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Medical Staff Bylaws

2016

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BYLAWS OF THE MEDICAL STAFF
WEST HILLS HOSPITAL AND MEDICAL CENTER

PREAMBLE

These Bylaws are adopted by the Medical Staff of West Hills Hospital and Medical Center, to provide a framework for self-governance. These Bylaws provide the structure for Medical Staff operations, organized Medical Staff relations with the Board of Trustees, and relations with applicants, members of the Medical Staff, Advanced Practice Professionals and others who exercise privileges. The Bylaws also permit the Medical Staff to discharge its responsibilities in matters involving the quality of medical care.

DEFINITIONS

1. **"ADVANCED PRACTICE PROFESSIONAL" or "APP"** means those independent and dependent Advanced Practice Professionals who are not members of the Medical Staff but are permitted to provide patient care services at the Hospital within their licensed scope of practice and the privileges granted by the Board.

2. **"AFFILIATED ENTITY"** means any entity which is directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with the Hospital.

3. **"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.

4. **"BOARD OF DIRECTORS"** means the governing board of the corporation owning the Hospital acting pursuant to the corporation's regulations.

5. **"BOARD OF TRUSTEES"** or **"BOARD"** means the governing body of the Hospital. As appropriate to the context and consistent with the Board of Trustees Bylaws, it may also mean any Board committee or individual authorized to act on behalf of the Board.

6. **"CHIEF EXECUTIVE OFFICER"** means the administrator appointed by the Board of Trustees to act on its behalf in the overall management of the Hospital.

7. **"CHIEF OF STAFF"** means the chief officer of the Medical Staff elected by Members of the Medical Staff.

8. **"CLINICAL PRIVILEGES" or "PRIVILEGES"** means the permission granted to Practitioners to provide patient care services and includes access to those Hospital resources, including equipment, facilities and Hospital personnel which are necessary to effectively exercise those privileges. All privileges are limited, as appropriate, by licensure and legal restrictions on the Practitioner's scope of practice.

9. **"CLOSED MEETING"** means any meeting of any committee of the Medical Staff at which privileged and/or confidential information regarding quality assessment and improvement and/or peer review information is presented or discussed. The chairperson of any meeting will determine if a meeting is a closed meeting. Only appointed committee members and guests invited by the committee chairperson may attend closed meetings.

10. **"CORRECTIVE ACTION"** means an action taken by the Medical Executive Committee as a result of an Investigation, including, but not limited to, actions which create the right to a hearing pursuant to the terms of these Bylaws.

11. **"CREDENTIALING PROCESSING CENTER" or "CPC"** means the regional credentialing center that provides intake, follow-up, data/image management, and verification of Requests for Consideration ("RFC") and Recredentialing Requests for Consideration ("RRFC") pursuant to a Service Level Agreement with the Hospital.

12. "**DATE OF RECEIPT"** means the date any notice, special notice, or other communication was delivered to a Practitioner. If a notice was sent by mail, it shall mean forty-eight (48) hours after it was deposited postage prepaid in the United States Postal Service. If a notice was sent return receipt requested, it shall mean the date the return

receipt was signed by the receiving party. If a notice is sent by email or fax, it shall mean the date and time the email or fax was transmitted.

13. **"DAYS"** means calendar days unless otherwise specified in these Bylaws.

14. **"DEPENDENT ADVANCED PRACTICE PROFESSIONAL"** means an appropriately licensed or certified health care Practitioner who is not eligible for Medical Staff membership and whose licensure or certification does not permit, and/or the Hospital does not authorize the independent exercise of privileges. Dependent Advanced Practice Professionals may only provide patient care services pursuant to individually delineated privileges as authorized by the Practitioner's supervising physician and the Medical Executive Committee and approved by the Board. Dependent Advanced Practice Professionals holding privileges at the Hospital are considered members of the Advanced Practice Professional Staff.

15. **"DESIGNEE"** In these Bylaws and other Medical Staff documents, the terms such as Chief of Staff, Department Chairperson, Section Chairperson, or any other identified Medical Staff or administrative elected or appointed representative means the person identified or their designee.

16. **"DISCIPLINARY ACTION"** means an action taken by the Medical Executive Committee which creates the right to a hearing pursuant to the Bylaws.

17. **"EXECUTIVE SESSION"** means the segment of a medical staff committee meeting in which only Medical Staff members holding voting privileges on the committee shall attend. The chairperson may, however, request other individuals attend an executive session in an informational non-voting capacity.

18. **"EX OFFICIO"** means by virtue of an office or position held. Ex Officio members on committees have no voting rights unless otherwise specified.

19. **"FEDERAL HEALTH CARE PROGRAM"** means any plan or program that provides health benefits whether directly, through insurance or otherwise, which is funded directly in whole or in part by the United States government or a state health program (with the exception of the Federal Employees Health Benefits program). Significant Federal Health Care Programs include but are not limited to Medicare, Medicaid, Blue Cross Federal Employees Program ("FEP")/Tricare/CHAMPUS and the veterans' programs.

20. **"HOSPITAL"** means West Hills Hospital and Medical Center.

21. **"INDEPENDENT ADVANCED PRACTICE PROFESSIONAL"** means an appropriately licensed or certified health care Practitioner who is not eligible for Medical Staff membership and whose licensure or certification permits, and the Hospital authorizes the independent provision of patient care services without direction or supervision and within the scope of individually delineated privileges. Independent Advanced Practice Professionals may only provide patient care services pursuant to individually delineated privileges as authorized by the Medical Executive Committee and approved by the Board. Independent Advanced Practice Professionals holding privileges at the Hospital are considered members of the Advanced Practice Professional Staff.

22. **"INELIGIBLE PERSON"** means any individual who is (1) currently excluded, suspended, debarred, or otherwise ineligible to participate in federal health care programs; (2) has been convicted of a criminal offense related to the provision of health care items or services buy has not yet been excluded, debarred, or otherwise declared ineligible; or (3) is currently excluded on a state exclusion list.

23. "**IN GOOD STANDING**" means a Practitioner currently meets all Medical Staff requirements for membership and privileges, all mandatory meeting attendance and emergency on-call requirements, is not in arrears in dues payments or completion of medical records, is not under investigation, suspension or restriction of membership or any privileges for medical disciplinary cause or reason, has no restriction of licensure or any certification, is not currently subject to a performance improvement plan or privilege retention agreement, and has no limitation of voting or other prerogatives imposed by operation of Bylaws, Rules and Regulations, or policy of the Medical Staff.

24. **"INVESTIGATION"** means a process specifically initiated by the Medical Executive Committee, as described in Article

VI, to determine the validity of a concern or complaint raised against a Practitioner and does not include activity by the Medical Staff Physician Well-Being Committee.

25. **"MEDICAL EXECUTIVE COMMITTEE" or "MEC"** means the committee of the Medical Staff that shall constitute the governing body of the Medical Staff.

26. **"MEDICAL STAFF"** means the organization of those Physicians (M.D. or D.O.), dentists, podiatrists, and psychologists who have been granted recognition as members of the Medical Staff pursuant to the terms of these Bylaws.

27. **"MEDICAL STAFF YEAR"** means the period from January 1 through December 31.

28. **"MEMBER"** unless otherwise expressly specified in these Bylaws, means any physician, dentist, podiatrist, or psychologist holding a current license to practice within the scope of his or her licensure who is a member of the Medical Staff.

29. **"MONTHLY"**, when referring to meetings, means at least ten (10) times per year.

30. **"NON-PRIVILEGED HEALTHCARE PRACTITIONER"** means an individual who by HCA Policy is allowed to order specific diagnostic tests and services, but who is not a member of the Medical Staff and has not been granted privileges to practice at the Hospital.

31. **"NOTICE"** means written communication emailed, faxed, hand delivered, or sent through the United States Postal Service addressed to a Practitioner at his/her current email address, fax number, or postal address as it appears in the office records of the Medical Staff or the Hospital. It is the Practitioner's responsibility to assure all address information on record at the Hospital is accurate. Unless otherwise stated in these Bylaws or as determined by the chairperson of a Medical Staff committee/department, all communication with Practitioners and applicants will be by email.

32. **"OFFICER ELECTION DATE"** means the fourth (4^{th}) Monday in November.

33. **"OPEN MEETING"** means a meeting of the Medical Staff which is not closed and may be attended by any Medical Staff Member.

34. **"PEER"** means an individual from the same discipline (for example, physician and physician, dentist and dentist) and with qualifications relative to the peer review issues being discussed. For purposes of peer review, a peer of an Advanced Practice Professional could be another Advanced Practice Professional or a physician qualified to perform similar tasks and/or procedures.

35. **"PEER REVIEW"** means the concurrent or retrospective review of an individual Practitioner's clinical performance and/or professionalism by one or more peers through a procedure approved by the Medial Staff. Medical Staff peer review procedures are described in various Medical Staff policies and other documents.

36. **"PHYSICIAN"** means an individual with an M.D. or D.O. degree or the equivalent degree (i.e., foreign) as recognized by the Medical Board of California ("MBC") or the California Board of Osteopathic Examiners ("BOE") who is licensed by either the MBC or the BOE.

37. **"PRACTITIONER"** means an individual credentialed by the Medical Staff who is a members of either the Medical or Advanced Practice Professional Staff or otherwise hold privileges at the Hospital.

38. **"RECREDENTIALING REQUEST FOR CONSIDERATION" or "RRFC"** means the form that a Practitioner submits to the CPC for evaluation in order to request consideration for renewed Medical Staff membership and/or privileges.

39. **"REQUEST FOR CONSIDERATION" or "RFC"** means the form that a Practitioner completes and submits to the CPC for evaluation in order to request consideration for initial membership in the Medical Staff and/or privileges.

40. **"RULE" or "RULES"** means requirements defined by the Medical Staff in Medical Staff Bylaws, Rules and Regulations,

and/or Medical Staff policy. All Practitioners are required to follow applicable rules.

41. **"SPECIAL NOTICE"** means a written notice either hand delivered or sent by certified mail with a return receipt requested through the United States Postal Service.

ARTICLE I: NAME AND PURPOSE

1.1 NAME

The name of the organization is the **"MEDICAL STAFF OF WEST HILLS HOSPITAL AND MEDICAL CENTER."**

1.2 MEDICAL STAFF PURPOSES

The purpose of the Medical Staff is:

a. To assure that all patients admitted to or treated in the Hospital receive care at a level of quality and efficiency consistent with generally accepted standards attainable within the Hospital's means and circumstances, and that patient care services are provided only within the scope of the privileges granted to the Practitioner providing the clinical service;

b. To provide for a level of professional performance that is consistent with generally accepted standards attainable within the Hospital's means and circumstances;

c. To organize and support professional education, community health education, and support services;

d. To initiate and maintain Medical Staff Rules and Regulations and Medical Staff Policies that govern how the Medical Staff carries out its responsibilities for the professional work performed in the Hospital;

e. To provide a means for the Medical Staff, Board, and Hospital administration to discuss issues of mutual concern;

f. To provide for accountability of the Medical Staff to the Board for the quality of all medical care to patients and for the ethical and professional practices of its Practitioners; and,

g. To be self-governing and accountable to the Board for the competency of credentialed Practitioners and the quality and appropriateness of care provided at the Hospital.

ARTICLE II: MEDICAL AND ADVANCED PRACTICE PROFESSIONAL STAFF MEMBERSHIP QUALIFICATIONS AND DUTIES

2.1 NATURE OF MEDICAL STAFF MEMBERSHIP

No physician, dentist, or podiatrist shall admit patients to the Hospital unless he/she is either a Member of the Medical Staff and has been granted admitting privileges or has been granted temporary privileges which include admitting privileges. A Practitioner cannot examine or treat a Hospital patient without current privileges for the services being provided. Appointment to the Medical Staff shall permit the exercise of only those specifically delineated privileges which are granted in accordance with these Bylaws.

2.2 QUALIFICATIONS FOR MEDICAL STAFF MEMBERSHIP

2.2-1 GENERAL QUALIFICATIONS FOR PHYSICIANS, DENTISTS, PODIATRISTS, AND PSYCHOLOGISTS

Membership on the Medical Staff is a privilege which shall be extended only to those Practitioners who meet and continue to meet the standards and requirements set forth in these Bylaws. Only those Practitioners who meet the general qualifications and duties as set forth in these Bylaws for membership on a continuous basis may be admitted to the Medical Staff. The fact that a Practitioner meets the following qualifications does not, by itself, entitle such Practitioner to

membership on the Medical Staff. Membership eligibility shall be determined through the credentialing process in accordance with Article IV of these Bylaws.

2.2-2 PARTICULAR QUALIFICATIONS

a. Physicians.

1) An applicant for physician membership on the Medical Staff, except for the Emeritus Staff, must hold an M.D. or D.O. degree or their equivalent and a valid and unsuspended certificate to practice medicine issued by the Medical Board of California or the California Board of Osteopathic Examiners.
2) Physicians applying for initial Medical Staff membership and appointment after January 1, 2016:

a) Must be currently certified by a board recognized by the American Board of Medical Specialties, the American Osteopathic Association, or another board or association with equivalent requirements approved by the Medical Board of California and the MEC. Board certification must be in a specialty and/or a sub-specialty appropriate to the area of the Practitioner's primary practice and privileges as determined by the MEC, or;
b) Must have successfully completed an approved residency/fellowship training program recognized by the American Board of Medical Specialties, the American Osteopathic Association or another board or association with equivalent requirements approved by the Medical Board of California and MEC, in a specialty and/or sub-specialty appropriate to the area of his/her practice as determined by the MEC, must be an active candidate in the board certification process and must meet the requirements of 2.2-2 (2) (c).
c) Those applicants who are not board certified at the time of application but who have completed their residency/fellowship or other applicable training within the last seven years will be eligible for Medical Staff membership and/or privileges. However, in order to remain eligible for Medical Staff membership and/or privileges, those individuals must achieve board certification in their primary area of practice within seven (7) years from the date of completion of their residency, fellowship or other required training. Failure to achieve board certification within seven (7) years will result in automatic termination of Medical Staff membership and/or privileges.
d) Individual departmental Rules and Regulations and/or privilege delineation forms may identify training, experience, and/or board certification requirements that are more stringent and exceed those described in this Section.
e) Once board certification is achieved, the physician must continuously maintain his/her board certification status in the specialty or sub-specialty in which he/she primarily practices and holds privileges. Failure to maintain board certification will result in automatic termination of Medical Staff membership and/or privileges.
f) Exceptions to the provisions in this Section related to board certification and maintenance of board certification may be made by the MEC, at its sole discretion, for cause.
g) Provisions of Section 2.2-2(a-g) do not apply to physicians holding membership and privileges prior to January 1, 2016.

b. Dentist. An applicant for dental membership on the Medical Staff, except for the Emeritus Staff, must hold a D.D.S. or equivalent degree and a valid and unsuspended certificate to practice dentistry issued by the Board of Dental Examiners of California. Oral surgeons requesting initial Medical Staff membership and privileges after January 1, 2016 must be board certified by the American Board of Oral and Maxillofacial Surgery (ABOMS) or have successfully completed a residency program in an accredited oral and maxillofacial surgery program recognized by the American Dental Association. Board qualified oral surgeons must achieved board certification within the timeframe established by the ABOMS and within seven (7) years of residency training completion. Board certification must be continuously maintained. Failure of a Practitioner to achieve board certification within four (7) years of residency completion or failure to continuously maintain board certification will result in the automatic termination of the Practitioner's Medical Staff membership and/or privileges. Exceptions to this board certification requirement may be made by the MEC for cause.

c. Podiatrist. An applicant for podiatric membership on the Medical Staff, except for the Emeritus Staff, must hold a D.P.M. degree and a valid and unsuspended certificate to practice podiatry issued by the Medical Board of California.

Podiatrists applying for initial Medical Staff membership and privileges after January 1, 2016, must be board certified by the American Board of Foot and Ankle Surgery (ABFAS), formally known as the American Board of Podiatric Surgery (ABPS), and have successfully completed at least two (2) years of a hospital based post-graduate podiatric surgical residency training in a program approved by the Council on Podiatric Medical Education. The hospital-based post-graduate training obtained must be relevant to the privileges requested. Board qualified podiatrists must be achieved board certification within the timeframe established by the ABFAS and within seven (7) years of residency completion. Board certification must be continuously maintained. Failure of the Practitioner to achieve board certification within seven (7) years or failure to maintain continuous board certification will result in the automatic termination of the Practitioner's Medical Staff membership and/or privileges. Exceptions to this board certification requirement may be made by the MEC for cause.

d. Psychologist. An applicant for clinical psychology membership on the Medical Staff and privileges, except for Emeritus Staff, must hold a doctorate degree in clinical psychology, have not less than two (2) years of clinical patient care 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 unrestricted certificate to practice in California issued by the Board of Psychology. Psychologists may not hold admitting privileges and may only provide clinical services upon request of a Medical Staff member.

e. Automatic termination of membership and/or privilege for failure to achieve or maintain board certification does not entitle a Practitioner to hearing rights as defined in these Bylaws.

2.2-3 FAILURE TO MEET MEDICAL STAFF QUALIFICATIONS

A Practitioner who does not meet all relevant qualifications for membership and/or privileges is ineligible to apply for Medical Staff membership and/or privileges and the application shall not be accepted for review. If it is determined during the processing that an applicant does not meet all relevant qualifications, the review of the application will be discontinued. An applicant who does not meet all relevant Medical Staff qualifications is not entitled to hearing rights describes in these Bylaws, but may submit comments and a request for reconsideration of the specific qualification which adversely affected the Practitioner's ability to apply. Those comments and requests will be reviewed by the MEC and the MEC will issue a final decision on the matter.

2.3 QUALIFICATIONS AND RIGHTS OF ADVANCED PRACTICE PROFESSIONALS

2.3-1 MEMBERSHIP

The APP Staff shall include those Practitioners who do not qualify for membership on the Medical Staff but provide clinical services to Hospital patients. The APP Staff may include both Independent APP and Dependent APP. All APP's must follow the requirements outlined in the Medical Staff Policy – Advanced Practice Professionals.

2.3-2 INDEPENDENT ADVANCED PRACTICE PROFESSIONALS

Independent APP's shall include those non-Medical Staff members whose license or certificate permits, and the Medical Staff and Hospital authorizes, the individual provision of patient care services without direction or supervision within the scope of the Independent APP's individually delineated privileges. Independent APP's:

a. Must be assessed, credentialed, and monitored through the existing Medical Staff credentialing, quality assessment, and performance improvement functions;

b. May not admit patients or assume primary patient care responsibilities for inpatients; and,

c. Are not required to have a sponsoring or supervising physician.

2.3-3 DEPENDENT ADVANCED PRACTICE PROFESSIONALS

Dependent APP's are licensed or certified healthcare Practitioners whose license or certification does not permit, or the Medical Staff and Hospital does not authorize, the independent exercise of privileges. Dependent APP may only provide patient care services pursuant to individually delineated privileges. Dependent APP's:

a. Must be assessed, credentialed, and monitored through the existing Medical Staff credentialing, quality assessment, and performance improvement functions;

b. May not admit patients or assume primary patient care responsibilities for inpatients;

c. May provide clinical services only under physician supervision and through the use of standardized procedures or protocols approved by the supervising physician and the MEC; and,

d. Must have current supervising agreement signed by their supervising physician.

2.3-4 QUALIFICATIONS

APP staff members must meet qualifications described in the Medical Staff Policy – Advanced Practice Professionals.

2.3-5 MECHANISM FOR GRANTING PRIVILEGES FOR ADVANCED PRACTICE PROFESSIONAL STAFF MEMBERS

APP's shall have their privileges reviewed and approved through the same mechanism described in Article IV of these Medical Staff Bylaws.

2.3-6 SUSPENSION, MODIFICATION, RESTRICTION, OR TERMINATION OF ADVANCED PRACTICE PROFESSIONAL PRIVILEGES

a. Automatic Suspension: An APP's privileges are contingent on the APP's continuous compliance with requirements described in these Bylaws, the Medical Staff Rules and Regulations, Medical Staff and Hospital policies, and the Medical Staff Policy – Advanced Practice Professionals. Failure to meet these requirements will result in an automatic termination of the APP's privileges. The APP is not entitled to hearing rights described in Section 7.11 following an automatic suspension.

b. Disciplinary Action Following an Investigation: An APP's privileges may also be modified, restricted, or terminated following an investigation by recommendation of the MEC and action of the Board. The procedure for conducting the investigation shall be determined by the MEC. The APP is entitled to hearing rights as described in Section 7.11.

c. Summary Suspension: A modification, restriction, or termination may be implemented summarily without an investigation by the Chief of Staff, the MEC, or a department chair if the failure to take that action may result in an imminent danger to the health of any individual, including future Hospital patients. The summary modification, restriction, or termination shall become effective immediately on imposition and the person or body responsible shall promptly give written notice to the APP, the MEC, and the Board. The APP is entitled to hearing rights as described in Section 7.11.

2.4 EFFECT OF OTHER AFFILIATIONS

No person shall be entitled to membership in the Medical or APP staff or to exercise any privileges merely because that person holds a certain degree, is licensed to practice in California or 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 any other health care facility.

2.5 NONDISCRIMINATION

No person shall be denied appointment, clinical privileges, or any of the rights of membership simply on the basis of race, creed, color, religion, gender, sexual orientation, gender identity/expression, disability, age, veteran status, political belief or affiliation, ancestry, or national or ethnic origin.

2.6 BASIC DUTIES, RESPONSIBILITIES AND OBLIGATIONS OF MEDICAL AND APP STAFF MEMBERSHIP

The ongoing basic duties and responsibilities of each Medical and APP staff member include:

a. Documenting and continuously providing evidence of current licensure, adequate experience, education and training, current professional competence in the exercise of requested privileges, good judgment, and current adequate physical and mental health status relative to the privileges requested, so as to demonstrate to the satisfaction of the Medical Staff that they are professionally and ethically competent and that patients treated by them can reasonably expect to receive quality medical care;

b. When requesting Medical Staff membership and privileges, meeting the criteria for membership and privileges in at least one department of the Medical Staff;

c. Complying with Medical Staff meeting attendance requirements as may be established by the MEC related to a particular category of Medical Staff membership, such as the Active Staff Category;

d. Providing patients with the quality of care meeting the professional standards of the Medical Staff of this Hospital;

e. Participating in the Medical Staff peer review/performance improvement program, ongoing professional practice evaluation (OPPE) program, proctoring/focused professional practice evaluation (FPPE) program.

f. Serving as a proctor when appointed by a department chairperson or the MEC. Proctors must make reasonable accommodations when a request is made to proctor a particular case/procedure;

g. Providing requested information in connection with Medical Staff peer review activities (including applications for appointment and reappointment). A Practitioner has the burden of producing sufficient information regarding his/her clinical and professional performance to permit an adequate evaluation of the Practitioner's qualifications to hold membership and/or privileges. In addition to providing clinical information, the Practitioner may be required to submit a complete history and physical examination, a specialty medical assessment, psychometric testing, blood, hair or other chemical analysis, a fitness for duty evaluation, and/or a psychological examination as deemed appropriate by the MEC. Any such examination(s) and testing shall be at the Practitioner's expense and will be performed by a physician(s), laboratory, or testing facility approved by the MEC. Failure to provide such information when requested as part of a Medical Staff peer review activity will result in an automatic suspension as described in Section 6.3-10 of these Bylaws;

h. Abiding by the Medical Staff Bylaws, Rules and Regulations, credentialing and privilege criteria, and Medical Staff and Hospital policies;

i. Discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the Practitioner by virtue of Medical Staff membership, including accepting committee, proctoring, and peer review assignments;

j. Participating in the organizational performance improvement program as requested by the MEC;

k. Agreeing to keep confidential and discuss only within established Medical Staff committees the proceedings of Medical Staff activities related to quality assessment and peer review;

l. Maintaining in force professional liability insurance covering the exercise of all requested privileges, in not less than $1,000,000 per occurrence and $3,000,000 in aggregate as described in the Medical Staff Rules and Regulations;

m. Remaining eligible to participate in Federal Health Care Programs. A Practitioner may not become an ineligible person and maintain Medical or APP staff membership or privileges;

n. Maintaining all DEA certificates with an in-state California address. If privileges are requested which include the prescribing of medications, the Practitioner must maintain current DEA certification for DEA Schedules 2, 2N, 3, 3N, 4, and 5. Exceptions to this requirement for all DEA Schedules 2 through 5 may be made by the MEC for cause;

o. Preparing and completing in a timely fashion, medical records for all the patients to whom the Practitioner provides care in the Hospital;

p. Timely payment of all Medical Staff dues and fines;

q. Abiding by the lawful, ethical principles of the American Medical Association, the California Medical Association, or the Practitioner's professional association;

r. Working cooperatively with other Practitioners, Hospital staff, Hospital administration, and others so as not to adversely affect patient care;

s. Providing continuing coverage for his or her patients and making appropriate arrangements for coverage when not available. This includes coverage for the Practitioner's patients who may come to the Hospital for emergency services. Each Practitioner must have at least one (1) identified covering Practitioner who is qualified to provide coverage, exceptions to this requirement may be made by the MEC for cause;

t. Refusing to engage in fee-splitting or in improper inducements for patient referral;

u. Participating in continuing education and other training programs as required by the Medical Staff or the MEC;

v. Providing information to and/or testifying on behalf of the Medical Staff or an accused Practitioner regarding any matter under an Investigation pursuant to Article VI, or which is the subject of a hearing pursuant to Article VII;

w. Participating in any emergency services "on call" panel or Hospital consultation panel as may be required by the MEC;

x. Protecting and preserving the confidentiality of patient health, services, and payment information imposed by state and federal confidentiality laws and the confidentiality policies of West Hills Hospital and Medical Center including without limitation the Health Insurance Portability and Accountability Act of 1996 as amended ("HIPAA");

y. Cooperating with the Hospital in matters involving its fiscal responsibilities and policies, including those relating to payment or reimbursement by governmental and third party payers;

z. Cooperating with all oversight activities related to utilization and medical appropriateness;

aa. Complying with MEC approved clinical practice protocols;

bb. Maintaining an active personal email account. Unless otherwise stated in these Bylaws or as determined by the chairperson of a Medical Staff committee/department, all communication with Practitioners and applicants will be by email. It is each Practitioner's responsibility to assure his/her email address listed with Medical Staff Services (MSS) is valid and current. Notices are deemed to be received when sent to a Practitioner's email address as listed in the records of the MSS Department.

cc. Complying with evidence-based guidelines that are established by, and must be reported to, regulatory or accrediting agencies or patient safety organizations including those related to national patient safety initiatives and core measures, or clearly documenting in the medical record the clinical reasons for variance;

dd. Participating in necessary electronic health record (EHR) and computerized practitioner order entry (CPOE) training and utilizing the EHR, CPOE, practitioner documentation (pDoc), and other technology in use by the Hospital when preparing a medical record for each patient; and,

ee. Discharging such other staff obligations as may be established from time to time by the Medical Staff or MEC.

Failure of a Practitioner to fulfill the basic duties, responsibilities and/or obligations of medical or APP staff membership will result in automatic suspension as described in Section 6.3-8.

2.6-1 PROMPT NOTIFICATION OF STATUS CHANGES

Each applicant, Member, and APP agrees to notify the Medical Staff promptly and no later than seven (7) days from the occurrence of any event representing a change or modification of information relevant to credentialing and/or competency. Such information includes:

a. Receipt of written notice of any adverse action by the Medical Board of California, or any other Practitioners' state or federal licensing board, taken or pending including but not limited to an accusation filed, temporary restraining order, or imposition of any interim suspension, probation, or limitations affecting license to practice medicine or the Practitioner's designated profession;

b. Voluntary or involuntary relinquishment or restriction of any license or registration;

c. Voluntary or involuntary termination or restriction of Medical Staff or other healthcare organization membership or privilege;

d. Any action taken by any hospital or other health care organization which has resulted in the filing of a Business and Professions Code Section 805 or 805.01 report with the Medical Board of California or a report filed with the National Practitioner Data Bank;

e. The denial, revocation, suspension, reduction, limitation, or non-renewal of membership and/or privileges at any hospital or other health care organization;

f. The voluntary relinquishment of membership and/or privileges at any hospital or other health care organization during an investigation for reasons related to clinical competence or professional conduct;

g. Any material reduction in professional liability coverage including changes in the scope of coverage;

h. Any action on a DEA certificate including a revocation, suspension, limitation, or probation on the right to prescribe medications;

i. Receipt of notice of any legal action related to a filed or served malpractice suit or malpractice-related arbitration action;

j. Conviction of any crime excluding minor traffic violations;

k. Changes in health status affecting the Practitioner’s ability to perform privileges which have been granted; or,

l. Receipt of any proposed or actual exclusion or adverse action, including but not limited to fraud and abuse proceedings or convictions under Medicare or Medicaid programs, or any other federally funded or state health care programs.

2.6-2 REQUIREMENT TO COOPERATE WITH MEDICAL STAFF QUALITY ASSESSMENT AND PRACTITIONER TESTING PROCESSES

a. Practitioners are required to cooperate with Medical Staff committees and Medical Staff representatives in the discharge of their official duties to monitor quality of care and patient safety. This includes responding properly and appropriately to Medical Staff correspondence, participating in peer review activities including proctoring, appearing at peer review meetings when requested, participating in OPPE, cooperating with any review related to an FPPE, and cooperating with a Medical Staff Investigation as defined in Section 6.1.

b. The responsibility to participate in peer review activities also includes:

    1) Providing information related to any investigation or other peer review action including information concerning actions taken by licensing or accreditation bodies, other hospitals, or other health care entities;

2) Submitting to psychological, physical, and laboratory examination and testing for purposes of resolving issues of fitness to perform mental or physical functions associated with the Practitioner's privileges. All testing will occur at the expense of the involved Practitioner;
3) Submitting to clinical evaluation and testing to assess current competence;
4) Providing admission and procedure logs related to clinical activity at other healthcare facilities;
5) Providing outside redacted patient records relevant to a Medical Staff quality review;
6) Providing clinical information from the Practitioner's private office that is necessary to resolve questions that have arisen through the peer review process;
7) Providing information related to professional liability coverage and/or liability actions; and,
8) Complying with other requests made pursuant to Sections 12.8 and 12.9.

c. If there is an immediate concern about drug or alcohol related impairment that may reasonably pose a threat to patient safety, the Chief of Staff, a department chairperson, or designee may require a Practitioner to submit to immediate blood, urine, or other drug/alcohol related laboratory testing. If there is an immediate concern and a Medical Staff representative is not available, the Chief Executive Officer or designee may request immediate blood, urine, or other drug/alcohol related laboratory testing. Other non-urgent requests for psychological, physical and/or laboratory testing may be mandated by the MEC or the Physician Well Being Committee.

d. Failure to comply with requirements described in Sections 2.6 (g) and 2.6-2 (a-c) constitutes grounds for automatic suspension of the Practitioner's privileges as described in Sections 6.3-8 and 6.3-10.

