

Ventura County Medical Center Medical Staff Bylaws



Medical Staff Bylaws

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Medical Staff Bylaws

PREAMBLE

These Bylaws are adopted in recognition of the mutual accountability, interdependence and responsibility of the Medical Staff and the Governing Board of Ventura County Medical Center in protecting the quality of medical care provided in the hospital and assuring the competency of the hospital's Medical Staff. The Bylaws provide a framework for self-government, assuring an organization of the Medical Staff that permits the Medical Staff to discharge its responsibilities in matters involving the quality of medical care, to govern the orderly resolution of issues and the conduct of Medical Staff functions supportive of those purposes, and to account to the Governing Board for the effective performance of Medical Staff responsibilities. These Bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Governing Board, and relations with applicants to and members of the Medical Staff.

Accordingly, the Bylaws address the Medical Staff's responsibility to establish criteria and standards for Medical Staff membership and privileges, and to enforce those criteria and standards; they establish 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, its committees, and departments, and review and analysis of patient medical records; they describe the standards and procedures for selecting and removing Medical Staff Officers; and they address the respective rights and responsibilities of the Medical Staff and the Governing Board.

Finally, notwithstanding the provisions of these Bylaws, the Medical Staff acknowledges that the Governing Board must act to protect the quality of medical care provided and the competency of the Medical Staff, and to ensure the responsible governance of the hospital. In adopting these Bylaws, the Medical Staff commits to exercise its responsibilities with diligence and good faith; and in approving these Bylaws, the Governing Board commits to allowing the Medical Staff reasonable independence in conducting the affairs of the Medical Staff. Accordingly, the Governing Board will not assume a duty or responsibility of the Medical Staff precipitously, unreasonably, or in bad faith; and will do so only in the reasonable and good faith belief that the Medical Staff has failed to fulfill a substantive duty or responsibility in matters pertaining to the quality of patient care.

Approval:
Executive Committee: February 13, 2018
Medical Staff: April 23, 2018
Governing Board: June 13, 2018

DEFINITIONS

1. **Allied Health Professional or AHP** means an individual, other than a licensed physician, dentist, clinical psychologist or podiatrist, who exercises independent judgment within the areas of his or her professional competence and the limits established by the Governing Board, the Medical Staff, and the applicable State Practice Act, who is qualified to render direct or indirect medical, dental, psychological or podiatric care under the supervision or direction of a Medical Staff member possessing privileges to provide such care in the hospital, and who may be eligible to exercise privileges and prerogatives in conformity with the policies adopted by the Medical Staff and Governing Board, these Bylaws and the Rules. AHPs are not eligible for Medical Staff membership.
2. **Chief Executive Officer (CEO)** means the person designated by the Governing Board or their designated authority (HCA director) to serve as Administrator in matters of the Medical Staff.
3. **Chief Medical Officer (CMO)** means the hospital medical director or his or her designee.
4. **Chief of Staff** means the chief officer of the Medical Staff elected by the Medical Staff.
5. **Date of Receipt** means the date any notice, special notice or other communication was delivered personally; or if such notice, special notice or communication was sent by mail, it shall mean 72 hours after the notice, special notice, or communication was deposited, postage prepaid, in the United States mail. (See also, the definitions of **Notice** and **Special Notice**.)
6. **Days** mean calendar days unless otherwise specified.
7. **Ex Officio** means service by virtue of office or position held. An ex officio appointment is without vote unless specified otherwise.
8. **Governing Board** means the Ventura County Board of Supervisors.
9. **HCA Director** Refers to the Health Care Agency Director, designated authority of the Governing Board.
10. **Hospital** means Ventura County Medical Center, including all inpatient hospital campuses, all outpatient specialty, medical and mental health clinics that are operated under the auspices of the hospital's license.
11. **Medical Executive Committee or Executive Committee** means the executive committee of the Medical Staff.
12. **Medical Staff** means the organizational component of the hospital that includes all physicians (M.D. or D.O.), dentists, clinical psychologists, *and* podiatrists who have been granted recognition as members pursuant to these Bylaws.
13. **Medical Staff Year** means the period from July 1 through June 30.
14. **Member** means any currently licensed physician (M.D. or D.O.), dentist, clinical psychologist or podiatrist, who has been appointed to the Medical Staff.
15. **Notice** means a written communication delivered personally to the addressee (including electronic mail) or sent by United States mail, first-class postage prepaid, addressed to the addressee at the last address as it appears in the official records of the Medical Staff or the hospital. (See also, the definitions of **Date of Receipt** and **Special Notice**.)

16. **Oversight Committee** refers to representative entity of the Board of Supervisors charged with carrying out the duties and responsibilities of the Governing Board and serving as the liaison group between the Medical Staff and the Administration of VCMC and the Board of Supervisors.
17. **Physician** means an individual with an M.D. or D.O. degree who is currently licensed to practice medicine.
18. **Practitioner** means, unless otherwise expressly limited, any currently licensed physician (M.D. or D.O.), dentist, clinical psychologist, podiatrist or allied health professional who is privileged through the medical staff process.
19. **Privileges** or **Clinical Privileges** means the permission granted to a Medical Staff member or AHP to render specific patient services.
20. **Rules** refers to the Medical Staff and/or department rules adopted in accordance with these Bylaws unless specified otherwise.
21. **Special Notice** means a notice sent by certified or registered mail, return receipt requested. (See also, the definitions of **Date of Receipt** and **Notice** above.)
22. **VCHCP** - Ventura County Healthcare Plan refers to Managed Health Plan established and operated through the Ventura County HCA Director's office with which VCMC will engage in specified joint credentialing and peer review activities.
23. **Telemedicine** is the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video or data communications.

Article 1 Name and Purposes

1.1 NAME

The name of this organization shall be the Medical Staff of Ventura County Medical Center.

1.2 DESCRIPTION

1.2-1 The Medical Staff organization is structured as follows: The members of the Medical Staff are assigned to a Staff category depending upon nature and tenure of practice at the hospital. All new members are assigned to the Provisional Staff. Upon satisfactory completion of the provisional period, the members are assigned to one of the Staff categories described in Bylaws, Article 3, Categories of the Medical Staff.

1.2-2 Members are also assigned to departments, depending upon their specialties, as follows: Family Medicine, Medicine, Obstetrics and Gynecology, Pediatrics, Psychiatry, Psychology, and Surgery. Each department is organized to perform certain functions on behalf of the department, such as credentials review and peer review.

1.2-3 There are also Medical Staff committees, which perform staff-wide responsibilities, and which oversee related activities being performed by the departments.

1.2-4 Overseeing all of this is the Medical Executive Committee, comprised of the elected officers of the Medical Staff, the department chiefs, immediate past chief of staff, Residency Director, Chief Medical Officer, and ex officio members without vote including HCA Director, the Medical Director of the Hospital, Ambulatory care, Specialty Clinics, and Behavioral Health, the Chief Executive Officer, Chief Nursing Executive, Chief Resident and others appointed by the Chief of Staff.

1.3 PURPOSES AND RESPONSIBILITIES

1.3-1 The Medical Staff's purposes are:

- a. To assure that all patients admitted or treated in any of the hospital services receive a uniform standard of quality patient care, treatment and efficiency consistent with generally accepted standards attainable within the hospital's means and circumstances.
- b. To provide for a level of professional performance that is consistent with generally accepted standards attainable within the hospital's means and circumstances.
- c. To organize and support professional education and community health education and support services.
- d. To initiate and maintain Rules for the Medical Staff to carry out its responsibilities for the professional work performed in the hospital.
- e. To provide a means for the Medical Staff, Governing Board and administration to discuss issues of mutual concern and to implement education and changes intended to continuously improve the quality of patient care.
- f. To provide for accountability of the Medical Staff to the Governing Board.
- g. To exercise its rights and responsibilities in a manner that does not jeopardize the hospital's license, Medicare and Medi-Cal provider status, or accreditation.

1.3-2 The Medical Staff's responsibilities are:

- a. To provide quality patient care.
- b. To account to the Governing Board for the quality of patient care provided by all members authorized to practice in the hospital through the following measures:
 - 1. Review and evaluation of the quality of patient care provided through valid and reliable patient care evaluation procedures;
 - 2. An organizational structure and mechanisms that allow on-going monitoring of patient care practices;
 - 3. A credentials program, including mechanisms of appointment, reappointment and the matching of clinical privileges to be exercised or specified services to be performed with the verified credentials and current demonstrated performance of the Medical Staff applicant or member;
 - 4. A continuing education program based at least in part on needs demonstrated through the medical care evaluation program;
 - 5. A utilization review program to provide for the appropriate use of all medical services.
- c. To recommend to the Governing Board action with respect to appointments, reappointments, staff category and department assignments, clinical privileges and corrective action.
- d. To establish and enforce, subject to the Governing Board approval, professional standards related to the delivery of health care within the hospital.
- e. To account to the Governing Board for the quality of patient care through regular reports and recommendations concerning the implementation, operation, and results of the quality review and evaluation activities.
- f. To initiate and pursue corrective action with respect to members where warranted.
- g. To provide a framework for cooperation with other community health facilities and/or educational institutions or efforts.
- h. To establish and amend from time to time as needed Medical Staff Bylaws, Rules and policies for the effective performance of Medical Staff responsibilities, as further described in these Bylaws.
- i. To select and remove Medical Staff officers.
- j. To assess Medical Staff dues and utilize Medical Staff dues as appropriate for the purposes of the Medical Staff.

Article 2 Medical Staff Membership

2.1 NATURE OF MEDICAL STAFF MEMBERSHIP

Medical Staff membership and/or privileges may be extended to and maintained by only those professionally competent practitioners who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and the Rules. A practitioner, including one who has a contract with the hospital to provide medical-administrative services, may admit or provide services to patients in the hospital only if the practitioner is a member of the Medical Staff or has been granted temporary privileges in accordance with these Bylaws and the Rules. Appointment to the Medical Staff shall confer only such privileges and prerogatives as have been established by the Medical Staff and granted by the Governing Board in accordance with these Bylaws.

2.2 QUALIFICATIONS FOR MEMBERSHIP

2.2-1 GENERAL QUALIFICATIONS

Membership on the Medical Staff and privileges shall be extended only to practitioners who are professionally competent and continuously meet the qualifications, standards, and requirements set forth in the Medical Staff Bylaws and Rules. Medical Staff membership (except honorary Medical Staff) shall be limited to practitioners who are currently licensed or qualified to practice medicine, podiatry, clinical psychology or dentistry in California.

2.2-2 BASIC QUALIFICATIONS

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

- a. Qualify under California law to practice with an out-of-state license or be licensed as follows:
 1. Physicians must be licensed to practice medicine by the Medical Board of California or the Board of Osteopathic Examiners of the State of California;
 3. Dentists must be licensed to practice dentistry by the California Board of Dental Examiners;
 4. Podiatrists must be licensed to practice podiatry by the California Board of Podiatric Medicine;
 5. Clinical psychologists must be licensed to practice clinical psychology by the California Board of Psychology and Division of Allied Health Professions of the Medical Board of California and meet the requirements set forth in their department Rules and Regulations.
- b. If practicing clinical medicine, dentistry, or podiatry, have a federal Drug Enforcement Administration number, excluding pathologists.
- c. Be certified by or currently qualify to take the board certification examination of a board recognized by the American Board of Medical Specialties, the American Osteopathic Specialty Certifying Board, the American Board of Oral and Maxillofacial Surgery,

the American Board of Podiatric Surgery, or the American Board of Orthopedic Podiatric Medicine in the specialty that the practitioner will practice at the hospital, or have completed a residency approved by the Accreditation Council for Graduate Medical Education that provided complete training in the specialty or subspecialty that the practitioner will practice at the hospital. This section shall not apply to dentists or clinical psychologists. Certain specific Board Certification requirements are outlined in departmental Rules and Regulations.

- d. Be eligible to receive payments from the federal Medicare and state Medicaid (Medi-Cal) programs.
- e. Maintain professional liability insurance coverage which covers all care provided by the practitioner at VCMC in the amounts of at least \$1,000,000/occurrence and \$3,000,000/aggregate.
- f. Have actively practiced for an average of at least 10 hours per week in the specialty he or she will practice at the hospital for 12 of the previous 24 months (or have completed a residency within the previous 18 months).
- g. Pledge to provide or arrange for continuous care to his or her patients.
- h. If requesting privileges only in services operated under an exclusive contract, be a member, employee or subcontractor of the group or person that holds the contract.

A practitioner who does not meet these basic standards is ineligible to apply for Medical Staff membership, and the application shall not be accepted for review, except that applicants for the honorary Medical Staff do not need to comply with any of the basic standards. If it is determined during the processing that an applicant does not meet all of the basic qualifications, the review of the application shall be discontinued. An applicant who does not meet the basic standards is not entitled to the procedural rights set forth in these Bylaws, but may submit comments and a request for reconsideration of the specific standards which adversely affected such practitioner. Those comments and requests shall be reviewed by the Medical Executive Committee and the Governing Board, which shall have sole discretion to decide whether to consider any changes in the basic standards or to grant a waiver as allowed by Bylaws, Section 2.2-4, below.

2.2-3 ADDITIONAL QUALIFICATIONS FOR MEMBERSHIP

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

- a. Document his or her:
 - 1. Adequate experience, education, and training in the requested privileges;
 - 2. Current professional competence;
 - 3. Good judgment; and
 - 4. Adequate physical and mental health status (subject to any necessary reasonable accommodation) to demonstrate to the satisfaction of the Medical Staff that he or she is sufficiently healthy and professionally and ethically competent so that patients can reasonably expect to receive the generally recognized professional level of quality and safety of care for this community. Without limiting the foregoing, with respect to communicable diseases, practitioners are expected to know their own health status, to take such precautionary measures as may be warranted under the circumstances to protect patients and others present in the hospital, and to comply with all

reasonable precautions established by hospital and/or Medical Staff policy respecting safe provision of care and services in the hospital.

b. Be determined to:

1. Adhere to the lawful ethics of his or her profession;
2. Be able to work cooperatively with others in the hospital setting so as not to adversely affect patient care or hospital operations; and
3. Be willing to participate in and properly discharge Medical Staff responsibilities.

2.2-4 WAIVER OF QUALIFICATIONS

Insofar as is consistent with applicable laws, the Governing Board has the discretion to deem a practitioner to have satisfied a qualification, after consulting with the Medical Executive Committee, if it determines that the practitioner has demonstrated he or she has substantially comparable qualifications and that this waiver is necessary to serve the best interests of the patients and of the hospital. There is no obligation to grant any such waiver, and practitioners have no right to have a waiver considered and/or granted. A practitioner who is denied a waiver or consideration of a waiver shall not be entitled to any hearing and appeal rights under these Bylaws.

2.3 EFFECT OF OTHER AFFILIATIONS

No practitioner shall be entitled to Medical Staff membership merely because he or she 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 he or she had, or presently has, staff membership or privileges at another health care facility.

2.4 NONDISCRIMINATION

Medical Staff membership or particular privileges shall not be denied on the basis of age, religion, race, creed, color, national origin, or any physical or mental impairment if, after any necessary reasonable accommodation, the applicant complies with the Bylaws or Rules of the Medical Staff or the hospital.

2.5 ADMINISTRATIVE AND CONTRACT PRACTITIONERS

2.5-1 CONTRACTORS WITH NO CLINICAL DUTIES

A practitioner employed by or contracting with the hospital in a purely administrative capacity with no clinical duties or privileges is subject to the regular personnel policies of the hospital and to the terms of his or her contract or other conditions of employment and need not be a member of the Medical Staff.

2.5-2 CONTRACTORS WHO HAVE CLINICAL DUTIES

- a. A practitioner with whom the hospital contracts to provide services which involve clinical duties or privileges must be a member of the Medical Staff, achieving his or her status by the procedures described in these Bylaws. Unless a written contract or agreement, executed after this provision is adopted, specifically provides otherwise, or unless otherwise required by law, those privileges made exclusive or semi-exclusive pursuant to a closed-staff or limited-staff specialty policy will automatically terminate, without the right of access to the review, hearing, and appeal procedures of the Bylaws, Article 14, Hearings and Appellate Reviews, upon termination or expiration of such practitioner's contract or agreement with the hospital.
- b. Contracts between practitioners and the hospital shall prevail over these Bylaws and the Rules, except that the contracts may not reduce any hearing rights granted when an action will be taken that must be reported to the Medical Board of California or the federal National Practitioner Data Bank.

2.5-3 SUBCONTRACTORS

Practitioners who subcontract with practitioners or entities who contract with the hospital may lose privileges granted pursuant to an exclusive or semi-exclusive arrangement (but not their Medical Staff membership) if their relationship with the contracting practitioner or entity is terminated, or the hospital and the contracting practitioner's or entity's agreement or exclusive relationship is terminated. The hospital may enforce such an automatic termination even if the subcontractor's agreement fails to recognize this right.

2.6 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

Except for honorary members (*see Appendix 3E Honorary and Retired Staff*), each Medical Staff member and each practitioner exercising temporary privileges shall continuously meet all of the following responsibilities:

- 2.6-1** Provide his or her patients with care that is generally recognized professional level of quality and efficiency.
- 2.6-2** Abide by the Medical Staff Bylaws and Rules and all other lawful standards, policies and Rules of the Medical Staff and the hospital.
- 2.6-3** Abide by all applicable laws and regulations of governmental agencies and comply with applicable standards of The Joint Commission.
- 2.6-4** Discharge such Medical Staff, department committee and service functions for which he or she is responsible by appointment, election or otherwise.
- 2.6-5** Abide by all applicable requirements for timely completion and recording of a physical examination and medical history, as further described at Section 5.4-3.
- 2.6-6** Acquire a patient's informed consent for all procedures and treatments identified in the Bylaws, Section 15.1-5, and abide by the procedures for obtaining such informed consent.
- 2.6-7** Prepare and complete, in a timely and accurate manner, the medical and other required records for all patients to whom the practitioner in any way provides services in the hospital.

- 2.6-8** Abide by the ethical principles of his or her profession.
- 2.6-9** Refrain from unlawful fee splitting or unlawful inducements relating to patient referral.
- 2.6-10** Refrain from any unlawful harassment or discrimination against any person (including any patient, hospital employee, hospital independent contractor, Medical Staff member, volunteer, or visitor) based upon the person's age, sex, religion, race, creed, color, national origin, health status, ability to pay, or source of payment.
- 2.6-11** Refrain from delegating the responsibility for diagnosis or care of hospitalized patients to a practitioner or Allied Health Professional who is not qualified to undertake this responsibility or who is not adequately supervised.
- 2.6-12** Coordinate individual patients' care, treatment and services with other practitioners and hospital personnel, including, but not limited to, seeking consultation whenever warranted by the patient's condition or when required by the Rules or policies and procedures of the Medical Staff or applicable department.
- 2.6-13** Actively participate in and regularly cooperate with the Medical Staff in assisting the hospital to fulfill its obligations related to patient care, including, but not limited to, continuous organization-wide quality measurement, assessment, and improvement, peer review, utilization management, quality evaluation, ongoing and Focused Professional Practice Evaluations and related monitoring activities required of the Medical Staff, and in discharging such other functions as may be required from time to time.
- 2.6-14** Upon request, provide information from his or her office records or from outside sources as necessary to facilitate the care of or review of the care of specific patients.
- 2.6-15** Recognize the importance of communicating with appropriate department officers and/or Medical Staff Officers when he or she obtains credible information indicating that a fellow Medical Staff member may have engaged in unprofessional or unethical conduct or may have a health condition which poses a significant risk to the well-being or care of patients and then cooperate as reasonably necessary toward the appropriate resolution of any such matter.
- 2.6-16** Accept responsibility for participating in Medical Staff proctoring in accordance with the Rules and policies and procedures of the Medical Staff.
- 2.6-17** Complete continuing medical education that meets all licensing requirements and is appropriate to the practitioner's specialty.
- 2.6-18** Adhere to the Medical Staff Standards of Conduct (as further described in Section 2.7, below), so as not to adversely affect patient care or hospital operations.
- 2.6-19** Participate in emergency service coverage and consultation panels as allowed and as required by the Rules.
- 2.6-20** Cooperate with the Medical Staff in assisting the hospital to meet its uncompensated or partially compensated patient care obligations.
- 2.6-21** Participate in patient and family education activities, as determined by the department or Medical Staff Rules, or the Medical Executive Committee.

- 2.6-22** Notify the Medical Staff office in writing promptly, and no later than 14 calendar days, following any action taken regarding the member's license, Drug Enforcement Administration registration, privileges at other facilities, changes in liability insurance coverage, any report filed with the National Practitioner Data Bank, or any other action or change in circumstances that could affect his/her qualifications for Medical Staff membership and/or clinical privileges at the hospital.
- 2.6-23** Continuously meet the qualifications for and perform the responsibilities of membership as set forth in these Bylaws. A member may be required to demonstrate continuing satisfaction of any of the requirements of these Bylaws upon the reasonable request of the Medical Executive Committee. This shall include, but is not limited to, mandatory health or psychiatric evaluation and mandatory drug and/or alcohol testing, the results of which shall be reportable to the Medical Executive Committee, and the Well-Being Committee.
- 2.6-24** Discharge such other staff obligations as may be lawfully established from time to time by the Medical Staff or Medical Executive Committee.

