# MEDICAL STAFF BYLAWS

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PREAMBLE

Providence Holy Cross Medical Center, Mission Hills (the “Hospital”), is a private, nonprofit corporation organized under the laws of the State of California.

The Hospital’s purpose is to serve as a general, acute care hospital providing patient care, education and research.

The Hospital is operated under the sponsorship of the Sisters of the Providence and is governed by a Board of Trustees.

These Bylaws are adopted in order to establish a framework for self-governance of Medical Staff activities and accountability to the Board of Trustees.

These Bylaws create a framework within which Medical Staff Members can act with a reasonable degree of freedom and confidence.

These Bylaws provide the professional and legal structure for Medical Staff operations, Medical Staff relations with the Board of Trustees, and relations with applicants to and Members of the Medical Staff.

Only duly qualified Physicians, Dentists and Podiatrists shall be eligible for Medical Staff membership, privileges and prerogatives.

Some duly qualified Allied Health Professionals may be eligible to participate in the provision of certain patient care services under specific circumstances as stated in these Bylaws.

The Physicians, Dentists and Podiatrists practicing in this Hospital are hereby organized as the Medical Staff of Providence Holy Cross Medical Center in conformity with these Bylaws.

It is the Medical Staff’s responsibility to establish criteria and standards for Medical Staff membership and clinical privileges, quality assurance, utilization review, and other Medical Staff activities consistent with the Bylaws, Rules and Regulations, Policies, and requirements of Providence Holy Cross Medical Center.

DEFINITIONS

1. ALLIED HEALTH PROFESSIONAL or AHP shall mean an individual (other than a Physician, Dentist or Podiatrist) who exercises independent judgment within the area(s) of the individual’s professional competence and within the limits established by the Governing Body, the Medical Staff and the applicable State Practice Acts; who is qualified to render direct or indirect medical, dental or podiatric care under the supervision or direction of a Medical Staff Member possessing Clinical Privileges to provide such care in this Hospital; and who may be eligible to exercise Practice Privileges and prerogatives in conformity with the rules adopted by the Governing Body, these Bylaws and the Medical Staff Rules and Regulations and Policies. AHPs shall not be eligible for Medical Staff membership.

2. BYLAWS shall mean the Medical Staff Bylaws as adopted and amended by the Medical Staff.

3. CHIEF EXECUTIVE shall mean either the person appointed by the Governing Body to act on its behalf in the overall management of the Hospital or such person’s authorized designee.
4. **CHIEF OF STAFF** shall mean the President of the Medical Staff elected by the Medical Staff.

5. **CLINICAL PRIVILEGES or PRIVILEGES** shall mean the permission granted to a Medical Staff Member to render specific diagnostic, therapeutic, medical, dental, podiatric or surgical services to patients at the Hospital.

6. **DENTIST** shall mean an individual currently licensed by the Dental Board of California.

7. **DEPARTMENT** shall mean the clinical departments created by the Medical Staff pursuant to these Bylaws.

8. **GOOD STANDING** shall mean a member who is currently not under suspension or serving with any limitation of voting or other prerogatives imposed by these Bylaws, Rules and Regulations, and/or Policies.

9. **GOVERNING BODY** shall mean the Hospital’s Board of Trustees or a duly authorized Committee thereof.

10. **HOSPITAL** shall mean Providence Holy Cross Medical Center, Mission Hills, California.

11. **INVESTIGATION** shall mean a process specifically conducted by or on behalf of the Medical Executive Committee to determine the validity, if any, of a concern or complaint raised against a Member, and does not include any activity of the Well-Being Committee.

12. **MEDICAL EXECUTIVE COMMITTEE** shall mean the executive committee of the Medical Staff, which serves as the governing body of the Medical Staff.

13. **MEDICAL STAFF** shall mean the formal organization of all licensed Physicians, Dentists and Podiatrists who have been appointed as Members pursuant to these Bylaws.

14. **MEDICAL STAFF YEAR** shall mean the period from January 1 to December 31.

15. **MEDICO-ADMINISTRATIVE OFFICER** shall mean a Practitioner employed by, contracting with, or otherwise serving the Hospital (on a full-time or part-time basis), whose responsibilities are both administrative and clinical in nature. Clinical responsibilities, as used herein, shall refer to those responsibilities requiring the Practitioner to exercise clinical judgment with respect to patient care, and to supervise the professional activities of all those Practitioners under the Medico-Administrative Officer’s direction (which supervision shall be in addition to the regular peer review performed by the Medical Staff).

16. **MEDICAL DISCIPLINARY CAUSE OR REASON** shall mean 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.

17. **MEMBER** shall mean any Practitioner who has been appointed to the Medical Staff pursuant to these Bylaws.

18. **PHYSICIAN** shall mean an individual with an M.D. or D.O. degree who is currently licensed to practice medicine by the Medical Board of California or the Osteopathic Medical Board of California.

19. **PODIATRIST** shall mean an individual currently licensed by the California Board of Podiatric Medicine.

20. **POLICIES** shall mean those policies adopted and amended by the Medical Staff and/or Departments in accordance with these Bylaws.
21. **PRACTICE PRIVILEGES** shall mean the permission granted to an Allied Health Professional to participate in the provision of certain patient care services at the Hospital.

22. **PRACTITIONER** shall mean, unless otherwise expressly limited, any Physician, Dentist or Podiatrist.

23. **PREROGATIVE** shall mean a participatory right of a Member, granted by virtue of assignment to a specific category of the Medical Staff which is exercisable in accordance with the conditions imposed by the Bylaws, Rules and Regulations, Policies, and other Hospital rules.

