LADMC LA Downtown Medical Center LLC

# Medical Staff Bylaws

Created May 2019

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## ARTICLE I: PURPOSES AND TERMS

### 1.1 PURPOSES OF THE BYLAWS

These bylaws are adopted in order to provide for the organization of the medical staff of LA Downtown Medical Center hospital 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, and relations with applicants to and members of the medical staff. They also serve as a means to ensure that all patients admitted to or treated in any of the facility department or services of the hospital shall receive a high standard of care as well as to provide an appropriate educational setting which will maintain scientific standards and foster continuous advancement in professional knowledge and skill.

### 1.2 DEFINITIONS OF TERMS

1.2-1 ADMINISTRATOR/CHIEF EXECUTIVE OFFICER means the person appointed by the Governing Board to serve in an administrative capacity.

1.2-2 AUTHORIZED REPRESENTATIVE or HOSPITAL'S AUTHORIZED REPRESENTATIVE means the individual designated by the hospital and approved by the medical executive committee to provide information to and request information from the National Practitioner Data Bank according to the terms of these bylaws.

1.2-3 GOVERNING BOARD means the governing body of the hospital.

1.2-4 CHIEF OF STAFF means the chief officer of the medical staff elected by members of the medical staff.

1.2-5 CLINICAL PRIVILEGES or PRIVILEGES means the permission granted to medical staff members to provide patient care and include unrestricted access to those hospital resources (including equipment, facilities and hospital personnel) which are necessary to effectively exercise those privileges.

1.2-6 HOSPITAL means LA Downtown Medical Center hospital.

1.2-7 IN GOOD STANDING means a member is currently not under suspension or serving with any limitation of voting or other prerogatives imposed by operation of the bylaws, rules and regulations or policy of the medical staff.

1.2-8 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 member of the medical staff, and does not include activity of the medical staff aid committee.

1.2-9 MEDICAL EXECUTIVE COMMITTEE or MEC means the executive committee of the medical staff which shall constitute the governing body of the medical staff as described in these bylaws.

1.2-10 MEDICAL STAFF or STAFF means those physicians (MD or DO or their equivalent as defined in Section 2.2-2(a)(1)), dentists, podiatrists and clinical psychologists who have been granted recognition as members of the medical staff pursuant to the terms of these bylaws.

1.2-11 MEDICAL STAFF YEAR means the period from January 1st to December 31st of a single calendar year.

1.2-12 MEMBER means, unless otherwise expressly limited, any physician (MD or DO or their equivalent as defined in Section 2.2-2(a)(1)), dentist, podiatrist or clinical psychologist holding a current license to practice within the scope of that license who is a member of the medical staff.

1.2-13 PHYSICIAN means an individual with an MD or DO degree or the equivalent degree (i.e., foreign) as recognized by the Medical Board of California (MBC) or the Board of Osteopathic Examiners (BOE), who is licensed by either the MBC or the BOE.

1.2-14 PRACTITIONER means, unless otherwise expressly limited, any currently licensed physician (MD or DO), dentist, clinical psychologist, or podiatrist.

## 1.3 NAME

The name of this organization is the Medical Staff of LA Downtown Medical Center.

## ARTICLE II: MEMBERSHIP

### 2.1 NATURE OF MEMBERSHIP

No physician, dentist, podiatrist, or clinical psychologist including those in a medical administrative position by virtue of a contract with the hospital, shall admit or provide medical or health-related services to patients in the hospital unless the physician is a member of the medical staff or has been granted temporary privileges in accordance with the procedures set forth in these bylaws. Appointment to the medical staff shall confer only such clinical privileges and prerogatives as have been granted in accordance with these bylaws.

### 2.2 QUALIFICATIONS FOR MEMBERSHIP

2.2-1 GENERAL QUALIFICATIONS

Membership on the medical staff and privileges shall be extended only to practitioner who are professionally competent and continuously meet the qualifications, standards, and requirements set forth in the medical staff bylaws.

2.2-2 BASIC QUALIFICATIONS

A practitioner must demonstrate compliance with all basic standards set forth in this Section in order to have an application for medical staff membership accepted for review. The practitioner must:

a. Qualify to practice in California as follows:

   1) Physicians must hold an MD or DO degree or their equivalent and a valid and unsuspended license to practice medicine issued by the Medical Board of California or the California Board of Osteopathic Examiners. For purposes of this section, "or their equivalent" shall mean any degree (i.e., foreign) recognized by the Medical Board of California or the California Board of Osteopathic Examiner;

   2) Podiatrists must hold a DPM degree and a valid and unsuspended certificate to practice podiatry issued by the Medical Board of California;

   3) Dentists must hold a DDS or equivalent degree and a valid and unsuspended license to practice dentistry issued by the California Board of Dental Examiners;

   4) Clinical psychologists must hold a PhD in clinical psychology, or PsyD, and have not less than two years clinical experience in a multi-disciplinary facility licensed or operated by this or another state or by the United States to provide health care or be listed in the latest edition of the National Register of Health Service Providers in Psychology, and hold a valid and unsuspended license to practice clinical psychology issued by the California Board of Psychology and Division of Allied Health Professions of the Medical Board of California. If experience is less than two years, membership may still be granted at the discretion of the Medical Executive Committee.

b. If practicing medicine, dentistry or podiatry, have a valid and unsuspended federal Drug Enforcement Administration (DEA) certificate.

c. Have professional liability insurance in not less than the minimum amounts as from time to time may be jointly determined by the Governing Board and Medical Executive Committee.

d. Pledge to provide continuous care to his or her patients.

A practitioner who does not meet these basic standards is ineligible to apply for medical staff membership, and the application shall not be accepted for review, except that applicants for the honorary medical staff do not need to comply with any of the basic standards. If it is determined during the processing that an applicant does not meet all of the basic qualifications, the review of the application shall be discontinued. An applicant who does not meet the basic standards is not entitled to the procedural rights set forth in these bylaws.

2.2-3 ADDITIONAL QUALIFICATIONS FOR MEMBERSHIP

In addition to meeting the basic standards, the practitioner must:

a. Document his or her:

1) Adequate education, training and experience in the requested privileges;

2) Current professional competence;

3) Good judgment; and

4) Adequate physical and mental health status to demonstrate to the satisfaction of the medical staff that he or she is professionally and ethically competent so that patients can reasonably expect to receive the generally recognized professional level of quality of care for this community.

b. Be determined to:

1) Adhere to the lawful ethics of his or her profession;

2) Be able to work cooperatively with others in the hospital setting so as to not adversely affect patient care or hospital operations; and

3) Be willing to participate in and properly discharge medical staff responsibilities.

## 2.3 EFFECT OF OTHER AFFILIATIONS

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

## 2.4 NONDISCRIMINATION

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

## 2.5 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

Except for the honorary and retired staff, the ongoing responsibilities of each member of the medical staff include:

(a) providing patients with the quality of care meeting the professional standards of the medical staff of this hospital;

(b) abiding by the medical staff bylaws, medical staff rules and regulations, and policies and medical-staff approved hospital policies and procedures, including those related to the security of electronic health records;

(c) discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the member by virtue of medical staff membership, including committee assignments, serving as a proctor, or performing peer review;

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

(e) abiding by the lawful ethical principles of the California Medical Association or member's professional association;

(f) aiding in any medical staff approved educational programs for medical students, interns, resident physicians, resident dentists, staff physicians, podiatrists and dentists, nurses, student nurses and other personnel;

(g) working cooperatively with members, nurses, hospital administration and others so as not to adversely affect patient care;

(h) making appropriate arrangements for coverage of that member's patients as determined by the medical staff;

(i) refusing to engage in improper inducements for patient referral;

(j) participating in continuing education programs as determined by the medical staff;

(k) participating voluntarily in such emergency service coverage or consultation panels as may be determined by the medical staff;

(l) discharging such other staff obligations as may be lawfully established from time to time by the medical staff or medical executive committee;

(m) providing information to and/or testifying on behalf of the medical staff or an accused practitioner regarding any matter under an investigation pursuant to paragraph 6.2-3, and any matter which is the subject of a hearing pursuant to Article VII; and

(n) performing, if granted the requisite privileges, or arranging for the performance of, a history and physical on every patient he/she admits. As detailed in the Medical Staff Rules/Regulations, a medical history and physical examination shall be completed no more than 30 days before, or 24 hours after, admission or registration, but prior to surgery or a procedure requiring anesthesia services. When the medical history and physical examination is completed within 30 days before admission or registration, the physician must complete and document an updated examination of the patient within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The history and physical must be completed and documented by a physician, an oral maxillofacial surgeon, or other qualified licensed individual in accordance with state law and Hospital policy as further defined in the general rules and regulations.

## 2.6 DISRUPTIVE BEHAVIOR, DISCRIMINATION, AND HARASSMENT PROHIBITED

2.6-1 STANDARDS OF BEHAVIOR

(a) 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, as further described in the medical staff's Disruptive Behavior & Workplace Harassment Policy. This applies to interactions and communications with or relating to medical staff colleagues, allied health professional staff, 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 medical care, maintain a safe work environment, and avoid disruption of hospital operations. Disruptive, discriminatory, or harassing behavior, as defined below, will not be tolerated.

(b) If a medical staff member believes that a hospital employee is behaving or has behaved inappropriately, the medical staff member may communicate constructive criticism politely and discreetly, and may report perceived misconduct to the employee's supervisor(s), and/or the Director of Human Resources ("DHR"). However, if the medical staff member believes that an employee's conduct warrants a reprimand or disciplinary action, then the medical staff member should report the employee's conduct to the DHR, and work with the DHR and other administrative and medical staff personnel as appropriate to resolve the problem. The types of conduct described in Section 2.6-2 below, are not acceptable responses to perceived employee deficiencies or misconduct, or disagreements with physician colleagues or the hospital.

2.6-2 DEFINITIONS

a) "Disruptive Behavior" is aberrant behavior manifested through personal interaction with physicians, hospital personnel, health care professionals, patients, family members, or others, which interferes with patient care or could reasonably be expected to interfere with the process of delivering quality care. Examples of disruptive behavior include, but are not limited to, refusing

to cooperate with other caregivers; rude and inappropriate comments, particularly in the presence of patients, family, or peers; improper use of medical records to criticize other caregivers or the hospital; and insistence on idiosyncratic procedures or services.

b) "Discrimination" is conduct directed against any individual (e.g., against another medical staff member, AHP, hospital employee, or patient) 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, behavioral disability, medical disability, marital status, sex, gender, or sexual orientation.

c) "Harassment" is a course of conduct (including but not limited to violence or threat of violence) directed at a specific person that seriously alarms, upsets, or annoys the person, and that serves no legitimate purpose. A single incident may constitute harassment if sufficiently egregious. Concerns about the conduct or performance of other hospital personnel can and should be raised and addressed in accordance with these bylaws (see Section 2.6.1 above) and the applicable hospital policies and procedures, and such concerns do not constitute a "legitimate purpose" for engaging in harassing behavior.

d) "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 indicating that employment and/or employment benefits are conditioned upon acquiescence in sexual activities.

### 2.6-3 INVESTIGATION AND DISCIPLINARY ACTION

In the event that a member of the medical staff is the subject of a complaint alleging any of the behavior described in Section 2.6-2, the member shall be subject to the investigation and disciplinary action procedures and protections found Section 6.2. Notwithstanding any other provision of these bylaws or the rules and regulations, documentation relating to such investigations, their conclusions, and any resulting corrective action shall be maintained by the medical staff office as peer review documents.

## ARTICLE III: CATEGORIES OF MEMBERSHIP

### 3.1 CATEGORIES

The categories of the medical staff shall include the following: active, courtesy, consulting, provisional, honorary, retired, temporary, and administrative. At appointment and each time of reappointment, the member's staff category shall be determined.

### 3.2 ACTIVE STAFF

3.2-1 QUALIFICATIONS

The active staff shall consist of members who:

(a) meet the qualifications for membership set forth in Section 2.2;

(b) have offices or residences which, in the opinion of the medical executive committee, are located close enough to the hospital to provide appropriate continuity of quality care;

(c) regularly care for patients in this hospital or are regularly involved in medical staff functions, as determined by the medical staff or that regularly admit, or are otherwise regularly involved in the care of in excess of 11 patients a year in the hospital; and

(d) except for good cause shown as determined by the medical staff, have satisfactorily completed their designated term in the provisional staff category.

3.2-2 PREROGATIVES

Except as otherwise provided, the prerogatives of an active medical staff member shall be to:

(a) admit patients and exercise such clinical privileges as are granted pursuant to Article V;

(b) attend and vote on matters presented at general and special meetings of the medical staff and of the department and committees to which the member is duly appointed; and

(c) hold staff, division, or department office and serve as a voting member of committees to which the member is duly appointed or elected by the medical staff or duly authorized representative thereof, so long as the activities required by the position fall within the member's scope of practice as authorized by law.

3.2-3 TRANSFER OF ACTIVE STAFF MEMBER

After two consecutive years in which a member of the active staff fails to regularly care for patients in this hospital or be regularly involved in medical staff functions as determined by the medical staff, that member shall be automatically transferred to the appropriate category, if any, for which the member is qualified.

### 3.3 THE COURTESY MEDICAL STAFF

3.3-1 QUALIFICATIONS

The courtesy medical staff shall consist of members who:

(a) meet the general qualifications set forth in subsections (a)-(b) of Section 3.2 1;

(b) do not regularly care for patients or are not regularly involved in medical staff functions as determined by the medical staff or that admit, or regularly care for (or reasonably anticipate admitting or regularly caring for) not more than 11 patients per year in the hospital;

(c) are members in good standing of the active or associate medical staff of another California licensed hospital, although exceptions to this requirement may be made by the medical executive committee for good cause; and

(d) have satisfactorily completed appointment in the provisional category.

3.3-2 PREROGATIVES

Except as otherwise provided, the courtesy medical staff member shall be entitled to:

(a) admit patients to the hospital with the limitations imposed by Section 3.3-1(b) and exercise such clinical privileges as are granted pursuant to Article V; and

(b) attend in a non-voting capacity meetings of the medical staff and the department of which the individual is a member, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment.

Courtesy staff members shall not be eligible to hold office in the medical staff.

3.3-3 LIMITATION

Courtesy staff members who admit patients or regularly care for patients at the hospital shall, upon review of the medical executive committee, be obligated to seek appointment to the appropriate staff category.

## 3.4 THE CONSULTING MEDICAL STAFF

3.4-1 QUALIFICATIONS

Any member of the medical staff in good standing may consult in that member's area of expertise; however, the consulting medical staff shall consist of such practitioners who:

(a) are not otherwise members of the medical staff and meet the qualifications set forth in Section 2.2,;

(b) possess adequate clinical and professional expertise;

(c) are willing and able to come to the hospital on schedule or promptly respond when called to render clinical services within their area of competence;

(d) are members of the active or associate medical staff of another hospital licensed by California or another state, although exceptions to this requirement may be made by the medical executive committee for good cause; and

(e) have satisfactorily completed appointment in the provisional category.

3.4-2 PREROGATIVES

The consulting medical staff member shall be entitled to:

(a) exercise such clinical privileges as are granted pursuant to Article V; and

(b) attend meetings of the medical staff and the department of which that person is a member, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment.

Consulting staff members shall not be eligible to hold office in the medical staff organization, but may serve on committees.

## 3.5 PROVISIONAL STAFF

3.5-1 QUALIFICATIONS

The provisional staff shall consist of members who:

(a) meet the general medical staff membership qualifications set forth in Sections 3.2-1(a) and (b) or 3.4-1(a)-(d); and

(b) immediately prior to their application and appointment were not members (or were no longer members) in good standing of this medical staff.

3.5-2 PREROGATIVES

The provisional staff member shall be entitled to:

(a) admit patients and exercise such clinical privileges as are granted pursuant to Article V; and

(b) attend meetings of the medical staff and the department of which that person is a member, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment.

Provisional staff members shall not be eligible to hold office in the medical staff organization, but may serve upon committees.

3.5-3 OBSERVATION OF PROVISIONAL STAFF MEMBER

Each provisional staff member shall undergo a period of observation by designated monitors as described in Section 5.3. 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.

3.5-4 TERM OF PROVISIONAL STAFF STATUS

A member shall remain in the provisional staff for a period of two years, unless that status is extended by the medical executive committee for an additional period of up to two years upon a determination of good cause, which determination shall not be subject to review pursuant to Articles VI or VII.

3.5-5 ACTION AT CONCLUSION OF PROVISIONAL STAFF STATUS

(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, courtesy or consulting staff as appropriate, upon recommendation of the medical executive committee; and

(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. The member shall not be entitled to the procedural rights of Article VII, Hearings and Appellate Review, if advancement was denied because of a failure to have a sufficient number of cases proctored.

## 3.6 HONORARY, RETIRED, AND AFFILIATE STAFF

3.6-1 QUALIFICATIONS

(a) The Honorary Staff

The honorary staff shall consist of physicians, dentists, podiatrists, and clinical psychologists who do not actively practice at the hospital but are deemed deserving of membership by virtue of their outstanding reputation, noteworthy contributions to the health and medical sciences, or their previous long-standing service to the hospital, and who continue to exemplify high standards of professional and ethical conduct.

(b) The Retired Staff

The retired staff shall consist of members who have retired from active practice and, at the time of their retirement, were members in good standing of the active medical staff who continue to adhere to appropriate professional and ethical standards.

(c) The Affiliate Staff

The affiliate staff shall consist of physicians, dentists, podiatrists [clinical psychologists] who do not actively practice at the hospital but are an important resource for medical staff educational activities.

3.6-2 PREROGATIVES

Honorary, retired and affiliate staff members are not eligible to admit patients to the hospital or to exercise clinical privileges in the hospital, or to vote or hold office in this medical staff organization, but they may serve upon committees with or without vote at the discretion of the medical executive committee. They may attend staff and department meetings, including open committee meetings and educational programs. They are not subject to the reappointment/recredentialing process and are not required to pay annual medical staff dues for membership.

## 3.7 TEMPORARY STAFF

3.7-1 QUALIFICATIONS

The temporary staff shall consist of physicians, dentists, podiatrists and clinical psychologists who do not actively practice at the hospital but are important resource individuals for medical staff quality assessment and improvement activities. Such persons shall be qualified to perform the functions for which they are made temporary members of the staff.

3.7-2 PREROGATIVES

Temporary medical staff members shall be entitled to attend all meetings of committees to which they have been appointed for the limited purpose of carrying out quality assessment and improvement functions. They shall have no privileges. They may not admit patients to the hospital or hold office in the medical staff organization. They may, however, serve on designated committees with or without vote at the discretion of the medical executive committee. Finally, they may attend medical staff meetings outside of their committees, upon invitation.

## 3.8 ADMINISTRATIVE STAFF

3.8-1 QUALIFICATIONS

Administrative staff category membership shall be held by any physician who is not otherwise eligible for another staff category and who is retained by the hospital or medical staff solely to perform ongoing medical administrative activities.

