive Committee or Board Chair may appoint members from other staff categories or practitioners who are not members of the Medical Staff. (Such appointment shall include designation of the Chairman). Membership on a Judicial Review Committee shall consist, when feasible, of at least one member who shall have the same specialty as the petitioner. All other members shall have M.D. or D.O. degrees.

10.3-10 Failure to Appear or Proceed

The petitioner's failure, without good cause, to personally attend and proceed at such hearing in an efficient and orderly manner shall be deemed to constitute voluntary acceptance of the recommendations or actions involved. The Hearing Officer is authorized to determine whether a practitioner has failed without good cause to personally attend or proceed in accordance with the Bylaws, law, or an order of the Hearing Officer.

10.3-11 Postponements and Extensions

Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted in these Bylaws may be permitted by the Judicial Review Committee, or its Chairman acting upon its behalf, within the discretion of the Committee or its Chairman on a showing of good cause.

10.3-12 Pre-Hearing Procedure

(a) Witness Lists

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 failure to provide the names of any witness at least ten (10) days before the hearing shall constitute good cause for a continuance.

(b) Discovery

1) The practitioner shall have the right to inspect and copy (at his expense) documents or other evidence in support of that party at the hearing. The practitioner shall have the right to inspect and copy documents or other evidence upon which the charges are based, and 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 relevant exculpatory evidence in the possession of the medical center or Medical Staff.

2) The body whose decision prompted the hearing shall have the right to inspect and copy at its expense any documents or other evidence relevant to the charges which the practitioner has in his possession or under his control 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 or other sanctions, including but not limited to, adverse findings of fact related to the subject information. 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.

(c) Pre-Hearing Document Exchange

At the request of either party, the parties must exchange all documents that will be introduced at the hearing. The documents must be exchanged at least ten (10) days prior to the hearing. A failure to comply with this rule is good cause for the hearing officer to grant a continuance. Repeated failures to comply shall be good cause for the hearing officer to limit the introduction of any documents not provided to the other side in a timely manner.

d) Procedural Disputes

It shall be the duty of the member and the Medical Executive Committee or its designee to exercise reasonable diligence in notifying the Chairman 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 PRE-HEARING decisions may be succinctly made at the hearing.

e) Representation

The hearings provided for in these Bylaws are for the purpose of intra professional resolution of matters bearing on professional conduct, professional competency, or character.

The member shall be entitled to representation by legal counsel in any phase of the hearing, should he 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.

f) The Hearing Officer

The President of the Medical Staff with consultation from the Hospital CEO 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 an attorney regularly utilized by the medical center for legal advice regarding its 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, including failure to comply with rulings or other procedural obligations or disrupting the proceedings, the hearing officer may take such discretionary action as seems warranted by the circumstances, including terminating the proceeding and deeming the practitioner has waived his right to a hearing. If requested by the Judicial Review Committee, the hearing officer may participate in the deliberation of such committee and be a legal advisor to it, but the hearing officer shall not be entitled to vote.

g) Record of the Hearing

A shorthand reporter shall be present to make a record of the hearing proceedings, and the pre-hearing proceedings if deemed appropriate by the hearing officer. The cost of attendance of the shorthand reporter shall be borne by the medical center, but the cost of the transcript, if any, shall be borne by the party requesting it. The Judicial Review Committee may, but shall not be required to, order that oral evidence shall be taken only on oath administered by any person lawfully authorized to administer such oath.

h) Rights of the Parties

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.

Within reasonable limitations, both sides at the hearing may call and examine witnesses for relevant testimony, introduce relevant exhibits or other documents, cross-examine or impeach witnesses who shall have testified orally on any matter relevant to the issues, and otherwise rebut evidence, as long as these rights are exercised in an efficient and

expeditious manner. The members may be called by the Medical Executive Committee and examined as if under cross-examination.

i) Miscellaneous Rules

Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under this Article. Any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence upon 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. Final findings of other peer review proceedings or licensing agency action (include settlements) are admissible and may be the basis for adverse findings of fact in this proceeding. The Judicial Review Committee may interrogate the witnesses or all additional witnesses if it deems such action appropriate. At its discretion, the Judicial Review Committee may request or permit both sides to file written arguments.

j) Burdens of Presenting Evidence and Proof

1) At the hearing, unless otherwise determined for good cause, the Medical Executive Committee shall have the initial duty to present evidence of each case or issue in support of its action or recommendation. The member shall be obligated to present evidence in response. 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 was reasonable and warranted.

2) An applicant for Medical Staff privileges shall bear the burden of persuading the Judicial Review Committee, by a preponderance of the evidence, of his qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning his 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 was reasonable and warranted.

k) Adjournment and Conclusion

After consultation with the Chairman of the Judicial Review Committee, the hearing officer may adjourn the hearing and reconvene the same without special notice at such times and intervals as may be reasonable and warranted with due consideration for reaching an expeditious conclusion to the hearing. Both the Medical Executive Committee and the member may submit written statements at the close of the hearing. Upon conclusion of the presentation of oral and written evidence, or the receipt of closing written arguments, if submitted, the hearing shall be closed.

l) Basis for Decision

The decision of the Judicial Review Committee shall be based on the evidence introduced at the hearing, including all logical and reasonable inferences from the evidence and the testimony. The decision of the Judicial Review Committee shall be subject to such rights of appeal as described in these Bylaws.

10.3-13 Decision of the Judicial Review Committee

Within thirty (30) days after the closure of its deliberations, the Judicial Review Committee shall render a decision which shall be accompanied by a report in writing and shall be delivered to the Medical Executive Committee. If the member is currently under suspension, however, the time for the decision and report shall be fifteen (15) days. A copy of said decision also shall be forwarded to the Chief Executive Officer, the Governing Board, and to the member. The report shall contain a concise statement of the reasons in support of the decision, including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the conclusion reached. Both the member and the Medical Executive Committee shall be provided a written explanation of the procedure for appealing the decision. The decision of the Judicial Review Committee shall be subject to such rights of appeal or review as described in these Bylaws.

10.3-14 Appeal

a) Time for Appeal

Within thirty (30) days after receipt of the decision of the Judicial Review Committee, either the member or the Medical Executive Committee body whose decision prompted the hearing may request an appellate review. A written request for such review shall be delivered to the President of the Medical Staff, the Chief Executive Officer and the other party in the hearing. If a request for appellate review is not requested within such period, that action or recommendation shall be affirmed by the Governing Board as the final action if it is supported by substantial evidence, following a fair procedure thereupon become the final action of the Medical Staff. The Governing Board shall consider the decision within ninety (90) days, and shall give it great weight.

b) Grounds for Appeal

A written request for an appeal shall include an identification of the grounds for appeal and a clear and concise statement of the facts in support of the appeal. The grounds for appeal from the hearing shall be: (a) substantial noncompliance with the procedures required by these Bylaws or applicable law which has created demonstrable prejudice; (b) the decision was not supported by the weight of the evidence based upon the hearing record or such additional information as may be permitted pursuant to Section 9.5-5.

c) Appeal Board

The Governing Board may sit as the appeal board, or it may appoint an appeal board which shall be composed of not less than three (3) members of the Governing Board. Knowledge of the matter involved shall not preclude any person from serving as a member of the appeal board, so long as that person did not take part in a prior hearing on the same matter. The appeal board may select an attorney to assist in the proceeding, but that attorney shall not be entitled to vote with respect to the appeal.

d) Appeal Procedure

The proceedings by the appeal board shall be in the nature of an appellate hearing based upon the record of the hearing before the Judicial Review Committee, provided that the appeal board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the Judicial Review Committee in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the Judicial Review Committee for the taking of further evidence and for decision. Each party shall have the right to be represented by legal counsel, or any other representative designated by that party in connection with the appeal, to present a written statement in support of his or her position on appeal and, to personally appear and make oral argument. The appeal board may thereupon conduct, at a time convenient to itself, deliberation outside the presence of the appellant and respondent and their representatives. The appeal board shall present to the Governing Board its written recommendation as to whether the Governing Board should affirm, modify, or reverse the Judicial Review Committee decision, or remand the matter to the Judicial Review Committee for further review and decision.

e) Decision

1) Except as provided below, within thirty (30) days after the conclusion of the appellate review proceedings, the Governing Board shall render a final decision.

2) The Governing Board may affirm, modify or reverse the decision of the Judicial Review Committee and may instead, or shall, where a fair procedure has not been afforded, remand the matter to the Judicial Review Committee for reconsideration, stating the

purpose for the referral. The Governing Board shall give great weight to the Judicial Review Committee recommendation, and shall not act arbitrarily or capriciously. If the matter is remanded to the Judicial Review Committee for further review and recommendation, the Committee shall promptly conduct its review and make its recommendations to the Governing Board. This further review and the time required to report back shall not exceed thirty (30) days in duration except as the parties may otherwise agree or for good cause as jointly determined by the Judicial Review Committee and the Chairman of the Governing Board or his designee.

3) The decision shall be in writing, shall specify the reasons for the action taken, and shall be forwarded to the President, the Medical Executive and Credentials Committees, the subject of the hearing, and the Chief Executive Officer.

10.3-15 Exceptions to Hearing Fair Review and Appeal Rights

a) Exclusive Contracts. The Governing Board may determine as a matter of policy and in accordance with State and Federal law that certain hospital clinical facilities may be used only on an exclusive basis in accordance with written contracts between the hospital and qualified professionals. Applications for initial appointment or for privileges related to those hospital facilities and services specified in such contract(s) will not be accepted for processing unless submitted with confirmation from the Chief Executive Officer that they are from applicants that have an existing or proposed contract with the hospital.

b) Contract Practitioners. A practitioner who is providing contract services pursuant to Section 4.7 must meet the same membership qualifications, must be processed for appointment, reappointment, and clinical privilege delineation in the same manner, and must fulfill all of the obligations for membership category and clinical privileges as any other applicant or member.

c) Termination/Reduction of Privileges. Practice at the hospital is always contingent upon continued staff membership, and is also dependent on the clinical privileges granted. The right of a practitioner who is providing contract services to practice at the hospital is automatically terminated when his or her staff membership expires or is terminated. Similarly, his or her right to render services under the contract is automatically limited to the extent that his or her clinical privileges are reduced, restricted or terminated.

d) Expiration/Termination of Contract. The effect expiration or other termination of a contract upon a practitioner's staff membership and clinical privileges will be governed solely by the terms of the practitioner's contract. If the contract is silent on the matter, then contract expiration or termination will not affect the practitioner's staff membership or clinical privileges, except that the practitioner may not thereafter exercise any clinical privileges for which the hospital has made exclusive contractual arrangements with another practitioner.

e) Automatic Suspensions, Resignations and Terminations. Practitioner has no right to a hearing, fair review or appeal to review automatic actions taken pursuant to

Section 9.8 of these Bylaws. However, if a practitioner disputes that the underlying action occurred that is the basis for the automatic suspension, resignation or termination, the practitioner shall request and be granted an interview with the Medical Executive Committee, where the practitioner shall present any and all relevant information and documents available to the practitioner that may be requested by the Medical Executive Committee to substantiate that the underlying action did not occur.