2.7 STANDARDS OF CONDUCT

Members of the Medical Staff are expected to adhere to the Medical Staff Standards of Conduct including, but not limited to, the following:

2.7-1 General

- a. It is the policy of the Medical Staff to require that its members fulfill their Medical Staff obligations in a manner that is within generally accepted bounds of professional interaction and behavior. The Medical Staff is committed to supporting a culture and environment that values integrity, honesty and fair dealing with each other, and to promoting a caring environment for patients, practitioners, employees and visitors.
- b. Rude, combative, obstreperous behavior, as well as willful refusal to communicate or comply with reasonable rules of the Medical Staff and the hospital may be found to be disruptive behavior. It is specifically recognized that patient care and hospital operations can be adversely affected whenever any of the foregoing occurs with respect to interactions at any level of the hospital, in that all personnel play an important part in the ultimate mission of delivering quality patient care.
- c. In assessing whether particular circumstances in fact are affecting quality patient care or hospital operations, the assessment need not be limited to care of specific patients, or to direct impact on patient health. Rather, it is understood that quality patient care embraces—in addition to medical outcome—matters such as timeliness of services, appropriateness of services, timely and thorough communications with patients, their families, and their insurers (or third party payers) as necessary to effect payment for care, and general patient satisfaction with the services rendered and the individuals involved in rendering those services.

2.7-2 Conduct Guidelines

- a. Upon receiving Medical Staff membership and/or privileges at the hospital, the member enters a common goal with all members of the organization to endeavor to maintain the quality of patient care and appropriate professional conduct.
- b. Members of the Medical Staff are expected to behave in a professional manner at all times and with all people—patients, professional peers, hospital staff, visitors, and others in and affiliated with the hospital.

- c. Interactions with all persons shall be conducted with courtesy, respect, civility and dignity. Members of the Medical Staff shall be cooperative and respectful in their dealings with other persons in and affiliated with the hospital.
- d. Complaints and disagreements shall be aired constructively, in a non-demeaning manner, and through official channels.
- e. Cooperation and adherence to the reasonable Rules of the hospital and the Medical Staff is required.
- f. Members of the Medical Staff shall not engage in conduct that is offensive or disruptive, whether it is written, oral or behavioral.

2.7-3 Adoption of Rules

The Medical Executive Committee may promulgate Rules further illustrating and implementing the purposes of this Section including, but not limited to, procedures for investigating and addressing incidents of perceived misconduct, and, where appropriate, progressive or other remedial measures. These measures may include alternative avenues for medical or administrative disciplinary action, which in turn may include but are not limited to conditional appointments and reappointments, requirements for behavioral contracts, mandatory counseling, practice restrictions, and/or suspension or revocation of Medical Staff membership and/or privileges.

Article 3 Categories of the Medical Staff

3.1 CATEGORIES

Each Medical Staff member shall be assigned to a Medical Staff category based upon the qualifications defined in the Categories of Membership. The members of each Medical Staff category shall have the prerogatives and carry out the duties defined in the Bylaws and Rules. Action may be initiated to change the Medical Staff category or terminate the membership of any member who fails to meet the qualifications or fulfill the duties described in the Bylaws or Rules. Changes in Medical Staff category shall not be grounds for a hearing unless they adversely affect the member's privileges.

The Medical Staff shall consist of the following categories. The Rules applicable to each staff category are set forth in the corresponding appendix.

See Appendix

- ☐ Active Staff 3A
- ☐ Community Affiliate Staff 3B
- ☐ Courtesy Medical Staff 3C
- ☐ Honorary and Retired Staff 3D
- ☐ Provisional Staff 3E
- ☐ Telemedicine Staff 3F

3.2 QUALIFICATIONS GENERALLY

Each practitioner who seeks or enjoys staff appointment must continuously satisfy the basic qualifications for membership set forth in the Bylaws and Rules, except those that are specifically waived for a particular category, and the additional qualifications that attach to the staff category to which he or she is assigned. The Governing Body may, after considering the Medical Executive Committee's recommendations, waive any qualification in accordance with Bylaws, Section 2.2-4, Waiver of Qualifications.

3.3 PREROGATIVES AND RESPONSIBILITIES

3.3-1 The prerogatives available to a Medical Staff member depending upon staff category enjoyed are:

- a. **Admit patients:** Admit patients consistent with approved privileges.
- b. **Eligible for Clinical Privileges:** Exercise those clinical privileges that have been approved.

- c. **Vote:** Vote on any Medical Staff matter including Bylaws amendments, officer selection and other matters presented at any general or special staff meetings and on matters presented at department meetings.
- d. **Hold Office:** Hold office in the Medical Staff and in the department to which he or she is assigned.
- e. **Serve on Committees:** Serve on committees and vote on committee matters.

3.3-2 The responsibilities which Medical Staff members will be expected to carry out in addition to the basic responsibilities set forth in the Bylaws, Article 2, Section 2.6, Basic Responsibilities of Medical Staff Membership, are to:

- a. **Medical Staff Functions:** Contribute to and participate equitably in staff functions, at the request of a Department Chief or staff officer, including: contributing to the organizational and administrative activities of the Medical Staff, such as quality improvement, risk management and utilization management; serving in Medical Staff and department offices and on hospital and Medical Staff committees; participating in and assisting with the hospital's medical education programs; proctoring of other practitioners; and fulfilling such other staff functions as may reasonably be required.
- b. **Consulting:** Consulting with other staff members consistent with his or her delineated privileges.
- c. **Attend Meetings:** Attend at least the minimum number of staff and department meetings specified in the Medical Staff Bylaws.
- d. **Pay Fees/Dues:** Pay staff application fees, dues and assessments in the amounts specified in the rules.

3.3-3 Prerogatives and Obligations of Staff Categories

The prerogatives and obligations of each staff category are described in the table on the following page.

3.4 QUALIFICATIONS FOR STAFF CATEGORY

3.4-1 Assignment and Transfer in Staff Category

- a. Medical Staff members shall be assigned to the category of staff membership based upon the qualifications identified below. Active staff members who fail to achieve the minimum activity for two consecutive years shall be automatically transferred to the appropriate category. Action shall be initiated to evaluate and possibly terminate the privileges and membership of any staff member who has failed to have any activity. A Courtesy Member who has exceeded the maximum activity permitted for two consecutive years shall be deemed to have requested transfer to the appropriate category. The Medical Executive Committee shall approve these assignments and transfers, which shall then be evaluated in accordance with the bylaws and these rules. The transfers shall be done at the time of reappointment.
- b. In assigning practitioners to the proper staff category, the Medical Staff shall also consider whether the practitioner participated in other aspects of the hospital's activities by, for example, serving on committees. The Governing Body (on recommendation of the Medical Executive Committee) may rescind an automatic transfer, but only if the practitioner clearly demonstrates that unusual circumstances unlikely to occur again in his or her practice caused the failure to meet the minimum or maximum requirements.

3.5 GENERAL EXCEPTIONS TO PREROGATIVES

Regardless of the category of membership in the Medical Staff, limited license members:

3.5-1 May not hold any general Medical Staff office but may be permitted to serve on the Medical Executive Committee.

3.5-2 Shall have the right to vote only on matters within the scope of their licensure. Any disputes over voting rights shall be determined by the chair of the meeting, subject to final decision by the Medical Executive Committee.

3.5-3 Shall exercise privileges only within the scope of their licensure and as limited by the Medical Staff Bylaws and Rules.

3.6 LEAVE OF ABSENCE

3.6-1 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 two (2) years. 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.

3.6-2 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 Section 4.2 shall be followed.

3.6-3 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.

3.6-4 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.

3.6-5 Military Leave of Absence

Requests for leave of absence to fulfill military service obligations shall be granted upon notice and review by the medical executive committee. Reactivation of membership and clinical privileges previously held shall be granted, notwithstanding the provisions of Section 4.2, but may be granted subject to monitoring and/or proctoring as determined by the medical executive committee.

Appendix 3A Active Staff

The Active Staff shall consist of the members who:

1. Are regularly involved in caring for patients or demonstrate, by way of other substantial involvement in Medical Staff or hospital activities, a genuine concern and interest in the hospital. Regular involvement in patient care shall mean admitting inpatients or outpatients, treating or consulting on at least fifteen or more cases each Medical Staff year.
2. Have been members in good standing of the provisional staff for at least six months.

SUMMARY OF APPLICABLE PREROGATIVES, RESPONSIBILITIES, ETC.		APPLICABLE
<i>Prerogatives</i>		
Admits, consults or treats patients (inpatients and outpatients)		Yes
Eligible for clinical privileges		Yes
Vote		Yes
Hold office		Yes
Serve as Committee Chair		Yes
Serve on Committee and vote on Committee matters		Yes
<i>Responsibilities</i>		
Medical staff functions		Yes
Consulting		Yes
Emergency room call		Yes
Attend required meetings		Yes
Pay application fee		Yes
Pay dues		Yes
<i>Additional Particular Qualifications</i>		
Must first complete provisional		Yes
Malpractice insurance		Yes
File application and apply for reappointment		Yes

Appendix 3B Community Affiliate Staff

The Community Affiliate Staff shall consist of members without clinical privileges who may or may not have an Active Staff appointment at another hospital but who may request read only access to the Hospital's electronic medical records to (i) provide continuity of care for their patients, or (ii) remain connected with the Hospital and/or Active Staff.

<i>SUMMARY OF APPLICABLE PREROGATIVES, RESPONSIBILITIES, ETC.</i>		<i>APPLICABLE</i>
<i>Prerogatives</i>		
Admits, consults or treats patients (inpatients and outpatients)		Limited to refer & follow only
Eligible for clinical privileges		No
Vote		No
Hold office		No
Serve as Committee Chair (requires MEC approval)		Yes
Serve on Committee and vote on Committee matters		Yes
<i>Responsibilities</i>		
Medical staff functions		No
Consulting		No
Emergency room call		No
Attend required meetings		No
Pay application fee		Yes
Pay dues		Yes
<i>Additional Particular Qualifications</i>		
Must first complete provisional		No
Malpractice insurance		No
File application and apply for reappointment		Yes

Appendix 3C Courtesy Staff

The Courtesy Medical Staff shall consist of the members who:

1. Admit, consult or otherwise provide services for at least an average of one patient a year in the hospital, but fewer than fifteen patients during each Medical Staff year.
2. Prior to reappointment, provide evidence of current clinical performance at the hospital where they practice in such form as the member's department or the Medical Executive Committee may require in order to evaluate their current ability to exercise the requested clinical privileges.
3. Have completed at least six months of satisfactory performance on the provisional staff.

<i>SUMMARY OF APPLICABLE PREROGATIVES, RESPONSIBILITIES, ETC.</i>	<i>APPLICABLE</i>
<i>Prerogatives</i>	
Admits, consults or treats patients (inpatients and outpatients)	Yes
Eligible for clinical privileges	Yes
Vote	No
Hold office	No
Serve as Committee Chair (requires MEC approval)	Yes
Serve on Committee and vote on Committee matters	Yes
<i>Responsibilities</i>	
Medical staff functions	Yes
Consulting	Yes
Emergency room call	No
Attend required meetings	No
Pay application fee	Yes
Pay dues	Yes
<i>Additional Particular Qualifications</i>	
Must first complete provisional	Yes
Malpractice insurance	Yes
File application and apply for reappointment	Yes

Appendix 3D Honorary and Retired Staff

The Honorary and Retired Staff shall consist of practitioners who are deemed deserving of membership by virtue of their outstanding reputations, noteworthy contributions to the health and medical sciences, or their previous long-standing service to the hospital, and members who were in good standing when they retired.

<i>SUMMARY OF APPLICABLE PREROGATIVES, RESPONSIBILITIES, ETC.</i>	<i>APPLICABLE</i>
<i>Prerogatives</i>	
Admits, consults or treats patients (inpatients and outpatients)	No
Eligible for clinical privileges	No
Vote	No
Hold office	No
Serve as Committee Chair	No
Serve on Committee and vote on Committee matters	Yes
<i>Responsibilities</i>	
Medical staff functions	No
Consulting	No
Emergency room call	No
Attend required meetings	No
Pay application fee	No
Pay dues	No
<i>Additional Particular Qualifications</i>	
Must first complete provisional	No
Malpractice insurance	No
File application and apply for reappointment	No

Appendix 3E Provisional Staff

The Provisional Staff shall consist of the members who:

1. Are initial appointees to the Medical Staff and plan to qualify for, and seek transfer to, the Active, Courtesy or Telemedicine Staff in 12 months.
2. In the ordinary course of events, are transferred to Active, Courtesy or Telemedicine status after serving at least six but not more than 12 months on the provisional staff. Action shall be initiated by the Medical Executive Committee to terminate the privileges and membership of a provisional member who does not qualify for advancement within 12 months. The member shall not be entitled to any hearing and appeal under Bylaws, Article 14, Hearings and Appellate Reviews, if advancement was denied because of a failure to have a sufficient number of cases proctored or because of a failure to maintain a satisfactory level of activity. The member shall be entitled to the hearing and appeal rights under Bylaws, Article 14, Hearings and Appellate Reviews, if advancement was denied because the member's clinical performance or professional conduct was unsatisfactory.

SUMMARY OF APPLICABLE PREROGATIVES, RESPONSIBILITIES, ETC.		APPLICABLE
<i>Prerogatives</i>		
Admits, consults and treats patients (inpatients and outpatients)		Yes
Eligible for clinical privileges		Yes
Vote		Yes, Provisional Active only
Hold office		No
Serve as Committee Chair		No
Serve on Committee and vote on Committee matters		Yes
<i>Responsibilities</i>		
Medical staff functions		Yes
Consulting		Yes
Emergency room call		Yes
Attend required meetings		Yes
Pay application fee		Yes
Pay dues		Yes
<i>Additional Particular Qualifications</i>		
Must first complete provisional		N/A
Malpractice insurance		Yes
File application and apply for reappointment		Yes

Appendix 3F Telemedicine Staff

1. Telemedicine Definitions

- a. Distant Site is the location at which the telemedicine equipment is located and from which the Telemedicine Provider delivers his/her patient care services.
- b. Originating Site is the location at which the patient is located.
- c. Telemedicine Provider is the individual provider who uses the telemedicine equipment at the Distant Site to render services to patients who are located at the Originating Site. The Telemedicine Provider is generally a physician, but other health professionals may also be involved as Telemedicine Providers. The Telemedicine Provider would generally contract with (or in the case of non-physicians, be employed by) the entity that serves as the Distant Site.

2. Prerogatives and Responsibilities of the Telemedicine Staff

The Telemedicine Staff shall consist of Telemedicine Providers who provide diagnostic or treatment services, from the Distant Site to hospital patients at the Originating Site via telemedicine devices. Telemedicine devices include interactive (involving real time or near real time two-way transfer of medical data and information) audio, video, or data communications between physician and patient. Telemedicine does not include telephone or electronic mail communications.

SUMMARY OF APPLICABLE PREROGATIVES, RESPONSIBILITIES, ETC.		APPLICABLE
Prerogatives		
Admits; consults or treats patients (inpatients and outpatients)		Yes, Excludes admitting privileges
Eligible for clinical privileges		Yes
Vote		No
Hold office		No
Serve as Committee Chair		No
Serve on Committee and vote on Committee matters		No
Responsibilities		
Medical staff functions		Yes
Consulting		Yes
Emergency room call		No
Attend required meetings		No
Pay application fee		Yes
Pay dues		Yes
Additional Particular Qualifications		
Must first complete provisional		Yes
Malpractice insurance		Yes
File application and apply for reappointment		Yes

3. Additional Provisions Applicable to Telemedicine Staff

a. Responsibility to Communicate Concerns/Problems:

- 1) There is a need for clear delineation of reporting responsibilities respecting the Telemedicine providers' performance. At the very least, the Medical Staff officials at this hospital must be informed of any practitioner-specific problems that arise in the delivery of services to this hospital's patients.
- 2) Additionally, this hospital should communicate to the Medical Staff officials at the Distant Site, through peer review channels, any problems that may arise in the delivery of care by the Telemedicine provider to patients at this hospital.
- 3) Similarly, when a member of this hospital's Medical Staff is providing telemedicine services to patients at another facility, this hospital's Medical Staff should communicate to the Medical Staff officials at the Originating Site, through peer review channels, any problems that may arise in the delivery of telemedicine services by members of this hospital's Medical Staff.
- 4) The Chief of Staff may enter into appropriate information sharing agreements and/or develop and implement appropriate protocols to effectuate these provisions.

a. Responsibility to Review Practitioner-Specific Performance:

- 1) Special proctoring arrangements may be made for qualified practitioners at the Distant Site to proctor cases performed by new members of the Telemedicine Staff.
- 2) Primary responsibility to assess what, if any, practitioner-specific performance improvement and/or corrective action may be warranted rests with the Originating Site. If such action gives rise to procedural rights at the hospital, the provisions of Bylaws, Article 14, Hearings and Appellate Reviews, will apply

Appendix 3G Summary of Categories

SUMMARY OF APPLICABLE PREROGATIVES, RESPONSIBILITIES, ETC....						
	Active	Community Affiliate	Courtesy	Honorary	Provisional	Telemedicine
Pre rogatives						
Admits, consults & treats patients	Yes	Limited to refer & follow only	Yes	No	Yes	Excludes admitting privileges Yes
Eligible for clinical privileges	Yes	No	Yes	No	Yes	
Vote	Yes	No	No	No	Provisional Active only	No
Hold office	Yes	No	No	No	No	No
Serve as Committee Chair	Yes	requires MEC approval	requires MEC approval	No	No	No
Serve & vote on Committee	Yes	Yes	Yes	Yes	Yes	No
Responsibilities						
Medical staff function	Yes	No	Yes	No	Yes	Yes
Consulting	Yes	No	Yes	No	Yes	Yes
Emergency room call	Yes	No	No	No	Yes	No
Attend required meetings	Yes	No	No	No	Yes	No
Pay application fee	Yes	Yes	Yes	No	Yes	Yes
Pay dues	Yes	Yes	Yes	No	Yes	Yes
Additional Particular Qualifications						
Must first complete provisional	Yes	No	Yes	No	N/A	Yes
Malpractice insurance	Yes	No	Yes	No	Yes	Yes
File application & apply for reappointment	Yes	Yes	Yes	No	Yes	Yes

Article 4 Procedures for Appointment and Reappointment

4.1 GENERAL

The Medical Staff shall consider each application for appointment, reappointment and privileges, and each request for modification of Medical Staff category using the procedure and the criteria and standards for membership and clinical privileges set forth in the Bylaws and the Rules. The Medical Staff shall perform this function also for practitioners who seek temporary privileges and for Allied Health Professionals. The Medical Staff shall assess each applicant for appointment or reappointment and make an objective, evidence-based decision based upon assessment of the applicant vis-à-vis the hospital's "general competencies," (as further described at Bylaws, Section 5.2), before recommending action to the Governing Board. The Governing Board shall ultimately be responsible for granting membership and privileges (provided, however, that these functions may be delegated to the Chief of Staff and Chief Executive Officer with respect to requests for temporary privileges). By applying to the Medical Staff for appointment or reappointment (or by accepting honorary Medical Staff appointment), the applicant agrees that regardless of whether he or she is appointed or granted the requested privileges, he or she will comply with the responsibilities of Medical Staff membership and with the Medical Staff Bylaws and Rules as they exist and as they may be modified from time to time.

4.2 OVERVIEW OF THE PROCESS

The following chart depicts the basic steps of the appointment, reappointment, and temporary privileges processes. Details of each step are described in Rule 1 of the Medical Staff Rules.

APPOINTMENT AND REAPPOINTMENT		
Person or Board	Function	Report to
Medical Staff Coordinator	Verify application information	Credentials Committee (See Rule 1.5)
Credentials Committee	Review applicant's qualifications vis-à-vis Medical Staff Bylaws general standards; recommend appointment	Department Committee (See Rule 1.7-1)
Department	Review applicant's privilege requests vis-à-vis standards developed by department; recommend appointment and privileges	Medical Executive Committee (See Rule 1.7-2)
Medical Executive Committee	Review recommendations of Credentials Committee and department; recommend appointment and privileges	Governing Body (See Rule 1.7-3)

Governing Board	Review recommendations of the Medical Executive Committee; make decision	Final Action (See Rule 1.7-4)
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REAPPOINTMENT AND PRIVILEGES		
Person or Body	Function	Report to
Medical Staff Coordinator	Verify reappointment information	Department (See Rule 1.5)
Department	Review applicant's performance vis-à-vis standards developed by department; recommend appointment and privileges	Medical Executive Committee (See Rule 1.7-2)
Medical Executive Committee	Review recommendations of department recommend appointment and privileges	Governing Board (See Rule 1.7-3)
Governing Board	Review recommendations of the Medical Executive Committee; make decision	Final Action (See Rule 1.7-4)

TEMPORARY PRIVILEGES		
Person or Board	Function	Report to
Medical Staff Coordinator	Verify key information	Department (See Rule 1.5 and Bylaws Section 5.5-2)
Department Chief	Review applicant's qualifications vis-à-vis standards developed by department; recommend temporary privileges	(See Bylaws Section 5.5-2d.)
Chief of Staff	Review recommendations of Department Chief; recommend temporary privileges	Chief Executive Officer (See Bylaws Section 5.5-2d.)
Chief Medical Officer	Review recommendations of Chief of Staff and recommend temporary privileges	Chief Executive Officer (See Bylaws Section 5.5-2d.)
Chief Executive Officer	Make decision	Final action (See Bylaws Section 5.5-2d.)