The administrative staff shall consist of members who:

(a) are charged with assisting the medical staff in carrying out medical-administrative functions, including but not limited to quality assessment and improvement and utilization review;

(b) document their (1) current licensure, (2) adequate experience, education and training, (3) current professional competence, (4) good judgment, and (5) current physical and mental health status, so as to demonstrate to the satisfaction of the medical staff that they are professionally and ethically competent to exercise their duties;

(c) are determined (1) to adhere to the ethics of their respective professions, (2) to be able to work cooperatively with others so as not to adversely affect their judgment in carrying out quality assessment and improvement functions, and (3) to be willing to participate in and properly discharge those responsibilities determined by the medical staff.

3.8-2 PREROGATIVES

The administrative staff shall be entitled to:

Attend meetings of the medical staff and various departments, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except to the extent the right to vote is specified at the time of appointment.

Administrative staff members shall not be eligible to hold office in the medical staff organization, admit patients or exercise clinical privileges.

## 3.9 LIMITATION OF PREROGATIVES

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

## 3.10 GENERAL EXCEPTIONS TO PREROGATIVES

Regardless of the category of membership in the medical staff, limited license members:

(a) shall only have the right to vote on matters within the scope of their licensure. In the event of a dispute over voting rights, that issue shall be determined by the chair of the meeting, subject to final decision by the medical executive committee; and

(b) shall exercise clinical privileges only within the scope of their licensure and as set forth in Section 5.4.

## 3.11 MODIFICATION OF MEMBERSHIP

On its own, upon recommendation of the credentials committee, or pursuant to a request by a member under Section 4.6-1(b), or upon direction of the governing board as set forth in Section 6.2-6, the medical executive committee may recommend a change in the medical staff category of a member consistent with the requirements of the bylaws.

## ARTICLE IV: APPOINTMENT AND REAPPOINTMENT

(Including Telemedicine Services)

### 4.1 GENERAL

Except as otherwise specified herein, no person (including persons engaged by the hospital in administratively responsible positions) shall exercise clinical privileges in the hospital or via telemedicine link unless and until that person applies for and receives appointment to the medical staff is granted privileges as set forth in these bylaws, or, with respect to allied health practitioners, has been granted a service authorization or privileges under applicable medical staff policies. By applying to the medical staff for appointment or reappointment (or, in the case of members of the honorary staff, by accepting an appointment to that category), the applicant acknowledges responsibility to first review these bylaws and medical staff rules, regulations and policies, and agrees that throughout any period of membership that person will comply with the responsibilities of medical staff membership and with the bylaws, rules and regulations and policies of the medical staff as they exist and as they may be modified from time to time. Appointment to the medical staff shall confer on the appointee only such clinical privileges as have been granted in accordance with these bylaws.

### 4.2 BURDEN OF PRODUCING INFORMATION

In connection with all applications for appointment, reappointment, advancement, or transfer, the applicant shall have the burden of producing information for an adequate evaluation of the applicant's qualifications and suitability for the clinical privileges and staff category requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information. The applicant's failure to sustain this burden shall be grounds for denial of the application. To the extent consistent with law, this burden may include submission to a medical or psychological examination, at the applicant's expense, if deemed appropriate by the medical executive committee which may select the examining physician. The applicant may select the examining physician from an outside panel of three physicians chosen by the medical executive committee.

### 4.3 APPOINTMENT AUTHORITY

Appointments, denials and revocations of appointments to the medical staff shall be made as set forth in these bylaws, but only after there has been a recommendation from the medical staff, or as set forth in Section 6.2-6.

### 4.4 DURATION OF APPOINTMENT AND REAPPOINTMENT

Except as otherwise provided in these bylaws, initial appointments to the medical staff shall be for a period of up to two years. Reappointments shall be for a period of up to two medical staff years.

### 4.5 APPLICATION FOR INITIAL APPOINTMENT AND REAPPOINTMENT

#### 4.5-1 APPLICATION FORM

An application form shall be developed by the medical executive committee. The form shall require detailed information which shall include, but not be limited to, information concerning:

(a) the applicant's qualifications, including, but not limited to, professional education, training and experience, current licensure, current DEA registration (if applicable), and continuing medical education information related to the clinical privileges to be exercised by the applicant;

(b) professional peer references familiar with the applicant's current professional competence and ethical character;

(c) requests for membership categories, departments, and clinical privileges;

(d) past or pending professional disciplinary action, voluntary or involuntary denial, revocation, suspension, reduction or relinquishment of medical staff membership or privileges or any licensure or registration, and related matters;

(e) current physical and mental health status, to the extent necessary to determine the applicant's ability to perform obligations or requested privileges, or as otherwise permitted by law;

(f) final judgments, settlements, or arbitration awards made against the applicant in professional liability cases, and any filed and served cases pending;

(g) maintain in force professional liability coverage, in not less than the minimum amounts, if any, as from time to time may be jointly determined by the medical executive committee and governing board; and

(h) any past, pending or current exclusion of suspension from a state or federal health care program, or any investigation or disciplinary action by any governmental agency relating to the applicant's professional license or practice.

Each application for initial appointment to the medical staff shall be in writing or via online submission, submitted on the prescribed form with all provisions completed (or accompanied by an explanation of why answers are unavailable), and signed by the applicant. When an applicant requests an application, that person shall be given a copy of these bylaws, the medical staff rules and regulations, and, as deemed appropriate by the medical executive committee, copies or summaries of any other applicable medical staff policies relating to clinical practice in the hospital. Failure to disclose the information requested in the application for initial appointment or reappointment, or knowingly providing false or misleading information may result in disciplinary action, including suspension or termination of membership or privileges, or in a decision that the application does not qualify for credentialing consideration.

4.5-2 EFFECT OF APPLICATION

In addition to the matters set forth in Section 4.1, by applying for appointment to the medical staff each applicant:

(a) signifies willingness to appear for interviews in regard to the application;

(b) authorizes consultation with others who have been associated with the applicant and who may have information bearing on the applicant's competence, qualifications and performance, and authorizes such individuals and organizations to candidly provide all such information;

(c) consents to inspection of records and documents that may be material to an evaluation of the applicant's qualifications and ability to carry out clinical privileges requested, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying;

(d) releases from any liability, to the fullest extent provided by law, all persons for their acts performed in connection with investigating and evaluating the applicant;

(e) releases from any liability, to the fullest extent provided by law, all individuals and organizations who provide information regarding the applicant, including otherwise confidential information;

(f) 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;

(g) if a requirement then exists for medical staff dues, acknowledges responsibility for timely payment;

(h) agrees to provide for continuous quality care for patients;

(i) pledges to maintain an ethical practice, including refraining from illegal inducements for patient referral, providing for the continuous care of the applicant's patients, 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 and allied health practitioners;

(j) pledges to be bound by the medical staff bylaws, rules and regulations, and policies; and

(k) agrees that if membership and privileges are granted, and for the duration of medical staff membership, the member has an ongoing and continuous duty to report to the medical staff office within thirty (30) days any and all information that would otherwise correct, change, modify or add to any information provided in the application or most recent reapplication.

4.5-3 VERIFICATION OF INFORMATION

The applicant shall deliver a completely filled-in, signed, and dated application and supporting documents to the appropriate medical staff officer and an advance payment of medical staff dues or fees, if any is required. The administrator shall be notified of the application. The application and all supporting materials then available shall be transmitted to the chair of each department in which the applicant seeks privileges and to the credentials committee. The credentials committee, and the administrator when requested to assist by the credentials committee, shall expeditiously seek to collect or verify the references, licensure status, and other evidence submitted in support of the application. The hospital's authorized representative shall query the National Practitioner Data Bank regarding the applicant or member and submit any resulting information to the credentials committee for inclusion in the applicant's or member's credentials file. The applicant shall be notified of any problems in obtaining the information required, and it shall be the applicant's obligation to obtain any reasonably requested information. Failure to provide any requested information within thirty (30) days of a request shall be deemed a voluntary withdrawal of the application. When collection and verification of information is accomplished, all such information shall be transmitted to the credentials committee and the appropriate department(s). No final action on an application may be taken until receipt of the Data Bank report.

4.5-4 DEPARTMENT ACTION

After receipt of the application, the chair or appropriate committee of each department to which the application is submitted, shall review the application and supporting documentation, may seek additional information, and may conduct a personal interview with the applicant at the chair's or committee's discretion. The chair or appropriate committee shall evaluate all matters deemed relevant to a recommendation, including information concerning the applicant's provision of services within the scope of privileges granted, his/her clinical and technical skills and any relevant data available from hospital performance improvement activities, and the re-applicant's participation in relevant continuing education and shall transmit to the credentials committee a written report and recommendation as to appointment and, if appointment is recommended, as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached. The chair may also request that the medical executive committee defer action on the application.

4.5-5 CREDENTIALS COMMITTEE ACTION

The credentials committee shall review the application, evaluate and verify the supporting documentation, the department chair's report and recommendations, and other relevant information. The credentials committee may elect to interview the applicant and seek additional information. As soon as practicable, the credentials committee shall transmit to the medical executive committee a written report and its recommendations as to appointment and, if appointment is recommended, as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. The committee may also recommend that the medical executive committee defer action on the application.

4.5-6 MEDICAL EXECUTIVE COMMITTEE ACTION

At its next regular meeting after receipt of the credentials committee report and recommendation, or as soon thereafter as is practicable, the medical executive committee shall consider the report and any other relevant information. The medical executive committee may request additional information, return the matter to the credentials committee for further investigation, and/or elect to interview the applicant. The medical executive committee shall immediately forward to the administrator, for prompt transmittal to the governing board, or in cases eligible for expedited processing, the committee duly appointed by the board to handle expedited cases, a written report and recommendation as to medical staff appointment and, if

appointment is recommended, as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. The committee may also defer action on the application. The reasons for each recommendation shall be stated.

4.5-7 EFFECT OF MEDICAL EXECUTIVE COMMITTEE ACTION

(a) Favorable Recommendation: When the recommendation of the medical executive committee is favorable to the applicant, it shall be immediately forwarded, together with supporting documentation, to the governing board or, in cases eligible for expedited processing, applicable committee duly appointed by the board to handle expedited cases.

(b) Adverse Recommendation: When a final recommendation of the medical executive committee is adverse to the applicant, the governing board and the applicant shall be promptly informed by written notice. The applicant shall then be entitled to procedural rights as provided in Article VII.

4.5-8 ACTION ON THE APPLICATION

The governing board or, in cases eligible for expedited processing, the duly appointed committee of the board, may accept the recommendation of the medical executive committee or may refer the matter back to the medical executive committee for further consideration, stating the purpose for such referral and setting a reasonable time limit for making a subsequent recommendation. If, after referring a matter back to the medical executive committee, the governing board and medical executive committee continue to disagree regarding the action to be taken, the matter shall be referred to the Ad Hoc Dispute Mediation Committee. The following procedures shall apply with respect to action on the application:

(a) If the medical executive committee issues a favorable recommendation, the governing board or its duly appointed committee in cases eligible for expedited processing shall affirm the recommendation of the medical executive committee unless the governing board concludes that the medical staff has failed to fulfill a substantive duty or responsibility in matters pertaining to the quality of care.

(1) If the governing board concurs in that recommendation, the decision of the board shall be deemed final action.

(2) If the tentative final action of the governing board is unfavorable, the administrator shall give the applicant written notice of the tentative adverse recommendation and the applicant shall be entitled to the procedural rights set forth in Article VII. If procedural rights are waived by the applicant, the decision of the governing board shall be deemed final action.

(3) In cases eligible for expedited processing, if the duly appointed committee of the board and the board concur in that recommendation, the positive decision shall be ratified by the governing board at its next regularly scheduled meeting. The ratification by the board shall be deemed final. If the committee's decision is adverse to the applicant, or the board fails to ratify the committee's decision, the matter shall be referred back to the medical executive committee for evaluation.

(b) In the event the recommendation of the medical executive committee, or any significant part of it, is unfavorable to the applicant the procedural rights set forth in Article VII shall apply.

(1) If procedural rights are waived by the applicant, the recommendations of the medical executive committee shall be forwarded to the governing board for final action.

(2) If the applicant requests a hearing following the adverse medical executive committee recommendation pursuant to Section 4.5-8(b) or an adverse governing board tentative final action pursuant to 4.5-8(a) (2), the governing board shall take final action only after the applicant has exhausted all procedural rights as established by Article VII. After exhaustion of the procedures set forth in Article VII, the board shall make a final

decision. The board's decision shall be in writing and shall specify the reasons for the action taken.

(c) Applicants are ineligible for expedited processing if, at the time of appointment, any of the following has occurred:

(1) The applicant submits an incomplete application.

(2) The medical executive committee makes a final recommendation that is adverse or with limitation.

(3) There is a current challenge or previously successful challenge to licensure.

(4) The applicant has received an involuntary termination of medical staff membership at another organization.

(5) The applicant has received involuntary limitation, reduction, denial, or loss of medical privileges.

(6) There has been either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment adverse to the applicant.

4.5-9 NOTICE OF FINAL DECISION

(a) Notice of the final decision shall be given to the chief of staff, the medical executive and the credentials committees, the chair of each department concerned, the applicant, and the administrator.

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

4.5-10 REAPPLICATION AFTER ADVERSE APPOINTMENT DECISION

An applicant who has received a final adverse decision regarding appointment shall not be eligible to reapply to the medical staff for a period of two years. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as may be required to demonstrate that the basis for the earlier adverse action no longer exists.

4.5-11 TIMELY PROCESSING OF APPLICATIONS

Applications for staff appointments shall be considered in a timely manner by all persons and committees required by these bylaws to act thereon. While special or unusual circumstances 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: 90 days from receipt of all necessary documentation;

(b) review and recommendation by department(s): 45 days after receipt of all necessary documentation from the medical staff office;

(c) review and recommendation by credentials committee: 45 days after receipt of all necessary documentation from the department(s);

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

(e) final action: 90 days after receipt of all necessary documentation by the medical staff office.

## 4.6 REAPPOINTMENT AND REQUESTS FOR MODIFICATIONS OF STAFF STATUS OR PRIVILEGES

4.6-1 APPLICATION

(a) At least 4 months prior to the expiration date of the current staff appointment (except for temporary appointments), a reapplication form developed by the medical executive committee shall be mailed or otherwise delivered to the member. If an application for reappointment is not received at least 60 days prior to the expiration date, written notice shall be promptly sent to the applicant advising that the application has not been received. At least 30 days prior to the expiration date, each medical staff member shall submit to the credentials committee the completed application form for renewal of appointment to the staff, and for renewal or modification of clinical privileges. The reapplication form shall include all information necessary to update and evaluate the qualifications of the applicant including, but not limited to, the matters set forth in Section 4.5-1, as well as other relevant matters. Upon receipt of the application, the information shall be processed as set forth commencing at Section 4.5-3.

(b) A medical staff member who seeks a change in medical staff status or modification of clinical privileges may submit such a request at any time upon a form developed by the medical executive committee, except that such application may not be filed within 6 months that a similar request has been denied.

4.6-2 EFFECT OF APPLICATION

The effect of an application for reappointment or modification of staff status or privileges is the same as that set forth in Section 4.5-2.

4.6-3 STANDARDS AND PROCEDURE FOR REVIEW

When a staff member submits an application for reappointment, or when the member submits an application for modification of staff status or clinical privileges, the member shall be subject to an in-depth review generally following the procedures set forth in Sections 4.5-3 through 4.5 11.

4.6-4 FAILURE TO FILE REAPPOINTMENT APPLICATION

Failure without good cause to timely file a completed application for reappointment shall result in the automatic termination of the member's admitting privileges and expiration of other practice privileges and prerogatives at the end of the current staff appointment. A reappointment application received past the due date or following such termination shall be processed in the manner specified for applications for initial appointment. In the event membership terminates for the reasons set forth herein, the procedures set forth in Article VII shall not apply.

## 4.7 LEAVE OF ABSENCE

4.7-1 LEAVE STATUS

At the discretion of the medical executive committee, a medical staff member may obtain a voluntary leave of absence from the staff upon submitting a written request to the medical executive committee stating the approximate period of leave desired, which may not exceed one year. During the period of the leave, the member shall not exercise clinical privileges at the hospital, and membership rights and responsibilities shall be inactive, but the obligation to pay dues, if any, shall continue, unless waived by the medical staff.

4.7-2 TERMINATION OF LEAVE

At least 30 days prior to the termination of the leave of absence, or at any earlier time, the medical staff member may request reinstatement of privileges by submitting a written notice to that effect to the medical executive committee. The staff member shall submit a summary of activities during the leave. The medical executive committee shall make a recommendation concerning the reinstatement of the member's privileges and prerogatives, and the procedure provided in Sections 4.1 through 4.5-11 shall be followed. Reinstatement may be granted subject to monitoring and/or proctoring as determined by the medical executive committee.

4.7-3 FAILURE TO REQUEST REINSTATEMENT

Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the medical staff and shall result in automatic termination of membership, privileges, and prerogatives. A member whose membership is automatically terminated shall be entitled to submit a written statement to the medical executive committee on his/her behalf regarding whether the failure to request reinstatement was unintentional or excusable, or otherwise. A request for medical staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

4.7-4 MEDICAL LEAVE OF ABSENCE

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

4.7-5 MILITARY LEAVE OF ABSENCE

Requests for leave of absence to fulfill military service obligations shall be granted upon notice and review by the medical executive committee. Reactivation of membership and clinical privileges previously held shall be granted, notwithstanding the provisions of Sections 4.7-2 and 4.7-3, but may be granted subject to monitoring and/or proctoring as determined by the medical executive committee.

## 4.8 CREDENTIALING OF TELEHEALTH PROVIDERS

4.8-1 "Telehealth" or "Telemedicine" means the mode of delivering health care services and information via communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the "originating site" and the health care provider is at a "distant site." Telehealth includes synchronous interactions and asynchronous store and forward transfers.

4.8-2 The Medical Executive Committee and Governing Board may identify health care services or procedures which may be performed at the Hospital and may identify categories of Telehealth Providers entitled to request Telehealth privileges.

4.8-3 The Hospital and the Medical Staff may enter into written agreements with other hospitals or with Telemedicine Entities in accordance with state and federal law in order to permit the Medical Staff to rely on credentialing information provided by such contracted entities. Notwithstanding, such contract arrangements the Medical Staff shall independently verify the California professional licensure status of all providers requesting Telehealth privileges and shall independently query the National Practitioner Data Bank and the applicable state licensure board in relation to all such applicants.

4.8-4 The following process will be used to credential and recommend privileges for Telehealth Providers:

(a) The Medical Executive Committee may approve a list of qualifications and information to be verified for Telehealth Providers in each approved Telehealth category.

(b) To be considered for privileges, each Telehealth Provider must agree, in writing, to comply with Hospital and Medical Staff policies, including policies relating to confidentiality of patient and peer review information, applicable to the Provider's practice.

(c) If an agreement is in effect as provided by Section 4.8-3, above, the Chair of the applicable Clinical Department shall review a certified summary of the qualifications of each proposed Telehealth Provider provided by the remote hospital or Telemedicine Entity, together with evidence of current California licensure and reports from the applicable licensing board and National Practitioner Data Bank, if available.