10.4 National Practitioner Data Bank Reporting

Adverse Actions: The authorized representative shall report an adverse action to the National Practitioner Data Bank as required by applicable law. Additional reporting will take place as applicable to state and federal authorities, and or registries. 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 the final action.

(a) denial of Medical Staff membership.

(b) denial of reappointment to the Medical Staff.

(c) suspension of Medical Staff membership or clinical privileges.

(d) termination of Medical Staff membership.

(e) denial of requested clinical privileges, other than temporary privileges.

(f) reduction in clinical privileges.

(g) termination of privileges, other than temporary privileges.

(h) denial of membership in requested Medical Staff category or involuntary change in Medical Staff category.

(i) summary suspension of clinical privileges, other than temporary privileges, for fourteen (14) consecutive days or less or restriction of clinical privileges for a cumulative total of less than thirty (30) days in a twelve (12) month period, for a medical disciplinary cause or reason.

ARTICLE XI
OFFICERS

11.1 Officers

11.1-1 The Officers of the Medical Staff shall be:

a) President

b) Vice President of the Medical Staff

c) Secretary

d) Treasurer

11.2 Qualification of Officers

11.2-1 Each officer must be a member of the Active Medical Staff for the last three (3) years at the time of his nomination and election, and must be an Active Medical Staff member in good standing during his term of office.

11.2-2 The office of President Elect shall be filled by a staff member who has had previous leadership experience on a Clinical Department or Standing Committee of the Medical Staff, and will have served on the MEC for at least 2 years prior to assuming the office. The President Elect must also be certified by a specialty of the American Board of Medical Specialties or the Bureau of Osteopathic Specialists. The President Elect at the time of nomination must have been involved in 48 patients and attended 50% of department meetings, and a minimum of at least eight total meetings (including committee meetings) each year in the past two years. **(Approved 9/28/16)**

11.2-3 In order to attain continuity in filling the office of Secretary/Treasurer, previous leadership and experience on the Department and Standing Committees, should be considered in nomination for this office.

11.2-4 The offices of Members-At-Large shall be filled by members of the Active Staff in good standing. The Members at Large at the time of nomination must have been involved in 48 patients and attended 50% of department or general staff meetings in the past two years. **(Approved 9/28/16)**

11.2-5 Disclosure of Conflict of Interest

All nominees for election to the Medical Staff offices shall disclose in writing to the medical Executive and the Governing Body those personal, professional, or financial affiliations or relationships of which they are reasonably aware that could foreseeably result in a conflict of

interest with their activities or responsibilities on behalf of the Medical Staff. The Medical Executive Committee shall evaluate the significance of such disclosures and discuss any significant conflicts with the nominee. If a Medical Staff Officer who has disclosed a conflict is elected, he or she shall recuse himself or herself from deliberations and votes relating to the subject matter of the conflict.

11.3 Nominations

Candidates for office under the provision of Article XIII shall be selected by a Nominating Committee of five (5) members of the Active Staff. Members of this Committee shall be proposed by the President to the Medical Executive Committee every other year at its September meeting. The Nominating Committee shall elect its own Chairman and preferably its members should include past Presidents of the Medical Staff. The President of the Medical Staff will not be a member of this Committee.

The Nominating Committee shall nominate one (1) candidate for each of the three officers and one (1) candidate for the three members-at-large who serve on the Medical Executive Committee. The Committee shall announce those names in writing to the Active Medical Staff members no later than fifteen (15) days prior to the Annual Meeting or twenty one (21) days prior to the mailing date if a mail ballot is selected by the Medical Executive Committee for election of President elect, Secretary/Treasurer and three (3) Members-At-Large. Further nominations may be made by an Active Medical Staff member provided the name of the candidate, with his consent, is submitted in writing to the Chairman of the Nominating Committee at least five (5) working days prior to the Annual Meeting or prior to the mailing date of a mail ballot with written endorsements from at least by five (5) Active members. If the election will be conducted at the Annual Meeting, nominations from the floor will be recognized if the nominee is present and consents.

11.4 Notification of Nominees

All of the Nomination Committee's nominees shall be notified of their nominations by mail by the Secretary**/**Treasurer of the Medical Staff. Their written acceptance of the nomination must be returned to the Secretary/Treasurer within fourteen (14) days after notification. No person may be nominated for more than one office; any member who is nominated for more than one office must determine the office the member wishes to pursue and relinquish other nominations prior to the mailing of ballots.

11.5 Election of Officers and Members-at-Large

The President Elect and Secretary-Treasurer shall be elected at the annual meeting of the medical staff which falls during the election year. Voting shall be by secret written ballot and authenticated sealed mail ballots may be counted. Written ballots shall include handwritten signatures on the envelope for comparison with signatures on file, when necessary. A nominee shall be elected upon receiving a majority vote on the first ballot, a run-off election shall be held

promptly between the two (2) candidates receiving the highest number of votes. In the case of a tie on the second ballot, the majority vote of the Medical Executive Committee shall decide the election by secret written ballot at its next meeting or a special meeting called for that purpose.

11.6 Term of Office

The term of office for officers and members-at-large shall be two (2) years from January 1 to December 31 of the following year, or until a successor is elected. No officer shall serve more than two (2) consecutive terms. The term of office for the President of the Medical Staff will be limited to one (1) term. Portions of terms are to be evaluated in accordance with Section 11.8-2 in determining if the portion shall be deemed a term. After serving for the second consecutive two (2) year term, the President of the Medical Staff cannot hold any of the offices specified in Section 9.1-1 for the next following two (2) years.

11.7 Removal of Officers

Any officer or at-large member of the Medical Executive Committee whose election is subject to these bylaws may be removed from office for valid cause, including, but not limited to, gross neglect or misfeasance in office, serious acts of moral turpitude, or failure to remain a member in good standing of the Medical Staff. Except as otherwise provided, recall of a Medical Staff officer or at-large member may be initiated by fifty percent (50%) of the membership of the Medical Executive Committee, or shall be initiated by a petition signed by one-third (1/3) of the members of the Active voting Medical Staff. An elected officer or at-large member may be summarily removed (pending ratification of the removal by the Medical Staff) by two-third (2/3) affirmative votes of the Medical Executive Committee. The removal from office of a Medical Staff officer or at-large member shall not occur unless there has been a vote in favor of the recall by two thirds (2/3) of those voting at a meeting of the Medical Staff. A Medical Staff vote to recall or to ratify a removal shall be scheduled to meet within thirty (30) days after either the criteria have been satisfied to initiate the recall or the individual has been summarily removed pending ratification.

11.8 Vacancies

11.8-1 In case of vacancy in the Office of the President, the President Elect shall serve as President. In the event of a vacancy in any other office due to resignation or death or following a removal pursuant to Section 11.7, the Medical Executive Committee shall meet, within ten (10) days after such vacancy to elect another active member to fill the position for the balances of the term.

11.8-2 Officers filling vacancies for an unexpired term of less than one (1) year shall not be considered to have served for that term in determining whether the officer qualifies to be nominated to be an officer of the Medical Staff.

ARTICLE XII
DUTIES OF OFFICERS

12.1 President

The PRESIDENT of the Medical Staff shall serve as the Chief of the Medical Staff to:

12.1-1 Act as Chairman of the Medical Executive Committee and may only vote on matters before the Medical Executive Committee to break a tie vote.

12.1-2 Act in coordination and cooperation with the Chief Executive Officer in all matters of mutual concern within the medical center.

12.1-3 Call, preside at, and be responsible for the agenda of all General Meetings of the Medical Staff.

12.1-4 Serve as an "Ex-Officio" member without vote, of all other Medical Staff committees except the Nominating Committee.

12.1-5 Enforce the Medical Staff Bylaws and Rules and Regulations, implementing sanctions where indicated, and promoting compliance with procedural safeguards where corrective action has been requested or initiated.

12.1-6 Appoint all Committee Chairpersons with the approval of the Medical Executive Committee unless otherwise provided in these Bylaws. Chairpersons appoint Committee members subject to approval of the Medical Executive Committee.

12.1-7 Represent the views, policies, needs, and grievances of the Medical Staff to the Governing Board and to the Chief Executive Officer. Serve as the spokesperson for the Medical Staff in external professional and public relations. Serve with the Governing Board and Administration, as well as liaison with outside licensing or accreditation agencies.

12.1-8 Be responsible for the educational activities of the Medical Staff.

12.1-9 Call special meetings of the Medical Staff on his own initiative, at the request of the Medical Executive Committee, the Chief Executive Officer, Governing Board of the medical center, or on the written request of ten (10) Active members of the Medical Staff.

12.1-10 Be responsible for the functioning of the clinical organization of the medical center and keep or cause to be kept a careful supervision over all the clinical work in the medical center.

12.1-11 Appoint special committees, subject the approval of the Medical Executive Committee, and appoint ad hoc committees to assist the President of the Medical Staff and Medical Executive Committee to fulfill their functions hereunder.

12.1-12 May receive a stipend from the Medical Staff dues which is determined by the Medical Executive Committee.

12.2 President Elect

The PRESIDENT ELECT shall:

12.2-1 Be a member of the Medical Executive Committee.

12.2-2 Preside as Chair of Multidisciplinary Peer Review Committee

12.2-3 Automatically succeed to the Office of President at the conclusion of his term as President Elect.

12.3 Secretary/Treasurer

12.3-1 The Secretary shall:

a) Board Certified.

b) Be a member of the Medical Executive Committee.

c) Keep or cause to be kept records of all proceedings of the Medical Staff as conducted at its regular, special, and executive meetings.

d) Call meetings on order of the President at attend to all correspondence.

e) Be responsible for a record of attendance and be custodian of all records and papers belonging to the Medical Staff.

f) Review consent agenda and Medical Executive Committee minuites ahead of time.

