VENTURA COUNTY
MEDICAL CENTER

Ventura County Medical Center
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: November 8, 2022
Medical Staff: March, 3 2023
Governing Board/Oversight Committee: June 8, 2023

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 Oversight Committee, 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 Oversight Committee, 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 appointed by the Governing Board to carry out the duties and responsibilities to manage, operate and maintain the Ventura County Health Care System on behalf 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 (Medical Doctor/M.D. or Doctor of Osteopathy/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 the representative entity of the Governing Board charged with carrying out certain duties and responsibilities of the Governing Board, including acting as the governing authority with respect to the Medical Staff, as further set forth in the Bylaws of the Oversight Committee. Accordingly, for purposes of these Bylaws, the Rules, and any applicable Medical Staff policies, any reference to the term "Governing Board" shall be deemed to refer to the "Oversight Committee" as appropriate, unless context specifies otherwise.

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 Hospital will engage in specified joint credentialing and peer review activities.

23. **Telemedicine** is the practice of health care delivery, diagnosis, consultation, treatment, care management, transfer of medical data, and education via information and communication technologies.

VENTURA COUNTY MEDICAL CENTER

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 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 or privileges, as follows: Emergency Medicine, 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 as set forth in these Bylaws.

1.3 PURPOSES AND RESPONSIBILITIES

1.3.1 The Medical Staff's purposes are:

a. To ensure 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 (through the Oversight Committee) 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 Oversight Committee action with respect to appointments, reappointments, staff category and department assignments, clinical privileges and corrective action.

d. To establish and enforce, subject to approval by the Oversight Committee, professional standards related to the delivery of health care within the hospital.

e. To account to the Governing Board, acting through the Oversight Committee, 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 Oversight Committee 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 qualifications 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;

   2. Dentists must be licensed to practice dentistry by the California Board of Dental Examiners;

   3. Podiatrists must be licensed to practice podiatry by the California Board of Podiatric Medicine;

   4. 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.

b. If practicing clinical medicine, dentistry, or podiatry, have a federal Drug Enforcement Administration registration 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 or residents performing services at the hospital. 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, and other federally sponsored health care programs.

e. Maintain professional liability insurance coverage which covers all care provided by the practitioner at Hospital 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 qualifications 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 qualifications. 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.

2.2.3 ADDITIONAL QUALIFICATIONS FOR MEMBERSHIP

In addition to meeting the basic qualifications, 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 Medical Executive Committee has the discretion to deem a practitioner to have satisfied a qualification 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. The Medical Executive Committee may choose to consult with the practitioner's respective Department or Clinical Section. There is no obligation to grant any such waiver, and practitioners have no right to have a waiver considered and/or granted. All waivers are subject to approval by the Oversight Committee pursuant to Article 4. 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, sex, race, color, religion, ancestry, national origin, medical condition, genetic information, marital status, sexual orientation, citizenship, primary language, immigration status, 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.

b. To the extent a contract between a practitioner and the hospital places conditions, duties, and/or responsibilities in addition to those set forth in the Bylaws, Rules, or applicable Medical Staff and hospital policies on the practitioner, the provisions of the contract shall prevail, except that the contract may not reduce any hearing rights described in the Bylaws, Article 14.

c. The Medical Staff is responsible for reviewing the quality of clinical care provided to patients by members of the Medical Staff as set forth in the Bylaws, Rules, and applicable policies.

2.5.3 SUBCONTRACTORS

Practitioners who subcontract with practitioners or entities to provide services which involve clinical duties or privileges must also be a member of the Medical Staff, achieving his or her status by the procedures described in these Bylaws.

2.6 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

Except for Honorary and Retired Staff members *(see Article 3)*, 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 and policies 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, race, color, religion, ancestry, national origin, disability, medical condition, genetic information, marital status, sexual orientation, citizenship, primary language, immigration status, ability to pay, or source of payment.

2.6.11 Refrain from delegating the responsibility for diagnosis or care of 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 immediately and no later than 72 hours, following any action taken regarding the member's license (including, but not limited to, restrictions, probations, accusations and/or proposed actions), Drug Enforcement Administration registration, changes in liability insurance coverage, and any report filed with the National Practitioner Data Bank. For any other action or change in circumstances that could affect the member's qualifications for Medical Staff membership and/or clinical privileges at the hospital, such as changes in privileges at other hospitals, the member must notify the Medical Staff office in writing promptly, and no later than 14 calendar days, following such action.

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, cooperating with any requests from the Medical Staff office or organized committees and representatives of the Medical Staff, and/or any other peer review inquiries or investigations, as well as submitting to mental or physical examinations, including drug and/or alcohol testing, as requested by the Chief of Staff or the Medical Executive 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

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, visitors and others. It is therefore the policy of the Medical Staff to require that its members continuously fulfill their Medical Staff obligations in a manner that is within generally accepted bounds of professional interaction and behavior and meets the requirements for professional conduct established in these Bylaws, the Rules and applicable Medical Staff and hospital policies.

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—and shall not engage in conduct that is offensive, disruptive, dishonest or inappropriate, whether it is written, oral or behavioral. Such behavior can adversely affect patient care and hospital operations. In assessing whether particular circumstances in fact are affecting quality patient care or hospital operations, however, the assessment need not be limited to care of specific patients, or to direct impact on patient health.

VENTURA COUNTY MEDICAL CENTER

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:

3.1.1 Active Staff

The Active Staff shall consist of the members who 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.

3.1.2 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.

3.1.3 Courtesy Medical Staff

The Courtesy Medical Staff shall consist of the members who:

a. 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.

b. 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.

3.1.4 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. Granting of Honorary and Retired Staff status is within the discretion of the Medical Executive Committee, subject to approval by the Oversight Committee.

3.1.5 Telemedicine Staff

Telemedicine refers to the mode of delivering health care services via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care. Telemedicine is generally provided by physicians, but other health professionals may also be involved, who are either contractors or employees of the entity services at the distant site, meaning the location where the equipment and provider are located. Telemedicine includes synchronous and asynchronous interactions involving real time or near real time two-way transfer of medical data and information. The Telemedicine Staff shall consist of providers who administer telemedicine services from the distant site to the hospital, referred to as the originating site (where the patient is located).