24. **RULES AND REGULATIONS** shall mean the rules and regulations adopted and amended by the Medical Staff and/or Departments in accordance with these Bylaws.

25. **TELEMEDICINE** shall mean the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video or data communications.
ARTICLE I

NAME

The name of this organization shall be the Medical Staff of Providence Holy Cross Medical Center, Mission Hills.

ARTICLE II

PURPOSE

The purposes of this organization are:

2.1 To assure that all patients admitted to, or treated in, the Hospital or any of its facilities receive the highest standard of care and the highest level of professional performance attainable within the Hospital’s means and circumstances.

2.2 To assure such a standard of care and such a level of professional performance by all those authorized to practice in the Hospital is achieved, through the appropriate delineation of both the Clinical Privileges granted to each Practitioner and the Practice Privileges granted to each AHP and through an ongoing review and evaluation of each Practitioner’s and AHP’s performance in the Hospital.

2.3 To initiate and maintain Rules and Regulations and Policies for the Medical Staff to carry out its responsibilities for the professional work performed in the Hospital.

2.4 To provide a means for the Medical Staff, Governing Body and Hospital administration to discuss issues of concern and implement education and other changes intended to improve the quality of patient care.

ARTICLE III

MEMBERSHIP

3.1 NATURE OF MEMBERSHIP

Medical Staff membership and Clinical Privileges shall be extended only to professionally competent Practitioners who continuously meet the qualifications, standards and requirements set forth within these Bylaws. Appointment to the Medical Staff shall confer upon a Member only such Clinical Privileges and Prerogatives as shall have been granted in accordance with these Bylaws. Practitioners shall not admit patients to, or provide services to patients in, this Hospital unless they are Members of the Medical Staff and/or have been granted Temporary Privileges or Telemedicine Clinical Privileges in accordance with the procedures set forth within these Bylaws. Medico-administrative contracts or other contracts with the Hospital do not automatically confer Medical Staff membership or Clinical Privileges on a Practitioner.

No individual shall be entitled to appointment to the Medical Staff merely because he or she holds a certain degree, is licensed to practice in California or any other state, is a member of any professional organization, is certified by any clinical board or because such person had, or presently has, staff membership or clinical privileges at another health care facility. Only a Practitioner who can meet and continue to meet the standards and requirements set forth in these Bylaws shall be eligible to apply for and/or maintain Medical Staff membership.
3.2 MINIMUM QUALIFICATIONS FOR MEMBERSHIP

3.2-1 GENERAL MINIMUM QUALIFICATIONS

Practitioners shall be qualified for Medical Staff membership only if they:

a) document their (1) current licensure, (2) adequate experience, education and training, (3) current professional competence, (4) good judgment and (5) adequate physical and mental health status, so as to demonstrate to the satisfaction of the Medical Staff that they are professionally and ethically competent to provide quality medical care to the Hospital's patients; and

b) (1) demonstrate their adherence to the ethics of their respective profession, (2) are able to work cooperatively with others so as not to adversely affect patient care or hospital operations, and (3) are willing to participate in and properly discharge those responsibilities determined by the Medical Staff.

3.2-2 SPECIFIC MINIMUM QUALIFICATIONS

a) Licensure

1) Physicians must hold an M.D. or D.O. degree issued by a medical or osteopathic school and a valid, unrevoked and unsuspended license to practice medicine issued by the Medical Board of California or the Osteopathic Medical Board of California.

2) Dentists must hold a D.D.S. (or an equivalent) degree issued by a dental school and a valid, unrevoked and unsuspended license to practice dentistry issued by the Dental Board of California.

3) Podiatrists must hold a D.P.M. degree and a valid, unrevoked and unsuspended license to practice podiatry issued by the California Board of Podiatric Medicine.

b) Participation in Medicare, Medi-Cal or Other Federal- or State-Funded Programs

1) Except for Honorary Staff Members, all Practitioners must not be excluded from Medicare, Medi-Cal, and other applicable federal- or state-funded programs.

2) All Practitioners must notify the Medical Executive Committee within 15 days of being notified that any regulatory agency is excluding, intends to exclude, or proposes to exclude them from participation in Medicare, Medi-Cal, or any other federal- or state-funded program.

3) Practitioners confirmed to be excluded by any regulatory agency are not eligible for Clinical Privileges at the Hospital or any of the Hospital's sister institutions. If such exclusion is verified, the Practitioner's application shall be deemed voluntarily withdrawn, and/or the Practitioner's current Medical Staff membership and Clinical Privileges at the Hospital shall be deemed immediately and voluntarily relinquished, with no procedural rights under these Bylaws.
c) **Drug Enforcement Administration Number**

All Practitioners, except Honorary Staff Members and those Practitioners who do not prescribe as part of their practice, must have an unrestricted federal Drug Enforcement Administration number.

d) **Professional Liability Insurance**

Except for Honorary Staff Members, all Practitioners must have and maintain a professional liability insurance policy with liability limits equal to or greater than the minimum liability limits required by the Hospital. Such professional liability insurance policy must not exclude from coverage any of the procedures for which the Practitioner is seeking Clinical Privileges, and the liability limits must not be eroded by defense costs.

e) **Proximity to Hospital**

All Practitioners must maintain their offices or residences close enough to the Hospital to provide continuous care to their patients. The distance to the Hospital may vary depending upon the Medical Staff category, Clinical Privileges that are involved and the feasibility of arranging alternative coverage. The minimum distance or criteria for proximity to the Hospital may be defined in the Rules and Regulations.

f) **Board Certification**

1) As used herein, “Board Certified” refers to certification by a board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the American Board of Podiatric Surgery, the American Board of Orthopedic Podiatric Medicine, the American Board of General Dentistry, the American Board of Oral and Maxillofacial Surgery, or any other specialty board or association with equivalent requirements approved by the Medical Board of California, the Osteopathic Medical Board of California, the Dental Board of California, or the California Board of Podiatric Medicine.