Article 5 Privileges

5.1 EXERCISE OF PRIVILEGES

Except as otherwise provided in these Bylaws or the Rules, every practitioner or Allied Health Professional providing direct clinical services at this hospital shall be entitled to exercise only those setting-specific privileges granted to him or her. Practitioners who wish to participate in the delivery of telemedicine services (whether to patients of this hospital, or to patients of another facility that this hospital is assisting via telemedicine technology) must apply for and be granted setting and procedure-specific telemedicine privileges. (Additionally, practitioners who are not otherwise members of this hospital's Medical Staff who wish to provide services via telemedicine technology must apply for and be granted membership and privileges as part of the Telemedicine Staff (per Article 3, Categories of Membership, Appendix 3G Telemedicine Staff) in order to provide services to patients of this hospital.)

5.2 CRITERIA FOR PRIVILEGES/GENERAL COMPETENCIES

5.2-1 Criteria for Privileges

Subject to the approval of the Medical Executive Committee and Governing Board, each department will be responsible for developing criteria for granting setting-specific privileges (including, but not limited to, identifying and developing criteria for any privileges that may be appropriately performed via telemedicine). These criteria shall address the hospital's general competencies (as described below) and assure uniform quality of patient care, treatment, and services. Insofar as feasible, affected categories of Allied Health Professionals shall participate in developing the criteria for privileges to be exercised by Allied Health Professionals. Such criteria shall not be inconsistent with the Medical Staff Bylaws, Rules or policies. Each department's approved criteria for granting privileges shall be included in the department's rules.

5.2-2 General Competencies

The Medical Staff shall assess all practitioners' current proficiency in the hospital's general competencies, which shall be established by the departments and shall include assessment of patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. Each department shall define how to measure these general competencies as applicable to the privileges requested, and shall use them to regularly monitor and assess each practitioner's current proficiency.

5.3 DELINEATION OF PRIVILEGES IN GENERAL

5.3-1 Requests

Each application for appointment and reappointment to the Medical Staff must contain a request for the specific privileges desired by the applicant. A request for a modification of privileges must be supported by documentation of training and/or experience supportive of the request. The basic steps for processing requests for privileges are described at Bylaws, Section 4.2.

5.3-2 Basis for Privilege Determination

Requests for privileges shall be evaluated on the basis of the hospital's needs and ability to support the requested privileges and assessment of the applicant's general competencies with respect to the requested privileges, as evidenced by the applicant's license, education, training, experience, demonstrated professional competence, judgment and clinical performance, (as confirmed by peers knowledgeable of the applicant's professional performance), health status, the documented results of patient care and other quality improvement review and monitoring, performance of a sufficient number of procedures each year to develop and maintain the applicant's skills and knowledge, and compliance with any specific criteria applicable to the privileges requested. Privilege determinations shall also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where an applicant exercises privileges.

5.3-3 Telemedicine Privileges

- a. The initial appointment of telemedicine privileges may be based upon:
 1. The practitioner's full compliance with this hospital's privileging standards;
 2. By using this hospital's standards but relying on information provided by an accredited hospital or health care entity at which the practitioner routinely practices
- b. Reappointment of a Telemedicine Staff member's privileges may be based upon performance at this hospital, and, if insufficient information is available, upon information from an accredited hospital or health care entity where the practitioner routinely practices.

5.4 ADMISSIONS; RESPONSIBILITY FOR CARE; HISTORY AND PHYSICAL REQUIREMENTS; AND OTHER GENERAL RESTRICTIONS ON EXERCISE OF PRIVILEGES BY LIMITED LICENSE PRACTITIONERS

5.4-1 Admitting Privileges

- a. The following categories of licensees are eligible to independently admit patients to the hospital:
 1. Physicians (MDs or DOs), Podiatrists, and Oral Surgeons.
- b. The following categories of licensees are eligible to co-admit patients to the hospital:
 1. Dentists;
 2. Clinical Psychologists.
- c. Additionally, AHPs with admitting privileges may admit patients upon order of a member of the Medical Staff who has admitting privileges and who maintains responsibility for the overall care of the patient.
 1. Physician Assistants;
 2. Nurse Practitioners

5.4-2 Responsibility for Care of Patients

- a. All patients admitted to the hospital must be under care of a member of the Medical Staff.
- b. The admitting member of the Medical Staff shall establish, at the time of admission, the patient's condition and provisional diagnosis.

- c. For patients admitted by or upon order of a dentist, oral surgeon, clinical psychologist or podiatrist, a physician member must assume responsibility for the care of the patient's medical or psychiatric problems that are 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 or clinical privileges.

5.4-3 History and Physicals and Medical Appraisals

- a. Practitioners, with appropriate privileges, may perform history and physical examinations.
- b. When evidence of appropriate training and experience is documented, a limited license practitioner may perform the history or physical on his or her own patient. Otherwise, a physician member must conduct or directly supervise the admitting history and physical examination (except the portion related to dentistry, clinical psychology or podiatry).
- c. All patients admitted for care in a hospital by a dentist, oral surgeon, clinical psychologist or podiatrist shall receive the same basic medical appraisal as patients admitted to other services, and a physician member or a limited license practitioner with appropriate privileges shall determine the risk and effect of any proposed treatment or surgical procedure on the general health status of the patient. 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).
- d. The admitting or referring member of the Medical Staff shall assure the completion of a physical examination and medical history on all patients within 24 hours after admission (or registration for a surgery or procedure requiring anesthesia or moderate or deep sedation), or immediately before. This requirement may be satisfied by a complete history and physical that has been performed within the 30 days prior to admission or registration (the results of which are recorded in the hospital's medical record) so long as an examination for any changes in the patient's condition is completed and documented in the hospital's medical record within 24 hours after admission or registration.
- e. Additionally, the history and physical must be updated within 24 hours prior to any surgical procedure or other procedure requiring general anesthesia or moderate or deep sedation. The practitioner responsible for administering anesthesia may, if granted clinical privileges, perform this updating history and physical.

5.4-4 Surgery and High Risk Interventions by Limited License Practitioners

- a. Surgical procedures performed by dentists and podiatrists shall be under the overall supervision of the Chief of the designated department or the Chief's designee.
- b. Additionally, the findings, conclusions, and assessment of risk must be confirmed or endorsed by a physician member with appropriate privileges, prior to major high-risk diagnostic or therapeutic interventions.

5.5 TEMPORARY PRIVILEGES

5.5-1 Circumstances

- a. Temporary privileges may be granted after appropriate application in the following circumstances for a time limited period not to exceed 120 days:
 1. For a new applicant with a completed application pending approval of the Medical Executive Committee and Governing Board;
 2. For practitioners providing locum tenens coverage for a member of the Medical Staff. Temporary privileges of this nature may not be granted in more than two instances or exceed a cumulative total of 120 days in a calendar year, after which the practitioner must apply for Medical Staff membership or
 3. As otherwise necessary to fulfill an important patient care need.
- b. Temporary members of the Medical Staff who are granted temporary membership for purposes of serving on standing or Ad Hoc Committees for investigation proceedings are not, by virtue of such membership, granted temporary clinical privileges.

5.5-2 Application and Review

- a. Temporary privileges may be granted after the applicant completes the application procedure and the Medical Staff office completes the application review process. The following conditions apply:
 1. There must first be verification of:
 - i. Current licensure;
 - ii. Relevant training or experience;
 - iii. Current competence;
 - iv. Ability to perform the privileges requested.
 - v. malpractice insurance
 2. The results of the National Practitioner Data Bank and Medical Board of California queries have been obtained and evaluated.
 3. The applicant has:
 - i. Filed a complete application with the Medical Staff office;
 - ii. No current or previously successful challenge to licensure or registration;
 - iii. Not been subject to involuntary termination of Medical Staff membership at another organization; and
 - iv. Not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges.
- b. There is no right to temporary privileges. Accordingly, temporary privileges should not be granted unless the available information supports, with reasonable certainty, a favorable determination regarding the requesting applicant's or Allied Health Professional's qualifications, ability and judgment to exercise the privileges requested.
- c. If the available information is inconsistent or casts any reasonable doubts on the applicant's qualifications, action on the request for temporary privileges may be deferred until the doubts have been satisfactorily resolved.
- d. Temporary privileges may be granted by the Chief Executive Officer, or his or her designee on the recommendation of the Chief Medical Officer or Chief of Staff.

- e. A determination to grant temporary privileges shall not be binding or conclusive with respect to an applicant's pending request for appointment to the Medical Staff.

5.5-3 General Conditions and Termination

- a. Members granted temporary privileges shall be subject to the proctoring and supervision in accordance with the Focused Professional Practice Evaluation requirements specified in the Rules.
- b. Temporary privileges shall automatically terminate at the end of the designated period, unless affirmatively renewed as provided at Bylaws, Section 5.5-1(a) or earlier terminated as provided at Bylaws, Section 5.5-3(c), below.
- c. Temporary privileges may be terminated with or without cause at any time by the Chief of Staff, Chief Medical Officer or the Chief Executive Officer after conferring with the Chief of Staff or the responsible Department Chief. The termination of temporary privileges shall not be reviewable according to the procedures set forth in the Medical Staff Bylaws unless required to be reported pursuant to California Business and Professions Code section 805.
- d. Whenever temporary privileges are terminated, the Chief of Staff or Chief Medical Officer shall assign a member to assume responsibility for the care of the affected practitioner's patient(s). The wishes of the patient and affected practitioner shall be considered in the choice of a replacement member.
- e. All persons requesting or receiving temporary privileges shall be bound by the Bylaws and Rules.

5.6 DISASTER AND EMERGENCY PRIVILEGES

5.6-1 Disaster privileges may be granted when the hospital's disaster plan has been activated and the organization is unable to handle the immediate patient needs. The following provisions apply:

- a. Disaster privileges may be granted on a case-by-case basis by the Chief Executive Officer, based upon recommendation of the Chief of Staff, or in his or her absence, the recommendation of the responsible Department Chief, upon presentation of a valid government-issued photo identification issued by a state or federal agency and any of the following:
 - 1. A current picture hospital identification card;
 - 2. A current license to practice and primary source verification of the license;
 - 3. Identification indicating that the practitioner is a member of a Disaster Medical Assistance Team;
 - 4. Identification indicating that the practitioner has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state, or municipal entity;
 - 5. Presentation by current hospital or Medical Staff member(s) with personal knowledge regarding the practitioner's identity.
- b. Persons granted disaster privileges shall wear identification badges denoting their status as a Disaster Medical Assistance Team member.

- c. The Medical Staff office shall begin the process of verification of credentials and privileges as soon as the immediate situation is under control, using a process identical to that described in Bylaws, Section 5.5-2, above (except that the individual is permitted to begin rendering services immediately, as needed). The primary source verification of licensure and competence will be completed within 72 hours if at all possible. If this cannot be accomplished, the reason will be documented in the provider's file.
- d. The responsible Department Chief or Chief of Staff shall arrange for appropriate concurrent or retrospective monitoring of the activities of practitioners granted disaster privileges.

5.6-2 In the event of an emergency, any member of the Medical Staff or credentialed Allied Health Professional shall be permitted to do everything reasonably possible, within the scope of their licensure, to save the life of a patient or to save a patient from serious harm. The member or Allied Health Professional shall promptly yield such care to a qualified member when one becomes available.

5.7 TRANSPORT AND ORGAN HARVEST TEAMS

Properly licensed practitioners who individually, or as members of a group or entity, have contracted with the hospital to participate in transplant and/or organ harvesting activities may exercise clinical privileges within the scope of their agreement with the hospital.

5.8 DISSEMINATION OF PRIVILEGES LIST

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

Article 6 Allied Health Professionals

6.1 QUALIFICATIONS OF ALLIED HEALTH PROFESSIONALS

Allied Health Professionals (AHPs) are not eligible for Medical Staff membership. They may be granted practice privileges if they hold a license, certificate or other credentials in a category of AHPs that the Governing Board (after securing Medical Executive Committee comments) has identified as eligible to apply for practice privileges, and only if the AHPs are professionally competent and continuously meet the qualifications, standards and requirements set forth in the Medical Staff Bylaws and Rules.

6.2 CATEGORIES

The Governing Board shall determine, based upon comments of the Medical Executive Committee and such other information as it has before it, those categories of AHPs that shall be eligible to exercise privileges in the hospital. Such AHPs shall be subject to the supervision requirements developed in each department and approved by the Interdisciplinary Practice Committee, the Medical Executive Committee, and the Governing Board.

6.3 PRIVILEGES AND DEPARTMENT ASSIGNMENT

6.3-1 AHPs may exercise only those setting-specific privileges granted to them by the Governing Board. The range of privileges for which each AHP may apply, and any special limitations or conditions to the exercise of such privileges, shall be based on recommendations of the Interdisciplinary Practice Committee, subject to approval by the Medical Executive Committee and the Governing Board.

6.3-2 An AHP must apply and qualify for practice privileges, and practitioners who desire to supervise or direct AHPs who provide dependent services must apply and qualify for privileges to supervise approved AHPs. Applications for initial granting of practice privileges and biennial renewal thereof shall be submitted and processed in a similar manner to that provided for practitioners, unless otherwise specified in the Rules.

6.3-3 Each AHP shall be assigned to the department or departments appropriate to his or her occupational or professional training and, unless otherwise specified in these Bylaws or the Rules, shall be subject to terms and conditions similar to those specified for practitioners as they may logically be applied to AHPs and appropriately tailored to the particular AHP.

6.4 PREROGATIVES

The prerogatives which may be extended to an AHP shall be defined in the Rules and/or hospital policies. Such prerogatives may include:

6.4-1 Provision of specified patient care services; which services may be provided independently or under the supervision or direction of a Medical Staff member and consistent with the practice privileges granted to the AHP and within the scope of the AHP's licensure or certification, as specified in the Rules. These privileges may include performance of medical screening exam (MSE).

6.4-2 Service on the Medical Staff, department and hospital committees.

- 6.4-3** Attendance at the meetings of the department to which the AHP is assigned, as permitted by the department rules, and attendance at hospital education programs in the AHP's field of practice.

6.5 RESPONSIBILITIES

Each AHP shall:

- 6.5-1** Meet those responsibilities required by the Rules and as specified for practitioners in Bylaws, Section 2.6, as they may be logically applied to reflect the more limited practice of the AHP.
- 6.5-2** Retain appropriate responsibility within the AHP's area of professional competence for the care and supervision of each patient in the hospital for whom the AHP is providing services.
- 6.5-3** Participate in peer review and quality improvement and in discharging such other functions as may be required from time to time.

6.6 PROCEDURAL RIGHTS OF ALLIED HEALTH PROFESSIONALS

6.6-1 Fair Hearing and Appeal

Denial, revocation, or modification of AHPs' privileges shall be the prerogative of the Interdisciplinary Practices Subcommittee, subject to approval by the Chief of Staff, the Medical Executive Committee, and the Governing Body. The procedural rights described at Bylaws, Article 14, Hearings and Appellate Reviews, shall apply.

6.6-2 Automatic Termination

Notwithstanding the provisions of Bylaws, Section 6.6-1, an AHP's privileges shall automatically terminate, without review pursuant to Bylaws, Section 6.6-1 or any other Section of the Medical Staff Bylaws, in the event:

- a. The Medical Staff membership of the supervising practitioner is terminated, whether such termination is voluntary or involuntary;
- b. The supervising practitioner no longer agrees to act as the supervising practitioner for any reason, or the relationship between the AHP and the supervising practitioner is otherwise terminated, regardless of the reason therefore; or
- c. The AHP's certification or license expires, is revoked, or is suspended.
- d. Loss of professional liability insurance, exclusion from participation in federally funded programs such as Medicare and Medi-Cal, and failure to pay dues and assessments, if present.

Where the AHP's privileges are automatically terminated for reasons specified in Section 6.6-2(a), above, the AHP may apply for reinstatement as soon as the AHP has found another supervising practitioner 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.

6.6-3 Review of Category Decisions

The rights afforded by this Section shall not apply to any decision regarding whether a category of AHP shall or shall not be eligible for practice privileges and the terms,

prerogatives, or conditions of such decision. Those questions shall be submitted for consideration to the Governing Board, which has the discretion to decline to review the request or to review it using any procedure the Governing Board deems appropriate.

Article 7 Performance Evaluation and Monitoring

7.1 GENERAL OVERVIEW OF PERFORMANCE EVALUATION AND MONITORING ACTIVITIES

The credentialing and privileging processes described in Bylaws, Article 4, Procedures for Appointment and Reappointment, and Article 5, Privileges, require that the Medical Staff develop ongoing performance evaluation and monitoring activities to ensure that decisions regarding appointment to membership on the Medical Staff and granting or renewing of privileges are, among other things, detailed, current, accurate, objective and evidence-based. Additionally, performance evaluation and monitoring activities help assure timely identification of problems that may arise in the ongoing provision of services in the hospital. Problems identified through performance evaluation and monitoring activities are addressed via the appropriate performance improvement and/or remedial actions as described in Bylaws, Article 13, Performance Improvement and Corrective Action.

7.2 PERFORMANCE MONITORING GENERALLY

- 7.2-1** Except as otherwise determined by the Medical Executive Committee and Governing Board, the Medical Staff shall regularly monitor all members' privileges in accordance with the provisions set forth in these Bylaws and such performance monitoring policies as may be developed by the Medical Staff and approved by the Medical Executive Committee and the Governing Board.
- 7.2-2** Performance monitoring is not viewed as a disciplinary measure, but rather is an information-gathering activity. Performance monitoring does not give rise to the procedural rights described in Bylaws, Article 14, Hearings and Appellate Reviews (unless the form of monitoring is Level III proctoring and its imposition becomes a restriction of privileges because procedures cannot be done unless a proctor is present and proctors are not available after reasonable attempts to secure a proctor).
- 7.2-3** The Medical Staff shall clearly define how information gathered during performance monitoring shall be shared in order to effectuate change and additional action, if determined necessary.
- 7.2-4** Performance monitoring activities and reports shall be integrated into other quality improvement activities.
- 7.2-5** The results of any practitioner-specific performance monitoring shall be considered when granting, renewing, revising or revoking clinical privileges of that practitioner.

7.3 ONGOING PROFESSIONAL PERFORMANCE EVALUATIONS

- 7.3-1** Each department of the Medical Staff shall recommend, for Medical Executive Committee and Governing Board approval, the criteria to be used in the conduct of Ongoing Professional Performance Evaluations for its practitioners.
- 7.3-2** Methods that may be used to gather information for Ongoing Professional Performance Evaluations include, but are not limited to:
- a. Periodic chart review;
 - b. Direct observation;
 - c. Monitoring of diagnostic and treatment techniques;
 - d. Discussion with other individuals involved in the care of each patient including consulting physicians, assistants at surgery, nursing and administrative personnel.
- 7.3-3** Ongoing performance reviews shall be factored into the decision to maintain, revise or revoke a practitioner's existing privilege(s).

7.4 FOCUSED PROFESSIONAL PRACTICE EVALUATION

- 7.4-1** The Medical Staff is responsible for developing a focused professional practice evaluation process that will be used in predetermined situations to evaluate, for a time-limited period, a practitioner's competency in performing specific privilege(s). The Medical Staff may supplement these Bylaws with policies, for approval by the Medical Executive Committee and the Governing Board, that will clearly define the circumstances when a focused evaluation will occur, what criteria and methods should be used for conducting the focused evaluation, the duration of the evaluation period, requirements for extending the evaluation period, and how the information gathered during the evaluation process will be analyzed and communicated.
- 7.4-2** Information for a focused evaluation process may be gathered through a variety of measures including, but not limited to:
- a. Retrospective or concurrent chart review;
 - b. Monitoring clinical practice patterns;
 - c. Simulation;
 - d. External peer review;
 - e. Discussion with other individuals involved in the care of each patient;
 - f. Proctoring, as more fully described at Bylaws, Section 7.4-4, below.
- 7.4-3** A Focused Professional Practice Evaluation shall be used in at least the following situations:
- a. All initial appointees to the Medical Staff and all members granted new privileges shall be subject to a period of focused professional practice evaluation in accordance with these Bylaws and the Rules of the department in which the applicant or member will be exercising those privileges. Such focused evaluation will generally include a period of Level I proctoring in accordance with Bylaws, Section 7.4-4(a), below, unless additional circumstances appear to warrant a higher level of proctoring, as described below.
 - b. In special instances, focused evaluation will be imposed as a condition of renewal of privileges (for example, when a member requests renewal of a privilege that has been

performed so infrequently that it is difficult to assess the member's current competency in that area). Such evaluation will generally consist of Level I proctoring in accordance with Bylaws, Section 7.4-4(a)(1) below, unless additional circumstances appear to warrant a higher proctoring level, as described below.

- c. When questions arise regarding a practitioner's competency in performing specific privilege(s) at the hospital as a result of specific concerns or circumstances, a focused evaluation may be imposed. Such evaluations may include either Level II or III proctoring, in accordance with these Bylaws, Sections Section 7.4-4(a)(1) or (2).
- d. As otherwise defined in these Bylaws or applicable Focused Professional Practice Evaluation policies.
- e. Nothing in the foregoing precludes the use of other Focused Professional Practice Evaluation tools, in addition to or in lieu of proctoring, as deemed warranted by the circumstances.

