

BYLAWS
FOR THE
MEDICAL STAFF
OF
CITRUS VALLEY MEDICAL CENTER

Inter-Community Campus
Queen of the Valley Campus

APPROVED OCTOBER 28, 2009

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ARTICLE I: PURPOSES AND TERMS

1.1 PURPOSES OF THE BYLAWS

These bylaws are adopted in order to provide for the organization of the medical staff of Citrus Valley Medical Center (Inter-Community Campus/Queen of the Valley Campus) and to provide a framework for self-government in order to permit the medical staff to discharge its responsibilities in matters involving the oversight of care, treatment, and services, and to govern the orderly resolution of those purposes. These bylaws provide the professional and legal structure for medical staff operations, organized medical staff relations with the Board of Directors, and relations with applicants to and members of the medical staff.

These medical staff bylaws constitute an agreement negotiated at arm's length between the parties and to which the parties intend to be bound.

1.2 DEFINITIONS

- 1.2-1 ADMINISTRATOR means the person appointed by the Board of Directors to serve in an administrative capacity.
- 1.2-2 AUTHORIZED REPRESENTATIVE or HOSPITAL'S AUTHORIZED REPRESENTATIVE means the individual designated by the hospital and approved by the Medical Executive Committee to provide information to and request information from the National Practitioner Data Bank according to the terms of these bylaws.
- 1.2-3 BOARD OF DIRECTORS means the governing body of the hospital.
- 1.2-4 CHIEF OF STAFF means the chief officer of the medical staff elected by members of the medical staff.
- 1.2-5 CLINICAL PRIVILEGES or PRIVILEGES means the permission granted to medical staff members to provide patient care and includes unrestricted access to those hospital resources (including equipment, facilities and hospital personnel), which are necessary to effectively exercise those privileges.
- 1.2-6 HOSPITAL means Citrus Valley Medical Center (Inter-Community Campus/Queen of the Valley Campus.)
- 1.2-7 IN GOOD STANDING means a member is currently not under suspension or serving with any limitation of voting or other prerogatives imposed by operation of the bylaws, rules and regulations or policy of the medical staff.
- 1.2-8 INVESTIGATION means a process specifically instigated by the Medical Executive Committee to determine the validity, if any, to a concern or complaint raised against a member of the medical staff, and does not include activity of the Physicians' Advisory Committee.
- 1.2-9 MEDICAL EXECUTIVE COMMITTEE means the executive committee of the medical staff, which shall constitute the governing body of the medical staff as described in these bylaws.

- 1.2-10 MEDICAL STAFF or STAFF means those physicians (MD or DO or their equivalent as defined in Section 2.2-2(a)) dentist, podiatrist who have been granted recognition as members of the medical staff pursuant to the terms of these bylaws.
- 1.2-11 MEDICAL STAFF YEAR means the period from January 1 to December 31.
- 1.2-12 MEMBER means, unless otherwise expressly limited, any physician (MD or DO or their equivalent as defined in Section 2.2-2(a)), dentist, podiatrist, holding a current license to practice within the scope of that license who is a member of the medical staff.
- 1.2-13 PHYSICIAN means an individual with a MD or DO degree or the equivalent degree (i.e., foreign) as recognized by the Medical Board of California (MBC) or the Board of Osteopathic Examiners (BOE), who is licensed by either the MBC or the BOE.
- 1.2-14 CAMPUS means Inter-Community Campus 210 W. San Bernardino Road, Covina, CA 91723 and Queen of the Valley Campus 1115 So. Sunset Avenue, West Covina, CA 91790.
- 1.2-15 NAME The name of this organization is the Medical Staff of Citrus Valley Medical Center.
- 1.2-16 PRACTITIONER means an individual licensed to practice one of the professions eligible for membership in the medical staff

ARTICLE II: MEMBERSHIP

2.1 NATURE OF MEMBERSHIP

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

2.2 QUALIFICATIONS FOR MEMBERSHIP

2.2-1 GENERAL QUALIFICATIONS

Only physicians, dentists or podiatrists shall be deemed to possess basic qualifications for membership in the medical staff, except for the honorary and retired staff categories in which case these criteria shall only apply as deemed individually applicable by the medical staff, and who:

- (a) document their (1) current licensure, (2) adequate experience, education and training, (3) current professional competence, (4) good judgment, and (5) current adequate physical and mental health status 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) are determined (1) to adhere to the ethics of their respective professions, (2) to be able to work cooperatively with others so as not to adversely affect patient care, (3) to keep as confidential, as required by law, all information or records received in the physician-patient relationship, and (4) to be willing to participate in and properly discharge those responsibilities determined by the medical staff

- (c) maintain in force professional liability insurance in not less than the minimum amounts, if any, as from time to time may be jointly determined by the Board of Directors and Medical Executive Committee. The Medical Executive Committee, for good cause shown and with concurrence of the Board of Directors may waive this requirement with regard to such member as long as such waiver is not granted or withheld on an arbitrary, discriminatory or capricious basis. In determining whether an individual exception is appropriate, the following facts may be considered:
 - (1) Whether the member has applied for the requisite insurance:
 - (2) Whether the member has been refused insurance, and if so, the reasons for such refusal; and
 - (3) Whether insurance is reasonably available to the member, and if not, the reasons for its unavailability.
- (d) are certified or are progressing towards certification by (1) boards which are duly organized and recognized by an American Board of Medical Specialties member board or (2) a board or association with equivalent requirements approved by the Medical Board of California or (3) a board or association with an Accreditation Council for Graduate Medical Education-approved postgraduate training program that provides complete training in that specialty or subspecialty. Applicants/Re-applicants who are progressing toward board certification must become board certified within five years of the initial granting of medical staff membership, unless extended for good cause by the medical executive committee.

Current members of the medical staff who were not, as of date of adoption of this amendment, board certified or progressing toward board certification, and who cannot reasonably be expected to pursue board certification, may be considered for renewal of medical staff membership if they can document sufficient training, experience, and competence, and otherwise meet the requirements of medical staff membership.

Persons not fulfilling the above eligibility criteria including board certification may apply for special consideration and must demonstrate that their education, training, experience, demonstrated ability, judgment and medical skills are equivalent to or greater than the level of proficiency evidenced by the eligibility criteria listed above.

2.2-2 PARTICULAR QUALIFICATIONS

- (a) Physicians. An applicant for physician membership in the medical staff, except for the emeritus staff, must hold an MD or DO degree or their equivalent and a valid and unsuspended certificate to practice medicine issued by the Medical Board of California or the Board of Osteopathic Examiners of the State of California. For the purpose of this section, "or their equivalent" shall mean any degree (i.e., foreign) recognized by the Medical Board of California or the Board of Osteopathic Examiners.
- (b) Limited License Practitioners.
 - (1) Dentists. An applicant for dental membership in the medical staff, except for the emeritus staff, must hold a DDS or equivalent degree and a valid and unsuspended certificate to practice dentistry issued by the Board of Dental Examiners of California.
 - (2) Podiatrists. An applicant for podiatric membership on the medical staff, except for the emeritus staff, must hold a DPM degree and a valid and unsuspended certificate to practice podiatry issued by the Medical Board of California.

2.3 EFFECT OF OTHER AFFILIATIONS

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

2.4 NONDISCRIMINATION

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

2.5 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

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

- (a) providing patients with the quality of care meeting the professional standards of the medical staff of this hospital;
- (b) abiding by the medical staff bylaws, medical staff rules and regulations, and policies;
- (c) discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the member by virtue of medical staff membership, including committee assignments;
- (d) preparing and completing in timely fashion medical records for all the patients to whom the member provides care in the hospital;
- (e) abiding by the lawful ethical principles of the California Medical Association or member's professional association;
- (f) aiding in any medical staff approved educational programs for medical students, interns, resident physicians, resident dentists, staff physicians and dentists, nurses and other personnel;
- (g) working cooperatively with members, nurses, hospital administration and others so as not to adversely affect patient care;
- (h) making appropriate arrangements for coverage of that member's patients as determined by the medical staff;
- (i) refusing to engage in improper inducements for patient referral;
- (j) participating in continuing education programs as determined by the medical staff;
- (k) participating in such emergency service coverage or consultation panels as may be determined by the medical staff;
- (l) discharging such other staff obligations as may be lawfully established from time to time by the medical staff or Medical Executive Committee; and
- (m) providing information to and/or testifying on behalf of the medical staff on an accused practitioner regarding any matter under an investigation pursuant to paragraph 6.1-3, and those, which are the subject of a hearing pursuant to Article VII.

2.6 VOLUNTARY PARTICIPATION ON EMERGENCY DEPARTMENT BACKUP CALL PANELS

Participation on the emergency department backup call panel shall be voluntary. Membership on the medical staff shall not in any way be contingent on an applicant's willingness to participate on the emergency department's backup call panel.

2.7 HARASSMENT PROHIBITED

Harassment by a medical staff member against any individual (e.g., against another medical staff member, house staff, hospital employee or patient) on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex, or sexual orientation shall not be tolerated.

"Sexual harassment" is unwelcome verbal or physical conduct of a sexual nature, which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and visual harassment (such as the display of derogatory cartoons, drawings, or posters).

Sexual harassment includes unwelcome advances, requests for sexual favors, and any other verbal, visual, or physical conduct of a sexual nature when (1) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion, or other aspects of employment; or (2) this conduct substantially interferes with the individual's employment or creates an intimidating, hostile, or offensive work environment. Sexual harassment also includes conduct, which indicates that employment, and/or employment benefits are conditioned upon acquiescence in sexual activities.

The medical staff and the hospital shall seek to coordinate their investigations in respect to all allegations of harassment by any party so as to assure a fair and thorough process and prompt resolution of the complaint. If confirmed will result in appropriate corrective action, from reprimands up to and including termination of medical staff privileges or membership, if warranted by the facts.

2.8 CODE OF CONDUCT

To encourage a culture of safety and quality, organized medical staffs are encouraged to adopt a Code of Conduct as part of their medical staff bylaws. The medical staff bylaws, of which this Code of Conduct is part, shall be the exclusive means for review and disciplining medical staff members for inappropriate or disruptive behavior.

2.8-1 APPLICABLE DEFINITIONS:

"Appropriate behavior" means any reasonable conduct to advocate for patients, to recommend improvements in patient care, to participate in the operations, leadership or activities of the organized medical staff, or to engage in professional practice including practice that may be in competition with the hospital. Appropriate behavior is not subject to discipline under these bylaws.

"Disruptive behavior" means any abusive conduct including sexual or other forms of harassment, or other forms of verbal or non-verbal conduct that harms or intimidates others to the extent that quality of care or patient safety could be compromised.

"Harassment" means conduct toward others based on their race, religion, gender, sexual orientation, nationality or ethnicity, which has the purpose or direct effect of unreasonably interfering with a person's work performance or which creates an offensive, intimidating or otherwise hostile work environment.

"Inappropriate behavior" means conduct that is unwarranted and is reasonably interpreted to be demeaning or offensive. Persistent, repeated inappropriate behavior can become a

form of harassment and thereby become disruptive, and subject to treatment as “disruptive behavior.”

“Medical staff member” means physicians and others granted membership on the Medical Staff and, for purposes of this Code, includes individuals with temporary clinical privileges.

2.8-2 TYPES OF CONDUCT

a. APPROPRIATE BEHAVIOR

Medical staff members cannot be subject to discipline for appropriate behavior. Examples of appropriate behavior include, but are not limited to, the following:

- Criticism communicated in a reasonable manner and offered in good faith with the aim of improving patient care and safety;
- Encouraging clear communication;
- Expressions of concern about a patient’s care and safety;
- Expressions of dissatisfaction with policies through appropriate grievance channels or other civil non-personal means of communication;
- Use of cooperative approach to problem resolution;
- Constructive criticism conveyed in a respectful and professional manner, without blame or shame for adverse outcomes;
- Professional comments to any professional, managerial, supervisory, or administrative staff, or members of the Board of Directors about patient care or safety provided by others;
- Active participation in medical staff and hospital meetings (i.e. comments made during or resulting from such meetings can not be used as the basis for a complaint under this Code of Conduct, referral to the Health and Wellbeing Committee, economic sanctions, or the filing of an action before a state or federal agency);
- Membership on other medical staffs; and
- Seeking legal advice or the initiation of legal action for cause.

b. INAPPROPRIATE BEHAVIOR

Inappropriate behavior by medical staff members is discouraged. Persistent inappropriate behavior can become a form of harassment and thereby become disruptive, and subject to treatment as “disruptive behavior.” Examples of inappropriate behavior include, but are not limited to, the following:

- Belittling or berating statements;
- Name calling;
- Use of profanity or disrespectful language;
- Inappropriate comments written in the medical record;
- Blatant failure to respond to patient care needs or staff requests;
- Deliberate lack of cooperation without good cause;
- Intentionally condescending language; and
- Intentionally degrading or demeaning comments regarding patients and their families; nurses, physicians, hospital personnel and/or the hospital.

c. DISRUPTIVE BEHAVIOR

Disruptive behavior by medical staff members is prohibited. Examples of disruptive behavior include, but are not limited to, the following:

- Physically threatening language directed at anyone in the hospital including physicians, nurses, other medical staff members, or any hospital employee, administrator or member of the Board of Directors;
- Physical contact with another individual that is threatening or intimidating;
- Throwing instruments, charts or other things;
- Threats of violence or retribution;
- Sexual harassment; and,
- Other forms of harassment including, but not limited to, persistent inappropriate behavior and repeated threats of litigation.

d. INTERVENTIONS

Interventions should initially be non-adversarial in nature, if possible, with the focus on restoring trust, placing accountability on and rehabilitating the offending medical staff member, and protecting patient care and safety. The medical staff supports tiered, non-confrontational intervention strategies, starting with informal discussion of the matter with the appropriate section chief or department chairperson. Further interventions can include an apology directly addressing the problem, a letter of admonition, a final written warning, or corrective action pursuant to the medical staff bylaws, if the behavior is or becomes disruptive. The use of summary suspension should be considered only where the physician's disruptive behavior presents an imminent danger to the health of any individual. At any time rehabilitation may be recommended. If there is reason to believe inappropriate or disruptive behavior is due to illness or impairment, the matter may be evaluated and managed confidentially according to the established procedures of the medical staff's Health and Wellbeing Committee (or equivalent committee).

2.8-3 PROCEDURE

Complaints about a member of the medical staff regarding allegedly inappropriate or disruptive behavior should be in writing, signed and directed to the Chief of Staff of the medical staff or, if the Chief of Staff is the subject of the complaint, to the Chief of Staff-elect, and include to the extent feasible:

1. the date(s), time(s) and location of the inappropriate or disruptive behavior;
2. a factual description of the inappropriate or disruptive behavior;
3. the circumstances which precipitated the incident;
4. the name and medical record number of any patient or patient's family member who was involved in or witnessed the incident;
5. the names of other witnesses to the incident;
6. the consequences, if any, of the inappropriate or disruptive behavior as it relates to patient care or safety, or hospital personnel or operations; and
7. any action taken to intervene in, or remedy, the incident, including the names of those intervening.

At the discretion of the Chief of Staff (or Chief of Staff-Elect if the Chief of Staff is the subject of the complaint), the duties here assigned to the Chief of Staff can, from time to time, be delegated to another elected member of the medical staff ("designee").

The appropriate peer review committee (including MEC, departmental review committee or an ad hoc committee formed by the MEC) shall make such investigation as appropriate in the circumstances which may include seeking to interview the complainant, any witnesses and the subject of the complaint. The subject medical staff member shall be provided an opportunity to respond in writing to the complaint.

The complainant will be provided a written acknowledgement of the complaint.

In all cases, the medical staff member subject of the complaint shall be provided a copy of this Code of Conduct and a copy of the complaint in a timely fashion, as determined by the organized medical staff, but in no case more than 30 days from receipt of the complaint by the Chief of Staff or Chief of Staff-Elect. The medical staff member will be notified that the attempts to confront, intimidate, or otherwise retaliate against the complainant is a violation of this Code of Conduct and may result in corrective action against the medical staff member.

An ad hoc committee may be formed where none of the members of which may be economic competitors of the medical staff member, consisting of the Chief of Staff or Chief of Staff-Elect, or designee, and at least two additional elected members of the medical executive committee, one of whom shall be the medical staff member's department chairperson, provided the chairperson is not the subject of the complaint.

The Ad Hoc committee will make a determination of the authenticity and severity of the complaint. The ad hoc committee shall dismiss any unfounded complaint and may dismiss any complaint if it is not possible to confirm its authenticity or severity, and will notify both the complainant and the subject of the complaint of the decision reached.

If the ad hoc committee determines the complaint is well founded, the complainant and the subject of the complaint will be informed of the decision, and the complaint will be addressed as follows:

1. If this is the first incident of inappropriate behavior, the appropriate section chief, or chairperson of the offending medical staff member's assigned department, shall discuss the matter with the offending medical staff member, and emphasize that the behavior is inappropriate and must cease. The offending medical staff member may be asked to apologize to the complainant. The approach during this initial intervention should be collegial and helpful.
2. Further isolated incidents that do not constitute persistent, repeated inappropriate behavior will be handled by providing the offending medical staff member with notification of each incident, and a reminder of the expectation the individual comply with this Code of Conduct.
3. If the ad hoc committee determines the offending medical staff member has demonstrated persistent, repeated inappropriate behavior, constituting harassment (a form of disruptive behavior), or has engaged in disruptive behavior on the first offense, a letter of admonition will be sent to the offending medical staff member, and, as appropriate, a rehabilitation action plan developed by the ad hoc committee, with the advice and counsel of the medical executives committee.
4. If, in spite of this admonition and intervention, disruptive behavior recurs, the ad hoc committee shall meet with and advise the offending medical staff member such behavior must immediately cease or corrective action will be initiated. This "final warning" shall be sent to the offending medical staff member in writing.

5. If after the “final warning” the disruptive behavior recurs, corrective action (including suspension or termination or privileges) shall be initiated pursuant to the medical staff bylaws of which this Code of Conduct is a part, and the offending medical staff member shall have all of the due process rights set forth in the medical staff bylaws.
6. If a single incident of disruptive behavior or repeated incidents of disruptive behavior constitute an imminent danger to the health of an individual or individuals, the offending medical staff member may be summarily suspended as provided in the medical staff bylaws. The medical staff member shall have all of the due process rights set forth in the medical staff bylaws.
7. If no corrective action is taken pursuant to the medical staff bylaws, a confidential memorandum summarizing the disposition of the complaint, along with copies of any written warnings, letters of apology, and written responses from the offending medical staff member, shall be retained in the medical staff member’s credentials file for two (2) years, and then must be expunged if no related action is taken or pending. Informal rehabilitation, a written apology, issuance of a warning, or referral to the Health and Wellbeing Committee (or equivalent committee) will not constitute corrective action.
8. At any time during this procedure the medical staff member has a right to personally retain and be represented by legal counsel.

2.8-4 INAPPROPRIATE OR DISRUPTIVE BEHAVIOR AGAINST A MEDICAL STAFF MEMBER

Inappropriate or disruptive behavior which is directed against the organized medical staff or directed against a medical staff member by a hospital employee, administrator, board member, contractor, or other member of the hospital community shall be reported by the medical staff member to the hospital pursuant to hospital policy or code of conduct, or directly to the hospital governing board, the state or federal government, or relevant accrediting body, as appropriate.