2.6-3 CRIMINAL ARREST OR INDICTMENT

In the event a Practitioner is arrested or indicted for alleged criminal acts, the Practitioner shall immediately report the arrest or indictment to the Chief of Staff and provide all related documentary information, and an inquiry into the circumstances of the arrest or indictment shall be made by the MEC. The MEC shall review the circumstances leading to the arrest or indictment and shall determine if an Investigation, restriction or termination is warranted prior to the outcome of the arrest or indictment, and shall make a report of its findings and all recommendations to the Board.

2.7 ORGANIZED HEALTH CARE ARRANGEMENT AND HIPAA COMPLIANCE

The Hospital and all its Practitioners shall be considered members of, and shall participate in, the Hospital's Organized Health Care Arrangement ("OHCA") formed for the purpose of implementing and complying with the Standards for Privacy of Individually Identifiable Health Information promulgated by the U.S. Department of Health and Human Services pursuant to the Administrative Simplification provisions of HIPAA. An OHCA is a clinically integrated care setting in which individuals typically receive health care from more than one healthcare provider. An OHCA allows the Hospital to share information with the Practitioners and the Practitioners' offices for purposes of payment and practice operations. The patient will receive one Notice of Privacy Practices during the Hospital's registration or admissions process, which shall include information about the Organized Health Care Arrangement with the Medical Staff, physicians, APP's with privileges, and non-employees who provide patient care under an approved scope of practice. Each Medical Staff member, each Practitioner with temporary privileges, APP with privileges, and non-employee with an approved scope of practice agrees to comply with the Hospital's policies as adopted from time to time regarding the use and disclosure of individually identifiable health information ("IIHI") and protected health information ("PHI"), as those terms are defined by HIPAA or as any similar terms are defined by more stringent state law (collectively, "IIHI/PHI").

2.8 BEHAVIOR AND CULTURE OF SAFETY

The Medical Staff supports the Hospital's culture of safety and prohibits harassment and all forms of unprofessional or disruptive behavior. All Practitioners must demonstrate a willingness and capability based on current behavior and evidence of performance to follow the Medical Staff Policy – Professional Conduct Standards and work with and relate to other staff members, members of other health disciplines, Hospital management and employees, visitors and the community in general in a cooperative, professional, non-disruptive manner that is essential for maintaining a Hospital environment appropriate to quality and efficient patient care. Failure of a Practitioner to demonstrate appropriate behaviors as described in the Medical Staff Policy – Professional Conduct Standards will result in responsive action by the Medical Staff as described in the Medical Staff Policy – Professionalism Review.

ARTICLE III: CATEGORIES OF THE MEDICAL STAFF

3.1 CATEGORIES

The categories of the Medical Staff shall include the following: Active, Primary Care Active, Courtesy, Consulting, Telemedicine, Provisional, Emeritus, Administrative, and Affiliate. A Practitioner's staff category shall be determined at the time of appointment, reappointment and whenever indicated based on patient care activity volume and other qualification requirements. At the time of initial appointment, applicants shall list their intended category of membership following Provisional Staff Membership. The privileges requested must match the qualification requirements and privilege prerogatives available in the applicant's intended category of membership.

3.2 ACTIVE STAFF

3.2-1 QUALIFICATIONS

The Active Staff shall consist of Practitioners who:

a. Meet the general qualifications for membership set forth in Section 2.2;

b. Have offices and residences which, in the opinion of the MEC, are located closely enough to the hospital to provide appropriate continuity of care;

c. Have provided direct patient care services to at least twenty (20) unique patients at the Hospital in the last two (2) years. Unique patients are identified by a unique patient medical record account number. All services provided during that unique episode of care are counted as "one." Direct patient care encounters include inpatient attending, formal written/dictated consultations or reports, inpatient and/or outpatient surgical and/or invasive/non-invasive procedures as primary operator, and services provided in an outpatient department/clinic of the Hospital. To fulfill this requirement, a Practitioner must be identified as the attending, consulting, or performing Practitioner on (20) unique patient accounts or must otherwise provide evidence of direct clinical involvement, as described above, in the care of twenty (20) unique Hospital patients. The clinical services provided during these encounters must directly relate to the privileges requested. Exceptions to this volume requirement may be made for cause by the MEC, and;

d. Have satisfactorily completed their designated term in the Provisional Staff category as set forth in Section 3.7.

3.2-2 PREROGATIVES AND DUTIES

Active Medical Staff members:

a. May, based on the scope of the Practitioner's clinical activity at WHHMC and other hospitals, apply for admitting and attending privileges and exercise other privileges which are granted to the Practitioner pursuant to Article V;

b. May attend and vote on matters within the scope of the Practitioner's licensure and privileges which are presented at general and special meetings of the Medical Staff or any meeting of any department/section of which he/she is a member;

c. May hold any Medical Staff or departmental/section office for which the Practitioner is qualified so long as the activities required by the position fall within the Practitioner's scope of practice as authorized by law;

d. May serve as a voting member on any committee to which he or she is duly appointed or elected. Voting shall be only on issues within the member's scope of licensure;

e. May vote on Bylaws amendments and in department chairperson elections;

f. Must participate in Emergency Department and other specialty/program call coverage if requested to do so by the

MEC, and;

g. Must meet any meeting attendance requirements established by the MEC,

3.2-3 RELINQUISHMENT OF ACTIVE STAFF STATUS

The failure of an Active Staff Member to meet the requirements of Section 3.2-1(a-c) shall be deemed a voluntary relinquishment of Active Staff status and the Practitioner shall automatically be transferred to the appropriate staff category, if any, for which the Practitioner is eligible. In the event that the Practitioner is not eligible for any other category, his or her Medical Staff membership shall automatically terminate. No such transfer or termination shall be subject to the provisions of Article VII.

3.3 PRIMARY CARE ACTIVE STAFF

3.3-1 QUALIFICATIONS

The Primary care Active Staff shall consist of Practitioners who:

a. Meet the general qualifications for membership set forth in Section 2.2;

b. Are Practitioners holding privileges in the specialties of Internal Medicine, Family Medicine, or Pediatrics;

c. Are in active practice in the local community with a focus on outpatient primary care treatment and management and treat at least 500 outpatient primary care patients every two (2) years. Appropriate documentation of outpatient practice must be provided when requested;

d. Are willing to share outcome data from their outpatient practice related to important continuity of care measures;

e. Have offices and residences which, in the opinion of the MEC, are located closely enough to the hospital to provide appropriate continuity of care;

f. Have provided direct patient care services to at least ten (10) unique patients at the Hospital in the last two (2) years. Unique patients are identified by a unique patient medical record account number. All services provided during that unique episode of care are counted as "one." Direct patient care encounters include inpatient attending, formal written/dictated consultations or reports, inpatient and/or outpatient surgical and/or invasive/non-invasive procedures as primary operator, and services provided in an outpatient department/clinic of the Hospital. To fulfill this requirement, a Practitioner must be identified as the attending, consulting, or performing Practitioner on ten (10) unique patient accounts or must otherwise provide evidence of direct clinical involvement, as described above, in the care of ten (10) unique Hospital patients. The clinical services provided during these encounters must directly relate to the privileges requested. Exceptions to this volume requirement may be made for cause by the MEC, and;

g. Have satisfactorily completed their designated term in the Provisional Staff category as set forth in Section 3.7.

3.3-2 PREROGATIVES AND DUTIES

Primary Care Active Medical Staff members:

a. May apply for admitting/attending privileges with consultation provided the physician has admitted and attended to at least ten (10) unique inpatients with consultation at the Hospital in the last two (2) years;

    1) If admitting/attending privileges with consultation are granted, a specific consultant must be identified in the medical record at the time of admission by the Primary Care Active Staff Member. The consultant must be a specialist and may not be another primary care provider, and;
    2) The identified consultant must see the patient and enter a consultation report in the medical record within twenty-four (24) hours of admission, and;
    3) 20%, and at least two (2), of the patient records will be retrospectively reviewed and a proctoring form

completed by the consulting physician as part of the Primary Care Active Staff Member's ongoing professional practice evaluation.

b. Based on the scope of the physician's clinical activity at the Hospital, may apply for and exercise other privileges which are granted to the Practitioner pursuant to Article V, and;

c. Have the same prerogatives and duties as Active Staff Members as described in Section 3.2-2 (b-g).

3.3-3 RELINQUISHMENT OF PRIMARY CARE ACTIVE STAFF STATUS

The failure of a Primary Care Active Staff Member to meet the requirements of Section 3.3-1(a-f) shall be deemed a voluntary relinquishment of Primary Care Active Staff status and the Practitioner shall automatically be transferred to the appropriate staff category, if any, for which the Practitioner is eligible. In the event that the Practitioner is not eligible for any other category, his or her Medical Staff membership shall automatically terminate. No such transfer or termination shall be subject to the provisions of Article VII.

3.4 COURTESY STAFF

3.4-1 QUALIFICATIONS

The Courtesy Staff shall consist of Practitioners who:

a. Meet the general qualifications for membership set forth in Section 2.2;

b. Have offices and residences which, in the opinion of the MEC, are located closely enough to the hospital to provide appropriate continuity of care;

c. Are Members In Good Standing of the active medical staff of another accredited or CMS certified hospital and have been involved in at least twenty (20) documented unique patient care activities, as described in Section 3.2-1(c), at that accredited or CMS certified hospital in the preceding two (2) years. Exceptions to this requirement may be recommended by the MEC for cause;

d. Have provided direct patient care to at least four (4) but fewer than twenty (20) unique patients at the Hospital in the last two (2) years. Unique patients are identified by a unique patient medical record account number. Direct unique patient care encounters include inpatient attending, formal written/dictated consultations, inpatient and/or outpatient surgical and/or invasive/non-invasive procedures as primary operator, surgical assisting, inpatient visits/rounding provided as part of call coverage, and services provided in an outpatient department/clinic of the Hospital. The clinical services provided must directly relate to the privileges requested or the Practitioners must provide evidence of current competence for the privileges requested from the hospital(s) where they hold active staff status. Exceptions to this requirement may be made for cause by the MEC, and;

e. Have satisfactorily completed their designated term in the Provisional Staff category as set forth in Section 3.7

3.4-2 PREROGATIVES AND DUTIES

Courtesy Medical Staff members:

a. May apply for admitting and attending privileges and exercise those privileges which are granted pursuant to Article V;

b. May attend, in a nonvoting capacity, general and special meetings of the Medical Staff and open committee meetings and educational programs of any department/section of which he or she is a member;

c. May be appointed as voting or nonvoting members on any Medical Staff committee. Voting status of Courtesy Staff Members appointed to Medical Staff committees must be determined by the MEC at the time of committee appointment, and;

d. Shall not be eligible to hold any Medical Staff or department/section office, vote on Bylaw amendments, vote at General Medical Staff meetings, vote in Medical Staff Officer or department chairperson elections.

3.4-3 RELINQUISHMENT OF COURTESY STAFF STATUS

The failure of a Courtesy Staff Member to meet the requirements of Section 3.4-1 (a-d) shall be deemed a voluntarily relinquishment of Courtesy Staff status and the Practitioner shall automatically be transferred to the appropriate staff category, if any, for which the Practitioner is eligible. In the event the Practitioner is not eligible for any other category, his or her Medical Staff membership shall automatically terminate. No such transfer or termination shall be subject to the provisions of Article VII.

3.5 CONSULTING STAFF

3.5-1 QUALIFICATIONS

Any Member of the Medical Staff In Good Standing may consult in his or her area of expertise; however, the consulting Medical Staff shall consist of such Practitioners who:

a. Meet the general qualifications for Medical Staff membership set forth in Section 2.2;

b. Are involved in at least two (2) direct unique patient care activities at the Hospital per two (2) year period. These direct unique patient care activities include consultations, assisting at surgeries, and/or the performance of invasive procedures. Exceptions to this requirement may be made for cause by the MEC;

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 able to demonstrate their current competency directly related to the privileges requested and types of clinical services provided at the Hospital through documented hospital inpatient or at least two hundred and fifty (250) outpatient clinical activities in their specialty in the last two (2) years. Exceptions to this requirement may be made for cause by the MEC;

e. Provide relevant redacted patient records, procedure reports, or activity logs documenting current competency to the Medical Staff when requested, and;

f. Have satisfactorily completed their designated term in the Provisional Staff category as set forth in Section 3.7.

3.5-2 PREROGATIVES AND DUTIES

Consulting Medical Staff members:

a. Cannot admit or provide primary care to patients as an attending Practitioner but may otherwise exercise such privileges which are granted pursuant to Article V;

b. May be appointed as voting or nonvoting members on any Medical Staff committee. Voting status of Consulting Staff Members appointed to Medical Staff committees must be determined by the MEC at the time of committee appointment;

c. Shall not be eligible to hold any Medical Staff or department/section office, vote on Bylaw amendments, vote in Medical Staff Officer or department chairperson elections, and;

d. Shall not be eligible to hold any Medical Staff or department/section office, vote on Bylaw amendments, vote at General Medical Staff meetings, vote in Medical Staff Officer or department chairperson elections.

3.5-3 RELINQUISHMENT OF CONSULTING STAFF STATUS

Consulting Staff Members who do not meet the requirements of Section 3.5-1 (a-e) shall be deemed to have voluntarily relinquished Consulting Staff status and shall be automatically transferred to the appropriate staff category, if any, for which the Practitioner is eligible. In the event the Practitioner is not eligible for any other category, his or her Medical Staff membership shall automatically terminate. No such transfer or termination shall be subject to the provisions of Article VII.

3.6 TELEMEDICINE STAFF

3.6-1 DEFINITION AND QUALIFICATIONS

Telemedicine is the practice of medicine through the use of electronic or other communication technologies to provide or support clinical care of Hospital patients from a distant location without physical contact between the telemedicine Practitioner and the patient. Telemedicine services may involve direct electronic or other communication between the telemedicine Practitioner and the patient. The term "telemedicine" does not apply to pathologic specimens sent out for a second opinion. Practitioners holding privileges in other categories of membership may utilize available Hospital telemedicine equipment and links as clinically indicated. The Telemedicine Staff shall consist of members who:

a. Meet the general Medical Staff qualifications set forth in Section 2.2;

b. Do not have physical in-person contact with any Hospital patients, but rather require Medical Staff membership and telemedicine privileges to provide diagnostic and/or consultative services to Hospital patients via telemedicine technology and devices;

c. Meet all competency requirements relevant to the privileges requested and are willing and able to provide telemedicine services on schedule or promptly respond when called to render telemedicine services within their area of competency;

d. Provided telemedicine services to at least four (4) unique Hospital patients in the last two (2) years. Exceptions to this requirement may be made for cause by the MEC, and;

e. Have successfully completed their designated term in the Provisional Staff category as set forth in Section 3.7.

3.6-2 PREROGATIVES AND DUTIES

The Telemedicine Staff member:

a. May not act as an admitting or attending Practitioner;

b. May only provide telemedicine consultation relative to the specific privileges the telemedicine Practitioner holds;

c. May be appointed as voting or nonvoting members on any Medical Staff committee. Voting status of Telemedicine Staff Members appointed to Medical Staff committees must be determined by the MEC at the time of committee appointment;

d. May not vote or hold any Medical Staff office, except as described in 3.6-2(c), and;

e. Must actively participate in the Medical Staff and Hospital's peer review and quality improvement programs.

3.6-3 RELINQUISHMENT OF TELEMEDICINE STAFF STATUS

The failure of a Telemedicine Staff Member to meet the requirements of Section 3.6-1 (a-d) shall be deemed a voluntary relinquishment of Telemedicine Staff status and the Practitioner shall automatically be transferred to the appropriate staff category, if any, for which the Practitioner is eligible. In the event that the Practitioner is not eligible for any other category, his or her Medical Staff membership shall automatically terminate. No such transfer or termination shall be subject to the provisions of Article VII. Telemedicine Staff members may not transfer to the Affiliate Staff Category.

3.7 PROVISIONAL STAFF

3.7-1 QUALIFICATIONS

All Practitioners applying for initial appointment to the Medical Staff and requesting privileges, except those requesting Affiliate or Administrative Staff Category and those requesting temporary privileges, shall be appointed to the Provisional Staff for a period of at least one (1) year. At the time of appointment, an applicant shall list their intended category of membership following Provisional Staff membership. The scope of privileges requested must be included in the privilege prerogatives of the applicant's intended staff category. The Provisional Staff shall consist of Practitioners who:

a. Meet the applicable general Medical Staff membership qualifications set forth in Section 2.2;

b. Meet the requirements of Section 3.2-1(b) if the Practitioner has applied for admitting/attending privileges, and;

c. If applying for admitting/attending privileges without consultation, have provided direct patient care to at least twenty (20) unique patients, as described in Section 3.2-1(c), at an accredited or CMS certified hospital in the last two (2) years. The clinical services provided in the last two (2) years must relate directly to the privileges requested. Exceptions to this requirement may be made for cause by the MEC, and;

d. If applying for admitting/attending privileges with consultation (Primary Care Active Staff Category), have provided direct patient care to at least ten (10) unique patients, as described in Section 3.3-1(f), at an accredited or CMS certified hospital in the last two (2) years. The clinical services provided in the last two (2) years must relate directly to the privileges requested. Exceptions to this requirement may be made for cause by the MEC.

3.7-2 PREROGATIVES AND DUTIES

Provisional Medical Staff members:

a. May apply for admitting and attending privileges and exercise such privileges as are granted pursuant to Article V subject to any restrictions related to the Practitioner’s intended Medical Staff category following completion of their Provisional Staff requirements;

b. May attend, in a nonvoting capacity, general and special meetings of the Medical Staff, and meetings and educational programs of any department/section of which they are a member;

c. May be appointed as voting or nonvoting members on any Medical Staff committee. Voting status of Provisional Staff Members appointed to Medical Staff committees must be determined by the MEC at the time of committee appointment;

d. Shall not be eligible to hold any Medical Staff or department/section office, vote on Bylaw amendments, vote at General Medical Staff meetings, vote in Medical Staff Officer or department chairperson elections, and;

e. Must participate in Emergency Department and other specialty/program call coverage if requested or required to do so by the MEC.

3.7-3 OBSERVATION AND PROCTORING OF PROVISIONAL STAFF MEMBER

Each Provisional Staff Member, as part of the Medical Staff peer review and focused professional practice evaluation (FPPE) program, shall undergo a period of observation, evaluation, and proctoring as established by the MEC and described in Section 5.3 and the Medical Staff Policy – Proctoring.

3.7-4 ACTION AT CONCLUSION OF PROVISIONAL STAFF MEMBERSHIP

a. All Practitioners will remain in the Provisional Staff Category until all proctoring requirements have been met.

b. After one (1) year of Provisional Staff membership, if the Provisional Staff member has successfully completed all

proctoring requirements and has satisfactorily demonstrated his/her ability to exercise the privileges initially granted and otherwise appears qualified for continued Medical Staff membership, the Practitioner is eligible for advancement to another appropriate staff category by the MEC.

b. Failure to complete all proctoring requirements within one (1) year shall be governed by the provisions of Sections 5.3.

3.8 EMERITUS STAFF

3.8-1 QUALIFICATIONS

The Emeritus Staff shall consist of Physicians, dentists, and podiatrists who have been members of the Active Medical Staff for no less than twenty-five (25) years, do not actively practice at the Hospital, and continue to adhere to appropriate professional and ethical standards.

3.8-2 PREROGATIVES AND DUTIES

Emeritus Medical Staff members:

a. Are not eligible to admit patients to the Hospital or to exercise any privileges in the Hospital;

b. May serve on committees with or without vote upon request of the MEC;

c. May not otherwise vote or hold office but may attend open general and special Medical Staff meetings and educational programs, and;

d. May change categories of membership only through the application and credentialing process as established in these Bylaws.

e. Members of the Emeritus Medical Staff will be sent a letter every two (2) years from MSS asking if the Practitioner wishes to remain an Emeritus Medical Staff member. There will, however, be no requirement for reappointment.

3.9 ADMINISTRATIVE STAFF

3.9-1 QUALIFICATIONS

Administrative Staff category membership shall be held by any physician who is not currently a Medical Staff member in another staff category and who is retained by the Hospital or Medical Staff solely to perform ongoing medical administrative activities. Administrative Staff are not assigned to the Provisional Staff Category.

The Administrative Staff shall consist of Practitioners who:

a. Meet the general qualifications for membership set forth in Section 2.2;

b. Are charged with assisting the Medical Staff in carrying out medical-administrative functions, including but not limited to quality assessment, peer review, ongoing professional practice evaluation, performance improvement, focused professional practice evaluation, and utilization review;

c. Document their current licensure, adequate experience, education and training, current professional competence, good judgment, and 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, and;

d. Are determined to adhere to the ethics of their respective professions, to be able to work cooperatively with others so as not to adversely affect their judgment in carrying out the quality assessment and improvement functions, and to be willing to participate in and properly discharge those responsibilities determined by the Medical Staff.

3.9-2 PREROGATIVES AND DUTIES

Administrative Medical Staff members:

a. May not exercise any clinical privileges at the Hospital;

b. Shall be entitled to attend meetings of the Medical Staff, departments/sections, and committees, but shall have no right to vote at such meetings, except to the extent the right to vote is specified by the MEC;

c. Shall not be eligible to hold office in the Medical Staff organization, and;

d. Shall not be required to maintain professional liability insurance.

3.10 AFFILIATE STAFF

3.10-1 QUALIFICATIONS

Practitioners may be transferred to the Affiliate Staff Category from another staff category but may also apply directly to the Affiliate Staff Category for initial appointment. Practitioners who apply directly to the Affiliate Staff Category are not assigned to the Provisional Staff Category. The Affiliate Staff shall consist of Members who:

a. Meet the general Medical Staff qualifications set forth in Section 2.2 and;

b. Are in active practice in the local community with a focus on outpatient treatment and management and treat at least 500 outpatients a year in their office, and;

c. Are not members of another hospital medical staff.

Exceptions to these qualification requirements may be made by the MEC.

3.10-2 PREROGATIVES AND DUTIES

Affiliate Medical Staff members:

a. May not exercise any privileges at the Hospital;

b. May order outpatient diagnostic testing;

c. May attend open Medical Staff meetings without vote and may serve as voting or nonvoting members of Medical Staff committees if so appointed by the MEC;

d. May, with the patient's consent, visit, review the medical record, and round on their own patients when their own patients have been admitted to the Hospital;

e. May not write inpatient orders or make entries into a patient medical record, and;

f. May not use their Affiliate Staff membership in public marketing materials unless approved by the MEC.

3.10-3 RELINQUISHMENT OF AFFILIATE STAFF STATUS

Affiliate Staff Members who do not meet the requirements of Section 3.10-1 (a-c) shall be deemed to have voluntarily relinquished Affiliate Staff status and shall be automatically transferred to the appropriate staff category, if any, for which the Practitioner is eligible. In the event the Practitioner is not eligible for any other category, his or her Medical Staff membership shall automatically terminate. No such transfer or termination shall be subject to the provisions of Article VII.

3.11 LIMITATION OF PREROGATIVES

The prerogatives set forth under each membership category are general in nature and may be subject to limitation and special conditions attached to a particular Practitioner, by other sections of these Bylaws, the Medical Staff Rules and Regulations, or the MEC.

3.12 GENERAL EXCEPTIONS TO PREROGATIVES

Regardless of the category of membership, Practitioners shall only exercise those privileges and shall only have the right to vote on those matters that are within the scope of their licensure. In the event of a dispute over voting rights, the issue shall be determined by the chairperson of the meeting, subject to final decision by the MEC. If the final decision of the MEC is made after a vote has been taken, the results of the vote may change pursuant to the MEC's final decision.

3.13 MODIFICATION OF MEMBERSHIP CATEGORY

The MEC may change the Medical Staff category of a Practitioner consistent with the requirements of the Bylaws.

ARTICLE IV APPOINTMENT AND REAPPOINTMENT

Appointment to the Medical Staff or granting of clinical privileges shall confer on the individual only such prerogatives of membership that are granted by the Board. For purposes of these Bylaws, "membership in" is used synonymously with "appointment to" or "reappointment to" the Medical Staff. The granting of membership or approval of appointment does not automatically confer clinical privileges. All Medical Staff members and APP's with clinical privileges are subject to these Bylaws, Medical Staff Rules and Regulations, and Medical Staff policies. Only those individuals meeting both (1) all Threshold Eligibility Criteria, and (2) the six general competency requirements set forth in these Bylaws, shall be eligible to apply for appointment or reappointment to the Medical Staff or granted clinical privileges, and these professional criteria shall apply uniformly to all Medical Staff and APP applicants.

4.1 THRESHOLD ELIGIBILITY CRITERIA

To be eligible to apply for initial appointment or reappointment to the Medical Staff, with or without privileges, a Practitioner must be a physician, dentist or oral maxillofacial surgeon, podiatrist, or psychologist.

To be eligible for clinical privileges as an APP an individual must be an advanced practice registered nurse (APRN) or a physician assistant (PA).

Each Medical Staff and APP applicant shall:

4.1-1 Have proof of identity and either US citizenship or evidence of status as a lawful permanent resident of the US;

4.1-2 Have a current, unlimited, unrestricted, active legal license to practice in his or her respective profession in California, which license permits him/her to practice in the Hospital setting and authorizes him/her to receive and examine patients, diagnose conditions and prescribe and implement a treatment plan, and to prescribe medications necessary for the treatment of conditions and diagnoses within the Practitioner's area of practice, and have not had a license to practice restricted, revoked or suspended by any state licensing agency, or in the case of an APP, to practice within the full scope of licensure with any supervision as may be required by law;

a. If the applicant is an active duty military Practitioner, and will be practicing exclusively within the scope of military duties for patients who are members of the armed forces or their dependents, then current, unlimited, unrestricted, active licensure from any State shall be accepted.

b. If the applicant is an out-of-state Practitioner who will be providing patient care in this state under an exception to state licensure requirements, the exception must be verified with the State licensure board and documented. Any conditions associated with the exception (i.e., that the exception requires that the Practitioner must be licensed in his/her home State) must also be verified and documented.

4.1-3 Have a current, unrestricted Federal DEA registration valid for prescribing Schedules 2, 2N, 3, 3N, 4, and 5 within California and which permits him or her to prescribe all medications necessary for the treatment of conditions and diagnoses within the Practitioner's area of practice. Exceptions to the requirement for all DEA Schedules 2 through 5 may be made by the MEC for cause;

4.1-4 Meet all education, training, board eligibility and board certification requirements described in Section 2.2;

4.1-5 Be located or, if a new applicant, intend to relocate if granted privileges (office and residence) close enough to fulfill their Medical Staff or APP responsibilities and to provide timely and continuous care for his or her patients in the Hospital;

4.1-6 For APP's, have the necessary coverage by a supervising physician as required by State laws and regulations, or the supervision required in association with the clinical privileges granted to the APP;

4.1-7 Have current, valid professional liability insurance coverage in a form acceptable to the Hospital, including insurance through a carrier authorized to do business in the State of California as a licensed provider of professional malpractice insurance, insurance for the clinical privileges requested, and with limits of at least $1 million for each claim and $3 million in aggregate;

4.1-8 Have not been convicted of, or entered a plea of guilty or no contest to, Medicare, Medicaid, or other federal or state government or private third-party payer fraud or program abuse, nor have been required to pay civil monetary penalties for the same;

4.1-9 Have not been, and are not currently, excluded, precluded, or debarred from participation in Medicare, Medicaid, or other federal or state governmental health care program, as verified by screening ineligible persons against the OIG and SAM;

4.1-10 Have not had Medical Staff or APP appointment, employment or clinical privileges denied, revoked, involuntarily restricted, modified, or terminated; or voluntarily restricted, modified or terminated after notice of the commencement of an investigation or notice of an adverse recommendation by any peer review committee, by any health care facility or health plan for reasons related to clinical competence or professional conduct;

4.1-11 Have not resigned Medical Staff or APP appointment or relinquished privileges during a Medical Staff investigation or in exchange for not conducting such an investigation;

4.1-12 Have never been expelled from a post-graduate training program (residency, fellowship or an equivalent APP program);

4.1-13 Have never has an RFC, RRFC or application for membership or privileges deemed ineligible for continued processing by the Hospital, the CPC or any affiliated entity due to a finding of material omission or misrepresentation;

4.1-14 Have not been convicted of, or entered a plea of guilty or no contest, to any felony; or to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, child abuse, elder abuse, or violence;

4.1-15 Agree to sign consent forms to permit a consumer reporting agency to conduct a background check and report the results to the CPS and the Hospital;

4.1-16 Agree to fulfill all responsibilities regarding emergency service call coverage for his or her specialty as may be required by the MEC;

4.1-17 Have or agree to make appropriate coverage arrangements (as determined by the MEC) with other members of the Medical Staff for those times when the individual will be unavailable;

4.1-18 Demonstrate recent clinical activity relevant to the privileges requested in his or her primary area of practice during the last two years;

4.1-19 Meet any current or future eligibility requirements/criteria that are applicable to the clinical privileges being sought; and,

4.1-20 If applying for privileges in an area that is covered by an exclusive contract, meet the specific requirements set forth in that contract.

4.2 WAIVER OF THRESHOLD ELIGIBILITY CRITERIA

4.2-1 When an individual does not satisfy one or more of the Threshold Eligibility Criteria outlined above, the individual shall be notified by the Credentialing Processing Center (CPC) that the Request for Consideration (RFC) or the Reappointment Request for Consideration (RRFC) that does not satisfy a Threshold Eligibility Criterion will not be processed.

4.2-2 Any individual who does not satisfy one or more of the Threshold Eligibility Criteria outlined above may request that it be waived. The individual requesting the waiver bears the burden of demonstrating exceptional circumstances, and that his or her qualifications are equivalent to, or exceed, the criterion in question.

4.2-3 A request for a waiver shall be submitted to the MEC for consideration. In reviewing the request for a waiver, the MEC may consider the specific qualifications of the applicant in question, input from the relevant department chair, and the best interests of the Hospital and the communities it serves. Additionally, the MEC may, in its discretion, consider the application form and other information supplied by the applicant.

4.2-4 The MEC shall make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the specific basis for the recommendation.

4.2-5 No applicant is entitled to a waiver or to a hearing if the Board determines not to grant a waiver. A determination that an individual is not entitled to a waiver is not a "denial" of appointment or clinical privileges. Rather, it is a final determination that the individual is ineligible to request appointment or clinical privileges based on current information.

4.2-6 The granting of a waiver in a particular case is not intended to set a precedent for any other individual or group of individuals.

4.2-7 A RFC or RRFC that does not satisfy a Threshold Eligibility Criterion will not be processed until the Board has determined that a waiver should be granted.