7.4-4 Proctoring

a. Overview of Proctoring Levels

- 1. Level I proctoring shall be considered routine and is generally implemented as a means to review initially requested privileges in accordance with Bylaws, Section 7.4-3(a), above, and for review of infrequently used privileges in accordance with Bylaws, Section 7.4-3(b), above.
- 2. Level II proctoring is appropriate in situations where a practitioner's competency or performance is called into question, in accordance with Bylaws, Section 7.4-3(c), above, but where the circumstances do not involve a "medical disciplinary" cause or reason or where the proctoring does not constitute a restriction on the practitioner's privilege(s) (i.e., the practitioner is required to participate in proctoring, and to notify either the proctor or other designated individual(s) prior to providing services, but is permitted to proceed without the proctor if one is not available).
- 3. Level III proctoring is appropriate in situations where a practitioner's competency or performance is called into question due to a "medical disciplinary" cause or reason in accordance with Bylaws, Section 7.4-3(c), above, and where the form of proctoring is a restriction on the practitioner's privilege(s) (because the practitioner may not perform a procedure or provide care in the absence of the proctor). Upon imposition of Level III proctoring, that practitioner is afforded such procedural rights as provided at Bylaws, Article 14, Hearings and Appellate Reviews.

b. Overview of Proctoring Procedures

- 1. Whenever proctoring is imposed, the number (or duration) and types of procedures to be proctored shall be delineated.
- 2. During the proctoring, the practitioners must demonstrate they are qualified to exercise the privileges that were granted and are carrying out the duties of their Medical Staff category.
- 3. In the event that the new applicant has privileges at a neighboring hospital where members of this hospital's Medical Staff are familiar with the member to be proctored, and familiar with that neighboring hospital's peer review standards, privileging and proctoring information from the neighboring hospital may, at the discretion of the appropriate Department *chief*, be acceptable to satisfy a portion of the focused professional practice evaluation required for this hospital.

c. Proctor: Scope of Responsibility

1. All members who act as proctors of new appointees and/or members of the Medical Staff are acting at the direction of and as an agent for the department, the Medical Executive Committee and the Governing Board.
2. The intervention of a proctor shall be governed by the following guidelines:
 - i. A member who is serving as a proctor does not act as a supervisor of the member or practitioner he or she is observing. His or her role is to observe and record the performance of the member or practitioner being proctored, and report his or her evaluation to the department.
 - ii. A proctor is not mandated to intervene when he or she observes what could be construed as deficient performance on the part of the practitioner or member being proctored.
 - iii. In an emergency situation, a proctor may intervene, even though he or she has no legal obligation to do so.

d. Completion of Proctoring

The member shall remain subject to such proctoring until the Medical Executive Committee has been furnished with a report signed by the chief of the department to which the member is assigned with an evaluation of the member's performance and a statement that the member appears to meet all of the qualifications for unsupervised practice in the hospital.

e. Effect of Failure to Complete Proctoring

1. **Failure to Complete Necessary Volume.** Any practitioner or member undergoing Level I or Level II proctoring who fails to complete the required number of proctored cases within the time frame established in the Bylaws and Rules shall be deemed to have voluntarily withdrawn his or her request for membership (or the relevant privileges), and he or she shall not be afforded the procedural rights provided in Bylaws, Article 14, Hearings and Appellate Reviews. However, the department has the discretion to extend the time for completion of proctoring in appropriate cases subject to ratification by the Medical Executive Committee. The inability to obtain such an extension shall not give rise to procedural rights described in Bylaws, Article 14, Hearings and Appellate Reviews.
2. **Failure to Satisfactorily Complete Proctoring.** If a practitioner completes the necessary volume of proctored cases but fails to perform satisfactorily during proctoring, he or she may be terminated (or the relevant privileges may be revoked), and he or she shall be afforded the procedural rights as provided in Bylaws, Article 14, Hearings and Appellate Reviews.
3. **Effect on Advancement.** The failure to complete proctoring for any specific privilege shall not, by itself, preclude advancement from provisional staff. If advancement is approved prior to completion of proctoring, the proctoring will continue for the specified privileges. The specific privileges may be voluntarily relinquished or terminated, pursuant to Bylaws, Section 7.4-4(e) (1) or (2), if proctoring is not completed thereafter within a reasonable time.

Article 8 Medical Staff Officers

8.1 MEDICAL STAFF OFFICERS — GENERAL PROVISIONS

8.1-1 Identification

- a. The officers of the Medical Staff shall be the:
 1. Chief of Staff,
 2. Chief of Staff-Elect,
 3. Secretary-Treasurer, and
 4. Chief Medical Officer

The Secretary-Treasurer is elected at the last Medical Staff meeting of the Medical Staff year. The Chief of Staff-Elect shall ascend to the position of Chief of Staff upon the completion of term. The Secretary-Treasurer shall ascend to the position of Chief of Staff-Elect upon the completion of term. Officers shall take office on July 1 and will hold office for two years ending June 30th of the second year of the two-year term. Only a physician may hold office. The CMO is the Hospital Medical Director, who is appointed by the Governing Board.

- b. In addition, the Medical Staff's department Chiefs shall be deemed Medical Staff officers within the meaning of California law serving either one- or two-year terms as approved by their respective department committees.

8.1-2 Qualifications

All Medical Staff officers shall:

- a. Understand the purposes and functions of the Medical Staff and demonstrate willingness to assure that patient welfare always takes precedence over other concerns;
- b. Understand and be willing to work toward attaining the hospital's lawful and reasonable policies and requirements;
- c. Have administrative ability as applicable to the respective office;
- d. Be able to work with and motivate others to achieve the objectives of the Medical Staff and hospital;
- e. Demonstrate clinical competence in his or her field of practice;
- f. Be an active Medical Staff member (and remain in good standing as an active Medical Staff member while in office); and
- g. Not have any significant conflict of interest.

8.1-3 Disclosure of Conflict of Interest

- a. All nominees for election or appointment to Medical Staff offices (including those nominated by petition of the Medical Staff pursuant to Bylaws, Section 8.2-3) 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 that could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff. Generally, a conflict of interest arises when there is a divergence between an individual's private interests and his/her professional obligations, such that an independent observer might reasonably question whether the individual's professional actions or decisions are determined by those private interests. A conflict of interest depends on the

situation and not on the character of the individual. The fact that an individual practices in the same specialty as a practitioner who is being reviewed does not by itself create a conflict of interest. The evaluation of whether a conflict of interest exists shall be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. The Medical Executive Committee shall evaluate the significance of such disclosures and discuss any significant conflicts with the nominee. If a nominee with a significant conflict remains on the ballot, the nature of his or her conflict shall be disclosed in writing and circulated with the ballot.

- b. A person nominated from the floor shall be asked to verbally disclose conflicts to those in attendance at the meeting, and the Medical Executive Committee or its representative shall have an opportunity to comment thereon, prior to the vote.

8.2 METHOD OF SELECTION — GENERAL OFFICERS

8.2-1 Succession of Officers

The Chief of Staff-Elect shall accede to the position of Chief of Staff upon the Chief of Staff's completion of his or her term. The Secretary-Treasurer shall accede to the position of Chief of Staff-Elect upon the Chief of Staff-Elect's completion of his or her term.

8.2-2 Nominating Committee

A Nominating Committee shall be appointed by the Medical Executive Committee not later than (60) days prior to the last meeting of the Medical Staff election year, or at least 45 days prior to any special election. The Nominating Committee shall include at least the current Chief of Staff, the Chief of Staff -Elect, Past Chief of Staff and the Chief Medical Officer. The Nominating Committee shall nominate one or more nominees for the Secretary-Treasurer position. Nominations from the floor will be recognized if the nominee is present and consents:

8.2-3 Nomination by Petition

The Medical Staff may nominate candidates for office by a petition signed by at least ten members who are eligible to vote and a statement from the candidate signifying willingness to run. Such nominations must be received by the Chief of Staff at least 30 days prior to the scheduled elections.

8.2-4 Election

The election shall be by vote at the quarterly medical staff meeting held in the spring, and the outcome shall be determined by a majority of the votes cast by the voting Medical Staff members.

8.2-5 Term of Office

Officers shall be elected in the spring of election year and shall take office the following July 1st.

The term of office shall be two years. No officer shall serve consecutive terms in the same position unless he or she filled that position due to a vacancy created during the previous term.

8.3 RECALL OF OFFICERS

A general Medical Staff Officer may be recalled from office for any valid cause including, but not limited to, failure to carry out the duties of his or her office. Except as otherwise provided, recall of a general Medical Staff Officer may be initiated by the Medical Executive Committee or by a petition signed by at least 33-1/3 percent of the Medical Staff members eligible to vote for officers; but recall itself shall require a 66-2/3 percent vote of the Medical Executive Committee or 66-2/3 percent vote of the Medical Staff members eligible to vote for general Medical Staff Officers.

8.4 FILLING VACANCIES

Vacancies created by resignation, removal, death, or disability shall be filled as follows:

8.4-1 A vacancy in the office of Chief of Staff shall be filled by the Chief of Staff-Elect.

8.4-2 A vacancy in the office of Chief of Staff-Elect shall be filled by the Secretary-Treasurer

8.4-3 A vacancy in the office of Secretary-Treasurer shall be filled by appointment by the Medical Executive Committee after recommendation is made by the nominating committee.

8.5 DUTIES OF OFFICERS

8.5-1 Chief of Staff and Chief Medical Officer:

The Chief of Staff and the Chief Medical Officer (CMO) are the two lead physicians at VCMC responsible to coordinate the collaboration between the Governing Body and the Medical Staff. The main purpose of this collaboration is to assure high quality medical care at VCMC.

The CMO is a position appointed by the Governing Board and HCA Director with an indefinite term of office and which involves working as a regular and stable professional liaison between the Medical Staff, Governing Board, and Administration.

The Chief of Staff is elected by the members of the medical staff to serve a two-year term of office and acts as the leader and coordinator of the independent activities of the Medical Staff as defined in these Bylaws.

The specific duties and responsibilities of these leaders shall include, in addition to duties defined elsewhere in these bylaws:

- a. The Chief of Staff shall call, preside at, and be responsible for the agenda of all meetings of the Medical Staff and the Executive Committee.
- b. The Chief of Staff shall appoint all members of all committees of the Medical Staff, except the Executive Committee, in accordance with the requirements for the constituent membership set forth in the Medical Staff Bylaws.
- c. The CMO and the Chief of Staff shall be ex-officio members of all committees of the Medical Staff except for those on which they were appointed in accordance with these bylaws to be regular voting members. The Chief of Staff is the Chairperson of the Executive Committee and votes as a member of the Executive Committee.

- d. The CMO and Chief of Staff shall attend meetings of the Oversight Committee.
- e. The Chief of Staff will, in coordination with the CMO and the Hospital Administrator, arrange for the Medical Staff's representation and participation in any hospital deliberation affecting the discharge of Medical Staff responsibilities.
- f. The Chief of Staff and CMO shall convey to the Governing Board and the Hospital Administrator the recommendations of the Executive Committee of the Staff about appointments and reappointments to the Medical Staff, granting or restriction of clinical privileges of individual practitioners, disciplinary action against individual practitioners, or amendments and additions to the Medical Staff Rules and Regulations or Bylaws.
- g. The Chief of Staff and the CMO shall be responsible for the enforcement of the Medical Staff Rules and Regulations, for implementation of punitive measures for non-compliance where these are stipulated in the Bylaws or Rules and Regulations. Either one may submit to the Executive Committee for possible investigation cases where disciplinary action may be considered.
- h. The CMO shall have direct responsibility for the organization and administration of the Medical Staff Office in accordance with the terms of the Medical Staff Bylaws, Rules and Regulations and with Administrative Policies as approved by the Governing Board and also by the Executive Committee when the Policies are relevant to the character or quality of medical care. In all of the medical administrative matters he or she shall act in coordination and cooperation with the Hospital Administrator in giving effect to the adopted policies of the governing Board and Executive Committee.
- i. The CMO shall, by administrative memorandum designate who shall fulfill his or her duties and assignments during his or her absence.

8.5-2 Chief of Staff-Elect

The Chief of Staff-Elect shall assume 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 shall perform such other duties as the Chief of Staff may assign or as may be delegated by these Bylaws or the Medical Executive Committee.

8.5-3 Secretary-Treasurer

The Secretary-Treasurer shall be a member of the Medical Executive Committee and Credentials Committee. The duties shall include, but not be limited to working with the Medical Staff manager to:

- a. Maintain a roster of members;
- b. Attend to correspondence and notices on behalf of the Medical Staff;
- c. Excuse absences from meetings on behalf of the Medical Executive Committee;
- d. Implement measures needed to safeguard all funds of the Medical Staff;
- e. Report to the Medical Executive Committee and general medical staff at least quarterly regarding a summary of all deposits, disbursements and balances.
- f. Performing such other duties as ordinarily pertain to the office or as may be assigned from time to time by the Chief of Staff or Medical Executive Committee

Article 9 Committees

9.1 GENERAL

9.1-1 Designation

The Medical Executive Committee and the other committees described in these Bylaws and the Rules shall be the standing committees of the Medical Staff. Special or ad hoc committees may be created by the Medical Executive Committee or a department to perform specified tasks. Any committee — whether Medical Staff-wide or department or other clinical unit, or standing or ad hoc — that is carrying out all or any portion of a function or activity required by these Bylaws is deemed a duly appointed and authorized committee of the Medical Staff.

9.1-2 Appointment of Members

- a. 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.
- b. A Medical Staff committee created in these Bylaws is composed as stated in the description of the committee in these Bylaws or the Rules. Except as otherwise provided in the Bylaws, committees established to perform Medical Staff functions required by these Bylaws may include any category of Medical Staff members; Allied Health Professionals; representatives from hospital departments such as administration, nursing services, or health information services; representatives of the community; and persons with special expertise, depending upon the functions to be discharged. Each Medical Staff member who serves on a committee participates with votes unless the statement of committee composition designates the position as nonvoting.
- c. The Chief Executive Officer, or his or her designee, in consultation with the Chief of Staff, shall appoint any non-Medical Staff members who serve in non-ex officio capacities.
- d. The Committee Chair, after consulting with the Chief of Staff and Chief Executive Officer, may call on outside consultants or special advisors.
- e. Each Committee Chair shall appoint a Vice Chair to fulfill the duties of the Chair in his or her absence and to assist as requested by the Chair. Each Committee Chair or other authorized person chairing a meeting has the right to discuss and to vote on issues presented to the committee.

9.1-3 Representation on Hospital Committees and Participation in Hospital Deliberations

The Medical Staff may discharge its duties relating to accreditation, licensure, certification, disaster planning, facility and services planning, financial management and physical plant safety by providing Medical Staff representation on hospital committees established to perform such functions.

9.1-4 Ex Officio Members

The Chief of Staff, the Chief Executive Officer, or their respective designee and the Chief Medical Officer are ex officio members of all standing and special committees of the Medical Staff and shall serve without vote unless provided otherwise in the provision or resolution creating the committee.

9.1-5 Action Through Subcommittees

Any standing committee may use subcommittees to help carry out its duties. The Medical Executive Committee shall be informed when a subcommittee is appointed. The Committee Chair may appoint individuals in addition to, or other than, members of the standing committee to the subcommittee after consulting with the Chief of Staff regarding Medical Staff members, and the Chief Executive Officer regarding hospital staff.

9.1-6 Terms and Removal of Committee Members

Unless otherwise specified, a committee member shall be appointed for a term of two years, subject to unlimited renewal, and shall serve until the end of this period and until his or her successor is appointed, unless he or she shall sooner resign or be removed from the committee. Any committee member who is appointed by the Chief of Staff may be removed by a majority vote of the Medical Executive Committee. Any committee member who is appointed by the Department chief may be removed by a majority vote of his or her Department Committee or the Medical Executive Committee. The removal of any committee member who is automatically assigned to a committee because he or she is a general officer or other official shall be governed by the provisions pertaining to removal of such officer or official.

9.1-7 Vacancies

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

9.1-8 Conduct and Records of Meetings

Committee meetings shall be conducted and documented in the manner specified for such meeting in Bylaws, Article 11, Meetings.

9.1-9 Attendance of Nonmembers

Any Medical Staff member who is in good standing may ask the Chair of any committee for permission to attend a portion of that committee's meeting dealing with a matter of importance to that practitioner. The Committee Chair shall have the discretion to grant or deny the request and shall grant the request only if the member's attendance will reasonably aid the committee to perform its function. If the request is granted, the invited member shall abide by all Bylaws and Rules applicable to that committee.

9.1-10 Conflict of Interest

- a. In any instance where a Medical Staff member has or reasonably could be perceived to have a conflict of interest, as defined below, such individual shall not participate in the discussion or voting on the matter, and shall be excused from any meeting during that time. However, the individual with a conflict may be asked, and may answer, any questions concerning the matter before leaving. Any dispute over the existence of a conflict of interest shall be resolved by the chairperson of the committee, or, if it cannot be resolved at that level, by the Chief of Staff.
- b. A conflict of interest arises when there is a divergence between an individual's private interests and his/her professional obligations, such that an independent observer might reasonably question whether the individual's professional actions or decisions are determined by those private interests. A conflict of interest depends on the situation and not on the character of the individual. The fact that an individual practices in the same

specialty as a practitioner who is being reviewed does not by itself create a conflict of interest. The evaluation of whether a conflict of interest exists shall be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. The fact that a committee member or Medical Staff leader chooses to refrain from participation, or is excused from participation, shall not be interpreted as a finding of actual conflict.

9.1-11 Accountability

All committees shall be accountable to the Medical Executive Committee.

9.2 MEDICAL EXECUTIVE COMMITTEE

9.2-1 Composition

The Medical Executive Committee shall be comprised of the elected officers of the Medical Staff, the Department Chiefs, immediate Past Chief of Staff, Residency Director, Chief Medical Officer, and ex officio members without vote including HCA Director, the Medical Directors of Ambulatory Care, Specialty Clinics, and Behavioral Health, the Chief Executive Officer, Chief Nursing Executive, Chief Resident and others appointed by the Chief of Staff. The Chief of Staff shall chair the Medical Executive Committee. A majority of the committee shall be physicians.

9.2-2 Duties

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

- a. Supervise the performance of all Medical Staff functions, which shall include:
 1. Requiring regular reports and recommendations from the departments, committees and officers of the Medical Staff concerning discharge of assigned functions;
 2. Issuing such directives as appropriate to assure effective performance of all Medical Staff functions; and
 3. Following up to assure implementation of all directives.
- b. Coordinate the activities of the committees and departments.
- c. Assure that the Medical Staff adopts Bylaws and Rules establishing the structure of the Medical Staff, the mechanism used to review credentials and to delineate individual privileges, the organization of the quality assessment and improvement activities of the Medical Staff as well as the mechanism used to conduct, evaluate, and revise such activities, the mechanism by which membership on the Medical Staff may be terminated, and the mechanism for hearing procedures.
- d. Based on input and reports from the departments and the Credentials Committee, assure that the Medical Staff adopts Bylaws, Rules or regulations establishing criteria and standards, consistent with California law, for Medical Staff membership and privileges (including, but not limited to, any privileges that may be appropriately performed via telemedicine), and for enforcing those criteria and standards in reviewing the qualifications, credentials, performance, and professional competence and character of applicants and staff members.

- e. Assure that the Medical Staff adopt Bylaws, Rules or regulations establishing 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.
- f. Evaluate the performance of practitioners exercising clinical privileges whenever there is doubt about an applicant's, member's, or Allied Health Professional's ability to perform requested privileges.
- g. Based upon input from the departments and Credentials Committee, make recommendations regarding all applications for Medical Staff appointment, reappointment and privileges.
- h. When indicated, initiate Focused Professional Practice Evaluations and/or pursue disciplinary or corrective actions affecting Medical Staff members.
- i. With the assistance of the Chief of Staff and CMO, supervise the Medical Staff's compliance with:
 - 1. The Medical Staff Bylaws, Rules, and policies;
 - 2. The hospital's Bylaws, Rules, and policies;
 - 3. State and federal laws and regulations; and
 - 4. The Joint Commission accreditation requirements.
- j. Oversee the development of Medical Staff policies, approve (or disapprove) all such policies, and oversee the implementation of all such policies.
- k. Implement, as it relates to the Medical Staff, the approved policies of the hospital.
- l. With the Department chief, set departmental objectives for establishing, maintaining and enforcing professional standards within the hospital and for the continuing improvement of the quality of care rendered in the hospital; assist in developing programs to achieve these objectives including, but not limited to, Ongoing Professional Practice Evaluations, as further described at Bylaws, Article 7, Performance Evaluation and Monitoring.
- m. Regularly report to the Governing Board through the Chief of Staff and the Chief Medical Officer on at least the following:
 - 1. The outcomes of Medical Staff quality improvement programs with sufficient background and detail to assure the Governing Board that quality of care is consistent with professional standards; and
 - 2. The general status of any Medical Staff disciplinary or corrective actions in progress.
- n. Review and make recommendations to the Chief Executive Officer regarding quality of care issues related to exclusive contract arrangements for professional medical services. In addition, the Medical Executive Committee shall assist the hospital in reviewing and advising on sources of clinical services provided by consultation, contractual arrangements or other agreements, in evaluating the levels of safety and quality of services provided via consultation, contractual arrangements, or other agreements, and in providing relevant input to notice-and-comment proceedings or other mechanisms that may be implemented by hospital administration in making exclusive contracting decisions.