2) Beginning July 1, 2013, all Practitioners applying as initial applicants must be Board Certified in the primary specialty that they will practice at the Hospital. Practitioners who have completed their post-graduate training within the prior six (6) years may fulfill this requirement by demonstrating that they are in the process of obtaining such Certification.

3) Those Members who were in the process of obtaining Board Certification at the time of their initial appointment, as required by Section 3.2-2.f.2., must remain in good standing in that process, and must obtain such Certification within six (6) years of the completion of their post-graduate training, in order to be eligible for reappointment.

4) The Board Certification requirement does not apply to initial applicants who completed their post-graduate training prior to January 1, 1995.

5) The Medical Executive Committee may grant exceptions to the Board Certification requirement, for good cause, at its sole discretion.
Failure to Meet Specific Minimum Requirements

1) If it is determined during the processing of an application for appointment or reappointment to the Medical Staff that a Practitioner does not meet all of the Specific Minimum Qualifications set forth in this Section, then review of the application shall cease, and that application shall be deemed withdrawn.

2) A Practitioner whose application is withdrawn for failure to meet the Specific Minimum Qualifications set forth in this Section shall not be entitled to any procedural rights under these Bylaws.

3) Those Members who were in the process of obtaining Board Certification at the time of their initial appointment, as required by Section 3.2-2.f.2., and who fail to remain in good standing in that process, or to obtain Board Certification within six (6) years of the completion of their postgraduate training, will be deemed to have resigned their Membership and Clinical Privileges. Such automatic resignation shall not give rise to any procedural rights under these Bylaws.

3.3 INELIGIBILITY FOR MEDICAL STAFF MEMBERSHIP

Practitioners seeking Medical Staff membership will not be eligible to apply if, within the past eighteen (18) months, they have been denied appointment or reappointment to the Medical Staff, or their Medical Staff membership has been revoked, whether or not they availed themselves of any procedural rights under these Bylaws.

3.4 NONDISCRIMINATION

Medical Staff membership and/or Clinical Privileges shall not be denied on the basis of gender, race, age, creed, color or national origin.

3.5 MEDICO-ADMINISTRATIVE OFFICERS

3.5-1 Only Medical Staff Members may be engaged as Medico-Administrative Officers.

3.5-2 The Medical Staff membership and Clinical Privileges of any Medico-Administrative Officer also shall be subject to the terms and conditions of the Medico-Administrative Contract with the Hospital. To the greatest extent possible, all such Contracts shall be interpreted so as to be consistent with these Bylaws; however, if the terms of the Contract and these Bylaws conflict, the terms of the Contract shall govern.

3.5-3 Upon expiration or termination of a Medico-Administrative Contract, only those Clinical Privileges made exclusive pursuant to a closed-staff or limited-staff policy shall terminate automatically, without a right of access to any procedural rights contained within these Bylaws, unless the Contract provides otherwise.

3.5-4 Should any Medico-Administrative Officer enter into any subcontracts with any other Practitioners, AHPs, employees, or other subcontractors (collectively, “subcontractors”), such subcontracts shall provide that all Clinical Privileges made exclusive to the holder thereof shall be subject to automatic termination upon the termination of either (1) the underlying Medico-Administrative Contract or (2) the relationship between the Medico-Administrative Officer and the subcontractor giving rise to the subcontract. Notwithstanding the above, the failure of a Medico-Administrative Officer to include such a provision in any subcontract shall not preclude a determination by the Hospital that the
exclusive Clinical Privileges granted to that subcontractor were terminated automatically in either such instance.

3.6 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

Except for Honorary Staff Members, the ongoing responsibilities of each Member of the Medical Staff include:

3.6-1 Providing patients with the quality of care meeting the generally recognized professional level of quality and efficiency prevailing in the community;

3.6-2 Abiding by the Bylaws, Rules and Regulations, Policies, and all local, state and federal laws that regulate medical, dental or podiatric practice.

3.6-3 Discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the Member by virtue of Medical Staff membership, including committee assignments;

3.6-4 Preparing and completing in a timely fashion medical records for all the patients for whom the Member provides care in the Hospital, including compliance with such electronic health record policies and procedures as have been adopted by the Medical Staff.

3.6-5 Abiding by the lawful ethical principles of the profession and the Ethical and Religious Directives for Catholic Health Facilities.

3.6-6 Aiding in any Medical Staff-approved educational programs for Physicians, Dentists, Podiatrists, AHPs, nurses, and other personnel;

3.6-7 Working cooperatively with all Members, nurses, Hospital administrators and others in the best interests of patient care;

3.6-8 Making appropriate arrangements for coverage, as determined by the Medical Staff;

3.6-9 Refusing to engage in improper inducements for patient referral;

3.6-10 Participating in continuing education programs as determined by the Medical Staff;

3.6-11 Participating in such emergency service coverage or consultation panels as may be determined by the Medical Staff;

3.6-12 Discharging such other Medical Staff obligations as may be lawfully established from time to time by the Medical Staff or the Governing Board; and

3.6-13 Assuring the completion and documentation of a medical history and physical examination on all patients immediately before, or within 24 hours after, admission. This requirement may be satisfied if a complete history and physical was performed within the 30 days prior to admission (the results of which are recorded in the Hospital's medical record) as long as an examination for any changes in the patient’s condition is completed and documented in the patient’s medical record within 24 hours after admission. Additionally, the history and physical must be updated within 24 hours prior to any surgical procedure or other procedure requiring general anesthesia or moderate sedation. In cases of emergency procedures that are immediately necessary to save a patient’s life or limb, this provision shall not apply.
3.7 HARASSMENT PROHIBITED

Members shall not engage in any discrimination, harassment, or disruptive behavior against any individual (including, but not limited to, another Member; Hospital staff, employees, or administrators; patients; visitors; or any other individual affiliated with the Hospital) on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex, gender or sexual orientation. Claims of discrimination, harassment or disruptive behavior will be investigated and addressed in accordance with the Bylaws, Rules and Regulations, and Policies of both the Medical Staff and the Hospital.