(d) Following such review and any additional investigation the Department Chair may consider necessary, the Department Chair shall submit a written report and recommendation on each proposed Telehealth Provider to the Credentials Committee.

(e) The Credentials Committee shall review the application, evaluate and verify the supporting documentation, the Department Chair's report and recommendations, and any additional investigation that the Credentials Committee may consider necessary.

(f) Following such review, the Credentials Committee shall submit a written report and recommendation on each proposed Telehealth Provider to the Medical Executive Committee.

(g) The Medical Executive Committee shall consider the reports of the Department Chair and Credentials Committee and may direct any further investigation as it deems appropriate.

(h) The provisions of Sections 4.5-3 through 4.5-11 shall be followed, as applicable.

(i) Telehealth Providers may be initially appointed for up to two years and may be considered for reappointments following the procedures provided in this Section 4.8.

(j) Each Telehealth Provider shall be subject to Ongoing Professional Practice Evaluation and Focused Professional Practice Evaluation by the Chair of the applicable Clinical Department and the Medical Executive Committee in accordance with such process as they may consider proper. The Chair of the Clinical Department shall consider information pertaining to a Telehealth Practitioner from the remote hospital or Telemedicine Entity.

(k) Telehealth Providers shall not be entitled to vote in department, committee or Medical Staff meetings or serve on committees or hold office in the Medical Staff.

(l) A Telehealth Provider's Medical Staff membership and privileges may be terminated without cause upon 30 days written notice by either the Hospital or the Medical Staff and shall be automatically terminated if the agreement specified in Section 4.8-3 expires or is terminated. If a Telehealth Provider is subject to action based on medical disciplinary cause or reason which would entitle him to notice and hearing rights under California law, the provider shall be afforded the rights specified in Article VII.

## ARTICLE V: CLINICAL PRIVILEGES

### 5.1 EXERCISE OF PRIVILEGES

Except as otherwise provided in these bylaws, a member providing clinical services at this hospital shall be entitled to exercise only those clinical privileges specifically granted. Said privileges and services must be hospital specific, within the scope of any license, certificate or other legal credential authorizing practice in this state and consistent with any restrictions thereon, and shall be subject to the rules and regulations of the clinical department and the authority of the department chair and the medical staff. Medical staff privileges may be granted, continued, modified or terminated by the governing board only upon recommendation of the medical staff, only for reasons directly related to quality of patient care and other provisions of the medical staff bylaws,, and only following the procedures outlined in these bylaws.

### 5.2 DELINEATION OF PRIVILEGES IN GENERAL

5.2-1 REQUESTS

Each application for appointment and reappointment to the medical staff must contain a request for the specific clinical privileges desired by the applicant. A request by a member for a modification of clinical privileges may be made at any time, but such requests must be supported by documentation of training and/or experience supportive of the request.

5.2-2 BASES FOR PRIVILEGES DETERMINATION

(a) Requests for clinical privileges shall be evaluated on the basis of the member's education, training, experience, current demonstrated professional competence and judgment, clinical performance, current health status, and the documented results of patient care and other quality review and monitoring which the medical staff deems appropriate. Privilege determinations may also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a member exercises clinical privileges.

(b) No specific privilege may be granted to a member if the task, procedure or activity constituting the privilege is not available within the hospital despite the member's qualifications or ability to perform the requested privilege.

5.2-3 CRITERIA FOR "CROSS-SPECIALTY" OR NEW PRIVILEGES WITHIN THE HOSPITAL

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

### 5.3 PROCTORING (FPPE)

5.3-1 GENERAL PROVISIONS

Except as otherwise determined by the medical executive committee, all initial appointees to the medical staff and all members granted new clinical privileges shall be subject to a period of proctoring as further described in the Medical Staff's Peer Review Policy. Each appointee or recipient of new clinical privileges shall be assigned to a department where performance on an appropriate number of cases as established by the medical executive committee, or the department as designee of the medical executive committee, shall be observed and/or evaluated by the chair of the department, or the chair's designee, during the period of proctoring specified in the department's rules and regulations, to determine suitability to continue to exercise the clinical privileges granted in that department. The exercise of

clinical privileges in any other department shall also be subject to direct observation by that department's chair or the chair's designee. The member shall remain subject to such proctoring until the medical executive committee has been furnished with:

(a) a report signed by the chair of the department(s) to which the member is assigned describing the types and numbers of cases observed and the evaluation of the applicant's performance, a statement that the applicant appears to meet all of the qualifications for unsupervised practice in that department, has discharged all of the responsibilities of staff membership, and has not exceeded or abused the prerogatives of the category to which the appointment was made; and

(b) a report signed by the chair of the other department(s) 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 in those departments.

5.3-2 COMPLETION OF PROCTORING/ADVANCEMENT

The failure to complete proctoring for any specific privilege shall not, by itself, preclude advancement from provisional staff. If advancement is approved prior to completion of proctoring, such advancement shall be subject to completion of the requisite proctoring of the specified privileges within a specified time frame. If proctoring is then not completed within the specified time, the privileges, and membership if all privileges are impacted, may be terminated. Such termination shall not give rise to the procedural rights in Article VII.

If a member fails to perform satisfactorily during proctoring, the member's membership may be terminated or the relevant privileges revoked. In this instance, the member shall be afforded the procedural rights in Article VII.

## 5.4 CONDITIONS FOR PRIVILEGES OF LIMITED LICENSE PRACTITIONERS

5.4-1 ADMISSIONS

(a) Except as provided by subdivision (b), when dentists and oral surgeons, podiatrists, or clinical psychologists who are members of the medical staff admit patients, a physician member of the medical staff must conduct and document or directly supervise the admitting history and physical examination (except the portion related to dentistry, podiatry, or clinical psychology), and assume responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside of the limited license practitioner's lawful scope of practice.

(b) Oral and maxillofacial surgeons who have successfully completed a postgraduate program in oral and maxillofacial surgery accredited by a nationally recognized accrediting body approved by the U.S. Office of Education and have been determined by the medical staff to be competent to do so, may perform a history and physical examination and determine the ability of their patient to undergo surgical procedures the oral and maxillofacial surgeon proposes to perform. Completion of a history and physical by a qualified oral and maxillofacial surgeon under this subsection (b) shall satisfy the appraisal portion of the requirements of Section 5.4-3, below. For patients with existing medical conditions or abnormal findings beyond the surgical indications, a physician member of the medical staff must conduct or directly supervise the admitting history and physical examination, except the portion related to oral and maxillofacial surgery, and assume responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside of the oral and maxillofacial surgeon's lawful scope of practice.

Podiatrists shall be permitted to perform full-body history and physical examinations of their patients within the scope of their licensure as determined by the state Board of Podiatric Medicine, and as permitted under state and federal laws.

5.4-2 SURGERY

Surgical procedures performed by dentists and podiatrists shall be under the overall supervision of the chair of the department of surgery or the chair's designee.

5.4-3 MEDICAL APPRAISAL

All patients admitted for care in a hospital by a dentist or oral and maxillofacial surgeon, or clinical psychologist shall receive the same basic medical appraisal as patients admitted to other services, and the dentists or oral and maxillofacial surgeons, or clinical psychologists shall seek consultation with a physician member to determine the patient's medical status and need for medical evaluation whenever the patient's clinical status indicates the presence of a medical problem. Podiatrists shall be permitted to perform full-body history and physical examinations of their patients within the scope of their licensure as determined by the state Board of Podiatric Medicine, and as permitted under state and federal laws. Where a dispute exists regarding proposed treatment between a physician member and a limited license practitioner based upon medical or surgical factors outside of the scope of licensure of the limited license practitioner, the treatment will be suspended insofar as possible while the dispute is resolved by the appropriate department(s).

## 5.5 TEMPORARY CLINICAL PRIVILEGES

Temporary 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.

5.5-1 PATIENT CARE NEEDS

(a) Care of Specific Patient

Temporary clinical privileges may be granted where good cause exists to a physician, dentist, podiatrist or clinical psychologist to provide care to a specific patient (but not more than 90 days during a calendar year) provided that the procedure described in Section 5.5-4(a)(1) has been completed.

(b) Locum Tenens

Temporary clinical privileges may be granted to a person serving as a locum tenens for a current member of the medical staff to meet the care needs of that member's patients in his/her absence, provided that the procedure described in Section 5.5-4(a)(1) has been completed. Such person may attend only patients of the member(s) for whom that person is providing coverage, for a period not to exceed 90 days, unless the medical executive committee recommends a longer period for good cause.

(c) Other Important Patient Care Needs

Temporary clinical privileges may be granted to allow a physician, dentist, podiatrist or clinical psychologist to fulfill an important patient care, treatment, or service need (but not more than 90 days during a calendar year) provided that the procedure described in Section 5.5-4(a)(1) has been completed.

5.5-2 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 and awaiting review and approval of the medical executive committee or the governing board, provided that the procedure described in Section 5.5-4(a)(2) has been completed, the application is complete, 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. Such temporary privileges shall not exceed 90 days.

5.5-3 TEMPORARY MEMBERSHIP AND TEMPORARY PRIVILEGES NOT CO-EXTENSIVE

Temporary members of the medical staff pursuant to Section 6.1-3 are not, by virtue of such membership, granted temporary clinical privileges.

5.5-4 APPLICATION AND REVIEW

Upon receipt of a completed application and supporting documentation from a physician, dentist, podiatrist, or clinical psychologist authorized to practice in California, the chief medical officer or designee of the governing board, and on the recommendation of either the applicable clinical department chairperson or the chief of staff, may grant temporary privileges to a member who appears to have qualifications, ability and judgment consistent with Section 2.2-1, but only:

(1) With respect to applications by a locum tenens, or to fulfill an important patient care need, after verification of current licensure and current competence; or

(2) With respect to a new applicant awaiting review and approval of the medical staff executive committee and the governing board in compliance with the requirements in Section 5.5-2, after the following has been completed:

(a) the National Practitioner Data Bank report regarding the applicant for temporary privileges has been received and evaluated and current California licensure, relevant training and experience, current competence, ability to perform the privileges requested, and other criteria set forth in the policy for granting temporary privileges.

(b) the appropriate department chair has interviewed the applicant and has contacted at least one person who

(i) has recently worked with the applicant;

(ii) has directly observed the applicant's professional performance over a reasonable time; and

(iii) provides reliable information regarding the applicant's current professional competence to perform the privileges requested, ethical character, and ability to work well with others so as not to adversely affect patient care, or other criteria required by medical staff bylaws.

(c) the applicant's file has been recommended for approval by the applicable department(s) and by the credentials committee.

(d) the medical executive committee through the chief of staff, after reviewing the applicant's file and attached materials, recommends granting temporary privileges.

In the event of a disagreement between the chief executive officer or his or her designee and the medical executive committee regarding the granting of temporary clinical privileges, the matter shall be resolved as set forth in Section 4.5 8.

5.5-5 GENERAL CONDITIONS

(a) If granted temporary privileges, the applicant shall act under the supervision of the department chair to which the applicant has been assigned, and shall ensure that the chair, or the chair's designee, is kept closely informed as to the applicant's activities within the hospital.

(b) Temporary privileges shall automatically terminate at the end of the designated period, unless earlier terminated or suspended under Articles VI and/or VII of these bylaws or unless affirmatively renewed following the procedure as set forth in Section 5.5-4. A medical staff applicant's temporary privileges shall automatically terminate if the applicant's initial application is withdrawn. As necessary, the appropriate department chair or, in the chair's absence, the chair of the medical executive committee, shall assign a member of the medical staff to assume responsibility for the care of such member's patient(s). The wishes of the patient shall be considered in the choice of a replacement medical staff member.

(c) Requirements for proctoring and monitoring, including but not limited to those in Section 5.3, shall be imposed on such terms as may be appropriate under the circumstances upon any member

granted temporary privileges by the chief of staff after consultation with the departmental chair or the chair's designee.

(d) All persons requesting or receiving temporary privileges shall be bound by the bylaws and rules and regulations of the medical staff.

## 5.6 EMERGENCY PRIVILEGES

(a) In the case of an emergency involving a particular patient, any member of the medical staff with clinical privileges, to the degree permitted by the scope of the applicant's license and regardless of department, staff status, or clinical privileges, shall be permitted to do everything reasonably possible to save the life of the patient or to save the patient from serious harm provided that the care provided is within the scope of the individual's license. The member shall make every reasonable effort to communicate promptly with the department chair concerning the need for emergency care and assistance by members of the medical staff with appropriate clinical privileges, and once the emergency has passed or assistance has been made available, shall defer to the department chair with respect to further care of the patient at the hospital.

(b) In the event of an emergency under subsection (a), any person shall be permitted to do whatever is reasonably possible to save the life of a patient or to save a patient from serious harm. Such persons shall promptly yield such care to qualified members of the medical staff when it becomes reasonably available.

## 5.7 DISASTER PRIVILEGES

(a) In the case of a disaster in which the disaster plan has been activated and the hospital is unable to handle the immediate patient needs, the chief of staff, or in the absence of the chief of staff, the vice-chief of staff, may grant disaster privileges. In the absence of the chief of staff and vice-chief of staff and department chair(s), the administrator or the administrator'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. Prior to any grant of disaster privileges, the volunteer shall be required to produce a valid government-issued photo identification (e.g., driver's license or passport) and at least one of the following:

i. a current picture hospital I.D. card (identifying professional discipline);

ii. a current license to practice;

iii. primary source verification of licensure;

iv. identification indicating that the individual is a member of a Disaster Medical Assistance Team, the Medical Reserve Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, or other recognized state or federal response organization or group;

v. identification indicating that the individual has been granted authority, by a federal, state or municipal entity, to render patient care in emergency circumstances; or

vi. documented confirmation by a current medical staff member with personal knowledge regarding the practitioner's ability to act as a licensed independent practitioner during a disaster.

If possible, copies of these documents should be made. If it is not possible to make copies, the identification information, including full name, address, license number, issuing agency, etc., shall be recorded on the application for Disaster Privileges

(b) The volunteer shall be required to complete the Application for Disaster Privileges Form, indicating his/her malpractice carrier and the name of the hospital(s) where he/she currently holds privileges, and such other information as required by the Form. The volunteer shall also sign the Consent, Acknowledgment and Release of Information Form, permitting verification of credentials and agreeing to abide by the bylaws, rules and regulations. A copy of the bylaws, rules and regulations shall be made available to the volunteer.

(c) If possible, verification of licensure, insurance and hospital affiliations shall be made by telephone or electronic query. A query to the NPDB and OIG shall also be submitted, unless technically not possible. In the event this information cannot be verified prior to approval, such Disaster Privileges may still be granted pending later verification. Primary source verification of licensure shall begin as soon as the immediate situation is under control, and is initiated within 72 hours from the time the volunteer presents to the organization. In the extraordinary circumstance that primary source verification cannot be completed in 72 hours, it will be completed as soon as possible. In such instance, there must be documentation of: 1) why the primary source verification could not be performed in the required time frame; 2) evidence of demonstrated ability to continue to provide adequate care, treatment and services; and 3) an attempt to complete the verification as soon as possible.

(d) The available information shall be reviewed by the individual(s) authorized to grant Disaster Privileges. The on-site responsible member (i.e., in accordance with the hospital's emergency management plan, e.g., emergency department physician) shall interview the volunteer to determine the appropriate scope of assigned responsibilities.

(e) The volunteer shall be partnered with a member of similar specialty if possible. Identification of the partnering information shall be recorded with the other information regarding the volunteer.

(f) The volunteer shall be issued a temporary identification badge indicating his/her name, status as an approved volunteer, and notation of his/her partner.

(g) Within 72 hours following the initial Disaster Privileges, based on the information obtained during the verification process and during observation of the volunteer, the individual(s) authorized to grant Disaster Privileges shall make a determination as to whether the privileges shall continue.

(h) Any such Disaster Privileges may be terminated at any time, with or without cause or reason, and any such termination shall not give rise to any rights of review, hearing, appeal or other grievance mechanism. Disaster Privileges shall be terminated immediately if any information is received that suggests the volunteer is not capable of rendering services as approved.

## 5.8 MODIFICATION OF CLINICAL PRIVILEGES OR DEPARTMENT ASSIGNMENT

On its own, upon recommendation of the credentials committee, or pursuant to a request under Section 4.6-1(b), the medical executive committee may recommend a change in the clinical privileges or department assignment(s) of a member. The medical executive committee may also recommend that the granting of additional privileges to a current medical staff member be made subject to monitoring in accordance with procedures similar to those outlined in Section 5.3-1.

## 5.9 LAPSE OF APPLICATION

If a medical staff member requesting a modification of clinical privileges or department assignments fails to timely furnish the information reasonably necessary to evaluate the request, the application shall automatically lapse, and the applicant shall not be entitled to a hearing as set forth in Article VII.

## ARTICLE VI: PEER REVIEW AND CORRECTIVE ACTION

### 6.1 PEER REVIEW

The medical staff committees and/or departments are responsible for carrying out delegated review and quality improvement functions in accordance with the medical staff's peer review policy. Such peer review activities include, but are not limited to, quality improvement, utilization review, on-going professional practice evaluation (the evaluation of quality data, privilege volume data, and individual case reviews), focused professional practice evaluation (including individual monitoring, proctoring, and focused reviews), and other review and evaluation activities. Peer review activities are designed to include evaluation of all practitioners in accordance with the general competencies of patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and system-based practice, as further described in the medical staff's peer review policy. They may counsel, educate, refer for education or evaluation, 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) in the course of carrying out their duties without initiating formal corrective action proceedings. Comments, suggestions and warnings may be issued orally or in writing. The practitioner shall be given an opportunity to respond in writing and may be given an opportunity to meet with the committee or department. 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. This shall not be construed to confer any rights upon a practitioner to any routine monitoring and education prior to corrective action. These actions shall not constitute a restriction of privileges or grounds for any formal hearing or appeal rights under Article VII.

### 6.2 CORRECTIVE ACTION

#### 6.2-1 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 hospital; (2) unethical; (3) contrary to the medical staff bylaws and rules or regulations; or (4) below applicable professional standards, a request for an investigation or action against such member may be initiated by the chief of staff, a department chair, or the medical executive committee.

#### 6.2-2 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.

#### 6.2-3 INVESTIGATION

If the medical executive committee concludes 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. The medical executive committee in its discretion may appoint practitioners who are not members of the medical staff as temporary members of the medical staff for the sole purpose of serving on a standing or ad hoc committee, should circumstances warrant. If the investigation is delegated to an officer of 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 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 in Article VII, nor shall the procedural rules with respect to hearings 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.

6.2-4 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:

(a) determining no corrective action be taken and, if the executive committee determines there was no credible evidence for the complaint in the first instance, removing any adverse information from the member's file;

(b) referring the member to the Physician Well-Being Committee for evaluation and follow-up as appropriate;

(c) deferring action for a reasonable time where circumstances warrant;

(d) issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude committees or departments or their chairs 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;

(e) 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-admission, mandatory consultation, or monitoring;

(f) recommending reduction, modification, suspension or revocation of clinical privileges;

(g) recommending reductions of membership status or limitation of any prerogatives directly related to the member's delivery of patient care;

(h) recommending suspension, revocation or probation of medical staff membership; and

(i) taking other actions deemed appropriate under the circumstances.