12.3-2 The Treasurer shall:

a) Be Board Certified.

b) Be a member of the Meical Executive Committee.

c) Collect all dues and assessments.

d) Receive and safeguard all funds of the Medical Staff.

e) Review and regularly submit written reports to the Medical Executive Committee on the status of the fiscal matters of the Medical Staff and make recommendations on fiscal matters.

12.4 MEDICAL STAFF FISCAL MATTERS

12.4-1 Dues

The Medical Executive Committee shall have the power to recommend the amount of annual dues, assessments and fines, and to determine the manner of expenditure of such funds received.

Failure to pay dues, assessments or fines within four (4) months of receipt of a bill for dues will be considered voluntary forfeiture of Medical Staff membership after compliance with the notice requirements set forth below. Before any such voluntary forfeiture of Medical Staff membership may occur, the member must be notified by certified mail, return receipt requested that he has twenty-one (21) days to pay the dues , assessments or fines owed. Members of the Honorary, Emeritus, and Administrative Staffs shall not be required to pay dues, assessments or fines.

12.4-2 SPECIAL FUNDS

All matters pertaining to special funds, if identified with the Medical Staff or any Section of the Medical Staff, shall be reported to the Medical Executive Committee for consideration and method of administration of such funds.

12.4-3 Expenditures

1) All expenditures of the Medical Staff, greater than $1,000 shall be authorized by the Medical Executive Committee.

2) No income or assets of this organization will be a benefit to any private individual.

12.4-4 Fiscal Review

1) The Treasurer shall submit a written report to the regularly scheduled Medical Executive Committee meetings, and

quarterly to the general Medical Staff on fiscal matters of the Medical Staff.

2) The CPA, as designated by the Medical Executive Committee, will reconcile the Medical Staff account on the fifth and eleventh months of the Medical Staff fiscal year.

12.5 Members-At-Large

The two Members-at-Large shall be voting members of the Medical Executive Committee. Members-at-Large will also be memebers of the Code of Conduct and Continuing and Graduate Medical Education committees, and must attend at least 50% of all three committee meetings. If meeting attendance is not met after the first year, the Member-at-Large will be automatically removed from the Medical Executive Committee and the Medical Staff President will appoint an interim replacement. To be eligible to run for a subsequent term, the Member-at-Large must have attended a minimum of 50% of the above-listed meetings. Board Certification is not required.

ARTICLE XIII
MEDICAL STAFF DEPARTMENTS

13.1 Organization of Departments and Sections

13.1-1 Organization of Departments

The Medical Staff shall be divided into clinical Departments. Each Department shall be organized as a separate part of the Medical Staff and shall have a Chairman who is elected as specified in these Bylaws and has the authority, duties, and responsibilities as set forth in these Bylaws.

13.1-2 Organization of Sections

A Department may have organized specialty Sections which shall be directly responsible to the Department within which they function, and shall have a Section Chairman who is elected and has the authority, duties, and responsibilities specified in these Bylaws.

13.2 Medical Staff Departments and Specialties

The Medical Staff shall be divided into the following Departments in accordance with the guidelines set forth in these Bylaws:

13.2-1 Department of Anesthesiology and Pain Management

13.2-2 Department of Diagnostic Imaging, which includes the specialties of:

a) Diagnostic X-ray, Ultra Sound, CT Scanning, Magnetic Resonance Imaging (MRI), and Nuclear Medicine

b) Invasive Radiology, excluding Invasive Cardiology procedures

c) Non-invasive Vascular Studies

d) Radiation Oncology

13.2-3 Department of Family Practice, which includes the specialties of:

a) Family Practice

b) General Practice

13.2-4 Department of Medicine, which includes the specialties of:

a) Allergy and Immunology

b) Cardiology

c) Critical Care

d) Dermatology

e) Endocrinology

f) Gastroenterology

g) Gerontology

h) Hematology

i) Oncology

j) Infectious Diseases

k) Internal Medicine

l) Nephrology

m) Neurology

n) Physical Medicine and Rehabilitation

o) Psychiatry

p) Pulmonary Disease

q) Rheumatology

13.2-5 Department Of Obstetrics/Gynecology, which includes the specialties of:

a) Obstetrics

b) Gynecology

13.2-6 Department of Surgery, which includes the specialties of:

a) Dentistry

b) General Surgery

c) Laser Services

d) Neurosurgery

e) Ophthalmology

f) Orthopedic Surgery and Podiatry

g) Otolaryngology

h) Pathology

i) Plastic Surgery

ji) Thoracic

kj) Cardiovascular Surgery

lk) Urology

ml) Vascular Surgery

13.2-7 Department of Pediatrics, which includes the specialties of:

b) Pediatric Allergy/Immunology

c) Pediatric Cardiology

d) Pediatric Gastroenterology

e) Pediatric Infectious Disease

f) Neonatology

g) Pediatric Nephrology

h) Pediatric Neurosurgery

i) Pediatric Orthopedic Surgery

j) Pediatric Otolaryngology

13.2-8 Department of Emergency Medicine

13.3 Membership in Departments and/or Sections

Each member of the Medical Staff shall be assigned to only one (1) Department of the Medical Staff. After consideration of the recommendation of the Department and Credentials Committee, the Medical Executive Committee shall recommend assignment to Department and Section, if any.

13.4 Modifications in Organization

When appropriate, the Medical Executive Committee may recommend to the Medical Staff the creation, elimination, modification, or combination of Departments, Sections, or any other clinical organization units. The following guidelines shall be followed:

13.4-1. Minimum Requirements for the Formation of Organized Departments or Sections

DEPARTMENTS

a) Minimum of ten (10) combined Active Staff members, excluding the Departments of Anesthesia and Diagnostic Imaging..

b) At least four (4) meetings per year with minutes; each department to set a schedule for regular meetings and to have additional meetings to fulfill its responsibilities if deemed necessary by the department or its chair.

c) Elected (or appointed in case of failure to elect) Chairman responsible for monthly monitoring and evaluation, privilege delineation, and other functions as defined in this Article.

d) Quarterly monitoring and evaluation reports to Medical Executive Committee.

SECTION

a) Minimum of five (5) active members of the specialty required to form a section of a department

b) At least quarterly meetings with minutes.

c) Elected (or appointed in case of failure to elect) Chairman responsible for monitoring and evaluation, privilege delineation as necessary, and other duties as assigned by the responsible Department Chairman.

d) Quarterly reporting to the appropriate Department.

SPECIALTY

Each Department shall identify those clinical specialties comprising its membership. A Specialty does not constitute an organized Section of the Department. The members of a Specialty may request the formation of an organized Section only if it can be demonstrated that the minimum requirements can be met and the request is approved by both the Department and the Medical Executive Committee.

13.4-2 Elimination of Departments or Sections

Departments or Sections may be eliminated when the number of members in attendance is not in accordance with the meeting requirements as stated in these Bylaws, and will not be so in the foreseeable future, to accomplish assigned functions, or the patient or service activity associated with the component to be dissolved is no longer substantial enough to warrant imposition of the responsibility to accomplish those assigned functions on the members of the component.

13.4-3 Combination of Departments or Sections

Departments or Sections may be combined when the union of two (2) or more organizational components will result in more effective and efficient accomplishment of assigned

functions. The patient or service activity to be associated with the combination must be substantial enough, without being unwieldy, to warrant imposition of the responsibility to accomplish those assigned functions on the members of such combined components.

In all instances of modification, the Hospital's written plan of development as currently being implemented, and any constraints or mandates imposed by external planning authorities, shall be considered.

13.4-4 Amendment Procedure

Any changes in organization or structure of the Medical Staff shall be by amendment of these Bylaws as provided by Article XVIII.

13.5 Department Chairman and Vice-Chairman

13.5-1 Qualifications

Each Departmental Chairman and Vice-Chairman shall meet the following qualifications:

a) Be an Active member of the Medical Staff in good standing.

b) Be Board Certified by an appropriate specialty board if such physician is not available, a physician with additional training and experience in an appropriate specialty may serve as chair **(Approved 9/28/16)**

c) Be approved by the Medical Executive Committee.

d) At the time of nomination must have been involved in 48 patients and attended 50% of department or general staff meetings in the past two years. To be eligible to run for a subsequent term, the Department Chair must have attended a minimum of 50% of the following meetings during the previous term: Credentials and Multidisciplinary Peer Review committees. **(Approved 9/28/16)**

13.5-2 Election of the Chairman

a) Active Members of each Department, on call by the Chairman, shall meet during the month of November in even years for the purpose of electing the Chairman. Due notice in writing shall be given the Active Staff membership of the Department at least ten (10) working days preceding such meeting. The person receiving the most votes at the meeting shall be elected. If there is a tie vote between the two candidates who received the most votes, there will be a runoff between these two candidates at the same Department meeting. If there

continues to be a tie, a second run off between these two candidates will be by Mail Ballot sent to the Active Staff membership of the Department following the process described in Section 11.5. If there continues to be a tie, the Medical Executive Committee shall decide who will be deemed elected. If there is not a quorum at the Department meeting when elections are to be conducted, the election shall be by Mail Ballot, following the process described in Section 11.5.

b) The name of the Chairman elected by the Department shall be presented to the Medical Executive Committee for approval. Any disapproval by the Medical Executive Committee to be for valid cause as described in Section 11.7 or failure to meet any of the criteria specified in Section 13.5-1. If an elected Chair is not approved, the election process specified in Section 13.5-2 a) above shall be repeated.

c) In case of vacancy and in the event the members of a Department fail to elect a Chairman, because of lack of quorum or for any other reason, the President of the Staff shall appoint the Chairman with approval of the Medical Executive Committee for the full term or balance of a vacated term. The Medical Executive Committee in turn, will submit the name of the appointed Chairman to the Governing Board for final acceptance and approval.

d) The term of office of the Department Chairman shall be two (2) years and shall not exceed two (2) consecutive terms or until resignation, illness of more than sixty (60) days, or by removal from office by vote of two third (2/3) majority of Active Staff members of the Department or by vote of seventy-five percent (75%) of the Medical Executive Committee.

13.5-3 Selection of Vice Chairman

Each Department will also have a Vice Chairman who has the same qualifications as is stated in Section 13.5-1, and who is appointed by the Chairman from among the members of the Department, with approval of the Medical Executive Committee.

13.5-4 Selection of Chairman of Organized Sections

a) Qualifications and election shall be the same as for the Department Chairman. The selection must be approved by the Department before it is presented to the Medical Executive Committee for approval. The term of office will be for two (2) years and shall not exceed two (2) consecutive terms or until resignation, illness or more than sixty (60) days, or by removal from office by vote of two third (2/3) majority of Active Staff members of the Department or vote of seventy-five percent (75%) of the Medical Executive Committee.

b) Should a Section fail to elect its Chairman because of lack of quorum or other reasons, or should there be a vacancy, the Chairman of the Department, shall appoint the Chairman of the Section.