3.8 CODE OF CONDUCT

All Members are expected and required to abide by the Code of Conduct and ensure the delivery of high quality health care to the Hospital’s patients by communicating well, collaborating effectively, and working as a team. To this end, all Members are expected to conduct themselves in a professional manner whenever they are on the grounds of the Hospital and agree to conduct themselves in accordance with the following guidelines.

3.8-1 RESPECTFUL TREATMENT

Treat all individuals at the Hospital in a respectful and dignified manner at all times and acknowledge that language, attitude and appearance may impact delivery of quality patient care.

3.8-2 TEAMWORK

Work collaboratively as a team and communicate effectively with other Members, AHPs, Hospital staff, Hospital employees, Hospital administrators, and any other individual affiliated with the Hospital to resolve conflicts or address occasional lapses of decorum when they arise.

3.8-3 LANGUAGE

Avoid the use of language, either written or spoken, that is profane, vulgar, sexually suggestive or explicit, intimidating, degrading, or that contains racial, ethnic, or religious slurs.

3.8-4 BEHAVIOR

Refrain from any behavior that is deemed to be intimidating or harassing, including but not limited to, unwanted touching, sexually-oriented or degrading jokes or comments, obscene gestures, or throwing objects, and agree to not be impaired by the use of alcohol, prescription medications or illegal substances when engaged in patient care responsibilities within the Hospital or when serving in any on-call capacity.

3.8-5 CONFIDENTIALITY AND FEEDBACK

Maintain complete confidentiality of all patient care information and Practitioner and/or AHP performance evaluations, and report any concerns of a Practitioner or AHP’s competence and/or performance to those individual(s) or committee(s) authorized to receive such information and address such issues.
3.8-6 ETHICAL RESPONSIBILITIES

Be truthful and forthright in the provision of any and all information the Member brings forward, to the best of his or her ability.

3.9 LEAVE OF ABSENCE

3.9-1 LEAVE STATUS

A Member may request a leave of absence from the Medical Staff subject to approval by the Medical Executive Committee. Any Medical Staff Member wishing to take a leave of absence must have completed all applicable medical records and submit a written request to the Medical Executive Committee stating the reason for the leave of absence and the approximate duration of the intended leave, which may not exceed the expiration of the Member’s current term of appointment. During a Member’s leave of absence, all Clinical Privileges, Prerogatives and responsibilities shall be suspended; however, the Member shall continue to be responsible for payment of annual dues.

3.9-2 TERMINATION OF LEAVE

Any Member wishing to terminate a leave of absence from the Medical Staff and resume the exercise of any/all Clinical Privileges and Prerogatives must submit a written request to the Medical Executive Committee no later than sixty (60) days prior to the scheduled expiration date of the leave. The Medical Executive Committee may request additional information from the Member, such as a written summary of the relevant activities in which the Member was engaged during the leave and/or a physical examination, and may set a deadline for the submission of such information. The Medical Executive Committee shall make a decision based on the requirements and responsibilities for Medical Staff membership set forth in these Bylaws and the Rules and Regulations.

If a Member who is on leave fails to request reinstatement or to provide the Medical Executive Committee with any of the information that it requests within the time and in the manner set forth above, the Member shall be deemed to have voluntarily resigned his or her Medical Staff membership and Clinical Privileges. Such determination does not entitle the Member to any procedural rights under these Bylaws.

3.9-3 HEALTH ISSUES

It is the responsibility of all Members to notify the Chief of Staff and respective Department Chair(s) of any major or prolonged mental or physical health condition that might affect the cognitive or motor skills required in the performance of any Clinical Privileges granted to the Member. Illnesses that may require such notification include, without limitation: cerebral vascular accident, cardiovascular surgery with bypass, cardiac arrest with resuscitation, syncope, and seizure. Upon return from a leave of absence taken due to a mental or physical health condition, Members shall provide an attestation that they are capable of performing the Clinical Privileges granted. Upon receipt of such attestation, the respective Department Chair and/or the Chief of Staff will evaluate the Member to determine if monitoring or further evaluation is required to verify ability to perform the Clinical Privileges granted.
ARTICLE IV
CATEGORIES OF MEMBERSHIP

4.1 CATEGORIES

The categories of Membership on the Medical Staff are: Provisional, Active, Courtesy and Honorary. A change in Medical Staff category shall not be grounds for any procedural rights under these Bylaws, unless the change is based upon a Medical Disciplinary Cause or Reason.

The Prerogatives attendant to each membership category are general in nature and may be subject to limitation by the Bylaws, Rules and Regulations, and/or Policies.