6.2-5 SUBSEQUENT ACTION

(a) If corrective action as set forth in Section 7.2 is recommended by the medical executive committee, that recommendation shall be transmitted to the governing board.

(b) The recommendation of the medical executive committee shall be the final action of the medical staff unless the member requests a hearing, in which case the final decision shall be determined as set forth in Article VII.

6.2-6 INITIATION BY THE GOVERNING BOARD

If the medical executive committee fails to investigate or take disciplinary action in response to information about a member's competence, performance, or conduct that is provided in accordance with the provisions of this Article VI, and if the governing board determines that the medical executive committee's failure to proceed is contrary to the weight of the evidence, the governing board may direct the medical executive committee to initiate investigation or disciplinary action, but only after consultation with the medical executive committee. The board's request for medical staff action shall be in writing and shall set forth the basis for the request. If the medical executive committee fails to take action in response to such direction from the governing board, then the board may initiate the ad hoc dispute mediation process set forth in Article XI of these bylaws (unless immediate action is required to protect the health or safety or any individual, in which event the procedures for summary suspension shall apply). If the dispute mediation process does not result in action by the medical executive committee, and the governing board still believes action is necessary, then the governing board may initiate an investigation or corrective action. However, the governing board shall not initiate an investigation or corrective action under this section unless it has documented a reasonable and good faith belief that the medical staff has failed or declined to fulfill a substantive duty or responsibility pertaining to the quality or delivery of

patient care. In addition, any investigation or corrective action by the governing board shall only be taken after written notice to the medical executive committee, and shall fully comply with Articles VI and VII of these medical staff bylaws, and the board of directors shall not act precipitously, unreasonably, or in bad faith.

## 6.3 SUMMARY RESTRICTION OR SUSPENSION

### 6.3-1 CRITERIA FOR INITIATION

Whenever a member's conduct is such that failure to take action may result in an imminent danger to the health of any individual, the chief of staff, the medical executive committee, or the head of the department or designee in which the member holds privileges 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 board of [trustees/directors], the medical executive committee and the administrator. In addition, the affected medical staff member shall be provided with a written notice of the action which notice fully complies with the requirements of Section 6.3-2 below. The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. 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 chair or by the chief of staff, considering where feasible, the wishes of the patient in the choice of a substitute member.

### 6.3-2 WRITTEN NOTICE OF SUMMARY SUSPENSION

The affected medical staff member shall be promptly provided with written notice of such suspension. This initial written notice shall generally describe the reasons for the action. This initial notice shall not substitute for, but is in addition to, the notice required under Section 7.3-1 (which applies in all cases where the medical executive committee does not immediately terminate the summary suspension). The notice under Section 7.3-1 may supplement the initial notice provided under this section, by including any additional relevant facts supporting the need for summary suspension or other corrective action.

### 6.3-3 MEDICAL EXECUTIVE COMMITTEE ACTION

As soon as reasonably possible under all circumstances 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 VII, nor shall any procedural rules apply. 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 within two working days of the meeting.

### 6.3-4 PROCEDURAL RIGHTS

Unless the medical executive committee promptly terminates the summary restriction or suspension, it shall remain in effect during the pendency of the corrective action, hearing and appeal process, and the member shall be entitled to the procedural rights afforded by Article VII.

### 6.3-5 INITIATION BY THE GOVERNING BOARD

If the chief of staff, members of the medical executive committee and the chair of the department (or designee) in which the member holds privileges are not available to summarily restrict or suspend the member's membership or clinical privileges, the governing board (or designee) may immediately suspend a member's privileges if a failure to suspend those privileges is likely to result in an imminent danger to the health of any person, provided that the governing board (or designee) made reasonable attempts to contact the chief of staff, members of the medical executive committee and the chair of the department (or designee) 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. If the medical executive committee does ratify the summary suspension, all other provisions under Section 6.3 of these bylaws will apply. In this event, the date of imposition of the summary suspension shall be considered to be the date of ratification by the medical executive committee for purposes of compliance with notice and hearing requirements.

## 6.4 AUTOMATIC SUSPENSION OR LIMITATION

In the following instances, the member's privileges or membership may be suspended or limited as described, with no right to hearing. However, the member may appear before the medical executive committee or submit a written statement to the medical executive committee addressing the question of whether the grounds for automatic suspension as set forth below have occurred.

### 6.4-1 LICENSURE

(a) Revocation and Suspension: Whenever a member's license or other legal credential authorizing practice in this state is revoked or suspended, medical staff membership and clinical privileges shall be automatically revoked as of the date such action becomes effective.

(b) Restriction: Whenever a member's license or other legal credential authorizing practice in this state is limited or restricted by the applicable licensing or certifying authority, any clinical privileges which the member has been granted at the hospital which are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

(c) Probation: Whenever a member is placed on probation by the applicable licensing or certifying authority, membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

(d) Expiration. Whenever a member's license is expired or evidence of renewal has not been received, the member shall be automatically suspended until such time as evidence of current licensure has been received.

### 6.4-2 CONTROLLED SUBSTANCES

(a) Whenever a member's DEA certificate is revoked, limited, expired, or suspended, the member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.

(b) Probation: Whenever a member's DEA certificate is subject to probation, the member's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

### 6.4-3 MEDICAL RECORDS

Members of the medical staff are required to complete medical records within such reasonable time as may be prescribed by the medical executive committee. A limited suspension in the form of withdrawal of admitting and other related privileges until medical records are completed, shall be imposed by the chief of staff, or the chief of staff's designee, after notice of delinquency for failure to complete medical records 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 hospital cases, and providing professional services within the hospital for future patients. Bona fide vacation or illness may constitute an excuse subject to approval by the medical executive committee. Members whose privileges have been suspended for delinquent records may admit patients only in life-threatening situations. The suspension shall continue until lifted by the chief of staff or his or her designee. If within ninety days after implementation of suspension the member has not completed the delinquent records, the member's membership and privileges shall be automatically terminated.

6.4-4 FAILURE TO PAY DUES/ASSESSMENTS

Failure without good cause as determined by the medical executive committee, to pay dues or assessments, as required under Section 14.3, shall result in an automatic suspension of a member's clinical privileges, and if within ninety days after written warnings of the delinquency the member does not pay the required dues or assessments, the member's membership shall be automatically terminated.

6.4-5 PROFESSIONAL LIABILITY INSURANCE

Failure to maintain professional liability insurance, shall result in an automatic suspension of a member's clinical privileges, and if within 90 days after written warnings of the delinquency the member does not provide evidence of required professional liability insurance and evidence of coverage for the interim, the member's membership shall be automatically terminated.

6.4-6 FAILURE TO SATISFY SPECIAL ATTENDANCE REQUIREMENT

Failure of a member without good cause to provide information or appear when requested by a medical staff committee or department as described in these bylaws shall result in the referral to the medical executive committee for action, which may include automatic suspension of all privileges. The automatic suspension shall remain in effect until the practitioner has provided the requested information and/or satisfied the special attendance requirement which has been made by the medical executive committee.

6.4-7 FELONY CONVICTION OR PLEA

A practitioner who has been convicted of, or who has pleaded guilty or no contest to, a felony related directly to his/her professional practice, or patient relationships, or involving moral turpitude, within the past seven (7) years, shall not be entitled to apply for initial appointment to the medical staff. If a member of the medical staff is convicted of, or pleads guilty or no contest to a felony directly related to his/her professional practice or patient relationships, or involving moral turpitude, the member's medical staff membership and privileges shall be automatically suspended pending review by the medical executive committee. If the medical executive committee confirms that the felony was directly related to the member's professional practice or patient relationships or involving moral turpitude, the member's staff membership and privileges shall terminate without right to a hearing. If the medical executive committee determines the felony was not directly related to the member's professional practice or patient relationships, the member shall be permitted to request reinstatement.

6.4-8 EXCLUSION FROM GOVERNMENTAL PROGRAM

A practitioner who is excluded as a provider from any governmental health care program (including but not limited to Medicare and Medi-Cal) may not apply for initial appointment to the medical staff. If a member of the medical staff is excluded as a provider from such governmental program, the member's medical staff membership and privileges shall be automatically terminated without right to a hearing.

6.4-9 MEDICAL EXECUTIVE COMMITTEE DELIBERATION

As soon as practicable after action is taken or warranted as described in Section 6.4-1(b) or (c), 6.4-2, or 6.4-6, the medical executive committee shall convene to review and consider the facts, and may recommend any further corrective action as it may deem appropriate in accordance with these bylaws.

## ARTICLE VII: HEARINGS AND APPELLATE REVIEWS

### 7.1 APPLICATION OF THIS ARTICLE

7.1-1 MEMBERS TO WHOM THE ARTICLE APPLIES

For purposes of this Article, the term "member" refers to a medical staff member and shall include a medical staff applicant, unless otherwise stated.

7.1-2 PROCESS TO CHALLENGE QUASI-LEGISLATIVE MEASURES

Any practitioner whose clinical privileges, staff membership or practice opportunities are adversely affected by a quasi-legislative bylaw, rule, regulation, policy or procedure adopted by the Medical Staff in accordance with these bylaws may challenge the measure by providing written notice to the Medical Executive Committee setting forth all information, reasons and arguments supporting the challenge. Upon receipt of such a notice, the Medical Executive Committee shall conduct such review of the matter as it deems proper. Such review shall include an opportunity for the affected practitioner to address the Medical Executive Committee or at the discretion of the Medical Executive Committee, an hoc sub-committee. The Medical Executive Committee shall give the affected practitioner notice of its resolution of the issue with a copy to the Board of Governors. The Board of Governors may conduct its own review of the matter following notice from the Medical Executive Committee. Any disagreement between the Governing Body and the Medical Executive Committee shall be submitted to an Ad Hoc Dispute Resolution Committee.

7.1-3 PROCESS TO CHALLENGE ADVERSE ACTIONS REPORTABLE UNDER BUSINESS AND PROFESSIONS CODE SECTION 805

The notice, hearing and appeal provisions available to a practitioner to contest an action or final recommended action which must be reported to the Medical Board of California under Business and Professions Code Section 805 shall be governed by the provisions of this Article commencing with Section 7.2 below.

7.1-4 PROCESS TO CHALLENGE QUASI-JUDICIAL ACTIONS NOT REPORTABLE UNDER BUSINESS AND PROFESSIONS CODE SECTION 805

A practitioner whose is adversely and significantly affected by a quasi-judicial action or recommended action for which a review process is not otherwise provided in these bylaws or in medical staff rules, regulations or policies, and which is not reportable under Business and Professions Code Section 805, may contest such actions or recommended actions by delivering a written request for review to the Medical Executive Committee. If the action or recommended action was made by the Board of Governors, the practitioner may contest the matter by providing written request for review to the Board of Governors. Any such request for review must be delivered within thirty (30) days from the practitioner's receipt of notice of the action or recommendation.

Upon receipt of such a request for review, the applicable body shall afford the practitioner such review rights as it may deem appropriate. Such review rights shall include notice of the reasons for the action or recommendation, a reasonable opportunity to respond, and resolution of the matter by an unbiased panel.

Examples of matters reviewable under this section include, without limitation, restriction of clinical privileges for less than thirty (30) days in a twelve (12) month period; summary suspension of clinical privileges for 14 days or less; and termination, denial or restriction of privileges or membership rights for reasons other than medical disciplinary cause as defined in Business and Professions Code Section 805.

7.1-5 DUTY TO EXHAUST INTERNAL REMEDIES

All members and applicants are obligated to exhaust all remedies provided in this Article or elsewhere in medical staff bylaws, rules and regulations or policies before initiating legal action. Any practitioner who fails to exhaust the remedies (including all hearing and appeal remedies) provided in these bylaws before initiating legal action, shall be liable to pay the full costs, including legal fees, required to respond to such legal action.

7.1-6 TIMELY COMPLETION OF PROCESS

The hearing and appeal process shall be completed within a reasonable time.

7.1-7 FINAL ACTION

Recommended adverse actions described in Section 7.2 shall become final only after the hearing and appellate rights set forth in these bylaws have either been exhausted or waived, and only upon being adopted as final actions by the Board of Governors

## 7.2 GROUNDS FOR HEARING

Except as otherwise specified in these bylaws, any one or more of the following actions or recommended actions, if based on a medical disciplinary cause or reason, shall constitute grounds to request a hearing:

(a) denial of initial Medical Staff appointment or requested reappointment to the Medical Staff;

(b) denial of requested clinical privileges;

(c) summary suspension of staff membership or staff privileges for greater than 14 days;

(d) termination of Medical Staff membership; or clinical privileges;

(e) involuntary reduction or restriction of clinical privileges for 30 days or more in any 12-month period.

## 7.3 REQUESTS FOR HEARING

7.3-1 NOTICE OF ACTION OR PROPOSED ACTION

In all cases in which action has been taken or a recommendation made as set forth in Section 7.2, the member shall be given prompt written notice of (1) the recommendation or final proposed action and that such action, if adopted, shall be taken and reported to the Medical Board of California and/or to the National Practitioner Data Bank if required; (2) a brief description of the reasons for the proposed action; (3) the right to request a hearing pursuant to Section 7.3-3, and that such hearing must be requested in writing within 30 days and shall state whether the member wishes the judicial review committee to consider his/her request for representation by an attorney; and (4) a summary of the rights granted in the hearing pursuant to the medical staff bylaws, including the right to request approval of representation by legal counsel.

7.3-2 HEARINGS PROMPTED BY BOARD OF GOVERNORS ACTION

If the hearing is based upon an adverse decision or recommendation of the board of governors, the board of governors or its designee shall fulfill the duties assigned to the medical executive committee or the chief of staff when the medical executive committee is the body whose decision prompted the hearing. This shall include, but not be limited to, preparing the notice of adverse action or recommended action and right to a hearing, scheduling the hearing, providing the notice of hearing and statement of charges, and designating the judicial review committee, presenter and witnesses.

7.3-3 REQUEST FOR HEARING

The member shall have 30 days following receipt of notice of such action to request a hearing. The request shall be in writing addressed to the medical executive committee with a copy to the board of governors. Any such request shall include the member's intent with regard to representation. In the event the member does not request a hearing within the time and in the manner described, the member shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved.

7.3-4 TIME AND PLACE FOR HEARING

Upon receipt of a request for hearing, the medical executive committee shall schedule a hearing and, within 30 days give notice to the member of the time, place and date of the hearing. The date of the commencement of the hearing shall be not less than 30 days from the date of notice, nor more than 60 days from the date of receipt of the request by the medical executive committee 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, so long as the member has at least 30 days from the date of notice to prepare for the hearing or waives this right.

7.3-5 NOTICE OF HEARING

Together with the notice stating the place, time and date of the hearing, the chief of staff or designee on behalf of the medical executive committee shall provide the reasons for the recommended action, including the acts or omissions with which the member is charged and a list of the charts in question, where applicable.

7.3-6 JUDICIAL REVIEW COMMITTEE

When a hearing is requested, the medical executive committee shall recommend a judicial review committee to the board of governors for appointment. The board of governors shall be deemed to approve the selection unless it provides written notice to the medical executive committee stating the reasons for its objection within five days. The judicial review committee shall be composed of not less than 3 members of the medical staff. The judicial review committee members shall be unbiased; shall gain no direct financial benefit from the outcome, and shall not have acted as accusers, investigators, fact finders, initial decision makers or otherwise have not actively participated in the consideration of 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 may appoint members from other staff categories or practitioners who are not members of the medical staff. Such appointment shall include designation of the chair. Membership on a judicial review committee shall consist of one member who shall have the same healing arts licensure as the accused, and where feasible, include an individual practicing the same specialty as the member. All other members shall have MD or DO degrees or their equivalent as defined in Section 2.2-2(a)(1).

7.3-7 FAILURE TO APPEAR OR PROCEED

Failure without good cause of the member to personally attend and proceed at such a hearing in an efficient and orderly manner shall be deemed to constitute voluntary acceptance of the recommendations or actions involved.

7.3-8 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 hearing officer on a showing of good cause, or upon agreement of the parties.

## 7.4 HEARING PROCEDURE

7.4-1 PREHEARING PROCEDURE

(a) If either side to the hearing requests in writing a list of witnesses, within 15 days of such request, and in no event less than 10 days before commencement of the hearing, each party shall furnish to the other a written list of the names 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. Failure to disclose the identity of a witness at least ten days before the commencement of the hearing shall constitute good cause for a continuance.

(b) The member shall have the right to inspect and copy, at his/her expense, at least 30 days prior to the hearing, any documents or other evidence relevant to the charges which the medical executive committee possess or controls. The medical executive committee shall have the right to inspect and copy at least 30 days prior to the hearing, at its expense, any documents or other evidence relevant to the charges which the member possesses or controls as soon as practicable after receiving the request. The failure by either party to provide access to this information at least 30 days before the hearing shall constitute good cause for a continuance. The right to inspect and

copy by either party does not extend to confidential information referring solely to individually identifiable members, other than the member under review.

(c) The member and the medical executive committee shall have the right to receive all evidence which will be made available to the Judicial Review Committee. Failure to produce copies of all documents expected to be produced at least ten days before the commencement of the hearing shall constitute good cause for a continuance.

(d) The hearing officer shall consider and rule upon any request for access to information and may impose any safeguards the protection of the peer review process and justice requires. In so doing, the hearing officer shall consider:

(i) whether the information sought may be introduced to support or defend the charges;

(ii) the exculpatory or inculpatory nature of the information sought, if any;

(iii) the burden imposed on the party in possession of the information sought, if access is granted; and

(iv) any previous requests for access to information submitted or resisted by the parties to the same proceeding.

(e) 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.

(f) It shall be the duty of the member and the medical executive committee or its designee to exercise reasonable diligence in notifying the chair of the judicial review committee of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any prehearing decisions may be succinctly made at the hearing.

7.4-2 REPRESENTATION

The hearings provided for in these bylaws are for the purpose of intraprofessional resolution of matters bearing on professional conduct, professional competency, or character. The member and the medical executive committee shall not be represented by an attorney at the hearing unless the chief of staff, in consultation with the chairman of the board of governors permits both sides to be represented by legal counsel. The member shall be informed of his/her right to request representation by an attorney at the time of the notice of a right to request a hearing. In the absence of legal counsel, both the member and the medical executive committee shall be entitled to be represented by a California licensed practitioner who is not also an attorney at law. The foregoing shall not be deemed to deprive the member or the medical executive committee of its right to the assistance of legal counsel for the purpose of preparing for the hearing.