13.6 Medico-Administrative Directors of Services

Medico-administrative Directors of Services shall be appointed by the Governing Board, after consultation with the Medical Executive Committee. The rights and responsibilities of the foregoing individuals shall be subject to the terms and conditions of these Bylaws.

13.7 Functions of 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:

a) act as presiding officer at departmental meetings;

b) report to the Medical Executive Committee and President of the Medical Staff regarding all professional and administrative activities within the department;

c) generally monitor the quality of patient care and professional performance rendered by members with clinical privileges in the department through a planned and systematic process; oversee the effective conduct of the patient care, evaluation, and monitoring functions delegated to the department by the Medical Executive Committee in coordination and integration with organization-wide quality assessment and improvement activities.

d) develop and implement departmental programs for retrospective patient care review, ongoing monitoring of practice, credentials review and privilege delineation, medical education, utilization review, and quality assessment and improvement;

e) be a member of the Medical Executive Committee, and give guidance on the overall medical policies of the medical staff and hospital and make specific recommendations and suggestions regarding the department;

f) transmit to the Medical Executive Committee the department's recommendations concerning practitioner appointment and classification, reappointment, criteria for clinical privileges, monitoring of specified services, and corrective action with respect to persons with clinical privileges in the department;

g) endeavor to enforce the Medical Staff Bylaws, Rules, Policies and Regulations within the department;

h) implement within the department appropriate actions taken by the Medical Executive Committee;

i) consult in every phase of administration of the department, including cooperation with the nursing service and hospital administration in matters such as personnel

(including assisting in determining the qualifications and competence of department/service personnel who are not licensed independent practitioners and who provide patient care services) supplies, special regulations, standing orders and techniques.

j) assist in the preparation of such annual reports, pertaining to the department as may be required by the Medical Executive Committee or Chief Executive Officer;

k) recommend delineated clinical privileges for each member of the department;

l) appoint ad hoc committees to perform focused reviews or other functions in support of the functions of the Department Chair and Department to then report back to the Department Chair; and

m) perform such other duties commensurate with the office as may from time to time be reasonably requested by the President of the Medical Staff or the Medical Executive Committee.

n) 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.

o) Development and implementation of policies and procedures that guide and support the provision of care, treatment, and services.

p) Orientation and continuing education of all persons in the department or service.

q) Recommending space and other resources needed by the department or service.

r) Be a standing member of the Code of Conduct, Credentials, and Multidisciplinary Peer Reivew committees.

13.8 Functions of the Department

The general functions of each department shall include:

a) Conducting patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the department. The number of such reviews to be conducted during the year shall be as determined by the Medical Executive Committee in consultation with other appropriate committees. The department 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 member whose work is subject to such review is a member of that department.

b) Recommending to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the department.

c) Evaluating and making appropriate recommendations regarding the qualifications of applicants seeking appointment or reappointment and clinical privileges within that department.

d) Conducting, participating and making recommendations regarding continuing education programs pertinent to departmental clinical practice.

e) Reviewing and evaluating departmental adherence to: (1) medical staff policies and procedures and (2) sound principles of clinical practice.

f) Coordinating patient care provided by the department's members with nursing and ancillary patient care services.

g) Submitting written reports to the Medical Executive Committee concerning: (1) the department's review and evaluation activities, actions taken thereon, and the results of such action: and (2) recommendations for maintaining and improving the quality of care provided in the department and the hospital.

h) Meet for the purpose of considering patient care review findings and the results of the department's other review and evaluation activities, as well as reports on other department and staff functions. Utlization Review is not part of Peer Review.

i) Establishing such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring protocols.

j) Taking appropriate action when important problems in patient care and clinical performance or opportunities to improve care are identified.

k) Accounting to the Medical Executive Committee for all professional and medical staff administrative activities within the department.

l) Appointing such committees as may be necessary or appropriate to conduct departmental functions.

m) Formulating recommendations for departmental rules and regulations reasonably necessary for the proper discharge or its responsibilities subject to the approval by the Medical Executive Committee and the medical staff.

13.8-1 Meetings

Departmental meetings shall be held at least four (4) times per year, and report its activities and recommendations to the Medical Executive Committee.

13.9 Functions of Organized Sections

Each organized Section, upon the approval of the Executive Committee and Governing Board, shall perform the functions assigned to it by the Department Chairman. Such functions may include, without limitation, ongoing monitoring and evaluation of the quality and appropriateness of patient care and the clinical competence of all practitioners assigned to the Section; credentials review; privilege delineation; and continuing education programs. The Section shall transmit a regular report to the Department Chairman on the conduct of its assigned functions.

ARTICLE XIV
COMMITTEES OF THE MEDICAL STAFF

14.1 General Provisions

14.1-1 Types of Committees

Committees of the Medical Staff shall be Standing, Special, and Ad Hoc.

a) Standing Committees are set forth in these Bylaws.

b) Special Committees may be appointed by the President with the approval of the Medical Executive Committee, as may other Standing Committees, to carry out duties of the Medical Staff.

c) Ad Hoc Committees shall be limited in duration and scope and confined in their duties to a specific assignment with duration until the assignment is completed. They may be appointed by the President or a Department Chair.

14.1-2 Qualifications and Appointment of Committee Chairmen

All Committee Chairmen, unless otherwise specified in these Bylaws, shall be appointed by the President with the approval of the Medical Executive Committee. The terms shall be for two years. Committee Chairmen shall be members of the Active Staff in good standing at the time of their appointment and throughout their term. At the time of appointment the Committee Chairmen who sit on the Medical Executive Committee (Quality Management, Utilization Management, Credentials, Bylaws, and Continuing and Graduate Medical Education committees) must have

attended a minimum of eight total meetings (inclulding committee meetings) each year in the past two years. The Chair of Credentials Committee must be Board Certified. At the time of appointment, Committee chairs who are non-MEC members shall be members of the Medical Staff in good standing. In the event a Committee Chairman is determined to no longer be in good standing, he/she shall immediately and automatically be removed from such position.

14.1-3 Qualifications and Appointment of Committee Members

a) The process described below will be used for the appointment of Committee members to those standing Committees where selection of members is not otherwise described in these Bylaws.

By mid-November the President Elect shall send a cover letter including a form to all Active Staff members soliciting volunteers to serve on any of the listed Medical Staff Committees. The positive replies will be submitted to the respective Committee Chairmen appointed to serve the next year, who, according to their judgment, will select members of their Committees from the list of volunteers and general membership. The process should be complete prior to the first Medical Executive Committee meeting in January.

b) The President of the Medical Staff and the Chief Executive Officer or his designee of the medical center shall be Ex-Officio members of all Committees except the Nominating Committee.

c) Each Committee member must be a member of the appropriate Medical Staff category in good standing at the time of appointment and throughout his/her term. In the event a Committee member is determined to no longer be in good standing, he/she shall immediately and automatically be removed from such position.

14.1-4 Minutes of all Committee meetings shall be recorded and kept on file.

14.1-5 Following each meeting all Committees shall present reports in writing to the Medical Executive Committee or other designated standing Committee.

14.1-6 Department Committees are organized and membership is designated in accordance with Article XII.

14.1-7 Only Active members may serve on the Medical Executive Committee, Credentials Committee, Bylaws Committee, Well Being Committee, and Nominating Committee.

14.2 Standing Committees

14.2-1 Medical Executive Committee

a) Composition

All Active members of the organized medical staff, of any discipline or specialty are eligible for membership on the medical executive committee. Three (3) elected officers of the Medical Staff; outgoing President of the Medical Staff for two (2) years; Chairs of the following Departments: Anesthesiology and Pain Management, Diagnostic Imaging, Emergency Medicine, Family Practice, Medicine, Obstetrics/Gynecology, Pediatrics, and Surgery; Chairs of the following Committees: Quality Management, Utilization Management, Credentials, Bylaws and Continuing/Graduate Education Committee There will also be three (3) members-at-large, nominated by the Nominating Committee and elected by the Medical Staff in accordance with the provisions specified in Article XIV. All of the foregoing shall be entitled to vote. The Medical Executive Committee includes physicians and other individuals as determined by the organized medical staff. A majority of the Medical Executive Committee must be fully licensed doctors of medicine or osteopathy on the Active Medical Staff. However, all members of the organized medical staff, of any discipline or specialty, are eligible for membership on the Medical Executive Committee. **(Approved 9/28/16)**

The following shall be Ex-Officio members without the right to vote: Chief Executive Officer, Director of Medical Affairs, Chief Operating Officer, and Chief Nursing Officer. Others may be invited by the Chairman to attend meetings to address specific agenda items.

No voting member shall serve on the Medical Executive Committee for more than eight (8) consecutive years except for outgoing President when completing his term.

No member can occupy two (2) seats on the Medical Executive Committee. In case the Chairman of a Department also is elected or appointed to an additional position with a seat on the Medical Executive Committee, the Vice Chairman of the Department shall represent the Department on the Medical Executive Committee with full rights.

If the Chairman of any Department is unable to attend any meeting, the Vice Chairman will take his place with all rights. In case neither can attend, the Chairman may appoint a delegate, who is an Active member of the Department, with all privileges and obligations.