- o. Prioritize and assure that hospital-sponsored educational programs incorporate the recommendations and results of Medical Staff quality assessment and improvement activities.
- p. Establish, as necessary, such ad hoc committees that will fulfill particular functions for a limited time and will report directly to the Medical Executive Committee.
- q. Establish the date, place, time and program of the regular meetings of the Medical Staff.
- r. Represent and act on behalf of the Medical Staff between meetings of the Medical Staff.
- s. Take such other actions as may reasonably be deemed necessary in the best interests of the Medical Staff and the hospital.

The authority delegated pursuant to this Section 9.2-2 may be removed by amendment of these Bylaws , or by Resolution of the Medical Staff, approved by a 2/3 vote of the voting Medical Staff, taken at a general or special meeting noticed to include the specific purpose of removing specifically-described authority of the Medical Executive Committee.

9.2-3 Meetings

The Medical Executive should be scheduled to meet on a monthly basis and shall meet at least ten (10) times during the calendar year. A permanent record of its proceedings and actions shall be maintained.

Article 10 Departments and Sections

10.1 ORGANIZATION OF CLINICAL DEPARTMENTS

Each department shall be organized as an integral unit of the Medical Staff and shall have a Chief and Chief Elect who are selected and shall have the authority, duties, and responsibilities specified in the Rules. Additionally, each department may appoint a Department Committee and such other standing or Ad Hoc Committees as it deems appropriate to perform its required functions. The composition and responsibilities of each standing Department Committee shall be specified in the Rules. Departments may also form sections as described below.

10.2 DESIGNATION

10.2-1 Current Designation

The current departments are:

- Emergency Medicine
- Family Medicine
- Medicine
- Obstetrics and Gynecology
- Pediatrics
- Psychiatry
- Psychology
- Surgery (includes Anesthesia)

10.2-2 Future Departments

The Medical Executive Committee will periodically restudy the designation of the departments and recommend to the Governing Board what action is desirable in creating, eliminating, or combining departments for better organizational efficiency and improved patient care. Action shall be effective upon approval by the Medical Executive Committee and the Governing Board.

10.3 ASSIGNMENT TO DEPARTMENTS

Each member shall be assigned membership in at least one department, but may also be granted membership and/or clinical privileges in other departments consistent with the practice privileges granted.

10.4 FUNCTIONS OF DEPARTMENTS

The departments shall fulfill the clinical, administrative, quality improvement, risk management, utilization management, and collegial and education functions described in the Rules. When the department or any of its committees meets to carry out the duties described below, the meeting body shall constitute a peer review committee, which is subject to the standards and entitled to the protections and immunities afforded by federal and state law for peer review committees. Each department or its committees, if any, must meet regularly to carry out its duties.

10.5 DEPARTMENT CHIEF AND CHIEF-ELECT

10.5-1 Qualifications

Each Department Chief and Department Chief Elect shall be active Medical Staff members, shall have demonstrated ability in at least one of the clinical areas covered by the department, shall be Board certified, or affirmatively establishes through the privilege delineation process, that he/she possess comparable competence, and shall be willing and able to faithfully discharge the functions of his or her office. Specific qualifications shall be set forth in the Rules.

10.5-2 Selection

Department officers shall be elected by a majority of the votes cast by the voting Medical Staff members of the department. Candidates shall be selected by the nominating and elections procedures described in the Rules.

10.5-3 Term of Office

Each Department Chief and Chief Elect shall serve a one or two-year term as determined by their department. Their term will end with the Medical Staff year or when their successors are chosen, unless they shall sooner resign, be removed from office, or lose their Medical Staff membership or privileges in that department. Department officers are eligible to succeed themselves.

10.5-4 Removal

A department officer may be removed for failure to cooperatively and effectively perform the responsibilities of his or her office. Removal may be initiated by the Medical Executive Committee or by written request from 20 percent of the members of the department who are eligible to vote on department matters. Such removal may be effected by a 66-2/3 percent vote of the Medical Executive Committee members or by a 66-2/3 percent vote of the department members eligible to vote on department matters. The procedures for effecting removal shall be as described in the Rules.

10.5-5 Roles and Responsibilities of Department Officers

Specific roles and responsibilities of department officers shall be as set forth in the Rules. These roles and responsibilities include at least the following:

- a. Clinically related activities of the department.
- b. Administratively related activities of the department, unless otherwise provided by the hospital.
- c. Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges.

- d. Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department.
- e. Recommending clinical privileges for each member of the department.
- f. Assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization.
- g. Integration of the department or service into the primary functions of the organization.
- h. Coordination and integration of interdepartmental and intradepartmental services.
- i. Development and implementation of policies and procedures that guide and support the provision of care, treatment, and services.
- j. Recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services.
- k. Determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services.
- l. Continuous assessment and improvement of the quality of care, treatment, and services.
- m. Maintenance of quality control programs, as appropriate.
- n. Orientation and continuing education of all persons in the department
- o. Recommend space and other resources needed by the department

10.6 SECTIONS

Within each department, the practitioners of the various specialty groups may organize themselves as a clinical section. Each section may develop Rules specifying the purpose, responsibilities and method of selecting officers. These Rules shall be effective when approved as required by Bylaws, Article 15, General Provisions. While sections may assist departments in performance of departmental functions, responsibility and accountability for performance of departmental functions shall remain at the departmental level.

Article 11 Meetings

11.1 MEDICAL STAFF MEETINGS

11.1-1 Medical Staff Meetings

There shall be at least three meetings of the Medical Staff during each Medical Staff year. The date, place and time of the meeting(s) shall be determined by the Chief of Staff. The Chief of Staff shall present a report on significant actions taken by the Medical Executive Committee during the time since the last Medical Staff meeting and on other matters believed to be of interest and value to the membership. No business shall be transacted at any Medical Staff meeting except that stated in the agenda.

11.1-2 Special Meetings

Special meetings of the Medical Staff may be called at any time by the Chief of Staff, Medical Executive Committee, or Governing Board, or upon the written request of 10 percent of the voting members. The meeting must be called within 30 days after receipt of such request. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

11.1-3 Combined or Joint Medical Staff Meetings

The Medical Staff may participate in combined or joint Medical Staff meetings with staff members from other hospitals, health care entities, or the County Medical Society; however, precautions shall be taken to assure that confidential Medical Staff information is not inappropriately disclosed, and to assure that this Medical Staff (through its authorized representative(s)) maintains access to, and approval authority of, all minutes prepared in conjunction with any such meetings.

11.2 DEPARTMENT AND COMMITTEE MEETINGS

11.2-1 Regular Meetings

Departments and committees, by resolution, may provide the time for holding regular meetings and no notice other than such resolution shall then be required. Each department shall meet regularly, at least quarterly, to review and discuss patient care activities and to fulfill other departmental responsibilities.

11.2-2 Special Meetings

A special meeting of any department or committee may be called by, or at the request of, the Chair thereof, the Medical Executive Committee, Chief of Staff, or by 33-1/3 percent of the group's current members, but not fewer than three members. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

11.2-3 Combined or Joint Department or Committee Meetings

The departments or committees may participate in combined or joint department or committee meetings with staff members from other hospitals, health care entities or the County Medical Society; however, precautions shall be taken to assure that confidential Medical Staff information is not inappropriately disclosed, and to assure that this Medical Staff (through its authorized representative(s)) maintains access to, and approval authority of, all minutes prepared in conjunction with any such meetings.

11.3 NOTICE OF MEETINGS

Written notice stating the place, day and hour of any regular or special Medical Staff meeting or of any regular or special department or committee meeting not held pursuant to resolution shall be delivered either personally or by mail (including electronic mail) to each person entitled to be present not fewer than two working days nor more than 45 days before the date of such meeting. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

11.4 QUORUM

11.4-1 Medical Staff Meetings

Business may be transacted at any regular or duly noticed special meeting of the Medical Staff or its Committees or Department by a majority vote of those active staff members present except in matters where the Bylaws or Rules and Regulations specifically require a larger percentage of those present voting in the affirmative.

11.4-2 Committee Meetings

The presence of 33 1/3 percent of the voting members shall be required for Medical Executive Committee meetings. For other committees, a quorum shall consist of 25 percent of the voting members of a committee but in no event less than three voting committee members.

11.5 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be required by these Bylaws. Committee action may be conducted by telephone or internet conference, which shall be deemed to constitute a meeting for the matters discussed in that telephone or internet conference. Valid action may be taken without a meeting if at least 7 days notice of the proposed action has been given to all members entitled to vote, and it is subsequently approved in writing setting forth the action so taken, which is voted on by at least 66-2/3 percent of the members entitled to vote. The meeting chair shall refrain from voting except when necessary to break a tie.

11.6 MINUTES

Minutes of all meetings shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. Any action items voted on in the minutes shall be forwarded to the Medical Executive Committee or other designated committee and Governing Board. Each committee shall maintain a permanent file of the minutes of each meeting. When meetings are held with outside entities, access to minutes shall be limited as necessary to preserve the protections from discovery, as provided by California law.

11.7 ATTENDANCE REQUIREMENTS

11.7-1 Regular Attendance Requirements

Each member of a Medical Staff category required to attend meetings under Article 3.3, Prerogatives and Responsibilities, shall be required to attend four (4) general staff meetings during the two-year reappointment period.

11.7-2 Failure to Meet Attendance Requirements

Medical Staff members will be notified semi-annually if they have not yet met the full attendance requirements. Practitioners who have not met meeting attendance requirements before the end of the appointment/reappointment period will be reappointed for a maximum of two years on probationary status.

11.7-3 Special Appearance

A committee, at its discretion, may require the appearance of a practitioner during a review of the clinical course of treatment regarding a patient. If possible, the Chair of the meeting should give the practitioner at least 10 days advance written notice of the time and place of the meeting. In addition, whenever an appearance is requested because of an apparent or suspected deviation from standard clinical practice, special notice shall be given and shall include a statement of the issue involved and that the practitioner's appearance is mandatory. Failure of a practitioner to appear at any meeting with respect to which he or she was given special notice shall (unless excused by the Medical Executive Committee upon a showing of good cause) result in an automatic suspension of the practitioner's privileges for at least two weeks, or such longer period as the Medical Executive Committee deems appropriate. The practitioner shall be entitled to the procedural rights described in Bylaws, Article 14, Hearings and Appellate Reviews.

11.8 CONDUCT OF MEETINGS

Unless otherwise specified, meetings shall be conducted according to Robert's Rules of Order; however, technical failures to follow such rules shall not invalidate action taken at such a meeting.

Article 12 Confidentiality, Immunity, Releases and Indemnification

12.1 GENERAL

Medical Staff, department, or committee minutes, files and records — including information regarding any member or applicant to this Medical Staff — shall, to the fullest extent permitted by law, be confidential. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall become a part of the Medical Staff committee files and shall not become part of any particular patient's file or of the general hospital records. Dissemination of such information and records shall be made only where expressly required by law or as otherwise provided in these Bylaws.

12.2 BREACH OF CONFIDENTIALITY

Inasmuch as effective credentialing, quality improvement, 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, and inasmuch as practitioners and others participate in credentialing, quality improvement, and peer review activities with the reasonable expectations that this confidentiality will be preserved and maintained, any breach of confidentiality of the discussions or deliberations of Medical Staff departments, or committees, except in conjunction with another health facility, professional society or licensing authority for peer review activities, is outside appropriate standards of conduct for this Medical Staff 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 SHARING OF INFORMATION WITH VENTURA COUNTY HEALTH CARE PLAN (VCHCP)

Ventura County Medical Center (VCMC) and its Medical Staff have entered into a joint credentialing and peer review agreement with the Ventura County HCA Director's office, and the Ventura County Health Care Plan (VCHCP), a managed health plan operated through the Ventura County HCA Director's office. Committees of the Medical Staff, including but not limited to its Executive, Credentialing and Quality Improvement Committees, shall be authorized to share credentialing, peer review and quality improvement information with the HCA Director's office and VCHCP, for purposes of assuring and improving the quality of care and monitoring the qualifications of practitioners serving programs and facilities operated by the HCA Director's office of Ventura County.

12.4 ACCESS TO AND RELEASE OF CONFIDENTIAL INFORMATION

12.4-1 Access for Official Purposes

Medical Staff records, including confidential committee records and credentials files, shall be accessible by:

- a. Committee members, and their authorized representatives, for the purpose of conducting authorized committee functions.

- b. Medical Staff and department officers, and their authorized representatives, for the purpose of fulfilling any authorized function of such official.
- c. The Chief Executive Officer, the Governing Board, and their authorized representatives, for the purpose of enabling them to discharge their lawful obligations and responsibilities.
- d. Upon approval of the Chief Executive Officer and Chief of Staff, the peer review bodies of System Affiliates, as reasonably necessary to facilitate review of an applicant or member of such Affiliate's professional staff.
- e. Information which is disclosed to the Governing Board or its appointed representatives and to peer review bodies of System Affiliates shall be maintained as confidential.

12.4-2 Member's Access

- a. A Medical Staff member shall be granted access to his or her own credentials file, subject to the following provisions:
 - 1. Notice of a request to review the file shall be given by the member to the Chief of Staff, CMO (or his or her designee) at least seven days before the requested date for review.
 - 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, letter 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 (not to exceed two weeks). 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 Chief of Staff present.
 - 4. In the event a Notice of Charges is filed against a member, access to that member's credentials file shall be governed by Bylaws, Section 14.5-9.
- b. A member may be permitted to request correction of information as follows:
 - 1. After review of his or her file, a member may address to the Chief of Staff a written request for correction of information in the credentials file. Such request shall include a statement of the basis for the action requested.
 - 2. The Chief of Staff shall review such a request within a reasonable time and shall recommend to the Medical Executive Committee whether to make the correction as requested, and the Medical Executive Committee shall make the final determination.
 - 3. The member shall be notified promptly, in writing, of the decision of the Medical Executive Committee.
 - 4. In any case, a member shall have the right to add to his or her credentials file a statement responding to any information contained in the file. Any such written statement shall be addressed to the Medical Executive Committee, and shall be placed in the credentials file immediately following review by the Medical Executive Committee.

12.5 IMMUNITY AND RELEASES

12.5-1 Immunity from Liability for Providing Information or Taking Action

Each representative of the Medical Staff and hospital and all third parties shall be exempt from liability to an applicant, member or practitioner for damages or other relief by reason of providing information to a representative of the Medical Staff, hospital, or any other health-related organization concerning such person who is, or has been, an applicant to or member of the Medical Staff or who did, or does, exercise privileges or provide services at this hospital or by reason of otherwise participating in a Medical Staff or hospital credentialing, quality improvement, or peer review activities.

12.5-2 Activities and Information Covered

Activities

The immunity provided by this Bylaws, Article 12, shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health-related institution's or organization's activities concerning, but not limited to:

1. Applications for appointment, privileges, or specified services;
2. Periodic reappraisals for reappointment, privileges, or specified services;
3. Corrective action;
4. Hearings and appellate reviews;
5. Quality improvement review, including patient care audit;
6. Peer review;
7. Utilization reviews;
8. Morbidity and mortality conferences; and
9. Other hospital, department or committee activities related to monitoring and improving the quality of patient care and appropriate professional conduct.

Information

The acts, communications, reports, recommendations, disclosures, and other information referred to in this Bylaws, Article 12, may relate to a practitioner's professional qualifications, clinical ability, judgment, character, physical and mental health, emotional stability, professional ethics or other matter that might directly or indirectly affect patient care.

12.6 RELEASES

Each practitioner shall, upon request of the hospital, execute general and specific releases in accordance with the tenor and import of these Bylaws, Article 12; however, execution of such releases shall not be deemed a prerequisite to the effectiveness of these Bylaws, Article 12.

12.7 CUMULATIVE EFFECT

Provisions in these Bylaws and in Medical Staff application forms relating to authorizations, confidentiality of information, and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof.

12.8 INDEMNIFICATION

The hospital shall indemnify, defend, and hold harmless the Medical Staff and its individual members (“Indemnitee(s)”) from and against losses and expenses (including reasonable attorneys’ fees, judgments, settlements, and all other costs, direct or indirect) incurred or suffered by reason of or based upon any threatened, pending or completed action, suit, proceeding, investigation, or other dispute relating or pertaining to any alleged act or failure to act within the scope of peer review or quality assessment activities including, but not limited to:

- a. As a member of or witness for a Medical Staff, department committee, or hearing committee;
- b. As a member of or witness for the hospital Governing Board or any hospital task force, group or committee; and
- c. As a person providing information to any Medical Staff or hospital group, officer, Governing 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 hospital shall retain responsibility for the sole management and defense of any such claims, suits, investigations or other disputes against Indemnities, including, but not limited to, selection of legal counsel to defend against any such actions. The indemnity set forth herein is expressly conditioned on Indemnities’ good faith belief that their actions and/or communications are reasonable and warranted and in furtherance of the Medical Staff’s peer review, quality assessment or quality improvement responsibilities, in accordance with the purposes of the Medical Staff as set forth in these Bylaws. In no event will the hospital indemnify an Indemnitee for acts or omissions taken in bad faith or in pursuit of the Indemnitee’s private economic interests.

Article 13 Performance Improvement and Corrective Action

13.1 PEER REVIEW PHILOSOPHY

13.1-1 Role of Medical Staff in Organization wide Quality Improvement Activities

The Medical Staff is responsible to oversee the quality of medical care, treatment and services delivered in the hospital. An important component of that responsibility is the oversight of care rendered by members and Allied Health Professionals practicing in the hospital. The following provisions are designed to achieve quality improvements through collegial peer review and educative measures whenever possible, but with recognition that, when circumstances warrant, the Medical Staff is responsible to embark on informal corrective measures and/or corrective action as necessary to achieve and assure quality of care, treatment and services. Toward these ends:

- a. Members of the Medical Staff are expected to actively and cooperatively participate in a variety of peer review activities to measure, assess and improve performance of their peers in the hospital.
- b. The initial goals of the peer review processes are to prevent, detect and resolve problems and potential problems through routine collegial monitoring, education and counseling. However, when necessary, corrective measures, including formal investigation and discipline, must be implemented and monitored for effectiveness.
- c. Peers in the departments and committees are responsible for carrying out delegated review and quality improvement functions in a manner that is consistent, timely, defensible, balanced, useful and ongoing. The term “peers” generally requires that a majority of the peer reviewers be members holding the same license as the practitioner being reviewed, including, where possible, at least one member practicing the same specialty as the member being reviewed. Notwithstanding the foregoing, DOs and MDs shall be deemed to hold the “same licensure” for purposes of participating in peer review activities.
- d. The departments and committees may be assisted by the CMO or quality improvement staff members.

13.1-2 Informal Corrective Activities

The Medical Staff officers, departments and committees may counsel, educate, issue letters of warning or censure, or focused professional practice evaluation in accordance with Bylaws, Section 7.4(a)(2) in the course of carrying out their duties without initiating formal corrective action. Comments, suggestions and warnings may be issued orally or in writing. The practitioner shall be given an opportunity to respond in writing and may be given an opportunity to meet with the officer, department or committee. Any informal actions, monitoring or counseling shall be documented in the member’s file. Medical Executive Committee approval is not required for such actions, although the actions shall be reported to the Medical Executive Committee. The actions shall not constitute a restriction of privileges or grounds for any formal hearing or appeal rights under Bylaws, Article 14, Hearings and Appellate Reviews.

13.1-3 Criteria for Initiation of Formal Corrective Action

A formal corrective action investigation may be initiated whenever reliable information indicates a member may have exhibited acts, demeanor or conduct, either within or outside of the hospital, that is reasonably likely to be:

- a. Detrimental to patient safety or to the delivery of quality patient care within the hospital;
- b. Unethical;
- c. Contrary to the Medical Staff Bylaws or Rules;
- d. Below applicable professional standards;
- e. Disruptive of Medical Staff or hospital operations; or
- f. An improper use of hospital resources.

Generally, formal corrective action measures should not be initiated unless reasonable attempts at informal resolution have failed; however, this is not a mandatory condition, and formal corrective action may be initiated whenever circumstances reasonably appear to warrant formal action. Any recommendation of formal corrective action must be based on evaluation of applicant-specific information.

13.1-4 Initiation

- a. Any person who believes that formal corrective action may be warranted may provide information to the Chief of Staff, any other Medical Staff officer, any Department Chief, the Chief Medical Officer, or the Chief Executive Officer. This information will preferably be in writing.
- b. If the Chief of Staff, any other Medical Staff officer, any Department Chief, the Chief Medical Officer, or the Chief Executive Officer determines that formal corrective action may be warranted under Bylaws, Section 13.1-3, above, that person, entity, or committee may request the initiation of a formal corrective action investigation or may recommend particular corrective action. Such requests will be conveyed to the Medical Executive Committee in writing.
- c. The Chief of Staff shall notify the Chief Executive Officer or his or her designee in his or her absence, and the Medical Executive Committee and shall continue to keep them fully informed of all action taken. In addition, the Chief of Staff shall immediately forward all necessary information to the committee or person that will conduct any investigation, provided, however, that the Chief of Staff or the Medical Executive Committee may dispense with further investigation of matters deemed to have been adequately investigated by a committee pursuant to Bylaws, Section 13.1-6, below, or otherwise.