4.2 PROVISIONAL STAFF

4.2-1 QUALIFICATIONS AND ADVANCEMENT

a) The Provisional Staff shall consist of Members who meet all Minimum Qualifications for Membership, and: (1) have not yet satisfied the proctoring requirements specified in Article VII; and/or (2) have not fulfilled any other applicable requirements for advancement set forth in the Bylaws, Rules and Regulations and/or Policies.

b) Practitioners shall be appointed to the Provisional Staff for a minimum of twelve (12) months, and a maximum of twenty-four (24) months. After twelve (12) months of membership on the Provisional Staff, Members may be considered for advancement to the Courtesy or Active Staff. In order to advance to the Courtesy or Active Staff, Members must meet all the requirements for Courtesy or Active Staff membership, including the proctoring requirements set forth in Article VII. Advancement from the Provisional Staff requires a recommendation by the Medical Executive Committee and approval of the Governing Body.

c) If any Member of the Provisional Staff does not qualify for advancement to either the Courtesy or Active Staff within twenty-four (24) months of initial appointment, the Medical Executive Committee shall recommend that the Member’s Medical Staff membership and Clinical Privileges not be renewed.

4.2-2 PREROGATIVES

Members of the Provisional Staff shall be entitled to:

a) Admit, consult, or refer patients at the Hospital;

b) Exercise such Clinical Privileges as are granted pursuant to Article VII.

c) Serve on Medical Staff and/or Hospital committees; and

d) Attend, in a nonvoting capacity, any meetings of the Medical Staff and/or any Department(s) or committee(s) to which they are invited or assigned. Provisional Staff Members may not hold elective or appointed office or chair a committee.
4.3 **ACTIVE STAFF**

4.3-1 **QUALIFICATIONS**

The Active Staff shall consist of Members who:

a) Meet all Minimum Qualifications for Membership;

b) Were in good standing while on the Provisional Staff, during which time the proctoring requirements specified in Article VII were satisfied; and

c) Admitted or otherwise provided professional services in the Hospital for at least ten (10) patients during the most recent 12 month period or twenty (20) patients during the most recent twenty-four (24) month period between Medical Staff appointments.

4.3-2 **EXCEPTIONS TO THE QUALIFICATIONS**

a) Under special circumstances, and subject to Governing Body approval, a Member may petition the Medical Executive Committee to advance or continue on the Active Staff even if the above qualifications have not been met.

b) Any Member who is or will be on a corrective action contract (including but not limited to Medical Records Contract or Behavioral Contract) shall not qualify for advancement to Active Staff membership.

4.3-3 **FAILURE TO MEET THE QUALIFICATIONS**

In the event a Member of the Active Staff fails to meet any of the requirements set forth above, the Member shall be either reassigned to the Courtesy Staff or have his or her Medical Staff membership and Clinical Privileges terminated, as recommended by the Medical Executive Committee and approved by the Governing Body.

4.3-4 **PREROGATIVES**

Members of the Active Staff shall be entitled to:

a) Admit, consult, or refer patients at the Hospital;

b) Exercise such Clinical Privileges as are granted pursuant to Article VII;

c) Serve on Medical Staff, Departmental and/or Hospital committees;

d) Attend and vote on all matters presented at Medical Staff meetings and meetings of any Department(s) to which they are assigned;

e) Hold elective or appointed office; and

f) Chair any committee to which they have been duly elected or appointed, and vote on all matters presented at meetings of such committees.
4.4 COURTESY STAFF

4.4-1 QUALIFICATIONS

The Courtesy Staff shall consist of Members who:

a) Meet all Minimum Qualifications for Membership;

b) Were in good standing while on the Provisional Staff, during which time the proctoring requirements specified in Article VII were satisfied; and

c) Did not admit or otherwise provide professional services in the Hospital for at least ten (10) patients during the most recent 12 month period or twenty (20) patients during the most recent twenty-four (24) month period between Medical Staff appointments; or failed to meet the attendance requirements specified within Article XIII. No such Provisional Staff Members shall be eligible for elevation to the Active Staff until, at the time of the reappointment, such requirements shall have been met.

4.4-2 PREROGATIVES

Members of the Courtesy Staff shall be entitled to:

a) Admit, consult, or refer patients at the Hospital;

b) Exercise such Clinical Privileges as are granted pursuant to Article VII;

c) Serve on Medical Staff Departmental, and/or Hospital committees (unless otherwise provided within these Bylaws); and

d) Attend, in a nonvoting capacity, any meetings of the Medical Staff, and attend and vote on all matters presented at meetings of any Department(s) or committee(s) to which they are invited or assigned. Courtesy Staff Members may not hold elective or appointed office or chair a committee.

4.5 HONORARY STAFF

4.5-1 QUALIFICATIONS

The Honorary Staff shall consist of Members who:

a) Meet the General Minimum Qualifications for Membership; and

b) Are recognized for their outstanding reputations, their noteworthy contributions to the health and medical sciences or their previous, long-standing service to the Hospital.

4.5-2 PREROGATIVES

Honorary Staff Members shall not be entitled to admit patients to, or to exercise Clinical Privileges in, this Hospital. However, they may attend Medical Staff meetings, their respective Department meetings, and any education meetings that may be held. Honorary Staff Members may not vote on any Medical Staff matter and may not hold office on the Medical Staff or in the Department or the committees of which they are
members; however, Honorary Staff Member may serve, with a vote, on any Committees to which they are appointed.

4.6 MODIFICATION OF MEDICAL STAFF MEMBERSHIP CATEGORY

On its own, upon recommendation of the Credentials Committee, pursuant to a request by a Member, or upon direction by the Governing Body, the Medical Executive Committee may recommend a change in a Member’s Medical Staff category consistent with these Bylaws, the Rules and Regulations, and the Policies.