4.3 FACTORS FOR EVALUATION OF APPLICATION

When a RFC or RRFC is received that is complete and meets all Threshold Eligibility Criteria, it will be processed by the CPC and submitted to the Medical Staff as an application. Six general competencies (patient care, medical knowledge, professionalism, system-based practice, practice-based learning, and interpersonal communications) will be evaluated by the Medical Staff as part of the appointment and reappointment processes, as reflected in the following factors:

4.3-1 CURRENT COMPETENCE, EXPERIENCE, AND JUDGMENT

The applicant must document his/her relevant training and experience, and current clinical competence, skills and judgment including medical/clinical knowledge, technical and clinical skills, and clinical judgment, and an understanding of the contexts and systems within which care is provided, with sufficient adequacy, as determined at the discretion of the MEC and the Board, to demonstrate that patients receiving healthcare services from him/her will receive care of the generally recognized professional level of quality and efficiency established by the Hospital. Evidence of current competence and experience shall include, but shall not be limited to, responses to related questions provided in information from training programs, peers, and other facility affiliations. Evidence of current competence and experience shall also include, but not be limited to, documentation of continuing medical education, the results of performance improvement and peer review, recommendation(s) provided by Department Chairperson(s), and information provided by other hospitals and healthcare facilities where the Practitioner may practice.

4.3-2 CONDUCT/BEHAVIOR

The applicant must be able to demonstrate good reputation and character including compliance with the Medical Staff Policy – Professional Conduct Standards and the ability to work cooperatively with others and to treat others within the Hospital with respect. Evidence of ability to display appropriate conduct and behavior shall include, but shall not be limited to, responses to related questions provided in information from training programs, peers, and other facility affiliations. In the case of an applicant for reappointment, evidence of ability to display appropriate conduct and behavior shall also include, but not be limited to, a review of conduct during the previous term(s) of appointment and recommendation(s) provided by Section and Department Chairperson(s).

4.3-3 PROFESSIONAL ETHICS AND CHARACTER

The applicant must demonstrate adherence to the ethics of their profession, continuous professional development, an understanding of and sensitivity to diversity, and responsible attitude toward patients and their profession. By virtue of applying for Medical Staff membership or clinical privileges, and agreeing to abide by the Medical Staff Bylaws, the applicant shall agree to abide by applicable provisions of the Code of Conduct of HCA, and the code of ethical business and professional behavior of this Hospital.

4.3-4 HEALTH STATUS/ABILITY TO PERFORM

The applicant shall possess the ability to safely and competently perform the clinical privileges requested. In the event that the applicant has a physical or mental health issue that adversely affects his/her ability to practice within the clinical privileges requested, the applicant shall notify the Chief of Staff. Upon receipt of such notification, the Chief of Staff will meet with the applicant to determine the extent of the health issue. If it is determined that the health issue does not adversely affect the applicant's ability to perform the essential functions of the clinical privileges requested, the Chief of Staff and applicant will discuss whether there is a reasonable accommodation that would enable the applicant to perform such functions. If reasonable accommodation is necessary, the Hospital will provide such accommodation to the extent required by law, or if not so required, as determined to be appropriate within the sole discretion of the Hospital.

4.3-5 INTERPERSONAL AND COMMUNICATION SKILLS

The applicant shall possess an ability to work harmoniously with others, including, but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families, and other members of health care teams; and to communicate in English in an understandable manner sufficient for the safe delivery of patient care (as determined in the sole discretion of the Hospital), both verbally and in writing. Hospital records, including patients' medical records, shall be recorded in a legible fashion, in English.

4.3-6 COMMITMENT TO QUALITY CARE

The applicant shall demonstrate recognition of the importance of, and willingness to support, the Hospital's and Medical Staff's commitment to quality care and recognition that interpersonal skills and collegiality are essential to the provision of quality patient care.

4.4 NO ENTITLEMENT TO APPOINTMENT

No individual is entitled to be appointed or reappointed to the Medical Staff or to be granted particular clinical privileges merely because he or she:

4.4-1 Is licensed to practice a profession in this or any other state;

4.4-2 Is a member of any particular professional organization;

4.4-3 Is certified by any specialty certification board;

4.4-4 Resides in the geographic service area of the Hospital;

4.4-5 Is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity; or,

4.4-6 Has/had Medical Staff membership or clinical privileges in another hospital or health care organization.

4.5 HOSPITAL NEED AND ABILITY TO ACCOMMODATE

No person shall be appointed to the Medical Staff or granted clinical privileges if the Hospital is unable to provide adequate facilities and support services for the applicant or his/her patients. The Board may decline to accept, or have the Medical Staff review, requests for Medical Staff membership and/or particular clinical privileges in connection with appointment, reappointment, the initial granting of clinical privileges, requests for revision of clinical privileges, the renewal of clinical privileges or otherwise on the basis of the following:

4.5-1 AVAILABILITY OF FACILITIES/SUPPORT SERVICES

Clinical privileges shall be granted only for the provision of care that is within the scope of services, capacity, and capabilities of the Hospital. Prior to granting of a clinical privilege, the resources necessary to support the requested privilege shall be determined to be currently available, or available within a specified time frame. Resource considerations shall include whether there is sufficient space, equipment, staffing, financial resources or other necessary resources to support each requested privilege

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4.5-2 EFFECTS OF DECLINATION

Refusal to accept or review requests for Medical Staff membership or clinical privileges based upon Hospital need and ability to accommodate, as described in this Section, shall not constitute a denial of Medical Staff membership or clinical privileges and shall not entitle the individual to any procedural rights of hearing or appeal. Any portion of the application which is accepted (e.g., requests for clinical privileges that are not subject to a limitation) shall be processed in accord with these Bylaws.

4.6 BASIC OBLIGATIONS OF MEMBERSHIP AND/OR A REQUEST FOR MEMBERSHIP AND CLINICAL PRIVILEGES

By submitting a RFC or RRFC for Medical Staff membership and/or clinical privileges, the Practitioner signifies agreement to fulfill on a continuing basis the following obligations of holding Medical Staff membership and/or clinical privileges. The Practitioner agrees to comply with all duties described in Section 2.5 and also shall:

4.6-1 Appear by phone or in person for any requested interviews regarding his/her application, or subsequent to appointment or the granting of clinical privileges, to appear for any requested interviews related to questions regarding the applicant's performance;

4.6-2 Participate in necessary training and utilize the electronic record systems or other technology in use by the Hospital to prepare a patient record for each patient;

4.6-3 Complete the Hospital's new physician/practitioner orientation within a timeframe defined by the Hospital;

4.6-4 Agree that the Medical Staff may obtain an evaluation of the applicant's performance by a consultant selected by the Medical Staff if the Medical Staff and/or the Hospital considers it appropriate;

4.6-5 Agree that, if there is any misstatement in, or omission from, the RFC or RRFC application, the Hospital may stop processing (or, if appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished). The individual will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The Credentials Committee will review the individual's response and provide a recommendation to the MEC. The MEC will recommend to the Board whether the application should be processed further. In either situation, there shall be no entitlement to a hearing or appeal.

4.7 TERMS OF APPOINTMENT

Terms of membership and/or the granting of clinical privileges shall be for a period that may be less than, but shall not exceed two (2) years (24 months).

4.8 CREDENTIALS VERIFICATION

Upon the receipt of a completed RFC or RRFC form, the CPC shall arrange to verify the qualifications and obtain supporting information relative to the RFC or RRFC. The CPC shall consult primary sources of information about the individual's credentials, where feasible. Completion of a background check, verifications of licensure, controlled substance registration, specialty board certification, and professional liability claims history, a query of the NPDB, queries of the OIG Sanction Report, SAM List, and State exclusion list and collection of any other information necessary to verify that the individual satisfies all Threshold Eligibility Criteria shall be done within 150 days prior to the Board receiving the application. If there are delays in completing the RFC or RRFC, any of these verifications or queries that were done more than 150 days before the Board is scheduled to receive the application shall be repeated. Verification may be made by a letter or computer printout obtained from the primary source or it may be verbally or electronically transmitted (e.g., telephone, facsimile, email, Internet) information when the means of transmittal is directly from the primary source to the CPC and the verification is documented. If the primary source has designated another organization as its officially-designated agent in providing information to verify credentials, the CPC may use this other organization as the designated equivalent source. The CPC shall promptly notify the individual of any problems in obtaining required information. Any action on an application shall be withheld until it is completed; meaning that all information has been provided and verified, as defined in these Bylaws. All records obtained or created by the CPC are, and shall be treated as, confidential records of Medical Staff committees having the responsibility of evaluation and improvement of the quality of care rendered in the hospital, as defined by California Evidence Code §1157 and shall not be subject to discovery in any matter as provided by law.

4.8-1 BURDEN ON APPLICANT TO PROVIDE COMPLETE INFORMATION

a. Any individual requesting initial appointment, reappointment, or clinical privileges shall be sent (1) a letter that outlines the Threshold Eligibility Criteria for appointment and clinical privileges, and (2) a RFC or a RRFC form which requests proof that the individual meets the Threshold Eligibility Criteria for appointment, reappointment and clinical privileges. A completed RFC or RRFC form with copies of all required documents must be returned to the CPC. The CPC shall not have any obligation to process any RFC or RRFC unless it is complete. Only after a completed RFC or RRFC has been received and all information verified, and the individual has been deemed eligible to apply, shall the CPC submit the information to the Hospital as an application. There is no right to a hearing because of failure to submit a complete RFC or RRFC or because of a determination of ineligibility based upon inadequate or incomplete documentation.

b. RFCs may be provided to residents or fellows who are in the final six months of their training. Such RFCs may be processed, but final action shall not be taken until all applicable Threshold Eligibility Criteria are satisfied.

c. Individuals seeking appointment, reappointment and/or clinical privileges have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, character, ethics, and other qualifications and for resolving any doubts about an individual's qualifications. The information to be produced includes such quality data and other information as may be needed to assist in an appropriate assessment of overall qualifications for appointment, reappointment, and current clinical competence for any requested clinical privileges or scope of practice, including, but not limited to, information from other hospitals (e.g. procedure logs, admission logs, reacted History and Physical forms, redacted procedure reports, peer review and performance improvement information, etc.), mortality and morbidity data, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians.

d. Individuals seeking appointment, reappointment and/or clinical privileges have the burden of providing evidence that all the statements made and information given on the RFC or RRFC are accurate and complete.

e. The individual seeking appointment, reappointment, or clinical privileges is responsible for providing a complete application, including adequate responses from references. An incomplete application shall not be processed.

f. An application shall be complete when all questions on the application form have been answered, all supporting

documentation has been supplied, and all information has been verified from primary sources. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time during the credentialing process. Any application that continues to be incomplete 30 days after the individual has been notified of the additional information required shall be deemed to be withdrawn.

g. MSS shall oversee the process of analyzing the information gathered by the CPC, and confirming that all references and other information or materials deemed pertinent have been received.

4.8-2 APPOINTMENT AND REAPPOINTMENT INFORMATION

An RFC or RRFC shall contain a request for specific clinical privileges if privileges are being sought, and shall require detailed information concerning the individual's professional qualifications. In addition to other information, the RFC/RRFC shall seek the following:

a. Identifying information, including full name, social security number, date of birth, any aliases, and addresses of office & residence, and any other information required to verify identification or background. Verification of identity may be performed by a current/licensed notary public and documented with a notarized statement, or verification may be performed by the staff of MSS provided that the individual physically presents himself/herself for the verification process before the application may be considered complete.

b. For new applicants, an attestation of US citizenship, or evidence that the individual is in the US legally and has the required permission(s) to work in this country. For individuals who are not US citizens who are requesting reappointment or renewal of privileges, evidence of a current visa and current work permit shall be required. The requirements of this Section do not apply to an individual who is residing and working from a foreign country (i.e., a foreign-based telemedicine Practitioner) because the immigration laws of the US do not apply.

c. For a new applicant, written permission from the individual for a background check, and completion of the background check.

d. Evidence of current, unlimited, unrestricted licensure in the State of California and information from the individual regarding any current or past licensure in any healthcare profession or in any other state or other jurisdiction;

e. For individuals requesting medication prescribing privileges, evidence of a current, unlimited, unrestricted Federal DEA (Schedules 2, 2N, 3, 3N, 4, and 5) listing an in-state address;

f. For a new applicant, the names and addresses of educational institutions, and dates of attendance, for undergraduate and postgraduate education, including professional degrees earned, and in the case of a foreign graduate, ECFMG certificate;

g. For individuals for appointment who are not newly graduated from residency or fellowship program within the last year, and for individuals for reappointments or renewal of clinical privileges, documentation of the individual's participation in continuing education, specifically as related to the clinical privileges requested.

h. The names and contact information for three peers practicing in the same or like professional discipline as the individual, shall be requested from the individual, of which at least two peers shall provide a written evaluation of the individual's medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, professionalism, and ability to perform the clinical privileges requested before an application will be considered complete. The peers shall be persons with current knowledge of the individual who are not business/practice associates or related by blood or marriage and can provide an unbiased appraisal;

i. Information regarding specialty board certification, if applicable, including the name of the specialty board(s) and dates of board certification;

j. Information regarding all current healthcare facility affiliations, including the name and address of the facility(s) and dates of affiliation and reasons for termination of Medical Staff membership and limitation, reduction or termination of clinical privileges;

k. Evidence of current professional liability insurance, including the name of the carrier, amount and dates of coverage, and professional practice covered;

l. Medicare Provider NPI for the individual provider (i.e., not a NPI for a group practice);

m. Information as to any current, or pending sanctions affecting participation in any Federal Health Care Program, or any actions which might cause the individual to become an Ineligible Person, as well as any sanctions from a professional review organization;

n. Accurate and complete disclosure with regard to the following queries:
   1) Whether the individual's professional license or controlled substance registration (DEA, state or local), in any jurisdiction, has ever been disciplined, restricted, revoked, suspended, or surrendered, or whether such action is currently pending, or whether the individual has voluntarily or involuntarily relinquished such licensure or registration in any jurisdiction;
   2) Whether the individual has had any voluntary or involuntary termination of Medical Staff or APP membership, or voluntary or involuntary limitation, reduction, loss, or denial of clinical privileges at another Hospital or other healthcare facility;
   3) Whether the individual has had any notification of, or any involvement in a professional liability action, including any final judgments or settlements involving the individual; and
   4) Whether the individual has ever been subject to a criminal action, as defined in theses Bylaws, or whether any such action is pending

o. A statement from the individual that his/her health status is such that he/she has the ability to perform the clinical privileges that he/she is requesting;

p. Evidence that the individual has complied with the health screening and immunization requirements of the Hospital;

q. All Practitioners requesting admitting privileges shall submit a signed Physician Acknowledgement Statement. The Practitioner must complete the acknowledgment at the time he or she is granted admitting privileges at the Hospital, or before or at the time the Practitioner admits his or her first patient to the Hospital (i.e., when temporary privileges have been granted). Existing acknowledgments signed by Practitioners already on staff remain in effect as long as the Practitioner has admitting privileges at the Hospital. All Practitioners will also sign a Confidentiality and Security Agreement at the time of submitting a RFC for initial appointment and periodically as such Agreement may be revised, and shall agree that as a condition of membership or holding clinical privileges, the individual shall abide by the privacy and confidentiality policies of the Hospital. Completed Agreements will be maintained in the individual's credentials file.

r. Unless the individual is applying for Medical Staff membership only, all RFCs and RRFCs must include a specific written request for clinical privileges using prescribed forms. Requests for clinical privileges shall not be complete unless it includes supporting evidence of competence for each of the privileges requested and proof that the individual meets the criteria for each of the privileges requested

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4.8-3 REQUIRED CONSENTS AND AGREEMENTS

Once completed and all information verified by the CPC, the RFC/RRFC shall be turned over to the Hospital for processing as an application. By requesting an RFC or RRFC application, and/or applying for appointment, reappointment, or clinical privileges, the individual expressly accepts the conditions set forth in this Section:

a. ACCEPTANCE TO BE BOUND TO BYLAWS AND OTHER GOVERNING DOCUMENTS

The individual agrees that he/she has received and read the current Medical Staff Bylaws, Rules and Regulations, and Policies and agrees to be bound by them, including any amendments to Bylaws, Rules and Regulations and Policies as may be adopted by the Medical Staff;

b. AGREEMENT TO PROVIDE CONTINUOUS CARE

The individual agrees to provide continuous care to his/her patients, as defined in these Bylaws.

c. CONSENT TO RELEASE OF INFORMATION

The individual consents to the release and inspection of all records or other documents that may be material to an evaluation of his/her professional qualifications, including all health information and medical records necessary to verify the individual's health status as required by these Bylaws and for a new applicant a permission to conduct a background check, and a statement providing the maximum immunity and release from civil liability allowed by California law for all individuals requesting or providing information relative to the individual's professional qualifications or background, or evaluating and making judgments regarding such qualifications or background.

d. IMMUNITY FROM LIABILITY

By applying for and/or accepting appointment to the Medical Staff and by applying for, accepting and/or exercising clinical privileges within the Hospital, each applicant, Medical Staff appointee, and individual who is granted clinical privileges extends the maximum immunity to, and releases from all claims, damages and liability as allowed by California law:

1) The Hospital and the Board, any member of the Medical Staff and the Board, their authorized representatives, and third parties who provide information for any matter relating to RFC/RRFC, appointment, reappointment, clinical privileges, or the individual's qualifications for the same;
2) Any third party for releasing or disclosing information, including otherwise privileged or confidential information, to any Hospital representative concerning the individual whether the individual is a former or current applicant or Medical Staff appointee.
3) The immunity provided by the Medical Staff Bylaws shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with the Hospital's activities, including, but not limited to:

    a) Applications for appointment and/or clinical privileges;
    b) Periodic reappraisals undertaken for reappointment or for changes in clinical privileges;
    c) Corrective action;
    d) Hearings and appellate reviews;
    e) Patient care audits;
    f) Medical care evaluations;
    g) Utilization reviews;
    h) Other Hospital, staff, department, service, committee and subcommittee activities related to monitoring and maintaining quality patient care and appropriate professional conduct;
    i) Matters or inquiries concerning the credentials of any applicant, Medical Staff appointee, or Practitioner with clinical privileges;
    j) Matters directly or indirectly affecting patient care or the efficient operation of the Hospital; and
    k) Reports to the National Practitioners Data Bank established pursuant to the Health Care Quality Improvement Act.

4) Scope of Section

    All of the provisions in this Section are applicable in the following situations, including but not limited to:
    a) Whether or not appointment or clinical privileges are granted;
    b) Throughout the term of any appointment or reappointment period and thereafter;
    c) Should appointment, reappointment, or clinical privileges be revoked, reduced, restricted, suspended, and/or otherwise affected as part of the Hospital's professional review activities; and,
    d) As applicable, to any third-party inquiries received after the individual leaves the Medical Staff about his/her tenure as a member of the Medical Staff.

e. AUTHORIZATION TO OBTAIN INFORMATION FROM THIRD PARTIES

The individual specifically authorizes the Hospital, Medical Staff Leaders, and their authorized representatives (1) to solicit and act upon information, including otherwise privileged or confidential information, provided by third parties bearing on his or her credentials and agrees that any information so provided shall not be required to be disclosed to him or her if the third party providing such information does so on the condition that it be kept confidential (unless such information is the basis for an adverse recommendation and the applicant exercises his/her appeal rights under these Bylaws) (2) to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on his or her qualifications for initial and continued appointment to the Medical Staff, and (3) to obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of third parties that may be relevant to such questions. The individual also specifically authorizes third parties to release information, including otherwise privileged or confidential information, as well as reports, records, statements, recommendations and other documents in their possession, bearing on his or her credentials to any Hospital Representative, and consents to the inspection and procurement by any Hospital Representative of such information, records and other documents. Further, the individual agrees to sign necessary consent forms to permit a consumer reporting agency to conduct a criminal background check on the individual and report the results to the Hospital.

f. BACKGROUND INVESTIGATION

The individual requesting initial appointment or initial clinical privileges shall provide written permission to conduct a background investigation as part of the initial credentials verification process and on an ad hoc basis upon request by the MEC and/or Chief Executive Officer.

Circumstances that may trigger a request for an ad hoc background investigation include, but are not limited to:

1) Disciplinary action against the individual's license;
2) Sanctions or revocation of the individual's Federal DEA or State narcotic registration;
3) Identification of felony or misdemeanor arrests or convictions; or,
4) Reports of disruptive behavior, harassment, professional misconduct, or alcohol/substance abuse.

g. AUTHORIZATION TO MAINTAIN INFORMATION

The individual authorizes the Hospital to maintain information concerning the individual's specialty, demographic information, training, board certification, licensure and other confidential information in a centralized Practitioner data base for the purpose of making aggregate Practitioner information available for use by the Hospital and its affiliates. All such records and information are, and shall be treated as, confidential records of Medical Staff committees having the responsibility of evaluation and improvement of the quality of care rendered in the hospital, as defined by California Evidence Code §1157 and shall not be subject to discovery in any matter as provided by law

h. AUTHORIZATION TO RELEASE INFORMATION TO THIRD PARTIES

The individual authorizes Hospital representatives to release information to the Hospital's affiliated management entities, other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their agents when information is requested in order to evaluate his or her professional qualifications for appointment, privileges, and/or participation at the requesting organization/facility, and any licensure or regulatory matter. The individual also authorizes the Hospital to release confidential information, including peer review and/or quality assurance information, obtained from or about the Practitioner to peer review committees of the Hospital and affiliates of the Hospital for purposes of reducing morbidity and mortality and for the improvement of patient care.

All such records and information are, and shall be treated as, confidential records of Medical Staff committees having the responsibility of evaluation and improvement of the quality of care rendered in the hospital, as defined by California Evidence Code §1157 and shall not be subject to discovery in any matter as provided by law

i. HEARING AND APPEAL PROCEDURES

The individual agrees that the hearing and appeal procedures set forth in these Bylaws are the sole and exclusive remedy with respect to any professional review action taken by the Hospital and agrees that, if any adverse action is made with respect to him or her, he or she will follow and exhaust the administrative remedies afforded by the Medical Staff Bylaws and the Hearing Procedure as a prerequisite to any other action.

j. REPORTING

The individual consents to the reporting by any Hospital Representative of information to the National Practitioner Data Bank established pursuant to the Health Care Quality Improvement Act of 1986, and to other Federal agencies or to State agencies as required by laws, statutes or regulation, which such Hospital Representative believes in good faith is required by law to be reported.

k. AGREEMENT TO IMMEDIATELY NOTIFY HOSPITAL OF CHANGES IN INFORMATION

The individual shall specifically agree to immediately provide in writing within seven (7) days of being officially notified of a change in status, a notice to the Medical Staff and the Hospital, with or without request, of any new or updated information that is pertinent to the individual's professional qualifications or any question on the RFC/RRFC form, including but not limited to any change in Federal Health Care Program Ineligible Person status, any exclusion from a State Program, any change in licensure in any state, any change in DEA status or status with a State controlled substance regulatory agency, or any exclusion or other sanctions imposed or recommended by the U.S. Department of Health and Human Services or any state, the receipt of a Quality Improvement Organization (QIO) citation, any change in legal status to reside and/or work in the USA, any investigation by a specialty certification board, any payer contract termination, any change in health status, any change in location of office or residence, loss of on-call coverage, any criminal investigation, termination of or notice of non-renewal of professional liability insurance coverage, initiation of any corrective action by any health care facility or professional organization, and/or a quality denial letter concerning alleged quality problems in patient care.

4.8-4 APPLICATION PROCESSING

After verification is accomplished and the RFC or RRFC is deemed fully complete and it has been verified that all Threshold Eligibility Criteria have been met, the information shall be submitted as an application and it shall be reviewed and processed as follows:

a. Time Period for Processing: Once an application is deemed complete, it is expected to be processed within 150 days, unless it becomes incomplete. This time period is intended to be a guideline only and shall not create any right for the applicant to have the application processed within this precise time period. If the action of the Board has not been taken within 150 days after an application is turned over by the CPC for MSS File Review, the verifications must first be repeated to assure that the information is current before the Board takes action.

b. Determination of Clinical Privileges: Determination of initial clinical privileges shall be based upon the professional criteria used in evaluating applicant's credentials for Medical Staff appointment, and the professional criteria established by the Hospital for specific clinical privileges. In the course of development of its recommendation concerning an applicant's request for clinical privileges, the Credentials Committee shall forward to the Chairperson of the applicable Department the applicant's qualifications and request for clinical privileges. This request shall be communicated through a summary of the pertinent information, such as the electronic Cactus profile and supporting documents. Following receipt of the Department Chairperson's recommendation regarding the applicant's clinical privileges, the Credentials Committee shall consider such recommendation and, if the committee concurs, report to the MEC its recommendations for privileges to be granted to the applicant. The written comments of the MEC, if any, will be forwarded to the Board simultaneously with the recommendation of the Credentials Committee. Should the Credentials Committee not concur with the Department Chairperson's recommendation for clinical privileges, the request may be returned to the Department Chairperson for further consideration. The time frame for completion of the Department report(s) shall be within 30 days of receipt of a complete application. For APRNs, since they provide nursing care, treatment and services, their practice shall be under the supervision and direction of the Chief Nursing Officer (CNO) in addition to Medical Staff oversight. Therefore, the CNO shall make an evaluation and provide recommendations regarding the clinical privileges to be granted to an APRN, and any concerns regarding the clinical privileges requested or level of supervision needed.

c. Credentials Committee Report: The Credentials Committee shall receive from the Department Chairperson and review the application, supporting materials, the report of the Department Chairperson, and any such other available information as may be relevant to the applicant's qualifications. The Credentials Committee shall prepare a written report and recommendation for the MEC as to Medical Staff appointment and Medical Staff category in the case of applicants for Medical Staff membership, the Department/Section to be assigned, the clinical privileges to be granted, and any special conditions to be placed on the clinical privileges to be granted. In the event there are any adverse recommendations, the reasons shall be stated. The time frame for completion of the Credentials Committee action shall be at the next regular meeting of the committee following receipt of the Department report, to be within 30 days.

d. Criteria for Additional Inquiry: Additional inquiry shall be conducted by the Department Chairperson, Credentials Committee, or MEC for any of, but not limited to, the reasons listed below. Additional inquiry may include a personal interview with the applicant, a request for a letter of explanation from the applicant, further contact with sources of information, or any other means appropriate to resolving questions about the application. The application shall be deemed incomplete until additional inquiry is completed, and questions about the following matters are explained to the satisfaction of the Department Chairperson, Credentials Committee, MEC or Board. Criteria for additional inquiry are:

1) Inability to verify through original source documentation any of the information or credentials represented in the application;
2) Any unexplained gaps in medical staff or APP membership, clinical privileges and/or work history;
3) Any other inconsistent or less than favorable information about the applicant's professional qualifications, competence or character, as judged by the Department Chairperson, Credentials Committee, MEC or Board.

e. MEC Recommendation: The MEC shall receive from the Credentials Committee and review the application, supporting materials, the reports of the Department Chairperson and the Credentials Committee, and any such other available information as may be relevant to the applicant's qualifications. The MEC shall prepare a written report and recommendation for the Board as to Medical Staff appointment and Medical Staff category in the case of applicants for Medical Staff membership, the Department to be assigned, the clinical privileges to be granted, and any special conditions to be placed on the clinical privileges to be granted. The Board shall not take action upon any Credentials Committee recommendations until having received the written comments from the MEC. In the event there are any adverse recommendations, the reasons shall be stated. The time frame for the MEC to decide on a recommendation to the Board shall be at the next regular meeting of the committee following receipt of the Credentials Committee report.

f. EFFECT OF MEC RECOMMENDATION

1) Deferral: The MEC may defer making a recommendation where the deferral is not solely for the purpose of causing delay. A decision by the MEC to defer the application for further consideration shall state the reasons for deferral, provide direction for further investigation and state time limits for such further investigation. As soon as practical after the deferral, such decision to defer the application shall be followed with a subsequent favorable or adverse recommendation. The MEC may delegate the responsibility for further consideration to the Credentials Committee or Department Chairperson as deemed appropriate.
2) Favorable Recommendation: When the recommendation is favorable, the application shall be forwarded promptly to the Board for action at the Board' next regular meeting.
3) Adverse Recommendation: If the recommendation of the MEC is adverse as defined by Article VII of these Bylaws, the Chief of Staff shall promptly notify the applicant and the Board in writing. Such notice shall contain the information prescribed in Article VII of these Bylaws. In such case, the applicant shall be entitled to procedural rights provided in Article VII of these Bylaws, and the recommendation of the MEC will not be acted on by the Board until after the applicant has exercised or waived such rights.

g. BOARD ACTION

Unless subject to the provisions of the fair hearing and appeal provisions in these Bylaws, the Board shall act on the application at its next regular meeting following receipt of the recommendation from the MEC.

1) If the Board adopts the recommendation of the MEC, it shall become the final action of the Hospital.
2) If the Board does not adopt the recommendation of the MEC, the Board will refer the matter back to the MEC

with instructions for further review and recommendation and a time frame for responding to the Board. If the matter is referred back to the MEC, the MEC shall review the matter and shall forward its recommendation to the Board. If the Board adopts the recommendation of the MEC, it shall become the final action of the Hospital.

3) If the action of the Board is adverse to the applicant, the Secretary of the Board shall promptly send written notice to the applicant. Such notice shall contain the information prescribed in Article VII of these Bylaws. In such case, the applicant shall be entitled to procedural rights provided in Article VII of these Bylaws, and the adverse decision of the Board shall not become final until after the applicant has exercised or waived such rights. At its next regular meeting, after all of the applicant's hearing and appeal rights under these Bylaws have been exhausted or waived, the Board shall take final action.
4) All decisions to appoint shall include a delineation of clinical privileges when clinical privileges are being requested, the assignment of a Medical Staff category and Department/Section affiliation, and any applicable conditions placed on the appointment or clinical privileges. The applicant shall be so notified.
5) Subject to any applicable provisions of Article VII, notice of the Board' final decision shall be given in writing through the Secretary of the Board to the applicant. In the event a hearing and/or appeal were held, Article VII shall govern notice of the Board' final decision.

4.9 CREDENTIALS SUBJECT TO ONGOING VERIFICATION

In addition to being verified at the time of initial appointment and initial granting of privileges, and at reappointment or renewal or revision of clinical privileges, the following credentials shall be subject to primary source verification, at the time of expiration and renewal or as specified. Any failure to continuously maintain the following credentials during the entire term of appointment shall result in automatic suspension as provided in these Bylaws and shall be reported to the Credentials Committee:

4.9-2 Current licensure;

4.9-3 Drug Enforcement Administration registration;

4.9-4 Professional liability insurance;

4.9-5 Privilege-specific requirements for current certifications as applicable to the clinical privileges granted; and,

4.9-6 Eligibility to participate in the Federal Health Care Programs. The OIG Sanction Report, the SAM List and the State Exclusion List as applicable shall be checked according to the frequencies defined by Hospital policy.