2.8-5 ABUSE OF PROCESS

Threats or actions directed against the complainant by the subject of the complaint will not be tolerated under any circumstance. Retaliation or attempted retaliation by medical staff members against complainants will give rise to corrective action pursuant to the medical staff bylaws. Individuals who falsely submit a complaint shall be subject to corrective action under the medical staff bylaws or hospital employment policies, whichever applies to the individual.

2.8-6 PROMOTING AWARENESS OF CODE OF CONDUCT

The medical staff shall, in cooperation with the hospital, promote continuing awareness of this Code of Conduct among the medical staff and the hospital community, by;

1. sponsoring or supporting educational programs on disruptive behavior to be offered to medical staff members and hospital employees;
2. disseminating this Code of Conduct to all current medical staff members upon its adoption and to all new applicants for membership to the medical staff.
3. encouraging the Health and Wellbeing Committee (or equivalent committee) to assist members of the members exhibiting inappropriate or disruptive behavior to obtain education, behavior modification, or other treatment to prevent further infractions.

4. informing the members and the hospital staff of the procedures the medical staff and hospital have put into place for effective communication to hospital administration of any medical staff member's concerns, complaints and suggestions regarding hospital personnel, equipment, and systems.

ARTICLE III: CATEGORIES OF MEMBERSHIP

3.1 CATEGORIES

The categories of the medical staff shall include the following: provisional, active, courtesy, consulting, affiliate, emeritus, retired and administrative. Each time membership is granted or renewed, the member's staff category shall be determined.

3.2 ACTIVE STAFF

3.2-1 QUALIFICATIONS

The active staff shall consist of members who:

- (a) meet the general qualifications for membership set forth in Section 2.2;
- (b) have offices or residences that, in the opinion of the Medical Executive Committee, are located closely enough to the hospital to provide appropriate continuity of quality care:
- (c) regularly care for patients in this hospital or are involved in medical staff functions, as determined by the medical staff, regularly admit or are otherwise regularly involved in the care of in excess of 10 patients per year in the hospital; and
- (d) except for good cause shown as determined by the medical staff, have satisfactorily completed their designated term in the provisional staff category.

3.2-2 PREROGATIVES

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

- (a) admit patients and exercise such clinical privileges as are granted pursuant to Article V;
- (b) attend and vote on matters presented at general and special meetings of the medical staff and of the department and committees to which the member is duly appointed; and
- (c) hold staff, division, or department office and serve as a voting member of committees to which the member is duly appointed or elected by the medical staff or duly authorized representative thereof so long as the activities required by the position fall within the member's scope of practice as authorized by law.

3.2-3 TRANSFER OF ACTIVE STAFF MEMBER

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

3.3 THE COURTESY MEDICAL STAFF

3.3-1 QUALIFICATIONS

The courtesy medical staff shall consist of members who:

- (a) meet the general qualifications set forth in subsections (a)-(b) of Section 3.2-1;
- (b) do not regularly care for or are not regularly involved in medical staff functions as determined by the medical staff (admit, or regularly care for (or reasonably anticipate admitting or regularly caring for) not more than 10 patients per year in the hospital;

- (c) are members in good standing of the active medical staff of another California licensed hospital, although exceptions to this requirement may be made by the Medical Executive Committee for good cause; and
- (d) have satisfactorily their designated term in the provisional category.

3.3-2 PREROGATIVES

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

- (a) admit patients to the hospital with the limitations of Section 3.3-1(b) and exercise such clinical privileges as are granted pursuant to Article V; and
- (b) attend in a non-voting capacity meetings of the medical staff and the department of which the individual is a member, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment.

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

3.3-3 LIMITATION

Courtesy staff members who admit patients or regularly care for patients at the hospital shall, upon review of the Medical Executive Committee, be automatically transferred to the appropriate staff category.

3.4 PROVISIONAL STAFF

3.4-1 QUALIFICATIONS

The provisional staff shall consist of members who:

- (a) meet the general medical staff membership qualifications set forth in Sections 3.2-1(a) and (b) or 3.4-1(a)-(d); and
- (b) immediately prior to their application and granting of membership were not members (or were no longer members) in good standing of this medical staff.

3.4-2 PREROGATIVES

The provisional staff member shall be entitled to:

- (a) admit patients and exercise such clinical privileges as are granted pursuant to Article V; and
- (b) attend meetings of the medical staff and the department of which that person is a member, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment.

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

3.4-3 OBSERVATION OF PROVISIONAL STAFF MEMBER

Each provisional staff member shall undergo a period of observation by designated monitors as described in Section 5.3. The purpose of observation shall be to evaluate the member's (1) proficiency in the exercise of privileges initially granted and (2) overall eligibility for continued staff membership and advancement within staff categories. Observation of provisional staff members shall follow whatever frequency and format each department deems appropriate in order to adequately evaluate the provisional staff member including, but not limited to, concurrent or retrospective chart review, mandatory consultation, and/or direct observation. Appropriate records shall be maintained. The department chair shall communicate the results of the observation to the Medical Executive Committee.

3.4-4 TERM OF PROVISIONAL STAFF STATUS

A member may remain in the provisional staff for a period of one year unless that status is extended by the Medical Executive Committee for an additional period of up to one additional year upon a determination of good cause, which determination shall not be subject to review pursuant to Articles VI or VII.

3.4-5 ACTION AT CONCLUSION OF PROVISIONAL STAFF STATUS

- (a) If the provisional staff member has satisfactorily demonstrated the ability to exercise the privileges initially granted and otherwise appears qualified for continued medical staff membership, the member shall be eligible for placement in the active, courtesy or consulting staff as appropriate, upon recommendation of the Medical Executive Committee; and
- (b) In all other cases, the appropriate department shall advise the Medical Executive Committee which, in turn, shall make its recommendation to the Board of Directors regarding a modification or termination of clinical privileges or termination of medical staff membership.

3.5 THE AFFILIATE STAFF

3.5-1 QUALIFICATIONS

The Affiliate Staff shall consist of members who:

- (a) meet the qualifications set forth in Section 3.2-1(a) & (b);
- (b) do not regularly admit patients or regularly care for or participate in the care of not more than ten (10) patients in the hospital (within a year);
- (c) have satisfactorily completed their designated term in the provisional staff category;
- (d) shall be requested to provide activity from other hospital affiliations or when activity is non-applicable, concurrent proctoring by peers of the respective department shall be implemented;
- (e) attend medical staff meetings in a non-voting capacity;
- (f) shall not be eligible to hold office in the medical staff;

Affiliate staff members who admit patients or regularly care for patients at the hospital shall, upon review by respective department and Medical Executive Committee, be automatically transferred to the appropriate staff category.

3.6 THE CONSULTING MEDICAL STAFF

3.6-1 QUALIFICATIONS

The Consulting Staff is a special category and shall consist of physicians who may require certain limited privileges to provide specific services in the hospital. Privileges are granted only upon the concurrence of the applicant, the clinical department, the Medical Executive Committee with the approval of the Board of Directors.

- (a) The Consulting Staff shall consist of (1) physicians who do not wish admitting privileges, (2) consulting staff who will be limited to practitioners who possess a clinical expertise not available on a regular basis by other members of the medical staff at Citrus Valley Medical Center.
- (b) Individuals applying for the Consulting Staff category will make application in accordance with these Bylaws and will pay an application fee as determined by the Medical Executive Committee. They shall pay dues in an amount determined by the Medical Executive Committee.

- (c) Physicians in this category shall have no voting privileges and may not hold elective office. They may participate in medical staff committees on a voluntary basis, attend clinical department meetings by invitation and attend general staff meetings.
- (d) Physicians on the Consulting Staff shall not have tenure in this category applied toward requirements for a change to other membership categories (Courtesy or Active) of the Medical Staff. In the event the member shall submit a privilege card and letter of request indicating the clinical department in which privileges are requested, in the manner provided in these bylaws, and shall meet all of the requirements of these bylaws. The member will also be required to meet the proctoring requirements of the department.
- (e) Physicians in this category, will be appointed, monitored and reappointed by the appropriate clinical department, subject to the approval of the Medical Executive and Board of Directors. Individuals providing direct care in the hospital will have cases reviewed for quality and appropriateness of care prior to renewal of membership. They shall be subject to the same disciplinary procedures provided in these bylaws.
- (f) All applications for initial membership or renewal of membership to the Consulting Medical Staff shall follow the same procedure as indicated in these bylaws.

3.6-2 PREROGATIVES

The consulting medical staff member shall be entitled to:

- (a) exercise such clinical privileges as are granted pursuant to Article V; and
- (b) attend meetings of the medical staff and the department of which that person is a member, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment.
- (c) Consulting staff members shall not be eligible to hold office in the medical staff organization, but may serve committees.

3.7 THE EMERITUS (HONORARY) STAFF

3.7-1 QUALIFICATIONS

The Emeritus Staff

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

The Retired Staff

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

3.7-2 PREROGATIVES

Emeritus (Honorary), and Retired staff members are not eligible to admit patients to the hospital or to exercise clinical privileges in the hospital, or to vote or hold office in this medical staff organization, but they may serve upon committees with or without vote at the discretion of the Medical Executive Committee. They may attend staff and department meetings, including open committee meetings and educational programs.

3.8 TEMPORARY STAFF

3.8-1 QUALIFICATIONS

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

3.8-2 PREROGATIVES

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

3.9 ADMINISTRATIVE STAFF

3.9-1 QUALIFICATIONS

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

The administrative staff shall consist of members who:

- (a) are charged with assisting the medical staff in carrying out medical-administrative functions, including but not limited to quality assessment and improvement and utilization review;
- (b) document their (1) current licensure, (2) adequate experience, education and training, (3) current professional competence, (4) good judgment, and (5) current physical and mental health status, so as to demonstrate to the satisfaction of the medical staff that they are professionally and ethically competent to exercise their duties;
- (c) are determined (1) to adhere to the ethics of their respective professions, (2) to be able to work cooperatively with others so as not to adversely affect their judgment in carrying out the quality assessment and improvement functions, and (3) to be willing to participate in and properly discharge those responsibilities determined by the medical staff.

3.9-2 PREROGATIVES

The administrative staff shall be entitled to:

- (a) Attend meetings of the medical staff and various departments, at the invitation of the chair, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except to the extent the right to vote is specified at the time of appointment.
- (b) Administrative staff members shall not be eligible to hold office in the medical staff organization, admit patients or exercise privileges.

3.10 LIMITATION OF PREROGATIVES

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

3.11 GENERAL EXCEPTIONS TO PREROGATIVES

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

- (a) shall only have the right to vote on matters within the scope of their licensure. In the event of a dispute over voting rights, that issue shall be determined by the chair of the meeting, subject to final decision by the Medical Executive Committee; and
- (b) shall exercise privileges only within the scope of their licensure and as set forth in Section 5.4.

3.12 MODIFICATION OF MEMBERSHIP

On its own, upon recommendation of the clinical department, or pursuant to a request by a member under Section 4.6-1(b), or upon direction of the Board of Directors as set forth in Section 6.1-6, the Medical Executive Committee may recommend a change in the medical staff category of a member consistent with the requirements of the bylaws.

ARTICLE IV: APPOINTMENT AND REAPPOINTMENT

4.1 GENERAL

Except as otherwise specified herein, no person (including persons engaged by the hospital in administratively responsible positions) shall exercise privileges in the hospital unless and until that person applies for and obtains membership on the medical staff and is granted privileges as set forth in these bylaws. By applying to the medical staff for initial membership or renewal of membership (or, in the case of members of the emeritus staff, by accepting membership in that category), the applicant acknowledges responsibility to first review these bylaws and medical staff rules, regulations and policies, and agrees that throughout any period of membership that person will comply with the responsibilities of medical staff membership and with the bylaws, rules and regulations and policies of the medical staff as they exist and as they may be modified from time to time. Membership on the medical staff shall confer on the appointee only such clinical privileges as have been granted in accordance with these bylaws.

After the Medical Executive Committee fails to process an appointment or reappointment in a timely manner, without lawful cause, the Board of Directors may direct the Medical Executive Committee to process. If they do not, the Board may do so, but only after consultation with and prior written notice to the Medical Executive Committee.

4.2 BURDEN OF PRODUCING INFORMATION

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

4.3 AUTHORITY TO GRANT, DENY AND REVOKE MEMBERSHIP

Approvals, denials and revocations of appointments to the medical staff shall be made as set forth in these bylaws, but only after there has been a recommendation from the medical staff, or as set forth in Section 6.1-6.

4.4 DURATION OF MEMBERSHIP AND MEMBERSHIP RENEWAL

Except as otherwise provided in these bylaws, initial membership on the medical staff shall be for a period not to exceed two years. Membership renewals shall be for a period of up to two years.

4.5 APPLICATION FOR INITIAL MEMBERSHIP AND RENEWAL OF MEMBERSHIP

4.5-1 APPLICATION FORM

The Medical Executive Committee shall develop an application form. The form shall require detailed information which shall include, but not be limited to, information concerning:

- (a) the applicant's qualifications, including, but not limited to, professional training and experience, current licensure, current DEA registration, certification of CPR training, and continuing medical education information related to the clinical privileges to be exercised by the applicant;
- (b) peer references familiar with the applicant's professional competence and ethical character;
- (c) requests for membership categories, departments, and privileges;
- (d) past or pending professional disciplinary action, voluntary or involuntary denial, revocation, suspension, reduction or relinquishment of medical staff membership or privileges or any licensure or registration, and related matters.
- (e) current physical and mental health status;
- (f) final judgments or settlements made against the applicant in professional liability cases, and any filed and served cases pending;
- (g) professional liability coverage, if any is required; and
- (h) any past, pending or current exclusion from a federal health care program.

Each application for initial membership on the medical staff shall be in writing, submitted on the prescribed form with all provisions completed (or accompanied by an explanation of why answers are not available), and signed by the applicant. When an applicant requests an application form, that person shall be given a copy of these bylaws, the medical staff rules and regulations, and as deemed appropriate by the Medical Executive Committee, copies or summaries of other applicable medical staff policies relating to clinical practice in the hospital.

4.5-2 EFFECT OF APPLICATION

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

- (a) signifies willingness to appear for interviews in regard to the application;
- (b) authorizes consultation with others who have been associated with the applicant and who may have information bearing on the applicant's competence, qualifications and performance, and authorizes such individuals and organizations to candidly provide all such information;
- (c) consents to inspection of records and documents that may be material to an evaluation of the applicant's qualifications and ability to carry out clinical privileges requested, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying;
- (d) releases from any liability, to the fullest extent provided by law, all persons for their acts performed in connection with investigating and evaluating the applicant;

- (e) releases from any liability, to the fullest extent provided by law, all individuals and organizations who provide information regarding the applicant, including otherwise confidential information;
- (f) consents to the disclosure to other hospitals, medical associations, licensing boards, and to other similar organizations as required by law, any information regarding the applicant's professional or ethical standing that the hospital or medical staff may have, and releases the medical staff and hospital from liability for so doing to the fullest extent permitted by law;
- (g) if a requirement then exists for medical staff dues, acknowledges responsibility for timely payment;
- (h) agrees to provide for continuous quality care for patients;
- (i) pledges to maintain an ethical practice, including refraining from illegal inducements for patient referral, providing for the continuous care of the applicant's patients, seeking consultation whenever necessary, refraining from failing to disclose to patients when another surgeon will be performing the surgery, refraining from failing to disclose to patients when another surgeon will be performing the surgery, refraining from delegating patient care responsibility to non-qualified or inadequately supervised practitioners,
- (j) pledges to be bound by the medical staff bylaws, rules and regulations, policies, and
- (k) agrees that if membership and privileges are granted, and for the duration of medical staff membership, the member has an ongoing and continuous duty to report to the medical staff office within ten days any and all information that would otherwise correct, change, modify or add to any information provided in the application or add to any information provided in the application or most recent reapplication when such correction, change, modification or addition may reflect adversely on current qualifications for membership or privileges.

4.5-3 VERIFICATION OF INFORMATION

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

4.5-4 DEPARTMENT ACTION

After receipt of the application, the chair of each department to which the application is submitted, shall review the application and supporting documentation, and may conduct a personal interview with the applicant at the chair's or department's discretion.

The chair shall evaluate all matters deemed relevant to a recommendation, including information concerning the applicant's provision of services within the scope of privileges granted, and the re-applicant's participation in relevant continuing education, and shall transmit to the clinical department a written report and recommendation as to membership and, if membership is recommended, as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached. The chair may also request that the Medical Executive Committee defer action on the application.

4.5-5 AD HOC CREDENTIALS COMMITTEE ACTION

Credentialing will be performed at the Department level, but whenever necessary, the Ad Hoc Credentials Committee shall review the application, evaluate and verify the supporting documentation, the department chair's report and recommendations, and other relevant information. The Ad Hoc Credentials Committee may elect to interview the applicant and seek additional information. As soon as practicable, the Ad Hoc Credentials Committee shall transmit to the Medical Executive Committee a written report and its recommendations as to membership and, if membership is recommended, as to membership category, department affiliation, privileges to be granted, and any special conditions to be attached to the appointment. The committee may also recommend that the Medical Executive Committee defer action on the application.

4.5-6 MEDICAL EXECUTIVE COMMITTEE ACTION

At its next regular meeting after receipt of the clinical department's report and recommendation, or as soon thereafter as is practicable, the Medical Executive Committee shall consider the report and any other relevant information. The Medical Executive Committee may request additional information, return the matter to the clinical department for further investigation, and/or elect to interview the applicant. The Medical Executive Committee shall immediately forward to the Administrator, for prompt transmittal to the Board of Directors, or in cases eligible for expedited processing, the committee duly appointed by the Board to handle expedited cases, written report and recommendation as to medical staff membership and, if membership is recommended, as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. The committee may also defer action on the application. The reasons for each recommendation shall be stated.

4.5-7 EFFECT OF MEDICAL EXECUTIVE COMMITTEE ACTION

- (a) Favorable Recommendation: When the recommendation of the Medical Executive Committee is favorable to the applicant, it shall be immediately forwarded, together with supporting documentation, to the Board of Directors or, in cases eligible for expedited processing, applicable committee duly appointed by the Board to handle expedited calls.
- (b) Adverse Recommendation: When a final recommendation of the Medical Executive Committee is adverse to the applicant, the Board of Directors and the applicant shall be promptly informed by written notice. The applicant shall then be entitled to the procedural rights as provided in Article VII.

4.5-8 ACTION ON THE APPLICATION

The Board of Directors or, in cases eligible for expedited processing, the duly appointed committee of the board, may accept the recommendation of the Medical Executive Committee or may refer the matter back to the Medical Executive Committee for further consideration, stating the purpose for such referral and setting a reasonable time limit for making a subsequent recommendation. The following procedures shall apply with respect to action on the application:

- (a) If the Medical Executive Committee issues a favorable recommendation, the Board of Directors or its duly appointed committee in cases eligible for expedited processing shall affirm the recommendation of the Medical Executive Committee if the Medical Executive Committee's decision is supported by substantial evidence.