ARTICLE V

ALLIED HEALTH PROFESSIONALS

5.1 QUALIFICATIONS

AHPs, are not eligible for Medical Staff membership. AHPs may be eligible for Practice Privileges at the Hospital only if they:

5.1-1 Hold a license, certificate or other legal credential in an AHP category that the Medical Executive Committee has identified as being eligible to apply for Practice Privileges;

5.1-2 Document their experience, background, training, demonstrated ability, judgment and physical and mental health status;

5.1-3 Demonstrate that any patient treated by them will receive care recognized to be at or above the professional level of quality and competency prevailing in the community;

5.1-4 Demonstrate that patients treated by them shall receive the standard of care established by the Medical Staff;

5.1-5 Document adherence to the ethical principles of their profession and agreement to follow the ethical principles established by the Medical Staff;

5.1-6 Provide evidence of professional liability insurance that is appropriate for the Practice Privileges requested. The details of such insurance requirements shall be set forth in the Rules and Regulations; and

5.1-7 Are not excluded from Medicare, Medi-Cal, or any other federal- or state-funded program.

5.2 DESIGNATION OF CATEGORIES OF AHPs ELIGIBLE TO APPLY FOR PRACTICE PRIVILEGES

Based upon the Medical Executive Committee’s recommendations, the Governing Body shall determine the categories of AHPs that are eligible for Practice Privileges within the Hospital, the Practice Privileges, the mode of practice at the Hospital, and the prerogatives, terms, and conditions associated with each AHP category. Such information shall be included in the Rules and Regulations and reviewed annually by the Medical Executive Committee.

5.3 PROCEDURE FOR GRANTING PRACTICE PRIVILEGES

5.3-1 Each AHP who wishes to practice as a part of an already-designated AHP category within the Hospital must apply and qualify for Practice Privileges, and each Member who wishes to supervise or direct an AHP must possess related Clinical Privileges that will enable the Member to discharge such a supervisory responsibility.
5.3-2 Each application for initial or renewed Practice Privileges shall be in writing, submitted on a form developed by the Credentials Committee and approved by the Medical Executive Committee, signed by the AHP applicant, and, unless otherwise provided in the Rules and Regulations, submitted and processed in a manner parallel to that described for Practitioners in Articles VI and VII. Each initial AHP application for Practice Privileges shall be accompanied by a non-refundable processing fee in an amount set by the Medical Executive Committee.

5.3-3 Once an AHP’s initial application for Practice Privileges has been approved, the AHP shall be assigned to the appropriate clinical Department. Unless otherwise provided within the Rules and Regulations, each AHP shall be subject to the same terms and conditions that apply to Practitioners, within Article III, as such terms and conditions logically may be applied and appropriately tailored to fit the individual AHP’s occupational or professional training.

5.3-4 An AHP who fails to hold a license or certificate within an already-designated AHP category (if any) shall not be entitled to obtain Practice Privileges. However, that AHP may submit a written request to the Chief Executive asking the Governing Body to give consideration to the designation of an additional AHP category that would be appropriate to his or her occupational or professional training. The Governing Body shall refer the request to the Medical Executive Committee for its review and recommendation. The Governing Body shall give great weight to the Medical Executive Committee’s decision before rendering a final decision on the request.

5.4 NONDISCRIMINATION

Practice Privileges shall not be denied on the basis of sex, race, age, creed, color or national origin.

5.5 PREROGATIVES

The prerogatives which may be extended to an AHP shall be defined within the Rules and Regulations. Such prerogatives may include:

5.5-1 Provision of specified patient care services under the supervision or direction of a Member who is a Physician. Such patient care services shall be consistent with the Practice Privileges granted to the AHP and shall be within the scope of the AHP’s licensure or certification;

5.5-2 Service on Medical Staff, Departmental and Hospital Committees; and/or

5.5-3 Attendance, in a nonvoting capacity, at the meetings of the Department to which the AHP is assigned and attendance at Hospital education programs within the AHP’s field of practice.

5.6 RESPONSIBILITIES

Each AHP shall:

5.6-1 Meet those responsibilities specified within the Rules and Regulations or, if no such responsibilities shall have been so specified, then meet those of the Minimum Qualifications set forth in Section 3.6 as generally may be logically applied to the more limited practice of AHPs;
5.6-2 Retain appropriate responsibility within the AHP’s area of professional competence for
the care and supervision of each patient in the Hospital for whom the AHP is providing
services; and

5.6-3 Participate, as appropriate, in patient care assessment and other quality review,
evaluation and monitoring activities required of AHPs in supervising initial AHP
appointees (whether such appointees shall be within his same occupation or profession
or within a lesser-included occupation or profession) and in discharging such other
functions as may be required, from time to time by the Medical Staff.

5.7 CODE OF CONDUCT

All AHPs are expected and required to abide by the Code of Conduct to which Practitioners are
subject, set forth in Article III. All obligations imposed upon Members by the Code of Conduct
shall also apply to AHPs.

5.8 AUTOMATIC TERMINATION OF PRACTICE PRIVILEGES

An AHP’s Practice Privileges shall automatically terminate, and not be subject to any procedural
rights set forth below in the following circumstances:

5.8-1 The Member who is supervising the AHP is terminated from the Medical Staff, either
voluntarily or involuntarily, unless another Member in Good Standing agrees, in writing, to
supervise the AHP;

5.8-2 The Member who is supervising the AHP no longer agrees to act as the supervising
Member for any reason, or the relationship between the supervising Member and the
AHP is otherwise terminated, regardless of the reason, unless another Member in Good
Standing agrees, in writing, to supervise the AHP; or

5.8-3 The AHP’s certification or licensure expires, is revoked, or is suspended.