4.10 ELIGIBILITY FOR COMPLETING A RRFC

To be eligible to complete a RRFC or apply for reappointment and renewal of clinical privileges, an individual must satisfy the Threshold Eligibility Criteria defined in these Bylaws, and during the previous appointment term shall have:

4.10-2 Completed all required continuing medical education requirements;

4.10-3 Satisfied all Medical Staff responsibilities, including payment of dues, fines, and assessments;

4.10-4 Continued to meet all qualifications and eligibility criteria for appointment and the clinical privileges requested; and

4.10-5 For individuals requesting clinical privileges, the individual must have sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. Any individual seeking reappointment who has insufficient clinical activity at the Hospital must submit such information as may be requested by the Medical Staff (such as an admission/procedure logs, a copy of his/her confidential quality profile from his/her primary hospital, clinical information from the individual's private office practice, and/or a quality profile from a managed care organization) before the RRFC shall be considered complete and processed further.

4.11 EXPIRATION OF CURRENT APPOINTMENT

4.11-1 If a complete RRFC is not submitted timely, the individual's appointment and clinical privileges shall expire at the end of their current term of appointment. Only after a complete application is received by the Hospital from the CPC shall an individual be considered for a new appointment or new granting of clinical privileges.

4.12 ASSISTANCE WITH EVALUATION

The MEC, the Chief Executive Officer, or any committee authorized to review or evaluate applications for Medical Staff membership or clinical privileges, or conduct ongoing review or evaluation of performance of those who currently hold Medical Staff membership or clinical privileges, may, when acting within the scope of authority granted by these Bylaws and California law, as part of these duties:

4.12-2 Obtain the assistance of an independent consultant or others to evaluate the Practitioner being subject to review;

4.12-3 Request access to and consider the results of performance improvement or quality assessment activities of other hospitals or health care institutions with respect to the Practitioner under evaluation;

4.12-4 Request or require the Practitioner under evaluation to submit to interviews with consultants who may be retained to assist in the review or evaluation process;

4.12-5 Subject to Federal or State regulations, request that specific patient records or categories of records of patients treated by the Practitioner under evaluation be submitted for review, subject to appropriate protection of patient confidentiality; and,

4.12-6 Require detailed statements, data and information concerning matters that may impact the qualifications, professional competence or conduct of the Practitioner under evaluation, including information concerning threatened or pending legal or administrative proceedings.

4.13 CONDITIONAL APPOINTMENT, REAPPOINTMENT OR PRIVILEGES

4.13-1 Recommendations for appointment, reappointment, initial granting of privileges and/or renewal of privileges may be contingent upon an individual's compliance with certain specific conditions. These conditions may relate to behavior (e.g., demonstration of compliance to professional conduct standards) or to clinical issues (e.g., general consultation requirements, requirements for proctoring, completion of CME requirements). Unless the conditions being imposed constitute an adverse recommendation or action as set forth in these Bylaws or are reportable as defined by the Health Care Quality Improvement Act and/or California Business & Professions Code §805, the imposition of such conditions does not entitle an individual to request the procedural rights set forth in Article VII of these Bylaws.

a. If the individual successfully adheres to the conditions and completes the requirements, the individual shall be eligible to apply for full appointment, reappointment, or privileges.

b. If the individual does not adhere to the conditions or does not complete the requirements specified in the conditional appointment, reappointment, or privileges, then the actions as set forth in Article VI and VII of these Bylaws shall apply.

c. If the individual refuses to accept conditional appointment, reappointment, or privileges or any of the conditions or requirements imposed, the procedures as set forth in Article VI and VII of these Bylaws shall apply.

4.13-2 Conditional appointment, reappointments, or privileges may be recommended for periods of less than two (2) years in order to permit closer monitoring of an individual's compliance with any conditions that may be imposed. A recommendation for appointment, reappointment, or privileges for a period of less than two (2) years does not entitle an individual to the procedural rights set forth in Article VII of these Bylaws.

4.13-3 In the event an applicant for reappointment or renewal of privileges is the subject of an Investigation or hearing at the time reappointment or renewal of privileges is due or is being considered, a conditional reappointment or conditional privileges may be granted for the limited amount of time needed to complete the Investigation or hearing.

4.13-4 At the end a term of conditional appointment, reappointment, or privileges the individual shall be required to undergo all usual reappointment credentials verifications and privileging procedures.

4.14 PREVIOUSLY DENIED OR TERMINATED APPLICANTS

Notwithstanding any other provisions in these Bylaws, if an RFC or application is tendered by an individual who has been previously denied membership and/or clinical privileges, or who has had membership and/or clinical privileges terminated due to lack of sufficient qualifications required to maintain membership or clinical privileges, or whose prior RFC or application was deemed incomplete and withdrawn, and it appears that the new RFC or application is based on substantially the same information as when previously denied, terminated, or deemed withdrawn, then the RFC or application shall be deemed insufficient by the Credentials Committee and returned to the individual as unacceptable for processing. If an RFC or application is tendered by an individual who has been previously denied membership and/or clinical privileges, or who has had membership and/or clinical privileges terminated due to circumstances that permanently disqualify the applicant for membership or privileges, as has been so designated by prior action of the Board, then the RFC or application shall be returned to the individual as unacceptable for processing. No RFC or application shall be processed, and no right of hearing or appeal shall be available in connection with the return of such RFC or application.

4.15 INDIVIDUALS PROVIDING PROFESSIONAL SERVICES BY CONTRACT

4.15-2 QUALIFICATIONS AND SELECTION

Practitioners providing clinical services pursuant to a contract, agreement or other arrangement with the Hospital shall be subject to the same procedures as all other applicants for membership or privileges and shall be subject to the same obligations of Medical Staff membership or clinical privileges, as outlined in these Bylaws. Additional requirements for an agreement may be imposed. The Medical Staff, as in the case of other Practitioners, shall recommend the clinical privileges to admit and/or treat patients for Practitioners who are providing services through a Hospital contract, agreement, or other arrangement.

4.15-3 EFFECT OF CONTRACT TERMINATION ON MEDICAL STAFF MEMBERSHIP OR CLINICAL PRIVILEGES

The terms of any written contract between the Hospital and a Contract Practitioner or Contractor shall take precedence over these Bylaws as now written or hereafter amended, provided such contract does not violate the requirements of California Business & Professions Code §809.6. Such contract may provide, for example, that the Medical Staff membership and clinical privileges of a Contract Practitioner or individuals providing services through a Contractor are automatically terminated or modified in the event of termination of the written contract, and the Contract Practitioner or individuals providing services through a Contractor have no rights to a hearing and appeal or otherwise with regard to such termination or modification of Medical Staff membership or clinical privileges. The underlying grounds for termination of the contract may themselves be cause for initiating adverse action under these Bylaws.

4.16 RESIGNATION

Resignations from the Medical Staff should be submitted in writing and should state the date the resignation becomes effective. Resignations shall be submitted to MSS. Resignation of Medical Staff membership and/or clinical privileges may be granted for a Practitioner in good standing provided all incomplete medical records and Medical Staff and Hospital matters have been concluded. The Practitioner's Department Chairperson, the MEC, and the Board shall review letters of resignation. Once submitted, a resignation may not be withdrawn until it has been considered by the Board. If a Practitioner requests to withdraw a resignation before the resignation is accepted by the Board, the request for withdrawal shall also be forwarded to the Board for consideration. The Board may, but is not required to, honor the request for withdrawal of the resignation. Upon acceptance of the resignation by the Board, the Practitioner will be notified in writing. When a resignation is accepted or clinical privileges are relinquished during the course of an Investigation regarding concerns about behavior, conduct, competence, or professional performance, a report shall be submitted to the state

professional licensing board for reporting to the National Practitioner Data Bank (NPDB), as required by federal law and state law.

4.17 MINIMUM ACTIVITY REQUIREMENT

Practitioners who have failed to engage in at least one (1) patient care activity at the Hospital in the preceding two (2) years are ineligible to apply for renewal of privileges and the procedures set forth in Article VII shall not apply. Exceptions to this minimum activity requirement may be made by the MEC for cause. Activity requirements for specific Membership Categories are discussed in Article III.

4.18 LEAVE OF ABSENCE

4.18-1 LEAVE STATUS

At the discretion of the MEC, a Practitioner may obtain a voluntary leave of absence upon submitting a written request to the MEC stating the approximate period of leave desired, which may not be less than ninety (90) days or greater than one (1) year. In special circumstances the MEC may extend the leave period for up to one (1) additional year. During the period of the leave, the Practitioner shall not exercise privileges at the Hospital and membership rights and responsibilities shall be inactive, but the obligation to pay dues shall continue unless waived by the MEC. If a Practitioner's appointment expires prior to the termination of his/her leave of absence, the Practitioner must complete the reappointment process prior to exercising privileges at the Hospital. It is the Practitioner's responsibility to assure the reappointment process is completed in a timely manner.

4.18-2 MEDICAL LEAVE OF ABSENCE

The MEC shall determine the circumstances under which a particular Practitioner shall be granted a leave of absence for the purpose of obtaining treatment for medical condition or disability. Unless associated with a reportable restriction or other mandated reports, a medical leave of absence is not generally considered a reportable event. Prior to return from a medical leave of absence, the Practitioner must provide the MEC with information regarding his/her current health status. The MEC may require the Practitioner obtain a complete health evaluation or fitness for duty examination prior to returning from a medical leave of absence.

4.18-3 TERMINATION OF LEAVE

At least thirty (30) days prior to the termination of the leave of absence, the Practitioner may request reinstatement of privileges by submitting a written notice to that effect to the MEC. If the Practitioner's appointment expired during the leave of absence, he/she must submit a completed application for reappointment at least ninety (90) days prior to the leave of absence termination date. This includes providing information related to current competence to exercise the privileges requested. The Practitioner shall submit a summary of relevant activities during the leave. Based on review of this information, the MEC will make a recommendation concerning the reinstatement of the Practitioner's privileges.

4.18-4 FAILURE TO REQUEST REINSTATEMENT

Failure to request reinstatement in a timely manner shall be deemed a voluntary resignation and shall result in automatic termination of membership and privileges. A request for Medical Staff membership and/or privileges subsequently received from a Practitioner so terminated shall be treated as an application for initial appointment.

ARTICLE V: CLINICAL PRIVILEGES

5.1 EXERCISE OF PRIVILEGES

A Practitioner shall be entitled to exercise only those privileges specifically granted to him/her. Said privileges must be Hospital specific and within the scope of the Practitioner's license, certificate or other legal credential authorizing practice in the Hospital and this State. Privileges shall be exercised pursuant to the Medical Staff Bylaws, Rules and Regulations, and Medical Staff and Hospital administrative policy, and subject to the authority of department chairpersons and the MEC.

Credentialing criteria for various privileges have been established by the MEC and may be described in MEC minutes, Rules and Regulations, policy or on a privilege delineation form. Exceptions to any specific privilege credentialing criteria may be made by the MEC for cause. Failure to be granted a particular privilege because of failure to meet credentialing criteria or standards established by the MEC for that privilege does not generate hearing rights as described in Article VII. Privileging for APPs will follow the same general procedures described in this Article for Medical Staff members.

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 privileges desired by the applicant. Requests for new or additional privileges may be made by a Practitioner to the MEC at any time following initial appointment. Requests for new or additional privileges will be processed in the same manner as a privilege request at reappointment.

5.2-2 BASIS FOR PRIVILEGE DETERMINATIONS

a. Relevant provisions of Article IV apply to all requests for privileges.

b. Not all privileges are exercised at this Hospital. Requests for privileges not exercised at this Hospital may be denied solely on that ground. Any such denial shall not be subject to the provisions of Article VII.

c. Requests for privileges shall be evaluated on the basis of the Member's licensure, education, training, experience, demonstrated professional competence and judgment, clinical performance, 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 Practitioner exercises privileges.

d. The applicant must provide verifying information to document that he/she meets all criteria for privileges which have been developed by the MEC.

e. The burden of providing sufficient information to evaluate a request for privileges rests solely with the applicant Practitioner.

5.3 PROCTORING

5.3-1 GENERAL PROVISIONS

a. Proctoring requirements pertain to new privileges granted and will be carried out pursuant to the current Medical Staff Policy – Proctoring.

b. The Proctoring Policy defines core proctoring requirements by department. Advanced proctoring requirements are defined on specific privilege delineation forms, in Medical Staff policy or other MEC approved documents.

c. All proctoring requirements are established by the MEC and specific proctoring requirements may be added/modified by the MEC.

d. Practitioner specific proctoring requirements may be modified by the MEC for cause.

e. Whenever reasonably possible, proctoring should include all elective first admission/cases by the Practitioner being proctored.

f. When proctoring has been completed for a specific privilege, proctoring requirements for that privilege may be removed by recommendation of the department chairperson pending action of the MEC.

g. The institution of concurrent observation or proctoring for a Practitioner may occur as part of the peer review

process. The initiation of concurrent observation or proctoring does not generate hearing rights, as described in Article VII, unless the proctor must grant approval before the Practitioner being proctored can provide certain types of medical care or perform certain procedures.

5.3-2 FAILURE TO COMPLETE PROCTORING REQUIREMENTS

a. It is expected that all proctoring be completed within one (1) year of privileges being granted.

b. Failure to complete proctoring requirements due solely to the Practitioner's failure to perform the required number or type of proctored patient care activities within one (1) year of privileges being granted will result in an automatic termination of the Practitioner's membership and privileges unless an extension of up to one (1) additional year is granted by the MEC for cause. Failure to complete all proctoring requirements within one (1) year of an extension will result in automatic termination of the Practitioner's membership and privileges. Automatic termination of membership and privileges for failure to fulfill proctoring requirements is not subject to hearing rights described in Article VII.

c. Following any automatic termination for failure to complete proctoring requirements, a Practitioner may not apply as a new applicant for one (1) year, unless an exception is made by the MEC for cause.

d. If a Practitioner fails to successfully complete proctoring requirements because of quality of care concerns or any other medical disciplinary cause or reason, the failure to successfully complete proctoring will constitute a for cause termination of the privileges in question and the provisions of Article VII shall apply.

5.4 HISTORY AND PHYSICAL EXAMINATION PRIVILEGES REQUIREMENTS AND LIMITATIONS ON PRIVILEGES OF DENTISTS, PODIATRISTS AND ADVANCED PRACTICE PROFESSIONALS

5.4-1 ADMISSION HISTORY AND PHYSICAL EXAMINATIONS

a. Privileges to perform a medical history and physical examination shall be delineated by Practitioner, but are a core component of admission/attending privileges for any physician holding such privileges.

b. A medical history and physical examination shall be completed and documented by a physician, a qualified and privileged oral maxillofacial surgeon or podiatrist, or other qualified licensed individual holding the appropriate privilege.

c. A medical history and physical examination shall be completed and documented for each patient no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. When the medical history and physical examination was completed within thirty (30) days before admission or registration, an updated examination of the patient, including any changes in the patient's condition, must be completed and documented in the medical recorded within twenty-four (24) hours after admission or registration and prior to surgery or a procedure requiring anesthesia services. A typed or electronic copy of any history and physical examination used as the basis of an update examination must be present in the patient's medical record at the time the update note is recorded.

d. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented in the medical record in accordance with State law, CMS regulations, and Hospital policy.

e. If a history and physical examination is performed by an APP credentialed to perform such examinations, the history and physical examination must be reviewed and authenticated within twenty-four (24) hours after admission or registration and prior to any surgery or invasive procedure requiring anesthesia services by a Medical Staff Member who has been authorized by the Medical Staff to perform history and physical examinations.

f. Refer to the Medical Staff Rules and Regulations and related policies for additional explanation of history and physical examination requirements.

5.4-2 SCOPE OF THE HISTORY AND PHYSICAL EXAMINATION

The scope of the medical history and physical examination is determined by the clinical condition and needs of the patient but will include, as applicable:

a. Patient identification;

b. Chief complaint;

c. History of present illness; review of systems;

d. Personal medical history, including medications and allergies;

e. Family medical history; social history, including any abuse or neglect;

f. Physical examination, to include pertinent findings in those organ systems relevant to the presenting illness and to co-existing diagnoses;

g. Data reviewed; assessments, including problem list;

h. Plan of treatment;

i. If applicable, signs of abuse, neglect, addiction or emotional/behavioral disorder, which will be specifically documented in the physical examination, and any need for restraint or seclusion will be documented in the plan of treatment, and;

j. In the case of a pediatric patient developmental age, length or height, weight, head circumference (if appropriate) and immunization status.

5.4-3 PRIVILEGES LIMITATIONS FOR DENTISTS, PODIATRISTS AND PSYCHOLOGISTS

The following general provisions shall apply to dentists and podiatrists:

a. Admitting and other privileges of dentists and podiatrists may not exceed the scope of their licensure.

b. Patients admitted by dentists and podiatrists must receive all necessary and appropriate medical evaluations and care.

c. If a patient is admitted for inpatient or outpatient care by a dentist or podiatrist, and the episode of care requires some type of history and physical examination, the dentist or podiatrist must complete the relevant dental or podiatric portions of the history and physical examination. Except as noted below in Section 5.4-2 (f), an appropriately credentialed physician must conduct or supervise the remaining required elements of the history and physical examination.

d. A physician must assume responsibility for the care of the patient's medical problems present at the time of admission or which may arise during the episode of care which is outside of the dentist/podiatrist scope of licensure or privilege.

e. Any dispute between a dentist and/or podiatrist and a physician Member regarding proposed treatment must be promptly resolved by the appropriate department chairperson(s).

f. Oral & maxillofacial surgeons and podiatrists, who demonstrate training and current competence, may be credentialed to perform history and physical examinations.

Psychologists may only act as consultants and may not hold admitting, attending or physical examination privileges.

5.4-4 PRIVILEGES LIMITATIONS FOR ADVANCED PRACTICE PROFESSIONALS

The following general privilege provisions apply to all APPs:

a. APPs shall not admit patients and may only provide clinical services as described in the Medical Staff Policy – Advanced Practice Professionals.

b. A physician Member must be primarily responsible for the care of each patient to whom an APP provides care.

c. An APP may only provide clinical services to a patient pursuant to the request or order of a Medical Staff Member.

5.5 TEMPORARY CLINICAL PRIVILEGES

Temporary clinical privileges constitute temporary permission for Practitioners to provide care for patients at the Hospital. Temporary clinical privileges are distinguished from other privileges of the Hospital in that they are not based upon complete review and Board approval of credentials but are granted by the Chief Executive Officer, or designee, upon the recommendation of the Chief of Staff or designee.

a. A request for temporary privileges shall be made electronically or in writing, on forms approved for that purpose by the Hospital.

b. A request for temporary privileges must clearly define the specific privileges being requested.

c. Temporary clinical privileges may be granted only for a specific period of time and shall automatically expire at the end of the specified period, without recourse by the Practitioner under the Fair Hearing Procedure.

d. Temporary clinical privileges shall be granted only to individuals defined as Practitioners in these Bylaws.

e. Temporary privileges may only be granted for the reason described in Section 5.5-2.

f. In granting temporary privileges, special requirements may be imposed in order to monitor and assess the quality of care rendered by the Practitioner exercising such privileges.

5.5-1 QUALIFICATIONS

Except as specified in Section 5.5-2.3, prior to temporary privileges being granted, an applicant for temporary privileges must demonstrate that he/she possesses a current license within this State, a current and unrestricted DEA registration reflecting an in-state address for the State of California (if the Practitioner will be prescribing or administering controlled substances), evidence of ability to perform the temporary privileges requested, current competence related to the temporary privileges requested, documentation of professional liability insurance coverage as required by the Board and a signed Practitioner Acknowledgment Statement. A Practitioner's compliance with these qualification elements shall be verified and recorded in a temporary privilege credential file. In addition, the following elements will be met:

a. Qualifications and current competency for temporary privileges shall be verified from a primary source or designated agent of the primary source and documented.

b. The National Practitioner Data Bank shall be queried prior to the granting of temporary privileges.

c. The Hospital shall verify the applicant’s status as an Ineligible Person. For this purpose, the applicant shall provide his/her Medicare NPI, and the Hospital shall check the OIG Sanction Report, the SAM List, and the State Exclusion List. If the applicant is excluded from such participation, temporary privileges shall not be granted and any exclusion subsequent to having been granted temporary privileges shall result in immediate termination of such privileges without any right to the hearing and appeal procedures in Article VII of these Bylaws.

d. Each applicant shall agree in writing to be bound by the Medical Staff Bylaws, Rules and Regulations, Medical Staff policies, and applicable Hospital policies.

e. Practitioners who are granted temporary privileges will be subject to the Hospital's policy regarding focused professional practice evaluation (FPPE). Special requirements of supervision and reporting may be imposed on any individual granted temporary clinical privileges.

5.5-2 CONDITIONS AND AUTHORITY FOR GRANTING TEMPORARY CLINICAL PRIVILEGES

Temporary privileges may be granted by the Chief Executive Officer, or designee, upon receiving a favorable recommendation from the Chief of Staff, or designee, under the conditions described below in Sections 5.5-2.1 through 5.5-2.3. Individuals practicing based on temporary privileges shall be acting under the supervision of the chairperson(s) of the department(s) to which he/she is assigned.

a. All temporary privileges shall be time-limited, as specified for the type of temporary privileges listed below.

b. During the time temporary privileges are in effect, the exclusion lists shall be rechecked according to the frequencies defined by Hospital policy.

c. Temporary privileges shall automatically terminate at the end of the specific period for which they were granted without the Hearing and Appeal rights set forth in these Bylaws.

d. Temporary privileges shall be specifically delineated and may include the privilege to admit patients.

5.5-2.1 PENDENCY OF APPLICATION

After receipt of a complete application for Medical or APP staff membership, as defined in these Bylaws, which includes a written request for temporary privileges, an applicant qualified as described in Section 5.5-1 may be granted temporary privileges while his/her complete application is awaiting action by the MEC and Board. Temporary privileges granted under this condition shall not exceed one hundred and twenty (120) consecutive days. An applicant waiting processing of a complete application for Medical Staff membership shall be eligible for temporary privileges in pendency of the application only under the following conditions:

a. There are no pending or previous successful challenges to licensure or registration;

b. There are no pending or previous adverse membership actions at another hospital; and,

c. There are no pending or previous adverse actions against the applicant's privileges at another hospital.

5.5-2.2 CARE OF SPECIFIC PATIENTS OR ASSISTANCE WITH PROCTORING

Temporary privileges may be granted on a case-by-case basis when an important patient care or Medical Staff proctoring need justifies the authorization to practice for a limited period of time. After receipt of a written request for temporary privileges, a Practitioner qualified as described in Section 5.5-1 may be granted temporary privileges if the Practitioner has a specific skill not possessed by a currently available Hospital privileged Practitioner and the skill is needed by either a specific patient(s) or to proctor a specific Medical Staff privilege.

a. Temporary privileges granted under the conditions described above shall not exceed either the proctoring need(s) or length of stay of the specific patient(s) or one hundred and twenty (120) consecutive days, whichever is less.

b. Except for Practitioners serving as Medical Staff appointed proctors, a Practitioner may be granted temporary privileges no more than two instances in a twelve-month period. After a Practitioner has been granted temporary privileges the second time for care of specific patients within twelve months, he/she shall be required to apply for Medical or APP staff membership and/or clinical privileges before providing additional patient care, treatment or services at the Hospital.

5.5-2.3 DISASTER RESPONSE AND RECOVERY

Potential disaster situations shall be described in the Hospital Emergency Operations Plan and are defined as any occurrence that inflicts destruction or distress and that creates demands exceeding the capacities or capabilities of the Hospital to handle in a normal or routine way. Such occurrence may be due to a natural or a man-made disaster. Upon activation of the Hospital's Emergency Operations Plan and in a situation in which the Hospital is not able to meet immediate patient needs, temporary disaster privileges may be granted to an appropriately qualified Practitioner as described in Section 5.5-1, based upon the needs of the Hospital to augment staffing due to the disaster situation.

a. Privileges shall be approved by the Hospital Emergency Incident Commander (Chief Executive Officer/designee) or the Operations Chief, if that position is activated as part of the Hospital Emergency Operations Plan (EOP), upon recommendation by the Chief of Staff/designee or the EOP designated Medical Staff Director.

b. All decisions to grant temporary disaster privileges are at the discretion of the Hospital Emergency Incident Commander or designees, and shall be evaluated on a case-by-case basis in accordance with Hospital and patient care needs. Approvals shall be documented in writing.

c. The Chief of Staff/designee or the EOP designated Medical Staff Director shall also assign a Member of the Medical Staff the responsibility of supervising Practitioners granted temporary disaster privileges through direct observation, mentoring, or clinical record review.

d. Practitioners who are employees of any Federal agency, and Practitioners acting on behalf of a Federal agency in an official capacity, temporarily or permanently in the service of the United States government, whether with or without compensation, are immune from professional liability for malpractice committed within the scope of employment under the provisions of the Federal Tort Claims Act, and are, therefore, exempt from the requirement to have professional liability insurance coverage. Temporary privileges granted to Practitioners who are acting as agents of the Federal government shall be limited in their privileges at this Hospital to the scope of their Federal employment.

e. Temporary privileges granted to anyone under a disaster situation shall not exceed the disaster response and recovery period or one hundred and twenty (120) consecutive days, whichever is less.

f. In the event that the disaster creates extreme urgencies as defined in Section 5.6, a Practitioner could be permitted to provide patient care using emergency privileges.

g. Temporary disaster privileges may be granted upon presentation of a government-issued photo identification to anyone meeting the qualifications required in Section 5.5-1 of this Article. Credentials shall be verified as soon as the immediate disaster situation permits. The verifications shall be performed using a process identical to granting temporary privileges for an immediate patient care need. Verification shall be completed within 72 hours from the time the volunteer Practitioner presents to the organization, or as soon as reasonably possible in an extraordinary situation that prevents verifications within 72 hours. Verification shall include:
    1) A current photo identification card from a healthcare organization with a legible photo and that clearly identifies professional designation;
    2) A current license to practice in the State of California;
    3) Primary source verification of the license;
    4) Identification indicating that the individual is a Member of a Disaster Medical Assistance Team (DMAT), or MRC, ESAR-VHP or other recognized state or federal organization or group;
    5) Identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state or municipal entity; or,
    6) Confirmation by a Licensed Independent Practitioner currently privileged by the hospital or by a medical staff member with personal knowledge of the volunteer Practitioner's ability to act as a Licensed Independent Practitioner during a disaster.

h. The following order of preference should be used in granting temporary disaster privileges:
    1) Expert Practitioners from government agencies and credentialed Medical Staff members from other HCA hospitals;
    2) Volunteer Practitioners sent from known agencies (e.g., American Red Cross); Presentation by a current hospital or Medical Staff Member(s) with personal knowledge regarding the Practitioner's identity;

3) Volunteers from the community or surrounding areas.

i. If possible, photocopies of the above-listed credentials should be made and retained as part of a credentials file.

j. Upon approval, the Practitioner should be issued appropriate Hospital security identification as required by the Hospital, and should be assigned to a Medical Staff Member if possible, with whom to collaborate in the care of disaster victims.

k. The Medical Staff shall oversee the professional practice of volunteer Practitioners either by the direct observation or mentoring provided by the Medical Staff Member assigned to the volunteer Practitioner or when a Medical Staff Member is not available to be assigned, then by medical record review to be performed as designated by the Chief of Staff/designee or MEC.

l. The Hospital shall make a decision, based on information obtained regarding the credentials and professional practice of the Practitioner, within 72 hours of the volunteer Practitioner presenting to the Hospital regarding whether to continue the disaster privileges initially granted.

m. Continuing privileges shall be approved by the Hospital Emergency Incident Commander (Chief Executive Officer/designee) or the Operations Chief, if that position is activated as part of the EOP, upon recommendation by the Chief of Staff/designee or the EOP designated Medical Staff Director.

n. In the event that verification of information results in an inability to confirm the qualifications of the Practitioner, privileges should be immediately terminated.

o. When the emergency situation no longer exists, or when the Hospital's Practitioners can adequately provide care, temporary disaster privileges terminate.

5.5-3 DENIAL, REDUCTION OR TERMINATION OF TEMPORARY CLINICAL PRIVILEGES

The CEO may, at any time after consulting with the Chief of Staff, deny, reduce, or terminate temporary privileges subject to such hearing and/or appeal rights as may be provided by these Bylaws or California law.

5.6 EMERGENCY PRIVILEGES

In an emergency, any Practitioner, to the extent permitted by his/her license, and regardless of Medical Staff membership status, Medical Staff category or clinical privileges, shall be permitted to do everything possible to save the life of a patient or to save a patient from serious injury, including the loss of limb or function.

a. An emergency is a condition in which serious or permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

b. When the emergency no longer exists, care of the patient shall be assigned to a Medical Staff Member with the appropriate clinical privileges to provide the care needed by the patient.

c. If the Practitioner who provided emergency care wishes to continue to care for the patient, but does not possess the appropriate clinical privileges, the Practitioner may request such privileges if properly qualified.

ARTICLE VI: CORRECTIVE ACTION

6.1 CORRECTIVE ACTION

6.1-1 ROUTINE MONITORING AND EDUCATION

The Medical Staff departments and committees are responsible for carrying out delegated peer review and quality improvement functions. They may counsel, educate, recommend specific training, issue letters of warning or censure,

institute retrospective review 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 those functions without initiating Corrective Action. Routine monitoring and education pertains to all Practitioners. Comments, suggestions, and warnings may be issued orally or in writing. These activities may be carried out by the Medical Staff as part of ongoing professional practice evaluation, routine peer review, and/or focused professional practice evaluation. Peer review procedures are described in the Medical Staff Policy – Peer Review. MEC approval is not required for monitoring and education actions related to ongoing professional practice evaluation and routine peer review. Such actions shall not constitute Corrective Action, a restriction of membership or privileges or grounds for any formal hearing or appeal rights under Article VII.

6.1-2 CRITERIA FOR INITIATION OF CORRECTIVE ACTION

Any person may provide information to the Medical Staff about the conduct, performance, or competence of its Practitioners. When reliable information indicates a Practitioner may have exhibited acts, demeanor, or conduct reasonably likely to be:

a. Detrimental to patient safety or to the delivery of quality patient care within the Hospital,

b. Unethical or unprofessional, including violations of patient privacy,

c. Contrary to the Medical Staff Bylaws, Rules and Regulations, Medical Staff policies or Hospital policy,

d. Inconsistent with the performance standards of the Medical Staff, or

e. A violation of a privilege retention agreement described in Section 6.3-15.

A request for an Investigation or action against such Practitioner may be initiated by the Chief of Staff, a department chairperson, the MEC, the Chief Executive Officer, or the Board; provided, however, that the MEC's determination that a Practitioner has violated his/her privilege retention agreement shall itself constitute a request for an Investigation.