Any member of the Medical Executive Committee may be removed for valid cause, as described in Section 11.7. Except for officers and at-large-members, who's removal shall be processed as specified in Section 11.7, and Department Chairs, who's removal shall be processed as specified in Section 13.5-2, members of the Medical Executive Committee can be removed from the Medical Executive Committee by a two thirds (2/3) vote of the Medical Executive Committee.

b) Authority and Duties

1) To represent and to act on behalf of the Medical Staff, between meetings of the organized medical staff, within the scope of its responsibilities as defined by the organized medical staff,, subject to such limitation as may be imposed by these Bylaws;

2) To coordinate the activities and general policies of the Medical Staff not otherwise the responsibility of the Departments;

3) To receive and act upon committee reports; department and assigned activity groups;

4) To implement policies of the Medical Staff not otherwise the responsibility of the Departments;

5) To recommend action to the Chief Executive Officer on matters of Medico Administrative nature, including services to be provided by telemedicine;

6) To make recommendations on medical center management matters and long range planning, to the Governing Board directly or through the Chief Executive Officer of the medical center;

7) To fulfill the Medical Staff's responsibility to report to the Governing Board on the medical care rendered to patients in the medical center;

8) To ensure on the basis of reports from accreditation activities that the Medical Staff is kept abreast of the accreditation program and is informed of the accreditation status of the medical center;

9) To review the credentials of the applicants through Credentials Committee reports and make recommendations for Staff membership, assignments to Departments, and delineation of clinical privileges;

10) To review periodically all information available, (normally by means of Credentials and Department reports), regarding the performance and clinical competence of staff members and other practitioners with clinical privileges and as a result of such reviews to make recommendations for reappointments and renewal or changes in clinical privileges;

11) To evaluate the cardiovascular surgery services provided by the Medical Staff, make appropriate recommendations concerning those services and otherwise fulfill any requirements of California Code of Regulations, Title 22, Section 70431(j);

12) To take all reasonable steps to ensure professional ethical conduct and competent clinical performance on the part of all members of the Medical Staff, including the initiation of or participation in Medical Staff corrective or review measures when warranted;

13) To be the only Medical Staff Committee with power to commence an investigation or recommend or impose discipline for which the practitioner is entitled to request a hearing, fair review or appeal pursuant to Article X;

14) To make recommendations to administration regarding the appointment of Medical Staff representatives to any medical center committee;

15) To act on matters not specifically covered to these Bylaws, until the necessary addition to the Bylaws can be approved by the Medical Staff.

16) To obtain Active Medical Staff membership approval for donations and/or single item costs of $10,000 or more.

c) Meetings.

The Medical Executive Committee shall meet at least ten (10) times per Medical Staff year and shall maintain minutes of its proceedings and actions. Special meetings of the Medical Executive Committee may be called by the President of the Medical Staff, or one third (1/3) of the voting members of the Medical Executive Committee, or the Chief Executive Officer.

d) The Medical Executive Committee's authority to act, as provided in these bylaws and the rules and regulations of the Medical Staff, is delegated by the Medical Staff. The Medical Staff may remove any authority delegated to the Medical Executive Committee as follows:

1) If at least thirty percent (30%) of the members of the Active Medical Staff sign a written petition to consider removing authority delegated to the Medical Executive Committee, a special Medical Staff meeting shall be conducted for that purpose;

2) At such special meeting, the presence of fifty percent (50%) of the members of the Active Medical Staff shall constitute a quorum;

3) By affirmative vote of 2/3 of such quorum, the Medical Staff may remove any authority delegated to the Medical Executive Committee.

14.2-2 Bylaws Committee

a) Composition

The Committee shall consist of at least three (3) Active Staff members of the Medical Staff who have been in that category for at least [5] years, and the President Elect

President. The Chairman shall serve on the Medical Executive Committee and also serve as Parliamentarian of the Medical Staff. **(Approved 9/28/16)**

b) The DUTIES of this Committee shall be to:

1. Review the Bylaws, Rules and Regulations of the Medical Staff periodically and propose revisions as necessary;

2. Apprise the President and the Medical Executive Committee of any noncompliance with these Bylaws;

c) Meetings

The Bylaws Committee shall meet as necessary, maintain minutes of its proceedings, and report its recommendations to the Medical Executive Committee.

14.2-3 Code of Conduct Committee

a) Composition

This Committee shall be appointed by the President of the Medical Staff and shall include at least the President of the Medical Staff, the Immediately Past President of the Medical Staff, and the Chairs of the Department of Family Practice, Medicine, Obstetrics/Gynecology, Surgery and Pediatrics. The Chair shall be appointed by the Medical Executive Committee.

b) Duties

1. Recommending a Medical Staff code of conduct policy that addresses disruptive behavior and/or unethical behavior ("Unacceptable Behaviors") by members of the Medical and Allied Health Professional Staff including but not limited to procedures to review reports of Unacceptable Behaviors by Medical and Allied Health Professional Staff.

2. Developing relevant educational programs for the Medical and Allied Health Professional Staff regarding Unacceptable Behaviors.

3. Receiving and evaluating information reported regarding Unacceptable Behaviors.

4. Meeting with members of the Medical and Allied Health Professional Staff regarding any reports of their Unacceptable Behaviors to evaluate and discuss the reported Unacceptable Behaviors, to educate and to recommend voluntary corrective

measures to assist Medical and Allied Health Professional Staff to cease Unacceptable Behaviors.

5. Periodically review trends in reported Unacceptable Behaviors and other aggregate information that may be available to measure improvement in conduct, and to identify potential systematic measures to decrease stresses or other situations that may be contributing to Unacceptable Behaviors.

6. Make referrals to the Well-Being Committee for intervention if the Code of Conduct Committee is concerned that a member has a physical or mental health issue that may be causing the Unacceptable Behaviors.

7. Make referrals to the Medical Executive Committee for corrective action pursuant to Article IX of the Bylaws.

8. Such other functions as may be delegated to this Committee by the President of the Medical Staff or Medical Executive Committee from time to time to discourage Unacceptable Behaviors, recognizing that such behavior potentially has a negative effect on patient care and safety and on Hospital and Medical staff operations.

c) Meetings

The Committee shall meet as often as necessary at the call of its Chairman. It shall maintain minutes of its proceedings and shall make reports of its findings and recommendations to the Medical Executive Committee.

14.2-4 Continuing and GraduateMedical Education Committee

a) Composition

The Committee shall be composed of a Chairman and members of the teaching faculty representative of the involved departments and others deemed appropriate by the Chairman, on a regular or adhoc basis. The Chairman and members will be selected based on interest, experience, and expertise and interest in continuing and medical education.Ex-Officio members shall be a representative from Administration, Nursing, Quality Management, Pharmacy and the Director of Hospital Education. The Committee shall have at least three (3) members at all times. **(Approved 9/28/16)**

b) Duties

The Committee shall perform the following duties:

1. plan implement, coordinate and promote ongoing special clinical and scientific programs for the medical staff this includes:

2. Identifying the educational needs of the medical staff;
3. Formulating and/or editing clear statements of objectives for each program;
4. Assessing the effectiveness of each program, as well as assessing the effectiveness of the overall program;
5. Choosing appropriate teaching methods and knowledgeable faculty for each program; and
6. Documenting staff attendance at each program;
7. Assist in developing processes to assure optimal patient care and contribute to the continuing education of each practitioner
8. educational programs based upon the following: the type and nature of care, treatment and services offered by the hospital, updating knowledge and skills; exchanging new facts and acquiring new skills; incorporating new knowledge and skills into clinical practice; improving the attitude and conduct of the professional.
9. establish liaison with the Quality Improvement Committee of the medical center in order to be apprised of problem areas in patient care, which may be addressed by a specific medical education activity. Quality Management to make recommendations to the committee responsible for continuing medical educations for the development of appropriate educational programs.
10. Maintain close liaison with other hospital medical staff and department committees, including Pharmacy, Bioethics, and medical staff committees concerned with patient care.
11. The Committee is responsible for assuring the Medical Staff's compliance with the requirements for CME accreditation by the IMQ/CMA for all CME activities including Regularly Scheduled series, stand alone lectures, conferences and symposia.

Establish and implement written descriptions of the roles, responsibilities and patient care activities of the training program participants. These descriptions shall include information regarding how the supervising physician and training program director make decisions regarding each participant's progressive involvement and independence in patient care activities.

Evaluate the safety and quality of patient care provided by the participants, as well as the educational and supervisory needs of the participants.

Receive and review reports from the Medical Staff about the quality of care provided by, and the educational needs of, the training program participants and take appropriate action.

Make recommendations to the Medical Executive Committee regarding appropriate Medical Staff Rules and Regulations pertaining to:

the process for supervision of participants in training programs at the hospital; and

defining who may write patient care orders, under what circumstances the participant may write such orders, and what medical record entries, if any, must be countersigned by a supervising physician.

Establish and implement policies and procedures regarding:

working environment,

duty hours,

supervision,

curriculums,

evaluation system,

selection, promotion and dismissal

other appropriate matters

Establish and maintain appropriate oversight and liaison with program medical directors.

Assure compliance with sponsoring institution, ACGME and or other accrediting body requirements.

Conduct case reviews for the purpose of evaluating and improving the quality of patient care. Sub-committees or ad hoc committees may be created for such reviews, provided appropriate minutes are maintained and findings and recommendations are reported to the Committee.

c) Meetings

The Committee shall meet at least four times each Medical Staff year, shall maintain minutes of the program planning discussions and shall report its recommendations to the Medical Executive Committee.

14.2-5 Credentials Committee

a) Composition

1) This Committee shall consist of at least five (5) Active Staff members appointed by the Chairman selected on the basis that will ensure representation of the major clinical specialties. The Chairman shall be appointed as all other committee chairmen and may not serve more than two (2) consecutive years at a time.

2) In the event the Medical Staff participates in a Centralized Credentials Committee, credentialing of applicants and members seeking appointment or reappointment at the Hospital shall be conducted on a central basis through a Central Credentials Committee. The Central Credentials Committee shall include two physician members of the Active Staff of each participating hospital. These physician members of the Central Credentials Committee shall be selected by the Medical Executive Committee.

b) Duties

1) To review the credentials of all applicants and to make recommendations to the Medical Executive Committee on each applicant for membership and delineation of clinical privileges in compliance with Articles VII and VIII of these Bylaws.

2) To review periodically, all information available from the Department, regarding the competence of staff members and other members with clinical privileges; and as a result of such review to make recommendations for granting of privileges, reappointment and the assignment of practitioners to the various Departments or services, as provided in Articles VII and VIII of these Bylaws.

3) To review reports that are referred by the Medical Executive Committee, Medical Records Department, and pertinent data from Medical Education, Quality Management, and Utilization Management Committees; and Administration.

c) Meetings

The Credentials Committee shall meet at least ten (10) times per Medical Staff year, shall maintain minutes of its proceedings and actions, and shall report its findings and recommendations to the Medical Executive Committee.

14.2-6 Infection Prevention Committee

a) Composition

The Committee may include representatives from the Departments of Family Practice, Medicine, Surgery, Obstetrics/Gynecology and Pediatrics, and Pathology. The Chairman of the Committee will be a physician specializing in Infectious Diseases, unless none is available. Ex-Officio members will be representatives from Administration, Quality Assurance, Environmental Services, Nursing Staff from Surgery, Obstetrics/Gynecology and Pediatrics, and the Infection Control Nurse.

b) Duties

The Infection Prevention Committee shall be responsible for the surveillance of medical center infection potentials, the review and analysis of actual infections,

the promotion of a preventive and corrective program designed to minimize infection hazards, and the supervision of infection control in all phases of the medical center's activities including:

1) Operating Rooms, Delivery Rooms, Recovery Special Care Units and medical center Service Departments;

2) Sterilization procedures by heat, chemicals or otherwise;

3) Isolation procedures;

4) Prevention of cross infection by anesthesia apparatus or inhalation therapy equipment;

5) Participation in an Infection Control orientation program for new employees;

6) Disposal of infectious material;

7) Testing of medical center personnel for carrier status;

8) Carry out periodic review for antibiotic resistant bacteria;

9) Other situations as requested by the Medical Executive Committee.