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 Oversight Committee 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:** Attendance and participation at Medical Staff and department meetings is an expectation of membership. Failure to attend meetings may be deemed to be a waiver of the ability for the member to assert objections regarding matters discussed and decided at those meetings.

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 following table.

Staff Category	**Active Staff**	**Community Affiliate Staff**	**Courtesy Staff**	**Honorary and Retired Staff**	**Telemedicine Staff**
Prerogatives					
Admit, consult and/or treat patients (inpatients and outpatients)	☑	☑*	☑	☐	☑**
Eligible for clinical privileges	☑	☐	☑	☐	☐
Vote	☑	☐	☐	☐	☐
Hold office	☑	☐	☐	☐	☐
Serve as Committee Chair	☑	☑	☑	☐	☐
Serve on Committee and vote on matters	☑	☑	☑	☑	☐
Responsibilities					
Medical staff functions	☑	☐	☑	☐	☑
Consulting	☑	☐	☑	☐	☑
Call Coverage	☑	☐	☐	☐	☐
Pay application fee	☑	☑	☑	☐	☑
Pay Dues	☑	☑	☑	☐	☑
Additional Particular Qualifications					
Malpractice insurance maintained	☑	☐	☑	☐	☑
Timely file application and apply for reappointment	☑	☑	☑	☐	☑

*Limited to Refer & Follow Only.
**Excluding admitting Privileges.

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 above. 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 the 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 Oversight Committee (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

a. In accordance with Medical Staff policies, and at the discretion of the Medical Executive Committee, a medical staff member may obtain a leave of absence from the Medical Staff when they will be away from their patient care and Medical Staff responsibilities for a period longer than ninety (90) days, not to exceed two (2) years. When a member is on a formal leave of absence from clinical duties, there shall be an automatic suspension of privileges through the duration of the leave and the member's membership rights and responsibilities shall be inactive.

b. If the member's term of appointment is scheduled to expire during the term of leave, reappointment must be requested in a timely manner pursuant to the relevant provisions of these Bylaws, notwithstanding the leave. If the member's term of appointment expires

during the time when he/she is on leave, the practitioner must submit a completed initial application for membership and privileges.

3.6.2 Termination of Leave

At least 30 days prior to the intended termination of the leave of absence, or at any earlier time, the Medical Staff member must request reinstatement of privileges by submitting a written notice to that effect to the Medical Executive Committee. The member shall submit a summary of relevant activities during the leave, including written verification that the member's health status and ability to carry out delineated clinical privileges have been reviewed and were not adversely affected as a result of the time away from clinical practice at the hospital, if so requested. The Medical Executive Committee shall review relevant information and make a decision concerning the reinstatement of the member's qualifications and privileges, and the procedure provided in Bylaws, Section 4.2, shall be followed. The Medical Executive Committee may choose to interview the member and/or request information relevant to its decision.

Temporary resumption of clinical practice for a Medical Staff member who has submitted a reinstatement request may also be authorized by a joint decision of the CMO, Chief of Staff and the responsible Department Chief, subject to approval by the Medical Executive Committee.

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 Oversight Committee. The Governing Board, acting through the Oversight Committee, 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 BURDEN OF PRODUCING INFORMATION

In connection with all applications for appointment, reappointment, advancement or transfer, the applicant shall have the burden of producing information for an adequate evaluation of the applicant's qualifications and suitability for the clinical privileges and staff category requested. For proper evaluation of his/her character, emotional and mental status, physical health and ethics, and to resolve any reasonable doubt about these matters, he/she must satisfy requests for this information. This burden may include submission to a medical or psychological examination, at the applicant's expense, if deemed appropriate by the Medical Executive Committee, which may select the examining physician. The applicant's failure to sustain this burden shall be grounds for deeming an application as incomplete.

4.3 INCOMPLETE APPLICATION

4.3.1 Notwithstanding any other provision of these Bylaws, an application that is determined to be incomplete shall not qualify for a credentialing recommendation by any Medical Staff official or committee, regardless of any assessment or determination that may have been made as to its completeness at an earlier stage in the process. Should the applicant fail to make the application complete after being given a reasonable opportunity to do so, the credentialing process may be terminated at the discretion of the Medical Executive Committee, after giving the applicant an opportunity to be heard, either in writing and/or at a meeting, as determined by the Medical Executive Committee. Termination of the credentialing process under this provision shall not entitle the applicant to any hearing or appeal.

4.3.2 An applicant may be given an opportunity to render an incomplete application complete as described above. However, it is the applicant's responsibility to review the application carefully and verify that the information provided in it, or as part of it, is accurate and complete before it is submitted. Any substantial misrepresentation or misstatement in, or omission from, an application shall, itself alone, constitute cause for the Medical Staff to discontinue processing the application. Similarly, in the event that any substantial misrepresentation or misstatement in, or omission from, an application is discovered after the application has been approved, it shall

constitute cause for summary suspension and/or immediate revocation of Medical Staff membership and/or all clinical privileges. This provision may be invoked by the Medical Executive Committee, at its discretion, after giving the applicant an opportunity to address the issues in writing and/or at a meeting.

4.4 DURATION OF APPOINTMENT

Except as otherwise provided in these Bylaws, initial appointments to the Medical Staff shall be for a period not to exceed two (2) years. Every staff member who desires to remain on the Medical Staff will apply and be evaluated for reappointment and renewal of clinical privileges at least every two (2) years. Reappointments shall be for a period of up to two (2) years.

4.5 REAPPLICATION

A practitioner whose membership and/or privileges have been terminated or application has been denied following hearing, or whose membership and/or privileges have been recommended for revocation or denial and the practitioner resigned without exhausting hearing rights, shall be ineligible to apply for staff membership for at least thirty-six (36) months, unless the Medical Executive Committee chooses to consider the reapplication at an earlier date.