7.4-3 THE HEARING OFFICER

The medical executive committee shall recommend a hearing officer to the board of governors to preside at the hearing. The board of governors shall be deemed to approve the selection unless it provides written notice to the medical executive committee stating the reasons for its objections within five days. The hearing officer shall be an attorney at law qualified to preside over a quasi-judicial hearing, but attorneys from a firm regularly utilized by the hospital, the medical staff or the involved medical staff member or applicant for membership, for legal advice regarding their affairs and activities shall not be eligible to serve as hearing officer. The hearing officer shall gain no direct financial benefit from the outcome and must not act as a prosecuting officer or as an advocate. The hearing officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The hearing officer shall be entitled to determine the order of or procedure for presenting evidence and

argument during the hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure or the admissibility of evidence. If the hearing officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the hearing officer may take such discretionary action as seems warranted by the circumstances, in accordance with California law. If requested by the judicial review committee, the hearing officer may participate in the deliberations of such committee and be a legal advisor to it, but the hearing officer shall not be entitled to vote.

7.4-4 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 hospital, 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.

7.4-5 RIGHTS OF THE PARTIES

Within reasonable limitations, both sides at the hearing may call and examine witnesses for relevant testimony, introduce relevant exhibits or other documents, cross-examine or impeach witnesses who shall have testified orally on any matter relevant to the issues, and otherwise rebut evidence, as long as these rights are exercised in an efficient and expeditious manner. The member may be called by the medical executive committee and examined as if under cross-examination.

7.4-6 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 on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The judicial review committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate. At its discretion, the judicial review committee may request both sides to file written arguments. The hearing process shall be completed within a reasonable time after the notice of the action is received, unless the hearing officer issues a written decision that the member or the medical executive committee failed to provide information in a reasonable time or consented to the delay.

7.4-7 BURDENS OF PRESENTING EVIDENCE AND PROOF

(a) At the hearing the medical executive committee shall have the initial duty to present evidence for each case or issue in support of its action or recommendation. The member shall be obligated to present evidence in response.

(b) An applicant shall bear the burden of persuading the judicial review committee, by a preponderance of the evidence, of the applicant's qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning the applicant's current qualifications for membership and privileges. An applicant shall not be permitted to introduce information requested by the medical staff but not produced during the application process unless the applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

(c) Except as provided above for applicants, throughout the hearing, the medical executive committee shall bear the burden of persuading the judicial review committee, by a preponderance of the evidence, that its action or recommendation is reasonable and warranted.

7.4-8 ADJOURNMENT AND CONCLUSION

After consultation with the chair 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 a written statement 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.

7.4-9 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.

7.4-10 DECISION OF THE JUDICIAL REVIEW COMMITTEE

Within 30 days after final adjournment of the hearing, 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 15 days. A copy of said decision also shall be forwarded to the administrator, the board of governors, 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.

## 7.5 APPEAL

7.5-1 TIME FOR APPEAL

Within 10 days after receipt of the decision of the judicial review committee, either the member or the medical executive committee may request an appellate review. A written request for such review shall be delivered to the chief of staff, the administrator, and the other party in the hearing. If a request for appellate review is not requested within such period, that action or recommendation shall thereupon become the final action of the medical staff. The board of governors shall consider the decision within 70 days and shall give it great weight.

7.5-2 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 non-compliance with the procedures required by these bylaws or applicable law which has created demonstrable prejudice; (b) the decision was not supported by substantial evidence based upon the hearing record or such additional information as may be permitted pursuant to Section 7.5-5; or (c) the decision was not supported by the findings.

7.5-3 TIME, PLACE AND NOTICE

If an appellate review is to be conducted, the appeal board shall, within 30 days after receipt of request for appellate review, schedule a review date and cause each side to be given notice of the time, place and date of the appellate review. The appellate review shall commence within 60 days from the date of such request for appellate review, provided however, that when a request for appellate review concerns a member who is under suspension which is then in effect, the appellate review should commence within 45 days from the date of receipt of the request for appellate review. The time for appellate review may be extended by the appeal board for good cause.

7.5-4 APPEAL BOARD

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

selected by the board of governors shall be neither the attorney firm that represented either party at the hearing before the judicial review committee nor the attorney who assisted the hearing panel or served as hearing officer

7.5-5 APPEAL PROCEDURE

The proceeding 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 hearing; or the appeal board may remand the matter to 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 that party's position on appeal, and to personally appear and make oral argument. The appeal board may thereupon conduct, at a time convenient to itself, deliberations outside the presence of the appellant and respondent and their representatives. The appeal board shall present to the board of governors its written recommendations as to whether the board of governors should affirm, modify, or reverse the judicial review committee decision consistent with the standard set forth in Section 7.5-6, or remand the matter to the judicial review committee for further review and decision.

7.5-6 DECISION

(a) Except as provided in Section 7.5-6(b), within 30 days after the conclusion of the appellate review proceedings, the board of governors shall render a final decision. The board of governors may affirm, modify, reverse the decision or remand the matter for further review by the judicial review committee or any other body designated by the board of governors for reconsideration stating the purpose for the referral. The board of governors shall give great weight to the judicial review committee recommendation, and shall not act arbitrarily or capriciously. The board of governors may, however, exercise its independent judgment in determining whether a practitioner was afforded a fair hearing, whether the decision was reasonable and warranted, and whether any bylaw, rule or policy relied upon by the judicial review committee is unreasonable and unwarranted. If the board of governors determines that the practitioner was not afforded a fair hearing in compliance with the bylaws, the board of governors shall remand the matter.

(b) If the matter is remanded to the judicial review committee or other body designated by the board of governors for further review and recommendation, the committee shall promptly conduct its review and make its recommendations to the board of governors. This further review and the time required to report back shall not exceed 30.days in duration except as the parties may otherwise agree or for good cause as jointly determined by the chair of the board of governors and the judicial review committee.

(c) The decision shall be in writing, shall specify the reasons for the action taken, and provide findings of fact and conclusions articulating the connection between the evidence produced at the hearing, and the decision reached, and shall be forwarded to the chief of staff, the medical executive and credentials committees, the subject of the hearing, and the administrator.

7.5-7 RIGHT TO ONE HEARING

Except in circumstances where a new hearing is ordered by the board of governors or a court because of procedural irregularities or otherwise for reasons not the fault of the member, no member shall be entitled to more than one evidentiary hearing and one appellate review on any matter which shall have been the subject of adverse action or recommendation.

## 7.6 EXCEPTIONS TO HEARING RIGHTS

7.6-1 EXCLUSIVE USE SERVICES, HOSPITAL CONTRACT PRACTITIONERS

(a) Exclusive Use Services

The procedural rights of Article VII do not apply to a practitioner whose application for medical staff membership and privileges was denied or whose privileges were terminated on the basis that the privileges he/she seeks are granted only pursuant to an exclusive use policy. Such practitioners shall be the right, however, to request that the board of governors review the denial, and the board of governors shall have the discretion to determine whether to review such a request and, if it decides to review the request, to determine whether the practitioner may personally appear before and/or submit a statement in support of his/her position to the board of governors.

(b) Hospital Contract Practitioners.

The hearing rights of Article VII do not apply to practitioners who have contracted with the hospital to provide clinical services. Removal of these practitioners from office and of any exclusive privileges (but not their medical staff membership) shall instead be governed by the terms of their individual contracts with the hospital. The hearing rights of this Article VII shall apply if an action is taken which must be reported under Business and Professions Code Section 805 and/or privileges which are independent of the practitioner's contract are removed or suspended.

7.6-2 AUTOMATIC SUSPENSION OR LIMITATION OF PRACTICE PRIVILEGES

No hearing is required in the case of automatic actions taken pursuant to this section.

7.6-3 AUTOMATIC ACTION BASED UPON ACTIONS TAKEN BY ANOTHER PEER REVIEW BODY

a) The medical executive committee shall be empowered to (1) use as a basis for disqualification from membership and/or privileges or (2) automatically impose, any adverse action that has been taken within the preceding 36 months by another peer review body (as that term is used in the federal or California laws) after that action is considered final and the action was taken in conformance with California Business & Professions Code section 809 et seq. For purposes of this Section, an action shall be considered final when the practitioner has completed the hearing, appeal and judicial proceedings related to the action.

b) The practitioner shall not be entitled to any hearing or appeal unless the medical executive committee takes an action that is more restrictive than the final action taken by the original peer review body. Any hearing and appeal that is requested by the practitioner shall not address the merits of the action taken by the original peer review body, which were already reviewed at the original peer review body's hearing, and shall be limited to only the question of whether the automatic action is more restrictive than the original peer review body's action.

c) Nothing in section shall preclude the medical staff or Board of Governors from taking a more restrictive action than another peer review body based upon the same facts or circumstances

## ARTICLE VIII: ALLIED HEALTH PROFESSIONALS

### 8.1 DEFINITIONS

"Allied Health Professional (AHP)" means a health care professional, other than a physician, dentist, podiatrist or clinical psychologist who holds a license or other legal credential, as required by California law, to provide certain professional services.

"Service authorization", "service agreement", or "delegation agreement" mean the permission granted to an Allied Health Professional to provide specified patient care services within his or her qualifications and scope of practice.

### 8.2 QUALIFICATIONS

An Allied Health Professional is not eligible for medical staff membership, but is eligible for a service authorization in this hospital if he or she:

(a) Holds a license, certificate, or other legal credential in a category of AHPs which the board of governors has identified as eligible to apply for service authorizations (see Section 8.3, below); and

(b) Documents his or her education, experience, background, training, current competence, judgment, and ability with sufficient adequacy to demonstrate that any patient treated by the practitioner will receive care of the generally recognized professional level of quality established by the medical staff; and

(c) Is determined, on the basis of documented references: to adhere strictly to the lawful ethics of his or her profession, to work cooperatively with others in the hospital setting so as not to affect adversely patient care, and to be willing to commit to and regularly assist the medical staff in fulfilling its obligations related to patient care, within the areas of the practitioner's professional competence and credentials; and

(d) Agrees to comply with all medical staff and department and division bylaws, rules and regulations, and protocols to the extent applicable to the AHP; and

(e) Maintains professional liability insurance with a suitable insurer, with minimum limits as determined jointly by the medical executive committee and the board of governors.

### 8.3 CATEGORIES OF AHPS ELIGIBLE TO APPLY FOR SERVICE AUTHORIZATIONS

The categories of AHPs, based on occupation or profession, which shall be eligible to apply for service authorization in the hospital and the corresponding service authorization prerogatives, terms, and conditions for each such AHP category shall be designated by the board of governors, upon the recommendation of the medical executive committee, and when approved by the board of governors, shall be set forth in the medical staff rules and regulations. Such actions by the medical executive committee and the board of governors shall be based upon the recommendations of the relevant departments for the designation of categories of AHPs eligible to apply for service authorization and the delineation of corresponding service authorization prerogatives, terms, and conditions for each such AHP category. The board of governors shall review the designation of categories of AHPs eligible to apply for service authorizations at least annually and at other times, within its discretion or upon the recommendation of the medical executive committee.

### 8.4 PROCEDURE FOR GRANTING SERVICE AUTHORIZATION

8.4-1 (a) An AHP whose scope of practice allows independent practice must apply and qualify for a service authorization and must designate a physician member of the active medical staff who, concurrently with the AHP's application, applies for and is granted privileges to be responsible, to the extent necessary, for the general medical condition of patients for whom the AHP proposes to render services in the hospital.

(b) An AHP whose scope of practice does not allow independent practice must apply and qualify for a service authorization and must provide services under the supervision of an active medical staff member who has applied for, qualified for, and been granted specific privileges in accordance with the medical staff bylaws, rules and regulations, to supervise and direct the exercise of service authorizations by the same category of AHP as that of the applicant. An AHP under this subsection may apply to work under the supervision of one active medical staff member or, within the medical executive committee's

discretion, a group of medical staff members so long as each of the medical staff members has separately applied for and been granted privileges to supervise the AHP or the category of AHPs to which the applicant belongs. Whenever an AHP will be supervised by more than one active staff member, such supervision must be in strict accordance with rules and regulations developed by the appropriate department/division and approved by the medical executive committee.

(c) AHP applications for initial granting and renewal of service authorizations respecting nurses in expanded roles and physician's assistants shall be submitted to the Interdisciplinary Practice Committee. AHP applications for all other categories of AHPs who are eligible for service authorizations shall be submitted to the Committee on Interdisciplinary Practice. All AHP applications shall be processed in a parallel manner to that provided in Articles IV and V for medical staff members.

8.4-2 Except as is provided under Section 8.7-2(a), an AHP who (a) has received a final adverse decision regarding his or her application for a service authorization or (b) withdrew his or her application for a service authorization following an adverse recommendation by the medical executive committee, or (c) after having been granted a service authorization has received a final adverse decision resulting in termination of the authorization or (d) has relinquished his or her service authorization following the issuance of a medical staff or board of governors recommendation adverse to his or her service authorization, shall not be eligible to reapply for the service authorization affected by such decision or recommendation for a period of at least 6 months from the date that the adverse decision became final, the application was withdrawn, or the AHP relinquished his or her service authorization.

8.4-3 An AHP who does not have licensure or certification in an AHP category identified as eligible for service authorizations pursuant to Section 8.3 may not apply for a service authorization but may submit a written request to the administrator, asking the board of governors to consider designating the appropriate category of AHPs as eligible to apply for service authorizations. Upon receipt of such a request, the board of governors shall forward a copy of the request to the medical executive committee for its recommendation, and shall also request the recommendation of any affected department or division. The board of governors shall consider such request and the medical executive committee's recommendation, as well as the recommendation of any affected department or division, either before or at the time of its annual review of the categories of AHPs, in accordance with Section 8.3.

8.4-4 Each AHP who is granted a service authorization shall be assigned to the clinical department and division appropriate to his or her occupational or professional training and, unless otherwise specified in the medical staff rules and regulations, shall be subject to terms and conditions that parallel those specified in Article II-Membership, as they may logically apply to AHPs and may be appropriately tailored to the particular category of AHPs. Each AHP who practices independently must maintain communication with the relevant physician under Section 8.4-1 in order to enable the physician to assume responsibility, to the extent it is indicated, for the general medical condition of the patient. Each AHP who does not practice independently shall be subject to the supervision of one or more members of the active medical staff who have been granted privileges to provide such supervision or direction by the board of governors upon recommendation of the medical executive committee.

## 8.5 PREROGATIVES

The prerogatives which may be extended to a member of a particular category of AHP shall be defined in the medical staff rules and regulations. Such prerogatives may include:

(a) Provision of specified patient care services subject to a medical staff member's responsibility, to the extent indicated, for the patient's general medical condition and under the general oversight of the medical staff, and, where the AHP does not practice independently, also under the supervision and direction of a member of the active medical staff who has been granted specific privileges to supervise that category of AHP. AHP services must be consistent with the service authorization granted to the AHP and within the scope of the AHP's licensure or certification.

(b) Service on medical staff and hospital committees except as otherwise expressly provided in the medical staff bylaws, rules and regulations. An AHP may not serve as chair of medical staff committees.

(c) Attendance at meetings of the department to which he or she is assigned, as permitted by the department rules and regulations, and attendance at medical staff educational programs in his or her field of practice. An AHP may not vote at department/division meetings.

8.6 RESPONSIBILITIES

Each AHP shall:

(a) Meet those responsibilities required by the medical staff rules and regulations and if not so specified, meet those responsibilities specified in Section 2.5 of Article II as are generally applicable to the more limited practice of the AHP.

(b) Retain appropriate responsibility within his or her area of professional competence for the care of each patient in the hospital for whom he or she is providing services.

(c) Participate, when requested, in patient care audit and other quality review, evaluation, and monitoring activities required of AHPs, in evaluating AHP applicants, in supervising initial AHP appointees of his or her same occupation or profession or of an occupation or profession which is governed by a more limited scope of practice statute, and in discharging such other functions as may be required by the medical staff from time to time.

**8.7 TERMINATION, SUSPENSION OR RESTRICTION OF SERVICE AUTHORIZATIONS**

8.7-1 GENERAL PROCEDURES

(a) At any time, the chief of staff or chief of the department or division to which the AHP has been assigned may recommend to the medical executive committee that an AHP's service authorization be terminated, suspended or restricted. After investigation (including, if appropriate, consultation with the Interdisciplinary Practice Committee or the Committee on Interdisciplinary Practice), if the medical executive committee agrees that corrective action is appropriate, the medical executive committee shall recommend specific corrective action to the board of governors. Notice of the recommendation shall be sent by certified mail to the subject AHP, informing the AHP of the recommendation and the circumstances giving rise to the recommendation. Nothing in this Section shall prevent the chief of staff, chair of the department or designee to which the AHP has been assigned, or medical executive committee from imposing a summary suspension or restriction. In such case, except for actions involving clinical psychologists, the procedure in this Section shall be followed. In cases involving clinical psychologists, the procedure in Section 6.3 shall be followed.

(b) Nothing contained in the medical staff bylaws shall be interpreted to entitle an AHP, except for a clinical psychologist, to the hearing rights set forth in Articles VI and VII. However, an AHP who is not otherwise an employee, shall have the right to challenge any recommendation which would constitute grounds for a hearing under Section 7.2 of the bylaws (to the extent that such grounds are applicable by analogy to the AHP) by filing a written grievance (i.e., a letter objecting to the recommended action and requesting an interview) with the medical executive committee within fifteen (15) days of receipt of the notice. AHPs who are otherwise employees shall only be entitled to the grievance procedure offered through the hospital's human resources procedures. Upon receipt of a grievance, the medical executive committee shall appoint an ad hoc committee composed of practitioners not previously involved in the recommendation or otherwise biased, to afford the AHP an opportunity for an interview concerning the grievance. Although such interview shall not constitute a "hearing" as established by Article VII of the bylaws, and need not be conducted according to the procedural rules applicable to such hearings, the purpose of the interview is to allow both the AHP and the medical executive committee the opportunity to discuss the situation and to produce evidence in support of their respective positions. Minutes of the interview shall be retained.

(c) Within 30 days following the interview, the body who conducted the interview, based on the interview and all other aspects of the investigation, shall make a written recommendation to the

board of governors, indicating the bases for its recommendation. A copy of the recommendation shall be provided to the AHP and to the medical executive committee. Prior to acting on the matter, the board of governors shall offer the affected practitioner and the medical executive committee the right to appeal to the board or a subcommittee thereof. The final decision by the board of governors shall become effective upon the date of its adoption. The AHP and the medical executive committee shall be provided promptly with notice of the final action, sent by certified mail.

8.7-2 AUTOMATIC SUSPENSION, TERMINATION OR RESTRICTION

(a) Notwithstanding subsection 8.7-1, above, an AHP's service authorization shall automatically terminate in the event that:

(1) The AHP's certification, license, or other legal credential expires or is revoked.

(2) With respect to an AHP who must practice under physician supervision:

(A) The medical staff membership or privileges to supervise the AHP of the supervising physician is terminated, whether such termination is voluntary or involuntary; or

(B) The supervising physician no longer agrees to act in such capacity for any reason, or the relationship between the AHP and the supervising physician is otherwise terminated, regardless of the reason therefore;

Where the AHP's service authorization is automatically terminated for reasons specified in (2)(A) or (2)(B) above, the AHP may apply for reinstatement as soon as the AHP has found another physician active medical staff member who agrees to supervise the AHP and receives privileges to do so. In this case, the medical executive committee may, in its discretion, expedite the reapplication process.