13.1-5 Expedited Initial Review

- a. Whenever information suggests that corrective action may be warranted, the Chief of Staff or his or her designee and/or the CMO may, on behalf of the Medical Executive Committee, immediately investigate and conduct whatever interviews may be indicated. The information developed during this initial review shall be presented to the Medical Executive Committee, which shall decide whether to initiate a formal corrective action investigation.
- b. In cases of complaints of harassment or discrimination involving a patient, etc., an expedited initial review shall be conducted on behalf of the Medical Executive Committee by the Chief of Staff, the Chief of Staff's designee, or the CMO, together with representatives of administration, or by an attorney for the hospital. In cases of complaints of harassment or discrimination where the alleged harasser is a Medical Staff

member and the complainant is an employee, an expedited initial review shall be conducted by the Chief Medical Officer and the hospital's human resources director or their designee, or by an attorney for the hospital, who shall use best efforts to complete the expedited initial review within the time frame set out at Bylaws, Section 13.1-8, below. The Chief of Staff shall be kept apprised of the status of the initial review. The information gathered from an expedited initial review shall be referred to the Medical Executive Committee if it is determined that corrective action may be indicated against a Medical Staff member.

13.1-6 Formal Investigation

- a. If the Medical Executive Committee concludes action is indicated but that no further investigation is necessary, it may proceed to take action without further investigation.
- b. If the Medical Executive Committee concludes a further investigation is warranted, it shall direct a formal investigation to be undertaken. The Medical Executive Committee may conduct the investigation itself or may assign the task to an appropriate officer or standing or ad hoc committee to be appointed by the Chief of Staff. The investigating body should not include partners, associates or relatives of the individual being investigated. Additionally, the investigating person or body may, but is not required to, engage the services of one or more outside reviewers as deemed appropriate or helpful in light of the circumstances (e.g., to help assure an unbiased review, to firm up an uncertain or controversial review or to engage specialized expertise). 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, using best efforts to complete the expedited initial review within the time frame set out at Bylaws, Section 13.1-8, below, 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.
- c. Prior to any adverse action being approved, the Medical Executive Committee shall assure that the member was given an opportunity to provide information in a manner and upon such terms as the Medical Executive Committee, investigating body, or reviewing committee deems appropriate. The investigating body or reviewing body may, but is not obligated to, interview persons involved; however, such an interview shall not constitute a hearing as that term is used in Bylaws, Article 14, Hearings and Appellate Reviews, nor shall the hearings or appeals Rules apply.
- d. 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 action.
- e. The provisions of this Bylaws Section 13.1-6 (including a determination to dispense with formal investigation and proceed immediately to further action pursuant to Section 13.1-6(a)) shall demark the point at which an "impending investigation" is deemed to have commenced within the meaning of Business & Professions Code Section 805(c).

13.1-7 Medical Executive Committee Action

- a. As soon as practicable after the conclusion of the investigation, the Medical Executive Committee shall take action including, without limitation:
 1. Determining no corrective action should be taken and, if the Medical Executive Committee determines there was no credible evidence for the complaint in the first instance, clearly documenting those findings in the member's file;

2. Deferring action for a reasonable time;
 3. Issuing letters of admonition, censure, reprimand or warning, although nothing herein shall be deemed to preclude department or Committee Chairs from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letters are issued, the affected member may make a written response which shall be placed in the member's file;
 4. Recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of privileges including, without limitation, requirements for co-admissions, mandatory consultation or monitoring
 5. Recommending reduction, modification, suspension or revocation of privileges. If suspension is recommended, the terms and duration of the suspension and the conditions that must be met before the suspension is ended shall be stated;
 6. Recommending reductions of membership status or limitation of any prerogatives directly related to the member's delivery of patient care;
 7. Recommending suspension, revocation or probation of Medical Staff membership. If suspension or probation is recommended, the terms and duration of the suspension or probation and the conditions that must be met before the suspension or probation is ended shall be stated;
 8. Referring the member to the Well-Being Committee for evaluation and follow-up as appropriate; and
 9. Taking other actions deemed appropriate under the circumstances.
- b. If the Medical Executive Committee takes any action that would give rise to a hearing pursuant to Bylaws, Section 14.2, it shall also make a determination whether the action is a "medical disciplinary" action or an "administrative disciplinary" action. A medical disciplinary action is one taken for cause or reason that involves that aspect of a practitioner's competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care. All other actions are deemed administrative disciplinary actions. In some cases, the reason may involve both medical disciplinary and administrative disciplinary cause or reason, in which case, the matter shall be deemed medical disciplinary for Bylaws, Article 14, Hearings and Appellate Reviews, hearing purposes.
- c. And, if the Medical Executive Committee makes a determination that the action is medical disciplinary, it shall also determine whether the action is taken for any of the reasons required to be reported to the Medical Board of California pursuant to California Business & Professions Code Section 805.01.

13.1-8 Time Frames

Insofar as feasible under the circumstances, formal and informal investigations should be conducted expeditiously, as follows:

- a. Informal investigations should be completed and the results should be reported within 60 days.
- b. Expedited initial reviews should be completed and the results should be reported within 30 days.
- c. Other formal investigations should be completed and the results should be reported within 90 days.

13.1-9 Procedural Rights

- a. If, after receipt of a request for formal corrective action pursuant to Bylaws, Section 13.1-4, above, the Medical Executive Committee determines that no corrective action is required or only a letter of warning, admonition, reprimand or censure should be issued, the decision shall be transmitted to the Governing Board. The Governing Board may affirm, reject or modify the action. The Governing Board shall give great weight to the Medical Executive Committee's decision and initiate further action only if the failure to act is contrary to the weight of the evidence that is before it, and then only after it has consulted with the Medical Executive Committee and the Medical Executive Committee still has not acted. The decision shall become final if the Governing Board affirms it or takes no action on it within 70 days after receiving the notice of decision.
- b. If the Medical Executive Committee recommends an action that is a ground for a hearing under Bylaws, Section 14.2, the Chief of Staff shall give the practitioner special notice of the adverse recommendation and of the right to request a hearing. The Governing Board may be informed of the recommendation, but shall take no action until the member has either waived his or her right to a hearing or completed the hearing.

13.1-10 Initiation by Governing Board

- a. The Medical Staff acknowledges that the Governing Board must act to protect the quality of medical care provided and the competency of its Medical Staff, and to ensure the responsible governance of the hospital in the event that the Medical Staff fails in any of its substantive duties or responsibilities.
- b. Accordingly, if the Medical Executive Committee fails to investigate or take disciplinary action, contrary to the weight of the evidence, the Governing Board may direct the Medical Executive Committee to initiate an investigation or disciplinary action, but only after consulting with the Medical Executive Committee. If the Medical Executive Committee fails to act in response to that Governing Board direction, the Governing Board may, in furtherance of the Governing Board's ultimate responsibilities and fiduciary duties, initiate corrective action, but must comply with applicable provisions of Bylaws, Article 13, Performance Improvement and Corrective Action, and Article 14, Hearings and Appellate Reviews. The Governing Board shall inform the Medical Executive Committee in writing of what it has done.

13.2 SUMMARY RESTRICTION OR SUSPENSION

13.2-1 Criteria for Initiation

- a. Whenever a practitioner's conduct is such that a failure to take action may result in an imminent danger to the health of any individual, the Chief of Staff, the Medical Executive Committee, the Department Chief in which the member holds privileges, the Chief Medical Officer or the Chief Executive Officer may summarily restrict or suspend the Medical Staff membership or privileges of such member.
- b. Unless otherwise stated, such summary restriction or suspension (summary action) shall become effective immediately upon imposition, and the person or body responsible shall promptly give special notice to the member and written notice to the Governing Board, the Medical Executive Committee, and the Chief

Executive Officer. The special notice shall fully comply with the requirements of Bylaws, Section 13.2-1(d), below.

- c. The summary action 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 action, the member's patients shall be promptly assigned to another member by the Department Chief or by the CMO, or Chief of Staff considering, where feasible, the wishes of the patient and the affected practitioner in the choice of a substitute member.
- d. Within one working day of imposition of a summary suspension, the affected Medical Staff member shall be provided with verbal notice of such suspension; followed, within three working days of imposition, by written notice of such suspension. This initial written notice shall include a statement of facts demonstrating that the suspension was reasonable and warranted because failure to suspend or restrict the member's privileges summarily could reasonably result in an imminent danger to the health of any 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 Bylaws, Section 14.3-1 (which applies in all cases where the Medical Executive Committee does not immediately terminate the summary suspension). The notice under Bylaws, Section 14.3-1 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.
- e. The notice of the summary action given to the Medical Executive Committee shall constitute a request to initiate corrective action and the procedures set forth in Bylaws, Section 13.1-3, shall be followed.

13.2-2 Medical Executive Committee Action

Within one week after such summary action 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 Bylaws, Article 14, Hearings and Appellate Reviews, nor shall any procedural Rules apply. The Medical Executive Committee may thereafter continue, modify or terminate the terms of the summary action. It shall give the practitioner special notice of its decision, within two working days of the meeting, which shall include the information specified in Bylaws, Section 14.3-1 if the action is adverse.

13.2-3 Procedural Rights

Unless the Medical Executive Committee promptly terminates the summary action, and if the summary action constitutes a suspension or restriction of clinical privileges required to be reported to the Medical Board of California pursuant to Business & Professions Code Section 805), the member shall be entitled to the procedural rights afforded by Bylaws, Article 14, Hearings and Appellate Reviews including, but not limited to, a right to a preliminary hearing as described at Bylaws, Section 14.5.

13.2-4 Initiation by Governing Board

- a. If no one authorized under Bylaws, Section 13.2-1(a), above, to take a summary action is available to summarily restrict or suspend a member's membership or privileges, the Governing Board (or its designee) may immediately suspend or restrict a member's privileges if a failure to act immediately may result in imminent danger to the health of any individual, provided that the Governing Board (or its designee) made reasonable attempts to contact the Chief of Staff and the chief of the department to which the member is assigned before acting.
- b. Such summary action is subject to ratification by the Medical Executive Committee. If the Medical Executive Committee does not ratify such summary action within two working days, excluding weekends and holidays, the summary action shall terminate automatically.

13.3 AUTOMATIC SUSPENSION OR LIMITATION

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

13.3-1 Licensure

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

13.3-2 Drug Enforcement Administration Certificate

- a. **Revocation, Suspension, and Expiration.** Whenever a member's Drug Enforcement Administration certificate is revoked, limited, suspended or expired, the member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate as of the date such action becomes effective and throughout its term.
- b. **Probation.** Whenever a member's Drug Enforcement Administration 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.

13.3-3 Failure to Satisfy Special Appearance Requirement

A member who fails without good cause to appear and satisfy the requirements of Bylaws, Section 11.7-3 shall automatically be suspended from exercising all or such portion of privileges as the Medical Executive Committee specifies.

13.3-4 Medical Records

Medical Staff members are required to complete medical records within the time prescribed by the Medical Executive Committee. For failure to complete medical records within fourteen (14) days after the patient is discharged, a practitioner's clinical privileges (except with respect to his or her patient's already in the hospital) and his/her rights to admit patients and to provide any other professional services shall be administratively suspended. With the exception of emergency care for which only the practitioner is qualified and available to render, and the care of patients already hospitalized at the time of suspension, such temporary suspension shall include all admitting and clinical privileges, as well as scheduling of elective operations, assisting at elective operations. Unverified emergency admissions shall not be used to bypass such restriction. The suspended member shall not attend any patient admitted by another member unless he/she is the only practitioner available for a specific emergency consultation.

Failure to complete the medical records within four (4) months after the date a suspension became effective shall be deemed to be a voluntary resignation of the practitioner's medical staff membership and privileges.

Repeated failures to complete medical records in a timely manner shall be one of the factors considered for changing the member's staff category and denying reappointment, and shall be taken into consideration in connection with all other factors at the time of reappointment.

For purposes of this section, a failure to complete records will not be cause for administrative suspension if:

1. the member is ill, on vacation, or out of town for an extended period of time, the member notifies the Medical Staff office of the absence in advance, and the member completes the medical record(s) in question within fourteen (14) days of his/her return.
2. the practitioner is waiting for the results of a late report and the record is otherwise complete except for the discharge summary and the final diagnosis
3. the practitioner has dictated the reports and is waiting for hospital personnel to transcribe them.
4. the Medical Records Department is unable or otherwise fails to make requested medical records available to the practitioner upon his/her request.

Reporting

If required by Business and Professions Code, Section 805, an administrative suspension for failure to complete medical records will be reported under that section if:

- the suspension is for more than a cumulative total of thirty (30) days in any twelve (12) month period;
- AND
- the Chief of Staff has determined that the failure to complete the records constitutes conduct reasonably likely to be detrimental to patient safety or to the delivery of patient care.

13.3-5 Cancellation of Professional Liability Insurance

Failure to maintain professional liability insurance as required by these Bylaws shall

be grounds for automatic suspension of a member's privileges. Failure to maintain professional liability insurance for certain procedures shall result in the automatic suspension of privileges to perform those procedures. The suspension shall be effective until appropriate coverage is reinstated, including coverage of any acts or potential liabilities that may have occurred or arisen during the period of any lapse in coverage. A failure to provide evidence of appropriate coverage within six months after the date of automatic suspension shall be deemed a voluntary resignation of the member from the Medical Staff.

13.3-6 Failure to Complete Requirements for Specific Privileges

Departments may have specific requirements for certain clinical privileges such as obligatory course work or attendance at departmental conferences or reviews. If a member fails to meet these requirements the member will be considered to have voluntarily relinquished these specific privileges.

13.3-7 Failure to Pay Dues or Fines

If the member fails to pay required dues or fines within 30 days after written warning of delinquency, a practitioner's Medical Staff membership and privileges shall be automatically suspended and shall remain so suspended until the practitioner pays the delinquent dues. If after 60 consecutive days of suspension the member remains suspended, the member will be considered to have voluntarily resigned from the Medical Staff.

13.3-8 Failure to Comply with Government and Other Third Party Payor Requirements

The Medical Executive Committee shall be empowered to determine that compliance with certain specific third party payor, government agency, and professional review organization Rules or policies is essential to hospital and/or Medical Staff operations and that compliance with such requirements can be objectively determined. The Rules may authorize the automatic suspension of a practitioner who fails to comply with such requirements. The suspension shall be effective until the practitioner complies with such requirements.

13.3-9 Automatic Termination

If a practitioner is suspended for more than six months, his or her membership (or the affected privileges, if the suspension is a partial suspension) shall be automatically terminated. Thereafter, reinstatement to the Medical Staff shall require application and compliance with the appointment procedures applicable to applicants.

13.3-10 Executive Committee Deliberation and Procedural Rights

a. As soon as practicable after action is taken or warranted as described in Bylaws, Section 13.3-1, Section 13.3-2, or Section 13.3-3, the Medical Executive Committee shall convene to review and consider the facts and may recommend such further corrective action as it may deem appropriate following the procedure generally set forth commencing at Bylaws, Section 13.1-6, Formal Investigation. The Medical Executive Committee review and any subsequent hearings and reviews shall not address the propriety of the licensure or Drug Enforcement Administration action, but instead shall address what, if any, additional action should be taken by the hospital. There is no need for the Medical Executive Committee to act on automatic suspensions for failures to complete medical records (Bylaws, Section 13.3-4), maintain professional liability insurance (Bylaws, Section 13.3-5, to pay dues (Bylaws, Section 13.3-7, above) or comply with government and other third party payor Rules and policies (Bylaws,

Section 13.3-8, above).

- b. Practitioners whose privileges are automatically suspended and/or who have been deemed to have automatically resigned their Medical Staff membership shall be entitled to a hearing only if the suspension is reportable to the Medical Board of California or the federal National Practitioner Data Bank.

13.3-11 Notice of Automatic Suspension or Action

Special notice of an automatic suspension or action shall be given to the affected individual, and regular notice of the suspension shall be given to the Medical Executive Committee, Chief Executive Officer and Governing Board, but such notice shall not be required for the suspension to become effective. Patients affected by an automatic suspension shall be assigned to another member by the Department chief or Chief of Staff. The wishes of the patient and affected practitioner shall be considered, where feasible, in choosing a substitute member.

13.4 INTERVIEW

Interviews shall neither constitute nor be deemed a hearing as described in Bylaws, Article 14, Hearings and Appellate Reviews, shall be preliminary in nature, and shall not be conducted according to the procedural Rules applicable with respect to hearings. The Medical Executive Committee shall be required, at the practitioner's request, to grant an interview only when so specified in these Bylaws, Article 13. In the event an interview is granted, the practitioner shall be informed of the general nature of the reasons for the recommendation and may present information relevant thereto. A record of the matters discussed and the findings resulting from an interview shall be made.

13.5 CONFIDENTIALITY

To maintain confidentiality, participants in the corrective action process shall limit their discussion of the matters involved to the formal avenues provided in these Bylaws for peer review and discipline.

Article 14 Hearings and Appellate Reviews

14.1 GENERAL PROVISIONS

14.1-1 Review Philosophy

The intent in adopting these hearing and appellate review procedures is to provide for a fair review of decisions that adversely affect practitioners (as defined below), and at the same time to protect the peer review participants from liability. It is further the intent to establish flexible procedures which do not create burdens that will discourage the Medical Staff and Governing Board from carrying out peer review.

Accordingly, discretion is granted to the Medical Staff and Governing Board to create a hearing process which provides for the least burdensome level of formality in the process and yet still provides a fair review and to interpret these Bylaws in that light. The Medical Staff, the Governing Board, and their officers, committees and agents hereby constitute themselves as peer review bodies under the federal Health Care Quality Improvement Act of 1986 and the California peer review hearing laws and claim all privileges and immunities afforded by the federal and state laws.

14.1-2 Exhaustion of Remedies

If an adverse action as described in Bylaws, Section 14.2 is taken or recommended, the practitioner must exhaust the remedies afforded by these Bylaws before resorting to legal action.

14.1-3 Intra-Organizational Remedies

The hearing and appeal rights established in the Bylaws are strictly adjudicative rather than legislative in structure and function. The hearing committees have no authority to adopt or modify Rules and standards or to decide questions about the merits or substantive validity of Bylaws, Rules or policies. However, the Governing Board may, in its discretion, entertain challenges to the merits or substantive validity of Bylaws, Rules or policies and decide those questions. If the only issue in a case is whether a Bylaw, Rule or policy is lawful or meritorious, the practitioner is not entitled to a hearing or appellate review. In such cases, the practitioner must submit his challenges first to the Governing Board and only thereafter may he or she seek judicial intervention.

14.1-5 Definitions

Except as otherwise provided in these Bylaws, the following definitions shall apply under this Article:

- a. Body whose decision prompted the hearing refers to the Medical Executive Committee in all cases where the Medical Executive Committee or authorized Medical Staff officers, members or committees took the action or rendered the decision which resulted in a hearing being requested. It refers to the Governing Board in all cases where the Governing Board or its authorized officers, directors or committees took the action or rendered the decision which resulted in a hearing being requested.
- b. Practitioner, as used in this Article, refers to the practitioner who has requested a hearing pursuant to Bylaws, Section 14.3-2 of this Article.

14.1-6 Substantial Compliance

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

14.2 GROUNDS FOR HEARING

Except as otherwise specified in these Bylaws (including those Exceptions to Hearing Rights specified in Bylaws, Section 14.12, of this Article), any one or more of the following actions or recommended actions shall be deemed an actual or potential adverse action and constitute grounds for a hearing:

14.2-1 Denial of Medical Staff initial applications for membership and/or privileges.

14.2-2 Denial of Medical Staff reappointment and/or renewal of privileges.

14.2-3 Revocation of Medical Staff membership or privileges.

14.2-4 Suspension (other than summary suspension), restriction, involuntary reduction of Medical Staff membership and/or privileges, in effect for at least 30 days within a calendar year, relating to a medical disciplinary cause or reason.

14.2-5 Involuntary imposition of significant consultation or Level III proctoring requirements, as described at Bylaws, Section 7.4-4(a)(3), that cannot be completed within thirty days or such other time frame required for reporting the restriction to the Medical Board of California (i.e., Level I and Level II proctoring requirements, as well as transitory restrictions that do not require reporting to the Medical Board of the Data Bank do not entitle the practitioner to a hearing).

14.2-6 Summary suspension or restriction of Medical Staff membership and/or privileges in effect for more than 14 days, or during the pendency of corrective action and hearings and appeals procedures.

14.2-7 Any other “medical disciplinary” action or recommendation that must be reported to the Medical Board of California under the provisions of California Business & Professions Code , Section 805 or to the National Practitioner Data Bank.

14.3 REQUESTS FOR HEARING

14.3-1 Notice of Action or Proposed Action

a. In all cases in which action has been taken or a recommendation made as set forth in Bylaws, Section 14.2, the practitioner shall be given special notice of the recommendation or action and of the right to request a hearing pursuant to Bylaws, Section 14.3-2, below. The notice must state:

1. What action has been proposed against the practitioner;
2. Whether the action, if adopted, must be reported under Business & Professions Code Section 805;
3. A brief indication of the reasons for the action or proposed action;
4. That the practitioner may request a hearing;
5. That a hearing must be requested within 30 days; and
6. That the practitioner has the hearing rights described in the Medical Staff Bylaws,

including those specified in Bylaws, Section 14.5, Hearing Procedure.