VENTURA COUNTY MEDICAL CENTER

Article 5 Privileges

5.1 EXERCISE OF PRIVILEGES

Except as otherwise provided in these Bylaws, the Rules or applicable policy, 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 them. Privileges may be granted by the Oversight Committee on recommendation of the Medical Executive Committee to practitioners who are not members of the Medical Staff. Such individuals may include residents providing services in the hospital, or others deemed appropriate by the Medical Executive Committee and Oversight Committee. 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) 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 Oversight Committee, 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 ensure 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 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. Subject to approval of the Medical Executive Committee and Oversight Committee, 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 Staff Privileges

a. In processing a request for initial appointment of privileges by a Telemedicine Staff member, the Medical Staff will credential and grant privileges to the practitioner in accordance with the Bylaws, Rules, and applicable policies in the same manner as for any other applicant for the same privileges, including but not limited to the collection of information from primary sources. The Medical Staff may take into consideration information provided by a distant-site telemedicine entity when making recommendations on privileges for practitioners if the distant-site entity is a Joint Commission accredited hospital 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 provided by a Joint Commission accredited distant-site telemedicine hospital entity at which 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 (M.D.s or D.O.s), 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, including the following:

1. Physician Assistants;

2. Nurse Practitioners; and

3. Certified Nurse Midwives.

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 Medical History and Physical Examination; Assessment

a. A medical history and physical examination must be completed and documented for each patient no more than 30 days before or 24 hours after admission to the hospital or registration, but prior to surgery or a procedure requiring anesthesia services (excepting that Departments and/or Clinical Sections may implement more stringent documentation requirements subject to review and approval by the Medical Executive Committee). The medical history and physical examination will be conducted by a physician, an oral and maxillofacial surgeon, or other qualified practitioners with appropriate privileges to do so.

b. An updated examination of the patient, including any changes in the patient's condition, must be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination are completed within 30 days before admission or registration.

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 Oversight Committee;

   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. For practitioners seeking temporary privileges based upon fulfilling an important patient care need, a completed application for Medical Staff membership is not necessary; rather, the Medical Executive Committee will determine the form of application. In such circumstances, practitioners need only meet conditions 1 and 2 below for temporary privileges based on meeting an important patient care need. For all other practitioners seeking temporary privileges, however, Conditions 1 through 3 below 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 ensure 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 defined as health care professionals who hold a license as required by California law to provide certain patient care services, but 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 Oversight Committee (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, Rules, and policies.

6.2 CATEGORIES

The Oversight Committee 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 Oversight Committee.

6.3 PRIVILEGES AND DEPARTMENT ASSIGNMENT

6.3.1 AHPs may exercise only those setting-specific privileges granted to them by the Oversight Committee. 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 Oversight Committee.

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.

VENTURA COUNTY MEDICAL CENTER

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 ensure 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 Oversight Committee, 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 Oversight Committee.

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.

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 Oversight Committee 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 Oversight Committee, 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 war- rant 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).

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 and approved by the Medical

Executive Committee, 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 Oversight Committee.

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 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. 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, Article14, 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.

VENTURA COUNTY MEDICAL CENTER

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. Past Chief of Staff,
4. Secretary-Treasurer, and
5. Chief Medical Officer

The Secretary-Treasurer is elected prior to the end of the existing terms of office. 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 ensure 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 forty-five (45) days prior to the scheduled 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.

8.2.3 Nomination by Petition

The Medical Staff may also nominate candidates for office by a petition signed by at least ten (10) 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 thirty (30) days prior to the scheduled election.

8.2.4 Election

The election shall be determined by a majority of the votes cast by the voting Medical Staff members.

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 percent of the Medical Staff members eligible to vote for officers; but recall itself shall require a 66 percent vote of the Medical Executive Committee or 66 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 the Hospital responsible to coordinate the collaboration between the Governing Board and the Medical Staff. The main purpose of this collaboration is to ensure high quality medical care at the Hospital.

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 (through the Oversight Committee), 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 Oversight Committee 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 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 Oversight Committee 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 Oversight Committee 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 and Past Chief of Staff

The Chief of Staff-Elect or the immediate Past Chief of Staff shall assume the duties and authorities of the Chief of Staff in the absence of the Chief of Staff, as determined by the other Medical Staff Officers. The Chief of Staff-Elect and the Past Chief of Staff shall be members 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 at least quarterly and general medical staff at least annually 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

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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, Graduate Medical Education Program's Designated Institutional Officer, Trauma Medical Director, Chief Medical Officer, and ex officio members without vote including the Chief Executive Officer, the Ambulatory Care 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 ensure effective performance of all Medical Staff functions; and

   3. Following up to ensure implementation of all directives.

b. Coordinate the activities of the committees and departments.

c. Ensure 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, ensure 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. Ensure 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 to ensure compliance with Medical Staff Bylaws, Rules, and applicable Medical Staff and Hospital policies and practices and 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 initial applications for Medical Staff appointment 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 Profession Practice Evaluations, as further described at Bylaws, Article 7, Performance Evaluation and Monitoring.

m. Regularly report to the Oversight Committee 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 ensure the Oversight Committee 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 ensure 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 Committee should be scheduled to meet on a monthly basis and shall meet at least ten (10) times during the calendar year. A record of its proceedings and actions shall be maintained, and the Medical Executive Committee shall submit

reports of activities and records relating to the committee's functions to the Oversight Committee as frequently as necessary and at least quarterly.

9.3 CREDENTIALS COMMITTEE

9.3.1 Composition

The Credentials Committee shall be composed of at least seven (7) members of the active staff so selected as to ensure representation of the major specialties, and the CMO or his or her designee. The Secretary-Treasurer of the Medical Staff shall also serve on the Credentials Committee.

9.3.2 Duties

The duties of the Credentials Committee shall include:

a. Reviewing and evaluating the qualifications of each practitioner applying for initial appointment of clinical privileges.

b. Submitting required reports on the qualifications of each practitioner applying for membership or particular clinical privileges including recommendations with respect to appointment, membership category, clinical privileges, clinical departments, and special conditions.

c. Investigating, reviewing and reporting on matters referred by the Chief of Staff or the Medical Executive Committee regarding the qualification, conduct, professional character, ethics or competence of any applicant or Medical Staff member; and

a. Reviewing, evaluating, acting upon and submitting conclusions and recommendations for further action related to the content contained with referrals from other Medical Staff committees.

9.3.3 Meetings

The Credentials Committee shall meet as often as necessary, but at least ten (10) times during the calendar year. A permanent record of its proceedings and actions shall be maintained and the Credentials Committee shall submit reports of activities and records relating to the committee's functions to the Medical Executive Committee and Oversight Committee as frequently as necessary and at least quarterly.

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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 or otherwise structure the department as necessary to best fulfill its responsibilities. Such structural arrangements should be set forth in writing and subject to approval by the Medical Executive Committee.