10) The Infection Prevention Committee shall have the authority, through its Chairman or physician designee, to institute any appropriate recommendations for control measures or studies when there is reason to believe that there is a danger to any patient or personnel.

c) Meetings

The Infection Prevention Committee shall meet at least quarterly or more frequently at the discretion of the Chairman, shall maintain minutes of its proceedings and actions, and shall make quarterly reports to the Quality Management Committee, who in turn shall report at least quarterly to the Medical Executive Committee.

14.2-7 Interdisciplinary Practice Committee (IDPC)

a) Composition

The interdisciplinary practice committee (IDPC) shall consist of, at a minimum, the chief nursing officer, the chief executive officer or designee, and an equal number of

physicians appointed by the medical executive committee and registered nurses appointed by the chief nursing officer. Licensed or certified health professionals other than registered nurses who perform functions requiring standardized procedures shall be included in the committee. The chair of the committee shall be a physician member of the active medical staff appointed by the Medical Executive Committee.

b) Duties

The IDPC shall perform functions consistent with the requirements of law and regulation. The IDPC shall routinely report to the Governing Board through the Medical Executive Committee.

c) Meetings

The IDPC shall meet at the call of the chair at such intervals as the chair or the medical executive committee may deem appropriate. It shall maintain minutes of its proceedings.

14.2-8 Joint Conference Committee

a. Composition

The Joint Conference Committee shall be composed of an equal number of members of the Governing Board and of the Medical Executive Committee, but the medical staff members shall at least include the President of the Medical Staff, the President Elect, and the immediate past President of the Medical Staff. The chairmanship of the committee shall alternate yearly between the Governing Board and the Medical Staff.

b. Duties

The Joint Conference Committee shall constitute a forum for the discussion of matters of hospital and medical staff policy, practice, and planning, and the exclusive forum for interaction between the Governing Board and the Medical Staff on such matters as may be referred by the Medical Executive Committee or the Governing Board. The Joint Conference Committee shall serve as the review body for hospital strategic planning, reviewing all strategic plans before the plans are sent to the Governing Board. The committee may request additional information from management before acting to approve or disapprove such plans. Joint Conference Committee approval shall be required before the implementation of any strategic plan. The Joint Conference Committee shall serve as the body to handle medical staff and Governing Board disputes, and shall meet and confer in good faith to resolve such disputes. The Joint Conference Committee shall exercise any other responsibilities set forth in these bylaws.

c. Meetings

The Joint Conference Committee shall meet as needed and shall transmit written reports of its activities to the Medical Executive Committee and to the Governing Board.

14.2-9 Medical Bio-Ethics Committee

a) Composition

This Committee shall consist five (5) physicians, a representative from all clinical departments if possible, a representative of Medical Center Administration, a member of the Clergy, a community member if possible, a member of the Nursing Staff, a member of the Governing Body and the committee is encouraged to seek legal and ethical consultants when appropriate. A physician member shall serve as Chairman.

b) Duties

1) To provide consultation as requested regarding issues of ethics of termination or withholding of care and thereby to maintain or improve quality of care.

2) To provide education and information regarding ethical, legal and medical aspects of issues arising from termination or withholding of care.

3) To assist in the development of appropriate written policies concerning termination or withholding of care.

4) To provide consultation and to assist in developing appropriate policies regarding other ethical issues including but not limited to organ transplants, human experimentation, informed consent, determination of and declaration of death, rights of the newborn, and professional relations.

c) Meetings

The Medical Bio-Ethics Committee shall meet as often as necessary at the call of its Chairman. It shall maintain minutes of its proceedings and shall make reports of its findings and recommendations to the Medical Executive Committee.

14.2-10 Multidisciplinary Peer Review Committee

a) Composition

This Committee shall be comprised of the Department Chairperson and Vice Chair from each clinical department, , the Utilization Management Committee Chair, with no vote, the Quality Management Chair, with no vote and other members appointed by the Chair. The Chief Medical Officer, Chief Nursing Office and Director of Performance Improvement are

also members without vote. The Chair of the Committee shall be the Medical Staff President-Elect. **(Approved 9/2016)**

b) Duties

1) Serve as a multidisciplinary medical staff peer/chart review body.

2) Review and discuss the referred chart review cases. Serve to advise and make recommendations to the appropriate Departments, and the Medical Executive Committee.

3) Physicians having cases presented may be invited to be present for the discussion.

4) Responsible for monitoring overall medical performance and individual physician performance, making recommendations for any and all directly to the Medical Executive Committee.

5) Peer review will focus on process improvement as well as on practice issues and medical management. System issues identified during the review process will be reviewed by the multidisciplinary team (MDPR) as necessary to evaluate events and system variables. The peer review process is a non-biased activity to measure, assess, and where necessary, make recommendations to improve performance and patient safety.

c) Meetings.

The MDPR will meet monthly, or when necessary.

14.2-11 Nominating Committee

a) Composition

This Committee shall consist of five (5) members of the Active Staff. Members of this Committee shall be proposed by the President and the Medical Executive members at its meeting in September of the election Medical Staff year. The Nominating Committee shall elect its own Chairman.

b) Duties

To nominate candidates for the following offices:

1) President Elect

2) Secretary/Treasurer

3) Three Members-At-Large

c) Meetings

The Nominating Committee shall meet once every two (2) years.

14.2-12 Pharmacy and Therapeutics Committee

a) Composition

This Committee shall consist of at least one (1) representative from each Clinical Department of the Medical Staff if possible**.** The Chairman will be a physician. The Secretary of the Committee will be the Chief Pharmacist. Ex-Officio will be representatives from Administration, Quality Management, Nursing,

1) Serve as an advisory group to the Medical Staff and the Pharmacist on all matters pertaining to the choice of available drugs.

2) Develop and implement an ongoing mechanism for drug usage evaluation and report findings to all appropriate Departments.

3) Make recommendations concerning drugs to be stocked on the Nursing Units and by other services.

4) Develop and review periodically a formulary or drug list for use in the Medical Center.

5) Prevent unnecessary duplication in stocking drugs and drugs in combination having identical amounts of the same therapeutic ingredients.

6) Evaluate clinical data concerning new drugs or preparations requested for used in the Medical Center.

7) Establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs.

8) Review adverse drug reactions.

9) Review standing medication orders annually.

10) Establish standards concerning the use and control of investigational drugs and or research in the use of recognized drugs.

c) Meetings

The Committee shall meet at least four (4) times per year or more frequently at the discretion of the Chairman, shall maintain minutes of its proceedings, and report its findings and recommendations to the Quality Management Committee.

14.2-13 Quality Management Committee

a) Composition

The Quality Management Committee consists of a Chairman (appointed by the President of the Medical Staff); the Chairmen of all Medical Staff departments (or their designees); the Chairmen of the Continuing Medical Education, Quality Council, Infection Control, and Pharmacy & Therapeutics, Patient Safety Committees. Ex Officio members shall include the Chief Executive Officer (or designee); the Director/Clinical Process Improvement (or designee); Chief Nursing Officer (or designee) and the Patient Safety Officer. Representatives from Medical Records, Utilization Review, Infection Control, and other members from appropriate support services shall attend meetings as needed.

b) Purpose

The purposes of the Quality Management Committee shall be: (1) to assure the Medical Executive Committee and Governing Board that high quality patient care and professional services are provided throughout the Medical Center; (2) to design and implement a medical center-wide program to measure and improve quality of care; (3) to analyze information relating to quality improvement, peer review, patient safety, professional practice and related functions; and (4) to recommend policies, procedures and actions to promote high quality patient care and safety throughout the medical center.

c) Duties

The Quality Management Committee shall perform the following duties:

1. Recommend for approval of the Medical Executive Committee plans for maintaining quality patient care within the medical center. These include the following:

    a) Establish systems to measure performance and seek opportunities to improve it;

    b) Receive and analyze quality of care related information and data from the clinical departments, from nursing, from Quality ,and from the reporting committees;

    c) Recommend specific policies and corrective actions to improve patient care and quality of professional practice;

d) Set priorities for action on problem correction;

e) Refer priority problems for assessment and corrective action to appropriate Departments or committees, the Medical Executive Committee or the Governing Board.

f) Monitor the results of quality assessment and improvement activities throughout the medical center; and

g) Coordinate quality assessment and improvement activities.

h) he Quality Management chair should be the President Elect of the Medical Staff.

2. Receive and review reports from the following to analyze and improve care:

a) The Quality Management Committee (which shall consist of members appointed by the President of the Medical Staff and the Chief Executive Officer and which shall be charged with overall responsibility to monitor quality of care indicators and activities throughout the medical center)

b) The clinical departments;

c) Infection Control

d) Pharmacy & Therapeutics

e) Patient Safety and Patient Safety Data;

f) Nursing

g) Patient Satisfaction

3) Oversee the required Medical Staff monitoring and evaluation functions of Departmental Review (including but not limited to medical assessment and treatment of patients, appropriateness of clinical practice patterns, significant departures from established patterns of clinical practice, blood and blood component usage evaluation, drug usage evaluation, medical record review, pharmacy and therapeutics review, and surgical and other procedure case review, and external event data, to assure compliance and effectiveness, establishing Ad Hoc Committees or focused reviews as necessary.

4) Submit regular confidential reports to the Medical Executive Committee and, through the Medical Executive Committee, to the Governing Board on the quality of medical care provided and on quality review activities conducted.

5) Submit an annual report to the Medical Executive Committee and the Governing Board.

d) Meetings

The Quality Management Committee shall meet at least ten (10) times per Medical Staff year or as often as dictated, shall maintain minutes of its proceedings, and shall report its findings and recommendations to the Medical Executive Committee.