- b. The notice shall also advise the practitioner that he or she may request mediation of the dispute pursuant to Bylaws, Section 14.4, of these Bylaws and that mediation must be requested, in writing, within 10 days

14.3-2 Request for Hearing

- a. The practitioner shall have 30 days following receipt of special notice of such action to request a hearing (and, if applicable, a preliminary hearing, as further described in Bylaws, Section 14.5). The request shall be in writing addressed to the Chief of Staff with a copy to the Chief Executive Officer. If the practitioner does not request a hearing within the time and in the manner described, the practitioner shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved. Such final recommendation shall be considered by the Governing Board within 70 days and shall be given great weight by the Governing Board, although it is not binding on the Governing Board.
- b. The practitioner shall state, in writing, his or her intentions with respect to attorney representation at the time he or she files the request for a hearing. Notwithstanding the foregoing and regardless of whether the practitioner elects to have attorney representation at the hearing, the parties shall have the right to consult with legal counsel to prepare for a hearing or an appellate review.
- d. Any request for mediation must be received within 10 days of the date of receipt of the notice sent pursuant to Bylaws, Section 14.3-1(b).

14.4 MEDIATION OF PEER REVIEW DISPUTES

- 14.4-1** Mediation is a confidential process in which a neutral person facilitates communication between the Medical Executive Committee and a practitioner to assist them in reaching a mutually acceptable resolution of a peer review controversy in a manner that is consistent with the best interests of patient care.
- 14.4-2** The parties are encouraged to consider mediation whenever it could be productive in resolving the dispute.
- 14.4-3** In order to obtain consideration of mediation, the practitioner must request mediation in writing, as defined herein, within 10 days of his/her receipt of a notice of action or proposed action that would give rise to a hearing pursuant to Bylaws, Section 14.2.
- 14.4-4** If the practitioner and the Medical Executive Committee agree to mediation, all deadlines and time frames relating to the fair hearing process shall be tolled while the mediation is in process, and the practitioner agrees that no damages may accrue as the result of any delays attributable to the mediation.
- 14.4-5** Mediation cannot be used by either the Medical Staff or the practitioner as a way of unduly delaying the corrective action/fair hearing process. Accordingly, unless both the Medical Staff and the practitioner agree otherwise, mediation must commence within 30 days of the practitioner's request and must conclude within 30 days of its commencement. If the mediation does not resolve the dispute, the fair hearing process will promptly resume upon completion of the mediation.

- 14.4-6** The parties shall cooperate in the selection of a mediator (or mediators). Mediators should be both familiar with the mediation process and knowledgeable regarding the issues in dispute. The mediator may also serve as the Hearing Officer at any subsequent hearing, subject to the agreement of the parties which may be given prior to the mediation or after, with the parties to decide when they will agree on this issue. The costs of mediation shall be shared two-thirds by the Medical Staff and one third by the practitioner. The inability of the Medical Staff and the practitioner to agree upon a mediator within the required time limits shall result in the termination of the mediation process and the resumption of the fair hearing process.
- 14.4-7** Once selected, the mediator and the parties, working together, shall determine the procedures to be followed during the mediation. Either party has the right to be represented by legal counsel in the mediation process.
- 14.4-8** All mediation proceedings shall be confidential and the provisions of California Evidence Code Section 1119 shall apply except that communications that confirm that mediation was mutually accepted and pursued may be disclosed as proof that otherwise applicable time frames were tolled or waived. Any such disclosure shall be limited to that which is necessary to confirm mediation was pursued, and shall not include any points that are substantive in nature or address the issues presented. Except as otherwise permitted in this Section, no other evidence of anything said at, or any writing prepared for or as the result of, the mediation shall be used in any subsequent fair hearing process that takes place if the mediation is not successful.

14.5 HEARING PROCEDURE

14.5-2 Time and Place for Hearing

Upon receipt of a request for hearing, the Chief of Staff shall schedule a hearing and, within 30 days from the date he or she received the request for a hearing, give special notice to the practitioner of the time, place and date of the hearing. The date of the commencement of the hearing shall be not less than 30 days nor more than 60 days from the date the Chief of Staff received the request for a hearing; provided, however, that when the request is received from a member who is under summary action and has timely requested a preliminary hearing as described in Bylaws, Section 14.3-1, the timely commencement of a preliminary hearing shall be deemed to satisfy the provisions of these Bylaws for timely commencement of the hearing.

14.5-3 Notice of Charges

Together with the special notice stating the place, time and date of the hearing, the Chief of Staff shall state clearly and concisely in writing the reasons for the adverse proposed action taken or recommended, including the acts or omissions with which the practitioner is charged and a list of the charts in question, where applicable. The Chief of Staff will also provide a preliminary list of witnesses expected to testify at the hearing. A supplemental notice may be issued at any time, provided the practitioner is given sufficient time to prepare to respond.

14.5-4 Hearing Committee

- a. When a hearing is requested, the Chief of Staff shall appoint a Hearing Committee which shall be composed of not less than three members who shall gain no direct financial benefit from the outcome and who have not acted as accuser, investigator, fact finder,

initial decision maker 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 Hearing Committee. In the event that it is not feasible to appoint a Hearing Committee from the active Medical Staff, the Chief of Staff may appoint members from other Medical Staff categories or practitioners who are not Medical Staff members. Such appointment shall include designation of the chair. When feasible, the Hearing Committee shall include at least one member who has the same healing arts licensure as the practitioner and who practices the same specialty as the practitioner. The Chief of Staff may appoint alternates who meet the standards described above and who can serve if a Hearing Committee member becomes unavailable.

- b. Alternatively, an arbitrator may be used who is selected using a process mutually accepted by the body whose decision prompted the hearing and the practitioner. The arbitrator need not be either a health professional or an attorney. The arbitrator shall carry out all of the duties assigned to the Hearing Officer and to the Hearing Committee.
- c. The Hearing Committee, or the arbitrator, if one is used, shall have such powers as are necessary to discharge its or his or her responsibilities.

14.5-5 The Hearing Officer

- a. The use of a Hearing Officer to preside at a hearing is mandatory. The appointment of a Hearing Officer shall be by the Chief Executive Officer, as a representative of the Medical Executive Committee, as follows:
 - 1. Together with the notice of a hearing, the practitioner shall be provided a list of at least three but no more than five potential Hearing Officers meeting the criteria set forth in Bylaws, Section 14.5-5(b), below.
 - 2. The practitioner shall have five work days to accept any of the listed potential Hearing Officers, or to propose at least three but no more than five other names of potential Hearing Officers meeting the criteria set forth in Bylaws, Section 14.5-5(b), below.
 - 3. If the practitioner is represented by counsel, the parties' counsel may meet and confer in an attempt to reach accord in the selection of a Hearing Officer from the two parties' lists.
 - 4. If the parties are not able to reach agreement on the selection of a Hearing Officer within five working days of receipt of the practitioner's proposed list, the hospital's Chief Executive Officer shall select an individual from the composite list.
 - 5. Unless a Hearing Officer is selected pursuant to stipulation of the parties, he/she shall be subject to reasonable voir dire.
- b. 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.
- c. The Hearing Officer shall preside over the voir dire process and may question panel members directly, and shall make all rulings regarding service by the proposed hearing committee members or the Hearing Officer. 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.

- d. The Hearing Officer's authority shall include, but not be limited to, making rulings with respect to requests and objections pertaining to the production of documents, requests for continuances, designation and exchange of proposed evidence, evidentiary disputes, witness issues including disputes regarding expert witnesses, and setting reasonable schedules for timing and/or completion of all matters related to the hearing.
- e. 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, including, but not limited to, limiting the scope of examination and cross-examination and setting fair and reasonable time limits on either side's presentation of its case. Under extraordinary circumstances, the Hearing Officer may recommend termination of the hearing; however, the Hearing Officer may not unilaterally terminate the hearing and may only issue an order that would have the effect of terminating the hearing (a "termination order") at the direction of the Hearing Committee. The terminating order shall be in writing and shall include documentation of the reasons therefore. If a terminating order is against the Medical Executive Committee, the charges against the practitioner will be deemed to have been dropped. If, instead, the terminating order is against the practitioner, the practitioner will be deemed to have waived his/her right to a hearing. The party against whom termination sanctions have been ordered may appeal the terminating order to the hospital Governing Board. The appeal must be requested within 10 days of the terminating order, and the scope of the appeal shall be limited to reviewing the appropriateness of the terminating order. The appeal shall be conducted in general accordance with the provisions of Bylaws, Section 14.6. If the order is found to be unwarranted, the Hearing Committee shall reconvene and resume the hearing. If the Governing Board determines that the terminating order should not have been issued, the matter will be remanded to the Hearing Committee for completion of the hearing.
- f. Upon adjournment of the evidentiary portion of the hearing, the Hearing Officer shall meet with the members of the hearing committee to assist them with the process for their review of the evidence and preparation of the report of their decision. Upon request from the hearing committee members, the Hearing Officer may remain during the hearing committee's full deliberations. During the deliberative process, the Hearing Officer shall act as legal advisor to the hearing committee, but shall not be entitled to vote.
- g. In all matters, the Hearing Officer shall act reasonably under the circumstances and in compliance with applicable legal principles. In making rulings, the Hearing Officer shall endeavor to promote a less formal, rather than more formal, hearing process and also to promote the swiftest possible resolution of the matter, consistent with the standards of fairness set forth in these Bylaws. When no attorney is accompanying any party to the proceedings, the Hearing Officer shall have authority to interpose any objections and to initiate rulings necessary to ensure a fair and efficient process.

14.5-6 Representation

The practitioner shall have the right, at his or her expense, to attorney representation at the hearing. If the practitioner elects to have attorney representation, the body whose decision prompted the hearing may also have attorney representation. Conversely, if the practitioner elects not to be represented by an attorney in the hearing, then the body whose decision prompted the hearing shall not be represented by an attorney in the hearing. When attorneys are not allowed, the practitioner and the body whose decision prompted the hearing may be represented at the hearing only by a practitioner licensed to practice in the State of California who is not also an attorney.

14.5-7 Failure to Appear or Proceed

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

14.5-8 Postponements and Extensions

Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted in these Bylaws may be permitted upon a showing of good cause, as follows:

- a. Until such time as a Hearing Officer has been appointed, by the Hearing Committee or its Chair acting upon its behalf; or
- b. Once appointed by the Hearing Officer.

14.5-9 Discovery

- a. **Rights of Inspection and Copying.** The practitioner may inspect and copy (at his or her expense) any documentary information relevant to the charges that the Medical Staff has in its possession or under its control. The body whose decision prompted the hearing may inspect and copy (at its expense) any documentary information relevant to the charges that the practitioner has in his or her possession or under his or her control. The requests for discovery shall be fulfilled as soon as practicable. Failures to comply with reasonable discovery requests at least 30 days prior to the hearing shall be good cause for a continuance of the hearing.
- b. **Limits on Discovery.** The Hearing Officer shall rule on discovery disputes the parties cannot resolve. Discovery may be denied when justified to protect peer review or in the interest of fairness and equity. Further, the right to inspect and copy by either party does not extend to confidential information referring to individually identifiable practitioners other than the practitioner under review nor does it create or imply any obligation to modify or create documents in order to satisfy a request for information.
- c. **Ruling on Discovery Disputes.** In ruling on discovery disputes, the factors that may be considered include:
 1. Whether the information sought may be introduced to support or defend the charges;
 2. Whether the information is exculpatory in that it would dispute or cast doubt upon the charges or inculpatory in that it would prove or help support the charges and/or recommendation;
 3. The burden on the party of producing the requested information; and
 4. What other discovery requests the party has previously made.

- d. **Objections to Introduction of Evidence Previously Not Produced for the Medical Staff.** The body whose decision prompted the hearing may object to the introduction of the evidence that was not provided during an appointment, reappointment or privilege application review or during corrective action despite the requests of the peer review body for such information. The information will be barred from the hearing by the Hearing Officer unless the practitioner can prove he or she previously acted diligently and could not have submitted the information.

14.5-10 Pre-Hearing Document Exchange

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

14.5-11 Witness Lists

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

14.5-12 Procedural Disputes

- a. It shall be the duty of the parties to exercise reasonable diligence in notifying the Hearing Officer of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible in order that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be succinctly made at the hearing.
- b. The parties shall be entitled to file motions as deemed necessary to give full effect to rights established by the Bylaws and to resolve such procedural matters as the Hearing Officer determines may properly be resolved outside the presence of the full Hearing Committee. Such motions shall be in writing and shall specifically state the motion, all relevant factual information, and any supporting authority for the motion. The moving party shall deliver a copy of the motion to the opposing party, who shall have five working days to submit a written response to the Hearing Officer, with a copy to the moving party. The Hearing Officer shall determine whether to allow oral argument on any such motions. The Hearing Officer's ruling shall be in writing and shall be provided to the parties promptly upon its rendering. All motions, responses and rulings thereon shall be entered into the hearing record by the Hearing Officer.

14.5-13 Record of the Hearing

A court 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 court reporter shall be borne by the hospital, but the cost of the transcript, if any, shall be borne by the party requesting it. The practitioner is entitled to receive a copy of the transcript upon paying the reasonable cost for preparing the record. The Hearing Officer

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.

14.5-14 Rights of the Parties

Within reasonable limitations, both sides at the hearing may ask the Hearing Committee members and Hearing Officer questions which are directly related to evaluating their qualifications to serve and for challenging such members or the Hearing Officer, 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, receive all information made available to the Hearing Committee, and to submit a written statement at the close of the hearing, as long as these rights are exercised in an efficient and expeditious manner. The practitioner may be called by the body whose decision prompted the hearing or the Hearing Committee and examined as if under cross-examination. The Hearing Committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate.

14.5-15 Rules of Evidence

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 these Bylaws, Article 14. 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.

14.5-16 Burdens of Presenting Evidence and Proof

- a. At the hearing, the body whose decision prompted the hearing shall have the initial duty to present evidence for each case or issue in support of its action or recommendation. The practitioner shall be obligated to present evidence in response.
- b. An applicant for membership and/or privileges shall bear the burden of persuading the Hearing Committee, by a preponderance of the evidence, that he or she is qualified for membership and/or the denied privileges. The practitioner must produce information which allows for adequate evaluation and resolution of reasonable doubts concerning his or her current qualifications for membership and privileges.
- c. Except as provided above for applicants for membership and/or privileges, throughout the hearing, the body whose decision prompted the hearing shall bear the burden of persuading the Hearing Committee by a preponderance of the evidence, that its action or recommendation was reasonable and warranted.

14.5-17 Adjournment and Conclusion

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.

14.5-18 Basis for Decision

The decision of the Hearing Committee shall be based on the evidence and written statements introduced at the hearing, including all logical and reasonable inferences from the evidence and the testimony.

14.5-19 Presence of Hearing Committee Members and Vote

A majority of the Hearing Committee must be present throughout the hearing and

deliberations. In unusual circumstances when a Hearing Committee member must be absent from any part of the proceedings, he or she shall not be permitted to participate in the deliberations or the decision unless and until he or she has read the entire transcript of the portion of the hearing from which he or she was absent. The final decision of the Hearing Committee must be sustained by a majority vote of the number of members appointed.

14.5-20 Decision of the Hearing Committee

Within 30 days after final adjournment of the hearing, the Hearing Committee shall render a written decision. Final adjournment shall be when the Hearing Committee has concluded its deliberations. A copy of the decision shall be forwarded to the Chief Executive Officer, the Medical Executive Committee, the Governing Board, and by special notice to the practitioner. The report shall contain the Hearing Committee's findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached. Both the practitioner and the body whose decision prompted the hearing shall be provided a written explanation of the procedure for appealing the decision. The decision of the Hearing Committee shall be considered final, subject only to such rights of appeal or Governing Board review as described in these Bylaws.

14.6 APPEAL

Within 40 days after receiving the decision of the Hearing Committee, either the practitioner or the Medical Executive Committee may request an appellate review. A written request for such review shall be delivered to the Chief of Staff, the Chief Executive Officer and the other side in the hearing. If appellate review is not requested within such period, that action or recommendation shall thereupon become the final action of the Medical Staff. The Governing Board shall consider the decision within 70 days, and shall give it great weight.

14.6-2 Time, Place and Notice

If an appellate review is to be conducted, the Appeal Board shall, within 30 days after receiving a request for appeal, schedule a review date and cause each side to be given notice (with special notice to the practitioner) of the time, place, and date of the appellate review. The appellate review shall commence within 60 days from the date of such notice provided; however, when a request for appellate review concerns a member who is under suspension which is then in effect, the appellate review should commence within 45 days from the date the request for appellate review was received. The time for appellate review may be extended by the Appeal Board for good cause.

14.6-3 Appeal Board

The Governing Board may sit as the Appeal Board, or it may appoint an Appeal Board which shall be composed of not less than three members of the Governing Board. Knowledge of the matter involved shall not preclude any person from serving as a member of the Appeal Board, so long as that person did not take part in a prior hearing on the same matter. The Appeal Board may select an attorney to assist it in the proceeding. If an attorney is selected, he or she may act as an appellate Hearing Officer and shall have all of the authority of and carry out all of the duties assigned to a Hearing Officer as described in this Article 14. That attorney shall not be entitled to vote with respect to the appeal. The Appeal Board shall have such powers as are necessary to discharge its responsibilities.

14.6-4 Appeal Procedure

The proceeding by the Appeal Board shall, at the discretion of the Appeal Board, either be a de novo hearing or an appellate hearing based upon the record of the hearing before the Hearing 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 in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the hearing; or the Appeal Board may remand the matter to the Hearing 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. The appealing party shall submit a written statement concisely stating the specific grounds for appeal. In addition, each party shall have the right to present a written statement in support of his, her or its position on appeal. The appellate Hearing Officer may establish reasonable time frames for the appealing party to submit a written statement and for the responding party to respond. Each party has the right to personally appear and make oral argument. The Appeal Board may then, at a time convenient to itself, deliberate outside the presence of the parties.

14.6-5 Decision

- a. Within 30 days after the adjournment of the appellate review proceeding the Appeal Board shall render a final decision in writing. Final adjournment shall not occur until the Appeal Board has completed its deliberations.
- b. The Appeal Board may affirm, modify, reverse the decision or remand the matter for further review by the Hearing Committee or any other body designated by the Appeal Board.
- c. The Appeal Board shall give great weight to the Hearing Committee recommendation, and shall not act arbitrarily or capriciously. Unless the Appeal Board elects to conduct a de novo review, the Appeal Board shall sustain the factual findings of the Hearing Committee if they are supported by substantial evidence. The Appeal Board may, however, exercise its independent judgment in determining whether a practitioner was afforded a fair hearing, whether the decision is reasonable and warranted in light of the supported findings, and whether any bylaw, rule or policy relied upon by the Hearing Committee is unreasonable or unwarranted. The decision shall specify the reasons for the action taken and provide findings of fact and conclusions articulating the connection between the evidence produced at the hearing and the appeal (if any), and the decision reached, if such reasons, findings and conclusions differ from those of the Hearing Committee.
- d. The Appeal Board shall forward copies of the decision to each side involved in the hearing.
- e. The Appeal Board may remand the matter to the Hearing Committee or any other body the Appeal Board designates for reconsideration or may refer the matter to the full Governing Board for review. If the matter is remanded for further review and recommendation, the further review shall be completed within 30 days unless the parties agree otherwise or for good cause as determined by the Appeal Board.

14.7 ADMINISTRATIVE ACTION HEARINGS

The following modifications to the hearing process apply when the Medical Executive

Committee (or Governing Board) has taken or recommended an action described in Bylaws, Section 14.2 for a non-medical disciplinary cause or reason. Such actions shall be deemed administrative disciplinary actions.

14.7-1 Administrative Action Hearing

The affected practitioner shall be entitled to an administrative action hearing, conducted in accordance with Bylaws, Section 14.5, except as follows:

- a. At the election of the body whose decision prompted the hearing, the hearing shall be conducted by an arbitrator, meeting the qualifications of Bylaws, Section 14.5-4(b), and selected by mutual agreement of the parties, if agreement can be reached within 10 days, failing which the arbitrator shall be selected by the body whose decision prompted the hearing.
- b. The arbitrator shall have all of the rights and responsibilities of a Hearing Officer and a Hearing Committee, as described in Bylaws, Section 14.5.
- c. At the election of the body whose decision prompted the hearing, both parties shall have the right to be represented by an attorney, whether or not the other party elects to be represented by an attorney. The parties shall be notified of this election at the time the practitioner is notified of his/her right to a hearing. If attorney representation is permitted, the parties shall promptly notify each other of their elections regarding attorney representation, together with the name and contact information of their attorneys.

14.7-2 Nonreportability of Administrative Actions

Administrative disciplinary actions are not reportable to the Medical Board of California or the National Practitioner Data Bank.

14.7-3 Nonwaiver of Protections

Notwithstanding the foregoing, it is understood that circumstances precipitating administrative disciplinary actions may nonetheless involve or affect quality of care in the hospital (e.g., conduct that does or may impair the ability of others to render quality care, or that affects patients' perceptions of the quality of care rendered in the hospital). Processing a matter as an administrative disciplinary action does not waive any protections that may be available under California or federal law for peer review actions taken in furtherance of quality of care or services provided in the hospital.

14.8 RIGHT TO ONE HEARING

No practitioner 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.

14.9 CONFIDENTIALITY

To maintain confidentiality in the performance of peer review, disciplinary and credentialing functions, participants in any stage of the hearing or appellate review process shall limit their discussion of the matters involved to the formal avenues provided in the Medical Staff Bylaws.