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 Oversight Committee 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 Oversight Committee.

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, including reappointment or modification of such privileges.

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.

m. Orientation and continuing education of all persons in the department.

n. Recommend space and other resources needed by the department.

10.6 CLINICAL SECTIONS

Within each department, the practitioners of the various specialty groups may organize themselves as a clinical section, subject to approval by the Chief of the department and the Medical Executive Committee. Each section may develop Rules specifying the purpose, responsibilities and method of using and selecting officers, including Section Chiefs if deemed practical. These Rules shall be effective when approved as required by Bylaws, Article 15, General Provisions. While clinical 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

The Medical Staff shall meet regularly during each Medical Staff year as necessary, but at least annually. 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 Oversight Committee, 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 ensure that confidential Medical Staff information is not inappropriately disclosed, and to ensure 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 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 ensure that confidential Medical Staff information is not inappropriately disclosed, and to ensure 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. 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 by a majority vote of those members deemed present who are eligible to vote, provided the requirements of quorum are met. Quorum at Medical Staff meetings shall consist of 10 percent of the members of the Medical Staff eligible to vote, except in matters where the Bylaws or Rules specifically require a larger percentage of those voting.

11.4.2 Medical Executive Committee Meetings

Business may be transacted at any regular or duly noticed special meeting of the Medical Executive Committee by a majority vote of those members deemed present who are eligible to vote, provided the requirements of quorum are met. Quorum at Medical Executive Committee meetings shall consist of 33 percent of the voting members.

11.4.3 Department and Committee Meetings

Business may be transacted at any regular or duly noticed special meeting of the Departments or committees by a majority vote of those members deemed present who are eligible to vote, provided the requirements of quorum are met. Quorum at Department and committee meetings shall consist of 25 percent of the voting members, but in no event less than three voting 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.

Action may be conducted electronically (i.e. by telephone or internet conference), which shall be deemed to constitute a meeting for the matters discussed and voted upon.

An action may also be taken without a meeting if at least 7 days' notice of the proposed action has been given to all members eligible to vote, in writing, and votes are received by a quorum of such members as set forth in these Bylaws.

The meeting chair shall refrain from voting except when necessary to break a tie.

11.6 MINUTES

Minutes of 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 Oversight

Committee. Each committee shall maintain a 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

11.7.1 Regular Attendance Expected

Each member of a Medical Staff category is expected to attend and participate at meetings under Article 3.3, Prerogatives and Responsibilities, including general staff meetings during the two-year reappointment period. Failure to attend meetings may be deemed to be a waiver of the ability for the member to assert objections regarding matters discussed and decided at those meetings.

11.7.2 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 conclusions and reasonable inferences being made without the input of the practitioner.

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.

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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.

12.2.1 Member's Access

a. A Medical Staff member shall only be granted access to his or her own credentials file, pursuant 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. 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. However, such access is only provided in connection to the hearing proceedings. Use of the confidential information is not authorized for any other purpose without written consent from the Medical Executive Committee.

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.

12.3 IMMUNITY AND RELEASES

12.3.1 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.

12.3.2 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.

12.3.3 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.

12.4 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.

12.5 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.

12.6 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 Governing Board or Oversight Committee 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 or Oversight Committee 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 Indemnitees, including, but not limited to, selection of legal counsel to defend against any such actions. The indemnity set forth herein is expressly conditioned on the Indemnitee's 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 ensure 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 actions taken. In addition, the Chief of Staff shall 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 ensure an unbiased review, to firm up an uncertain or controversial review or to engage specialized expertise). The investigation shall proceed in a prompt manner, using best efforts to complete the expedited initial review and prepare a written report of the investigation to be submitted to the Medical Executive Committee as soon as practicable. As necessary, updates regarding timeframes and process may be provided to, or requested by, the Medical Executive Committee.

c. Prior to any adverse action being approved, the Medical Executive Committee shall ensure 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.

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 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 Oversight Committee. The Oversight Committee may affirm, reject or modify the action. The Oversight Committee 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 Oversight Committee 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 Oversight Committee may be informed of the recommendation, but shall take no action until the member has either waived his or her right to a hearing, completed the hearing, or otherwise exhausted his or her hearing rights.

13.1.9 Initiation by Oversight Committee

a. The Medical Staff acknowledges that the Oversight Committee 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 Oversight Committee 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 Oversight Committee direction, the Oversight Committee 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 Oversight Committee 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. 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 a practitioner's clinical privileges where the failure to take such action may result in an imminent danger to the health or safety of any individual, including current or future hospital patients.

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 Oversight Committee, 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 Oversight Committee

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 Oversight Committee (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 Oversight Committee (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 registration is revoked, limited, suspended or expired, the member shall automatically be divested of the right to prescribe medications covered by the registration. In addition, whenever a member's Drug Enforcement Administration registration is revoked, limited, suspended or expired, the practitioner's membership to the Medical Staff and clinical privileges shall automatically be impacted in a corresponding manner. This provision does not

limit the Medical Executive Committee's ability to conduct a further investigation into the events that led to the action by the Drug Enforcement Administration.

b. **Probation.** Whenever a member's Drug Enforcement Administration registration is subject to probation, the member's right to prescribe such medications shall automatically become subject to the same terms of the probation. If the probation impacts the member's ability to exercise his or her clinical privileges, those clinical privileges may be suspended or modified as necessary by the Medical Executive Committee after consultation with the Chief of the Department. This provision does not limit the Medical Executive Committee's ability to conduct a further investigation into the events that led to the probation.

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 patients 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 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.

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 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 Exclusion from Federal or State Health Care Programs

Exclusion from Medicare, Medi-Cal, and/or any other federal or state health care programs.

13.3.10 Failure to Meet Other Requirements

Failure to meet other requirements, such as providing evidence of current required health status documentation (e.g. annual tuberculosis test) or successful completion of required trainings, including but not limited to, compliance trainings.

13.3.11 Criminal Conviction

A member who is convicted, pleads guilty, or pleads no contest, to a misdemeanor or felony, if the Medical Executive Committee concludes that the misdemeanor or felony has a relationship to the qualifications, functions or duties of Medical Staff membership. Such suspension shall become effective immediately upon such

conviction (or plea of no contest) regardless of whether or not an appeal is taken or pending from said judgment.