(b) Notwithstanding subsection 8.7-1, above, in the event that the AHP's certification or license is restricted, suspended, or made the subject of an order of probation, the AHP's service authorization shall automatically be subject to the same restrictions, suspension, or conditions of probation.

(c) Where the AHP's privileges are automatically terminated, suspended, or restricted pursuant to this subsection, the notice and interview procedures under subsection 8.7-1 shall not apply and the AHP shall have no right to an interview except, within the discretion of the medical executive committee, regarding any factual dispute over whether or not the circumstances giving rise to the automatic termination, suspension, or restriction actually exist.

8.7-3 APPLICABILITY OF SECTION

The rights afforded by this section shall not apply to any decision regarding whether a category of AHP shall be eligible for a service authorization and the terms or conditions of such decision pursuant to Section 8.3 of this Article.

## 8.8 REAPPOINTMENT

Initial and renewal service authorization approvals shall be for a period of up to two years. Each Allied Health Professional must reapply for a renewed service authorization in accordance with Section 8.4.

## ARTICLE: IX OFFICERS

### 9.1 OFFICERS OF THE MEDICAL STAFF

9.1-1 IDENTIFICATION

The officers of the medical staff shall be the Chief of Staff, Vice Chief of Staff, Immediate Past Chief of Staff, Secretary, and Treasurer.

9.1-2 QUALIFICATIONS

Officers must be members of the active medical staff at the time of their nominations and election, and must remain members in good standing during their term of office. Failure to maintain such status shall create a vacancy in the office involved.

9.1-3 NOMINATIONS

(a) The medical staff election year shall be each odd numbered medical staff year. A nominating committee shall be appointed by the medical executive committee not later than 90 days prior to the annual staff meeting to be held at the end of the medical staff year or up to 45 days prior to any special election. The nominating committee shall consist of the current chief of staff, the vice chief of staff, and one other member of the medical executive committee, and [2] members chosen by vote of the department chairs from among the active medical staff who are not then members of the medical executive committee. The nominating committee shall nominate one or more nominees for each office. The nominations of the committee shall be reported to the medical executive committee at least 60 days prior to the election day and shall be delivered or mailed to the voting members of the medical staff at least 40 days prior to the election.

(b) Further nominations may be made for any office by any voting member of the medical staff, provided that the name of the candidate is submitted in writing to the chair of the nominating committee, is endorsed by the signature of at least 2 other members who are eligible to vote, and bears the candidate's written consent. These nominations shall be delivered to the chair of the nominating committee as soon as reasonably practicable, but at least 20 days prior to the date of election. If any nominations are made in this manner, the voting members of the medical staff shall be advised by notice delivered or mailed at least 10 days prior to the date of the election. Nominations from the floor will be recognized if the nominee is present and consents.

9.1-4 ELECTIONS

The vice chief of staff, secretary, and treasurer shall be elected at the annual meeting of the medical staff which falls during the election year by written ballot from eligible members prior to the end of the medical staff year during which an election is held. 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 of the valid votes cast. If no candidate for the office receives a majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes. 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.

9.1-5 TERM OF ELECTED OFFICE

Each officer shall serve a [2] year term, commencing on the first day of the medical staff year following the election. Each officer shall serve in each office until the end of that officer's term, or until a successor is elected, unless that officer shall sooner resign or be removed from office. At the end of that officer's term, the chief of staff shall automatically assume the office of immediate past chief of staff and the vice chief of staff shall automatically assume the office of chief of staff.

9.1-6 RECALL OF OFFICERS

Any medical staff officer may be removed from office for valid cause, including, but not limited to, gross neglect or misfeasance in office, or serious acts of moral turpitude. Recall of a medical staff officer may be initiated by the medical executive committee or shall be initiated by a petition signed by at least one-third of the members of the medical staff eligible to vote for officers. Recall shall be considered at a special meeting called for that purpose. Recall shall require a two-thirds vote of the medical staff members eligible to vote for medical staff officers who actually cast votes at the special meeting in person or by mail ballot.

9.1-7 VACANCIES IN ELECTED OFFICE

Vacancies in office occur upon the death or disability, resignation, or removal of the officer, or such officer's loss of membership in the medical staff. Vacancies, other than that of the chief of staff, shall be filled by appointment by the medical executive committee until the next regular election. If there is a vacancy in the office of chief of staff, then the vice chief of staff shall serve out that remaining term and shall immediately appoint an ad hoc nominating committee to decide promptly upon nominees for the office of vice chief of staff. Such nominees shall be reported to the medical executive committee and to the medical staff. A special election to fill the position shall occur at the next regular staff meeting. If there is a vacancy in the office of vice chief of staff, that office need not be filled by election, but the medical executive committee shall appoint an interim officer to fill this office until the next regular election, at which time the election shall also include the office of chief of staff.

## 9.2 DUTIES OF OFFICERS

9.2-1 CHIEF OF STAFF

The chief of staff shall serve as the chief officer of the medical staff. The duties required of the chief of staff shall include, but not be limited to:

(a) enforcing 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;

(b) calling, presiding at, and being responsible for the agenda of all meetings of the medical staff;

(c) serving as chair of the medical executive committee and calling, presiding at, and being responsible for the agenda of all meetings thereof;

(d) serving as an ex officio member of all other staff committees without vote, unless chief of staff membership in a particular committee is required by these bylaws;

(e) interacting with the administrator and governing board in all matters of mutual concern within the hospital;

(f) appointing, in consultation with the medical executive committee, committee members for all standing committees other than the medical executive committee and all special medical staff, liaison, or multi-disciplinary committees, except where otherwise provided by these bylaws and, except where otherwise indicated, designating the chairs of these committees;

(g) representing the views and policies of the medical staff to the governing board and to the administrator;

(h) being a spokesperson for the medical staff in external professional and public relations;

(i) performing such other functions as may be assigned to the chief of staff by these bylaws, the medical staff, or by the medical executive committee;

(j) serving on liaison committees with the governing board and administration, as well as outside licensing or accreditation agencies.

9.2-2 VICE CHIEF OF STAFF

The vice chief of staff shall assume all duties and authority of the chief of staff in the absence of the chief of staff. The vice chief of staff shall be a member of the medical executive committee and of the joint conference committee, and shall perform such other duties as the chief of staff may assign or as may be delegated by these bylaws, or by the medical executive committee.

9.2-3 IMMEDIATE PAST CHIEF OF STAFF

The immediate past chief of staff shall be a member of the medical executive committee and a member of the joint conference committee and shall perform such other duties as may be assigned by the chief of staff or delegated by these bylaws, or by the medical executive committee.

9.2-4 SECRETARY

The secretary shall be a member of the executive committee. The duties shall include, but not be limited to:

(a) maintaining a roster of members;

(b) keeping accurate and complete minutes of all medical executive committee and general medical staff meetings;

(c) calling meetings on the order of the chief of staff or medical executive committee;

(d) attending to all appropriate correspondence and notices on behalf of the medical staff;

(e) excusing absences from meetings on behalf of the medical executive committee; and

(f) performing such other duties as ordinarily pertain to the office or as may be assigned from time to time by the chief of staff or medical executive committee.

9.2-5 TREASURER

The secretary-treasurer shall be a member of the executive committee. The duties shall include, but not be limited to:

(a) receiving and safeguarding all funds of the medical staff;

(b) reporting the status of medical staff funds at minimum on a quarterly basis

(c) performing such other duties as ordinarily pertain to the office or as may be assigned from time to time by the chief of staff or medical executive committee.

## ARTICLE: X CLINICAL DEPARTMENTS AND DIVISIONS

### 10.1 ORGANIZATION OF CLINICAL DEPARTMENTS AND DIVISIONS

The medical staff shall be organized into clinical departments. Each department shall be organized as a separate component of the medical staff and shall have a chair selected and entrusted with the authority, duties, and responsibilities specified in Section 10.6. A department may be further divided, as appropriate, into divisions which shall be directly responsible to the department within which it functions, and which shall have a division chief selected and entrusted with the authority, duties and responsibilities specified in Section 10.7. When appropriate, the medical executive committee may recommend to the medical staff the creation, elimination, modification, or combination of departments or divisions.

### 10.2 CURRENT DEPARTMENTS AND DIVISIONS

10.2-1 The current departments are:

(a) Medicine – includes internal medicine, internal medicine sub-specialties, general practice, family medicine, urgent care medicine, and house physicians

(b) Surgery – includes all surgical specialties, surgical sub-specialties, anesthesiology, dentists, pathologists, and podiatrists

(c) Psychiatry – includes psychiatrists and clinical psychologists

10.2-2 The current divisions are:

(a) Podiatry

(b) Anesthesiology

(c) Cardio-Pulmonary Medicine and Critical Care

(d) Pathology

(e) Radiology

### 10.3 ASSIGNMENT TO DEPARTMENTS AND DIVISIONS

Each member shall be assigned membership in at least one department, and to a division, if any, within such department, but may also be granted membership and/or clinical privileges in other departments or divisions consistent with practice privileges granted.

### 10.4 FUNCTIONS OF DEPARTMENTS

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) Meeting at least [monthly] 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.

(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 department functions.

(m) Formulating recommendations for departmental rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to the approval by the medical executive committee.

## 10.5 FUNCTIONS OF DIVISIONS

Subject to approval of the medical executive committee, each division shall perform the functions assigned to it by the department chair. Such functions may include, without limitation, retrospective patient care reviews, evaluation of patient care practices, credentials review and privileges delineation, and continuing education programs. The division shall transmit regular reports to the department chair on the conduct of its assigned functions.

## 10.6 DEPARTMENT CHAIRS

### 10.6-1 QUALIFICATIONS

Each department shall have a chair and vice-chair who shall be members of the active staff and shall be qualified by licensure, training, experience and demonstrated ability in at least one of the clinical areas covered by the department. Department chairs must be certified by an appropriate specialty board or must demonstrate comparable competence.

### 10.6-2 SELECTION

Department chairs and vice-chairs shall be elected every 2 years by those members of the department who are eligible to vote for general officers of the medical staff. For the purpose of this election, each department chair shall appoint a nominating committee of 2 members at least 60 days prior to the meeting at which election is to take place. The recommendations of the nominating committee of one or more nominees for chair and vice-chair positions shall be circulated to the voting members of each department at least 20 days prior to the election. Nominations also may be made from the floor when the election meeting is held, as long as the nominee is present and consents to the nomination. Election of department chairs and vice-chairs shall be subject to ratification by the medical executive committee. Vacancies due to any reason shall be filled for the unexpired term through special election by the respective department with such mechanisms as that department may adopt.

### 10.6-3 TERM OF OFFICE

Each department chair and vice-chair shall serve a 2 year term which coincides with the medical staff year or until their successors are chosen, unless they shall sooner resign, be removed from office, or lose

their medical staff membership or clinical privileges in that department. Department officers shall be eligible to succeed themselves.

10.6-4 REMOVAL

After election and ratification, removal of department chairs and vice-chairs from office may occur for cause by a two-thirds vote of the medical executive committee and a two-thirds vote of the department members eligible to vote on departmental matters who cast votes.

10.6-5 DUTIES

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 to the chief of 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) participate in every phase of administration of the department, including cooperation with the nursing service and the 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, including budgetary planning, pertaining to the department as may be required by the medical executive committee;

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

(l) perform such other duties commensurate with the office as may from time to time be reasonably requested by the chief of staff or the medical executive committee.

## 10.7 DIVISION CHIEFS

10.7-1 QUALIFICATIONS

Each division shall have a chief who shall be a member of the active medical staff and a member of the division, and shall be qualified by training, experience, and demonstrated current ability in the clinical area covered by the division.

10.7-2 SELECTION

Each division chief shall be selected or elected with such mechanism as the medical staff may adopt. Vacancies due to any reason shall be filled for the unexpired term by the department chair.

10.7-3 TERM OF OFFICE

Each division chief shall serve a two-year term which coincides with the medical staff year or until a successor is chosen, unless the division chief shall sooner resign or be removed from office or lose medical staff membership or clinical privileges in that division. Division chiefs shall be eligible to succeed themselves.

10.7-4 REMOVAL

After appointment, a division chief may be removed by the department chair and the medical executive committee.

10.7-5 DUTIES

Each division chief shall:

(a) act as presiding officer at division meetings;

(b) assist in the development and implementation, in cooperation with the department chair, of programs to carry out the quality review, and evaluation and monitoring functions assigned to the division;

(c) evaluate the clinical work performed in the division;

(d) conduct investigations and submit reports and recommendations to the department chair regarding the clinical privileges to be exercised within the division by members of or applicants to the medical staff; and

(e) perform such other duties commensurate with the office as may from time to time be reasonably requested by the department chair, the chief of staff, or the medical executive committee.

## ARTICLE XI COMMITTEES

### 11.1 DESIGNATION

Medical staff committees shall include but not be limited to, the medical staff meeting as a committee of the whole, meetings of departments and divisions, meetings of committees established under this Article, and meetings of special or ad hoc committees created by the medical executive committee (pursuant to this Article) or by departments (pursuant to Sections 9.4(i) and (l)). The committees described in this Article shall be the standing committees of the medical staff. Special or ad hoc committees may be created by the medical executive committee to perform specified tasks. Unless otherwise specified, the chair and members of all committees shall be appointed by and may be removed by the chief of staff, subject to consultation with and approval by the medical executive committee. Medical staff committees shall be responsible to the medical executive committee.

### 11.2 GENERAL PROVISIONS

#### 11.2-1 TERMS OF COMMITTEE MEMBERS

Unless otherwise specified, committee members shall be appointed for a term of 2 years, and shall serve until the end of this period or until the member's successor is appointed, unless the member shall sooner resign or be removed from the committee.

#### 11.2-2 TERMINATION OF COMMITTEE MEMBERSHIP

If a member of a committee ceases to be a member in good standing of the medical staff, or loses employment or a contract relationship with the hospital, suffers a loss or significant limitation of practice privileges, or if any other good cause exists, that member may be removed by the medical executive committee.

#### 11.2-3 VACANCIES

Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made; provided however, that if an individual who obtains membership by virtue of these bylaws is removed for cause, a successor may be selected by the medical executive committee.

### 11.3 MEDICAL EXECUTIVE COMMITTEE

#### 11.3-1 COMPOSITION

The medical executive committee shall consist of the following persons:

(a) the officers of the medical staff;

(b) the department chairs;

(c) the division chairs;

(d) the chairs of standing committees

The administrator shall have the right to attend meetings of the medical executive committee, without vote.

#### 11.3-2 DUTIES

The duties of the Medical Executive Committee, as delegated by the medical staff, shall include, but not be limited to:

(a) representing and acting on behalf of the medical staff in the intervals between medical staff meetings, subject to such limitations as may be imposed by these bylaws;

(b) coordinating and implementing the professional and organizational activities and policies of the medical staff;

(c) receiving and acting upon reports and recommendations from medical staff departments, divisions, committees, and assigned activity groups;

(d) recommending actions to the board of [trustees/directors] on matters of a medical-administrative nature;

(e) adopting policies regarding the structure of the medical staff, the mechanisms to review credentials and delineate individual clinical privileges, the criteria for privileges, the granting of individual staff memberships and privileges, the organization of quality assessment and improvement activities and mechanisms of the medical staff, termination of medical staff membership and fair hearing procedures, needed changes to medical staff bylaws, and other matters relevant to the operation of an organized medical staff;

(f) evaluating the medical care rendered to patients in the hospital;

(g) participating in the development of all medical staff and hospital policy, practice, and planning;

(h) reviewing the qualifications, credentials, performance and professional competence, and character of applicants and staff members, and making recommendations to the governing board regarding staff appointments and reappointments, assignments to departments, clinical privileges, and corrective action;

(i) taking reasonable steps to promote ethical conduct and competent clinical performance on the part of all members including the initiation of and participation in medical staff corrective or review measures when warranted;

(j) taking reasonable steps to develop continuing education activities and programs for the medical staff;

(k) designating such committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the medical staff and approving or rejecting appointments to those committees by the chief of staff;

(l) reporting to the medical staff at each regular staff meeting;

(m) assisting in the obtaining and maintenance of accreditation;

(n) developing and maintenance of methods for the protection and care of patients and others in the event of internal or external disaster;

(o) appointing such special or ad hoc committees as may seem necessary or appropriate to assist the medical executive committee in carrying out its functions and those of the medical staff;

(p) reviewing the quality and appropriateness of services provided by contract physicians;

(q) reviewing and approving the designation of the hospital's authorized representative for National Practitioner Data Bank purposes;

(r) establishing a mechanism for dispute resolution between medical staff members (including limited license practitioners) involving the care of a patient;

(s) implementing, enforcing and safeguarding the self-governance rights of the medical staff pursuant to Business and Professions Codes Section 2282.5; and

(t) taking such steps as appropriate to meet and confer in good faith to resolve dispute with the governing board, or any other person or entity, regarding any self-governance rights of the medical staff.

(u) performing, or delegating to an appropriate committee, the following patient safety functions:

i. review and approve the hospital's patient safety plan, and review and revise the plan at least once a year, or more often as necessary to incorporate advancements in patient safety practices;

ii. receive and review reports of patient safety events, including but not limited to all adverse events or potential adverse events that are determined to be preventable (as

defined by state law), and health care associated infections (as defined by the Centers for Disease Control and Prevention's National Healthcare Safety Network);

iii. monitor implementation of corrective action for patient safety events;

iv. make recommendations to eliminate future patient safety events.

The authority delegated pursuant to this Section 11.3-2 may be limited or removed through amendments to the Bylaws as provided in Article XV.

11.3-3 MEETINGS

The medical executive committee shall meet as often as necessary, but at least quarterly and shall maintain a record of its proceedings and actions. The administrator or designee shall be invited to attend all meetings in a non-voting capacity.

## 11.4 CREDENTIALS COMMITTEE

11.4-1 COMPOSITION

The credentials committee shall consist of not less than 3 members of the active staff selected on a basis that will ensure, insofar as feasible, representation of major clinical specialties and each of the staff departments. The Medical Executive Committee has the right to assume the responsibilities of the credentials committee and may decide to create a separate committee at any time with the appropriate process for the creation of a committee consistent with the description below.

11.4-2 DUTIES

The credentials committee shall:

(a) review and evaluate the qualifications of each practitioner applying for initial appointment, reappointment, or modification of clinical privileges, and, in connection therewith, obtain and consider the recommendations of the appropriate departments;

(b) submit required reports and information on the qualifications of each practitioner applying for membership or particular clinical privileges including recommendations with respect to appointment, membership category, department affiliation, clinical privileges, and special conditions;

(c) investigate, review and report on matters referred by the chief of staff or the medical executive committee regarding the qualifications, conduct, professional character or competence of any applicant or medical staff member; and

(d) submit periodic reports to the medical executive committee on its activities and the status of pending applications.

11.4-3 MEETINGS

The credentials committee shall meet as often as necessary at the call of its chair. The committee shall maintain a record of its proceedings and actions and shall report to the medical executive committee.

## 11.5 MEDICAL RECORDS COMMITTEE

11.5-1 COMPOSITION

The medical records committee shall consist of, insofar as possible, at least one representative from each clinical department, the nursing service, the medical records department, and hospital administration.