5.9 PROCEDURAL RIGHTS OF ALLIED HEALTH PROFESSIONALS

AHPs and AHP applicants have the right to challenge a recommendation of the Credentials
Committee to deny, revoke, restrict, or not renew any or all of the AHP’s Practice Privileges.
Such a decision shall only entitle the AHP to the following procedural rights:

5.9-1 Notice of the Credentials Committee Action

The AHP shall be given written notice of the Credentials Committee’s recommended
action. The AHP shall have ten (10) days to request a review by the Medical Executive
Committee of the Credentials Committee’s recommended action.

5.9-2 Notice of Review by the Medical Executive Committee

If the AHP requests a review by the Medical Executive Committee, then the AHP shall be
given written notice of the general reasons for the action, and the date, time, and place of
the Medical Executive Committee’s review (“MEC Review”). Such written notice shall be
no later than fourteen (14) calendar days before the MEC Review.

5.9-3 MEC Review

a) Both the AHP and the Credentials Committee shall have the right to submit
written information and argument in support of their respective positions to the
Medical Executive Committee, at least five (5) calendar days prior to the MEC Review.

b) The AHP shall have a right to appear at the MEC Review, hear such evidence presented by the Credentials Committee in support of its recommended action, and to present evidence in support of the AHP’s challenge to that recommendation. Neither the AHP nor the Credentials Committee may be represented by legal counsel during the MEC Review.

c) The MEC shall provide written notice of its decision to both the AHP and Credentials Committee, including appeal rights.

5.9-4 Appeal Rights

a) Both parties have ten (10) days from receipt of the Medical Executive Committee’s decision to appeal to the Governing Body. The request for appeal shall state, with specificity, the basis for the appeal.

b) The appeal shall be conducted within thirty (30) days. The parties to the appeal shall be the Credentials Committee and the AHP.

c) Both parties shall have the right to present a written statement in support of their position on appeal. Neither party may be represented by legal counsel during the appeal.

d) At a convenient time, the Governing Body may deliberate outside the presence of both parties. The Governing Body shall issue a written decision to the AHP, Credentials Committee, and the Medical Executive Committee. The Governing Body's decision shall be final.

ARTICLE VI

PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

6.1 GENERAL PROCEDURE

6.1-1 The Medical Staff (through its designated Departments, Committees and Officers) shall consider and make recommendations to the Governing Body for each application for Medical Staff appointment or reappointment and Clinical Privileges and/or each request for modification of Medical Staff category or Clinical Privileges. The Medical Staff Office shall investigate and validate the content of each application before such application may be transmitted to the Medical Staff for consideration. The Medical Staff shall also perform this function for Practitioners who seek Telemedicine or Temporary Privileges under Article VII and for AHPs seeking Practice Privileges under Article V.

6.1-2 The Medical Staff shall investigate each applicant for appointment or reappointment and make an objective, evidence-based decision based upon assessment of all available information on the applicant, and shall submit its recommendation to the Governing Body. The Governing Body shall be ultimately responsible for granting membership and Clinical Privileges, provided, however, that these functions may be delegated by the Governing Body to the Chief of Staff and Chief Executive with respect to requests for Temporary Privileges or Disaster Privileges in Article VII. By applying to the Medical Staff for appointment or reappointment, the applicant agrees to comply with the responsibilities of Medical Staff membership, and with the Bylaws, Rules and Regulations, Policies, and
Hospital policies, regardless of whether the application is granted or denied, in whole or part.

6.2 **DURATION OF APPOINTMENT**

Initial appointments and reappointments to the Medical Staff shall be for a maximum period of twenty-four (24) months.

6.3 **APPLICATION FOR APPOINTMENT**

6.3-1 **CONTENT**

Each application for appointment to the Medical Staff shall be in writing, signed by the applicant, accompanied by a non-refundable processing fee in an amount set by the Medical Executive Committee, and submitted on a form developed by the Credentials Committee and approved by the Medical Executive Committee. At a minimum, the application form shall require the applicant to provide the following:

a) Detailed information concerning:

1) Evidence of citizenship or other legal authorization to be employed in the U.S.;

2) California licensure;

3) Any and all out of state licensure or certification;

4) Radiology/Radiography/Fluoroscopy or other certification, if applicable;

5) Drug Enforcement Administration (DEA) or other controlled substances registration application, or license; and

6) Any specialty board certification or application for board certification.

b) The names of at least three (3) professionally licensed Practitioners who hold the same type of professional license as the applicant, have current personal knowledge of the applicant's training, experience, professional qualifications, professional competency, and ethical character, and who have known the applicant for at least one (1) year. Whenever possible, the applicant should include the names of at least two (2) members of the Hospital's Active Staff.

c) Information concerning any pending or completed action, including any investigations, at any health care entity concerning the denial, revocation, suspension, reduction, limitation, probation, nonrenewal and voluntary or involuntary relinquishment by resignation, expiration, withdrawal or abandonment (including relinquishment that was requested or bargained for) of the applicant's: (1) membership on, or application to, a medical staff or provider panel, (2) Clinical Privileges, or application for the same, and/or (3) medical staff status or prerogatives, or request for the same.

d) Information concerning the applicant's: (1) status as a student/participant in good standing at any medical school, internship, residency, fellowship, preceptorship or other clinical education program; (2) membership or fellowship, or application for the same, in any local, county, state, regional, national or
international professional organization; and/or (3) professional school faculty position or membership, or application for the same.

e) Information concerning the applicant’s professional liability insurance coverage, which information shall include evidence of insurance, and information concerning any professional liability claims or notices of intention to sue that has been lodged against him or her (which information shall include details concerning the status or outcome of each such matter) or settlements made or any judgments entered against the applicant.