13.3.12 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.

13.4 PROCEDURAL RIGHTS FOR AUTOMATIC SUSPENSIONS OR LIMITATIONS

13.4.1 Medical Executive Committee Deliberation

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, applicable Federal or State Health Care Programs, or criminal conviction but instead shall address what, if any, additional action should be taken by the Medical Staff. There is no need for the Medical Executive Committee to act on automatic suspensions or limitations 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) comply with government and other third party payor Rules and policies (Bylaws, Section 13.3.8, above), or failure to comply with regulatory requirements (Bylaws, Section 13.3.10, above).

13.4.2 Hearings

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.

13.4.3 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 Oversight Committee, 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.

13.5 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. Should a member decline to be interviewed following a request from the Medical Executive Committee, the Medical Executive Committee shall be required to make necessary determinations without input from the member.

13.6 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.

VENTURA COUNTY MEDICAL CENTER

Article 14 Hearings and Appellate Reviews

14.1 GENERAL PROVISIONS

14.1.1 Review Philosophy

The intent of these hearing and appellate review procedures is to provide for a fair review of decisions that adversely affect practitioners (as described 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 Oversight Committee from carrying out peer review. Accordingly, discretion is granted to the Medical Staff and Oversight Committee 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, Governing Board, the Oversight Committee, 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 adverse action described in these provisions 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 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 hospital or Medical Staff policies. However, the Oversight Committee may, at its discretion, entertain challenges to the merits or substantive validity of Bylaws, Rules, or hospital or Medical Staff 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 or her challenges first to the Oversight Committee. The Oversight Committee shall consult with the Medical Executive Committee before taking final action regarding the Bylaw, Rule or policy involved.

14.1.4 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, the Oversight Committee, 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.

14.1.5 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 or recommended by the body whose decision prompted the hearing.

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), Rules, or policies, any one or more of the following actions or recommended actions shall be deemed grounds for a hearing:

14.2.1 Denial of Medical Staff membership, reappointment and/or renewal of clinical privileges, based on professional competence or conduct which affects or could affect adversely the health or welfare of a patient or patients.

14.2.2 Revocation of Medical Staff membership, based on professional competence or conduct which affects or could affect adversely the health or welfare of a patient or patients.

14.2.3 Revocation or reduction of clinical privileges, based on professional competence or conduct which affects adversely the health or welfare of a patient or patients.

14.2.4 Significant restriction of clinical privileges (except for proctoring incidental to new privileges, insufficient activity, or return from leave of absence) for more than fourteen (14) days based on professional competence or conduct which affects or could affect adversely the health or welfare of a patient or patients.

14.2.5 Suspension of Medical Staff membership and/or clinical privileges for more than fourteen (14) days based on professional competence or conduct which affects or could affect adversely the health or welfare of a patient or patients.

14.2.6 As required by applicable law.

14.3 REQUESTS FOR HEARING

14.3.1 Notice of Action or Proposed Action

In all cases in which action has been taken or a recommendation made as set forth in Bylaws, Section 14.2, the Practitioner shall be given prompt 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:

a. A description of the action or recommendation;

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

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

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

e. A summary of the Practitioner's rights at a hearing; and

f. A statement as to whether the action or recommendation must be reported to the Medical Board of California and/or the National Practitioner Data Bank.

14.3.2 Request for Hearing

The practitioner shall have 30 days following receipt of notice of the action or recommendation within which 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, and received by the Medical Staff Office within the deadline. A copy shall also be sent to the Chief Executive Officer by the Medical Staff Office. 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. Said action shall thereupon become the final action of the Medical Staff. The action or recommendation shall be presented for consideration by the Oversight Committee, which shall not be bound by it. If the Oversight Committee ratifies the action or recommendation, it shall thereupon become the final action of the Hospital. However, if the Oversight Committee, after consulting with the Chief of Staff, is inclined to take action against the practitioner that is more adverse than the action recommended by the Medical Staff, the Practitioner shall be so notified and given an opportunity for a hearing based on "an adverse action by the Governing Board," as provided herein.

14.4 PREHEARING PROCEDURE

14.4.1 Time and Place for Hearing

Upon receipt of a request for hearing, the Chief of Staff shall schedule a hearing and, within thirty (30) days from the date he or she received the request for a hearing, give written notice to the practitioner of the time, place and date of the hearing. The date of commencement of the hearing shall be not less than thirty (30) days or more than sixty (60) days from the date the Chief of Staff received the request for a hearing.

14.4.2 Notice of Charges

Together with the 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 action taken or recommended (if not already provided), including a description of the acts or omissions with which the practitioner is charged and a list of the charts or cases in question, where applicable. The Notice of Reasons or Charges may be supplemented or amended at any time prior to the issuance of the Hearing Committee's decision, provided the Practitioner is afforded a fair and reasonable opportunity to respond.

14.4.3 Hearing Committee

a. When a hearing is requested, the Chief of Staff shall appoint a Hearing Committee, also referred to as the Judicial Review Committee, which shall be composed of not less than three (3) members of the Active Medical Staff who shall gain no direct financial benefit from the outcome and who have not acted as accusers, investigators, fact-finders or initial decision-makers, and otherwise have not actively participated in the

consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude a member 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 practices in the same specialty as the Practitioner involved.

b. Alternatively, the Chief of Staff shall have the discretion to enter into an agreement with the Practitioner involved to hold the hearing before a mutually acceptable arbitrator. Failure or refusal to exercise this discretion shall not constitute a breach of the Medical Staff's responsibility to provide a fair hearing.

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. A majority of the Hearing Committee must be present throughout the hearing. In the event that a Hearing Committee member will be unable to attend a hearing session, 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 Hearing Committee or the arbitrator (if one is used) shall have such powers as are necessary to discharge its or his or her responsibilities.

14.4.4 The Hearing Officer

The Chief of Staff shall select a Hearing Officer to preside at the hearing. The Hearing Officer shall be an attorney-at-law who is qualified to preside over a quasi-judicial hearing, but an attorney regularly utilized by the Hospital or Medical Staff for legal advice regarding its affairs and activities shall not be eligible to serve as Hearing Officer. The Hearing Officer shall not be biased for or against any party, shall gain no direct financial benefit from the outcome, and must not act as a prosecuting officer or as an advocate. The Hearing Officer shall endeavor to ensure 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 the 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 that are raised prior to, during, or after the hearing. If the Hearing Officer determines that either party in a hearing is not proceeding in an efficient and expeditious manner, the Hearing Officer may take such action as he or she deems warranted by the circumstances. The Hearing Officer should participate in the deliberations of the hearing committee and be a legal advisor to it, but the Hearing Officer shall not be entitled to vote.