- (1) If the Board of Directors concurs in that recommendation, the decision of the Board shall be deemed final action.
 - (2) If the tentative final action of the Board of Directors is unfavorable, the Administrator shall give the applicant written notice of the tentative adverse recommendation and the applicant shall be entitled to the procedural rights set forth in Article VII. If the applicant waives procedural rights, the decision of the Board of Directors shall be deemed final action.
 - (3) In cases eligible for expedited processing, if the duly appointed committee and the Board concurs in that recommendation, the Board of Directors at its next regularly scheduled meeting shall ratify the positive decision. The ratification by the board shall be deemed final. If the committee's decision is adverse to the applicant, or the Board fails to ratify the committee's decision, the matter shall be referred back to the Medical Executive Committee for evaluation.
- (b) In the event the recommendation of the Medical Executive Committee, or any significant part of it, is unfavorable to the applicant the procedural rights set forth in Article VII shall apply.
- (1) If the applicant waives procedural rights, the recommendations of the Medical Executive Committee shall be forwarded to the Board of Directors for final action, which shall affirm the recommendation of the Medical Executive Committee if the Medical Executive Committee's decision is supported by substantial evidence.
 - (2) If the applicant requests a hearing following the adverse Medical Executive Committee recommendation pursuant to Section 4.5-8(b) or an adverse Board of Directors tentative final action pursuant to 4.5-8(a) (2), the Board of Directors shall take final action only after the applicant has exhausted all procedural rights as established by Article VII. After exhaustion of the procedures set forth in Article VII, the Board shall make a final decision and shall affirm the decision of the Judicial Review Committee if the Judicial Review Committee's decision is supported by substantial evidence, following a fair procedure. The Board's decision shall be in writing and shall specify the reasons for the action taken.
- (c) Applicants are ineligible for expedited processing if, at the time of membership, any of the following has occurred:
- (1) The applicant submits an incomplete application.
 - (2) The Medical Executive Committee makes a final recommendation that is adverse or with limitation.
 - (3) There is a current challenge or previously successful challenge to licensure.
 - (4) The applicant has received an involuntary termination of medical staff membership at another organization.
 - (5) The applicant has received involuntary limitation, reduction, denial, or loss of medical privileges.
 - (6) There has been a final judgment adverse to the applicant in a professional liability action.

4.5-9 NOTICE OF FINAL DECISION

- (a) Notice of the final decision shall be given to the Chief of Staff, the Medical Executive Committee and the chair of each department concerned, the applicant, and the Administrator.
- (b) A decision and notice to grant or renew membership shall include, if applicable: (1) the staff category to which the applicant becomes a member; (2) the department to which that person is assigned; (3) the clinical privileges granted; and (4) any special conditions attached to the appointment.

4.5-10 REAPPLICATION AFTER ADVERS APPOINTMENT DECISION

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

4.5-11 TIMELY PROCESSING OF APPLICATIONS

Applications for staff membership shall be considered in a timely manner by all persons and committees required by these bylaws to act thereon. While special or unusual circumstances may constitute good cause and warrant exceptions, the following maximum time periods provide a guideline for routine processing of applications:

- (a) evaluation, review, and verification of application and all supporting documents by the medical staff office: 60 days from receipt of all necessary documentation;
- (b) review and recommendation by department(s): 30 days after receipt of all necessary documentation from the medical staff office;
- (c) review and recommendation by the Executive Committee: 30 days after receipt of all necessary documentation from the department; and
- (d) final action: 120 days after receipt of all necessary documentation by the Medical Staff Office, 30 days in expedited cases, or seven (7) days after conclusion of hearing.

4.6 MEMBERSHIP RENEWAL AND REQUESTS FOR MODIFICATIONS OF STAFF STATUS OR PRIVILEGES

4.6-1 APPLICATION

- (a) At least six months prior to the expiration date of the current staff membership (except for temporary membership), a reapplication form developed by the Medical Executive Committee shall be mailed or delivered to the member. If an application for renewal of membership is not received at least 60 days prior to the expiration date, written notice shall be promptly sent to the applicant advising that the application has not been received. At least 45 days prior to the expiration date, each medical staff member shall submit to the department the completed application form for renewal of membership to the staff for the coming year, and for renewal or modification of clinical privileges. The reapplication form shall include all information necessary to update and evaluate the qualifications of the applicant including, but not limited to, the matters set forth in Section 4.5-1, as well as other relevant matters. Upon receipt of the application, the information shall be processed as set forth commencing at Section 4.5-3.
- (b) A medical staff member who seeks a change in medical staff status or modification of clinical privileges may submit such a request at any time upon a form developed by the Medical Executive Committee, except that such application may not be filed within one year of the time a similar request has been denied.

4.6-2 EFFECT OF APPLICATION

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

4.6-3 STANDARDS AND PROCEDURE FOR REVIEW

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

4.6-4 FAILURE TO FILE FOR RENEWAL OF MEMBERSHIP

Failure without good cause to timely file a completed application for renewal of membership shall result in the automatic suspension of the member's admitting privileges and expiration of other practice privileges and prerogatives at the end of the current staff membership period. If the member fails to submit a completed application for renewal of membership within 30 days past the date it was due, the member shall be deemed to have resigned membership in the medical staff. In the event membership terminates for the reasons set forth herein, the procedures set forth in Article VII shall not apply.

4.7 LEAVE OF ABSENCE

4.7-1 LEAVE STATUS

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

4.7-2 TERMINATION OF LEAVE

At least 30 days prior to the termination of the leave of absence, or at any earlier time, the medical staff member may request reinstatement of privileges by submitting a written notice to that effect to the Medical Executive Committee. The staff member shall submit a summary of relevant activities during the leave, if the Executive Committee so requests. The Medical Executive Committee shall make a recommendation concerning the reinstatement of the member's privileges and prerogatives, and the procedure provided in Sections 4.1 through 4.5-11 shall be followed.

4.7-3 FAILURE TO REQUEST REINSTATEMENT

Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the medical staff and shall result in automatic termination of membership, privileges, and prerogatives. A member whose membership is automatically terminated shall be entitled to the procedural rights provided in Article VII for the sole purpose of determining whether the failure to request reinstatement was unintentional or excusable, or otherwise. A request for medical staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial membership.

4.7-4 MEDICAL LEAVE OF ABSENCE

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

4.7-5 MILITARY LEAVE OF ABSENCE

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

ARTICLE V: CLINICAL PRIVILEGES

5.1 EXERCISE OF PRIVILEGES

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

5.2 DELINEATION OF PRIVILEGES IN GENERAL

5.2-1 REQUESTS

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

5.2-2 BASES FOR PRIVILEGES DETERMINATION

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

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

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

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

5.3 PROCTORING

5.3-1 GENERAL PROVISIONS

Except as otherwise determined by the Medical Executive Committee, all initial appointees to the medical staff and all members granted new clinical privileges shall be subject to a period of proctoring. Each member or recipient of new clinical privileges shall be assigned to a department where performance on an appropriate number of cases as established by the Medical Executive Committee, or the department as designee of the Medical Executive Committee, shall be observed by the chair of the department, or the chair's designee, during the period of proctoring specified in the department's rules and regulations, to determine suitability to continue to exercise the clinical privileges granted in that department. The exercise of clinical privileges in any other department shall also be subject to direct observation by that department's chair or the chair's designee. The member shall remain subject to such proctoring until the Medical Executive Committee has been furnished with:

- (a) a report signed by the chair of the department(s) to which the member is assigned describing the types and numbers of cases observed and the evaluation of the applicant's performance, a statement that the applicant appears to meet all of the qualifications for unsupervised practice in that department, has discharged all of the responsibilities of staff membership, and has not exceeded or abused the prerogatives of the category to which membership was granted; and
- (b) a report signed by the chair of the other department(s) in which the appointee may exercise clinical privileges, describing the types and number of cases observed and the evaluation of the applicant's performance and a statement that the member has satisfactorily demonstrated the ability to exercise the clinical privileges initially granted in those departments.

5.3-2 FAILURE TO OBTAIN CERTIFICATION

If a new member fails within the time of provisional membership to furnish the certification required, or if a member exercising new clinical privileges fails to furnish such certification within the time allowed by the department, those specific clinical privileges shall automatically terminate, and the member shall be entitled to a hearing, upon request, pursuant to Article VII.

5.3-3 MEDICAL STAFF ADVANCEMENT

The failure to obtain certification for any specific clinical privileges shall not, of itself, preclude advancement in medical staff category of any member. If such advancement is granted absent such certification, continued proctorship on the uncertified procedure shall continue for the specified time period.

5.4 CONDITIONS FOR PRIVILEGES OF LIMITED LICENSE PRACTITIONERS

5.4-1 ADMISSIONS

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

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

5.4-2 SURGERY

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

5.4-3 MEDICAL APPRAISAL

All patients admitted for care in a hospital by a dentist or oral and maxillofacial surgeon, or podiatrist shall receive the same basic medical appraisal as patients admitted to other services, and the dentists, oral and maxillofacial surgeons or podiatrists shall seek consultation with a physician member to determine the patient's medical status and need for medical evaluation whenever the patient's clinical status indicates the presence of a medical problem. Where a dispute exists regarding proposed treatment between a physician member and a limited license practitioner based upon medical or surgical factors outside of the scope of licensure of the limited license practitioner, the treatment will be suspended insofar as possible while the dispute is resolved by the appropriate department(s).

5.5 TEMPORARY CLINICAL PRIVILEGES

Temporary privileges are allowed under two circumstances only: to address a patient care need and to permit patient care to be provided while an application is pending.

5.5-1 CARE OF A SPECIFIC PATIENT

Temporary clinical privileges may be granted where good cause exists to a physician, dentist or podiatrist for the care of a specific patient (but not more than three (3) times during a calendar year) provided that the procedure described in Section 5.5-5(a)(1) has been completed.

5.5-2 LOCUM TENENS

Temporary clinical privileges may be granted to a person serving as a locum tenens for a current member of the medical staff to meet the care needs of that member's patients in his/her absence, provided that the procedure described in Section 5.5-5 has been completed. Such person may attend only patients of the member(s) for whom that person is providing coverage, for a period not to exceed thirty (30) consecutive days, unless the Medical Executive Committee recommends a longer additional period for good cause.

5.5-3 PENDING APPLICATION FOR MEDICAL STAFF MEMBERSHIP

Temporary clinical privileges may be granted to an applicant while of that person's application for medical staff membership and privileges is completed and awaiting review and approval of the medical executive committee or the board of directors, provided that the procedure described in Section 5.5-5 (a)(2) has been completed, and that the applicant has no current or previously successful challenge to professional licensure or registration, no involuntary termination of medical staff membership at any other organization, and no involuntary limitation, reduction, denial or loss of clinical privileges. Such persons may only attend patients for a period not to exceed 120 days.

5.5-4 TEMPORARY MEMBERSHIP AND TEMPORARY PRIVILEGES NOT CO-EXTENSIVE

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

5.5-5 APPLICATION AND REVIEW

- (a) Upon receipt of a completed application and supporting documentation from a physician, dentist or podiatrist authorized to practice in California, the Chief Executive Officer on the recommendation of either the applicable clinical department chairperson or the chief of staff, may grant temporary privileges to a member who appears to have qualifications, ability and judgment consistent with Section 2.2-1, but only after:
- (1) With respect to applications by a locum tenen's, or to fulfill an important patient care need, after verification of current licensure and current competence; or
 - (2) With respect to a new applicant awaiting review and approval of the Medical Staff Executive Committee and the Board of Directors in compliance with the requirements in Section 5.5-3 after the following has been completed:
 - (a) the National Practitioner Data Bank report regarding the applicant for temporary privileges has been received and evaluated and current California licensure has been verified.
 - (b) the appropriate department chair has interviewed the applicant and has contacted at least one person who
 - (i) has recently worked with the applicant;
 - (ii) has directly observed the applicant's professional performance over a reasonable time; and
 - (iii) provides reliable information regarding the applicant's current professional competence to perform the privileges requested, ethical character, and ability to work well with others so as not to adversely affect patient care, or other criteria required by medical staff bylaws.
 - (c) the applicant's file, including the recommendation of the department chair of the applicable department when available, or the chief of staff in all other cases, is forwarded to the clinical department and the Medical Executive Committee.
 - (d) The Medical Executive Committee through the Chief of Staff, after reviewing the applicant's file and attached materials, recommends granting temporary privileges.
- (b) If the applicant requests temporary privileges in more than one department, interviews may be conducted and written concurrence shall first be obtained from the appropriate department chairs and forwarded to the Medical Executive Committee. In the event of a disagreement between the Chief Executive Officer or his or her designee and the medical Executive Committee regarding the granting of temporary clinical privileges, the matter shall be resolved as set forth in Section 4.5-8.

5.5-6 GENERAL CONDITIONS

- (a) If granted temporary privileges, the applicant shall act under the supervision of the department chair to which the applicant has been assigned, and shall ensure that the chair, or the chair's designee, is kept closely informed as to the applicant's activities within the hospital.
- (b) Temporary privileges shall automatically terminate at the end of the designated period, unless earlier terminated or suspended under Articles VI and/or VII of these bylaws or unless affirmatively renewed following the procedure as set forth in Section 5.5-6. A medical staff applicant's temporary privileges shall automatically terminate if the applicant's initial membership application is withdrawn. As necessary, the appropriate department chair or, in the chair's absence, the chair of the Medical Executive Committee, shall assign a member of the medical staff to assume responsibility for the care of such member's patient(s). The wishes of the patient shall be considered in the choice of a replacement medical staff member.
- (c) Requirements for proctoring and monitoring, including but not limited to those in Section 5.3, shall be imposed on such terms as may be appropriate under the circumstances upon any member granted temporary privileges by the chief of staff after consultation with the departmental chair or the chair's designee.
- (d) All persons requesting or receiving temporary privileges shall be bound by the bylaws and rules and regulations of the medical staff.

5.6 EMERGENCY PRIVILEGES

- (a) In the case of an emergency involving a particular patient, any member of the medical staff with clinical privileges, to the degree permitted by the scope of the applicant's license and regardless of department, staff status, or clinical privileges, shall be permitted to do everything reasonably possible to save the life of the patient or to save patient from serious harm provided that the care provided is within the scope of the individual's license. The member shall make every reasonable effort to communicate promptly with the department chair concerning the need for emergency care and assistance by members of the medical staff with appropriate privileges, and once the emergency has passed or assistance has been made available, shall defer to the department chair with respect to further care of the patient at the hospital.
- (b) In the event of an emergency under subsection (a), any person shall be permitted to do whatever is reasonably possible to save the life of a patient or to save a patient from serious harm. Such persons shall promptly yield such care to qualified members of the medical staff when it becomes reasonably available.
- (c) Emergency privileges under subsection (a) shall not be used to force members to serve on emergency department call panels providing services for which they do not hold delineated clinical privileges.

5.7 DISASTER PRIVILEGES

- (a) In the case of a disaster in which the disaster plan has been activated and the hospital is unable to handle the immediate patient needs, the Chief of Staff, or in the absence of the Chief of Staff, the Chief of Staff-elect, may grant disaster privileges. In the absence of the Chief of Staff and Chief of Staff-elect and Department Chair(s), the Chief Executive Officers or the CEO's designee may grant the disaster privileges consistent with this subsection. The grant of privileges under this subsection shall be on a case-by-case basis at the sole discretion of the individual authorized to grant such privileges. An initial grant of disaster privileges is reviewed by a person authorized to grant disaster privileges within 72 hours to determine whether the disaster privileges should be continued.

- (b) The verification process of the credentials and privileges of individuals who receive disaster privileges under this subsection shall be developed in advance of a disaster situation. This process shall begin as soon as the immediate disaster situation is under control, and shall meet the following requirements in order to fulfill important patient care needs:
- (1) The medical staff identifies in writing the individual(s) responsible for granting disaster privileges.
 - (2) The medical staff describes in writing the responsibilities of the individual(s) responsible for granting disaster privileges.
 - (3) The medical staff describes in writing a mechanism to manage the activities of individuals who receive disaster privileges. There is a mechanism to allow staff to readily identify these individuals.
 - (4) The medical staff addresses the verification process as a high priority. The medical staff has a mechanism to ensure that the verification process of the credentials and privileges of individuals who receive disaster privileges begins as soon as the immediate situation is under control. This privileging process is identical to the process established under the medical staff bylaws for granting temporary privileges to fulfill an important patient care need.
 - (5) Those authorized under subsection (a) may grant disaster privileges upon presentation of a valid picture ID issued by a state, federal or regulatory agency and at least one of the following:
 - (i) A current picture hospital ID card clearly identifying professional designation.
 - (ii) A current license to practice.
 - (iii) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT) or MRC, ESAR-VHP, or other recognized state or federal organizations or groups.
 - (iv) Identification indicating that the individual has been granted authority by a federal, state, or municipal entity to render patient care in disaster circumstances.
 - (v) Identification by current hospital or medical staff member(s) with personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during a disaster.
- (c) Current professional licensure of those providing care under disaster privileges is verified from the primary source as soon as the immediate situation is under control and completed within 72 hours, unless extraordinary circumstances prohibit verification, in which case the following is documented:
- (1) The reasons verification could not be performed within 72 hours,
 - (2) Evidence of demonstrated ability to continue to provide adequate care, treatment and services.
 - (3) An attempt to rectify the situation as soon as possible.
- (d) Members of the medical staff shall oversee those granted disaster privileges.

5.8 MODIFICATION OF PRIVILEGES OR DEPARTMENT ASSIGNMENT

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

5.9 LAPSE OF REQUEST

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

ARTICLE VI: CORRECTIVE ACTION

6.1 CORRECTIVE ACTION

6.1-1 FOCUSED REVIEW

The medical executive committee shall define, on a continuing basis, the circumstances warranting further intensive review of a member or other practitioner's services provided under privileges held and establish the parameters for participation of the subject under review in the focused review process. When circumstances warrant, the chief of staff shall appoint a special committee of impartial medical staff members whose professional credentials establish their competence to analyze the grounds for the request and the performance of the practitioner. The panel shall conduct the review as peers following the time frames set for that focused review by the medical executive committee.¹ Focused review may result in recommendations for changes to improve the member's performance; recommendations for system, protocol or policy changes; a request for investigation or corrective action; or other action.

6.1-2 CRITERIA FOR INITIATION

Any person may provide information to the medical staff about the conduct, performance, or competence of its members. When reliable information indicates a member may have exhibited acts, demeanor, or conduct reasonably likely to be (1) detrimental to patient safety or to the delivery of quality patient care within the hospital; (2) unethical; (3) contrary to the medical staff bylaws and rules or regulations; or (4) below applicable professional standards, a request for an investigation or action against such member may be initiated by the chief of staff, a department chair, or the Medical Executive Committee.

6.1-3 INITIATION

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

6.1-4 INVESTIGATION

If the Medical Executive Committee concludes an investigation is warranted, it shall direct an investigation to be undertaken. The Medical Executive Committee may conduct the investigation itself, or may assign the task to an appropriate medical staff officer, medical staff department, or standing or ad hoc committee of the medical staff. The Medical Executive Committee in its discretion may appoint practitioners who are not members of the medical staff as temporary members of the medical staff for the sole purpose of serving on a standing or ad hoc committee, and not for the purpose of granting these practitioners temporary privileges under Section 5.5, should circumstances warrant. If the investigation is delegated to an officer or committee other than the Medical Executive Committee, such officer or committee shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the Medical Executive Committee as soon as practicable. The report may include recommendations for appropriate corrective action.

The member shall be notified that an investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The individual or body investigating the matter may, but is not obligated to, conduct interviews with persons involved; however, such investigation shall not constitute a "hearing" as that term is used in Article VII, nor shall the procedural rules with respect to hearings or appeals apply. Despite the status of any investigation, at all times the Medical Executive Committee shall retain authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension, termination of the investigative process, or other action.