6.1-3 INITIATION OF CORRECTIVE ACTION

A request for an Investigation is the first step in the Corrective Action process. The request must be in writing, submitted to the MEC, and supported by reference to the conduct alleged to warrant an Investigation. If the MEC initiates the request, it shall make an appropriate recording of the reasons.

6.1-4 INVESTIGATION

If the MEC concludes an Investigation is warranted, it shall direct an Investigation to be undertaken. The Chief of Staff may act on behalf of the MEC to initiate an Investigation, subject to subsequent review and approval of the MEC. The MEC 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 MEC, in its discretion, may appoint persons who are not members of the Medical Staff or APP Staff for the sole purpose of serving on or advising a standing or ad hoc investigating committee. If the Investigation is delegated to an officer or committee other than the MEC, such officer or committee shall proceed with the Investigation in a prompt manner and shall forward a written report of the Investigation to the MEC as soon as practicable. The report may include recommendations for Corrective Action. The Practitioner shall be notified that an Investigation is being conducted and shall be given an opportunity to meet with the investigative officer or committee and to provide information in a manner and on such terms as the investigative officer or committee deems appropriate. The investigating officer or committee 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 MEC and authorized officers shall retain authority and discretion to take whatever action may be warranted by the circumstances including summary suspension. Failure of a member to cooperate in an Investigation, as determined by the MEC in its reasonable discretion, will result in an automatic suspension of all privileges as described in Sections 6.3-8 and 6.3-10.

6.1-5 MEDICAL EXECUTIVE COMMITTEE ACTION

As soon as practicable after the conclusion of the Investigation, the MEC shall take action that may include, without limitation:

a. Determining no Corrective Action be taken;

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

c. Issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude department or section chairpersons from issuing written or oral warnings outside of the mechanism for Investigation;

d Taking other Corrective Actions not described in Section 7.2 that do not generate hearing rights;

e. Imposing or recommending probation or special limitation on continued Medical Staff membership or exercise of privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring;

f. Imposing or recommending reduction, modification, suspension or revocation of privileges;

g. Imposing or recommending reduction, modification, suspension or revocation of any prerogatives related to the Practitioner's delivery of patient care;

h. Imposing or recommending suspension, revocation or probation of Medical or APP Staff membership and/or privileges including summary restriction/suspension; and;

i Recommending other Disciplinary Action as is deemed appropriate under the circumstances.

Prior to the MEC taking any action or making any recommendation described above in subsections 6.1-5 (e-i), except summary action to restrict or suspend privileges as noted above and described in Section 6.2, the MEC shall afford the Practitioner a reasonable opportunity to meet with the MEC or a designated subcommittee of the MEC.

6.1-6 SUBSEQUENT INVESTIGATION REPORT AND BOARD ACTION

Actions, as described in Section 6.1-5, taken, imposed, or recommended by the MEC following an Investigation shall be transmitted to the Board.

a. If the MEC has recommended action as to which the Practitioner may request a hearing, the Board shall take no action until the Practitioner has waived or exhausted the hearing rights on the recommendation as set forth in Article VII unless a summary restrict or suspension is initiated as described in Section 6.2.

b. If the MEC has recommended action as to which the Practitioner may request a hearing and the Practitioner has waived his right to a hearing and the Board agrees with the MEC recommendation, the Board shall take the action recommended by the MEC.

c. If the MEC has recommended action as to which the Practitioner may request a hearing and the Practitioner has waived his right to a hearing and the Board disagrees with the MEC recommendation, the Board shall remand the matter to the MEC for further consideration, and the MEC shall promptly consider the remanded matter and submit a further recommendation to the Board.

d. If the MEC has recommended action as to which the Practitioner does not have the right to request a hearing and the Board disagrees with the recommendation of the MEC, the Board shall remand the matter back to the MEC for further consideration, in which case the MEC shall promptly consider the remanded matter and submit a further recommendation to the Board.

6.1-7 INITIATION OF CORRECTIVE ACTION BY THE BOARD

If information, as described in Section 6.1-2, is reported to the MEC and the MEC decides not to conduct an Investigation or otherwise initiate Corrective Action as set forth above, the matter may be reviewed by the Board. If the Board determines the MEC's decision is contrary to the weight of the evidence presented, the Board may consult with the Chief of Staff and thereafter direct the MEC to conduct an Investigation or otherwise initiate Corrective Action. In the event the MEC fails to take action in response to a directive from the Board, the Board may, after written notification to the MEC, conduct an Investigation or otherwise initiate Corrective Action. Any such proceeding shall afford the Practitioner the rights to which he or she is entitled under these Bylaws and applicable law.

6.2 SUMMARY RESTRICTION OR SUSPENSION

6.2-1 CRITERIA FOR INITIATION

The Chief of Staff, the MEC, or the chairperson of the department or designee of the department in which the Practitioner holds privileges may summarily restrict or suspend the Medical Staff privileges of such Practitioner if the failure to take that action may result in an imminent danger to the health of any individual, including future Hospital patients. Such summary restriction or suspension shall become effective immediately on imposition and the person or body responsible shall promptly give written notice to the Practitioner, the Board, the MEC and the Chief Executive Officer. The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated, or if none, indefinitely. Unless otherwise indicated by the terms of the summary restriction or suspension, the Practitioner's patients shall be promptly assigned to another Practitioner by the responsible chairperson of the department or by the Chief of Staff, considering where feasible the wishes of the patient in the choice of a substitute Practitioner. Unless an Investigation of the suspended Practitioner is already under way at the time the summary suspension or restriction is imposed, the imposition of a summary suspension shall constitute a request for Corrective Action Investigation pursuant to this Article.

6.2-2 WRITTEN NOTICE

Within one working day of imposition of a summary restriction suspension, the affected Practitioner shall be provided with written notice of such action.

6.2-3 MEDICAL EXECUTIVE COMMITTEE ACTION

As soon as practicable, and in any case within fourteen (14) calendar days, after such summary restriction or suspension has been imposed, a meeting of the MEC shall be convened to review and consider the action. The Practitioner shall be invited to attend such meeting and make a statement concerning the circumstances of the summary restriction or suspension, on such terms and conditions as the MEC may impose, although in no event shall any meeting of the MEC, with or without the Practitioner, constitute a "hearing" within the meaning of Article VII nor shall any of Article VII procedural rules apply. The MEC shall determine whether the summary restriction or suspension should be continued and may modify, continue, or terminate the summary restriction or suspension, but in any event it shall furnish the Practitioner with written notice of its decision.

6.2-4 PROCEDURAL RIGHTS

Unless the MEC terminates the summary restriction or suspension within 14 days, the Practitioner shall be entitled to the procedural rights to the extent provided under Article VII.

6.2-5 INITIATION OF SUMMARY RESTRICTION OR SUSPENSION BY THE BOARD

If none of the persons described above in Section 6.2-1 is available to impose a summary restriction or suspension, the Chairperson of the Board, or designee, may take such action if the failure to do so is likely to result in an imminent danger to the health of any person, including future Hospital patients. Prior to taking such action, the Board Chairperson or designee must make reasonable attempts to contact the Chief of Staff or the chairperson of the department (or designee) in which the Practitioner holds privileges. Such a suspension is subject to ratification by the MEC. If the MEC does not ratify the Board's action within two (2) working days, excluding weekends and holidays, the summary restriction or suspension shall terminate automatically. If the MEC ratifies the Board's action, the date of imposition of the summary restriction or suspension shall be used for notice and hearing requirements.

6.3 AUTOMATIC SUSPENSION, RESTRICTION, OR TERMINATION

The Chief Executive Officer shall notify a Practitioner whose membership has been, and/or privileges have been, automatically suspended, restricted or terminated in writing of the suspension, restriction, or termination; provided, however, that the automatic suspension is effective immediately upon the occurrence of the event causing the automatic suspension, restriction, or termination and is not subject to prior notice. The Chief Executive Officer shall also notify the Chief of Staff and appropriate Hospital staff members, and take necessary steps to enforce the action. Automatic suspension, restriction, or termination of membership and/or privileges shall not entitle the Practitioner to a fair hearing and appeal as described in Article VII.

In addition to other specific provisions described in these Bylaws or Medical Staff Rules and Regulations related to automatic suspension, restriction, or termination, the following circumstances shall constitute events causing automatic suspension, restriction, or termination of membership and/or privileges:

6.3-1 LICENSURE

If a Practitioner fails to meet or maintain a legal credential authorizing him/her to practice, or other condition or qualification necessary for Medical Staff membership and/or privileges, upon confirmation of the circumstances by the Chief Executive Officer, the individual's privileges shall be automatically suspended. If an individual's license to practice is limited or restricted, his/her privileges shall be automatically limited or restricted to the extent consistent with the limitation or restriction of his/her license.

6.3-2 CONTROLLED SUBSTANCE REGISTRATION

If prescribing rights for any/all schedule drugs covered in a Practitioner's DEA registration are relinquished, revoked, suspended, or restricted by disciplinary action taken by the DEA, Medical Board of California, or other law enforcement or judicial authority, all of the Practitioner's privileges will be automatically suspended. The automatic suspension will remain in effect until removed or modified by the Chief of Staff and Chief Executive Officer. The Chief Executive Officer will notify the Practitioner and appropriate Hospital staff members of the automatic suspension.

If a Practitioner fails to maintain a current unrestricted DEA registration because of a lapse in timely renewal or failure to timely request all schedules needed for the prescribing privileges granted, the Practitioner's prescribing privileges for the schedule(s) of drugs affected by the DEA restrictions will be automatically suspended. The automatic suspension will remain in place as long as the DEA restrictions are in place.

6.3-3 LIABILITY INSURANCE

If an individual's professional liability insurance is revoked or the individual fails to provide evidence of ongoing coverage as required in these Bylaws, his/her privileges shall be automatically suspended until the Medical Staff has evidence the Practitioner's liability insurance conforms to the coverage as required in these Bylaws.

6.3-4 ELIGIBILITY TO PARTICIPATE IN FEDERAL PROGRAMS

Becoming an Ineligible Person shall result in immediate automatic suspension of membership and privileges. The suspension will remain in effect until the Practitioner is no longer an Ineligible Person.

6.3-5 MEDICAL RECORDS

A medical record is considered to be delinquent when it has not been completed for any reason within fourteen (14) calendar days following a patient's discharge. When a Practitioner has failed to complete a medical record and the record becomes delinquent, his/her privileges shall be automatically suspended upon dispatching of the notice of the suspension as described in the Medical Staff Policy – Medical Record Delinquency and Suspension. The suspension shall continue until all of the Practitioner's delinquent records are completed. Continuous medical record suspension lasting longer than ninety (90) days is governed by the provisions of Section 6.4. In addition, accumulation of ninety (90) or more suspension days in any rolling twelve (12) month period will lead to an automatic termination of the Practitioner's membership and privileges.

6.3-6 MISREPRESENTATION

Whenever it is discovered that an applicant or Practitioner misrepresented or omitted information or erred in answering the questions on an application for membership or privileges or in answering interview queries, and the misrepresentation, omission, or error is material as reasonably determined by the MEC, the application process will immediate terminate and if the individual is a current Practitioner, his/her membership and privileges shall be automatically terminated. Material misrepresentation of a Practitioner or applicant's qualifications will be grounds to disqualify the individual from applying for membership and/or privileges for a time period of at least one (1) year but a longer time period may be specified by the MEC.

6.3-7 FAILURE TO MAINTAIN APPROPRIATE CALL COVERAGE

All Practitioners are required to maintain appropriate call coverage as described in the Medical Staff Rules and Regulations. Failure to maintain appropriate call coverage, as determined by the MEC, shall result in automatic suspension of privileges as described in the Medical Staff Rules and Regulations.

6.3-8 FAILURE TO FULFILL THE DUTIES AND RESPONSIBILITIES OF MEDICAL OR APP STAFF MEMBERSHIP, RESPOND TO A LETTER OF INQUIRY, MEET MANDATORY ATTENDANCE REQUIREMENTS, OR COOPERATE WITH MEDICAL STAFF REVIEW FUNCTIONS

Failure of a Practitioner to fulfill the duties and responsibilities of Medical or APP Staff membership, respond to a letter of inquiry, meet mandatory attendance requirements, participate in a focused professional practice evaluation, participate in an Investigation, or to cooperate with any Medical Staff review regarding the quality or appropriateness of the Practitioner's care and/or his/her professionalism, as determined by the MEC in its reasonable discretion, shall result in automatic suspension of the Practitioner's privileges. The automatic suspension will remain in effect until the associated requirements are met and the automatic suspension has been removed by the Chief of Staff.

6.3-9 FAILURE TO PAY DUES/ASSESSMENTS

Failure to pay dues or assessments, as described in Section 14.2, shall result in automatic suspension of the Practitioner's privileges.

6.3-10 FAILURE TO COOPERATE WITH MEDICAL STAFF PEER REVIEW, QUALITY MONITORING, INVESTIGATION, AND/OR PRACTITIONER TESTING REQUIREMENTS

Failure of a Practitioner to cooperate with or failure to provide requested information related to peer review, quality assessment, quality monitoring, an Investigation, health/competency testing requirements, and/or medical records and peer review documents from other healthcare organizations (including hospitals and other peer review bodies) in a timely manner, as determined by the MEC in its reasonable discretion, will result in automatic suspension of the Practitioner’s privileges. The automatic suspension will remain in effect until the Medical Staff requirements are met and the automatic suspension has been removed by the Chief of Staff.

6.3-11 FAILURE TO COMPLETE PROCTORING REQUIREMENTS

Failure to complete proctoring requirements due solely to the Practitioner's failure to perform the required number or type of proctored patient care activities within the timeframes described in Section 5.3, will result in an automatic termination of the Practitioner's membership and privileges.

6.3-12 FAILURE TO COMPLY WITH MEDICAL STAFF BYLAWS, RULES AND REGULATIONS, POLICIES, AND/OR MANDATORY CONTINUING MEDICAL EDUCATION REQUIREMENTS

Failure to comply with Medical Staff Bylaws, Rules and Regulations, policies, and/or continuing medical education requirements may, at the sole discretion of the MEC, result in an automatic suspension. The automatic suspension will remain in place until the identified deficiency has been corrected by Practitioner and the suspension has been removed by the Chief of Staff.

6.3-13 RELOCATION

Unless otherwise approved in advance by the Board upon recommendation of the MEC, the membership and privileges of any Practitioner who no longer meets the geographic proximity requirements of the Medical Staff because of relocation of residence or relocation of practice shall be automatically terminated.

6.3-14 FAILURE TO APPLY FOR REAPPOINTMENT OR RENEWAL OF PRIVILEGES IN A TIMELY MANNER

A Practitioner's failure to submit a complete reappointment application, including all necessary supporting documents, in a timely manner shall result in automatic termination of membership and privileges at the end of the Practitioner's current appointment period. In such, case the Practitioner shall be notified of the expiration of the term of membership and/or privileges and the need to submit an application for initial appointment if so desired.

6.3-15 FAILURE TO COMPLY WITH A PRIVILEGE RETENTION AGREEMENT

A privilege retention agreement is an agreement entered into by and among a Practitioner and both the Medical Staff (acting through the MEC) and the Hospital. A privilege retention agreement describes minimum standards for behavior and/or conduct to remediate unprofessional and/or disruptive behavior and/or conduct on the part of the Practitioner. Unprofessional and/or disruptive behaviors include, but are not limited to, those described in the Medical Staff Policy – Professional Conduct Standards. The agreement will follow the format described in the Medical Staff Policy – Privilege Retention Agreement. A Practitioner found to be in violation of a privilege retention agreement by the MEC will be subject to an automatic suspension of all clinical privileges for fourteen (14) days. The automatic suspension will commence twenty-four (24) hours after the Practitioner has been given notice of the MEC's determination that a privilege retention agreement violation has occurred. In addition, violation of a privilege retention agreement will also result in the initiation of an Investigation by the MEC, as described in Section 6.1-2. The purpose of the Investigation is to determine what if any additional Corrective Action is indicated. Additional Corrective Action may, if indicated, include summary restriction or suspension of privileges.

6.4 AUTOMATIC TERMINATION FOLLOWING AUTOMATIC SUSPENSION

When a Practitioner's membership or privileges are automatically suspended for any reason and the automatic suspension continues for more than ninety (90) days without reinstatement, the Practitioner's membership and privileges will be automatically terminated. Except to the extent required by law, automatic termination of membership and/or privileges shall not entitle the affected Practitioner to a fair hearing and appeal as described in Article VII. The Practitioner shall be notified of the automatic termination and the need to submit an application for initial appointment if desired by the Practitioner and permitted by these Bylaws.

If a Practitioner completes the Medical Staff appointment process within ninety (90) days from the date of an automatic termination and all criteria are met to allow for Medical Staff processing of the application, the Practitioner may, at the discretion of the MEC, be assigned to his/her pre-termination Medical Staff Category if he/she is appointed to the Medical Staff.

6.5 COVERAGE FOLLOWING AUTOMATIC SUSPENSIONS, RESTRICTION, OR TERMINATION

When an automatic suspension, restriction, or termination has been imposed, the Chief of Staff or the appropriate Department Chairperson shall arrange for alternative medical coverage of the affected Practitioner’s patients in the Hospital as necessary. The wishes of the patients shall be considered in the selection of an alternative coverage Practitioner. When the Practitioner being suspended or restricted is an APP, the supervising Physician shall be responsible for arranging alternative coverage for the care normally provided by the APP.

ARTICLE VII: HEARINGS AND APPELLATE REVIEWS

7.1 GENERAL PROVISIONS

7.1-1 INTENT

The intent of these hearing and appellate review procedures is to provide a fair review of certain recommendations and decisions that adversely affect a Member or an applicant for Medical Staff membership and privileges and at the same time protect the peer review participants from liability. Hearing and appeal rights for APPs are described in Section 7.11. It is further the intent to establish flexible procedures which do not create burdens that will discourage or impair the Medical Staff and Board from carrying out peer review. Accordingly, discretion is granted to the Medical Staff and Board to create a hearing process which provides for the least burdensome level of formality in the process while still providing a fair review and to interpret these Bylaws in that light. The Medical Staff, Board, and their officers, committees and agents hereby constitute themselves as peer review bodies under the Federal Health Care Quality Improvement Act of 1986 and the California peer review hearing laws and claim all rights, privileges and immunities afforded by the federal and state laws to peer review bodies.

7.1-2 EXHAUSTION OF REMEDIES

If adverse action described in Section 7.2 is taken or recommended, the applicant or Member must exhaust all of the remedies afforded by these Bylaws before resorting to legal action.

7.1-3 INTRAORGANIZATIONAL REMEDIES

The hearing and appeal rights established in these Bylaws are strictly "quasi-judicial" rather than "quasi-legislative" in structure and function. A Judicial Review Committee or arbitrator has no authority to adopt or modify rules and standards or to decide questions about the merits or substantive validity of Bylaws, Rules and Regulations or policies.

7.1-4 APPLICATION OF BYLAW ARTICLES FOR BOARD ACTIONS

If a Corrective Action is proposed by the Board pursuant to Section 6.1-7 and the proposed action is grounds for a hearing as described in Section 7.2, the provisions of this Article applicable to the MEC related to a Practitioner's hearing and appeal rights shall apply to the Board.

7.1-5 SUBSTANTIAL COMPLIANCE

Technical, immaterial, or non-prejudicial deviations from the procedures set forth in these Bylaws shall not be grounds for invalidating the action taken or recommended.

7.1-6 BUSINESS & PROFESSIONS CODE SECTIONS 809 ET SEQ.

The parties are bound by any additional notice, hearing and appeal provisions contained in California Business and Professions Code Sections 809 through 809.4. To the extent such sections might be inconsistent with this Article VII, the statutory sections shall control.

7.2 GROUNDS FOR HEARING

Members who are subject to an adverse recommendation or action are entitled to a hearing under these Bylaws only if the recommendation or action is based on medical disciplinary cause or reason and would generate a right to a hearing pursuant to California Business and Professions Code section 809 et seq. The following recommendations or actions, if based on professional competence or conduct which adversely affects or could affect adversely the health or welfare of a patient, future patients, or others and if required to be reported to the Member's licensing board and/or the National Practitioner Data Bank, shall entitle the Member affected thereby to a hearing:

a. Denial of initial staff appointment;

b. Denial of reappointment;

c. Suspension of staff membership for greater than fourteen (14) days;

d. Revocation of staff membership;

e. Limitation, for greater than fourteen (14) days, of the right to admit patients, other than limitations applicable to all individuals in a particular Staff Category or clinical specialty, or due to licensure limitations;

f. Denial of requested privileges;

g. Involuntary reduction, restriction, suspension, or revocation of privileges for greater than fourteen (14) days;

h. Involuntary imposition of significant consultation requirements where the supervising Member has the power to direct, assume or transfer care from the applicant or Member under review;

i. Any other Disciplinary Action or recommendation that must be reported, by law, to the state agency that issues the Member's license to practice or to the National Practitioner Data Bank.

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, said person or body shall give the Member prompt notice of the recommendation or action, including the following information:

a. A description of the action or recommendation;

b. A brief statement of the reasons for the action or recommendation;

c. A statement that the Member may request a hearing;

d. A statement of the time limit within which a hearing may be requested;

e. A summary of the Member’s rights at a hearing (which may be satisfied by reference to the pertinent sections of these Bylaws), and;

f. Whether the action or (if adopted) recommendation must be reported to the Member’s licensing board and/or the National Practitioner Data Bank.

7.3-2 REQUEST FOR HEARING

The Member shall have thirty (30) days following dispatch of notice of such action or recommendation to request a hearing. The request shall be in writing addressed to the Chief of Staff and must be received by the MSS Department within the thirty (30) day period. 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 action or recommendation. Said action or recommendation shall thereupon become the final action or recommendation of the Medical Staff. The action or recommendation shall be presented for consideration by the Board, which shall not be bound by it. If the Board ratifies the action or recommendation, it shall thereupon become the final action of the Hospital. However, if the Board, after consulting with the MEC, proposes action against the Member that is more adverse than the action recommended or taken by the Medical Staff, the Member shall be so notified and given an opportunity for a hearing based on "an adverse action by the Board, " as provided in Section 7.3-8.

7.3-3 TIME AND PLACE FOR HEARING

On timely receipt of a request for hearing, the MEC shall schedule a hearing and, within twenty-one (21) days of receipt of the request, the MEC shall give notice to the Member of the time, place and date of the hearing. Unless extended by the Hearing Officer for good cause or by agreement of the Member and MEC, the date of the commencement of the hearing shall be not less than thirty (30) days, nor more than sixty (60) days from the date of receipt of the request for a hearing.

7.3-4 NOTICE OF CHARGES

Together with the notice of hearing, the MEC shall state clearly and concisely in writing the reasons for the adverse action taken or recommended, including the acts or omissions with which the Member is charged and a list of the charts and/or records in question, where applicable. The notice of charges may be supplemented or amended at any time prior to the issuance of the Judicial Review Committee's or arbitrator's decision, provided the Member is afforded a fair and reasonable opportunity to respond.

7.3-5 JUDICIAL REVIEW COMMITTEE

When a hearing is requested, the Chief of Staff shall appoint a Judicial Review Committee, which shall be composed of not less than three (3) members of the Active Medical Staff who shall be unbiased, gain no direct financial benefit from the outcome, have not acted as accusers, investigators, fact-finders or initial decision-makers, and 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 from serving as a member of the Judicial Review Committee. Practice in the same specialty as the Member under review, in and of itself, shall not be presumed to create bias or a direct financial benefit in the outcome of the hearing. In the event that it is not feasible to appoint all members of the Judicial Review Committee from the Active Medical Staff, the Chief of Staff may appoint members from other staff categories or practitioners who are not Members of the Medical Staff. Such appointment shall include designation of a Chairperson of the Judicial Review Committee. Where feasible, one Judicial Review Committee member shall practice the same specialty as the Member who is the subject of the hearing.

A majority of the Judicial Review Committee must be present throughout the hearing. When a Judicial Review Committee member must be absent from any part of the proceedings, he or she shall not be permitted to participate in the deliberations or the decision unless and until he or she has read the entire transcript of the portion of the hearing from which he or she was absent.

Alternatively, the Chief of Staff, with the concurrence of the MEC, shall have the discretion to have the hearing held before an arbitrator or arbitrators selected by a process mutually acceptable to the Member and the MEC. In such case the arbitrator(s) shall have the powers and authority of a Judicial Review Committee and Hearing Officer as described herein.

7.3-6 FAILURE TO APPEAR

Failure without good cause of the Member to personally attend or to proceed in an efficient and orderly manner shall be deemed to constitute a waiver of hearing rights and a voluntary acceptance of the recommendations or actions involved. Good cause shall be determined by the Hearing Officer. The Member's voluntary acceptance of an action or recommendation pursuant to this provision shall be presented for consideration by the Board, and the matter will be addressed in the same manner as a waiver of hearing rights.

7.3-7 POSTPONEMENTS AND EXTENSIONS

Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted in these Bylaws may be agreed by the parties or permitted by the Hearing Officer or by the Judicial Review Committee or its Chairperson, upon a showing of good cause.

7.3-8 ADVERSE ACTION BY THE BOARD

If the hearing is based upon a proposed adverse action by the Board pursuant to Section 6.1-7 the Chairperson of the Board shall fulfill the functions assigned in this Article to the Chief of Staff. The procedure may be modified as warranted under the circumstances, provided that the hearing conforms to applicable law.

7.4 HEARING PROCEDURE

7.4-1 VOIR DIRE

The Member and the MEC shall have the right to a reasonable opportunity to voir dire the Judicial Review Committee members and the Hearing Officer, or the arbitrator, and the right to challenge for cause the appointment of any Judicial

Committee member, the Hearing Officer or arbitrator. The Hearing Officer shall establish the procedure by which this right may be exercised, which may include reasonable requirements that voir dire questions be proposed in writing in advance of the hearing and that the questions of the Judicial Review Committee be presented by the Hearing Officer. The Hearing Officer or arbitrator, as the case may be, shall rule on any challenge.

7.4-2 PREHEARING PROCEDURE

a. Each party may inspect and copy (at its own expense) any documentary information relevant to the charges that the other party has in its possession or under its control. The requests for discovery shall be fulfilled as determined by the Hearing Officer. Failure to comply with reasonable discovery requests at least thirty (30) days prior to the hearing shall be good cause for the Hearing Officer to grant a continuance of the hearing or order such other remedies as he/she deems appropriate.

b. The parties must exchange all documents that they intend to introduce at the hearing at least twenty (20) days prior to the hearing. A failure to comply with this rule is good cause for the Hearing Officer to grant a continuance or order such other remedies as he/she deems appropriate. Repeated failures to comply shall be good cause for the Hearing Officer to limit the introduction or use of any documents not provided to the other side in a timely manner.

c. It shall be the duty of the parties to exercise reasonable diligence in notifying the Hearing Officer of any pending or anticipated procedural dispute 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. The parties shall be entitled to file motions or otherwise request rulings as deemed necessary to give full effect to rights established by the Bylaws and to resolve such procedural matters as the Hearing Officer determines may properly be resolved outside the presence of the full Judicial Review Committee. All such motions or requests, the arguments presented by both parties, and rulings thereon shall be reflected in the hearing record in a manner deemed appropriate by the Hearing Officer.

d. The Hearing Officer shall rule on discovery disputes that the parties cannot resolve. Discovery may be denied or safeguards may be imposed when justified to protect peer review or in the interest of fairness and equity. Further, the right to inspect and copy by either party does not extend to confidential information referring to individually identifiable practitioners other than the Member under review, nor does it create or imply any obligation to modify or create documents in order to satisfy a request for information.

e. In ruling on discovery disputes, the factors that shall be considered include: (a) whether the information sought may be introduced to support or to defend against the charges; (b) whether the information is "exculpatory" in that it would dispute or cast doubt upon the charges or "inculpatory" in that it would prove or help support the charges and/or recommendation; (c) the burden imposed on the party in possession of the information sought, if access is granted; and (d) any previous requests for access to information submitted or resisted by the parties to the same proceeding.

f. Not less than fifteen (15) days prior to the hearing, each party shall furnish to the other a written list of the names and addresses of the individuals, so far as is then reasonably known or anticipated, who are expected to give testimony or evidence in support of that party at the hearing. Nothing in the foregoing shall preclude the testimony of additional witnesses whose possible participation was not reasonably anticipated. The parties shall notify each other as soon as they become aware of the possible participation of such additional witnesses. Failure to provide the name of any witness at least ten (10) days prior to the hearing date at which the witness is to appear shall constitute good cause for a continuance.

7.4-3 REPRESENTATION

Except as otherwise agreed by the Member and the MEC, neither the Member nor the MEC shall be represented at the hearing or in prehearing proceedings by an attorney at law. The Member shall be entitled to be accompanied by and represented at the hearing only by one practitioner licensed to practice medicine, osteopathy, dentistry, podiatry, or psychology in the State of California who is not also an attorney at law. The MEC shall appoint a representative or representatives who is/are not attorney(s) at law to present its action or recommendation, the materials in support thereof, examine witnesses, and respond to appropriate questions. For purposes of this Bylaw, the term "attorney at law" shall include any graduate of a law school, whether or not a member of the bar of any jurisdiction. The foregoing shall be

not be deemed to deprive any party of its right to be represented by legal counsel for the purpose of preparing for the hearing or any prehearing proceeding.

7.4-4 THE HEARING OFFICER

The Chief of Staff shall recommend to the Chief Executive Officer a Hearing Officer to preside at the hearing. The Hearing Officer shall be an attorney at law qualified to preside over a quasi-judicial peer review hearing, but an attorney regularly utilized by the Hospital or Medical Staff for legal advice regarding its affairs and activities shall not be eligible to serve as Hearing Officer. The Hearing Officer shall be unbiased, shall gain no direct financial benefit based on the outcome of the proceedings (payment for the Hearing Officer's services does not constitute a direct financial benefit) 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 material including 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. The Hearing Officer may attend the deliberations of the Judicial Review Committee and be a legal advisor to it, but the Hearing Officer shall not be entitled to vote. In the absence of a Hearing Officer, the Chairperson of the Judicial Review Committee or arbitrator shall perform the functions of the Hearing Officer.

7.4-5 RECORD OF THE HEARING

A shorthand reporter shall be present to make a record of the hearing proceedings and, if deemed appropriate by the Hearing Officer, the pre-hearing proceedings. 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.

7.4-6 ATTENDANCE

Except as otherwise provided in these Bylaws and subject to reasonable restriction by the Hearing Officer, the following shall be permitted to attend the entire hearing in addition to the Hearing Officer: the court reporter, the parties and their hearing representatives, the Medical Staff Director(s), and the Chief of Staff or his or her designee. The MEC's presenter shall be deemed to be its hearing representative. The Medical Staff Director(s), the Chief of Staff or designee, the MEC's presenter, the Member who is a party, and that Member's representative at hearing shall not be excluded from attending any portion of the hearing by reason of the possibility or expectation that he or she will be a witness.