14.4.5 Voir Dire

The Practitioner shall have the right to a reasonable opportunity to voir dire the Hearing Committee members and the Hearing Officer, and the right to challenge the appointment of any member or the Hearing Officer. The Hearing Officer shall establish the procedure by which this right may be exercised, which may include reasonable requirements that

voir dire questions be proposed in writing in advance of the hearing and that the questions be presented by the Hearing Officer. The Hearing Officer shall rule on any challenges in accordance with applicable legal principles defining standards of impartiality for hearing panels and hearing officers in proceedings of this type.

14.4.6 Representation

The hearings provided for in these Bylaws are for the purpose of intra-professional resolution of matters bearing on professional conduct, professional competency, or character. The Practitioner shall be entitled to representation by legal counsel in any phase of the hearing, if the Practitioner so chooses, and shall receive notice of the right to obtain representation by an attorney at law. In the absence of legal counsel, the member shall be entitled to be accompanied by and represented at the hearing by an individual of the member's choosing who is not also an attorney at law, and the Medical Executive Committee shall appoint a representative who is not an attorney to present its action or recommendation, the materials in support thereof, examine witnesses, and respond to appropriate questions. The Medical Executive Committee shall not be represented by an attorney at law if the Practitioner is not so represented. The foregoing shall not be deemed to deprive any party of its right to be represented by legal counsel for the purpose of preparing for the hearing.

In all instances, whether or not attorneys are allowed to represent the parties during the hearing, the Medical Executive Committee shall be represented by a member of the Medical Staff who shall be responsible for representing the Medical Executive Committee's interests in connection with the peer review matter and proceeding. This responsibility shall include the authority to make decisions regarding the detailed contents of the Notice of Reasons or Charges; to make decisions regarding the presentation of testimony and exhibits; to direct the activities of the Medical Executive Committee's attorney, if any; to consult with the specialists; and to amend the Notice of Reasons or Charges as he or she deems warranted during the course of the proceedings, subject to the Practitioner's procedural rights. However, the Medical Executive Committee's representative shall not have the authority to modify the nature of the Medical Executive Committee's action or recommendation without the Medical Executive Committee's approval.

14.4.7 Failure to Appear or Proceed; Non-Cooperation or Disruption

Failure without good cause of the Practitioner to attend and proceed at a hearing in an efficient and orderly manner, or serious or persistent misconduct or failure to cooperate in the hearing process by either party, shall be grounds for termination of the hearing as determined by the Hearing Committee in consultation with the Hearing Officer. Such conduct by the Practitioner shall be deemed to constitute a waiver of any hearing rights and acceptance of the recommendation(s) or action(s) taken by the Medical Executive Committee.

Such conduct by the Medical Executive Committee shall be deemed a failure to show that its action(s) or recommendation(s) were reasonable and warranted or, in the

case of an initial application, a failure to present evidence in opposition to the application.

The Hearing Committee's determination pursuant to this provision shall be presented for consideration by the Oversight Committee, which shall exercise its independent judgment as to the appropriateness of the Hearing Committee's action in terminating the hearing.

14.4.8 Postponements and Extensions

Once a timely request for a hearing has been made, postponements and extensions of the time beyond those referenced in the Article may be permitted by the Hearing Officer within his or her discretion.

14.4.9 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 Executive Committee has in its possession or under its control. The Medical Executive Committee 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. Requests for discovery shall be met as soon as practicable. Failure to comply with reasonable discovery requests at least thirty (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 that the parties cannot resolve. Discovery may be denied, or safeguards may be imposed when justified to protect peer review or in the interest of fairness and equity. Further, the right to inspect and copy by either party does not extend to confidential information referring to individually identifiable practitioners other than the 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 imposed on the party in possession of the information sought, if access is granted; and

4. Any previous requests for access to information submitted or resisted by the parties to the same proceeding.

d. **Objections to Introduction of Evidence Previously Not Produced**. The Medical Executive Committee may object to the introduction of 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 prior to the hearing.

14.4.10 Pre-Hearing Document Exchange

The parties shall exchange all documents that will be introduced at the hearing. The documents must be exchanged at least ten (10) days prior to the hearing. Failure to comply with this rule is good cause for the Hearing Officer to grant a continuance, or to limit the introduction of any documents not provided to the other party in a timely manner.

14.4.11 Witness Lists

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

14.4.12 Expert Witnesses

No expert testimony shall be permitted by non-members of the Medical Staff unless the following information is exchanged in written form no less than thirty (30) days before the date of the hearing:

a. A curriculum vitae setting forth the qualifications of the expert.

b. A complete expert witness report, which must include the following:

1. A complete statement of all opinions the expert will express and the bases and reasons for each opinion.

2. The facts or data considered by the expert in forming the opinions.

3. Any exhibits that will be used to summarize or support the opinions.

4. A representation that the expert has agreed to testify at the hearing.

c. A statement of the expert's hourly and daily fee for providing testimony and for consulting with the party who retained his or her services.

14.4.13 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 soon as possible in advance of the scheduled hearing, 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 or otherwise request rulings as deemed necessary to give full effect to rights established by the Bylaws and to resolve such procedural matters as the Hearing Officer determines may properly be resolved outside the presence of the full Hearing Committee. All such motions or requests, the arguments presented by both parties, and rulings thereon shall be reflected in the hearing record in a manner deemed appropriate by the Hearing Officer.

14.4.14 Record of the Hearing

A shorthand reporter shall be present to make a record of the hearing proceedings, and the pre-hearing proceedings if deemed appropriate by the Hearing Officer. The cost of attendance of the shorthand reporter shall be borne by the Hospital, but the cost of preparing a transcript, if any, or of a copy of the transcript that has already been prepared, shall be borne by the party requesting it. The Hearing Officer may, but shall not be required to, order that oral evidence shall be taken only under oath administered by a person lawfully authorized to administer such oath.