6.1-5 EXECUTIVE COMMITTEE ACTION

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

- (a) determining no corrective action be taken and, if the Executive Committee determines there was no credible evidence for the complaint in the first instance, removing any adverse information from the member's file;
- (b) referring the member to the Physician Advisory Committee for evaluation and follow-up as appropriate,
- (c) deferring action for a reasonable time where circumstances warrant;
- (d) issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude department heads from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letters are issued, the affected member may make a written response which shall be placed in the member's file;
- (e) recommending the imposition of terms of probation or special limitation upon continued medical staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admission, mandatory consultation, or monitoring;
- (f) recommending reduction, modification, suspension or revocation of clinical privileges;
- (g) recommending reductions of membership status or limitation of any prerogatives directly related to the member's delivery of patient care;
- (h) recommending suspension, revocation or probation of medical staff membership; and
- (i) taking other actions deemed appropriate under the circumstances.

6.1-6 SUBSEQUENT ACTION

- (a) All significant corrective actions recommended by the Medical Executive Committee shall be reported to the Board of Directors, provided the practitioner is not entitled to request a hearing in accordance with Article VII.
- (b) So long as the recommendation is supported by substantial evidence, the Board of Directors as final action shall adopt the recommendation of the Medical Executive Committee if the recommended action constitutes grounds for hearing, the practitioner is entitled to the hearing and appeal rights set forth in Article VII.

6.1-7 INITIATION BY BOARD OF DIRECTORS

If the Medical Executive Committee fails to investigate or take disciplinary action, contrary to the weight of the evidence, the Board of Directors may direct the Medical Executive Committee to initiate investigation or disciplinary action, but only after consultation with the Medical Executive Committee. The board's request for medical staff action shall be in writing and shall set forth the bases for the request. If the Medical Executive Committee fails to take action in response to that Board of Directors direction, the Board of Directors may initiate corrective action, after written notice to the Medical Executive Committee, but this corrective action must comply with Articles VI and VII of these medical staff bylaws.

6.2 SUMMARY RESTRICTION OR SUSPENSION

6.2-1 CRITERIA FOR INITIATION

Whenever a member's conduct appears to require that immediate action be taken to protect the life or well-being of patient(s) or to reduce a substantial and imminent likelihood of significant impairment of the life, health, safety of any patient, prospective patient, or other person. Where the failure to take that action may result in an imminent danger to the health of any individual, the Chief of Staff, the Medical Executive Committee, or the head of the department or designee in which the member holds privileges may summarily restrict or suspend the medical staff membership or clinical privileges of such member.

Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition and the person or body responsible shall promptly give written notice to the Board of Directors, the Medical Executive Committee and the Administrator. In addition, the affected medical staff member shall be provided with a written notice of the action which notice fully complies with the requirements of Section 6.2-2 below. The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary restriction or suspension, the member's patients shall be promptly assigned to another member by the department chair or by the chief of staff, considering where feasible, the wishes of the patient in the choice of a substitute member.

6.2-2 WRITTEN NOTICE OF SUMMARY SUSPENSION

Within one working day of imposition of a summary suspension, the affected medical staff member shall be provided with written notice of such suspension. This initial written notice shall include a statement of facts demonstrating that the suspension was necessary because failure to suspend or restrict the practitioner's privileges summarily could reasonably result in an imminent danger to the health of an individual. The statement of facts provided in this initial notice shall also include a summary of one or more particular incidents giving rise to the assessment of imminent danger. This initial notice shall not substitute for, but is in addition to, the notice required under Section 7.3-1 (which applies in all cases where the MEC does not immediately terminate the summary suspension). The notice under Section 7.3-1 may supplement the initial notice provided under this section, by including any additional relevant facts supporting the need for summary suspension or other corrective action.

6.2-3 MEDICAL EXECUTIVE COMMITTEE ACTION

Within one week after such summary restriction or suspension has been imposed, a meeting of the Medical Executive Committee or a subcommittee appointed by the Chief of Staff shall be convened to review and consider the action. Upon request, the member may attend and make a statement concerning the issues under investigation, on such terms and conditions as the Medical Executive Committee may impose, although in no event shall any meeting of the Medical Executive Committee, with or without the member, constitute a "hearing" within the meaning of Article VII, nor shall any procedural rules apply. The Medical Executive Committee may modify, continue, or terminate the summary restriction or suspension, but in any event it shall furnish the member with notice of its decision within two working days of the meeting.

6.2-4 PROCEDURAL RIGHTS

Unless the Medical Executive Committee promptly terminates the summary restriction or suspension, the member shall be entitled to the procedural rights afforded by Article VII. In addition, the affected practitioner shall have the following rights:

- (a) Any affected practitioner shall have the right to challenge imposition of the summary suspension, particularly on the issue of whether or not the facts stated in the notice present a reasonable possibility of “imminent danger” to an individual. Initially, the practitioner may present this challenge to the Medical Executive Committee at the meeting held within one week of imposition of the suspension. If the MEC's decision is to continue the summary suspension, then any practitioner who has properly requested a hearing under the medical staff bylaws may request that the hearing be bifurcated, with the first part of the hearing being devoted exclusively to procedural matters, including the propriety of summary suspension. Along with any other appropriate requests for rulings, the affected practitioner may request that the hearing officer (or hearing panel) stay the summary suspension, pending the final outcome of the hearing and any appeal.
- (b) At the conclusion of the procedural portion of the hearing, the hearing officer or hearing panel shall issue a written opinion on the issues raised, including whether or not the facts stated in the written notice to the affected practitioner adequately support a determination that failure to summarily restrict or suspend could reasonably result in “imminent danger:” to an individual. Such written opinion shall be transmitted to both the affected practitioner and the MEC within one week of the date of the procedural hearing.
- (c) If the hearing officer's or hearing panel's determination is that the facts stated in the notice required by Section 6.2-2 do not support a reasonable determination that failure to summarily restrict or suspend the practitioner's privileges could result in imminent danger, the summary suspension shall be immediately stayed pending the outcome of the hearing and any appeal.
- (d) If the hearing officer or hearing panel determines that the facts stated in the notice required by Section 6.2-2 support a reasonable determination that summary suspension was necessary to avoid imminent danger to an individual, the summary suspension shall remain in effect pending conclusion of the hearing and any appellate review.

6.2-5 INITIATION BY BOARD OF DIRECTORS

If the Chief of Staff, members of the Medical Executive Committee and the head of the department (or designee) in which the member holds privileges are not available to summarily restrict or suspend the member's membership or clinical privileges, the Board of Directors (or designee) may immediately suspend a member's privileges where the failure to take that action may result in an imminent danger to the health of any individual, provided that the Board of Directors (or designee) made reasonable attempts to contact the Chief of Staff, members of the Medical Executive Committee and the head of the department (or designee) before the suspension.

Such a suspension is subject to ratification by the Medical Executive Committee. If the Medical Executive Committee does not ratify such a summary suspension within two working days, excluding weekends and holidays, the summary suspension shall terminate automatically. If the Medical Executive Committee does ratify the summary suspension, all other provisions under Section 6.2 of these bylaws will apply. In this event, the date of imposition of the summary suspension shall be considered to be the date of ratification by the Medical Executive Committee for purposes of compliance with notice and hearing requirements.

6.3 AUTOMATIC SUSPENSION OR LIMITATION

In the following instances, the member's privileges or membership may be suspended or limited as described, and a hearing, if requested, shall be limited to the question of whether the grounds for automatic suspension as set forth below have occurred.

6.3-1 LICENSURE

- (a) Revocation, Suspension and Expiration: Whenever a member's license or other legal credential authorizing practice in this state is revoked, suspended, or expired, medical staff membership and clinical privileges shall be automatically revoked as of the date such action becomes effective.
- (b) Restriction: Whenever a member's license or other legal credential authorizing practice in this state is limited or restricted by the applicable licensing or certifying authority, any clinical privileges which the member has been granted at the hospital which are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.
- (c) Probation: Whenever a member is placed on probation by the applicable licensing or certifying authority, membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

6.3-2 CONTROLLED SUBSTANCES

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

6.3-3 MEDICAL RECORDS

Members of the medical staff are required to complete medical records within such reasonable time as may be prescribed by the Medical Executive Committee. A limited suspension in the form of withdrawal of admitting and other related privileges until medical records are completed, shall be imposed by the Chief of Staff, or the Chief of Staff's designee, after notice of delinquency for failure to complete medical records within such period.

For the purpose of this Section, "related privileges" means voluntary on-call service for the emergency room, scheduling surgery, (including but not limited to all operating room procedures, all cardiac procedures, Bronchoscopy and GI procedures), assisting in surgery, consulting on hospital cases, and providing professional services within the hospital for future patients. Bone fide vacation or illness may constitute an excuse subject to approval by the Medical Executive Committee. Members whose privileges have been suspended for delinquent records may admit patients only in life-threatening situations. The suspension shall continue until lifted by the chief of staff or the chief of staff's designee.

6.3-4 FAILURE TO PAY DUES/ASSESSMENTS

Failure without good cause as determined by the Medical Executive Committee, to pay dues or assessments, as required under Section 13.2, shall be ground for automatic suspension of a member's clinical privileges, and if within six months after written warnings of the delinquency the member does not pay the required dues or assessments, the member's membership shall be automatically terminated.

6.3-5 PROFESSIONAL LIABILITY INSURANCE

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

6.3-6 FAILURE TO SATISFY SPECIAL ATTENDANCE REQUIREMENT

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

6.3-7 MEDICAL EXECUTIVE COMMITTEE DELIBERATION

As soon as practicable after action is taken or warranted as described in Section 6.3-1(b) or (c), Section 6.3-2, 6.3-3, 6.3-4, 6.3-5, or 6.3-6, the Medical Executive Committee shall convene to review and consider the facts, and may recommend such further corrective action as it may deem in accordance with these bylaws.

ARTICLE VII: HEARINGS AND APPELLATE REVIEWS

7.1 GENERAL PROVISIONS

7.1-1 EXHAUSTION OF REMEDIES

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

7.1-2 APPLICATION OF ARTICLE

For purposes of this Article, the term "member" may include "applicant," as it may be applicable under the circumstances, unless otherwise stated.

7.1-3 TIMELY COMPLETION OF PROCESS

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

7.1-4 FINAL ACTION

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

7.2 GROUNDS FOR HEARING

Except as otherwise specified in these bylaws, any one or more of the following actions or recommended actions shall be deemed actual or potential adverse action and constitute grounds for a hearing:

- (a) denial of medical staff membership
- (b) denial of requested advancement in staff membership status, or category;
- (c) denial of renewal of medical staff;
- (d) demotion to lower medical staff category or membership status;
- (e) suspension of staff membership;

- (f) revocation of medical staff membership;
- (g) denial of requested clinical privileges;
- (h) involuntary reduction of current clinical privileges;
- (i) suspension of clinical privileges;
- (j) termination of all clinical privileges; or
- (k) involuntary imposition of significant consultation or monitoring requirements (excluding monitoring incidental to provisional status and Section 5.3)
- (l) if the action or recommendation must be reported to the Medical Board of California.

7.3 REQUESTS FOR HEARING

7.3-1 NOTICE OF ACTION OR PROPOSED ACTION

In all cases in which action has been taken or a recommendation made as set forth in Section 7.2, the Chief of Staff or designee on behalf of the Medical Executive Committee shall give the member prompt written notice of (1) the recommendation or final proposed action and that such action, if adopted, shall be taken and reported to the Medical Board of California and/or to the National Practitioner Data Bank, if required; (2) the reasons for the proposed action including the acts or omissions with which the member is charged; (3) the right to request a hearing pursuant to Section 7.3-2, and that such hearing must be requested within 30 days; and (4) a summary of the rights granted in the hearing pursuant to the medical staff bylaws. If the recommendation or final proposed action is reportable to the Medical Board of California and/or to the National Practitioner Data Bank, the written notice shall state the proposed text of the report(s).

7.3-2 REQUEST FOR HEARING

The member shall have 30 days following receipt of notice of such action to request a hearing. The request shall be in writing addressed to the Medical Executive Committee with a copy to the Board of Directors. In the event the member does not request a hearing within the time and in the manner described, the member shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved.

7.3-3 TIME AND PLACE FOR HEARING

Upon receipt of a request for hearing, the Medical Executive Committee shall schedule a hearing and, within 15 days give notice to the member of the time, place and date of the hearing. Unless extended by the Judicial Review Committee, the date of the commencement of the hearing shall be not less than 30 days from the date of notice, nor more than 60 days from the date of receipt of the request by the Medical Executive Committee for a hearing; provided, however, that when the request is received from a member who is under summary suspension the hearing shall be held as soon as the arrangements may reasonably be made, so long as the member has at least 30 days from the date of notice to prepare for the hearing or waives this right.

7.3-4 NOTICE OF HEARING

Together with the notice stating the place, time and date of the hearing, which date shall not be less than 30 days after the date of the notice unless waived by a member under summary suspension, the Chief of Staff or designee on behalf of the Medical Executive Committee shall provide the reasons for the recommended action, including the acts or omissions with which the member is charged, a list of the charts in question, where applicable, and a list of the witnesses (if any) expected to testify at the hearing on behalf of the Medical Executive Committee. The content of this list is subject to update pursuant to Section 7.4-1.

7.3-5 JUDICIAL REVIEW COMMITTEE

When a hearing is requested, the Medical Executive shall recommend a Judicial Review Committee to the Board of Directors. The Board of Directors shall be deemed to approve the selection unless it provides written notice to the Medical Executive Committee stating the reasons for its objection within 5 days. The Judicial Review Committee shall be composed of not less than [5] members of the medical staff. The Judicial Review Committee members shall gain no direct financial benefit from the outcome, and shall not have acted as accusers, investigators, fact finders, initial decision makers or otherwise have not actively participated in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude a member of the medical staff from serving as a member of the Judicial Review Committee. In the event that it is not feasible to appoint a Judicial Review Committee from the active medical staff, the Medical Executive Committee may appoint members from other staff categories or practitioners who are not members of the medical staff. Such appointment shall include designation of the chair.

Membership on a Judicial Review Committee shall consist of one member who shall have the same healing arts licensure as the accused, and where feasible, include an individual practicing the same specialty as the member. All other members shall have MD or DO degrees or their equivalent as defined in Section 2.2-2(a).

7.3-6 FAILURE TO APPEAR OR PROCEED

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

7.3-7 POSTPONEMENTS AND EXTENSIONS

Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted in these bylaws may be permitted by the hearing officer on a showing of good cause, or upon agreement of the parties.

7.4 HEARING PROCEDURE

7.4-1 PREHEARING PROCEDURE

- (a) If either side to the hearing requests in writing a list of witnesses, within 15 days of such request and in no event less than 10 days before commencement of the hearing, each party shall furnish to the other a written list of the names and addresses of the individuals, so far as is reasonably known or anticipated, who are anticipated to give testimony or evidence in support of that party at the hearing. The member shall have the right to inspect and copy documents or other evidence upon which the charges are based, as well as all other evidence relevant to the charges. The member shall also have the right to receive at least 30 days prior to the hearing a copy of the evidence forming the basis of the charges which is reasonably necessary to enable the member to prepare a defense, including all evidence which was considered by the Medical Executive Committee in determining whether to proceed with the adverse action, and any exculpatory evidence in the possession of the hospital or medical staff. The member and the Medical Executive Committee shall have the right to receive all evidence, which will be made available to the Judicial Review Committee.
- (b) The Medical Executive Committee shall have the right to inspect and copy at its expense any documents or other evidence relevant to the charges which the member possesses or controls as soon as practicable after receiving the request.
- (c) The failure by either party to provide access to this information at least 30 days before the hearing shall constitute good cause for a continuance. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable members, other than the member under review.

- (d) The hearing officer shall consider and rule upon any request for access to information and may impose any safeguards the protection of the peer review process and justice requires. In so doing, the hearing officer shall consider:
 - (i) whether the information sought may be introduced to support or defend the charges:
 - (ii) the exculpatory or inculpatory nature of the information sought, if any:
 - (iii) the burden imposed on the party in possession of the information sought, if access is granted; and
 - (iv) any previous requests for access to information submitted or resisted by the parties to the same proceeding.
- (e) The member shall be entitled to a reasonable opportunity to question and challenge the impartiality of Judicial Review Committee members and the hearing officer. Challenges to the impartiality of any Judicial Review Committee member or the hearing officer shall be ruled on by the hearing officer.
- (f) It shall be the duty of the member and the Medical Executive Committee or its designee to exercise reasonable diligence in notifying the chair of the Judicial Review Committee of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any prehearing decisions may be succinctly made at the hearing.

7.4-2 REPRESENTATION

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

The member shall be entitled to representation by legal counsel in any phase of the hearing, if the member so chooses, and shall receive notice of the right to obtain representation by an attorney-at-law and such notice shall inform the member that he should be so represented. An attorney chosen by the Medical Executive Committee shall represent the Medical Executive Committee and the member shall be so informed. In the absence of legal counsel, the member shall be entitled to be accompanied by and represented at the hearing by an individual of the member's choosing who is not also an attorney-at-law, and the Medical Executive Committee shall appoint a representative who is not an attorney to present its action or recommendation, the materials in support thereof, examine witnesses, and respond to appropriate questions. An attorney-at-law shall not represent the Medical Executive Committee if the member is not so represented. If the member chooses to have legal representation, the Medical Executive Committee shall have legal representation.

7.4-3 THE HEARING OFFICER

The Medical Executive Committee shall recommend a Hearing Officer to the Board of Directors to preside at the hearing. The Board of Directors shall be deemed to approve the selection unless it provides written notice to the Medical Executive Committee stating the reasons for its objections within 5 days. The hearing officer shall be an attorney-at-law qualified to preside over a quasi-judicial hearing, but attorneys from a firm regularly utilized by the hospital, the medical staff or the involved medical staff member or applicant for membership, for legal advice regarding their affairs and activities shall not be eligible to serve as hearing officer. The hearing officer shall gain no direct financial benefit from the outcome and must not act as a prosecuting officer or as an advocate. The hearing officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The hearing officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions, which pertain to matters of law, procedure or the admissibility of evidence.

If the hearing officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the hearing officer may take such discretionary action as seems warranted by the circumstances. If requested by the Judicial Review Committee, the hearing officer may participate in the deliberations of such committee and be a legal advisor to it, but the hearing officer shall not be entitled to vote.

7.4-4 RECORD OF THE HEARING

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

7.4-5 RIGHTS OF THE PARTIES

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

7.4-6 MISCELLANEOUS RULES

Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under this Article. Any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The Judicial Review Committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate. At its discretion, the Judicial Review Committee may request or permit both sides to file written arguments. The hearing process shall be completed within a reasonable time after the notice of the action is received; unless the hearing officer issues a written decision that the member or the Medical Executive Committee failed to provide information in a reasonable time or consented to the delay.

7.4-7 BURDENS OF PRESENTING EVIDENCE AND PROOF

- (a) At the hearing the Medical Executive Committee shall have the initial duty to present evidence for each case or issue in support of its action or recommendation. The member shall be obligated to present evidence in response.
- (b) An applicant shall bear the burden of persuading the Judicial Review Committee, by a preponderance of the evidence, of the applicant's qualifications by producing information, which allows for adequate evaluation and resolution of reasonable doubts concerning the applicant's current qualifications for membership and privileges. An applicant shall not be permitted to introduce information requested by the medical staff but not produced during the application process unless the applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.
- (c) Except as provided above for applicants, throughout the hearing, the Medical Executive Committee shall bear the burden of persuading the Judicial Review Committee, by a preponderance of the evidence, that its action or recommendation is reasonable and warranted.