7.4-7 RIGHTS OF THE PARTIES

Within reasonable limitations and so long as these rights are exercised in an efficient and expeditious manner, both parties 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, rebut evidence, and submit a written closing statement. The Member may be called by the MEC and examined as if under cross-examination.

7.4-8 MISCELLANEOUS RULES

Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not necessarily apply to a hearing conducted under this Article. Any material 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. The Hearing Officer shall also have discretion to ask questions of witnesses if he or she deems it appropriate for clarification or efficiency. At its discretion, the Judicial Review Committee may request both sides to file written opening and/or closing arguments.

7.4-9 BURDENS OF PRESENTING EVIDENCE AND PROOF

a. At the hearing, the MEC shall have the initial duty to present evidence in support of its action or recommendation. The Member shall be obligated to present evidence in response.

b. An initial applicant for Medical Staff membership and privileges shall bear the burden of persuading the Judicial Review Committee or arbitrator by a preponderance of the evidence of his/her qualifications for Medical Staff membership and privileges by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning the applicant's current qualifications. Initial applicants shall not be permitted to introduce information not produced during the application process unless the applicant establishes that the information was available during the application process but could not have been produced in the exercise of reasonable diligence. This provision shall not be construed to compel the Medical Staff to act on, or to afford an applicant a hearing regarding, an incomplete application.

c. Except as provided for initial applicants, the MEC shall bear the burden of persuading the Judicial Review Committee or arbitrator, by a preponderance of the evidence, that its action or recommendation is reasonable and warranted. The term "reasonable and warranted" means within the range of reasonable and warranted alternatives open to the MEC, as a matter of discretion, and not necessarily the only or best action or recommendation that could be formulated in the opinion of the Judicial Review Committee or arbitrator.

7.4-10 ADJOURNMENT AND CONCLUSION

After consultation with the Chairperson 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 MEC and the Member may submit a written statement at the close of the hearing. On conclusion of the presentation of oral and written evidence, or the receipt of closing written arguments, if submitted, the hearing shall be closed.

7.4-11 BASIS FOR DECISION

The decision of the Judicial Review Committee or arbitrator shall be based on the evidence introduced at the hearing, including all logical and reasonable inferences from the evidence and the testimony.

7.4-12 DECISION OF THE JUDICIAL REVIEW COMMITTEE OR ARBITRATOR

Within thirty (30) days after final adjournment of the hearing, the Judicial Review Committee or arbitrator shall render a decision which shall be accompanied by a report in writing and shall be delivered to the MEC. A copy of said decision shall also be forwarded to the Chief Executive Officer, the MEC, the Chief of Staff, the Board, and to the Member. The report shall contain the Judicial Review Committee's or arbitrator's findings of fact and conclusions articulating the connection between the evidence produced at the hearing and the decision reached. The reports to the Member and the MEC shall include a written explanation of the procedure for appealing the decision. The decision of the Judicial Review Committee or arbitrator shall be considered final, subject only to such rights of appeal or review as described in these Bylaws.

7.5 APPEAL

The process for appeal to the Board from the decision of a Judicial Review Committee or arbitrator is described below. The Board in its discretion may adopt other procedural rules for an appeal, provided such rules are not inconsistent with this Section 7.5, the Hospital's bylaws, or applicable law.

a. Time For Appellate Review

Within thirty (30) days after dispatch of the decision of the Judicial Review Committee or arbitrator, the Member and/or the MEC may request an Appellate Review hearing ("Appellate Review"). A written request for Appellate Review shall be delivered to the Chairperson of the Board with a copy to the other party and the Chief Executive Officer. If such a request for Appellate Review is not received within such period, the decision of the Judicial Review Committee or arbitrator shall be final, subject only to review by the Board.

It shall be the obligation of the party requesting Appellate Review to produce the record of the Judicial Review Committee or arbitration proceedings ("Appellate Record"). If both parties request an appeal, they may jointly or separately submit the Appellate Record. If the Appellate Record is not produced within fifteen (15) days following the request for Appellate Review, the party requesting Appellate Review shall be deemed to have waived Appellate Review, and the decision of the Judicial Review Committee or arbitrator shall be final, subject only to review by the Board. The Appellate Record shall consist of at least the following: the decision of the Judicial Review Committee or arbitrator; the request for Appellate Review; a complete transcript of the hearing, including opening and closing statements, testimony, and any oral arguments made outside the presence of the Judicial Review Committee; the notice of charges and all amendments to the charges; all documentary exhibits received into evidence; the Hearing Officer's or arbitrator's record of correspondence and other documentation regarding procedural matters; any documentary exhibits that were offered into evidence but excluded by the Hearing Officer or arbitrator; and any written statements or arguments submitted by the parties for consideration by the Hearing Officer, Judicial Review Committee or arbitrator. The party or parties requesting Appellate Review shall produce the Appellate Record in a format and in such quantity as may be specified by the Board.

b. Grounds For Appellate Review

The grounds for Appellate Review shall be:

1) Substantial noncompliance with the standards or procedures required by these Bylaws, or applicable law, which has created demonstrable prejudice;
2) The decision is arbitrary or capricious;
3) The evidence introduced in the hearing does not support the findings stated in the decision;
4) The findings do not support the decision;
5) The Judicial Review Committee or arbitrator failed to sustain an action or recommendation of the MEC that, based on the evidence, is reasonable and warranted, or;
6) The decision is inconsistent with applicable law or these Bylaws.

c. Appeal Board

The Board shall determine the composition of the Appeal Board, consistent with any relevant provisions of the Hospital's Bylaws. 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 action or recommendation being challenged. 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.

d. Time, Place and Notice

If an Appellate Review is to be conducted, the Appeal Board shall give notice of the time and place of the Appellate Review.

e. Appellate Review Procedure

The Appellate Review shall be in the nature of an appellate hearing based on the Appellate Record, consistent with any relevant provisions of the Hospital's Bylaws. Each party shall have the right to be represented by legal counsel or any other representative in connection with the Appellate Review, to present a written statement in support of his/her/its position on appeal and to personally appear and make oral argument, subject to such reasonable requirements as the Appeal Board may impose. However, 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 or arbitrator in the exercise of reasonable diligence, and subject to the same rights of cross-examination or confrontation that are provided at a hearing. The Appeal Board shall also have the discretion to remand the matter to the Judicial Review Committee or arbitrator for the taking of further evidence or for clarification or reconsideration of the decision. In such instances, the Judicial Review Committee or arbitrator shall report back to the Appeal Board within such reasonable time limits as the Appeal Board imposes.

After the arguments have been submitted, the Appeal Board shall conduct its deliberations outside the presence of the parties and their representatives. The Appeal Board, if other than the Board, shall present to the Board its

written recommendations as to whether the Board should affirm, modify or reverse the Judicial Review Committee or arbitrator's decision, or remand the matter to the Judicial Review Committee or arbitrator for reconsideration.

f. Decision

The Board shall render a decision in writing, consistent with any relevant provisions of the Hospital's Bylaws. The Board shall give great weight to the peer review recommendations and actions of the Medical Staff. The Board may affirm, reverse or modify the decision of the Judicial Review Committee or arbitrator, or it may remand the matter to the Judicial Review Committee or arbitrator for reconsideration. If the matter is remanded to the Judicial Review Committee or arbitrator for reconsideration, the Judicial Review Committee or arbitrator shall promptly conduct its review and make its/his/her recommendations to the Board. This reconsideration 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 determined by the Board. The decision of the Board shall constitute the final decision of the Hospital. Any recommendation affirmed by the Board shall become effective immediately. The Board shall send its written decision to both parties.

7.6 RIGHT TO ONE HEARING

No Member shall be entitled to more than one Judicial Review Committee or arbitration hearing and one Appellate Review related to a particular Judicial Review Committee or arbitration decision.

7.7 EXCEPTIONS TO HEARING RIGHTS

7.7-1 MEDICAL-ADMINISTRATIVE OFFICERS & CONTRACT PHYSICIANS

The hearing rights of Article VII do not apply to Members who have contracted with the Hospital to provide administrative or clinical services. Removal of these Members from office and removal of any privileges related to their contracted administrative or clinical services (but not their Medical Staff membership) shall instead be governed by the terms of their individual or their practice group's contracts and agreements with the Hospital. Notwithstanding the foregoing, the hearing rights of this Article VII shall apply if an action is taken, based on medical disciplinary cause or reason, which must be reported in compliance with Business and Professions Code Section 805 or to the National Practitioner Data Bank.

7.7-2 AUTOMATIC SUSPENSION, RESTRICTION, OR TERMINATION OF MEMBERSHIP OR PRIVILEGES

Any automatic suspension, restriction or termination of membership or privileges initiated pursuant to the Bylaws as described in Article VI does not invoke hearing rights as described in these Bylaws.

7.8 CHALLENGES TO RULES

The hearings provided for in this Article shall not be utilized to make determinations as to the substantive validity of a bylaw, rule, regulation or policy. A Practitioner may challenge the substantive validity of such bylaw, rule, regulation or policy in a written appeal to the MEC. The MEC shall review the challenge under such procedures as it may establish from time to time and shall issue a written decision regarding the substantive validity of the challenged bylaw, rule, regulation or policy. The Practitioner shall be entitled to submit a written appeal of the MEC's decision to the Board in accordance with the procedures the Board adopts, which decision will be final.

7.9 RELEASE

By requesting a hearing or appeal under this Article, a Practitioner shall be bound by the provisions in Article XIII of these Bylaws relating to immunity from liability in all matters relating thereto.

7.10 CONFIDENTIALITY

The investigations, proceedings and records conducted or created for the purpose of carrying conducting peer review activities under the Medical Staff Bylaws are to be treated as confidential and protected by state and federal law to the fullest extent.

7.11 HEARING AND APPEAL RIGHTS AND PROCEDURES FOR ADVANCED PRACTICE PROFESSIONALS

The provisions of Articles 7-1 through 7.7 do not apply to APPs. The following hearing and appeal process shall apply for APPs:

a. Adverse Action: Restriction, modification, or revocation of an APP's privileges may be implemented in accordance with Article 2.3-6 (b) and (c).

b. Notice and Scheduling: Written notice of the adverse action taken and the right to a hearing shall be promptly dispatched to the APP subject to the adverse action. The notice shall state that the APP has 30 days from dispatch of the notice in which to deliver to the MSS Department a written request for a hearing. If the APP does not request a hearing within thirty (30) days of notice dispatch, the APP shall be deemed to have waived his/her right to a hearing. If the APP requests a hearing, the hearing shall begin not less than thirty (30) or more than sixty (60) days from receipt of the hearing request, unless extended by the hearing panel.

c. Hearing Panel: The Chief of Staff shall appoint a hearing panel which shall include at least three members. The panel shall include the Chief of Staff or another MEC member, the Chief Executive Officer or another Hospital executive, and one additional member of the Medical or APP staff. The hearing panel may appoint a hearing officer to preside over the hearing process and advise the hearing panel.

d. Procedure: The hearing panel shall prescribe the procedure for the hearing. The hearing panel will determine if witnesses may be called during the hearing. If witnesses are allowed both sides may call witnesses. Both the APP subject to the adverse action and the MEC shall have the right to present information to the hearing panel, but neither may have legal representation present in the hearing session(s).

e. Hearing Panel Determination: Following presentation of information and hearing panel deliberations, the panel shall determine whether the adverse action is reasonable and warranted and shall report its determination in writing to the MEC and APP:
   1) Both the MEC and the APP have the right to request an appeal of the hearing panel's decision to the Board.
   2) A request for appeal must be made to the Board within fourteen (14) days of notice dispatch of the hearing panel's decision.

f. Appeal: The Board shall prescribe the procedure for the appeal.

g. Final Decision: The decision of the Board shall be final.

7.12 EFFECT OF LOSS OF PRIVILEGES

If a Practitioner's privileges at the Hospital are terminated, modified or diminished based on medical disciplinary cause or reason and the action was subject to hearing rights under Article VII, the Practitioner may not apply for such terminated, modified or diminished privileges at the Hospital for a period of at least three (3) years after the termination, modification or reduction.

ARTICLE VIII: OFFICERS OF THE MEDICAL STAFF AND ELECTED AT-LARGE MEDICAL EXECUTIVE COMMITTEE MEMBERS

8.1 IDENTIFICATION, ELECTION AND REMOVAL OF OFFICERS

8.1-1 IDENTIFICATION OF OFFICERS AND OFFICER ELECTION DATE

a. The Officers of the Medical Staff shall include the Chief of Staff, Immediate Past Chief of Staff, Chief of Staff Elect and Treasurer. The Officer positions for election in each even year are the Chief of Staff Elect and Treasurer. The Chief of Staff Elect automatically assumes the role of Chief of Staff in January following a Medical Staff Officer election. Officers of the Medical Staff will be elected and serve a two (2) year term.

b. Active Staff Member ballots for Medical Staff Officers must be received in the office of MSS no later than 5:00 pm on

the first Monday in November of every even year. This date is defined as the Officer Election Date. Ballots received after 5:00 pm on the Officer Election Date will be considered invalid and will not be counted. Finalizing the election results in November will allow the incoming Chief of Staff sufficient time to confer with the newly elected Officers prior to recommending Medical Staff committee members and chairpersons to the MEC for the upcoming two (2) years. If possible, the slate of Medical Staff committee members and chairpersons should be presented to the MEC for review in November of each even year to facilitate a smooth transition for January meetings.

8.1-2 QUALIFICATIONS

Officers must be members in Good Standing of the Active Staff at the time of their nominations and election and must remain Members of the Active Staff in Good Standing during their term of office. Given the nature of his/her duties, the Chief of Staff Elect must be a licensed physician. Failure to maintain these required qualifications, as determined by the MEC, shall create an automatic vacancy in the office involved.

8.1-3 NOMINATIONS

a. A Nominating Committee shall be appointed by the Chief of Staff and approved by the MEC at least ninety (90) days prior to the Officer Election Date in each even year.

b. The Nominating Committee, if possible, will include at least the Chief of Staff, Immediate Past Chiefs of Staff, two (2) additional MEC members and one (1) Active Staff Member who is not a current member of the MEC. Additional members may be recommended by the Chief of Staff. The Chief of Staff will chair the Nominating Committee.

c. The Nominating Committee shall submit to the MEC two (2) nominations for each elected office at least sixty (60) days prior to the Officer Election Date. The nominations list and a summary of the petition process for Officers, as described in Section 8.1-2 (d), will be emailed to each Active Medical Staff Member at least fifty-five (55) days prior to the Officer Election Date.

d. Nominations for elected office may also be made by petition, provided that a petition designating the nominee and containing the nominee's approval is signed by no less than twenty-five percent (25%) of the Members of the Active Medical Staff and is submitted to MSS at least forty five (45) days prior to the Officer Election Date. Eligibility to run and willingness to serve of any petitioned nomination(s) will be validated by the Chief of Staff and recorded by MSS. Validated petition nominations, if any, will be added to the final nomination list.

e. The final nomination list and electronic ballot will be emailed to all members of the Active Staff at least forty (40) days prior to the Officer Election Date.

8.1-4 ELECTION

a. Electronic ballots must be returned to MSS within fourteen (14) calendar days from the day they were emailed to Active Staff Members. Ballots submitted after that date will not be counted.

b. Election of all Officers requires obtaining a majority (greater than 50%) of the casted votes for that office.

c. If a candidate for a specific office does not receive a majority of the votes cast on the first ballot, a run-off election will be held between the two candidates for a specific office who received the highest number of votes.

d. Run-off electronic ballots will be emailed to Active Staff Members at least twenty days (20) prior to the Officer Election Date.

e. Run-off electronic ballots must be returned to MSS at least five (5) days prior to the Officer Election Date. Ballots submitted after that date will not be counted.

f. In the case of a tie for any office in a run-off election, a special MEC meeting will be called. The winner of the tie run-off Officer election will be determined by MEC vote.

8.1-5 TERM OF ELECTED OFFICE

Each Officer shall serve a two (2) year term commencing on the first day of January following his or her election. Each Officer shall serve in each office until the end of his or her term or until a successor is elected unless he/she resigns or is removed from office.

8.1-6 REMOVAL OF OFFICERS

An Officer will be removed automatically if he/she no longer meets the qualification requirements described in Section 8.1-2. In addition, removal of an Officer may be initiated by the MEC for failure to carry out the duties and responsibilities of the office as set forth in Section 8.2. Removal of an Officer may also be initiated for any reason by a petition signed by at least one-third of the Active Medical Staff. Whether initiated by the MEC or by Active Staff petition, removal of an Officer shall be considered at a special Medical Staff meeting called for that purpose. To take action to remove an Officer, the special Medical Staff meeting must have a quorum of at least fifty percent (50%) of Active Staff Members represented either in person or through electronic vote. Removal of an Officer shall require a majority vote (greater than 50%) of the Active Staff Members casting electronic ballots or voting in person at the special Medical Staff meeting where the fifty percent (50%) Active Staff quorum requirement is met.

8.1-7 VACANCIES IN ELECTED OFFICE

Vacancies in office can occur upon death or disability, resignation or removal of an Officer. Vacancies in office other than that of Chief of Staff and Immediate Past Chief of Staff shall be filled by appointment by the MEC until the next regular election. If there is a vacancy in the office of Chief of Staff, the then Chief of Staff Elect shall serve out the remaining Chief of Staff term. The MEC would then appoint a Chief of Staff Elect to serve until the next regular election. If there is a vacancy in the office of Immediate Past Chief of Staff, the office will remain vacant and any related vacant committee positions will be filled by recommendation of the Chief of Staff and approval of the MEC.

8.2 DUTIES OF THE OFFICERS

8.2-1 CHIEF OF STAFF

The Chief of Staff shall serve as the chief officer of the Medical Staff. The duties 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;

b. Calling, presiding at and being responsible for the agenda of all meetings of the Medical Staff;

c. Serving as chairperson of the MEC;

d. Serving as an Ex Officio Member of all other Medical Staff committees without vote, unless his or her voting membership in a particular committee is defined by these Bylaws or otherwise assigned by the MEC;

e. Interacting with the Chief Executive Officer and Board in all matters of mutual concern within the Hospital;

f. Appointing, with the MEC approval, committee members and chairpersons for all standing and special Medical Staff and interdisciplinary committees, except where otherwise provided by these Bylaws;

g. Serving as an ex-officio member of the Board, with or without vote, and representing the recommendations, views and policies of the Medical Staff to the Board and to the Chief Executive Officer;

h. Being a spokesperson for the Medical Staff in external professional and public relations;

i. Performing such other functions as may be assigned to him or her by these Bylaws, the Medical Staff or by the MEC;

j. Serve as liaison to outside licensing or accreditation agencies;

k. Serving on liaison committees with the Board and Hospital administration; and

l. Receiving and interpreting to the Medical Staff the policies of the Board and reporting to the Board on the monitoring and measurement of quality with respect to the Medical Staff's responsibility to provide high quality and safe medical care. This includes regular reporting related to the Board on peer review and credentialing issues.

8.2-2 CHIEF OF STAFF ELECT

The Chief of Staff Elect shall be a voting member of the MEC and assume all duties and authority of the Chief of Staff in the absence of the Chief of Staff. The Chief of Staff Elect shall chair the Patient Safety & Quality Committee and perform other duties as may be assigned from time to time by the Chief of Staff or the MEC.

8.2-3 TREASURER

The Treasurer shall be a voting member of the MEC and assume all duties and authority of the Chief of Staff in the absence of the Chief of Staff and Chief of Staff Elect. The Treasurer shall collect, disperse and account for Medical Staff funds and perform other such duties as pertinent to the office or as may be assigned by the Chief of Staff or the MEC. The Treasurer shall also act as the liaison between individual Practitioners and the MEC when questions arise regarding interpretation of provisions of the Bylaws, Rules and Regulations and Medical Staff policies.

8.3 ELECTION OF MEDICAL EXECUTIVE MEMBERS AT-LARGE

8.3-1 NUMBER OF ELECTED MEC AT-LARGE MEMBERS

Two (2) MEC at-large members will be elected by the Active Staff every even year coinciding with the election of Officers. Elected at-large MEC members will serve a two (2) year term.

8.3-2 QUALIFICATIONS, NOMINATION, PETITION AND ELECTION PROCESS

a. Elected at-large MEC members must be members in Good Standing of the Active Staff at the time of their nominations and election, and must remain Members of the Active Staff in Good Standing during their term of office.

b. The nomination, petition and election process for MEC at-large members will be the same as that described for Officers in Section 8.1-3 and 8.1-4. Two (2) candidates will be nominated for each MEC member at-large position, elements of the petition process apply and the names of the MEC at-large candidates will be included on the same ballot as the Officers.

c. Elected at-large members will be voting members of the MEC and subject to the same terms and conditions as other MEC members.

ARTICLE IX: CLINICAL DEPARTMENTS AND SECTIONS

9.1 ORGANIZATION OF CLINICAL DEPARTMENTS AND SECTIONS

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 chairperson and vice-chairperson selected and entrusted with the authority, duties and responsibilities specified in Section 9.6-9(a-b). A department may be further divided, as appropriate, into sections which shall have a section chief selected and entrusted with the authority, duties and responsibilities specified in Section 9.6-9(c). The MEC may recommend to the Board the creation, elimination, modification or combination of departments and sections. All provisions of this Article, where applicable, pertain to activities of both departments and sections of the Medical Staff.

9.2 DEPARTMENTS AND SECTIONS OF THE MEDICAL STAFF

9.2-1 CURRENT DEPARTMENTS

a. Anesthesia
b. Burn Medicine
c. Emergency Medicine
d. Medicine
e. Obstetrics-Gynecology
f. Pathology
g. Pediatrics
h. Radiology
i. Surgery

9.2-2 CURRENT SECTIONS

The Medical Staff currently has no Medical Staff sections, but the addition of one or more sections may be recommended to the Board by vote of the MEC without modification of these Bylaws.

9.3 ASSIGNMENTS TO DEPARTMENTS AND SECTIONS

Each Practitioner shall be assigned membership in one department and, when appropriate, one section but may also be granted privileges in other departments and sections. A Practitioner may only vote in their primary assigned department and section even if they hold privileges in other departments and sections.

9.4 DUTIES AND FUNCTIONS OF DEPARTMENTS

The departments shall meet as often as necessary at the call of the department chairperson to perform the following duties and functions:

9.4-1 CLINICAL DUTIES AND FUNCTIONS

a. Serve as a forum for the exchange of clinical information regarding clinical services provided by department members.

b. Provide recommendations to the department chairperson and/or the MEC with regard to the development of clinical practice guidelines related to care and clinical services provided by department members.

c. Provide recommendations to the department chairperson regarding criteria for privileges.

d. Ensure that patients receive appropriate and medically necessary care at the Hospital from departmental members.

e. Ensure that the same level of quality of patient care is provided by all individuals with delineated privileges within the department.

f. Provide recommendations to the department chairperson and/or the MEC with regard to issues related to standards of practice and/or clinical competence.

g. Ensure effective mechanisms for the clinical supervision of APPs and House Staff if any.

h. Provide information and/or recommendations to the department chairperson with regard to the criteria for granting privileges within the department.

i. Provide information and/or recommendations to the department chairperson and/or the MEC with regard to Medical Staff policies and procedures.

j. Provide recommendations to the department chairperson and/or the MEC with regard to ensuring appropriate call

coverage by department members.

9.4-2 QUALITY ASSESSMENT/PERFORMANCE IMPROVEMENT AND PATIENT SAFETY DUTIES AND FUNCTIONS

a. Ensure the performance of ongoing professional practice evaluation (OPPE), focused professional practice evaluation (FPPE), peer review and quality assessment activities relative to the performance of individuals with privileges in the department and report such activities to the MEC on a regular basis as described in the Medical Staff Policy – Peer Review.

b. Provide leadership for activities related to patient safety, including proactive risk assessments, root cause analysis in response to an unanticipated adverse event, addressing patient safety alerts and implementing procedures to comply with patient safety goals.

c. Ensure appropriate quality control is performed if applicable to the department.

d. Receive reports regarding Hospital performance improvement results that are applicable to the performance of the department and its members, and integrate the department's performance improvement activities with that of the Hospital by taking a leadership and participatory role in such activities, as outlined in the Hospital Performance Improvement Plan.

e. Recommend medical educational programs to meet the needs of department members, based on the scope of services provided by the department, changes in medical practice or technology and the results of departmental performance improvement activities.

9.4-3 DELEGATION OF DEPARTMENTAL DUTIES

a. The departments delegate to the department chairperson primary responsibility for making credentialing recommendations to the Credentials Committee and MEC.

b. The departments delegate to the Peer Review Committee the primary responsibility for peer review.

c. The department chairperson can call for a departmental meeting at any time to discuss credentialing and/or peer review issues and obtain input from departmental members.

d. Delegated duties of the department chairperson are further described in Section 9.6-9.

9.5 FUNCTIONS AND DUTIES OF SECTIONS

Sections and section chiefs report directly to their respective department and department chairperson. Following consultation with the appropriate department chair, a section shall meet as often as necessary at the call of the section chief to perform the following functions and duties:

a. Serve as a forum to discuss clinical aspects of care related to the section.

b. When requested by the department chairperson or MEC, meet to discuss specific issues related to quality assessment, peer review, performance improvement and/or credentialing.

c. Report all recommendations to the appropriate department chairperson and the MEC.

9.6 OFFICERS OF DEPARTMENTS AND SECTIONS

9.6-1 IDENTIFICATION

The officers of the departments and sections shall be the department chairperson, the department vice-chairperson and the section chief. Department chairpersons will be elected by the Active Staff department members. The department vice-chairperson and section chiefs, if any, will be recommended by the department chairperson and approved by the MEC.

9.6-2 QUALIFICATIONS

The officers of the departments and sections shall be Active Staff Members of the department in Good Standing. Each department chairperson and vice-chairperson shall have demonstrated ability in at least one of the clinical areas of the department. The section chief shall have demonstrated ability in the specialty represented by the section. All officers of the departments and sections shall be certified by an appropriate specialty board or affirmatively establish comparable competence through the credentialing process.

9.6-3 NOMINATIONS

a. A Nominating Committee shall be appointed by each department chairperson at least ninety (90) days prior to the Officer Election Date in the year a department chairperson's term will expire.

b. The Nominating Committee will include the department chairperson and at least two (2) additional Active Staff members from the department. The department chairperson will be the Nominating Committee chairperson.

c. The Nominating Committee shall submit to the MEC at least (1) nomination for department chairperson, who has agreed to run for the position, at least sixty (60) days prior to the Officer Election Date. The nomination list and a summary of the petition process for department chairperson, as described in Section 9.6-3 (d), will be emailed to each Active Staff member in the department at least fifty-five (55) days prior to the Officer Election Date.

d. Nominations for department chairperson may also be made by petition. A petition designating the nominee and containing the nominee’s approval to run for office must be signed by no less than twenty-five percent (25%) of the Active Staff department members and submitted to MSS at least forty five (45) days prior to the Officer Election Date. Eligibility to run and willingness to serve of any petitioned nomination(s) will be validated by the Chief of Staff and recorded by MSS. Validated petition nominations, if any, will be added to the final nomination list.

e. The final nomination list and electronic ballot will be emailed to all Active Staff department members at least forty (40) days prior to the Officer Election Date.

f. If there is only one candidate for a department chairperson after closure of the petition process, that person will be named department chairperson without an election ballot vote.

9.6-4 ELECTION

a. Electronic ballots must be returned to MSS within fourteen (14) calendar days from the day they were emailed to Active Staff Members. Ballots submitted after that date will not be counted.

b. Election of a department chairperson requires obtaining a majority (greater than 50%) of the casted votes for that office.

c. If a candidate does not receive a majority of the votes cast on the first ballot, a run-off election will be held between the two candidates who received the highest number of votes.

d. Run-off electronic ballots will be emailed to Active Staff department members at least twenty days (20) prior to the Officer Election Date.

e. Run-off electronic ballots must be returned to MSS at least five (5) days prior to the Officer Election Date. Ballots submitted after that date will not be counted.

f. In the case of a tie for department chairperson in a run-off election, the winner of the run-off election will be determined by MEC vote.

9.6-5 TERM OF OFFICE AND ELIGIBILITY FOR REAPPOINTMENT TO POSITION

Department and section officers shall serve a term of office of two years but will remain in office until a new chairperson/chief is named. Except for the departments of Anesthesia, Pathology, Radiology, Burn Medicine and Emergency Medicine, no person may serve as a department chairperson for more than two consecutive terms unless an additional consecutive term is approved by the MEC prior to the departmental election ballots being sent to Active Staff members. Departmental vice-chairpersons and section chiefs can serve consecutive terms if appointed by the chairperson and approved by the MEC.

9.6-6 RESIGNATION

Any department or section officer may resign at any time by giving written notice to the MEC. The acceptance of such resignation shall not be necessary to make it effective.

9.6-7 REMOVAL

Removal of a departmental vice-chairperson or section chief may be recommended by the department chairperson and becomes effective if approved by the MEC. Any department chairperson will be automatically removed from office for failure to maintain the required qualifications of office. A department chairperson may also be removed from office for cause.

a. For cause removal of a department chairperson may be initiated for any of the following:
    1) Failure to perform the duties of office;
    2) Failure to comply with or support the enforcement of the Medical Staff Bylaws, Rules and Regulations or policies;
    3) Failure comply with or support the compliance of the Hospital and the Medical Staff to applicable federal and state laws and regulations, and the standards or other requirements of any regulatory or accrediting agency having jurisdiction over the Hospital or any of its services; and/or,
    4) Failure to adhere to professional ethics or any other action(s) deemed injurious to the reputation of, or inconsistent with, the best interests of the Hospital or the Medical Staff.

b. The MEC may initiate for cause removal of a department chairperson by majority vote. For cause removal may also be initiated petition signed by a majority of department members holding Active Staff membership.

c. In either case, vote for removal of a department chairperson for cause will occur at a special departmental meeting called for that purpose with at least twenty (20) days' notice to departmental Active Staff Members.

d. Electronic ballots describing the reason for the requested removal will be sent out with the special meeting notice. Voting may be in person at the meeting or through electronic ballot. To be counted, electronic ballots must be received by MSS prior to the commencement of the meeting.

e. Removal from office will occur if approved by a majority of those Active Staff Members submitting an electronic ballot or voting in person.

9.6-8 VACANCY

In the event of a vacancy in one of the department chairperson the Chief of Staff shall appoint an interim chairperson until an election can be held as described in Sections 9.6-3 and 9.6-4. In the event of a vacancy in a department vice-chairperson or section chief position, the vacancy will be filled by recommendation of the chairperson of the department and MEC approval.