14.4.15 Attendance

Except as otherwise provided in these Bylaws and subject to reasonable restriction by the Hearing Officer, the following shall be permitted to attend the entire hearing in addition to the Hearing Officer, the court reporter, and the parties (with attorneys, if allowed): The Medical Staff Manager and/or Coordinator(s), one or more key consultants for each party, one or more key witnesses for each party, and the Administrator or his or her designee. An individual shall not be excluded from attending any portion of the hearing solely by reason of the possibility or expectation that he or she will be a witness for one of the parties.

14.4.16 Rights of the Parties

Within reasonable limitations, both parties may call and examine witnesses for relevant testimony; introduce relevant exhibits or other documents; cross-examine or impeach witnesses who have testified orally on any matter relevant to the issues, and otherwise rebut evidence; receive all information made available to the Hearing Committee; and submit a written statement, 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 question witnesses or call additional witnesses if it deems such action appropriate. The Hearing Officer shall also have the discretion to ask questions of witnesses if he or she deems it appropriate for purposes of clarification or efficiency.

14.4.17 Rules of Evidence

Judicial Rules of evidence and procedure relating to the conduct of a trial, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under these Bylaws, Article 14. Any relevant evidence, including hearsay, may be admitted if it is the sort of evidence on which responsible persons are accustomed to relying in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.

14.4.18 Burdens of Presenting Evidence and Proof

a. The body whose decision prompted the hearing shall have the initial duty to present evidence which supports its recommendation or action. 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 sufficiently qualified to be awarded such membership and/or privileges at this Hospital. This burden requires the production of information which allows for adequate evaluation and resolution of reasonable doubts concerning the Practitioner's current qualifications. The applicant shall not be permitted to introduce information that was not produced upon the request of any committee or person on behalf of the Medical Staff during the application process, unless the member establishes that the information could not have been produced in the exercise of reasonable diligence. This provision shall not be construed to compel the Medical Staff to act on, or to afford a practitioner a hearing regarding, an incomplete application.

c. Except as provided above, 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. The term "reasonable and warranted" means within the range of reasonable and warranted alternatives open to the body whose decision prompted the hearing, as a matter of discretion, and not necessarily the only or best action or recommendation that could be formulated in the opinion of the Hearing Committee. If the Hearing Committee finds, based on the evidence presented at the hearing, that the action being challenged is not within the range of reasonable and warranted alternatives open to the body whose decision prompted the hearing, the Hearing Committee may recommend a different result, which may be either more adverse or less adverse to the Practitioner than the action that prompted the hearing.

14.4.19 Adjournment and Conclusion

The Hearing Officer may adjourn and reconvene the hearing at such times and intervals as may be reasonable and warranted, with due regard for the objective of reaching an expeditious conclusion to the hearing. Both the Medical Executive Committee and the member may submit a written statement at the close of the hearing. Upon conclusion of the presentation of oral and written evidence, or the receipt of closing written arguments, if submitted, the hearing shall be closed.

14.5 DECISION

14.5.1 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.

14.5.2 Decision of the Hearing Committee

Within thirty (30) days after the 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 Administrator, the Chief of Staff, the Oversight Committee, and 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 review as described in these Bylaws.

14.6 APPEAL

14.6.1 Time for Appeal

Within ten (10) days after receipt of 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 Administrator and the other party in the hearing. If a request for appellate review is not received by the Administrator within such period, the decision of the Hearing Committee shall thereupon become final, except if modified or reversed by the Oversight Committee.

It shall be the obligation of the party requesting appellate review to produce the record of the Hearing Committee's proceedings. If the record is not produced within a reasonable period, as determined by the Oversight Committee or its authorized representative, appellate rights shall be deemed waived.

In the event of a waiver of appellate rights by a practitioner, if the Oversight Committee is inclined to take action which is more adverse than that taken or recommended by the Medical Executive Committee, the Oversight Committee must consult with the Medical Executive Committee before taking such action. If after such consultation the Oversight Committee is still inclined to take such action, then the practitioner shall be so notified. The notice shall include a brief summary of the reasons for the contemplated action, including a reference to any factual findings in the Hearing Committee's Decision that support the action. The Practitioner shall be given ten (10) days from receipt of that notice within which to request appellate review, notwithstanding his or her earlier waiver of appellate rights. The grounds for appeal and the appellate procedure shall be as described below. However, even if the Practitioner declines to appeal any of the Hearing Committee's factual findings, he or she shall still be given an opportunity to present written and oral arguments that the contemplated action which is more adverse than that taken or recommended by the Medical Executive Committee was not reasonable and

warranted. The action taken by the Oversight Committee after following this procedure shall be the final action of the Hospital.

14.6.2 Grounds for Appeal

A written request for an appeal shall include an identification of the grounds of appeal, and a clear and concise statement of the facts in support of the appeal. The recognized grounds for appeal for a Hearing Committee decision are:

a. Substantial non-compliance with the standards or procedures required by these Bylaws or applicable law which has created demonstrable prejudice;

b. The factual findings of the Hearing Committee are not supported by substantial evidence based upon the hearing record or such additional evidence as may be permitted pursuant to Section 14.7.5 below; or

c. The Hearing Committee failed to sustain an action or recommendation of the Medical Executive Committee that, based on the evidence in the hearing record, was reasonable and warranted.

14.6.3 Time, Place and Notice

The Appeal Board shall, within thirty (30) days after receipt of a request for appellate review, schedule a review date and cause each side to be given notice of time, place and date of the appellate review. The appellate review shall not commence less than thirty (30) or more than sixty (60) days from the date of notice; provided, however, that when a request for appellate review concerns a practitioner who is under suspension which is then in effect, the appellate review may commence as soon as the arrangements may reasonably be made. The time for appellate review may be extended by the Appeal Board for good cause.

14.6.4 Appeal Board

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

14.6.5 Appeal Procedure

The proceeding by the Appeal Board shall be in the nature of an appellate hearing based upon the record of the proceedings before the Hearing Committee. However, the Appeal Board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the Hearing Committee in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at a hearing.