7.4-8 ADJOURNMENT AND CONCLUSION

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

7.4-9 BASIS FOR DECISION

The decision of the Judicial Review Committee shall be based on the evidence introduced at the hearing, including all logical and reasonable inferences from the evidence and the testimony. The decision of the Judicial Review Committee shall be subject to such rights of appeal as described in these bylaws, but shall otherwise be affirmed by the Board of Directors as the final action if it is supported by substantial evidence, following a fair procedure.

7.4-10 DECISION OF THE JUDICIAL REVIEW COMMITTEE

Within 30 days after final adjournment of the hearing, the Judicial Review Committee shall render a decision, which shall be accompanied by a report in writing and shall be delivered to the Medical Executive Committee. If the member is currently under suspension, however, the time for the decision and report shall be 15 days. A copy of said decision also shall be forwarded to the Administrator, the Board of Directors, and to the member. The report shall contain a concise statement of the reasons in support of the decision including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the conclusion reached. If the final proposed action adversely affects the clinical privileges of a physician or dentist for a period longer than 30 days and is based on competence or professional conduct, the decision shall state the action if adopted will be reported to the National Practitioner Data Bank, and shall state the text of the report as agreed upon by the committee. The decision shall also state whether the action, if adopted, shall be reported to the Medical Board of California and shall state the text of the report as agreed by the committee. Both the member and the Medical Executive Committee shall be provided a written explanation of the procedure for appealing the decision. The decision of the Judicial Review Committee shall be subject to such rights of appeal or review as described in these bylaws, but shall otherwise be affirmed by the Board of Directors as the final action if it is supported by substantial evidence, following a fair procedure.

7.5 APPEAL

7.5-1 TIME FOR APPEAL

Within 10 days after receipt of the decision of the Judicial Review Committee, either the member of the Medical Executive Committee may request an appellate review. A written request for such review shall be delivered to the Chief of Staff, the Administrator, and the other party in the hearing. If a request for appellate review is not requested within such period, that action or recommendation shall be affirmed by the Board of Directors as the final action if it is supported by substantial evidence, following a fair procedure.

7.5-2 GROUNDS FOR APPEAL

A written request for an appeal shall include an identification of the grounds for appeal and a clear and concise statement of the facts in support of the appeal. The grounds for appeal from the hearing shall be: (a) substantial non-compliance with the procedures required by these bylaws or applicable law which has created demonstrable prejudice; (b) the decision was not supported by substantial evidence based upon the hearing record or such additional information as may be permitted pursuant to Section 7.5-5; (c) the text of the report(s) to be filed with the Medical Board of California and/or the National Practitioner Data Bank is not accurate.

7.5-3 TIME, PLACE AND NOTICE

If an appellate review is to be conducted, the Appeal Board shall, within 15 days after receipt of notice of appeal, schedule a review date and cause each side to be given notice of the time, place and date of the appellate review. The date of appellate review shall not be less than 30 nor more than 60 days from the date of such notice, provided however, that when a request for appellate review concerns a member who is under suspension which is then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made, not to exceed 15 days from the date of the notice. The appeal board for good cause may extend the time for appellate review.

7.5-4 APPEAL BOARD

The Board of Directors shall appoint an Appeal Board which shall be composed of not less than 5 non physician members of the Board of Directors and two physicians in the active practice of medicine who are not involved in the case, and where feasible are members of the Board of Directors.

The members of the Appeal Board shall gain no direct financial benefit from the outcome, and shall not have acted as accuser, investigator, fact finder, initial decision maker or otherwise have actively participated in consideration of the matter leading up to the recommendation or the action. Knowledge of the matter involved shall not preclude any person from serving as a member of the appeal board, so long as that person did not take part in a prior hearing on the same matter. The Appeal Board may select an attorney to assist it in the proceeding, but that attorney shall not be entitled to vote with respect to the appeal. The attorney firm selected by the Board of Directors shall not be the attorney firm that represented either party at the hearing before the Judicial Review Committee.

7.5-5 APPEAL PROCEDURE

The proceeding by the Appeal Board shall be in the nature of an appellate hearing based upon the record of the hearing before the Judicial Review Committee, provided that the Appeal Board may accept additional oral or written evidence subject to a foundational showing that such evidence could not have been made available to the Judicial Review Committee in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the Judicial Review hearing; or the Appeal Board may remand the matter to the Judicial Review Committee for the taking of further evidence and for decision. Each party shall have the right to be represented by legal counsel, or any other representative designated by that party in connection with the appeal, to present a written statement in support of that party's position on appeal, and to personally appear and make oral argument. The Appeal Board may thereupon conduct, at a time convenient to itself, deliberations outside the presence of the appellant and respondent and their representatives. The Appeal Board shall present to the Board of Directors its written recommendations as to whether the Board of Directors should affirm, modify, or reverse the Judicial Review Committee decision consistent with the standard set forth in Section 7.5-6 or remand the matter to the Judicial Review Committee for further review and decision.

7.5-6 DECISION

- (a) Except as provided in Section 7.5-6(b), within 30 days after the conclusion of the appellate review proceedings, the Board of Directors shall render a final decision and shall affirm the decision of the Judicial Review Committee if the Judicial Review Committee's decision is supported by substantial evidence, following a fair procedure.
- (b) Should the Board of Directors determine that the Judicial Review Committee decision is not supported by substantial evidence, the board may modify or reverse the decision of the Judicial Review Committee and may instead, or shall, where a fair procedure has not been afforded, remand the matter to the Judicial Review Committee for reconsideration, stating the purpose for the referral.

- (c) If the matter is remanded to the Judicial Review Committee for further review and recommendation, the committee shall promptly conduct its review and make its recommendations to the Board of Directors. This further review and the time required to report back shall not exceed 30 days in duration except as the parties may otherwise agree or for good cause as jointly determined by the chair of the Board of Directors and the Judicial Review Committee.
- (d) The decision shall be in writing, shall specify the reasons for the action taken, shall include the text of the report which shall be made to the National Practitioner Data Bank and the Medical Board of California, if any, and shall be forwarded to the chief of staff, the Medical Executive Committee and clinical department, the subject of the hearing, and the Administrator, at least (10) days prior to submission to the MBC.

7.5-7 RIGHT TO ONE HEARING

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

7.6 EXCLUSIVE CONTRACTS EXCEPTIONS TO HEARING RIGHTS

7.6-1 APPROPRIATENESS OF EXCLUSIVE CONTRACTS

The Board of Directors shall make the final decision to close or continue closure of a department/service pursuant to an exclusive contract or the transfer of an exclusive contract, only following a review by the Medical Executive Committee of the related quality of care issues pursuant to Section 14.9 and a determination of the appropriateness of the closure, continued closure or transfer as set forth below.

Medical Executive Committee will provide a forum for medical staff members; administration and other interested parties to express their opinions about closure continued closure of a department/service or transfer of an exclusive contract.

A determination to close, continued closure of a department/service pursuant to an exclusive contract or transfer of an exclusive contract must be based upon the preponderance of the evidence, viewing the record as a whole, presented by any and all interested parties, following notice and opportunity for comment.

The Board of Directors' decision shall uphold the medical staff's determination unless the Board of Directors makes specific written findings that the medical staff's determination is arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law.

- (a) In making its recommendation regarding the need to close or continue closure of a department/service pursuant to an exclusive contract, or transfer such contract, the Medical Executive Committee's inquiry will include the following:
 - (1) Whether the concerns or problems with respect to the department/service can be resolved with a less restrictive alternative, or
 - (2) Whether closure or continued closure would facilitate supervision and training of the nurses and technical staff in the department/service, or
 - (3) Whether closure or continued closure is appropriate because of failure of cooperation or arbitrary or intractable conduct interfering with the provision of appropriate care or the proper functioning of the hospital or the medical staff.
 - (4) Whether closure or continued closure would result in better access and physician coverage within the department/service, or
 - (5) Whether closure or continued closure would simplify scheduling and/or provide more flexibility in scheduling within the department/service, or

- (6) Whether closure or continued closure would promote more efficient use of equipment or personnel within the department/service, or
- (7) Whether closure or continued closure would provide incidental benefits (e.g., medical education, research) to the department/service, or
- (8) An unreasonable refusal to contract with third party payers that imperils access to services or is detrimental to hospital finance.

A determination to close a department/service pursuant to an exclusive contract must be based upon the evidence presented by medical staff members, administration and other interested parties, following notice and opportunity for comment.

- (b) In the event that the Medical Executive Committee and Board of Directors disagree as to the closure or continued closure of a department/service pursuant to an exclusive contract; the matter shall be referred to the Joint Conference Committee prior to the Board of Directors making a final decision.
- (b) The fair hearing rights of Article VII shall not apply to a physician not previously on the medical staff whose application for medical staff membership and clinical privileges were denied because of the closure of a department/service pursuant to an exclusive contract.
- (e) Medical Staff membership and clinical privileges will not automatically terminate when an exclusive contract is terminated or when the subcontractor's relationship with the contracting physician or contract medical group is terminated. However, when an exclusive contract is terminated, the contracting physician or contracted medical group will: (I) cooperate and facilitate the transition of the exclusive service to the new contracting physician or contracting medical group; (ii) promptly vacate any hospital premises used in connection with the provision of the exclusive service; and (iii) subject to the exception set forth in Section 7.6.2(a) (1), no longer have access to the equipment, personnel and supplies used in providing the exclusive service.
- (f) Notwithstanding any contractual provision, the Article VI and VII procedural rights shall apply if the termination of Medical Staff membership or clinical privileges is for a medical disciplinary cause or reason and, therefore, reportable to the Medical Board of California in accordance with Section 805 of the Business and Professions Code.

7.6-2 PRIVILEGES

- (a) The following applies to departments/services not currently operated pursuant to an exclusive contract as of the effective date (November 1, 1995) of the adoption of these Bylaws:
 - (1) Current members of the medical staff with clinical privileges in an open department/service that is subsequently closed pursuant to an exclusive contract will be allowed to continue to exercise those privileges on a case-by-case basis in that specific hospital, only if the physician is specifically requested to provide services by a patient or member of the medical staff. This exception is campus specific, i.e., if the department/service at the other campus is currently operated pursuant to an exclusive contract, the member will not be permitted to exercise privileges on a case-by-case basis at the other campus with a closed department/service.
 - (2) The case-by-case exercise of privileges in a closed department/service by a non-contracted physician does not give the non-contracted physician access to the patients served by the contracted physician or contracted medical group.
 - (3) The subsequent closure of a department/service pursuant to an exclusive contract will not be grounds to suspend or terminate existing privileges of a current member of the medical staff.

- (4) The subsequent closure of a department/service pursuant to an exclusive contract will not be grounds to deny reappointment of clinical privileges of a current member of the medical staff.
 - (5) Regardless of any provision to the contrary, existing privileges of a member of the medical staff in a department or service on any campus that was operated on an open basis as of the effective date of these Bylaws will not be suspended or terminated, nor shall the Hospital by contract seek such suspension or termination, except for such cause and pursuant to such procedures as may be found in these Bylaws.
- (b) The following applies to departments/services currently operated pursuant to an exclusive contract as of the effective date (November 1, 1995) of the adoption of these Bylaws:
- (1) Departments/services currently operated pursuant to an exclusive contract as of the effective date of the adoption of these Medical Staff Bylaws shall have the authority to prohibit and/or restrict the award of clinical privileges and/or provision of services by a non-contracted physician or non-contracted medical group. This clause shall be campus specific as of the effective date of these Bylaws.
 - (2) Departments/services currently operated on an exclusive basis may define who shall be the regularly scheduled physicians.

7.6-3 AUTOMATIC SUSPENSION OR LIMITATION OF PRACTICE PRIVILEGES

No hearing is required when a member's license or legal credential to practice has been revoked, suspended or expired as set forth in Section 6.3-1(a). In other cases described in Sections 6.3-1(A) and 6.3-2, the issues which may be considered at a hearing, if requested, shall not include evidence designed to show that the determination by the licensing or credentialing authority or certifying authority was unwarranted, but only whether the member may continue practice in the hospital with those limitations imposed.

7.6-4 DEPARTMENT/SERVICE FORMATION OR ELIMINATION

The Board of Directors shall make the final decision to form or eliminate a department/service only following a review by the Medical Executive Committee. The Medical Executive Committee will make its recommendation based upon consideration of the effects on quality of care, economics and/or community. A determination to form or eliminate a department/service must be based upon the evidence, presented by medical staff members, administration and other interested parties, following notice and an opportunity to comment.

In the event that the Medical Executive Committee and Board of Directors disagree as to the formation or elimination of a department/service, the matter shall be referred to the Joint Conference Committee prior to the Board of Directors making a final decision.

7.7 EXPUNCTION OF DISCIPLINARY ACTION

Upon petition, the Medical Executive Committee, in its sole discretion, may expunge previous disciplinary action upon a showing of good cause or rehabilitation.

7.8 NATIONAL PRACTITIONER DATA BANK REPORTING

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

7.9 DISPUTING REPORT LANGUAGE

If no hearing was requested, a member who is the subject of a proposed adverse action report to the Medical Board of California or the National Practitioner Data Bank may request an informal meeting to dispute the text of the report filed. The report dispute meeting shall not constitute a hearing and shall be limited to the issue of whether the report filed is consistent with the final action issued. The subject of the report, the chief of staff, the chair of the subject's department, and the hospital's authorized representative, or their respective designees, shall attend the meeting.

If a hearing was held, the dispute process shall be deemed to have been completed.

ARTICLE VIII: OFFICERS

8.1 OFFICERS OF THE MEDICAL STAFF

8.1-1 IDENTIFICATION

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

8.1-2 QUALIFICATIONS

Officers must be members of the active medical staff at the time of their nominations and election, and must remain members in good standing during their term of office. Failure to maintain such status shall create a vacancy in the office involved. All officers must be licensed as physicians and surgeons, given the nature of their duties in office.

8.1-3 NOMINATIONS

The Chief of Staff-elect and Secretary/Treasurer shall be elected and seated every two years and the results of the election shall be announced at the annual meeting of the medical staff. Only members of the active staff shall be eligible to vote.

The Nominating Committee shall consist of the current Chief of Staff, the Immediate Past Chief of Staff, and a member elected by each clinical department (Anesthesiology, Emergency Medicine, Family Medicine, Internal Medicine, OB/GYN, Pathology, Pediatrics, Psychiatry, Radiological Health Sciences, and Surgery). The Immediate Past Chief of Staff shall serve as Chairman.

This committee shall nominate one or more members from the active category of the medical staff for the office of Chief of Staff-elect and Secretary/Treasurer.

The chairman shall prepare a slate of candidates composed of the nominees to be presented to the Secretary of the Staff no later than eight (8) weeks prior to the annual meeting in December. Additional nominations shall be made by petition in the following manner:

The nominee, who shall be a member in good standing of the active staff, shall indicate in writing his/her willingness to be a candidate on a signed petition of at least fifteen (15) members of the active staff. The petition shall then be presented to the Secretary of the Staff for validation no later than six (6) weeks prior to the December meeting. If the petition is validated by the Secretary, the nominee's name shall appear on the ballot as an additional candidate for that office.

The Secretary shall prepare and mail a complete list of nominees for medical staff office to all members of the active medical staff no later than seven (7) weeks prior to the December meeting. This notice shall quote the procedures to follow for making additional nominations for any office of the Medical Staff. (Article VIII, Section 8.1-3 Election of Officers).

The Secretary shall prepare a ballot indicating the candidates nominated by the Nominating Committee and those nominated by valid petition as described in Section 8.1-3 (b) of this Article. This ballot shall be mailed to all members of the active staff no later than four (4) weeks prior to the December meeting.

8.1-4 ELECTIONS

Voting shall be by secret written ballot, and authenticated sealed mailed ballots may be counted. Written ballots shall include handwritten signatures on the envelope for comparison with signatures on file, when necessary. A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate for the office receives a majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes. In the case of a tie on the second ballot, the majority vote of the Medical Executive Committee shall decide the election by secret written ballot at its next meeting or a special meeting called for that purpose.

8.1-5 TERM OF ELECTED OFFICE

Each officer shall serve a two-year term, commencing on the first day of the medical staff year following the election. Each officer shall serve in each office until the end of that officer's term, or until a successor is elected, unless that officer shall sooner resign or be removed from office. At the end of that officer's term, the Chief of Staff shall automatically assume the office of Immediate Past Chief of Staff and the Chief of Staff-elect shall automatically assume the office of Chief of Staff.

8.1-6 RECALL OF OFFICERS

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

8.1-7 VACANCIES IN ELECTED OFFICE

Vacancies in office occur upon the death or disability, resignation, or removal of the officer, or such officer's loss of membership in the medical staff. Vacancies, other than that of the Chief of Staff, shall be filled by appointment by the Medical Executive Committee until the next regular election. If there is a vacancy in the office of Chief of Staff, then the Chief of Staff-elect shall serve out that remaining term and shall immediately appoint an ad hoc Nominating Committee to decide promptly upon nominees for the office of Chief of Staff-elect. Such nominees shall be reported to the Medical Executive Committee and to the medical staff. A special election to fill the position shall occur at the next regular staff meeting.

If there is a vacancy in the office of Chief of Staff-elect, that office need not be filled by election, but the Medical Executive Committee shall appoint an interim officer to fill this office until the next regular election, at which time the election shall also include the office of Chief of Staff.

8.2 DUTIES OF 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 where corrective action has been requested or initiated;
- (b) serving as Chair of the Medical Executive Committee and calling, presiding at, and being responsible for the agenda of all meetings thereof;
- (c) serving as an ex-officio member of all other staff committees without vote, unless Chief of Staff membership in a particular committee is required by these bylaws;
- (d) interacting with the administrator and Board of Directors in all matters of mutual concern within the hospital;
- (e) appointing, in consultation with the Medical Executive Committee, committee members for all standing committees other than the Medical Executive Committee and all special medical staff, liaison, or multi-disciplinary committees, except where otherwise provided by these bylaws and, except where otherwise indicated, designating the chairs of these committees;
- (f) representing the views and policies of the medical staff to the Board of Directors at every board of directors meeting;
- (g) being a spokesperson for the medical staff in external professional and public relations;
- (h) performing such other functions as may be assigned to the Chief of Staff by these bylaws, the medical staff, or by the Medical Executive Committee;
- (i) serving on liaison committees with the Board of Directors and administration, as well as outside licensing or accreditation agencies;

8.2-2 CHIEF OF STAFF-ELECT

The Chief of Staff-elect assumes all duties and authority of the Chief of Staff in the absence of the Chief of Staff. The Chief of Staff-elect shall be a member of the Medical Executive Committee and of the Joint Conference Committee, shall attend and represent, at the direction of and in the absence of the chief of staff, the views and policies of the medical staff to the board of directors at every board of directors meeting and shall perform such other duties as the Chief of Staff may assign or as may be delegated by these bylaws, or by the Medical Executive Committee.

8.2-3 IMMEDIATE PAST CHIEF OF STAFF

The Immediate Past Chief of Staff shall be a member of the Medical Executive Committee and a member of the Joint Conference Committee and shall perform such other duties as may be assigned by the Chief of Staff or delegated by these bylaws, or by the Medical Executive Committee.