11.5-2 DUTIES

The duties of the medical records committee shall include:

(a) review and evaluation of medical records, or a representative sample, to determine whether they: (1) properly describe the condition and diagnosis, the progress of the patient during hospitalization and at the time of discharge, the treatment and tests provided, the results thereof,

and adequate identification of individuals responsible for orders given and treatment rendered; and (2) are sufficiently complete at all times to facilitate continuity of care and communications between individuals providing patient care services in the hospital; and

(b) review and make recommendations for medical staff and hospital policies, rules and regulations relating to medical records, including completion, forms and formats, filing, indexing, storage, destruction, availability and methods of enforcement; and

(c) provide liaison with hospital administration and medical records personnel in the employ of the hospital on matters relating to medical records practices.

11.5-3 MEETINGS

The medical records committee shall meet as often as necessary at the call of its chair, but at least quarterly. It shall maintain a permanent record of its proceedings and activities, and shall report to the medical executive committee as necessary but at least quarterly.

## 11.7 UTILIZATION REVIEW COMMITTEE

11.7-1 COMPOSITION

The utilization review committee shall consist of sufficient members to afford fair representation. Subcommittees may be appointed by the committee for departments or divisions as the committee may deem appropriate.

11.7-2 DUTIES

The duties of the utilization review committee shall include:

(a) 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 the medical executive committee and shall make recommendations for the utilization of resources and facilities commensurate with quality patient care and safety;

(b) developing, implementing and annually reviewing a utilization review plan, including development of screens, criteria, and guidelines for utilization, which shall be approved by the medical executive committee;

(c) obtaining, reviewing, and evaluating information and raw statistical data obtained or generated by the hospital's case management system; and

(d) overseeing activities performed by physician advisors, if any, including review of the medical necessity for admissions, extended stays, services rendered, and maintaining proper continuity of care upon discharge, and documentation of same;

(e) evaluating the medical necessity of admissions, continued hospital services and professional services furnished, for particular patients where appropriate, and ensuring that (i) the attending physician is consulted and afforded an opportunity to present his/her views, and the availability of hospital facilities and services is considered prior to any decision that an admission or further inpatient stay is not medically necessary; (ii) a determination that admission or continued stay is not medically necessary is made by at least two physician members if the responsible practitioner does not concur with the determination or fails to present his/her view; and (iii) written notice of any decision that further inpatient care is not medically necessary is given within two (2) days following that determination. Reviews may not be conducted by a practitioner who has a direct financial interest in the hospital, and no practitioner shall have review responsibility for any case in which he or she was professionally involved.

11.7-3 MEETINGS

The utilization review committee shall meet as often as necessary at the call of its chair, but at least quarterly. It shall maintain a record of its findings, proceedings and actions, and shall make a monthly report of its activities and recommendations to the medical executive committee.

## 11.8 PHARMACY AND THERAPEUTICS COMMITTEE

### 11.8-1 COMPOSITION

The pharmacy and therapeutics committee shall consist of at least one representative from the medical staff, a voting representative from the pharmaceutical service, and non-voting representatives from the nursing service and hospital administration.

### 11.8-2 DUTIES

The duties of the pharmacy and therapeutics committee shall include:

(a) assisting in the formulation of professional practices and policies regarding the continuing evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs in the hospital, including antibiotic usage;

(b) advising the medical staff and the pharmaceutical service on matters pertaining to the choice of available drugs;

(c) making recommendations concerning drugs to be stocked on the nursing unit floors and by other services;

(d) periodically developing and reviewing a formulary or drug list for use in the hospital;

(e) evaluating clinical data concerning new drugs or preparations requested for use in the hospital;

(f) establishing standards concerning the use and control of investigational drugs and of research in the use of recognized drugs;

(g) maintaining a record of all activities relating to pharmacy and therapeutics functions and submitting periodic reports and recommendations to the medical executive committee concerning those activities;

(h) developing proposed policies and procedures for, and continuously evaluating the appropriateness of blood and blood products usage, including the screening, distribution, handling and administration, and monitoring of blood and blood components' effects on patients; and

(i) reviewing untoward drug reactions.

### 11.8-3 MEETINGS

The committee shall meet as often as necessary at the call of its chair but at least quarterly. It shall maintain a record of its proceedings and shall report its activities and recommendations to the medical executive committee as needed but at least quarterly.

## 11.9 INFECTION CONTROL COMMITTEE

### 11.9-1 COMPOSITION

The infection control committee shall consist of at least one member including representatives from the departments of medicine, surgery, pathology, nursing service, administration, and an individual employed in a surveillance or epidemiological capacity. It may include non-voting consultants in microbiology and non-voting representatives from relevant hospital services.

### 11.9-2 DUTIES

The duties of the infection control committee shall include:

(a) developing a hospital-wide infection control program and maintaining surveillance over the program;

(b) developing a system for reporting, identifying and analyzing the incidence and cause of health-care-associated infections, including assignment of responsibility for the ongoing collection and analytic review of such data, and follow-up activities, receiving and reports of such infections, monitoring implementation of corrective action for such infections, and making recommendations to eliminate future such infections;

(c) developing and implementing a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing and evaluating aseptic, isolation and sanitation techniques;

(d) developing written policies defining special indications for isolation requirements;

(e) coordinating action on findings from the medical staff's review of the clinical use of antibiotics;

(f) acting upon recommendations related to infection control received from the chief of staff, the medical executive committee, departments and other committees; and

(g) reviewing sensitivities of organisms specific to the facility.

11.9-3 MEETINGS

The infection control committee shall meet as often as necessary at the call of its chair but at least quarterly. It shall maintain a record of its proceedings and shall submit reports of its activities and recommendations to the medical executive committee.

## 11.10 TISSUE COMMITTEE

11.10-1 COMPOSITION

The tissue committee shall consist of at least one members of the medical staff, one of who shall be the chair of the department of pathology, or the chair's designee.

11.10-2 DUTIES

The duties of the tissue committee shall include review of surgical cases in which a specimen (tissue or non-tissue) is removed, as well as from those cases in which no specimen is removed. In the latter case, however, a screening mechanism based upon pre-established criteria may be established. The review shall include the indications for surgery and all cases in which there is a major discrepancy between the pre-operative and post-operative (including pathologic) diagnosis. Following the recommendation of the surgical departments, the medical executive committee may describe a system by which the function of the tissue committee shall be coordinated with departmental surgical case review.

11.10-3 MEETINGS

The committee shall meet as often as necessary at the call of its chair but at least quarterly. It shall maintain a record of its activities and shall report to the medical executive committee as needed but at least quarterly.

## 11.11 BYLAWS COMMITTEE

11.11-1 COMPOSITION

The bylaws committee shall consist of at least two members of the medical staff, including at least the vice chief of staff or chief of staff-elect and immediate past chief of staff.

11.11-2 DUTIES

The duties of the bylaws committee shall include:

(a) conducting an annual review of the medical staff bylaws, as well as the rules and regulations, policies and forms promulgated by the medical staff, its departments and divisions;

(b) submitting recommendations to the medical executive committee for changes in these documents as necessary to reflect current medical staff practices;

(c) receiving and evaluating for recommendation to the medical executive committee suggestions for modification of the items specified in subdivision (a)

11.11-3 MEETINGS

The bylaws committee shall meet as often as necessary at the call of its chair but at least [annually]. It shall maintain a record of its proceedings and shall report its activities and recommendations to the medical executive committee.

## 11.12 QUALITY ASSESSMENT AND IMPROVEMENT COMMITTEE (QUALITY COUNCIL)

11.12-1 COMPOSITION

The quality assessment and improvement committee shall consist of such members as may be designated by the medical executive committee including, insofar as possible, at least one representative from each clinical department, from the nursing service and from administration.

11.12-2 DUTIES

The quality assessment and improvement committee shall perform the following duties:

(a) recommend for approval of the medical executive committee plans for maintaining quality patient care within the hospital. These may include mechanisms to:

(1) establish systems to identify potential problems in patient care;

(2) set priorities for action on problem correction;

(3) refer priority problems for assessment and corrective action to appropriate departments or committees;

(4) monitor the results of quality assessment and improvement activities throughout the hospital; and

(5) coordinate quality assessment and improvement activities.

(b) submit regular confidential reports to the medical executive committee on the quality of medical care provided and on quality assessment and improvement activities conducted.

11.12-3 MEETINGS

The committee shall meet as often as necessary at the call of its chair, but at least quarterly. It shall maintain a record of its proceedings and report its activities and recommendations to the medical executive committee and governing board on a regular basis, except that routine reports to the board shall not include peer evaluations related to individual members.

## 11.13 PHYSICIAN WELL-BEING COMMITTEE

11.13-1 COMPOSITION

The medical staff aid committee shall be comprised of no less than two active members of the medical staff, a majority of which, including the chair, shall be physicians. Except for initial appointments, each member shall serve a term of two years, and the terms shall be staggered as deemed appropriate by the executive committee to achieve continuity. Insofar as possible, members of this committee shall not serve as active participants on other peer review or quality assessment and improvement committees while serving on this committee.

11.13-2 DUTIES

The committee may receive referrals and self-referrals, as well as reports related to the health, well-being, or impairment of medical staff members. The committee shall evaluate the credibility of a complaint, allegation or concern. With respect to matters involving individual medical staff members, the committee may, on a voluntary basis, provide such advice, counseling, or referrals as may seem appropriate. The committee shall monitor the activities and safety of patients under the care of physicians in rehabilitation

and periodically thereafter, and shall initiate action if a monitored practitioner fails to complete any required rehabilitation. Such activities shall be confidential, including the identity of informants; however, in the event information received by the committee clearly demonstrates that the health or known impairment of a medical staff member poses an unreasonable risk of harm to hospitalized patients, that information may be referred for corrective action. The committee shall also consider general matters related to the health and well-being of the medical staff and, with the approval of the medical executive committee, develop educational programs or related activities.

11.13-3 MEETINGS

The committee shall meet as often as necessary, but at least quarterly. It shall maintain only such record of its proceedings as it deems advisable, but shall report on its activities on a routine basis, but at least quarterly, to the medical executive committee.

## 11.14 BIOETHICS COMMITTEE

11.14-1 COMPOSITION

The bioethics committee shall consist of physicians and such other staff members as the medical executive committee may deem appropriate. It may include nurses, lay representatives, social workers, clergy, ethicists, attorneys, administrators and representatives from the governing board, although a majority shall be physician members of the medical staff.

11.14-2 DUTIES

The bioethics committee may participate in development of guidelines for consideration of cases having bioethical implications; development and implementation of procedures for the review of such cases; development and/or review of institutional policies regarding care and treatment of such cases; retrospective review of cases for the evaluation of bioethical policies; consultation with concerned parties to facilitate communication and aid conflict resolution; and education of the hospital staff on bioethical matters.

11.14-3 MEETINGS

The committee shall meet as often as necessary at the call of its chair. It shall maintain a record of its activities and report to the medical executive committee.

## 11.15 COMMITTEE ON INTERDISCIPLINARY PRACTICE,

11.15-1 COMPOSITION

The committee on interdisciplinary practice (CIDP) shall consist of, at a minimum, the director of nursing, the administrator or designee, and an equal number of physicians appointed by the medical executive committee and registered nurses appointed by the director of nursing. 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.

11.15-2 DUTIES

The CIDP shall perform functions consistent with the requirements of law and regulation. The CIDP shall routinely report to the governing board through the medical executive committee and, in addition, shall submit an annual report directly to the governing board and the medical executive committee.

11.15-3 MEETINGS

The CIDP shall meet at the call of the chair at such intervals as the chair or the medical executive committee may deem appropriate.

## 11.16 COMMITTEE ON ALLIED HEALTH PRACTITIONERS

11.16-1 COMPOSITION

The committee on allied health practitioners (CAHP) shall consist of at least one member of the medical staff, a majority of whom shall be physicians, including the chair. The interdisciplinary committee reserves the right to assume the responsibilities of the allied health practitioners committee and may decide to create a separate committee at any time with the appropriate process for the creation of a committee consistent with the description below.

11.16-2 DUTIES

The duties of the CAHP shall include the following:

(a) evaluating and making recommendations regarding the need for and appropriateness of the performance of in-hospital services by allied health practitioners (AHPs).

(b) evaluating and making recommendations regarding:

(1) the mechanism for evaluating the qualifications and credentials of AHPs who are eligible to apply for and provide in-hospital services;

(2) the minimum standards of training, education, character, competence, and overall fitness of AHPs eligible to apply for the opportunity to perform in-hospital services;

(3) identification of in-hospital services which may be performed by an AHP, or category of AHPs, as well as any applicable terms and conditions thereon; and

(4) the professional responsibilities of AHPs who have been determined eligible to perform in-hospital services.

(c) making recommendations regarding appropriate monitoring, supervision, and evaluation of AHPs who may be eligible to perform in-hospital services.

(d) evaluating and reporting whether in-hospital services proposed to be performed or actually performed by AHPs are inconsistent with the rendering of quality medical care and with the responsibilities of members of the medical staff.

(e) evaluating and reporting on the effectiveness of supervision requirements imposed upon AHPs who are rendering in-hospital services.

(f) periodically evaluating and reporting on the efficiency and effectiveness of in-hospital services performed by AHPs.

(g) coordinating insofar as necessary with the committee on interdisciplinary practice.

11.16-3 MEETINGS

The CAHP shall meet as often as necessary at the call of its chair but at least quarterly. It shall maintain a record of its proceedings and it shall submit reports of its activities and recommendations to the medical executive committee.

## 11.17 CONTINUING MEDICAL EDUCATION COMMITTEE

11.17-1 COMPOSITION

The continuing medical education committee shall be composed of physician members and other health professionals of the medical staff whose number shall be appropriate to the size of the hospital and amount of program activities produced annually. The composition shall be a chairperson, who shall serve for at least two years, and committee members who shall serve staggered terms in order to assure continuity. If the hospital has a Director of Medical Education, that individual should be at least an ex-officio member of the committee.

11.17-2 DUTIES

The continuing medical education committee shall perform the following duties:

(a) plan, implement, coordinate and promote ongoing special clinical and scientific programs for the medical staff. This includes:

(1) identifying the educational needs of the medical staff;

(2) formulating clear statements of objectives for each program;

(3) assessing the effectiveness of each program;

(4) choosing appropriate teaching methods and knowledgeable faculty for each program; and

(5) documenting staff attendance at each program.

(b) assist in developing processes to assure optimal patient care and contribute to the continuing education of each practitioner.

(c) establish liaison with the quality assessment and improvement program of the hospital in order to be apprised of problem areas in patient care, which may be addressed by a specific continuing medical education activity.

(d) maintain close liaison with other hospital medical staff and department committees concerned with patient care.

(e) make recommendations to the medical executive committee regarding library needs of the medical staff.

(f) advise administration of the financial needs of the continuing medical education program.

11.17-3 MEETINGS

The continuing medical education committee shall meet as often as necessary, but at least quarterly. It shall maintain minutes of the program planning discussions and report to the medical executive committee.

## 11.18 AD HOC DISPUTE MEDIATION COMMITTEE

All disputes between hospital administration or the board of directors and the medical staff ("Party" or "Parties" as applicable) relating to the medical staff's rights of self-governance as set forth in California Business and Professions Code Section 2282.5 ("Dispute") that have not been resolved by prior informal meetings and discussions shall be addressed and mediated in accordance with the process described in this Section. In the event either Party determines that a Dispute exists, such Party shall give written notice to the other Party, stating the nature of the Dispute. Within three (3) business days following receipt of such notice, both Parties shall appoint representatives to the committee as provided below. Neither Party shall initiate any legal action related to the Dispute until the committee has completed its efforts to mediate the Dispute.

11.18-1 COMPOSITION

An ad hoc committee shall be comprised of three (3) members appointed by the board of directors, and three (3) members appointed by the medical executive committee. The six (6) members shall appoint an outside professional mediator as the seventh member, and the mediator shall serve as chair of the committee, but shall have no vote. The Parties shall cooperate to select the mediator from a list of candidates provided by a service such as JAMS (Judicial Arbitration and Mediation Service) or the American Arbitration Association. The cost of the mediator shall be divided equally between the Parties.

11.18-2 DUTIES

The committee shall receive and promptly review the written request(s) for initiation of the Dispute mediation process. The committee may request such assistance as it deems necessary to gather relevant information and consider the opposing viewpoints. The committee then shall meet and confer in good faith to formulate a recommendation for mediation of the Dispute. The committee's efforts shall continue for up to sixty (60) days. After that period, the mediator shall prepare a written report of the committee's findings and recommendations and transmit it to the Parties if the committee has reached consensus, or the committee may ask the Parties for additional time to consider the Dispute. Both Parties must agree to any such extension of time. If the committee has not reached consensus, but chooses not to request additional time, the mediator shall submit a written report outlining any areas of agreement and the remaining issues, but shall not make any recommendations. Following receipt of the mediator's report,

the Parties may adopt the committee's recommendations, agree to some alternative resolution of the Dispute, or refer the Dispute back to the committee with instructions for further mediation efforts. Unless requested by the Parties to continue its deliberations, the committee shall dissolve thirty (30) days after the mediator has made his or her report to the Parties.

## ARTICLE: XII MEETINGS

### 12.1 MEETINGS

12.1-1 ANNUAL MEETING

There shall be an annual meeting of the medical staff. The chief of staff, or such other officers, department or division heads, or committee chairs the chief of staff or medical executive committee may designate, shall present reports on actions taken during the preceding year and on other matters of interest and importance to the members. Notice of this meeting shall be given to the members at least 14 days prior to the meeting.

12.1-2 REGULAR MEETINGS

Regular meetings of the members shall be held semi-annually except that the annual meeting shall constitute the regular meeting during the six month period in which it occurs. The date, place and time of the regular meetings shall be determined by the medical executive committee, and adequate notice shall be given to the members.

12.1-3 AGENDA

The order of business at a meeting of the medical staff shall be determined by the chief of staff and medical executive committee. The agenda shall include, insofar as feasible:

(a) reading and acceptance of the minutes of the last regular and all special meetings held since the last regular meeting;

(b) administrative reports from the chief of staff, departments, and committees, and the administrator;

(c) election of officers when required by these bylaws;

(d) reports by responsible officers, committees and departments on the overall results of patient care audits and other quality review, evaluation, and monitoring activities of the staff and on the fulfillment of other required staff functions;

(e) old business; and

(f) new business.

12.1-4 SPECIAL MEETINGS

Special meetings of the medical staff may be called at any time by the chief of staff or the medical executive committee, or shall be called upon the written request of 10% of the members of the active medical staff. The person calling or requesting the special meeting shall state the purpose of such meeting in writing. The meeting shall be scheduled by the medical executive committee within 30 days after receipt of such request. No later than 10 days prior to the meeting, notice shall be delivered to the members of the staff which includes the stated purpose of the meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

### 12.2 COMMITTEE AND DEPARTMENT MEETINGS

12.2-1 REGULAR MEETINGS

Except as otherwise specified in these bylaws, the chairs of committees, departments and divisions may establish the times for the holding of regular meetings. The chairs shall make every reasonable effort to ensure the meeting dates are disseminated to the members with adequate notice.