14.2-14 Research Oversight Committee

a) COMPOSITION

The Committee shall be composed of an Active Staff member from each Medical Staff Department, one of whom shall be appointed as Chair. Ex officio members shall include the Chief Executive Officer or designee, the Director of Research Services, the Chief Compliance Officer, the Chief Nursing Officer, the Vice President of Medical Affairs, a Risk Management representative, the Director of Pharmacy, and a representative from the Medical-Bioethics Committee. Representatives from other departments or services may be requested to consult with the Committee as needed.

b) The DUTIES of this Committee shall be to:

1) Receive and consider proposed research protocols from independent investigators or other institution's Institutional Review Boards and review such protocols for compliance with:

i) the medical center's mission;
ii) the medical center's strategic plan;
iii) state and local laws and regulations;
iv) the medical center's professional standards;
v) the medical center's policies and resources;
vi) current Medical Staff membership of principle investigator.

The Committee may meet with the proposing investigator/IRB representative if further information is needed.

2) Receive reports of protocol approvals from hospital-contracted IRB (for independent investigator activities) or other institution's IRBs (for cooperative research projects).

3) Continually monitor all research involving human subjects.

4) Receive and review annual reports of all research activities from hospital-contracted IRB (for independent investigator activities) and other institution's IRBs (for cooperative research projects).

5) Receive and review all reports of irregularities, serious adverse occurrences, breach of protocol, or other issues relating to all research activities. Make recommendations regarding subsequent action consistent with the Medical Center's Administrative Policy and Procedure on Research Oversight Committee/Informed Consent.

6) Monitor compliance with the Medical Center's Administrative Policy and Procedure on Research Oversight Comittee/Informed Consent, including approval of Transfer Continuation Studies.

c) MEETINGS

The Research Oversight Committee shall meet as necessary to fulfill its duties, but at least annually. The Research Oversight Committee shall maintain a record of its proceedings, and shall reports its recommendations to the Medical Executive Committee.

14.2-15 Utilization Management Committee

a) Composition

The Chairman will be appointed by the President of the Medical Staff with the approval of the Medical Executive Committee. The Committee shall consist of not less than five (5) medical staff members representing all major services of the medical center and the President Elect. There shall be sufficient membership to adequately conduct reviews. Ex-Officio members who shall serve without vote will be from Administration, Nursing, Medical Records, Utilization Review, Quality Management, and Social Services. No individual may participate in the Committee's review that has a direct financial interest (for example, an ownership interest) in the hospital or who was professionally involved in the care of the patient whose case is being reviewed.

b) Duties

1) The Utilization Management Committee is responsible for conducting utilization review studies designed to evaluate the

appropriateness of admissions to the hospital, lengths of stay, discharge practices, use of medical and hospital services and related factors which may contribute to the effective utilization of services. The committee shall communicate the results of its studies and other pertinent data to Medical Executive Committee and shall make recommendations for the utilization of resources and facilities commensurate with quality patient care and safety.

2) the implementation of the Utilization Review Plan, which provides for the timely review of the medical necessity of admissions, continuing stay review, and professional services rendered. This plan shall be approved by the Medical Executive Committee and be in compliance with Local, State and Federal Regulations and approved by the Medical Staff, Administration, and the Governing Board.

3) To recommend change in medical center procedures of Medical Staff utilization practices as indicated on analysis of review findings.

4) To assure that all hospitalizations and inpatient services are medically necessary.

5) To analyze and identify factors that may contribute to unnecessary or ineffective utilization of inpatient services and facilities, and to make recommendations designed to minimize ineffective utilization.

6) To maintain close liaison with the Social Services Department working toward the assurance of proper continuity of care upon discharge through, among other things, the accumulation of data on the availability of other suitable health care facilities and services outside the medical center.

7) Regular monthly utilization review studies will be carried out on a sampling basis for selected diagnostic and operation categories using criteria established by the Medical Staff.

8) The Committee shall also review methods and procedures of selected services to identify utilization problems and recommend solutions.

9) Any clinical peer review issues identified will be referred to the MDPR (Multidisciplinary Peer Review Committee) for review.

c) Meetings

The Utilization Management Committee shall meet at least ten (10) times per Medical Staff year. It shall maintain minutes of its proceedings and actions and shall make regular reports of findings and recommendations to the Medical Executive Committee.

14.2-16 Well-Being Committee

a) Composition

This Committee shall consist of three (3) to five (5) members of the Active Staff who will be members of integrity, highest ethics, and moral standing with no conflict of interest. Members of this committee may participate in review of a particular peer review case if requested by the chair, but may not serve as active participants on other peer review committees or on the Quality Management Committee while serving on this Committee.

b) Duties

1) To receive reports through self-referrals (with confidentiality, except as limited by law or Section 3) below) or referrals by others (with provisions for confidentiality of informants), related to the health, well-being or impairment of medical staff members and, as deemed appropriate, investigate such reports for the credibility of the complaint, allegation, or concern;

2) With respect to matters involving individual Medical Staff members, the Committee may, on a voluntary, confidential basis, provide such advice, counseling, or referrals as to the appropriate professional internal or external resources for diagnosis and treatment of the condition or concern as may seem appropriate;

3) The Committee does not have disciplinary authority; however, in the event information demonstrates that the health or known impairment of a Medical Staff member poses an unreasonable risk of harm to patients or others, to refer the matter to the Medical Executive Committee, through the President of the Medical Staff, for corrective action, and as required by law;

4) The Committee may provide suggestions and advice to other appropriate committees or officers regarding reasonable safeguards concerning a member's continued practice in the hospital while undergoing treatment;

5) The Committee shall monitor the affected practitioner and the safety of patients until any rehabilitation or disciplinary process is complete, and periodically thereafter, if deemed appropriate by the Committee.

6) To protect the welfare of the members of the Medical Staff; and

7) To consider general matters related to the health and well-being of the Medical Staff and, with the approval of the Medical Executive Committee, to develop relevant educational programs or other related activities about illness and impairment recognition issues specific to Medical Staff members.

8. Initiates appropriate actions when a licensed independent practitioner fails to complete the required rehabilitation program.

c) Meetings

The Well-Being Committee shall meet as often as necessary at the call of the Chairman. It shall maintain confidential records of its proceedings and actions and shall submit confidential reports of its findings and recommendations to the Medical Executive Committee at least quarterly.

ARTICLE XV
MEETINGS

15.1 General Staff Meetings

15.1-1 The Annual Meeting Of The Active Staff

The annual meeting of the Active Staff shall be the last meeting before the end of the calendar year. This is held in December or such other time designated by the Medical Executive Committee at which the retiring officers and committees shall make their reports and evaluation of the medical work of the Medical Center. Subsequently, a quarterly meeting of the entire Medical Staff will be held.

15.1-2 Quarterly Meetings

Quarterly meetings shall be for all members of the Medical Staff. They will be held at a time and place designated by the Medical Executive Committee. The principal objective of these meetings is to consider factors relevant to improvement in the care of patients. The program of these meetings shall include a review of the patient care in the medical center. Other topics may be discussed and voted on at these meetings.

15.1-3 Special Meetings

Special meeting of the Medical Staff may be called at any time by the President, at the request of the Chief Executive Officer, the Medical Executive Committee or ten (10) of the Active or Senior members of the Medical Staff. Notification shall be given at least forty-eight (48)

hours before the time set for the meeting. Business conducted at the special meeting shall be confined to that designated in the notification as per Agenda.

15.1-4 Executive Session

Executive session is a meeting of a medical staff committee which only medical staff members may attend and members of the Administrative Executive Management, Quality Management Staff, Medical Staff Services Staff and, others are expressly requested by the committee to attend. Executive session may be called by the presiding officer at the request of any medical staff committee member, and shall be called by the presiding officer pursuant to a duly adopted motion. Executive session may be called to discuss peer review issues, personnel issues, or any other sensitive issues requiring confidentiality.

15.2 Departmental Meetings

15.2-1 Each Department shall hold a Departmental meeting, conducted by the Chairman, at least four (4) per year. This is to review and evaluate the clinical work of the practitioners in the Department, to conduct continuing medical education programs, and to discuss matters relevant to the Department's performance and efficiency. Minutes of these meetings shall reflect specifically the areas of medical care analysis and shall become a part of the records of the Medical Staff.

15.2-2 Special Department/Section/Committee Meeting: This meeting will convene at the request of the Chairman, Medical Executive Committee, and President of the Medical Staff or written request of one third (1/3) of the current members eligible to vote. Notice shall be given at least twenty-four (24) hours before the time set for the meeting.

15.3 Attendance at Meetings

Specification of members not required to attend meetings is covered in Article IV. They may, however, elect to attend meetings.

15.4 Special Appearance

At the discretion of the chair or presiding officer, when a practitioner’s practice or conduct is scheduled for discussion at a department, section, committee, or subcommittee meeting, the member may be requested to attend. If a suspected deviation from an accepted clinical practice or conduct is involved, a notice may be sent requiring the member’s attendance. If attendance is required, the notice shall be given at least seven (7) days prior to the meeting, shall include the time and place of the meeting and a general indication of the issue involved, and shall advise the Practitioner if his/her attendance is required. Failure of a Practitioner to attend or respond to any meeting for which the practitioner was notified that his/her attendance is required, unless excused by the President of the Medical Staff upon a demonstration of good cause by the Practitioner, shall result in the automatic suspension of the Practitioner’s clinical privileges until

such time that the attendance requirement is satisfied. On a case-by-case basis, the Department Chairman and President of the Medical Staff may agree to terminate the automatic suspension upon receipt of the Practitioner's written response which addresses the specific peer review issues which were to be discussed at the meeting and which provides an acceptable explanation for failure to attend the required meeting.

15.5 Quorum

15.5-1 General Staff Meetings

The presence of not less than ten (10) of the Active (Senior) Staff at any regular or special meeting of the Staff shall constitute a quorum.

15.5-2 Department, Section, and Committee Meetings

In order to conduct business, three (3) members shall constitute a quorum at any meeting of such department, clinical section, or committee other than the Medical Executive Committee. A quorum of fifty percent (50%) of the voting membership shall be required for the Medical Executive Committee.

15.6 Manner of Action

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members. In parliamentary matters, Roberts Rule of Order Standard Code of Parliamentary Procedures shall prevail. Meetings may be attended or conducted via a conference call in which each of the individuals can hear each other and speak with each other. Actions also may be taken by a unanimous written consent of the members. Although the views of persons not in attendance may be communicated, persons not in attendance at a meeting either in person or by conference call shall not be permitted to vote by proxy.

15.7 Minutes

Minutes of each regular and special meeting of a committee or Department shall be prepared and shall include a record of the attendance of members, vote taken on each matter, and shall contain enough detail to reflect the content and nature of discussion. The Minutes will be considered approved when the Department/Committee approves the minutes, as noted in the minutes A summary report shall be forwarded to the Medical Executive Committee. Each committee and Department shall maintain a permanent file of the minutes of each meeting.