8.2-4 SECRETARY/TREASURER

The Secretary/Treasurer shall be a member of the Executive Committee. The duties shall include, but not be limited to:

- (a) maintaining a roster of members;
- (b) keeping accurate and complete minutes of all Medical Executive Committee and General Medical Staff meetings;
- (c) calling meetings on the order of the Chief of Staff or Medical Executive Committee;

- (d) attending to all appropriate correspondence and notices on behalf of the medical staff;
- (e) receiving and safeguarding all funds of the medical staff;
- (f) excusing absences from meetings on behalf of the Medical Executive Committee; and
- (g) performing such other duties as ordinarily pertain to the office or as may be assigned from time to time by the Chief of Staff or Medical Executive Committee.

8.3 COMPENSATION OF MEDICAL STAFF OFFICERS

Medical staff officers should be compensated for their work spent representing and leading the medical staff. Such compensation shall come from the medical staff bank account, for which the medical staff has sole responsibility. The payment to individual physicians should be in the amount determined by the MEC. If the hospital provides any funds specifically earmarked for such compensation, those funds should be requested and accounted for in the medical staff budget for hospital approval. Payment to each physician under this provision shall be contingent upon each physician's proper performance of those duties, and the evaluation and determination of the quality of that performance is in the sole determination of the MEC.

8.4 MEDICAL STAFF REPRESENTATIVES TO THE BOARD

On or before January 31st of each year, the Medical Staff shall nominate two (2) or more members of the Active staff to serve on standing committees of the Board of Directors. The nominees recommended by the Medical Staff shall agree in writing to comply with all applicable policies on Board committee appointment and shall be considered for (i) nomination by the Governance Committee and, if so nominated, (ii) appointment to a Board committee by the Hospital Board of Directors in accordance with the Bylaws of the Hospital. The Governance Committee shall within one year consider in good faith the nominees presented by the Medical Staff for appointment to the Board of Directors.

8.5 CMA OMSS Representative

The Chief of Staff shall appoint, with the concurrence of the Medical Executive Committee a physician member of the active medical staff to serve as CMA Organized Medical Staff Section representative [and alternate].

ARTICLE IX: CLINICAL DEPARTMENTS AND DIVISIONS

9.1 ORGANIZATION OF CLINICAL DEPARTMENTS AND DIVISIONS

The medical staff shall be organized into clinical departments. Each department shall be organized as a separate component of the medical staff and shall have a chair selected and entrusted with the authority, duties, and responsibilities specified in Section 9.6. A department may be further divided, as appropriate, into divisions which shall be directly responsible to the department within which it functions, and which shall have a division chief selected and entrusted with the authority, duties and responsibilities specified in Section 9.7. When appropriate, the Medical Executive Committee may recommend to the medical staff the creation, elimination, modification, or combination of departments or divisions.

9.2 CURRENT DEPARTMENTS AND DIVISIONS

The current departments and divisions are:

- a. Department of Anesthesiology
- b. Department of Emergency Medicine
- c. Department of Family Medicine
- d. Department of Internal Medicine

- Cardiology
- Physical Medicine & Rehabilitation
- e. Department of Obstetrics & Gynecology
- f. Department of Pathology
- g. Department of Pediatrics
 - Neonatal Intensive Care Unit (NICU)
- h. Department of Psychiatry
- i. Department of Radiological Health Sciences
- j. Department of Surgery
 - Cardiovascular

9.3 ASSIGNMENT TO DEPARTMENTS AND DIVISIONS

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

9.4 FUNCTIONS OF DEPARTMENTS

The general functions of each department shall include:

- (a) conducting patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care, treatment and services provided to patients within the department. The number of such reviews to be conducted during the year shall be as determined by the Medical Executive Committee in consultation with other appropriate committees. The department shall routinely collect information about important aspects of patient care provided in the department, periodically assess this information, and develop objective criteria for use in evaluating patient care. Patient care reviews shall include all clinical work performed under the jurisdiction of the department, regardless of whether the member whose work is subject to such review is a member of that department;
- (b) recommending to the Medical Executive Committee criteria for the granting of clinical privileges and the performance of specified services within the department;
- (c) evaluating and making appropriate recommendations regarding the qualifications of applicants seeking membership or renewal of membership and clinical privileges within that department;
- (d) conducting, participating and making recommendations regarding continuing education programs pertinent to departmental clinical practice;
- (e) reviewing and evaluating departmental adherence to: (1) medical staff policies and procedures and (2) sound principles of clinical practice;
- (f) coordinating patient care provided by the department's members with nursing and ancillary patient care services;
- (g) submitting written reports to the Medical Executive Committee concerning: (1) the department's review and evaluation activities, actions taken thereon, and the results of such action; and (2) recommendations for maintaining and improving the quality of care provided in the department and the hospital;
- (h) meeting at least quarterly for the purpose of considering patient care review findings and the results of the department's other review and evaluation activities, as well as reports on other department and staff functions;
- (i) establishing such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring protocols;

- (j) taking appropriate action when important problems in patient care and clinical performance or opportunities to improve care are identified;
- (k) accounting to the Medical Executive Committee for all professional and medical staff administrative activities within the department;
- (l) appointing such committees as may be necessary or appropriate to conduct department functions; and
- (m) formulating recommendations for departmental rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to the approval by the Medical Executive Committee and the medical staff.
- (n) collaboration with hospital wide clinical patient safety program
- (o) collaboration with hospital wide pain management program

9.5 FUNCTIONS OF DIVISIONS

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

9.6 DEPARTMENT CHAIR

9.6-1 QUALIFICATIONS

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

9.6-2 SELECTION

Department chairs and chairs-elect shall be elected every year by those members of the department who are eligible to vote for general officers of the medical staff, subject to the rules & regulations of each department. Election of department chairs and chair-elect shall be subject to ratification by the Medical Executive Committee. Vacancies due to any reason shall be filled for the un-expired term through special election by the respective department with such mechanisms as that department may adopt.

9.6-3 TERM OF OFFICE

Each department chair and chair-elect shall serve a one-year term, which coincides with the medical staff year or until their successors are chosen, unless they shall sooner resign, be removed from office, or lose their medical staff membership or clinical privileges in that department. Department officers shall be eligible to succeed themselves.

9.6-4 REMOVAL

After election and ratification, removal of department chairs and chairs-elect from office may occur for cause by a two-thirds vote of the Medical Executive Committee or two-thirds vote of the department members eligible to vote on departmental matters who cast votes.

9.6-5 DUTIES

Each chair shall have the following authority, duties and responsibilities, and the chair-elect, in the absence of the chair, shall assume all of them and shall otherwise perform such duties as may be assigned:

- (a) act as presiding officer at departmental meetings;

- (b) report to the Medical Executive Committee and to the Chief of Staff regarding all professional and administrative activities within the department;
- (c) generally monitor the quality of patient care and professional performance rendered by members with clinical privileges in the department through a planned and systematic process; oversee the care, treatment and services, evaluation, and monitoring functions delegated to the department by the Medical Executive Committee in coordination and integration with organization-wide quality assessment and improvement activities.
- (d) develop and implement departmental programs for retrospective patient care review, on-going monitoring of practice, credentials review and privilege delineation, medical education, utilization review, and quality assessment and improvement;
- (e) be a member of the Medical Executive Committee, and give guidance on the overall medical policies of the medical staff and hospital and make specific recommendations and suggestions regarding the department;
- (f) transmit to the Medical Executive Committee the department's recommendations concerning practitioner membership and classification, renewal of membership, criteria for clinical privileges, monitoring of care, treatment and services, and corrective action with respect to persons with clinical privileges in the department;
- (g) endeavor to enforce the medical staff bylaws, rules, policies and regulations within the department;
- (h) implement within the department appropriate actions taken by the Medical Executive Committee;
- (i) participate in every phase of administration of the department, including cooperation with the nursing service and the hospital administration in matters such as personnel, including assisting in determining the qualifications and competence of department/service personnel who are not licensed independent practitioners and who provide patient care services), supplies, special regulations, standing orders and techniques;
- (j) assist in the preparation of such annual reports, including budgetary planning, pertaining to the department as may be required by the Medical Staff Executive Committee;
- (k) recommend delineated clinical privileges for each member of the department; and
- (l) perform such other duties commensurate with the office as may from time to time be reasonably requested by the Chief of Staff or the Medical Executive Committee.
- (m) collaboration with hospital wide clinical patient safety program
- (n) collaboration with hospital wide pain management program

9.7 DIVISION CHIEFS

9.7-1 QUALIFICATIONS

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

9.7-2 SELECTION

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

9.7-3 TERM OF OFFICE

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

9.7-4 REMOVAL

After appointment and ratification, the department chair and the Medical Executive Committee may remove a division chief.

9.7-5 DUTIES

Each division chief shall:

- (a) act as presiding officer at division meetings;
- (b) assist in the development and implementation, in cooperation with the department chair, of programs to carry out the quality review, and evaluation and monitoring functions assigned to the division;
- (c) evaluate the clinical work performed in the division;
- (d) conduct investigations and submit reports and recommendations to the department chair regarding the clinical privileges to be exercised within the division by members of or applicants to the medical staff; and
- (e) perform such other duties commensurate with the office as may from time to time be reasonably requested by the department chair, the Chief of Staff, or the Medical Executive Committee.

ARTICLE X: COMMITTEES

10.1 DESIGNATION

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

10.2 GENERAL PROVISIONS

10.2-1 TERMS OF COMMITTEE MEMBERS

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

10.2-2 REMOVAL

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

10.2-3 VACANCIES

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

10.3 MEDICAL EXECUTIVE COMMITTEE

10.3-1 COMPOSITION

The Medical Executive Committee shall consist of the following persons:

- (a) the officers of the medical staff;
- (b) the department chairs and chairs-elect;
- (c) The medical staff representatives to the Board

The Chief Executive Officer (CEO) of the hospital or his or her designee attends each executive committee meeting on an ex-officio basis, without vote.

10.3-2 DUTIES

The duties of the Medical Executive Committee shall include, but not be limited to:

- (a) representing and acting on behalf of the medical staff in the intervals between medical staff meetings, subject to such limitations as may be imposed by these bylaws;
- (b) coordinating and implementing the professional and organizational activities and policies of the medical staff;
- (c) receiving and acting upon reports and recommendations from medical staff departments, divisions, committees, and assigned activity groups;
- (d) recommending actions to the Board of Directors on matters of a medical-administrative nature;
- (e) adopting policies regarding the structure of the medical staff, the mechanisms to review credentials and delineate individual clinical privileges, the granting of individual staff memberships and privileges, the organization of quality assessment and improvement activities and mechanisms of the medical staff, termination of medical staff membership and fair hearing procedures, needed changes to medical staff bylaws, and other matters relevant to the operation of an organized medical staff;
- (f) evaluating the care, treatment and services rendered to patients in the hospital;
- (g) participating in the development of all hospital policy, practice, and planning;
- (h) reviewing the qualifications, credentials, performance and professional competence, and character of applicants and staff members, and making recommendations to the Board of Directors regarding staff membership and renewal of membership, assignments to departments, clinical privileges, and corrective action;
- (i) taking reasonable steps to promote ethical conduct and competent clinical performance on the part of all members including the initiation of and participation in medical staff corrective or review measures when warranted;
- (j) taking reasonable steps to develop continuing education activities and programs for the medical staff;
- (k) designating such committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the medical staff and approving or rejecting appointments to those committees by the chief of staff;
- (l) reporting to the medical staff at each regular staff meeting;
- (m) assisting in the obtaining and maintenance of accreditation;
- (n) developing and maintenance of methods for the protection and care of patients and others in the event of internal or external disaster;
- (o) appointing such special or ad hoc committees as may seem necessary or appropriate to assist the Medical Executive Committee in carrying out its functions and those of the medical staff;
- (p) reviewing the quality and appropriateness of services provided by contract physicians,
- (q) reviewing and approving the designation of the hospital's authorized representative for National practitioner Data Bank purposes, and
- (r) establishing a mechanism for dispute resolution between medical staff members (including limited license practitioners) involving the care of a patient

- (s) overseeing the collaboration and participation of the medical staff in the hospital-wide performance improvement program, patient safety and pain management programs.
- (t) providing members of the medical staff with the right to request ability to speak to the Medical Executive Committee about any issue subject to the granting of the floor by the Chief of Staff. This shall be duly noted as, "Request the privilege of the floor."
- (u) affirmatively implementing, enforcing and safeguarding the self-governance rights of the medical staff to the fullest extent permitted by law, such rights of the medical staff including but not limited to the following:ⁱⁱ
 - ~~(i)~~(1) initiating, developing and adopting medical staff bylaws, rules and regulations, and amendments thereto, subject to the approval of the hospital governing board, which approval shall not be unreasonably withheld;ⁱⁱⁱ
 - ~~(ii)~~(2) selecting and removing medical staff officers;^{iv}
 - ~~(iii)~~(3) assessing medical staff dues and utilizing the medical staff dues as appropriate for the purposes of the medical staff;^v
 - ~~(iv)~~(4) the ability to retain and be represented by independent legal counsel at the expense of the medical staff;^{vi}
 - (5) establishing, in medical staff bylaws, rules or regulations, criteria and standards for medical staff membership and privileges, and for enforcing those criteria and standards;
 - ~~(v)~~(6) establishing in medical staff bylaws, rules or regulations, clinical criteria and standards to oversee and manage quality assurance, utilization review and other medical staff activities including, but not limited to, periodic meetings of the medical staff and its committees and departments and review and analysis of patient medical records;^{vii}
 - ~~(vi)~~(7) taking such action as appropriate to enforce Section 14.10 of these bylaws regarding the prohibition against retaliation directed towards a member.^{viii}
- (v) taking such other steps as appropriate to meet and confer in good faith to resolve disputes with the governing body, or any other person or entity, regarding any self-governance rights of the medical staff.^{ix}
- (w) after having met and conferred in good faith to remedy any dispute under subsection(s)^x of this section, exercising its discretion as appropriate to resolve the dispute, up to and including resort to resolution of the matter in the courts as permitted by law.
- (x) reviewing the job description (e.g. qualifications, responsibilities, and reporting relationships) of medical directorships in the hospital both to assure their adequacy for medical staff purposes, and to avoid a conflict of duties between the medical director and any medical staff leader;
- (y) participating in the interview and review of candidates for position of any medical director in the hospital,
- (z) reviewing the performance of the hospital's medical directors periodically and transmitting the results of that review to the hospital board for its consideration.

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10.3-3 MEETINGS

The Executive Committee shall meet as often as necessary, but at least a minimum of ten times per year and shall maintain a record of its proceedings and actions. The administrator or designee shall be invited to attend all meetings in a non-voting capacity.

10.4 JOINT CONFERENCE COMMITTEE

10.4-1 COMPOSITION

The Joint Conference Committee shall be composed of an equal number of members of the Board of Directors and of the Medical Executive Committee, but the medical staff members shall at least include the Chief of Staff, the Chief of Staff-elect, and the Immediate Past Chief of Staff. The administrator shall be a non-voting ex-officio member. The chairmanship of the committee shall alternate yearly between the Board of Directors and the Medical Staff.

10.4-2 DUTIES

The Joint Conference Committee shall constitute a forum for the discussion of matters of hospital and medical staff policy, practice, and planning, and the exclusive forum for interaction between the Board of Directors and the medical staff on such matters as may be referred by the Medical Executive Committee or the Board of Directors. The joint conference committee shall serve as the body to handle medical staff and board of directors' disputes, and shall meet and confer in good faith to resolve such disputes. The Joint Conference Committee shall exercise any other responsibilities set forth in these bylaws.

10.4-3 MEETINGS

The Joint Conference Committee shall meet on the call by the Medical Executive Committee or the Board of Directors, and shall transmit written reports of its activities to the Executive Committee and to the Board of Directors.

10.5 PHARMACY AND THERAPEUTICS COMMITTEE

10.5-1 COMPOSITION

The Pharmacy and Therapeutics Committee shall consist of at least five representatives from the medical staff, a voting representative from the pharmaceutical service, and a non-voting representative from the nursing service and hospital administration.

10.5-2 DUTIES

The duties of the Pharmacy and Therapeutics Committee shall include:

- (a) assisting in the formulation of professional practices and policies regarding the continuing evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs in the hospital, including antibiotic usage;
- (b) advising the medical staff and the pharmaceutical service on matters pertaining to the choice of available drugs;
- (c) making recommendations concerning drugs to be stocked on the nursing unit floors and by other services;
- (d) periodically developing and reviewing a formulary or drug list for use in the hospital;
- (e) evaluating clinical data concerning new drugs or preparations requested for use in the hospital;
- (f) establishing standards concerning the use and control of investigational drugs and of research in the use of recognized drugs;
- (g) maintaining a record of all activities relating to pharmacy and therapeutics functions and submitting periodic reports and recommendations to the Medical Executive Committee concerning those activities;
- (h) reviewing untoward drug reactions.

10.5-3 MEETINGS

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

10.6 INFECTION CONTROL COMMITTEE

10.6-1 COMPOSITION

The Infection Control Committee shall consist of at least three (3) members including representatives from the departments of medicine, surgery, obstetrics/gynecology, pediatrics, pathology, nursing service, administration, and an individual employed in a surveillance or epidemiological capacity. It may include non-voting consultants in microbiology and non-voting representatives from relevant hospital services.

10.6-2 DUTIES

The duties of the Infection Control Committee shall include:

- (a) developing a hospital-wide infection control program and maintaining surveillance over the program;
- (b) developing a system for reporting, identifying and analyzing the incidence and cause of nosocomial infections, including assignment of responsibility for the ongoing collection and analytic review of such data, and follow-up activities;
- (c) developing and implementing a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing and evaluating aseptic, isolation and sanitation techniques;
- (d) developing written policies defining special indications for isolation requirements;
- (e) coordinating action on findings from the medical staff's review of the clinical use of antibiotics;
- (f) acting upon recommendations related to infection control received from the chief of staff, the Medical Executive Committee, departments and other committees; and
- (g) reviewing sensitivities of organisms specific to the facility.

10.6-3 MEETINGS

The Infection Control Committee shall meet as often as necessary at the call of its chair but at least quarterly. It shall maintain a record of its proceedings and shall submit reports of its activities and recommendations to the Medical Executive Committee.

10.7 BYLAWS COMMITTEE

10.7-1 COMPOSITION

The Bylaws Committee shall consist of at least five members of the medical staff, including at least the Chief of Staff-elect and Immediate Past Chief of Staff.

10.7-2 DUTIES

The duties of the Bylaws Committee shall include:

- (a) conducting an annual review of the medical staff bylaws, as well as the rules and regulations, policies and forms promulgated by the medical staff, its departments and divisions;
- (b) submitting recommendations to the Medical Executive Committee for changes in these documents as necessary to reflect current medical staff practices; and
- (c) receiving and evaluating for recommendation to the Medical Executive Committee suggestions for modification of the items specified in subdivision (a), and
- (d) reviewing the hospital bylaws and policies for inconsistencies and conflicts with medical staff documents and reporting issues and recommendations to the medical executive committee for its review.

10.7-3 MEETINGS

The Bylaws Committee shall meet as often as necessary at the call of its chair but at least annually. It shall maintain a record of its proceedings and shall report its activities and recommendations to the Medical Executive Committee.