The Appeal Board shall also have the discretion to remand the matter to the Hearing Committee for the taking of further evidence or for clarification or reconsideration of the Hearing Committee's decision. In such instances, the Hearing Committee shall report back to the Appeal Board within such reasonable time limits as the Appeal Board imposes. Each party shall have the right to be represented by legal counsel before the Appeal Board, to present a written argument to the Appeal Board, and to appear and make an oral argument and respond to questions in accordance with the procedure established by the Appeal Board. After the arguments have been submitted, the Appeal Board shall conduct its deliberations outside the presence of the parties and their representatives. If the Oversight Committee itself does not sit as the Appeal Board, the Appeal Board shall present to the Oversight Committee its written recommendations as to whether the Oversight Committee should affirm, modify, or reverse the Hearing Committee decision, or remand the matter to the Hearing Committee for further review and decision.

14.6.6 Decision

Within sixty (60) days after the submission of arguments as provided above, the Appeal Board shall provide notice rendering a decision in writing and shall forward copies thereof to each side involved in the hearing. For good cause, the Appeal Board may extend this deadline. The Appeal Board may affirm, reverse or modify the decision of the Hearing Committee, and its decision shall constitute the final decision of the hospital.

14.7 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.

14.8 EXCEPTIONS TO HEARING RIGHTS

14.8.1 Exclusive Contracts

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 contract.

14.8.2 Allied Health Professionals

AHPs are not entitled to the hearing rights set forth in this Article unless otherwise required by applicable law. However, an AHP may challenge an adverse action in the manner provided by the Rules and established Medical Staff policies.

14.8.3 Automatic Suspension or Limitation of Privileges

No hearing is required when a member's license or legal credential to practice has expired, or been revoked or suspended as set forth in Bylaws, Section 13.3.1 or as otherwise set forth in these Bylaws.

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Article 15 General Provisions

15.1 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 Oversight Committee. 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 Oversight Committee.

15.2 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.

15.3 MEDICAL SCREENING EXAMS

15.3.1 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, certified nurse midwife, 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.

15.3.2 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.

15.4 LEGAL COUNSEL

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

15.5 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.

15.6 DISPUTES WITH THE GOVERNING BOARD

In the event of a dispute between the Medical Staff and the Governing Board or the Oversight Committee 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 Oversight Committee. A neutral mediator acceptable to both the Oversight Committee 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 Oversight Committee; or ii. At least a majority of the Oversight Committee 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 Oversight Committee shall make its final determination giving great weight to the actions and recommendations of the Medical Executive Committee. Further, the Oversight Committee 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.

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15.7 NO RETALIATION

Neither the Medical Staff, its members, committees or department heads, the Governing Board, its chief administrative officer, the Oversight Committee, 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.

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Article 16 Adoption and Amendment of Medical Staff Bylaws, Rules, and Policies

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 Oversight Committee, 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 When proposed by the Medical Executive Committee, there will be communication of the amendment to the Medical Staff at least 30 days before a vote is taken by the Medical Staff. The notice shall include the exact wording of the existing bylaw language, if any, and the proposed change(s). The proposed amendments shall also be submitted to the Oversight Committee for comments at least 30 days before they are distributed to the Medical Staff for a vote. The Oversight Committee 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 percent 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 Oversight Committee for review and comment as described in this Section. The Medical Executive Committee has the right to have its comments regarding the proposed amendments circulated to the Oversight Committee when the proposed amendments are submitted to the Oversight Committee 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 25 percent of the Medical Staff members eligible to vote, provided that a copy of the proposed documents or amendments as approved by the Medical Executive Committee was provided to each staff member eligible to vote with the notice of a meeting at least two weeks prior to the vote.

b. Amendments approved by the Medical Staff shall become effective when approved by the Oversight Committee. Approval by the Oversight Committee

shall not be withheld unreasonably, and the amendments will be automatically approved within 60 days if no action is taken by the Oversight Committee. If approval is withheld, the reasons for doing so shall be specified by the Oversight Committee in writing, and shall be forwarded to the Chief of Staff and the Medical Executive Committee. Neither party may amend the Bylaws unilaterally.

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 Oversight Committee to such effect, including a reasonable period of time for response, the Oversight Committee 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 Oversight Committee in its actions.

16.3 RULES AND POLICIES

16.3.1 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.

16.3.2 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 percent of the voting members of the Medical Staff. The Rules may be adopted, amended or repealed by an affirmative vote of 10 percent of the Medical Staff members eligible to vote, provided that a copy of the proposed documents or amendments as approved by the Medical Executive Committee was provided to each staff member eligible to vote with the notice of the meeting at least two weeks prior to the vote. The Rules require approval by the Medical Executive Committee and Oversight Committee.

16.3.3 Department Rules

Subject to the approval of the Medical Executive Committee and Oversight Committee, each department shall formulate its own rules, policies, and procedures 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 Department Rules shall not be inconsistent with the Medical Staff or hospital Bylaws, Rules or other policies.

16.3.4 Medical Staff Policies

a. Policies shall be developed as necessary to implement more specifically the general principles found within these Bylaws and the Rules. New or revised policies (proposed policies) may emanate from any responsible committee,

Department, Clinical Section, medical staff officer, or by petition signed by at least 33 percent of the voting members of the Medical Staff for consideration by the Medical Executive Committee. Proposed policies shall not be inconsistent with the Medical Staff or hospital Bylaws, Rules or other policies.

b. Medical Executive Committee approval of the proposed policies is required. If the proposed policy is one generated by petition of at least 33 percent of the voting members of the Medical Staff, the Medical Executive Committee shall notify the Medical Staff if it fails to approve the proposed policy.

16.3.5 Conflict

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

16.3.6 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 percent 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 Oversight Committee for its consideration in making its final decision with respect to the proposed Rule, policy, or issue.

16.4 NON-SUBSTANTIVE CHANGES/TECHNICAL CORRECTIONS/CLARIFICATIONS

The Medical Executive Committee shall have authority to adopt non-substantive changes/technical corrections/clarifications needed to the Bylaws, Rules, and policies. Such changes shall not affect the intent of the sections being changed. After approval by the Medical Executive Committee, such changes shall be communicated promptly in writing to the Oversight Committee. Such changes are subject to approval by the Oversight Committee, which approval shall not be withheld unreasonably. Following approval by the Oversight Committee, the changes will be communicated to the Medical Staff within a time that is reasonable under the circumstances (which may be when the Medical Staff is notified of the next substantive change to the Bylaws, Rules, or policies affected).