9.6-9 RESPONSIBILITY AND AUTHORITY OF DEPARTMENT AND SECTION OFFICERS

a. Department Chairperson: Each department chairperson shall be responsible for the organization of the department and delegation of duties to department members to promote quality of patient care in the department. In addition to those duties described in Section 9.4-3, any identified departmental duties or functions may be delegated to the department chairperson by the department. Members of the department and others with privileges in the

department shall be responsible to the department chairperson. Each department chairperson shall be responsible for the following duties:

1) Presiding at all meetings of the department;
2) Appointing department members to the positions of section chief and to membership positions on departmental committees, if any;
3) Serving as an ex-officio Member of all departmental committees, if any;
4) Serving as a Member of the MEC with accountability to the MEC with regarding the activities and functioning of the department, specifically to regularly report the peer review, quality assessment and performance improvement activities of the department to the MEC;
5) Overseeing all clinically related activities of the department;
6) Overseeing all administrative activities of the department unless otherwise provided by the Hospital;
7) Continuing surveillance of the professional performance of all individuals in the department who have delineated privileges;
8) Participating in the evaluation of Practitioners practicing within the department;
9) Recommending to the Medical Staff the criteria for privileges that are relevant to the care provided in the department;
10) Recommending to the Credentials Committee and/or MEC privileges for each Practitioner of the department and sections under the department;
11) Assessing and/or recommending to the relevant Hospital authority off-site sources for needed patient care services not provided by the department or the Hospital;
12) Integrating the department into the primary functions of the Hospital;
13) Coordinating and integrating interdepartmental and intradepartmental services;
14) Developing and implementing policies and procedures that guide and support the provision of services;
15) Recommending a sufficient number of qualified and competent persons to provide care or services;
16) Determining the qualifications and competence of department personnel who are not licensed independent practitioners and who provide patient care services;
17) Ensuring the continuous assessment and improvement of the quality of care and services provided;
18) Maintaining quality control programs as appropriate;
19) Ensuring the orientation and continuing education of all persons in the department;
20) Recommending appropriate space and other resources needed by the department, and;
21) Providing for the orientation and continuing education of all persons in the department or service.

b. Department Vice-Chairperson: The vice-chairperson shall assist the department chairperson in the performance of the department chairperson's duties and shall assume the duties of the chairperson in his/her absence.

c. Section Chief: The section chief shall be responsible for promoting quality of patient care in the section. Each section chief shall be responsible for the following duties:

1) Chairing all section meetings;
2) Following consultation with the appropriate department chairperson, calling and giving notice of a meeting of the section to be held on an ad hoc basis when issues are identified that require the members to discuss quality of care or other issues unique to their specialty;
3) Being accountable to the department chairperson and reporting to the departmental chairperson any quality assessment and performance improvement activities of the section, and;
4) Making credentialing recommendations to the department chairperson regarding the privileges of section members.

ARTICLE X: COMMITTEES OF THE MEDICAL STAFF

10.1 GENERAL COMMITTEE ISSUES

a. The purpose of all Medical Staff committees is to monitor, evaluate, and improve the quality of care rendered in the Hospital. Through its actions Medical Staff committees strive to continuously improve the quality and safety of patient care services and perform clinical monitoring and improvement functions relative to the needs of the Hospital, the regulations of the state and federal government, and the relevant accreditation standards. As described in California Evidence Code 1157, neither the proceedings nor the records of organized committees of the Hospital's

Medical Staff shall be subject to discovery.

b. Medical Staff organized committees include the Medical Staff meeting as a committee of the whole, meetings of departments/sections, meetings of committees established under this Article, meetings of special or ad hoc committees and other regular or special Medical Staff meetings.

c. The committees described in this Article shall be the standing committees of the Medical Staff. The committee's composition description may identify specific required members. Unless otherwise specified in the Bylaws, the chairperson and members of all standing committees will be appointed by the Chief of Staff subject to approval by the MEC.

d. Non-voting ad hoc committee members may be appointed to any Medical Staff committee by the committee chairperson when deemed necessary. Additional voting committee members may be recommended by the committee chairperson or Chief of Staff subject to MEC approval.

e. The voting status of Medical Staff committee members will be determined by the MEC when members are appointed. Unless otherwise specified in these Bylaws or by the MEC, all Active and Primary Care Active Medical Staff members are appointed as voting committee members.

f. Unless otherwise specified in these Bylaws, all non-Medical Staff members appointed to Medical Staff committees are non-voting. When non-Medical Staff committee members have been granted a vote on a Medical Staff committee by the MEC, such voting rights shall only be exercised relative to the committee member's area of clinical expertise and restricted by his/her scope of licensure

g. The Chief of Staff and Chief Executive Officer, or designee, are ex-officio non-voting members of all Medical Staff committees but may be voting members if designated as voting members by the MEC or defined in the Bylaws.

h. Whenever reasonably possible, the chairperson of any Medical Staff Committee will be a Medical Staff Member. Unless otherwise restricted by the MEC, the committee chairperson has the right to vote on all committee matters not just in the case of a tie vote.

i. The chairperson of any Medical Staff committee may call for an executive session. Only Medical Staff members holding voting privileges on the committee shall attend the executive session meeting. The chairperson may however request other individuals attend an executive session in an informational non-voting capacity.

j. All members of Medical Staff committees agree to treat the discussions, proceedings, and records of the Medical Staff meetings as confidential. Any breach of confidentiality shall be considered a serious violation of professionalism and may be the basis for Medical Staff Corrective Action.

k. All Medical Staff committees report to the MEC.

10.2 COMMITTEE PROVISIONS

10.2-1 TERMS OF COMMITTEE MEMBERS

Unless otherwise specified, members of standing committees will be appointed for a term of two (2) year's corresponding with the terms of the Medical Staff Officers.

10.2-2 REMOVAL

Except for the MEC members as defined in Section 10.3-4, any committee member may be removed by majority vote of the MEC. If a committee member is an ex-officio member identified as a committee member in the Bylaws, removal also requires approval of the Board.

10.2-3 VACANCIES

Unless otherwise specifically provided, a committee vacancy shall be filled in the same manner as the original appointment was made.

10.2-4 ADDITION, DELETION, OR MODIFICATION OF STANDING COMMITTEES OF THE MEDICAL STAFF

The MEC may recommend directly to the Board the addition, deletion or modification of any standing committee of the Medical Staff as may be described in these Bylaws with the exception of the MEC. Modification of the MEC, as described in Section 10.3 requires a Bylaw amendment vote of the Active Medical Staff pursuant to Article XV.

10.2-5 ATTENDANCE OF ATTORNEY AT A MEDICAL STAFF MEETING

No Medical or APP Staff member may be accompanied by or represented by an attorney at any Medical Staff committee or other Medical Staff meeting except as defined in Article VII of these Medical Staff Bylaws unless authorized in advance by the MEC. This provision does not apply to Medical Staff members who are also attorneys when they are representing themselves during a Medical Staff committee or other Medical Staff meeting.

10.2-6 MEETING ATTENDANCE REQUIREMENTS

a. Members of the Medical Staff are encouraged to attend at least fifty percent (50%) of the meetings of those departments, sections, and committees to which they have been assigned. Mandatory meeting attendance may be required by vote of the MEC. If mandatory meeting attendance is required, the MEC will notify all affected Practitioners by email of the specific requirements.

b. Additional mandatory meeting attendance requirements are also described in Section 12.9.

c. Members of the MEC are required to attend at least fifty percent (50%) of all regular MEC meetings as described in Section 10.3-2 (o).

10.2-7 COMMITTEE MEMBER SUBSTITUTION

If a department chairperson is unable to attend an MEC meeting, the department vice-chairperson may attend the MEC as a voting member in his/her absence. Any other committee voting member substitution requires pre-approval by the Chief of Staff.

10.2-8 RECORD OF MEDICAL STAFF MEETINGS

It is the responsibility of the meeting chairperson to assure a written record is maintained for each Medical Staff meeting. The records will be kept in MSS or other secure location.

10.3 MEDICAL EXECUTIVE COMMITTEE

10.3-1 COMPOSITION

All members of the Medical Staff of any discipline or specialty are eligible for membership on the MEC. Except for the Medical Staff Officers and the Chairpersons of the Anesthesia, Burn Medicine, Pathology, Radiology and Emergency Medicine Departments, voting members of the MEC shall not serve more than two (2) consecutive terms (four (4) consecutive years) unless an additional consecutive term is approved by the MEC. The majority of voting MEC members shall be licensed physicians. The Chief of Staff shall serve as the Chairperson of the MEC and may invite others who are not members of the MEC to attend specific MEC meetings. The MEC shall consist of the following members:

a. Voting members include:
    1) Chief of Staff
    2) Chief of Staff Elect
    3) Secretary/Treasurer
    4) Immediate Past Chief of Staff
    5) Anesthesia Chairperson

6) Burn Medicine Chairperson
7) Emergency Medicine Chairperson
8) Medicine Chairperson
9) Obstetrics/Gynecology Chairperson
10) Pathology Chairperson
11) Pediatrics Chairperson
12) Radiology Chairperson
13) Surgery Chairperson
14) Two (2) elected members at-large as described in Section 8.3
15) Two (2) members at-large recommended by the Chief of Staff and approved by the MEC

b. Ex-officio members without a vote include:
1) Peer Review Committee Chairperson
2) Credentials Committee Chairperson
3) Chief Executive Officer
4) Chief Medical Officer
5) Vice-President of Quality
6) Chief Nursing Officer
7) Chief Financial Officer
8) Chief Operating Officer

10.3-2 DUTIES

The MEC shall, through delegated authority from the Medical Staff, act on behalf of the organized Medical Staff in the intervals between Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws. The organized Medical Staff does, however, retain the right and ability to adopt Medical Staff Bylaws, Rules and Regulations, and policies and amendments thereto and to propose them directly to the Board utilizing processes described in Section 15.4. The MEC shall perform or direct the performance of duties described in this Section and other duties relative to the functions of leadership, performance improvement and other key Medical Staff functions identified by accreditation or regulatory agencies. Any delegated MEC duties may be removed by the Medical Staff utilizing the process described in Section 15.4. The following delegated duties shall be performed by the MEC:

a. Providing relevant and current Medical Staff Bylaws, Rules and Regulations and Medical Staff policies, subject to the approval of the Board.

b. Providing liaison and communication with all levels of Hospital governance and administration with regard to policy decisions affecting patient care services.

c. Collaborating with other leaders of the organization in Hospital planning.

d. Reviewing the qualifications, evidence of current competence and the recommendations of the department chairperson for each individual applying for Medical Staff membership or privileges, and make recommendations for appointment, reappointment, staff category, assignment to departments/sections, privileges, and any Disciplinary Actions to the Board.

e. Organizing the Medical Staff's quality assessment and performance improvement activities and establishing a mechanism designed to conduct, evaluate, and revise such activities.

f. Conducting and supervising Medical Staff peer review activities and requesting evaluation of a Practitioner privileged through the Medical Staff process in instances where there is doubt about the Practitioner's ability to perform the privileges held and/or requested.

g. Receiving and acting on reports and recommendations from Medical Staff committees, departments/sections and assigned activity groups, specifically as related to Medical Staff quality assessment and performance improvement activities.

h. Making recommendations directly to the Board with regard to all of the following:
   1) Medical Staff structure;
   2) Structure and membership of Medical Staff committees;
   2) Mechanism used to review credentials and to delineate individual privileges;
   3) Recommendations of individuals for Medical Staff membership and/or termination of membership;
   4) Recommendations for delineated privileges and/or termination of privileges for each eligible Practitioner credentialed by the Medical Staff;
   5) Methods for participation of the Medical Staff in organizational quality assessment, performance improvements and patient safety activities;
   6) The Medical Staff's evaluation of the quality of patient care services provided by the Medical Staff and the Hospital;

i. Reporting to the Medical Staff substantive actions taken by the MEC on behalf of the Medical Staff.

j. Making recommendations to the Chief Executive Office on matters medico-administrative in nature.

k. Ensuring that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of the Hospital.

l. Recommending to the relevant Hospital authority off-site sources needed for clinical patient care services which are not provided by the Hospital.

m. Taking all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all Practitioners credentialed by the Medical Staff.

n. Assuring the communication of significant quality and performance improvement information to the Medical Staff and the Board.

o. MEC members are expected to attend at least fifty percent (50%) of all regularly schedule MEC meetings in any rolling twelve (12) month period. Exceptions to this mandatory meeting attendance requirement may be made by the MEC for cause. See Section 10.3-4.

10.3-3 MEETINGS AND REPORTING

The MEC will meet at least ten (10) times per year. The MEC shall report on their activities to the Medical Staff and the Board.

10.3-4 REMOVAL OF MEDICAL EXECUTIVE COMMITTEE MEMBERS

a. MEC members who do not meet the (50%) meeting requirement described Section 10.3-2 (o) will be deemed to have voluntarily resigned from the MEC.

b. A member will be automatically removed from the MEC if he/she no longer meets requirements related to his/her position on the MEC or is no longer a member in Good Standing.

c. Removal of a MEC member may also be initiated for failure to carry out the duties and responsibilities of the position as set forth in Section 10.3-2. Removal of a MEC Member for failure to carry out duties and responsibilities may be initiated by the two-thirds (2/3) majority vote of the MEC or by a petition signed by, at least, twenty percent (20%) of Medical Staff members eligible to vote. If initiated by the MEC or by the Medical Staff, removal of a MEC member shall require a majority vote of voting members casting an electronic ballot.

d. Voluntary resignation or removal from the MEC of a voting member will result in automatic in removal from any office or position associated with the Practitioner's MEC membership. Any vacancies created by such a voluntary resignation or removal will be filled by the MEC for the remainder of the current term except for the position of Chief of Staff which would be filled by the Chief of Staff Elect. The MEC may, at its sole discretion, also elect to hold special elections to fill vacant positions other than a vacancy in the position of Chief of Staff.

10.4 BIOETHICS COMMITTEE

10.4-1 COMPOSITION

The Bioethics Committee shall be composed of at least four (4) members of the Medical Staff, and members from the nursing service, clergy, social services and an administrative representative.

10.4-2 DUTIES

The Bioethics Committee may participate in the development of guidelines for consideration in cases having bioethical implications, development and implementation of procedures for 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 Hospital staff on bioethical matters.

10.4-3 MEETINGS

The Committee will meet as often as necessary at the call of the chairperson.

10.5 BYLAWS COMMITTEE

10.5-1 COMPOSITION

The Bylaws Committee shall be composed of at least four (4) Active Staff members, one of whom shall be the immediate past Chief of Staff, and one shall be the current Chief of Staff.

10.5-2 DUTIES

The purposes of the Bylaws Committee is to assure that the Medical Staff Bylaws adequately and accurately describe the structure and function of the Medical Staff, including but not limited to: the mechanism used to review credentials and to delineate individual privileges, the organization of the Medical staff quality improvement activities including the procedures for conducting, evaluating, and revising such activities, the mechanism for terminating Medical Staff membership, and the fair hearing procedures. The Bylaws Committee shall assure that the Bylaws are reviewed at least annually and updated as necessary.

10.5-3 MEETINGS

The Committee will meet at least annually.

10.6 CONTINUING MEDICAL EDUCATION COMMITTEE

10.6-1 COMPOSITION

The Continuing Medical Education (CME) Committee shall be composed of members representing each department of the Medical Staff. Additional ex-officio members without vote shall include the CME Coordinator, the Medical Librarian, the Hospital Pharmacist, and a representative from MSS and the Quality Department.

10.6-2 DUTIES

The duties of the Committee shall be:

a. To assess the educational needs of the Medical Staff and formulate appropriate CME activities to respond to those needs. CME programs shall relate, at least in part, to the type and nature of services offered by the Hospital and the findings of performance improvement activities;

b. To evaluate individual CME activities as they occur as well as evaluate the overall CME program at least annually;

c. To prepare a CME budget for each fiscal year;

d. To formulate and recommend to the MEC CME policies and forms;

e. To ensure all CME criteria for Category I activities are met;

f. To be responsible for approving all Category I Credit activities;

g. To assess the library needs of the Hospital and Medical Staff and to recommend purchase of materials and other aids designed to meet the educational and professional needs of the clinical staff, and;

h. To evaluate library resources annually.

10.6-3 MEETINGS

The Committee will meet at least quarterly.

10.7 CREDENTIALS COMMITTEE

10.7-1 COMPOSITION

The Credentials Committee shall be composed of at least four (4) Active Staff members. Ex-officio members shall include nursing and APP representation on an ad hoc basis.

10.7-2 DUTIES

The Credentials Committee shall perform the function of credentialing, as described in these Bylaws under the oversight and direction of the MEC. The Credentials Committee shall review all applications for appointment, reappointment, and the granting, renewal or revision of privileges and make recommendations as to whether the applicants meet the Medical Staff's criteria for membership and/or privileges. In addition, the following specific functions shall be performed by the Credentials Committee:

a. Oversee a mechanism to ensure that all Medical Staff members and individuals with privileges continuously meet required credentialing requirements;

b. Make recommendations related to granting privileges, ensure that the same level of quality of care is provided by all individuals with delineated privileges, within Medical Staff departments, across departments, and between members and non-members of the Medical Staff who have delineated privileges;

c. Oversee a mechanism to ensure that the scope of practice of individuals with privileges is limited to the privileges granted, and;

d. Make recommendations to the MEC with regard to any revisions in the process for appointment, reappointment or delineation of privileges.

10.7-3 MEETINGS

The Credentials Committee will meet at least quarterly.

10.8 INFECTION CONTROL COMMITTEE

10.8-1 COMPOSITION

The Infection Control Committee shall consist of representatives from the departments of Emergency Medicine, Medicine, Surgery, Obstetrics/Gynecology and Pathology. Voting members will also include a member from Nursing Service, Administration, Quality Management and an infection control practitioner employed in a surveillance or epidemiological capacity. It may include non-voting consultants in microbiology and non-voting representatives from relevant Hospital services.

10.8-2 DUTIES

a. To develop and monitor the Hospital's infection control program, and the staff's treatment of infectious disease, including review of the clinical use of antimicrobials and surveillance of nosocomial infections.

b. The Committee shall approve action to prevent or control infections and the infection potential among patients and Hospital personnel.

c. At least every three (3) years, the Committee shall review and approve all policies relating to the infection control program, unless otherwise required more frequently per regulatory agency.

10.8-3 MEETINGS

The Committee will meet at least quarterly.

10.9 JOINT CONFERENCE COMMITTEE

10.9-1 COMPOSITION

The Joint Conference Committee shall be composed of:

a. Four (4) MEC members appointed by the Chief of Staff;

b. Three (3) Board members appointed by the Board Chairperson, and;

c. The Chief Executive Officer or designee.

The Joint Conference Committee shall always have four (4) Medical Staff members and four (4) Board members including the Chief Executive Officer as a Board member. All members of the Joint Conference Committee, including the Committee Chairperson, shall be voting Members. The Chairperson of the Committee will be appointed by the Chief of Staff.

10.9-2 DUTIES

The Joint Conference Committee shall constitute a forum for discussion of matters of Hospital and Medical Staff policy, practice, and planning and serve as a forum for interaction between Medical Staff, administration, and the Board on such matters as may be referred to the Joint Conference Committee for discussion. The Joint Conference Committee shall also serve as a committee for management of conflict between the Medical Staff, administration, and the Board, as described in the Interdisciplinary Policy – Leadership Conflict Management.

10.9-3 MEETINGS

The Committee will meet as often as necessary.

10.10 OPERATIONS IMPROVEMENT COMMITTEE

10.10-1 COMPOSITION

The Operations Improvement Committees (OICs) are interdisciplinary Medical Staff committees composed of physicians, other clinical staff, administrators, and other assigned members as may be appropriate. Operations Improvement Committees may be formed for any Hospital clinical service, clinical location, or treatment program by recommendation of

the MEC and approval of the Board. The composition of specific Operations Improvement Committees is described in the individual committee's charter.

10.10-2 DUTIES

The duties of the Operations Improvement Committees shall include the following:

a. Evaluate and improve the quality of care provided to patients related to the clinical service, clinical location, or treatment program represented. This evaluation will not include physician peer review. Any physician performance concerns will be referred to the Medical Staff Peer Review Committee;

b. Assess, monitor, and improve, as may be necessary, processes and systems to optimize operational and clinical efficiency of the service, clinical location or treatment program represented;

c. Implement and assess appropriate quality control measures related to the service, clinical location or treatment program represented;

d. Implement performance improvement activities as may be necessary to improve the processes and outcomes of care related to service, clinical location or treatment program represented;

e. Assure ongoing compliance with Joint Commission standards and regulatory requirements related to the service, clinical location or treatment program represented, and;

f. Review and recommend to the MEC or other appropriate committee relevant policies, procedures, and protocols that may be necessary for the operation of the clinical service, clinical location or treatment program represented.

10.10-3 MEETINGS

The OIC committees will meet as often as necessary.

10.11 PEER REVIEW COMMITTEE

10.11-1 COMPOSITION

The Peer Review Committee shall include at least five (5) physician members of the Active Staff. The Vice-President of Quality will be an ex-officio member without vote.

10.11-2 QUORUM AND ATTENDANCE

a. The quorum for Peer Review Committee Meetings is four (4) voting members.

b. If a member of the Committee fails to attend four (4) consecutive meetings or 50% of the total meetings in a year, the Chairperson of the Committee will request that the Chief of Staff replace the Committee member.

10.11-3 DUTIES

a. Assist in the implementation of the Medical Staff peer review program as defined in the Medical Staff Policy – Peer Review and act as the primary committee in the oversight of clinical peer review.

b. Oversee the development and implementation of the Medical Staff ongoing professional practice evaluation (OPPE) program.

c. Coordinate the review of OPPE outcome data with the Credentials Committee and MEC.

d. Coordinate ongoing Medical Staff participation in the Hospital's performance improvement program related to issues of concern identified through the Committee's review of care.

e. Ensure that when the findings of the quality assessment process (either aggregate data or single events) are relevant to an individual's performance, the Committee shall conduct peer review or focused professional practice evaluation (FPPE) of the individual's competence as described in the Medical Staff policy – Peer Review.

f. Participate in the Hospital's annual Performance Improvement program evaluation and in the development or revisions to the Performance Improvement Plan, including making recommendations for the establishment of priorities for the program.

g. Ensure that Medical Staff quality assessment and improvement activities address applicable review requirements found in regulatory and accreditation laws, regulations, and standards.

h. Ensure that the Committee's review activities address the scope of patient care services provided by credentialed Practitioners.

i. Provide ongoing and timely review of care provided by credentialed Practitioners through the review of open and closed medical records.

10.11-4 MEETINGS

The Committee will meet at least quarterly.

10.12 PHARMACY AND THERAPEUTICS

10.12-1 COMPOSITION

a. Pharmacy and Therapeutics Committee voting members will include at least one physician representative from the departments of Surgery, Medicine, Anesthesia, OB/GYN, Emergency Medicine and the Director of Pharmacy.

Ex-officio non-voting members will include representation from Administration, Nursing, Respiratory Therapy, Physical Therapy, Diagnostic Imaging, Operating Room, Infection Control and Dietary.

b. Representatives from Housekeeping, Laundry, Nutrition Services, Central Services and Plant Operations shall be available on an ad hoc basis.

10.12-2 DUTIES

a. To develop and approve all policies and procedures relating to medication management, including but not limited to the procurement, storage, distribution, use and administration of drugs and diagnostic testing materials.

b. To develop and maintain the Hospital formulary by analyzing the needs of the patient population, efficacy, utilization, existing like drugs, safety, effectiveness, and cost.

c. To develop an approved definition of a drug reaction and review all untoward events in accordance with the definition. To monitor for trends and opportunities to reduce drug reaction risk.

d. To develop, approve and communicate the definition of a medication error.

e. To supervise the mechanism to report and analyze medication errors for opportunities to improve the medication process, control, safety and to provide oversight and recommendation for necessary education.

f. To develop and oversee the Hospital's antimicrobial management, medication error reduction, and medication safety programs.

g. To develop, maintain and analyze a medication usage program for opportunities to improve medication utilization, safety, appropriateness and effectiveness

h. To review and develop policies regarding the therapeutic agents to be stocked on the nursing units and other departments; considering safety, packaging, volumes and maintaining control.

i. To develop a list of high-risk medications and define policy on the handling, storage, distribution and administration of the medications.

j. To develop and monitor the control and safety of medication processes as they relate to controlled substances.

k. To develop and review standards involving the use, control and cost of investigational drugs and of research in the use of FDA approved drugs.

l. To develop a mechanism to efficiently and safely manage all medication recalls and to monitor patient care/safety outcomes as they relate to the specific drugs recalled.

m. To develop mechanisms to educate and analyze the effectiveness of the education related to, but not limited to the following: new drugs, drug recalls, drug warnings, drug shortages, cost variations and efficacy, appropriateness and packaging, dosing issues, policy change, medication safety and reporting.

10.12-3 MEETINGS

The Committee will meet at least quarterly.

10.13 PRACTITIONER WELL-BEING COMMITTEE

10.13-1 COMPOSITION

The Practitioner Well-Being Committee will be composed of no fewer than three (3) Active Staff members, the majority of whom, including the Chairperson, shall be physicians. Whenever possible the Committee should include a member who is a psychiatrist.

10.13-2 DUTIES

a. The Committee shall strive to help improve the quality of care for patients by helping to resolve matters relating to Medical Staff Member's health, well-being or impairment before they evolve into significant patient care problems.

b. The Committee may receive reports related to the health, well-being, or impairment of Medical Staff members and, as it deems appropriate, may investigate such reports. The confidentiality of the person reporting shall be protected. With respect to matters involving individual Medical Staff members, the Committee may, on its own initiative, upon request of the involved Practitioner, or upon request of a Medical Staff or department committee or officer, provide such advice, counseling, or referrals as may seem appropriate. Such activities shall be confidential; however, if the Committee receives information that demonstrates that the health or impairment of a Medical Staff Member may pose a risk of harm to Hospital patients (or prospective patients), that information shall be referred to the Chief of Staff who will determine whether corrective action is necessary to protect patients.

c. The Committee shall also consider general matters related to the health and well-being of Medical Staff members and, with the approval of the MEC, develop educational programs or related activities.

d. Perform other functions as described in the Medical Staff Policy – Practitioner Well-Being.

10.13-3 MEETINGS AND REPORTING

The Committee will meet as often as necessary. The Committee will maintain only such record of its proceedings as it deems advisable and will routinely report a summary of its activity to the MEC.

10.14 PROFESSIONAL STANDARDS COMMITTEE

10.14-1 COMPOSITION

Members of the Professional Standards Committee shall include the Chief of Staff, the Chairpersons of the Practitioner Well-Being Committee, the Chief Executive Officer, the Vice President of Quality and the appropriate Department Chairperson(s). Other Medical Staff and APP members may be appointed to the Committee by the Chief of Staff on an "as needed" basis. The exact membership of the Committee will vary depending on the issues being reviewed. The Chairperson of the Committee shall be the Chief of Staff.

10.14-2 DUTIES

Duties of the Professional Standards Committee shall include the review of identified concerns related to a provider's behavior and compliance with expected standards of professionalism as defined in the Professional Conduct Standards and Professionalism Review Medical Staff Policies. The Committee shall also review issues related to recurrent non-compliance with Medical Staff Bylaws, Rules and Regulations, policies and applicable Hospital policies. The Professional Standards Committee will oversee the performance of all focused professional practice evaluations (FPPEs) related to disruptive behavior and/or current rule violations.

10.14-3 MEETINGS

The Committee will meet as necessary.

10.15 PATIENT SAFETY & QUALITY COMMITTEE

The Patient Safety & Quality Committee is responsible for prioritizing, defining and monitoring quality control, performance improvement and patient safety activities of the Hospital. By joining together Medical Staff leadership, administration and Hospital staff, the Patient Safety & Quality Committee facilitates integration between Hospital and Medical Staff clinical practice processes. Our Quality Council Committee is outcome improvement driven and patient focused.

10.15-1 COMPOSITION

The Patient Safety & Quality Committee voting members will include at least the Chief of Staff Elect, five (5) physician members representing various Medical Staff departments, the Chief Executive Officer, the Chief Nursing Officer, Vice President of Quality and the Director of Risk Management. Additional voting or non-voting members may be added by the MEC.

10.15-2 DUTIES

a. Develop and implement a Performance Improvement and Patient Safety Plan that includes:
    1) Prioritizing performance improvement activities by utilizing strategic planning and goal setting, establishing meaningful metrics and benchmarks, assuring timely data collection assessment and assuring the performance programs established result in measurable improvements in outcomes and patient care.
    2) Assuring each hospital department and clinical service collects and analyzes appropriate quality control data and takes timely action on undesirable variations
    3) Overseeing the collection and analysis of Hospital performance and patient safety data. Such data may include, but is not be limited to:

        a) Processes involving patient safety risk or potential for sentinel events
        b) Infection control surveillance
        c) Utilization review
        d) Medication and blood product usage
        e) Information management
        f) Resource utilization
        g) Education of patients/families
        h) Effectiveness of pain management
        i) Patient, staff and physician satisfaction

j) Processes identified for monitoring by the state, CMS or the Joint Commission

4) Communication of performance improvement goals, activities and results to the Medical and Hospital staff.

b. Fostering our Hospital's Culture of Safety.

c. Providing oversight of the Patient Grievance Process including aggregation and analysis of grievance data to identify trends and opportunity for improvement.

d. Chartering interdisciplinary Performance Improvement Teams to collaborate and improve performance in areas identified.

e. Providing organizational direction and recommendations for education related to performance improvement methods and procedures.

f. Facilitating preparation and follow-up for accreditation and regulatory agency surveys.

g. Providing summary reports of Organizational Performance Improvement and Patient Safety activities to the Medical Staff, Hospital staff and the Board.

h. Evaluating the effectiveness of the Performance Improvement and Patient Safety program on an annual basis and revising the Plan as needed.

10.16 TISSUE REVIEW AND TRANSFUSION

10.16-1 COMPOSITION

Voting Committers include representatives from the Medical Staff departments, a representative from pathology and the physician director of the blood bank. Ex officio non-voting members shall include representatives from hospital administration, nursing service, and blood bank services.

10.16-2 DUTIES

a. Surgical Case and Tissue Functions:
   1) Screen all surgical cases in which a specimen (tissue or non-tissue) was removed;
   2) Review all cases in which no specimen was removed when a specimen was expected;
   3) Review cases where there is a discrepancy between the preoperative and postoperative (including pathological) diagnoses. Such review shall include a review of the indications for surgery;
   4) Perform such reviews and studies as may be necessary to monitor and ensure the quality and efficiency of care provided to patients undergoing operative procedures.

b. Transfusion Functions:
   1) Review statistical reports on blood utilization with particular attention to the use of whole blood versus blood components and the number of cross matches ordered to the number of units transfused;
   2) Review all transfusions of whole blood, and blood components including ordering, distributing, handling and dispensing, administration and monitoring the blood and blood components effects on patients;
   3) Review all transfusion reactions, review all multiple transfusions (the number of units over which review will be required to be established by the Committee), and review profiles of component usage. Such review shall include indications for transfusion of blood or blood products;
   4) Perform such reviews and studies as may be necessary to monitor and ensure the quality and efficiency of care provided to those using blood bank services.