10.8 QUALITY ASSESSMENT, UTILIZATION REVIEW AND CLINICAL OUTCOME AND IMPROVEMENT COMMITTEE

10.8-1 COMPOSITION

The Quality Assessment, Utilization Review and Clinical Outcome Improvement Committee shall consist of such members as may be designated by the Medical Executive Committee including, insofar as possible, at least one representative from each clinical department, from the nursing service and from administration.

10.8-2 DUTIES

The Quality Assessment and Improvement Committee shall perform the following duties:

- (a) recommend for approval of the Medical Executive Committee plans for maintaining quality patient care within the hospital. These may include mechanisms to:
 - (1) establish systems to identify potential issues in patient care;
 - (2) prioritizing quality improvement initiatives;
 - (3) refer priority problems for assessment and corrective action to appropriate departments or committees;
 - (4) monitor the results of quality assessment and improvement activities throughout the hospital; and
 - (5) coordinate quality assessment and improvement activities.
- (6) Comply with the utilization review function of the Medical Staff, subject to the direction of the Medical Executive Committee.
- (b) Promote evidence based medical practice and measurement of clinical outcomes.
- (c) Submit regular confidential reports to the Medical Executive Committee on the quality of medical care provided and on quality assessment and improvement activities conducted.

10.8-3 MEETINGS

The committee shall meet as often as necessary at the call of its chair, but at least a minimum of ten. It shall maintain a record of its proceedings and report its activities and recommendations to the Medical Executive Committee and Board of Directors on a regular basis, except that routine reports to the Board shall not include peer evaluations related to individual members.

10.9 PHYSICIANS' ADVISORY COMMITTEE

10.9-1 COMPOSITION

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

10.9-2 DUTIES

The Physicians' Advisory 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 also. With respect to matters involving individual medical staff members, the committee may, on a voluntary basis, provide such advice, counseling, or referrals as may seem appropriate. Such activities shall be confidential; however, in the event information received by the committee clearly demonstrates that the health or known impairment of a medical staff member poses an unreasonable risk of harm to patients, that information may be referred for corrective action. The committee shall also consider general matters related to the health and well being of the medical staff and, with the approval of the Executive Committee, develop educational programs or related activities.

10.9-3 MEETINGS

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

10.10 ETHICS COMMITTEE

10.10-1 COMPOSITION

The Ethics Committee shall consist of physicians and such other staff members, as the Medical Executive Committee may deem appropriate. It may include nurses, lay representatives, social workers, clergy, ethicists, attorneys, administrators and representatives from the Board of Directors, although a majority shall be physician members of the medical staff.

10.10-2 DUTIES

The Ethics Committee may participate in development of guidelines for consideration of cases having ethical implications; development and implementation of procedures for the review of such cases; development and/or review of institutional policies regarding care and treatment of such cases; retrospective review of cases for the evaluation of bioethical policies; consultation

with concerned parties to facilitate communication and aid conflict resolution; and education of the hospital staff on ethical matters. This committee is strictly of advisory nature.

10.10-3 MEETINGS

The committee shall meet quarterly and as often as necessary at the call of its chair. It shall maintain a record of its activities and report to the Medical Executive Committee.

10.11 COMMITTEE ON INTERDISCIPLINARY PRACTICE

10.11-1 COMPOSITION

The Committee on Interdisciplinary Practice (CIDP) shall consist of, at a minimum, the Vice president of Patient Care Services, the administrator or designee, and an equal number of physicians appointed by the Medical Executive Committee and registered nurses appointed by the Vice President of Patient Care Services. Licensed or certified health professionals other than registered nurses who perform functions requiring standardized procedures shall be included in the committee. The chair of the committee shall be a physician member of the active medical staff appointed by the Medical Executive Committee.

10.11-2 DUTIES

The CIDP shall perform functions consistent with the requirements of law and regulation. The CIDP shall routinely report to the Board of Directors through the Medical Executive Committee and, in addition, shall submit an annual report directly to the Board of Directors and the Medical Executive Committee.

10.11-3 MEETINGS

The CIDP shall meet at the call of the chair at such intervals as the chair or the Medical Executive Committee may deem appropriate.

10.12 CONTINUING MEDICAL EDUCATION COMMITTEE

10.12-1 COMPOSITION

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

10.12-2 DUTIES

The Continuing Medical Education Committee shall perform the following duties:

- (a) plan, implement, coordinate and promote ongoing special clinical and scientific programs for the medical staff. This includes:
 - (1) identifying the educational needs of the medical staff;
 - (2) formulating clear statements of objectives for each program;
 - (3) assessing the effectiveness of each program;
 - (4) choosing appropriate teaching methods and knowledgeable faculty for each program; and
 - (5) documenting staff attendance at each program
 - (6) overseeing the activities of the medical library
- (b) assist in developing processes to assure optimal patient care and contribute to the continuing education of each practitioner
- (c) establish liaison with the quality assessment and improvement program of the hospital in order to be apprised of problem areas in patient care, which may be addressed by a specific continuing medical education activity.
- (d) maintain close liaison with other hospital medical staff and department committees concerned with patient care.
- (e) make recommendations to the Medical Executive Committee regarding library needs of the medical staff.
- (f) advise administration of the financial needs of the continuing medical education program.

10.12-3 MEETINGS

The Committee shall meet as often as necessary, but at least quarterly. It shall maintain minutes of the program planning discussions and report to the Medical Executive Committee.

10.13 CANCER COMMITTEE

10.13-1 COMPOSITION

The Cancer Committee shall include representatives from Oncology, Surgery, Radiology, Urology, Pediatrics, Gynecology, Hematology-Oncology, Pathology, Family Practice, Nursing, Social Services, Administration, Rehabilitation (Physical Medicine), Hospice, Pharmacy, Nutrition, Quality Improvement and the Cancer Registry.

10.13-2 DUTIES

The Cancer Committee shall establish procedures and reporting mechanisms that ensure:

- (1) Planning, initiation evaluation, implementation of all cancer related activities;
- (2) Organize, publicize, conduct and evaluate regular educational and consultative cancer conferences that are multidisciplinary, patient oriented and institution-wide;
- (3) Completion of minimum of two patient care evaluation studies annually;
- (4) Insure consultative services from all major disciplines are available for patients;
- (5) Insure cancer rehabilitation services are available and implemented;
- (6) Implement a supportive care system for all patients with cancer:

- (7) Document the policy-advisory function on a quarterly basis;
- (8) Insure the cancer conferences include major cancer sites yearly and are primarily patient oriented and prospective and;
- (9) Ensure consultative services are available to patients with cancer through multidisciplinary physician attendance at conferences.

10.13-3 MEETINGS

The Cancer Committee shall meet as often as necessary but not less than quarterly and shall report its recommendations and findings to the Medical Executive Committee.

10.14 STRATEGIC PLANNING COMMITTEE

The Strategic Planning Committee is the advisory arm of the Medical Executive Committee. It is committed to the development and implementation of quality patient care and patient safety throughout the organization.

The Strategic Planning Chair is to be appointed by the Chief of Staff and membership of the committee shall be composed of the Chief of Staff, Chief of Staff Elect, Immediate Past Chief and additional members shall, in collaboration with the Chief of Staff and the CVHP CEO determine committee membership.

ARTICLE XI: MEETINGS

11.1 MEETINGS

11.1-1 ANNUAL MEETING

There shall be an annual meeting of the medical staff. The Chief of Staff, or such other officers, department or decision heads, or committee chairs the Chief of Staff or Medical Executive Committee may designate, shall present reports on actions taken during the preceding year and on other matters of interest and importance to the members. Notice of this meeting shall be given to the members at least 15 days prior to the meeting.

11.1-2 REGULAR MEETINGS

Regular meetings of the members shall be held each quarter, except that the annual meeting shall constitute the regular meeting during the quarter in which it occurs. The Medical Executive Committee shall determine the date; place and time of the regular meetings, and adequate notice shall be given to the members.

11.1-3 AGENDA

The Chief of Staff and Medical Executive Committee shall determine the order of business at a meeting of the medical staff. The agenda shall include, insofar as feasible:

- (a) reading and acceptance of the minutes of the last regular and all special meetings held since the last regular meeting;
- (b) administrative reports from the Chief of Staff, departments, and committees, and the administrator;
- (c) election of officers when required by these bylaws;
- (d) reports by responsible officers, committees and departments on the overall results of patient care audits and other quality review, evaluation, and monitoring activities of the staff and on the fulfillment of other required staff functions;
- (e) old business, and
- (f) new business.

11.1-4 SPECIAL MEETINGS

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

11.2 COMMITTEE AND DEPARTMENT MEETINGS

11.2-1 REGULAR MEETINGS

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

11.2-2 SPECIAL MEETINGS

A special meeting of any medical staff committee, department or division may be called by the chair thereof, the Medical Executive Committee, or the Chief of Staff, and shall be called by written request of 25% of the current members, eligible to vote, but not less than five members.

11.3 QUORUM

11.3-1 STAFF MEETINGS

The presence of 25% of the total members of the active medical staff at any regular or special meeting in person or through written ballot shall constitute a quorum for the purpose of amending these bylaws or the rules and regulations of the medical staff or for the election or removal of medical staff officers. The presence of 25% of such members shall constitute a quorum for all other actions.

11.3-2 DEPARTMENT AND COMMITTEE MEETINGS

A quorum of 50% of the voting members shall be required for Medical Executive meetings. For other committees, a quorum shall consist of two of the voting members of a committee and the chair but in no event less than two voting members.

11.4 VOTING AND MANNER OF ACTION

11.4-1 VOTING

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

11.4-2 MANNER OF ACTION

Except as otherwise specified, the actions of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be specifically required by these bylaws. Committee action may be conducted by telephone conference, which shall be deemed to constitute a meeting for the matters discussed in that telephone conference. A committee may take valid action without a meeting if it is acknowledged by a writing setting forth the action so taken which is signed by at least 50% of the members entitled to vote.

11.5 MINUTES

Except as otherwise specified herein, minutes of meetings shall be prepared and retained. They shall include, at a minimum, a record of the attendance of members and the vote taken on significant matters. A copy of the minutes shall be signed by the presiding officer of the meeting and forwarded to the Medical Executive Committee.

11.6 ATTENDANCE REQUIREMENTS

11.6-1 REGULAR ATTENDANCE

Except as stated below, each member of the Active and Provisional Staff shall regularly attend:

- (a) The Annual Medical Staff meeting;
- (b) Staff meetings duly convened pursuant to these bylaws; and
- (c) Meetings to which the member is assigned.

Each member of the Temporary, Consulting or Courtesy staff and members of the Provisional Staff who qualify under criteria applicable to Courtesy or Consulting members shall be required to attend such meetings as may be determined by the Medical Executive Committee. Temporary members of the medical staff under Section 6.1-3 are excluded from meetings requirements.

11.6-2 SPECIAL ATTENDANCE

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

11.7 CONDUCT OF MEETINGS

Unless otherwise specified, meetings shall be conducted according to Sturgis Standard Code of Parliamentary Procedure however; technical or non-substantive departures from such rules shall not invalidate action taken at such a meeting.

11.8 EXECUTIVE SESSION

Executive session is a meeting of a medical staff committee, department, or division, or of the medical staff as a whole which only voting medical staff members selected by the chair and ratified by the voting members of the department, who are not also employed by the hospital may attend, unless others are expressly requested by the member presiding at the meeting to attend. Executive session may be called by the presiding member at the request of any medical staff committee member, and shall be called by the presiding member pursuant to a duly adopted motion. Executive session may be called to discuss peer review issues, personnel issues, or any other sensitive issues requiring confidentiality. Any individual who is the subject of the Executive Session may be excused.

ARTICLE XII: CONFIDENTIALITY, IMMUNITY AND RELEASES

12.1 AUTHORIZATION AND CONDITIONS

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

- (a) authorizes representatives of the hospital and the medical staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the applicant's professional ability and qualifications;
- (b) authorizes persons and organizations to provide information concerning such practitioner to the medical staff;
- (c) agrees to be bound by the provisions of this Article and to waive all legal claims against any representative of the medical staff or the hospital who would be immune from liability under Section 13.3 of this Article; and
- (d) acknowledges that the provisions of this Article are express conditions to an application for medical staff membership, the continuation of such membership, and to the exercise of privileges at this hospital.

12.2 CONFIDENTIALITY OF INFORMATION

12.2-1 GENERAL

Records and proceedings of all medical staff committees having the responsibility of evaluation and improvement of quality of care rendered in this hospital, including, but not limited to, meetings of the medical staff meeting as a committee of the whole, meetings of departments and divisions, meetings of committees established under Section XI, and meetings of special or ad hoc committees created by the MEC or by departments and including information regarding any member or applicant to this medical staff shall, to the fullest extent permitted by laws, be confidential.

12.2-2 BREACH OF CONFIDENTIALITY

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

12.3 IMMUNITY FROM LIABILITY

12.3-1 FOR ACTION TAKEN

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

12.3-2 FOR PROVIDING INFORMATION

Each representative of the medical staff and hospital and all third parties shall be immune, to the fullest extent permitted by law, from liability to an applicant or member for damages or other relief by reason of providing information to a representative of the medical staff or hospital concerning such person who is, or has been, an applicant to or member of the staff or who did, or does, exercise clinical privileges or provide services at this hospital.

12.4 ACTIVITIES AND INFORMATION COVERED

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

- (a) application for membership, renewal of membership, or clinical privileges;
- (b) corrective action;
- (c) hearings and appellate reviews;
- (d) utilization reviews;
- (e) other department, or division, committee, or medical staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and
- (f) queries and reports concerning the National Practitioner Data Bank, peer review organization, MBC and similar queries and reports.

12.5 RELEASES

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

12.6 INDEMNIFICATION

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

ARTICLE XIII: GENERAL PROVISIONS

13.1 RULES AND REGULATIONS

Upon the request of (1) the Medical Executive Committee, or the Chief of Staff or the Bylaws Committee after approval by the Medical Executive Committee, or (2) upon timely written petition signed by at least 10% of the members of the medical staff in good standing who are entitled to vote, consideration shall be given to the adoption, amendment, or repeal of the Medical Staff rules and regulations.

The medical staff shall initiate and adopt such rules and regulations, as it may deem necessary for the proper conduct of its work and shall periodically review and revise its rules and regulations to comply with current medical staff practice. Recommended changes to the rules and regulations shall be submitted to the Medical Executive Committee for review and evaluation prior to presentation for consideration by the medical staff as a whole under such review or approval mechanism as the medical staff shall establish.

Following adoption such rules and regulations shall become effective upon approval of the Board of Directors, which approval shall not be withheld unreasonably or automatically after 120 days if no action is taken by the Board of Directors. In the latter event, the Board of Directors shall be deemed to have approved the rule(s) and regulation(s) adopted by the medical staff. Rules and regulations shall be reviewed and may be revised if necessary, every two years.

Applicants and members of the medical staff shall be governed by such rules and regulations as are properly initiated and adopted. If there is a conflict between the bylaws and the rules and regulations, the bylaws shall prevail. The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the medical staff rules and regulations.

13.2 DUES OR ASSESSMENTS

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

13.2-1 MEDICAL STAFF FUNDS

Medical Staff funds, regardless from what source (i.e., medical staff dues, hospital funds) shall be under the sole control of the Medical Staff.

13.2-2 HOSPITAL-PROVIDED FUNDS DEPOSITED TO THE MEDICAL STAFF FUND

Funds shall be deposited into the Medical Staff account from the hospital to assure the medical staff the financial ability to solely administer those functions required under the bylaws.

13.3 AUTHORITY TO ACT

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

13.4 DIVISION OF FEES

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

13.5 NOTICES

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

1. Name and proper title of addressee, if known or applicable
Name of department, division or committee
c/o Medical Staff Services Director, Chief of Staff
Citrus Valley Medical Center - Inter-Community Campus
210 W. San Bernardino Road
Covina, CA 91723

2. Name and proper title of addressee, if known or applicable
Name of department, division or committee
c/o Medical Staff Services Director, Chief of Staff
Citrus Valley Medical Center - Queen of the Valley Campus
1115 So. Sunset Avenue
West Covina, CA 91790

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

13.6 DISCLOSURE OF INTEREST

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

13.7 NOMINATION OF MEDICAL STAFF REPRESENTATIVES

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

13.8 MEDICAL STAFF CREDENTIALS FILES

13.8-1 INSERTION OF ADVERSE INFORMATION

The following applies to actions relating to requests for insertion of adverse information into the medical staff member's credentials file:

- (a) As stated previously, in Section 6.1-1, any person may provide information to the medical staff about the conduct, performance or competence of its members.
- (b) When a request is made for insertion of adverse information into the medical staff member's credentials file, the respective department chair and Chief of Staff shall review such a request.
- (c) After such a review a decision will be made by the respective department chair and Chief of Staff to:
 - (1) not insert the information;
 - (2) notify the member of the adverse information by a written summary and offer the opportunity to rebut this assertion before it is entered into the member's file; or
 - (3) insert the information along with a notation that a request has been made to the MEC for an investigation as outlined in Section 6.1-2 of these bylaws.
- (d) This decision shall be reported to the MEC. The MEC, when so informed, may either ratify or initiate contrary actions to this decision by a majority vote.

13.8-2 REVIEW OF ADVERSE INFORMATION AT THE TIME OF REAPPRAISAL AND RENEWAL OF MEMBERSHIP

The following applies to the review of adverse information in the medical staff member's credentials file at the time of reappraisal and renewal of membership.

- (a) Prior to recommendation on renewal of membership, the Clinical Department, as part of its reappraisal function, shall review any adverse information in the credentials file pertaining to a member.
- (b) Following this review, the Clinical Department shall determine whether documentation in the file warrants further action.
- (c) With respect to such adverse information, if it does not appear that an investigation and/or adverse action on renewal of membership are warranted, the Clinical Department shall so inform the MEC.
- (d) However, if an investigation and/or adverse action on renewal of membership are warranted, the Clinical Department shall so inform the MEC.
- (e) No later than 60 days following final action on renewal of membership, the MEC shall, except as provided in (g):
 - (1) initiate a request for corrective action, based on such adverse information and on the Clinical Department's recommendation relating thereto, or
 - (2) cause the substance of such adverse information to be summarized and disclosed to the member.
- (f) The member shall have the right to respond thereto in writing, and the MEC may elect to remove such adverse information on the basis of such response.
- (g) In the event that adverse information is not utilized as the basis for a request for corrective action, or disclosed to the member as provided herein, it shall be removed from the file and discarded, unless the Medical Executive Committee, by a majority vote, determines that such information is required for continuing evaluation of the member's:
 - 1. character;
 - 2. competence; or
 - 3. professional performance

13.8-3 CONFIDENTIALITY

The following applies to records of the medical staff and its departments and committees responsible for the evaluation and improvement of patient care:

- (a) The records of the medical staff and its departments and committees responsible for the evaluation and improvement of the quality of patient care rendered in the hospital shall be maintained as confidential.
- (b) Access to such 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.
- (c) Information which is disclosed to the governing body of the hospital or its appointed representatives -- in order that the governing body may discharge its lawful obligations and responsibilities -- shall be maintained by that body as confidential.
- (d) Information contained in the credentials file of any member may be disclosed with the member's consent, or at any medical staff or professional licensing board, or as required by law. However, any disclosure outside of the medical staff shall require the authorization of the Chief of Staff and the concerned Department Chair and notice to the member.
- (e) A medical staff member shall be granted access to the individual's credentials file, subject to the following provisions:
 - (1) timely notice of such shall be made by the member to the chief of staff or the chief of staff's designee;

- (2) the member may review, and receive a copy of, only those documents provided by or addressed personally to the member. A summary of all other information -- including peer review committee findings, letters of reference, proctoring reports, complaints, etc. -- shall be provided to the member, in writing, by the designated officer of the medical staff, within a reasonable period of time, as determined by the medical staff. Such summary shall disclose the substance, but not the source, of the information summarized;
- (3) the review by the member shall take place in the Medical Staff Office, during normal work hours, with an officer or designee of the medical staff present.
- (f) In the event a Notice of action or proposed action is filed against a member, Section 7.4-1 shall govern access to that member's credentials file.