ARTICLE XVI
CONFIDENTIALITY, IMMUNITY, AND RELEASES

16.1 Special Definitions

For the purpose of this Article, the following definitions shall apply:

16.1-1 INFORMATION means records of proceedings, minutes, other records, reports, memoranda, statements, recommendations, data and other disclosures whether in writing or oral form relating to any of the subject matters specified in Section 15.5.

16.1-2 HEALTH PRACTITIONER means a Medical Staff member or applicant or an Allied Health Professional.

16.1-3 REPRESENTATIVE means the Board, any Director, a Committee, a Chief Executive Officer or Administrator of a medical center or Care Institution or their designee, a Medical Staff entity, an organization of health practitioners, a professional review organization, a state or local board of Medical Quality (i.e., Medical Board of California) and any individual authorized by any of the foregoing to perform specific information gathering or disseminating functions.

16.1-4 THIRD PARTIES mean both individuals and organizations providing information to any representative.

16.2 Authorizations and Conditions

By applying for or exercising clinical privileges or providing specified patient care services within this medical center, a health practitioner:

16.2-1 Authorizes representatives of the medical center and the Medical Staff to solicit, provide, and act upon information bearing on his professional ability and qualifications.

16.2-2 Authorizes third parties and their representatives to provide information, including otherwise privileged or confidential information, concerning such health practitioner to the medical center and its Medical Staff.

16.2-3 Agrees to be bound by the provisions of this Article and to waive all legal claims against any representative who acts in accordance with the provisions of this Article.

16.2-4 Acknowledges that the provisions of this Article are express conditions to his application for or acceptance of Medical Staff membership and the continuation of such membership, or to his exercise of clinical privileges or provision of specified patient services at this medical center.

16.3 Confidentiality

Records and proceeding of all medical staff committees having the responsibility of evaluation and improvement of quality of care rendered in this hospital, including, but not limited to meetings of the medical staff meeting as a committee of the whole, meetings of departments, meetings of committees established under these bylaws, and meetings of special or ad hoc committees created by the Medical Executive Committee or by departments and including information regarding any member or applicant to this medical staff shall, to the fullest extent permitted by law, be confidential.

16.3-1 Breach of Confidentiality

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

16.4 Immunity from Liability

16.4-1 For Action Taken

Each representative of the medical center and Medical Staff shall be immune, to the fullest extent permitted by law, from liability to a health practitioner for damages or other relief for any action taken or statement or recommendation made within the scope of his duties as a representative and within the scope hereof.

16.4-2 For Providing Information

Each representative of the medical center and Medical Staff and all third parties shall be immune, to the fullest extent permitted by law, from liability to a health practitioner for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative concerning a health practitioner who is or has been an applicant to or member of the staff or who did or does exercise clinical privileges or provide specified services at this medical center.

16.5 Activities and Information Covered

16.5-1 Activities

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

a) Applications for appointment, clinical privileges, or the right to perform specified services;

b) Periodic reappraisals for reappointment, clinical privileges; or specified services;

c) Corrective action;

d) Hearings and appellate review;

e) Patient care;

f) Utilization reviews;

g) Other medical center, department, committee or Medical Staff activities relating to monitoring and maintaining quality patient care and appropriate professional conduct;

h) PRO (Peer Review Organizations), NPDB**,** Medical Board of California state and federal authorities, registries, and/or like reports.

16.5-2 Information

The acts, communications, reports, recommendations, disclosures, and other information referred to in this Article may relate to professional qualifications, clinical ability, judgment, character, physical and mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly effect patient care.

16.6 Releases

Each health practitioner shall, upon request of the medical center, execute general and specific releases in accordance with the provisions, tenor, and import of this Article. Executive of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

16.7 Indemnification

The hospital shall indemnify, defend and hold harmless the medical staff and its individual members from and against losses and expenses (including attorneys' fees, judgments, settlements, and all other costs, direct or indirect) incurred or suffered by reason of or based upon any threatened, pending or completed action, suit, proceeding, investigation, or other dispute relating or pertaining to any alleged act or failure to act within the scope of peer review or quality assessment activities including, but not limited to, (1) as a member of or witness for a medical staff department, service, committee or hearing panel, (2) as a member of or witness for the hospital board or 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 XVII
RULES AND REGULATIONS

17.1 General Rules and Regulations

Each Medical Staff Department and Committee shall recommend such General Rules and Regulations, applicable to its operations and which cover medical center procedures in more detail than the Bylaws, as may be necessary for proper conduct of its work. Such Rules and Regulations shall be part of these Bylaws when approved by the Medical Executive Committee and the Governing Board and are more flexible than the Bylaws. The Medical Staff is to be notified of adoption and amendment of General Rules and Regulations. In the event that any such General Rules and Regulations conflict with the Medical Staff Bylaws, the Medical Staff Bylaws shall control and supersede the Rules and Regulations with which they are in conflict. Medical Staff Bylaws, Rules and Regulations, and policies and the governing body’s bylaws shall not conflict.

17.2 Departmental Rules and Regulations

Each Department shall adopt Rules and Regulations specifically applicable to a given Department for proper conduct of its work. These Departmental Rules and Regulations will become effective when approved by the Department, Medical Executive Committee, and the Governing Board. Department Rules and Regulations shall not conflict with and shall be subject to the General Rules and Regulations and these Bylaws. The process to amend the Department Rules and Regulations shall be the same as the process to adopt Department Rules and Regulations.

17.3 Policies and Procedures

Policies may be developed to implement more specifically the general principles in the Bylaws and Rules and Regulations. All policies, procedures, criteria, standards or other documents for use in Medical Staff activities, including but not limited to, membership, privileges, performance improvement, utilization review, review and analysis of patient medical records must be approved by the Medical Executive Committee and the Governing Body. Upon adoption, they shall be deemed part of the Medical Staff Bylaws, Rules and Regulations. Policies shall not conflict with and shall be subject to the General Rules and Regulations and these Bylaws.

ARTICLE XVIII
AMENDMENTS AND REVISIONS

18.1 Procedure to Amend and Revise

18.1-1 Proposed Bylaws amendments, including the adoption, amendment or repeal of these Bylaws, shall be submitted to a vote of the Medical Staff, eligible to vote, upon approval by a majority of the Medical Executive Committee. In the event there is a conflict between the members of the medical staff and the Medical Executive Committee on issues including, but not limited to, proposals to adopt a role, regulation, or policy or an amendment thereto, the matter shall be forwarded to the Joint Conference Committee as noted in Article, XIV Section 2.-9, or Judicial Review Committee.

18.1-2 Proposed Bylaws or amendments may be approved by the Medical Staff through either of the following processes; the Medical Executive Committee to determine which of the following two processes shall be used to approve the proposed Bylaws amendments:

a) Proposed Bylaws amendments and a ballot shall be mailed by postal or electronic means to all of the Active Medical Staff members. The notice shall include the exact wording of the existing Bylaws and the proposed change. The notice shall inform members that they have thirty (30) days to return their ballots to the Medical Staff Office. The affirmative vote of a majority of the returned ballots received within the foregoing thirty (30) days are required for the Medical Staff to approve the proposed Bylaws amendments. The President of the Medical Staff, President Elect and Medical Staff Director shall count the ballots.

b) The proposed Bylaws amendments may be approved by a majority of the Medical Staff members who are present at a meeting and entitled to vote at either (i) a regular Medical Staff meeting if such changes were offered at a prior Medical Staff meeting or the notice of the regular meeting included the exact wording of the existing Bylaws and the proposed change, or (ii) a special meeting if such changes were offered at a prior Medical Staff meeting or the notice of the special meeting included the exact wording of the existing Bylaws and the proposed change.

c) Upon the request of the Medical Executive Committee, or timely written petition signed by at least ten percent (10%) of the members of the Medical Staff in good standing who are entitled to vote, consideration shall be given to the adoption, amendment, or repeal of these bylaws. Such action shall be taken at a regular or special meeting, or by mail ballot, provided that written notice of the proposed change was sent to all members at least thirty (30) days in advance of the next regular or special meeting at which action is to be taken. The notice shall include the exact wording of the existing bylaws language, if any, and the proposed change(s)

d) Urgent Need – When an urgent action is necessary in order to comply with a federal or state law or regulation or accreditation requirement, the Medical Executive Committee may provisionally adopt and the Governing Body may provisionally approve the urgent amendment without prior notification of the Medical Staff. Following the provisional adoptions and approval, the Medical Executive Committee shall immediately notify the Medical Staff of the urgent amendment. The Medical Staff has the opportunity to retrospectively review and comment on the urgent amendment. If there is no conflict between the Medical Staff and the Medical Executive Committee, then the urgent amendment will stand as a final action of the Governing Body. If there is a conflict over the urgent amendment, then, to resolve this conflict, the Medical Staff may resolve the conflict in accordance with these bylaws.

18.2 Adoption

Bylaw changes adopted by the medical staff shall become effective following approval by the Governing Board, which approval shall not be withheld unreasonably or automatically within ninety (90) days if no action is taken by the Governing Board. Medical staff members are provided with copies of the revisions in the bylaws, rules and regulations and medical staff policies. If approval is withheld, the reasons for doing so shall be specified by the Governing Board in writing, and shall be forwarded to the President of the Medical Staff, the Medical Executive Committee and Bylaws Committee. Neither the Governing Board nor the Medical Staff can unilaterally amend the Medical Staff Bylaws and its Rules and Regulations.

18.3 Exclusivity

The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the medical staff bylaws.

18.4 Effect of the Bylaws

Upon adoption and approval as provided in Article XVIII, in consideration of the mutual promises and agreements contained in these bylaws, the hospital and the medical staff, intending to be legally bound, agree that these bylaws shall constitute part of the contractual relationship existing between the hospital and the medical staff members, both individually and collectively.

18.5 Affiliations

Affiliations between the hospital and other hospitals, health care systems or other entities shall not, in and of themselves, affect these bylaws.

18.6 Construction of Terms and Headings

The captions or headings in these bylaws are for convenience only and are not intended to limit or define the scope of or affect any of the substantive provisions of these bylaws. These bylaws apply with equal force to both genders wherever either term is used.

ARTICLE XIX
PARLIMENTARY AUTHORITY

In parliamentary matters, Roberts Rules of Order of Parliamentary Procedures shall prevail. (**Approved 10/22/14)**