14.10 RELEASE

By requesting a hearing or appellate review under these Bylaws, a practitioner agrees to be

bound by the provisions in the Medical Staff Bylaws relating to immunity from liability for the participants in the hearing process.

14.11 GOVERNING BOARD COMMITTEES

In the event the Governing Board should delegate some or all of its responsibilities described in these Bylaws, Article 14 to its committees (including a committee serving as an Appeal Board), the Governing Board shall nonetheless retain ultimate authority to accept, reject, modify or return for further action or hearing the recommendations of its committee.

14.12 EXCEPTIONS TO HEARING RIGHTS

14.12-1 Exclusive Use Services, Hospital Contract Practitioners

a. Exclusive Use Services

The procedural rights of Bylaws, Article 14 do not apply to a practitioner whose application for Medical Staff membership and privileges was denied or whose privileges were terminated on the basis that the privileges he or she seeks are granted only pursuant to an exclusive use policy. Such practitioners shall have the right, however, to request that the Governing Board review the denial, and the Governing Board shall have the discretion to determine whether to review such a request and, if it decides to review the request, to determine whether the practitioner may personally appear before and/or submit a statement in support of his or her position to the Governing Board.

b. Hospital Contract Practitioners

The hearing rights of Bylaws, Article 14 do not apply to practitioners who have contracted with the hospital to provide clinical services. Removal of these practitioners from office and of any exclusive privileges (but not their Medical Staff membership) shall instead be governed by the terms of their individual contracts and agreements with the hospital. The hearing rights of Bylaws, Article 14 shall apply if an action is taken which must be reported under Business & Professions Code Section 805 and/or the practitioner's Medical Staff membership status or privileges which are independent of the practitioner's contract are removed or suspended.

14.12-2 Allied Health Professionals

Nothing contained in the Medical Staff Bylaws shall be interpreted to entitle an Allied Health Staff member to the hearing rights set forth in Articles 14.2 through 14.7. However, an AHP shall have the right to challenge any recommendation which would constitute grounds for a hearing under Article 14.2 of the Bylaws (to the extent that such grounds are applicable by analogy to the Allied Health Staff) by filing a written request for an AHP Health Staff hearing with the Medical Executive Committee within fifteen (15) days of receipt of the Notification Letter. Upon receipt of a request, the Medical Executive Committee or its designee, shall afford the AHP an opportunity for an AHP Health Staff hearing concerning the grievance. The hearing need not be conducted according to the procedural rules applicable to member hearings; however the purpose of the AHP Health Staff hearing 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. A record of the AHP Health Staff hearing shall be made. Within 30 days following the AHP Health Staff hearing, the

Medical Executive Committee, based on the AHP Health Staff hearing and all other aspects of the investigation, shall make a final recommendation to the Governing Board or designee, 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 Governing Board or designee may, in its discretion, offer the affected practitioner the right to appeal to the Board or a subcommittee thereof. The Governing Board or designee 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 Governing Board or designee 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.

4.12-3 Denial of Applications for Failure to Meet the Minimum Qualifications

Practitioners shall not be entitled to any hearing or appellate review rights if their membership, privileges, applications or requests are denied because of their failure to have a current California license to practice medicine, dentistry, clinical psychology or podiatry; to maintain an unrestricted Drug Enforcement Administration certificate (when it is required under these Bylaws or the Rules); to maintain professional liability insurance as required by the Rules; or to meet any of the other basic standards specified in Bylaws, Section 2.2-2 or to file a complete application.

14.12-4 Automatic Suspension or Limitation of Privileges

- a. No hearing is required when a member's license or legal credential to practice has been revoked or suspended as set forth in Bylaws, Section 13.3-1. In other cases described in Bylaws, Section 13.3-1 and Section 13.3-2, 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 the Drug Enforcement Administration was unwarranted, but only whether the member may continue to practice in the hospital with those limitations imposed.
- b. Practitioners whose privileges are automatically suspended and/or who have resigned their Medical Staff membership for failing to satisfy a special appearance (Bylaws, Section 13.3-3), failing to complete medical records (Bylaws, Section 13.3-4), failing to maintain malpractice insurance (Bylaws, Section 13.3-5), failing to pay dues (Bylaws, Section 13.3-7, or failing to comply with particular government or other third party payor Rules or policies (Bylaws, Section 13.3-8) are not entitled under Bylaws, Section 13.3-9 to any hearing or appellate review rights except when a suspension for failure to complete medical records will exceed 30 days in any 12-month period, and it must be reported to the Medical Board of California.

14.12-5 Failure to Meet Minimum Activity Requirements

Practitioners shall not be entitled to the hearing and appellate review rights if their membership or privileges are denied, restricted or terminated or their Medical Staff categories are changed or not changed because of a failure to meet the minimum activity requirements set forth in the Medical Staff Bylaws or Rules. In such cases, the only review shall be provided by the Medical Executive Committee through a subcommittee consisting of at least three Medical Executive Committee members. The subcommittee shall give the practitioner notice of the reasons for the intended denial or change in membership, privileges, and/or category and shall schedule an interview with the subcommittee to

occur no less than 30 days and no more than 100 days after the date the notice was given. At this interview, the practitioner may present evidence concerning the reasons for the action, and thereafter the subcommittee shall render a written decision within 45 days after the interview. A copy of the decision shall be sent to the practitioner, Medical Executive Committee and Governing Board. The subcommittee decision shall be final unless it is reversed or modified by the Medical Executive Committee within 45 days after the decision was rendered, or the Governing Board within 90 days after the decision was rendered.

Article 15 General Provisions

15.1 RULES AND POLICIES

15.1-1 Overview and Relation to Bylaws

These Bylaws describe the fundamental principles of Medical Staff self-governance and accountability to the Governing Board. Accordingly, the key standards for Medical Staff membership, appointment, reappointment and privileging are set out in these Bylaws. Additional provisions, including, but not limited to, procedures for implementing the Medical Staff standards may be set out in Medical Staff or department Rules, or in policies adopted or approved as described below. Upon proper adoption, as described below, all such Rules and policies shall be deemed an integral part of the Medical Staff Bylaws.

15.1-2 General Medical Staff Rules

The Medical Staff shall initiate and adopt such Rules as it may deem necessary and shall periodically review and revise its Rules to comply with current Medical Staff practice. New Rules or changes to the Rules (proposed Rules) may emanate from any responsible committee, department, medical staff officer, or by petition signed by at least 33% of the voting members of the Medical Staff. Additionally, hospital administration may develop and recommend proposed Rules, and in any case should be consulted as to the impact of any proposed Rules on hospital operations and feasibility. Proposed Rules shall be submitted to the Medical Executive Committee for review and action, as follows:

- a. Except as provided at Section 15.1-2(d), below, with respect to circumstances requiring urgent action, the Medical Executive Committee shall not act on the proposed Rule until the Medical Staff has had a reasonable opportunity to review and comment on the proposed Rule. This review and comment opportunity may be accomplished by distributing proposed Rules by email at least fourteen days prior to the scheduled Medical Executive Committee meeting, together with instructions how interested members may communicate comments. A comment period of at least 14 days shall be afforded, and all comments shall be summarized and provided to the Medical Executive Committee prior to Medical Executive Committee action on the proposed Rule.
- b. Medical Executive Committee approval is required, unless the proposed Rule is one generated by petition of at least 33% of the voting members of the Medical Staff. In this latter circumstance, if the Medical Executive Committee fails to approve the proposed Rule, it shall notify the Medical Staff. The Medical Executive Committee and the Medical Staff each has the option of invoking or waiving the conflict management provisions of Section 15.1-6:
 1. If conflict management is not invoked within 30 days it shall be deemed waived. In this circumstance, the Medical Staff's proposed Rule shall be submitted for vote, and if approved by the Medical Staff pursuant to Section 15.1-2(b)(3), the proposed Rule shall be forwarded to the Governing Board for action. The Medical Executive Committee may forward comments to the Governing Board regarding the reasons it declined to approve the proposed Rule.
 2. If conflict management is invoked, the proposed Rule shall not be voted upon or forwarded to the Governing Board until the conflict management process has been completed, and the results of the conflict management process shall be communicated to the Governing Board.

3. With respect to proposed Rules generated by petition of the Medical Staff, approval of the Medical Staff requires the affirmative vote of a majority of the Medical Staff members voting on the matter by mailed secret ballot, provided at least 14 days' advance written notice, accompanied by the proposed Rule, has been given, and at least 50% of voting members have cast their vote.
- c. Following approval by the Medical Executive Committee or favorable vote of the Medical Staff as described above, a proposed Rule shall be forwarded to the Governing Board for approval, which approval shall not be withheld unreasonably. The Rule shall become effective immediately following approval of the Governing Board or automatically within 60 days if no action is taken by the Governing Board.
- d. Where urgent action is required to comply with law or regulation, the Medical Executive Committee is authorized to provisionally adopt a Rule and forward it to the Governing Board for approval and immediate implementation, subject to the following. If the Medical Staff did not receive prior notice of the proposed Rule (as described at Section 15.1-2(a)) the Medical Staff shall be notified of the provisionally-adopted and approved Rule, and may, by petition signed by at least 33% of the voting members of the Medical Staff require the Rule to be submitted for possible recall; provided, however, the approved Rule shall remain effective until such time as a superseding Rule meeting the requirements of the law or regulation that precipitated the initial urgency has been approved pursuant to any applicable provision of this Section 15.1-2.

If there is a conflict between the Bylaws and the Rules, the Bylaws shall prevail.

15.1-3 Department Rules

Subject to the approval of the Medical Executive Committee and Governing Board, each department shall formulate its own Rules for conducting its affairs and discharging its responsibilities. Additionally, hospital administration should be consulted as to the impact of any proposed department Rules on hospital operations and feasibility. Such Rules shall not be inconsistent with the Medical Staff or hospital Bylaws, Rules or other policies.

15.1-4 Medical Staff Policies

- a. Policies shall be developed as necessary to implement more specifically the general principles found within these Bylaws and the Medical Staff Rules. New or revised policies (proposed policies) may emanate from any responsible committee, department, medical staff officer, or by petition signed by at least 33% of the voting members of the Medical Staff. Proposed policies shall not be inconsistent with the Medical Staff or hospital Bylaws, Rules or other policies, and upon adoption shall have the force and effect of Medical Staff Bylaws.
- b. Medical Executive Committee approval is required, unless the proposed policy is one generated by petition of at least 33% of the voting members of the Medical Staff. In this latter circumstance, if the Medical Executive Committee fails to approve the proposed policy, it shall notify the Medical Staff. The Medical Executive Committee and the Medical Staff each has the option of invoking or waiving the conflict management provisions of Section 15.1-6.
 1. If conflict management is not invoked within 30 days it shall be deemed waived. In this circumstance, the Medical Staff's proposed policy shall be submitted for vote, and if approved by the Medical Staff pursuant to Section 15.1-5(b)(3), the proposed Rule shall be forwarded to the Governing Board for action. The Medical Executive

Committee may forward comments to the Governing Board regarding the reasons it declined to approve the proposed policy.

2. If conflict management is invoked, the proposed policy shall not be voted upon or forwarded to the Governing Board until the conflict management process has been completed, and the results of the conflict management process shall be communicated to the Medical Staff and the Governing Board.
3. Approval of the Medical Staff shall require the affirmative vote of a majority of the Medical Staff members voting on the matter by mailed secret ballot, provided at least 14 days' advance written notice, accompanied by the proposed Rule, has been given and at least 50% of voting members have cast their vote.
- c. Following approval by the Medical Executive Committee or the voting Medical Staff as described above, a proposed Rule shall be forwarded to the Governing Board for approval, which approval shall not be withheld unreasonably. The policy shall become effective immediately following approval of the Governing Board or automatically within 60 days if no action is taken by the Governing Board.
- d. The Medical Staff shall be notified of the approved policy, and may, by petition signed by at least 50% of the voting members of the Medical Staff require the policy to be submitted for possible recall; provided, however, the approved policy shall remain effective until such time as it is repealed or amended pursuant to any applicable provision of this Section 15.1-5.

15.1-6 Conflict Management

In the event of conflict between the Medical Executive Committee and the Medical Staff (as represented by written petition signed by at least 33% of the voting members of the Medical Staff) regarding a proposed or adopted Rule or policy, or other issue of significance to the Medical Staff, the Chief of Staff shall convene a meeting with the petitioners' representative(s). The foregoing petition shall include a designation of up to five members of the voting Medical Staff who shall serve as the petitioners' representative(s). The Medical Executive Committee shall be represented by an equal number of Medical Executive Committee members. The Medical Executive Committee's and the petitioners' representative(s) shall exchange information relevant to the conflict and shall work in good faith to resolve differences in a manner that respects the positions of the Medical Staff, the leadership responsibilities of the Medical Executive Committee, and the safety and quality of patient care at the hospital. Resolution at this level requires a majority vote of the Medical Executive Committee's representatives at the meeting and a majority vote of the petitioner's representatives. Unresolved differences shall be submitted to the Governing Board for its consideration in making its final decision with respect to the proposed Rule, policy, or issue.

15.2 FORMS

Application forms and any other prescribed forms required by these Bylaws for use in connection with Medical Staff appointments, reappointments, delineation of privileges, corrective action, notices, recommendations, reports and other matters shall be approved by the Medical Executive Committee and the Governing Board. Upon adoption, they shall be deemed part of the Medical Staff Rules. They may be amended by approval of the Medical Executive Committee and the Governing Board.

15.3 DUES

The Medical Executive Committee shall have the power to establish reasonable annual dues, if any, for each category of Medical Staff membership, and to determine the manner of expenditure of such funds received. However, such expenditures must be appropriate to the purposes of the Medical Staff.

15.4 MEDICAL SCREENING EXAMS

15.4-1 All patients who present to the hospitals, including the Emergency Department, Psychiatric Unit and the Labor and Delivery Unit, and who request examination and treatment for an emergency medical condition or active labor, shall be evaluated for the existence of an emergency medical condition or, where applicable, active labor. This screening examination shall be performed by a qualified medical personnel (QMP).

a. Qualified Medical Personnel (QMP): A Qualified Medical Personnel is a physician, nurse practitioner, physician assistant, and a specialty trained nurse such as obstetrics nurse who performs the medical screening examination and, in the case the QMP is not a physician, communicates the findings to a physician to determine if an emergency medical condition exists.

b. In all circumstances: In the event the qualified medical person performing the screening exam is uncertain about the nature of the patient's condition or the existence of an emergency medical condition or active labor, a physician from the appropriate Department shall be required to examine the patient and make the determination of an emergency medical condition or active labor.

15.4-2 Medical screening examinations and emergency services shall be provided in compliance with all applicable provisions of state and federal law, and hospital policies and procedures respecting Emergency Medical Services.

15.5 LEGAL COUNSEL

The Medical Staff may, at its expense, retain and be represented by independent legal counsel.

15.6 AUTHORITY TO ACT

Any member who acts 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.

15.7 DISPUTES WITH THE GOVERNING BOARD

In the event of a dispute between the Medical Staff and the Governing Board relating to the independent rights of the Medical Staff, as further described in California Business & Professions Code Section 2282.5, the following procedures shall apply.

a. Invoking the Dispute Resolution Process

1. The Medical Executive Committee may invoke formal dispute resolution, upon its own initiative, or upon written request of 25 percent of the members of the active staff.

2. In the event the Medical Executive Committee declines to invoke formal dispute resolution, such process shall be invoked upon written petition of 33 percent of the members of the active staff.

b. Dispute Resolution Forum

1. Ordinarily, the initial forum for dispute resolution shall be the Officers of the Medical Staff, the Chief Executive Officer and the Health Care Agency Director which shall meet and confer.
2. However, upon request of at least 2/3 of the members of the Medical Executive Committee, the meet and confer will be conducted by a meeting of the full Medical Executive Committee and the full Governing Board. A neutral mediator acceptable to both the Governing Board and the Medical Executive Committee may be engaged to further assist in dispute resolution upon request of:
 - i. At least a majority of the Medical Executive Committee plus two members of the Governing Board; or
 - ii. At least a majority of the Governing Board plus two members of the Medical Executive Committee.
- c. The parties' representatives shall convene as early as possible, shall gather and share relevant information, and shall work in good faith to manage and, if possible, resolve the conflict. If the parties are unable to resolve the dispute the Governing Board shall make its final determination giving great weight to the actions and recommendations of the Medical Executive Committee. Further, the Governing Board determination shall not be arbitrary or capricious, and shall be in keeping with its legal responsibilities to act to protect the quality of medical care provided and the competency of the Medical Staff, and to ensure the responsible governance of the hospital.

15.8 NO RETALIATION

Neither the Medical Staff, its members, committees or department heads, the Governing Board, its chief administrative officer, or any other employee or agent of the hospital or Medical Staff, shall discriminate or retaliate, in any manner, against any patient, hospital employee, member of the Medical Staff, or any other health care worker of the health facility because that person has done either of the following:

- a. Presented a grievance, complaint, or report to the facility, to an entity or agency responsible for accrediting or evaluating the facility, or the Medical Staff of the facility, or to any other governmental entity.
- b. Has initiated, participated, or cooperated in an investigation or administrative proceeding related to, the quality of care, services, or conditions at the facility that is carried out by an entity or agency responsible for accrediting or evaluating the facility or its Medical Staff, or governmental entity.

Article 16 Adoption and Amendment of Bylaws

16.1 MEDICAL STAFF RESPONSIBILITY AND AUTHORITY

- 16.1-1** The Medical Staff shall have the initial responsibility and delegated authority to formulate, adopt and recommend Medical Staff Bylaws and amendments which shall be effective when approved by the Governing Board, which approval shall not be unreasonably withheld. Such responsibility and authority shall be exercised in good faith and in a reasonable, timely and responsible manner, reflecting the interests of providing patient care of the generally recognized level of quality and efficiency, and maintaining a harmony of purpose and effort with the Governing Board. Additionally, hospital administration may develop and recommend proposed Bylaws, and in any case should be consulted as to the impact of any proposed Bylaws on hospital operations and feasibility.
- 16.1-2** Proposed amendments shall be submitted to the Governing Board for comments at least 30 days before they are distributed to the Medical Staff for a vote. The Governing Board has the right to have its comments regarding the proposed amendments circulated with the proposed amendments at the time they are distributed to the Medical Staff for a vote.
- 16.1-3** Amendments to these Bylaws shall be submitted for vote upon the request of the Medical Executive Committee or upon receipt of a petition signed by at least 33% of the voting Medical Staff members. Amendments submitted upon petition of the voting Medical Staff members shall be provided to the Medical Executive Committee at least 30 days before they are submitted to the Governing Board for review and comment as described in Section 16.1-3. The Medical Executive Committee has the right to have its comments regarding the proposed amendments circulated to the Governing Board when the proposed amendments are submitted to the Governing Board for comments; and to have its comments circulated to the Medical Staff with the proposed amendments at the time they are distributed to the Medical Staff for a vote.

16.2 METHODOLOGY

- 16.2-1** Medical Staff Bylaws may be adopted, amended or repealed by the following combined actions:
- a. These Bylaws may be adopted, amended or repealed by the affirmative vote of two thirds of the staff members who are present and eligible and qualified to vote on Bylaws cast at a regular or special staff meeting provided that a copy of the proposed documents or amendments as approved by the Executive Committee was given to each staff member entitled to vote thereon with the notice of the meeting at least two weeks prior to the meeting. If a copy of the proposed amendments was not distributed with the notice of the meeting, the proposed amendments shall be distributed at one quarterly or special meeting and voted on at the next quarterly or special meeting. Amendments so approved shall become effective when approved by the Governing Board. Approval shall not be withheld unreasonably, and the amendments will be automatically approved within 60 days if no action is taken by the Board. If approval is withheld, the reasons for doing so shall be specified by the Board in writing, and shall be forwarded to the Chief of Staff and the Executive Committee. Neither party may amend the Medical Staff Bylaws unilaterally.

- b. The approval of the Governing Board, which shall not be unreasonably withheld. If approval is withheld, the reasons for doing so shall be specified by the Governing Board in writing, and shall be forwarded to the Chief of Staff, the Medical Executive Committee and the Bylaws Committee.

16.2-2 In recognition of the ultimate legal and fiduciary responsibility of the Governing Board, the organized Medical Staff acknowledges, in the event the Medical Staff has unreasonably failed to exercise its responsibility and after notice from the Governing Board to such effect, including a reasonable period of time for response, the Governing Board may impose conditions on the Medical Staff that are required for continued state licensure, approval by accrediting bodies, or to comply with law or a court order. In such event, Medical Staff recommendations and views shall be carefully considered by the Governing Board in its actions.

16.3 TECHNICAL AND EDITORIAL CORRECTIONS

The Medical Executive Committee shall have the power to approve technical corrections, such as reorganization or renumbering of the Bylaws, or to correct punctuation, spelling or other errors of grammar expression or inaccurate cross-references. No substantive amendments are permitted pursuant to this Section. Corrections may be effected by motion and acted upon in the same manner as any other motion before the Medical Executive Committee. After approval, such corrections shall be communicated in writing to the Medical Staff and to the Governing Board. Such corrections are effective upon adoption by the Medical Executive Committee; provided however, they may be rescinded by vote of the Medical Staff or the Governing Board within 120 days of the date of adoption by the Medical Executive Committee. For purposes of this Section, "vote of the Medical Staff" shall mean a majority of the votes cast, provided at least 25 percent of the voting members of the Medical Staff cast ballots.