13.8-4 MEMBER'S OPPORTUNITY TO REQUEST CORRECTION/DELETION OF AND TO MAKE ADDITION TO INFORMATION IN FILE

- (a) After review of the file as provided under Section 14.8-3(e) the member may address to the Chief of Staff a written request for correction or deletion of information in the credentials file. Such request shall include a statement of the basis for the action requested.
- (b) The Chief of Staff shall review such a request within a reasonable time and shall recommend to the MEC, after such review, whether or not to make the correction or deletion requested. The MEC, when so informed, shall either ratify or initiate action contrary to this recommendation, by a majority vote.
- (c) The member shall be notified promptly, in writing, of the decision of the MEC.
- (d) In any case, a member shall have the right to add to the individual's credentials file, upon written request to the MEC, a statement responding to any information contained in the file.

13.9 MEDICAL STAFF ROLE IN EXCLUSIVE CONTRACTING

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

- (a) the decision to execute an exclusive contract in a previously open department or service;
- (b) the decision to renew or modify an exclusive contract in a particular department or service;
- (c) the decision to terminate an exclusive contract in a particular department or service.

13.10 RETALIATION PROHIBITED

- (a) Neither the medical staff, its members, committees or department Chairs, the Board of Directors, its Chief Administrative Officer, or any other employee or agent of the hospital or medical staff, may engage in any punitive or retaliatory action against any member of the medical staff because that member claims a right or privilege afforded by, or seeks implementation of any provision of, these medical staff bylaws.
- (b) The medical staff recognizes and embraces that it is the public policy of the State of California that a physician and surgeon be encouraged to advocate for medically appropriate health care for his or her patients. To advocate for medically appropriate health care includes, but is not limited to, the ability of a physician to protest a decision, policy, or practice that the physician, consistent with that degree of learning and skill ordinarily possessed by reputable physicians practicing according to the applicable legal standard of care, reasonably believes impairs the physician's ability to provide medically appropriate health care to his or her patients.

No person, including but not limited to the medical staff, the hospital, its employees, agents, directors or owners, shall retaliate against or penalize any member for such advocacy or prohibit, restrict or in any way discourage such advocacy, nor shall any person prohibit, restrict, or in any way discourage a member from communicating to a patient information in furtherance of medically appropriate health care.

- (c) This section does not preclude corrective and/or disciplinary action as authorized by these medical staff bylaws.

13.11 MEDICAL STAFF REPRESENTATION BY LEGAL COUNSEL

Upon the authorization of the medical staff, or of the medical executive committee acting on its behalf, the medical staff may retain and be represented by independent legal counsel.

Such representation shall be at the expense of the Medical Staff, except as the law may otherwise provide.

ARTICLE XIV: ALLIED HEALTH PROFESSIONALS

14.1 DEFINITIONS

“Allied Health Practitioner (AHP)” means a health care professional, other than a physician who holds a license or other legal credential, as required by California law, to provide certain professional services.

“Allied Health Staff” means those Allied Health Practitioners who are neither employees of the hospital nor, pursuant to the terms of these bylaws, eligible for medical staff membership, but have been granted a service authorization to provide certain clinical services.

“Service authorization” means the permission granted to an Allied Health Staff member to provide specified patient care services within his or her qualifications and scope of practice.

14.2 QUALIFICATIONS

An Allied Health Practitioner who is neither an employee of the hospital nor eligible for medical staff membership is eligible for a service authorization in this hospital if he or she:

- (a) Holds a license, certificate or other legal credential in a category of AHP’s which the Board of Directors has identified as eligible to apply for service authorizations (see Section 8.3 below); and
- (b) Documents his or her experience, background, training, current competence, judgment, and ability with sufficient adequacy to demonstrate that any patient treated by the practitioner will receive care of the generally recognized professional level of quality established by the medical staff; and
- (c) Is determined, on the basis of documented references: to adhere strictly to the lawful ethics of his or her profession; to work cooperatively with others in the hospital setting so as not to affect adversely patient care, and to be willing to commit to and regularly assist the medical staff in fulfilling its obligations related to patient care, within the areas of the practitioner’s professional competence and credentials; and
- (d) Agrees to comply with all medical staff and Department and Division bylaws, rules and regulations, and protocols to the extent applicable to the AHP; and
- (e) Maintains professional liability insurance with a suitable insurer, with minimum limits as determined by the Executive Committee.

14.3 CATEGORIES OF ALLIED HEALTH PROFESSIONALS ELIGIBLE TO APPLY FOR SERVICE AUTHORIZATIONS

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

14.4 PROCEDURE FOR GRANTING SERVICE AUTHORIZATION

14.4-1 (a) An AHP whose scope of practice allows independent practice must apply and qualify for a service authorization and must designate a physician member of the active medical staff who, concurrently with the AHP's application, applies for and is granted privileges to be responsible, to the extent necessary, for the general medical condition of patients for whom the AHP proposes to render services in the hospital.

(b) An AHP whose scope of practice does allow independent practice must apply and qualify for a service authorization and must provide services under the supervision of an active medical staff member who has applied for, qualified for, and been granted specific privileges in accordance with the Medical Staff Bylaws, rules and regulations, to supervise and direct the exercise of service authorizations by the same category of AHP as that of the applicant. An AHP under this subsection may apply to work under the supervision of one active medical staff member or, within the Medical Executive Committee's discretion, a group of medical staff members so long as each of the medical staff members has separately applied for and been granted privileges to supervise the AHP or the category of AHP's to which the applicant belongs. Whenever more than one active staff member will supervise an AHP, such supervision must be in strict accordance with rules and regulations developed by the appropriate department/division and approved by the Medical Executive Committee.

(c) AHP applications for initial granting and renewal of service authorizations respecting nurses in expanded roles and physician's assistants who are eligible for Allied Health Staff membership shall be submitted to the Interdisciplinary Practice Committee. AHP applications for all other categories of AHP's who are eligible for membership on the Allied Health Staff shall be submitted to the Interdisciplinary Practice Committee. All such applications shall be processed in a parallel manner to that provided in Articles IV and V for medical staff members, except that the IDP Committee shall perform the function, which would otherwise be performed by the Credentials Committee, unless otherwise specified in the medical staff rules and regulations.

- 14.4-2 Except as is provided under Section 14.7-2(a), an AHP who (a) has received a final adverse decision regarding his or her application for a service authorization or (b) withdrew his or her application for a service authorization following an adverse recommendation by the Executive Committee, or (c) after having been granted a service authorization has received a final adverse decision resulting in termination of the authorization or (d) has relinquished his or her service authorization following the issuance of a Medical Staff or Board of Directors recommendation adverse to his or her service authorization, shall not be eligible to reapply for the service authorization affected by such decision or recommendation for a period of at least twelve months from the date that the adverse decision became final, the application was withdrawn, or the AHP relinquished his or her service authorization.
- 14.4-3 An AHP who does not have licensure or certification in an AHP category identified as eligible for service authorizations pursuant to Section 14.3 may not apply for a service authorization but may submit a written request to the Administrator, asking the Board of Directors to consider designating the appropriate category of AHP's as eligible to apply for service authorizations. Upon receipt of such a request, the Board of Directors shall forward a copy of the request to the Executive Committee for its recommendation, and shall also request the recommendation of any affected department or division. The Board of Directors shall consider such request and the Executive Committee's recommendation, as well as the recommendation of any affected department or division, either before or at the time of its annual review of the categories of AHP's, in accordance with Section 14.3.
- 14.4-4 Each AHP who is granted a service authorization shall be assigned to the clinical department appropriate to his or her occupational or professional training and, unless otherwise specified in the medical staff rules and regulations, shall be subject to terms and conditions that parallel those specified in Article II, as they may logically apply to AHP's and may be appropriately tailored to the particular category of AHP's. Each AHP who practices independently must maintain communication with the relevant physician under Section 14.4-1 in order to enable the physician to assume responsibility, to the extent it is indicated, for the general medical condition of the patient. Each AHP who does not practice independently shall be subject to the supervision of one or more members of the active medical staff who have been granted privileges to provide such supervision or direction by the Board of Directors upon recommendation of the Executive Committee.

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

- (a) Provision of specified patient care services subject to a medical staff member's responsibility, to the extent indicated, for the patient's general medical condition and under the general oversight of the medical staff, and, where the AHP does not practice independently, also under the supervision and direction of a member of the active medical staff who has been granted specific privileges to supervise that category of AHP. AHP services must be consistent with the service authorization granted to the AHP and within the scope of the AHP's licensure or certification.
- (b) Service on medical staff and hospital committees except as otherwise expressly provided in the medical staff bylaws, rules and regulations. An AHP may not serve as chair of medical staff committees.
- (c) Attendance at meetings of the department to which he or she is assigned, as permitted by the Department's rules and regulations, and attendance at medical staff educational programs in his or her field of practice. An AHP may not vote at department/division meetings.

14.6 RESPONSIBILITIES

Each AHP shall:

- (a) Meet those responsibilities required by the medical staff rules and regulations and if not so specified, meet those responsibilities specified in Section 2.5 of Article II as are generally applicable to the more limited practice of the AHP.
- (b) Retain appropriate responsibility within his or her area of professional competence for the care of each patient in the hospital for whom he or she is providing services.
- (d) Participate, when requested, in patient care audit and other quality review, evaluation, and monitoring activities required of AHP's, in evaluating AHP applicants, in supervising initial AHP appointees of his or her same occupation or profession or of an occupation or profession which is governed by a more limited scope of practice statute, and in discharging such other functions as may be required by the medical staff from time to time.

14.7 TERMINATION, SUSPENSION OR RESTRICTION OF SERVICE AUTHORIZATIONS.

14.7-1 GENERAL PROCEDURES

- (a) At any time, the Chief of Staff or Chief of the Department or Division to which the AHP has been assigned may recommend to the Medical Executive Committee that an AHP's service authorization be terminated, suspended or restricted. After investigation (including, if appropriate, consultation with the Interdisciplinary Practice Committee, if the Medical Executive Committee agrees that corrective action is appropriate, the MEC shall recommend specific corrective action to the hospital's Board of Directors. A Notification Letter regarding the recommendation shall be sent by certified mail to the subject AHP. The Notification Letter shall inform the AHP of the recommendation and the circumstances giving rise to the recommendation.
- (b) Nothing contained in the Medical Staff Bylaws shall be interpreted to entitle an Allied Health Staff member, except for a clinical psychologist, to the hearing rights set forth in Articles VI and VII. However, an AHP shall have the right to challenge any recommendation which would constitute grounds for a hearing under Section 7.2 of the Bylaws to the extent that such grounds are applicable by analogy to the Allied Health Staff, by filing a written grievance (i.e., a letter objecting to the recommended action and requesting an interview) with the Medical Executive Committee within fifteen (15) days of receipt of the Notification Letter. Upon receipt of a grievance, the medical Executive Committee or its designee shall afford the AHP an opportunity for an interview concerning the grievance. Although such interview shall not constitute a "hearing" as established by Article VII of the Bylaws, and need not be conducted according to the procedural rules applicable to such hearings, the purpose of the interview is to allow both the AHP and the party recommending the action the opportunity to discuss the situation and to produce evidence in support of their respective positions. Minutes of the interview shall be retained.
- (c) Within fifteen (15) days following the interview, the Medical Executive Committee, based on the interview and all other aspects of the investigation, shall make a final recommendation to the Board of Directors, which shall be communicated in writing, sent by certified mail, to the subject AHP. The final recommendation shall discuss the circumstances giving rise to the recommendation any pertinent information from the interview. Prior to acting on the matter, the Board of Directors may, in its discretion, offer the affected practitioner the right to appeal to the Board or a subcommittee thereof.

The Board of Directors shall adopt the Medical Executive Committee's recommendation, so long as it is reasonable, appropriate under the circumstances and supported by substantial evidence. The final decision by the Board of Directors shall become effective upon the date of its adoption. The AHP shall be provided promptly with notice of the final action, sent by certified mail.

14.7-2 SUMMARY SUSPENSION

- (a) Notwithstanding Section 8.7-1 an Allied Health Practitioner's service authorization may be immediately suspended or restricted where the failure to take such action may result in an imminent danger to the health of any individual. Such summary suspension or restriction may be imposed by the Chief of Staff, the Medical Executive Committee, or the head of the department or designee to which the Allied Health Practitioner has been assigned (or his/her designee). Unless otherwise stated, the summary action shall become effective immediately upon imposition, and the person responsible for taking such action shall promptly give written notice of the action to the Board of Directors, the Medical Executive, and the Administrator. The notice shall also inform the practitioner of his or her right to file a grievance. The practitioner's right to file a grievance and subsequent interview procedures shall be in accordance with Section 8.7-1, except that all reasonable efforts shall be made to ensure that the practitioner is given an interview and that final action is taken within fifteen (15) days or as promptly thereafter as practicable.
- (b) Within one (1) working day of the summary action, the affected practitioner shall be provided with written notice of the action. The notice shall include the reasons for the action and that such action was necessary because of a reasonable probability that failure to take the action could result in imminent danger to the health of an individual.
- (c) Within fifteen (15) working days following the action, the Interdisciplinary Practice Committee shall meet to consider the matter and make a recommendation to the Executive Committee as to whether the summary suspension should be vacated or continued pending the outcome of any interview with the affected practitioner. Within eight (8) days following the imposition of the action, the Medical Executive Committee shall meet and consider the matter in light of any recommendation forwarded from the Interdisciplinary Practice Committee. Within two (2) working days following the Medical Executive Committee's meeting, the Medical Executive Committee shall provide written notice to the affected practitioner regarding its determination on whether the summary action should be vacated or continued pending the outcome of any interview proceeding.

14.7-3 AUTOMATIC SUSPENSION, TERMINATION OR RESTRICTION

- (a) Notwithstanding subsection 8.7-1, above, an AHP's service authorization shall automatically terminate in the event that:
 - (1) The AHP's certification, license, or other legal credential expires or is revoked.
 - (2) With respect to an AHP who must practice under physician supervision:
 - (a) The medical staff membership or privileges to supervise the AHP of the supervising physician is terminated, whether such termination is voluntary or involuntary; or
 - (b) The supervising physician no longer agrees to act in such capacity for any reason, or the relationship between the AHP and the supervising physician is otherwise terminated, regardless of the reason therefore;Where the AHP's service authorization is automatically terminated for reasons specified in (2)(a) or (2)(b) above, the AHP may apply for reinstatement as soon as the AHP has found another physician active medical staff member who agrees to supervise the AHP and receives privileges to do so. In this case, the Medical Executive Committee may, in its discretion, expedite the reapplication process.

- (b) Notwithstanding subsection 8.7-1, above, in the event that the AHP's certification or license is restricted, suspended, or made the subject of an order of probation, the AHP's service authorization shall automatically be subject to the same restrictions, suspension, or conditions of probation.
- (c) Where the AHP's privileges are automatically terminated, suspended, or restricted pursuant to this subsection, the notice and interview procedures under subsection 8.7-1 shall not apply and the AHP shall have no right to an interview except, within the discretion of the Medical Executive Committee, regarding any factual dispute over whether or not the circumstances giving rise to the automatic termination, suspension, or restriction actually exist.

14.7-4 APPLICABILITY OF SECTION

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

14.7-5 REAPPLICATION

Every two years, each AHP on the Allied Health Staff must reapply for a renewed service authorization in accordance with Section 8.4.

ARTICLE XV: ADOPTION AND AMENDMENT OF BYLAWS

15.1 PROCEDURE

Upon the request of (1) the Medical Executive Committee, or the chief of staff or the Bylaws Committee after approval by the Medical Executive Committee, or (2) upon timely written petition signed by at least 10% of the members of the medical staff in good standing who are entitled to vote, consideration shall be given to the adoption, amendment, or repeal of these bylaws.

The Bylaws are reviewed at a minimum annually and may not be unilaterally amended.

Amendments to these Bylaws shall be made in accordance with the following procedure:

- (1) The Chief of Staff shall have the Bylaws Committee study any part of the Bylaws, which the Medical Executive Committee may feel require amendment.
- (2) The Bylaws Committee will present its proposed amendments to the Medical Executive Committee for discussion and approval.
- (3) The proposed amendments as approved by the Medical Executive Committee shall then be mailed to all members of the Active Staff for their evaluation.
- (4) The Medical Executive Committee will accept written suggestions for further changes in the proposed amendments from members of the Staff for one month. Final revisions of the proposed amendments will be mailed to all members of the Active Staff with a ballot to indicate a vote for acceptance or rejection of each proposed amendment.

Amendments receiving two-thirds majority affirmative votes for adoption shall become effective when approved by the Board of Directors.

The approved amendments will be printed and mailed to all members of the Medical Staff for incorporation into the Bylaws.

15.2 APPROVAL

Bylaws changes adopted by the medical staff shall become effective following approval by the Board of Directors, which approval shall not be withheld unreasonably or automatically within 90 days if no action is taken by the Board of Directors. Medical staff members are provided with copies of the revisions in the bylaws, rules and regulations and medical staff policies. If approval is withheld, the reasons for doing so shall be specified by the Board of Directors in writing, and shall be forwarded to the Chief of Staff, the Medical Executive and Bylaws Committee.

15.3 EXCLUSIVITY

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

15.4 EFFECT OF THE BYLAWS

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

- (a) These bylaws may not be unilaterally amended or repealed by the medical staff or board of directors
- (b) No medical staff governing document and no hospital corporate bylaws or other hospital governing document shall include any provision purporting to allow unilateral amendment of the medical staff bylaws or other medical staff governing document.

15.5 SUCCESSOR IN INTEREST

These bylaws, and privileges of individual members of the medical staff accorded under these bylaws, will be binding upon the medical staff, and the Board of Directors of any successor in interest in this hospital, except where hospital medical staffs are being combined. In the event that the staffs are being combined, the medical staffs shall work together to develop new bylaws, which will govern the combined medical staffs, subject to the approval of the hospital's Board of Directors or its successor in interest. Until such time as the new bylaws are approved, the existing bylaws of each institution will remain in effect.

15.6 AFFILIATIONS

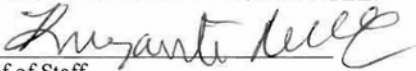
Affiliations between the hospital and other hospitals, health care systems or other entities shall not, in and of themselves, affect these bylaws.

15.7 CONSTRUCTION OF TERMS AND HEADINGS

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

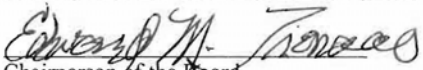
ADOPTED by the Medical Staff:

MEDICAL EXECUTIVE COMMITTEE:

 October 20, 2009
Chief of Staff

 October 20, 2009
Secretary-Treasurer

APPROVED BY THE BOARD OF DIRECTORS:

 October 28, 2009
Chairperson of the Board