10.16-3 MEETINGS

The Committee will meet at least quarterly.

10.17 UTILIZATION REVIEW COMMITTEE

10.17-1 COMPOSITION

Voting members will include at least five (5) members of the Active Staff, the Chief Financial Officer, the Director of Health Information Management, and the Director of Case Management.

10.17-2 DUTIES

a. Assess and manage the utilization of resource;

b. Manage the quality, appropriateness and clinical necessity of admissions, continued stays;

c. Oversee Utilization Management with the assistance of the Medical Staff and Administration;

d. Implement a comprehensive Utilization/Case Management plan;

e. Develop and update the Information Management Plan, and;

f. Oversee the timely and appropriate use of the Hospital's computerized medical record including CPOE and Pdoc.

10.17-3 MEETING AND REPORTING

The Committee will meet at least quarterly.

ARTICLE XI: GENERAL MEDICAL STAFF MEETINGS

11.1 REGULAR GENERAL MEDICAL STAFF MEETINGS

The General Medical Staff shall meet at least two (2) times per year. The last meeting of each year shall be designated as the annual meeting of the Medical Staff. Members of the Medical Staff shall be notified by email of the meeting time and location at least twenty (20) days prior to regular General Medical Staff meetings.

11.2 SPECIAL GENERAL MEDICAL STAFF MEETINGS

a. The Chief of Staff may give notice of a special General Medical Staff meeting of the Medical Staff at any time. The Chief of Staff shall call a special meeting within fifteen (15) days after receipt of a written request for same from the MEC or not less than twenty percent (20%) of the voting Medical Staff members stating the purpose of such meeting. The Chief of Staff shall designate the time and location for any special General Medical Staff meeting. At the discretion of the MEC, attendance at special General Medical Staff meetings may be limited to voting Medical Staff members.

b. Notice stating the time, location, and nature of business to be conducted for any special General Medical Staff meeting shall be emailed to appropriate Staff Members not less than twenty (20) days before the date of such meeting.

c. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

11.3 QUORUM

Unless a special quorum requirement is specified in these Bylaws related to a specific type of action, a quorum for any regular or special General Medical Staff meeting shall be those voting Members either present or represented by electronic ballot.

11.4 MANNER OF ACTION AT A GENERAL MEDICAL STAFF MEETING

a. The voting rights of various Categories of Medical Staff membership are described in Article III.

b. If an action is to be taken at a regular or special General Medical Staff meeting the action shall be subject to voting Members voting either in person at the meeting or through electronic ballot.

c. The MEC shall send a written summary of action items along with an electronic ballot. Electronic notice and ballot will be sent to each voting Member at least twenty (20) days before the date of such meeting. In order to be counted, electronic ballots must be received by MSS prior to the commencement of the meeting.

d. Except as otherwise specified, the action of a majority of those voting either in person or by electronic ballot at a General Medical Staff meeting shall be the action of the Medical Staff. If a Member votes electronically prior to commencement of the meeting, he/she will not be permitted to vote in person at the meeting. Electronic votes are final. A list of all Members who have voted electronically will be maintained by MSS and available for review by the presiding officer at the meeting.

11.5 AGENDA

a. The agenda at any regular General Medical Staff meeting shall be:
   1) Call to order;
   2) Acceptance of the minutes of the last General Medical Staff meeting;
   3) Unfinished business;
   4) Report from the Chief of Staff;
   5) Reports of the Chief Executive Officer of the Hospital;
   6) New business including Member voting on any action items identified as described in Section 11.4;
   7) Educational presentations, if any, and;
   8) Adjournment.

b. The agenda of any special General Medical Staff meeting shall be:
   1) Reading of the notice calling the meeting and discussion of business items for which the meeting was called;
   2) Voting on action items described in Section 11.4, and;
   3) Adjournment.

11.6 MINUTES

Minutes of Medical Staff meetings shall be prepared and retained by MSS. They shall include, at a minimum, a record of attendance, a summary of significant discussions and the voting results of any action items.

ARTICLE XII: DEPARTMENT, SECTION, AND COMMITTEE MEETINGS

12.1 REGULAR MEETINGS

Departments/sections shall meet on an as-needed basis when called by the department/section chairperson. Committees shall meet regularly in accordance with these Bylaws or as called by the committee chairperson.

12.2 SPECIAL MEETINGS

A special meeting of any department/section or committee may be called by the chairperson, by the Chief of Staff, or by one-third (1/3) of the group's voting members, but not less than two (2) voting members.

12.3 NOTICE OF SPECIAL MEETINGS

Email or oral notice stating the place, day and hour of any special meeting shall be provided to members of a department/section or committee not less than five (5) days before a special meeting, by the person calling the meeting or designee.

12.4 QUORUM

A quorum for any Medical Staff department/section or committee meeting shall be at least three (3) voting members. A quorum for a meeting of the MEC shall be at least fifty percent (50%) of the voting members.

12.5 MANNER OF ACTION

The action of a majority of the voting members at a regular or special meeting at which there is a quorum shall be the action of the department/section or committee. Actions may be taken through in person meetings or through telephonic/virtual meetings as described in Section 12.10.

12.6 NON-VOTING MEMBERS

Persons serving as non-voting members shall not be counted in determining the existence of a quorum.

12.7 MINUTES

Minutes of each regular and special Medical Staff meeting shall be prepared by the committee chairperson or designee and shall include a record of the attendance of members, substantive issues discussed and any actions taken. MSS shall maintain a permanent record of the minutes of each meeting.

12.8 MANDATORY RESPONSE TO A COMMITTEE INQUIRY

a. Practitioners are required to respond in a timely manner to all notices of inquiry from a Medical Staff committee. Letters of inquiry may be emailed, hand delivered or mailed through the Postal Service to the involved Practitioner. A Practitioner is required to respond to a letter of inquiry within fourteen (14) days of email or hand delivery and within sixteen (16) days of a letter mailed through the Postal Service.

b. If a response has not been received within the timeframes described above, a second notice will be emailed, hand delivered or mailed through the Postal Service. If an appropriate response relevant to the elements of inquiry has not been received from the Practitioner within seven (7) days of email/hand delivery or nine (9) days of a letter mailed through the Postal Service, all of the Practitioner's privileges will be automatically suspended as described in Section 6.3-8. The suspension will remain in effect until an appropriate response to the letter of inquiry has been received and the automatic suspension has been removed by the Chief of Staff.

c. Automatic suspension of privileges pursuant to this Section shall not constitute grounds for hearing rights.

12.9 MANDATORY COMMITTEE ATTENDANCE REQUIREMENTS

a. The chairperson of any Medical Staff committee may give email or other written notice to a Practitioner that his/her attendance at a meeting to discuss his/her clinical competence, behavior or conduct, or any other quality assessment or performance improvement issue is mandatory. Notice of mandatory meeting attendance will be given by email or hand delivery at least fourteen (14) days prior to the mandatory meeting date and at least sixteen (16) days prior if mailed through the Postal Service.

b. A Practitioner's failure to attend a meeting to which he/she was given notice that attendance was mandatory, unless excused by the Chief of Staff for good cause, shall result in an automatic suspension of all of the Practitioner's privileges as described in Section 6.3-8. Such automatic suspension shall remain in effect until the Practitioner's mandatory attendance requirement has been met and the automatic suspension has been removed by the Chief of Staff.

c. If the Practitioner makes a timely request for postponement of mandatory meeting attendance supported by an adequate showing that his/her absence will be unavoidable, his/her attendance may be postponed to the next regular or special meeting of the committee by the chairperson or by the Chief of Staff.

d. If the committee chairperson is the Practitioner involved, such a postponement may only be granted by the Chief of Staff.

e. This requirement shall not preclude any committee from reviewing the competence or conduct of any Practitioner in his/her absence.

f. Automatic suspension of privileges pursuant to this section shall not constitute grounds for hearing rights.

12.10 TELEPHONIC AND VIRTUAL MEETINGS

a. When cause exists, any Medical Staff department/section or committee chairperson may elect to hold a telephonic meeting. Notice of a telephonic meeting will be given to each committee member either verbally or by email at least three (3) days prior to the meeting and each member will be provided with a meeting call-in telephone number.

b. When cause exists, any Medical Staff committee chairperson may elect to hold a virtual meeting using email vote. Email meetings will only be used when members are being asked to vote on one or more specific issues. Each specific issue will be clearly defined in the electronic meeting notice. Each member will have three (3) days after the email notice has been sent to respond to the committee chairperson, or designee, with their vote regarding the specific issues. Votes submitted after three (3) days will not be considered. Actions taken by electronic vote will be considered the action of the committee.

c. A record will be kept of all telephonic and virtual meetings by the committee chairperson or designee. The record will include substantive discussions and any actions taken. The record of telephonic and virtual meetings will be presented for verification and approval at the next regular committee meeting.

d. Quorum and action requirements for a telephonic and virtual meeting shall be the same as the regular committee meeting.

ARTICLE XIII: MEMBERSHIP REQUIREMENTS AND INDEMNIFICATION

13.1 CONDITIONS, AUTHORIZATION, RELEASES AND IMMUNITY

By applying for and/or exercising privileges within this Hospital, an individual:

a. Applicant for Medical Staff membership or clinical privileges and every Member of the Medical Staff or individual with clinical privileges shall agree that the provisions of this Article shall specifically control with regard to his/her relationship to the Medical Staff, other members of Medical Staff, members of the Board and the Hospital. By submitting an application for membership or clinical privileges, by accepting appointment or reappointment to the Medical Staff or clinical privileges, or by exercising clinical privileges including temporary privileges, each individual specifically agrees to be bound by these Bylaws, including the provisions of this Article during the processing of his/her application and at any time thereafter, and such provisions shall continue to apply during his/her term of membership or term of clinical privileges;

b. 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 individual's professional ability and qualifications;

c. Authorizes persons and organizations to provide information concerning the individual to the Medical Staff

d. Agrees to be bound by the provisions of this Article and to waive all legal claims, to the fullest extent permitted by law, against any representative of the Medical Staff or the Hospital who acts in accordance with the provisions of this Article and/or other relevant sections of the Bylaws, and;

e. Acknowledges that the provisions of this Article are express conditions to the granting and continuing exercise of Medical Staff membership and privileges at this Hospital.

Each applicant, Member or other individual exercising privileges 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 and other sections in the Bylaws. Execution of such releases, however, shall not be deemed a prerequisite to the effectiveness of this Article.

13.1-1 IMMUNITY FROM LIABILITY FOR ACTION TAKEN

Each representative of the Medical Staff and Hospital shall be exempt, to the fullest extent permitted by law, from liability to an applicant, Member or other individual exercising privileges, for damages or other relief for any action taken, statements or recommendations made within the scope of his/her duties as a representative of the Medical Staff or Hospital.

13.1-2 IMMUNITY FROM LIABILITY FOR PROVIDING INFORMATION

Each representative of the Medical Staff and Hospital and all third parties shall be exempt, to the fullest extent permitted by law, from liability to any applicant, Member or other individual exercising privileges, for damages or other relief by reason of providing any information concerning such person in connection with any evaluation of his or her competence or conduct.

13.1-3 ACTIVITIES AND INFORMATION COVERED

The Board, any committees of the Medical Staff and/or of the Board who conduct professional review activities and any individuals within the Hospital authorized to conduct professional review activities, hereby constitute themselves as Professional Review Bodies as defined in the Health Care Quality Improvement Act of 1986, California Business and Profession Code Sections 805-808 and California Evidence Code 1157. Each professional review body hereby claims all privileges and immunities afforded to it by said federal and state statutes.

a. Any action taken by a professional review body pursuant to these Medical Staff Bylaws shall be in the reasonable belief that it is in furtherance of quality health care (including the provision of care in a manner that is not disruptive to the delivery of quality medical care at the Hospital) only after a reasonable effort has been made to obtain the true facts of the matter, after adequate notice and hearing procedures are afforded to any applicant or Medical Staff appointee, and only in the reasonable belief that the action is warranted by the facts known after a reasonable effort has been made to obtain the facts.

b. There shall be, to the fullest extent permitted by law, immunity from civil liability arising from any act, communication, report, recommendation or disclosure performed, given or made, even if the information involved would otherwise be protected.

c. No action, cause of action, damage, liability or expense shall arise or result from, nor shall any legal action be commenced with respect to any such act, communication, report, recommendation, or disclosure. Such immunity shall apply to all acts, communications, reports, recommendations and disclosures performed, given or made in connection with, or for, or on behalf of any activities of any other healthcare facility or provider including, without limitation, those relating to:
    1) Applications for appointment to the Medical Staff or for clinical privileges;
    2) Periodic appraisals or reviews for reappointment or for renewal or revisions to clinical privileges;
    3) Corrective action or disciplinary action, including suspension, probation, limitation or revocation of Medical Staff membership or clinical privileges;
    4) Hearing and appellate review;
    5) Medical care evaluations;
    6) Ongoing professional practice evaluation or focused professional practice evaluation
    7) Peer review evaluations;
    8) Utilization review and resource management, and;
    9) Any other Hospital, departmental, service or committee activities related to quality patient care, professional conduct or professional relations.

Such matters may concern, involve or relate to, without limitation, such person's professional qualifications, clinical competence, character, behavior, fitness to practice, physical and mental condition, ethical or moral standards or any other matter that may or might have an effect or bearing on patient care.

13.2 DISCLOSURE OF CONFLICTS OF INTEREST

a. Individuals shall disclose any conflict of interest, as defined by the Board, or potential conflict of interest in any transaction, occurrence or circumstance which exists or may arise with respect to his/her participation on any committee or in his/her activities in Medical Staff affairs, including departmental activities and in the review of cases.

b. Where such a conflict of interest exists or may arise, the individual shall not participate in the activity, or as appropriate, shall abstain from voting. This provision does not prohibit any person from voting for himself/herself.

c. When performing a function outlined in the Bylaws, applicable policies, or the Rules and Regulations, if any Medical or APP Staff member has or reasonably could be perceived as having a conflict of interest or a bias in any credentialing or peer review matter involving another individual, the individual with a conflict shall not participate in the final discussion or voting on the matter, and shall be excused from any meeting during that time. However, the individual may provide relevant information and may answer any questions concerning the matter before leaving.

d. Any member with knowledge of the existence of a potential conflict of interest or bias on the part of any other member may call the conflict of interest to the attention of the Chief of Staff, or the applicable department or committee chairperson who will make a final determination as to whether the provisions in this Article should be triggered.

e. The fact that a Practitioner is in the same specialty as a member whose performance is being reviewed does not automatically create a conflict.

f. In addition, the evaluation of whether a conflict of interest exists shall be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. No staff member has a right to compel disqualification of another Practitioner based on an allegation of conflict of interest.

g. The fact that a committee member or Medical Staff leader chooses to refrain from participation, or is excused from participation, shall not be interpreted as a finding of actual conflict.

13.3 MAINTAINING CONFIDENTIALITY OF INFORMATION

13.3-1 GENERAL

All Medical Staff files and records, including information regarding any applicant, member or other individual exercising privileges, shall be considered Medical Staff minutes or records. They shall be confidential and protected from discovery pursuant to California Evidence Code Section 1157 to the fullest extent permitted by law. Dissemination of such information and records shall only be made where expressly required by law, or pursuant to officially adopted policies of the Medical Staff or, where no officially adopted policy exists, only with the express approval of the MEC.

13.3-2 BREACH OF CONFIDENTIALITY

Inasmuch as effective credentialing and peer review must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of Medical Staff by any Practitioner is outside of the Medical Staff's standards of acceptable conduct and is considered disruptive and unprofessional behavior. If it is determined that such a breach has occurred, the MEC shall undertake appropriate responsive action up to and including removal from the Medical or APP Staff. Medical Staff discussions, communications, or deliberations with other medical staffs, hospitals, professional societies, or licensing authorities do not constitute a breach of confidentiality.

13.3-3 MEDICAL STAFF RECORDS

Access to Medical Staff records shall be limited to duly appointed officers and committees of the Medical Staff for the sole purpose of discharging Medical Staff responsibilities and subject to the requirement that confidentiality be maintained.

13.3-4 BOARD INFORMATION

Medical Staff information or records which are disclosed to the Board of the Hospital or its appointed representatives, in order that the Board may discharge its lawful obligations and responsibilities, shall be maintained by that body as confidential and is not considered a breach of confidentiality.

13.4 INDEMNIFICATION

To afford Medical and APP Staff members the full protections of the Health Care Quality Improvement Act related to his/her duties as a representative of the Medical Staff or Hospital in peer review, credentialing, and other Medical Staff committee activity, the activities shall have the following characteristics:

a. The activities undertaken shall be performed on behalf of the Hospital.

b. The activities shall be performed in good faith.

c. Any professional review action shall be taken:
   1) In the reasonable belief that the action was in the furtherance of quality healthcare;
   2) After a reasonable effort to obtain the facts of the matter;
   3) After adequate notice and hearing procedures are afforded to the individual involved or after such other procedures as are fair to the individual under the circumstances, and;
   4) In the reasonable belief that the action was warranted by the facts known after such reasonable efforts to obtain the facts.

d. The activities shall substantially comply with the Medical Staff Bylaws, Rules and Regulations and policies.

Practitioners performing activities meeting the above listed criteria shall qualify for indemnification for those activities through the Hospital.

13.5 NO CONTRACT INTENDED

a. Notwithstanding anything herein to the contrary, it is understood that these Bylaws and the Rules and Regulations do not create, nor shall they be construed as creating in fact or by implication or otherwise, a contract of any nature between or among the Hospital or the Board or the Medical Staff and any Practitioner or any person granted privileges. Any clinical or other privileges are simply privileges which permit conditional use of the Hospital facilities, subject to the terms of these Bylaws and the Rules and Regulations.

b. Notwithstanding the foregoing, the provisions containing undertakings in the nature of an agreement or an indemnity or a release shall be considered contractual in nature and not a mere recital and shall be binding upon Medical Staff applicants and Practitioners applying for granted privileges in the Hospital.

13.6 NO AGENCY

Practitioners shall not by virtue of these Bylaws or Medical Staff appointment, be authorized to act on behalf of, or bind the Hospital, and shall not hold themselves out as agents, apparent agents or ostensible agents of the Hospital, except where specifically and expressly authorized in a separate written contract with the Hospital.

ARTICLE XIV: GENERAL PROVISIONS

14.1 RULES AND REGULATIONS AND MEDICAL STAFF POLICIES

14.1-1 AMENDMENTS TO MEDICAL STAFF RULES AND REGULATIONS

a. The MEC will amend or adopt Medical Staff Rules and Regulations as may be necessary for proper conduct of work and will periodically review and revise such Medical Staff Rules and Regulations to comply with current Medical Staff practices.

b. At least fourteen (14) days prior to the MEC finalizing proposed amendment to Medical Staff Rules and Regulations, the MEC will notify the Active Staff of the proposed amendment by email.

c. If the Active Staff is not in agreement with the proposed amendment, the Medical Staff may initiate the petition process described in Section 15.4.

d. If the petition process is initiated, no action will be taken by the MEC until the petition process is complete unless the proposed action is deemed to be urgent as described in Section 14.1-2.

e. If the petition process is not initiated, the Rule and Regulation recommendations of the MEC will be forwarded to the Board for action.

14.1-2 URGENT AMENDMENT TO RULES AND REGULATIONS

a. If an urgent amendment to the Rules and Regulations is necessary to comply with law or regulation, the MEC and Board may provisionally approve an amendment without prior notification to the Active Staff.

b. The Active Staff will be immediately notified of any urgent amendment to the Rules and Regulations.

c. If the Active Staff is not in agreement with the urgent amendment, the Medical Staff may follow the petition process described in Section 15.4.

14.1-3 AMENDMENTS TO MEDICAL STAFF POLICY

a. The MEC will amend or adopt Medical Staff policies as may be necessary for proper conduct of work and will periodically review and revise Medical Staff policies to comply with current Medical Staff practices.

b. Recommended changes to Medical Staff policies will be generated by or submitted to the MEC for review.

c. MEC recommendations regarding policy additions/revisions will be submitted to the Board for approval.

14.1-4 ADOPTION OF MEDICAL STAFF RULES AND REGULATIONS AND/OR POLICIES BY THE BOARD

a. Medical Staff Rules and Regulations and/or policies approved by the MEC or the Active Staff will become effective following approval by the Board. Board approval shall not be withheld unreasonably.

b. Within thirty (30) days after Board approval to amend the Rules and Regulations or amend/adopt a Medical Staff policy, the MEC will notify the Medical and APP Staff of the revised Rule and Regulation language and/or the policy names by email. A full version of the new or revised Rules and Regulations and policies will be available for review on the Hospital's intranet site. If the Active Staff is not in agreement with Rule and Regulation and/or policy changes, the Active Staff may initiate the petition process described in Section 15.4.

14.1-5 ADHERENCE TO MEDICAL STAFF BYLAWS, RULES AND REGULATIONS, POLICIES, AND HOSPITAL ADMINISTRATIVE POLICIES

Applicants, Practitioners, and others holding privileges will be governed by all applicable Medical Staff Bylaws, Rules and Regulations, and Medical Staff and Hospital policies and procedures.

14.1-6 RESOLUTION OF CONFLICTS BETWEEN THE BYLAWS, RULES AND REGULATIONS, AND POLICIES

The Medical Staff Bylaws, Rules and Regulations, and policies should not conflict. If there is a conflict between the Bylaws and Rules and Regulations, the Bylaws will prevail. If there is a conflict between Rules and Regulations and Medical Staff policies, the Rules and Regulations will prevail. If there is a conflict between the Bylaws and policy, the Bylaws will prevail.

14.2 FEES, FINES, AND ASSESSMENTS

The MEC has the power to establish the amount of applicable fees, dues, fines, and assessments to be paid by applicants, Medical and APP Staff members. The MEC will determine the manner of collection and expenditure of such funds.

Failure to pay MEC required fees, dues, fines and assessments within the timeframes established by the MEC will result in automatic suspension as described in Section 6.3-9.

14.3 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 sexes wherever either term is used.

14.4 AUTHORITY TO ACT

Any Practitioner who acts in the name of this Medical Staff without proper authority will be subject to such responsive action as the MEC deems appropriate.

14.5 DIVISION OF FEES

Any division of fees by Members of the Medical Staff is forbidden and any such division of fees will be cause for exclusion or expulsion from the Medical Staff.

14.6 NOTICES AND COMMUNICATION

Routine communication to Practitioners will occur by email. The MEC and any department/section/committee chairperson may elect to communicate with a Practitioner through written notice other than email. Written notice, other than electronic communication, may either be hand-delivered or sent through United States Postal Service.

14.7 NOMINATIONS OF MEDICAL STAFF REPRESENTATIVES

Positions as Medical Staff representatives to local, state and national Hospital Medical Staff sections will be filled by vote of the MEC.

14.8 CONFIDENTIALITY OF THE CREDENTIAL FILE

Practitioners will be granted limited access to his/her own credentials file subject to the following:

a. A request for access must be submitted in writing to the Chief of Staff;

b. The Practitioner may review, and receive a copy of, only those documents provided by or addressed personally to the Practitioner. A summary of other information including peer review committee findings, letters of reference, proctoring reports, complaints and other documents will be provided to the individual. Such summary will disclose the substance but not the source of the information summarized, and;

c. The review by the individual will take place in MSS during normal work hours with an Officer or designee of the Medical Staff present.

14.9 MEDICAL STAFF ROLE IN EXCLUSIVE CONTRACTING

a. In the following situations, the MEC will review and make recommendations to the Board regarding quality of care issues related to exclusive contracts prior to a decision being made:

1) Execution of an exclusive contract in a previously open department or service;
2) Renewal or modification of an exclusive contract in a particular department or service, and;
3) Termination of an existing exclusive contract in a particular department or service.

b. The MEC will conduct the review using an appropriate mechanism and may elect to conduct a notice and comment hearing to assess the quality of care issues related to such arrangements. The results of the MEC assessment will be reported to the Chief Executive Officer and the Board.

c. The Board will consider the recommendations of the MEC regarding quality of care issues related to the exclusive contract but will not be bound by MEC recommendations.

14.10 CONFLICT MANAGEMENT

14.10-1 CONFLICTS BETWEEN THE HOSPITAL LEADERSHIP GROUPS

a. Conflicts may arise between members of the Hospital's three (3) leadership groups; the Board, senior administration and leaders of the Medical Staff. The leadership groups will make best efforts to address and resolve all conflicts through consensus and arrive at decisions that are in the best interests of patients, the Hospital, and the members of the Medical Staff.

b. When the Board and/or administration plans to act or is considering acting in a manner contrary to the recommendations of the MEC, the Medical Staff Officers will meet with administrative leaders and seek to resolve the conflict through informal discussions. If these informal discussions fail to resolve the conflict, the formal conflict management process described in the Interdisciplinary Policy – Leadership Conflict Management will be initiated.

14.10-2 CONFLICTS BETWEEN THE MEDICAL STAFF AND THE MEDICAL EXECUTIVE COMMITTEE

a. The MEC will make best efforts to address and resolve all conflicts between the MEC and the Medical Staff in the best interests of patients, the Hospital, and the members of the Medical Staff. When the MEC plans to act or is considering acting in a manner contrary to the wishes of the Medical Staff, the Medical Staff will present their recommendations to the MEC with a written petition signed by at least twenty-five percent (25%) of the Active Staff.

b. Three (3) Medical Staff Officers, or other designees identified by the MEC, will meet with three (3) members of the Medical Staff who will present the Medical Staff's written petition recommendations/concerns and seek to resolve the conflict through informal discussions.

c. If these informal discussions fail to resolve the conflict within thirty (30) days, the Medical Staff may either petition a change in Bylaws, Rules and Regulations or policy as described in Section 15.4 or may communicate its recommendations/concerns in writing directly to the Board.

14.11 TECHNICAL MODIFICATIONS OR CORRECTIONS TO MEDICAL STAFF DOCUMENTS

The MEC has the power to adopt corrections to the Medical Staff Bylaws, Rules and Regulations, and policies as are, in its judgment, technical modifications or corrections. Examples include reorganization of articles/sections, renumbering items, punctuation/spelling/grammar/reference corrections, updating terms and nomenclature to reflect current practice and standardization of terms and references. Substantive amendments are not permitted by this Section. Technical modifications or corrections must be reviewed and approved by the MEC prior to the changes becoming effective but do not require Board approval.

14.12 MANNER OF ACTION IN MEDICAL STAFF VOTING

To become a final approved action, any item up for vote requires the affirmative vote of at least fifty percent (50%) of those eligible to vote. Any identified quorum requirements must be met for a vote to be valid. The chairperson of any committee

has the same voting rights as any other committee member. To be counted, all electronic ballots must be returned to MSS within fourteen (14) calendar days of being sent, unless a longer period has been identified by the MEC in the voting notice.

ARTICLE XV: ADOPTION AND AMENDMENTS OF BYLAWS AND PETITION TO AMEND THE BYLAWS, RULES AND REGULATIONS OR POLICY

15.1 PROCEDURE TO ADOPT OR AMEND BYLAWS

A request to amend the Bylaws may be made to the MEC by the Chief of Staff, the Bylaws Committee or any MEC member. Amendments recommended for approval by the MEC will be submitted for Active Staff vote.

a. Proposed Bylaw amendments and an electronic ballot will be sent to each Active Staff member's email address of record. The notices will include the exact wording of the existing Bylaws language, if any, and the proposed amendments.
b. Active Staff members will have twenty (20) days following ballot receipt to return their Bylaws vote ballot to MSS. Ballots received after that time will not be counted.

Additionally, the MEC may recommend directly to the Board the addition, deletion or modification of any standing committee of the Medical Staff as may be described in Section 10.2-4 with the exception of the MEC.

15.2 QUORUM AND ACTION ON BYLAW CHANGES

At least twenty-five percent (25%) of eligible Active Staff members must submit a ballot to achieve a quorum in a Bylaws vote. Provided a quorum is reached, approval of Bylaw amendments requires the affirmative vote of at least fifty percent (50%) of those votes submitted.

15.3 APPROVAL OF BYLAWS

Bylaws changes adopted by vote of the Active Medical Staff will become effective following approval of the Board which approval shall not be withheld unreasonably. Neither the Board nor the Medical Staff may unilaterally amend or repeal any section(s) of the Medical Staff Bylaws. If approval by the Board is withheld, the reason for doing so must be specified in writing and forwarded to the Chief of Staff and the MEC.

If the Bylaws are amended through Active Staff vote and Board approval, all Practitioners will be notified the Bylaws have been amended and an electronic copy of the amended Bylaws made available on the Hospital's intranet.

15.4 PETITION FROM THE ACTIVE STAFF TO AMEND BYLAWS, RULES AND REGULATIONS OR POLICY

a. In addition to other procedures set forth in these Bylaws for amending the Bylaws, Rules and Regulations and policies, these documents may be amended through the Medical Staff petition process. A written petition stating the exact documents and language to be changed must be signed by at least twenty-five percent (25%) of the Active Staff.

b. The MEC will review the petition within thirty (30) days of its receipt. Within fourteen (14) days after review of the petition the MEC will either:
    1) Recommend approval of the petition amendments to the Board, or;
    2) Send the proposed petition amendments, along with any comments from the MEC and an electronic ballot to the Active Staff for vote. Action related to this Section requires a quorum response from of least twenty-five percent (25%) of the Active Staff, or;
    3) Notify Active Members who signed the petition of the MEC's concerns with the proposed amendments, and confirm initiation of the conflict management process described in Section 14.10-2. If the conflict between the MEC and the Medical Staff cannot be resolved within forty-five (45) days, the MEC will carry out actions described in Section 15.4 (b) (2);

15.5 EXCLUSIVE MECHANISM

The mechanisms described herein are the sole methods for the initiation, adoption, amendment or repeal of the Medical Staff Bylaws.

15.6 REVIEW

These Bylaws will be reviewed at least every three (3) years. Any necessary revisions to the Bylaws will be made according to the described amendment procedure.

15.7 SUCCESSOR IN INTEREST

These Bylaws and the membership privileges accorded under these Bylaws will be binding upon the Medical Staff and the Board of any successor in interest in this Hospital except where Hospital medical staffs are being combined. In the event that staffs are being combined, the medical staffs will work together to develop new bylaws which will govern the combined medical staffs subject to the approval of the 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.

Revisions:
BOT 10/13/16