12.2-2 SPECIAL MEETINGS

A special meeting of any medical staff committee, department or division may be called by the chair thereof, the medical executive committee, or the chief of staff, and shall be called by written request of one-third of the current members, eligible to vote, but not less than three members.

### 12.3 QUORUM

12.3-1 STAFF MEETINGS

The presence of two-thirds of the total members of the active medical staff at any regular or special meeting in person or through written ballot shall constitute a quorum for the purpose of amending these bylaws or the rules and regulations of the medical staff or for the election or removal of medical staff officers. The presence of two percent of such members shall constitute a quorum for all other actions.

12.3-2 DEPARTMENT AND COMMITTEE MEETINGS

A quorum of 10% percent of the voting members shall be required for medical executive and credentials committee meetings. For other committees, a quorum shall consist of one of the voting member of a committee but in no event less than one voting member. For department and division meetings, a quorum shall consist of two of the voting members.

## 12.4 VOTING AND MANNER OF ACTION

12.4-1 VOTING

Unless otherwise specified in these bylaws, only members of the medical staff may vote in medical staff departmental or staff elections, and at department and medical staff meetings and all duly appointed members of medical staff committees are entitled to vote on committee matters, except as may otherwise be specified in these bylaws.

12.4-2 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, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be specifically required by these bylaws. Committee action may be conducted by telephone conference or other electronic communication which shall be deemed to constitute a meeting for the matters discussed in that telephone conference or other electronic communication. Valid action may be taken without a meeting by a committee if it is acknowledged by a writing setting forth the action so taken which is signed by at least the committee chair.

## 12.5 MINUTES

Except as otherwise specified herein, minutes of meetings shall be prepared and retained. They shall include, at a minimum, a record of the attendance of members and the vote taken on significant matters.

## 12.6 ATTENDANCE REQUIREMENTS

12.6-1 REGULAR ATTENDANCE

Except as stated below, each member of the active and provisional staff shall be required to attend:

(a) The annual medical staff meeting;

(b) At least 1 of all other general staff meetings duly convened pursuant to these bylaws; and

(c) At least 1 of all meetings of each department, division, and committee to which the member is assigned.

Verified attendance via telephone conference or other electronic communication shall be accepted. Each member of the temporary, consulting or courtesy staff and members of the provisional staff who qualify under criteria applicable to courtesy or consulting members shall be required to attend such meetings as may be determined by the medical executive committee. Temporary members of the medical staff under Section 6.2-3 are excluded from meetings requirements.

12.6-2 ABSENCE FROM MEETINGS

Any member who is compelled to be absent from any medical staff, department, division, or committee meeting shall promptly provide to the regular presiding officer thereof the reason for such absence.

Unless excused for good cause by the presiding officer of the department, division, or committee, or the secretary-treasurer for medical staff meetings, failure to meet the attendance requirements may be grounds for removal from such committee or for corrective action.

12.6-3 SPECIAL ATTENDANCE

At the discretion of the chair or presiding officer, when a member's practice or conduct is scheduled for discussion at a regular department, division, or committee meeting, the member may be requested to attend. If a suspected deviation from standard clinical practice is involved, the notice shall be given at least 7 days prior to the meeting and shall include the time and place of the meeting and a general indication of the issue involved. Failure of a member to appear at any meeting to which notice was given, unless excused by the medical executive committee upon a showing of good cause, shall be a basis for corrective action.

## 12.7 CONDUCT OF MEETINGS

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

## 12.8 EXECUTIVE SESSION

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

## ARTICLE XIII: CONFIDENTIALITY, IMMUNITY AND RELEASES

### 13.1 AUTHORIZATION AND CONDITIONS

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

(a) authorizes representatives of the hospital and the medical staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the applicant's professional ability and qualifications;

(b) authorizes persons and organizations to provide information concerning such practitioner to the medical staff;

(c) agrees to be bound by the provisions of this Article and to waive all legal claims against any representative of the medical staff or the hospital who would be immune from liability under Section 13.3 of this Article; and

(d) acknowledges that the provisions of this Article are express conditions to an application for medical staff membership, the continuation of such membership, and to the exercise of clinical privileges at this hospital.

### 13.2 CONFIDENTIALITY OF INFORMATION

13.2-1 GENERAL

Records and proceedings 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 and divisions, meetings of committees established under Article XI, 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.

13.2-2 BREACH OF CONFIDENTIALITY

As effective peer review and consideration of the qualifications of medical staff members and applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of medical staff departments, divisions, or committees, except in conjunction with other hospital, professional society, or licensing authority, is outside appropriate standards of conduct 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.

13.2-3 ACCESS TO AND RELEASE OF CONFIDENTIAL INFORMATION

Medical staff records, including committee and department records and credentials files may be accessed and released only in accordance with the medical staff's policy and procedure on access to medical staff records.

### 13.3 IMMUNITY FROM LIABILITY

13.3-1 FOR ACTION TAKEN

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

13.3-2 FOR PROVIDING INFORMATION

Each representative of the medical staff and hospital and all third parties shall be immune, to the fullest extent provided by law, from liability to an applicant or member for damages or other relief by reason of providing information to a representative of the medical staff or hospital concerning such person who is,

or has been, an applicant to or member of the staff or who did, or does, exercise clinical privileges or provide services at this hospital.

## 13.4 ACTIVITIES AND INFORMATION COVERED

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

(a) application for appointment, reappointment, or clinical privileges;

(b) corrective action;

(c) hearings and appellate reviews;

(d) utilization reviews;

(e) other department, or division, committee, or medical staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and

(f) queries and reports concerning the National Practitioner Data Bank, peer review organization, the Medical Board of California, and similar queries and reports.

## 13.5 RELEASES

Each applicant or member shall, upon request of the medical staff or hospital, execute general and specific releases in accordance with the express provisions and general intent of this Article. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

## 13.6 INDEMNIFICATION

The hospital shall indemnify, defend and hold harmless the medical staff, its individual members, and its appointed representatives (e.g. expert witnesses, lay committee members, hearing officers) 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, quality assessment, or activities related to establishing standards, policies and/or procedures pursuant to the self-governing medical staff provisions, 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. All disputes relating to the application of this provision shall be referred to the Ad Hoc Dispute Mediation Committee for resolution.

## 13.7 PATIENT PRIVACY

### 13.7-1 COMMITMENT TO PRIVACY RULE COMPLIANCE.

The use and disclosure of health information is governed, in part, by the Standards for Privacy of Individually Identifiable Health Information pursuant to the Health Insurance Portability and Accountability Act of 1996 (the "Privacy Rule") and the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), as they may be amended from time to time. Members and Allied Health Professionals shall protect the privacy of patients' health information as required by the Privacy Rule, the HITECH Act, and applicable state law. Further, the medical staff is committed to complying with the Privacy Rule in a manner that reasonably minimizes disruption to quality patient care.

### 13.7-2 ORGANIZED HEALTH CARE ARRANGEMENT.

The Privacy Rule permits multiple covered entities who provide care in a clinically integrated care setting, such as the hospital setting, to declare themselves an Organized Health Care Arrangement ("OHCA"). OHCA status generally permits its health care provider participants to use and disclose health information for purposes of treatment, payment and health care operations of the arrangement. Such activities include peer review, credentialing, quality assurance and utilization review. As such, OHCA status protects patient privacy while minimizing disruption to quality patient care. Accordingly, by applying for and exercising clinical privileges at the hospital, each member and Allied Health Professional agrees to participate in the hospital's OHCA. As such, all members or Allied Health Professionals shall abide by the hospital's Privacy Policies and Procedures.

13.7-3 JOINT NOTICE OF PRIVACY PRACTICES.

The Privacy Rule requires a health care provider that is a Covered Entity (as defined in the Privacy Rule) to deliver a notice of privacy practices to a patient no later than the provider's first date of service to the patient. Health care providers that participate in an OHCA may comply with this requirement by joint notice. The implementation of a joint notice streamlines compliance with the Privacy Rule. Accordingly, with respect to Protected Health Information (as defined in the Privacy Rule) created or received by a member or Allied Health Professional in connection with his or her provision of services in the hospital, by applying for and exercising clinical privileges at the hospital, each member and Allied Health Professional agrees to abide by the terms of the joint Notice of Privacy Practices of the hospital and the medical staff then in effect.

13.7-4 DISCIPLINE.

Whenever a member or Allied Health Professional uses or discloses health information in a manner inconsistent with the hospital's Privacy Policies and Procedures or joint Notice of Privacy Practices, the member/Professional may be disciplined in accordance with these bylaws.

## ARTICLE XIV: GENERAL PROVISIONS

### 14.1 MEDICAL STAFF RULES AND REGULATIONS AND POLICIES

The medical executive committee is hereby authorized to establish medical staff rules, and policies as provided in this Article. Rules and policies shall be reviewed every 2 years.

14.1-1 GENERAL RULES

The medical executive committee may propose the adoption, amendment or repeal of general medical staff rules or regulations for approval by the board of [trustees/directors], following notice to the members of the active staff. If one-third or more of the members of the active staff sign the petition objecting to the proposed rule and regulation the MEC/Medical Staff Dispute Resolution Process provided in Article XVI will be followed. General medical staff rules shall become effective when approved by the governing board – which approval shall not be unreasonably withheld. If the governing board withholds its approval for a general rule recommended by the medical executive committee, the medical executive committee may submit the matter to an Ad Hoc Dispute Mediation Committee for mediation as provided in Article XI, Section 11.18.

14.1-2 CLINICAL DEPARTMENT RULES

A clinical department may propose rules applicable to that department to the medical executive committee. Clinical department rules shall become effective upon approval by the medical executive committee and the governing board. The governing board shall not unreasonably withhold its approval. If the board of governing board does not approve a proposed clinical department rule, the medical executive committee may submit the matter to an Ad Hoc Dispute Mediation Committee for mediation as provided in Article XI, Section 11.18.

14.1-3 MEDICAL STAFF POLICIES

The medical executive committee may establish or revise policies and procedures consistent with the bylaws and general rules following written notice to the medical staff. If one-third or more of the members of the active staff sign a petition opposing a policy presented by the Medical Executive Committee, the MEC shall initiate the MEC/General Medical Staff Dispute Resolution Process set forth in General Rule X.

14.1-4 INITIATION OF GENERAL RULES OR POLICIES BY ACTIVE STAFF MEMBERS

Voting members of the active staff may propose adoption, amendment or repeal of general rules or of medical staff policies by following the process provided in Article XV, Section 15.1(b), below.

14.1-5 URGENT AMENDMENT OF RULES

The medical executive committee, with the approval of the governing board, may adopt amendments to general medical staff rules or department rules provisionally without notice to the general medical staff upon a documented need for an urgent amendment to comply with applicable law or regulation. Following notice of such action, members of the active staff, by petition signed by at least one-third of such members, may ask the medical executive committee to reconsider such changes.

14.1-6 EXCLUSIVITY

Neither the medical staff nor the governing board shall unilaterally amend the rules or policies. Applicants and members of the medical staff shall be governed by such rules and policies as are properly initiated and adopted. If there is a conflict between the bylaws and the rules or policies, the bylaws shall prevail. The mechanisms described herein shall be the sole methods for the initiation, adoption, amendment, or repeal of the medical staff rules and policies.

### 14.2 ACTIVE STAFF PETITION TO MEDICAL EXECUTIVE COMMITTEE

If members of the active staff, by written petition signed by at least one-third of such members, ask the medical executive committee to reconsider any action or policy of the medical executive committee, the medical executive

committee shall promptly schedule a meeting with up to three individuals representing those who have signed the petition to discuss the request.

### 14.3 DUES OR ASSESSMENTS

The medical executive committee shall have the power to recommend the amount of annual dues or assessments, if any, for each category of medical staff membership, subject to the approval of the medical staff, and to determine the manner of expenditure of such funds received.

### 14.4 AUTHORITY TO ACT

Any member or members who act in the name of this medical staff without proper authority shall be subject to such disciplinary action as the medical executive committee may deem appropriate.

### 14.5 DIVISION OF FEES

Any division of 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.

### 14.6 NOTICES

Except where specific notice provisions are otherwise provided in these bylaws, any and all notices, demands, requests required or permitted to be mailed shall be in writing properly sealed, and shall be sent through United States Postal Service, first-class postage prepaid. An alternative delivery mechanism may be used if it is reliable, as expeditious, and if evidence of its use is obtained. Notice to the medical staff or officers or committees thereof, shall be addressed as follows:

Name and proper title of addressee, if known or applicable

Name of department, division or committee

[c/o medical staff coordinator, chief of staff]

Hospital name

Street address

_____, California _____

Mailed notices to a member, applicant or other party, shall be to the addressee at the address as it last appears in the official records of the medical staff or the hospital.

### 14.7 DISCLOSURE OF INTEREST

All nominees for election or appointment to medical staff offices, department chairships, or the medical executive committee shall, at least 20 days prior to the date of election or appointment, disclose in writing to the medical executive committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware which could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the medical staff.

### 14.8 NOMINATION OF MEDICAL STAFF REPRESENTATIVES

Candidates for positions as medical staff representatives to local, state and national hospital medical staff sections should be filled by such selection process as the medical staff may determine. Nominations for such positions shall be made by a nominating committee appointed by the medical executive committee.

### 14.9 MEDICAL STAFF ROLE IN EXCLUSIVE CONTRACTING

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, or in a limited fashion pursuant to a closed/limited staff policy. The medical staff may review and make recommendations to the governing board regarding quality of care issues related to such exclusive arrangements 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 in a particular department or service;

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

## 14.10 RETALIATION PROHIBITED

Neither the medical staff, its members, committees or department heads, the governing body, its chief administrative officer, or any other employee or agent of the hospital or medical staff, may engage in any punitive or retaliatory action against any member of the medical staff because that member claims a right or privilege afforded by, or seeks implementation of any provision of, these medical staff bylaws.

## ARTICLE XV: ADOPTION AND AMENDMENT OF BYLAWS

### 15.1 PROCEDURE

Proposals to adopt, amend or repeal the bylaws may be initiated by either of the following methods:

(a) The medical executive committee, with the recommendation of the bylaws committee, or on its own motion, may recommend adoption, amendment or repeal of the bylaws to the voting members of the medical staff as provided in this Article.

(b) The members of the active staff, by a written petition signed by at least one-third of the active staff members, may petition the medical executive committee to initiate a proposal to adopt, amend or repeal the bylaws. Such petition shall identify exact language to be added, changed or deleted. If the medical executive committee agrees with the proposed change, it may recommend the change as provided in subsection (a), above. If the medical executive committee does not agree with the proposed change, the medical executive committee shall initiate the MEC/Medical Staff Dispute Resolution Process set forth in Article XVI. If the disagreement has not been resolved within 180 days from the date the proposal was delivered to the medical executive committee, the president shall call a special meeting of the active staff, as provided below, to consider the proposal.

### 15.2 ACTION BY THE ACTIVE STAFF

If a proposal is initiated as provided above, the president shall inform the members of the active staff, by US mail, or by electronic means, that the text of the proposed change can be obtained from the medical staff office. Not less than 30 days, and not more than 90 days, from the date of such notice, the president shall call a special meeting of the medical staff to consider the proposed change.

To be adopted, a proposed change to the bylaws must be approved by a majority of the members of the active staff voting in person or by written ballot at the special medical staff meeting. The Medical Executive Committee shall determine whether the vote shall be conducted by secret ballot at the meeting or by mail ballot. If a mail ballot is used, the ballots shall be opened and counted at the special meeting and the results shall be announced. Any objections to the balloting may be raised at the special meeting only.

### 15.3 APPROVAL

Upon approval by the active staff as provided above, the proposed bylaws change shall be submitted to the for approval. If no action on the proposed change is taken by the governing board within 60 days, the proposed change shall be deemed to have been approved by the governing board. The governing board may not unreasonably withhold its approval from the active staff's recommended change. If the governing board votes to disapprove any part of the recommended change, the governing board chair shall give the president of the medical staff written notice of the reasons for non-approval within ten business days from the governing board's action. At the request of the medical executive committee, the governing board's disapproval shall be submitted to the Ad Hoc Dispute Mediation Committee for mediation as provided in Article XI, Section 11.18.

### 15.4 EXCLUSIVITY

The medical staff and the hospital bylaws shall be consistent. To the extent of any inconsistency, the medical staff bylaws shall prevail. Neither the medical staff nor the governing board may unilaterally amend the bylaws. The mechanisms described herein shall be the sole methods for the initiation, adoption, amendment, or repeal of the medical staff bylaws.

### 15.5 SUCCESSOR IN INTEREST/AFFILIATIONS

15.5-1 SUCCESSOR IN INTEREST

These bylaws, and privileges of individual members of the medical staff accorded under these bylaws, will be binding upon the medical staff, and the governing board] of any successor in interest in this hospital, except where hospital medical staffs are being combined. In the event that the staffs are being combined, the medical staffs shall work together to develop new bylaws which will govern the combined

medical staffs, subject to the approval of the hospital's governing board or its successor in interest. Until such time as the new bylaws are approved, the existing bylaws of each institution will remain in effect.

15.5-2 AFFILIATIONS

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

## 15.6 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 XVI: MEDICAL EXECUTIVE COMMITTEE-MEDICAL STAFF DISPUTE RESOLUTION PROCESS

Disputes between the Medical Executive Committee and voting members of the Active Staff, as defined in Article XIV and XV of these Bylaws, shall be resolved as follows:

(a) If a majority of the members of the Active Staff sign a petition proposing a change to these Bylaws or the General Medical Staff Rules and Regulations or policies, or objecting to an action of the Medical Executive Committee relating to these Bylaws, General Medical Staff Rules and Regulations, policies or other official Medical Executive Committee actions, such petition shall be transmitted to the Medical Executive Committee via the Chief of Staff or the Medical Staff Office.

(b) The Medical Executive Committee shall, within sixty (60) days after it receives such petition via the Chief of Staff or Medical Staff Office, meet with representatives of those who have signed the petition to discuss and attempt to resolve the matter by mutual agreement.

(c) If the Medical Executive Committee and such representatives cannot agree on the subject matter of such petition, a consultant or a mediator may be engaged, by mutual agreement of the Medical Executive Committee and such representatives, to assist in resolving the dispute. If such a consultant or a mediator is engaged, the parties shall share equally in the costs of such consultant or mediator, provided however, that in no event shall the consultant or mediator be the Board of Directors or a representative thereof.

(d) If a matter relating to these Bylaws or the General Medical Staff Rules and Regulations or policies is not resolved within ninety (90) days after such matter was transmitted to the Medical Executive Committee via the Chief of Staff or Medical Staff Office, the Medical Executive Committee and such representatives shall prepare separate written statements of their respective positions and submit them to the Board of Directors within no more than thirty (30) days thereafter, to be considered by the Board of Directors for final decision.

ADOPTED by the medical staff on

May 02, 2019

Signed: Jacob Flores, MD, Chief of Staff

APPROVED by the Governing Board on

May 03, 2019

Signed: Vicki Rollins, Governing Board Committee Chair