f) Information concerning any pending or completed action, including any investigation, by any government agency or law enforcement body for an alleged failure to comply with laws, statutes, regulations or other legal requirements which may be applicable to the practice of the applicant’s profession or to the rendition of services to the applicant’s patients.

g) Information concerning whether the applicant ever has been charged with violating any criminal law, including felonies and misdemeanors, but excluding minor traffic violations.

h) Information concerning any pending or completed action, including any investigation, by any government agency or third party payor regarding the applicant’s patient admission, treatment, discharge, charging, collection or utilization practices, including, but not limited to, Medicare and Medi-Cal fraud and abuse investigations, proceedings and convictions.

i) Information concerning the applicant’s physical and mental health condition.

j) Identification of the Staff category, clinical Department and Clinical Privileges for which the applicant wishes to be considered, and documentation of training and experience in support of the Clinical Privileges requested.

k) A summary of clinical activity over the past twenty-four months.

l) Information concerning the applicant’s Continuing Medical Education activities for the prior two (2) years.

m) A current Curriculum Vitae.

n) An acknowledgment that the applicant has received (or been given access to), read, and agrees to be bound by, the terms of the Bylaws, Rules and Regulations, Policies, and any Hospital policies, as they may be amended from time to time, regardless of whether the applicant is ultimately granted Medical Staff membership and the Clinical Privileges requested.

o) Any other information or documents required under the Bylaws, Rules and Regulations, and/or Policies.

6.3-2 EFFECT OF APPLICATION

By applying for appointment to the Medical Staff, all applicants thereby:

a) Signify their willingness to appear for interviews in connection with the consideration of their applications.
b) Authorize the Hospital, the Medical Staff and their representatives to consult with others (including medical staff members at other hospitals) who have been associated with the applicant or who otherwise may have information bearing upon the applicant’s: professional qualifications, physical, mental and professional competence to exercise the Clinical Privileges requested, performance in the practice setting, emotional stability, character and personality, ability to cooperate with others, moral and ethical qualifications for Membership, and other qualifications for appointment and Clinical Privileges; and authorizes and directs such persons and organizations to provide all such information (including otherwise privileged or confidential information) to the Hospital, the Medical Staff and their representatives.

c) Consent to the inspection and copying by the Hospital, Medical Staff and their representatives of all records and documents (including medical records at other hospitals) that may be material to an evaluation of the applicant’s professional qualifications, physical, mental and professional competence and performance, emotional stability, character and personality, ability to cooperate with others, moral and ethical qualifications, and any other qualifications for appointment and the Clinical Privileges requested.

d) Release from any liability, to the fullest extent permitted by law, the Hospital, Medical Staff and their representatives for the acts performed in connection with the processing and verification of their applications for appointment and Clinical Privileges.

e) Release from any liability, to the fullest extent permitted by law, all persons and organizations who provide information (including otherwise privileged or confidential information) to the Hospital, its Medical Staff and their representatives concerning their applications for appointment and Clinical Privileges.

f) Certify that they promptly will provide updated information to the Credentials Committee if any changes occur with the information provided on their applications, during the application process, and throughout their membership on the Medical Staff.

6.4 PROCESSING THE APPLICATION

6.4-1 TIME GUIDELINES FOR PROCESSING

Each application shall be considered in a timely and good faith manner by all those required by these Bylaws to take action thereon.

6.4-2 BASIS FOR APPOINTMENT

Each recommendation concerning an applicant’s candidacy for Medical Staff membership and Clinical Privileges shall be based upon whether such applicant meets the Minimum Qualifications for Membership and all other standards, requirements and criteria specified elsewhere within the Bylaws, Rules and Regulations, and Policies.

6.4-3 APPLICANTS’ BURDEN

All applicants shall have the burden of producing accurate and adequate information to ensure a proper evaluation of their experience, background, training, demonstrated
ability, physical and mental health status, and all other qualifications specified in the Bylaws, Rules and Regulations, and Policies.

Any falsification, misrepresentation, omission, and/or failure to sustain the burden of producing information shall be grounds for immediate termination of the application process, and the application will be deemed incomplete. The applicant will be notified by certified mail of the termination of the application process and shall not be entitled to any procedural rights under the Bylaws.

6.4-4 COLLECTION AND VERIFICATION OF INFORMATION

All applicants shall deliver a completed application to the Medical Staff Office. The Medical Staff Office shall collect and verify the information on the application and provided by the applicant. Once the collection and verification process has been completed, the Medical Staff Office shall transmit the application and all supporting materials to the appropriate Department for consideration and action. If, during the course of the collection and verification process, the Medical Staff Office should become unable to obtain and verify the necessary information, the applicant shall be so notified, in writing, in accordance with the Rules and Regulations and/or Policies, after which it shall be the applicant’s responsibility to ensure that any such missing information is submitted immediately. Any application that, according to the Credentials Committee, has remained incomplete for thirty (30) days following an applicant’s receipt of such a notification shall be deemed voluntarily withdrawn. The applicant shall be promptly notified, in writing, of the withdrawal and informed that he or she must reapply in order to be considered for Medical Staff membership and Clinical Privileges.

6.4-5 DEPARTMENT ACTION

The Chair, Vice-Chair, or approved designee, of the Department to which the applicant has requested assignment shall review the application, supporting documentation, and any other relevant information available concerning the applicant’s candidacy for Medical Staff membership and Clinical Privileges. As a part of such review, the applicant may be required to appear for an interview and/or to supply additional information and documentation. Also, during the course of such review, each of the other Departments (if any) in which the applicant has requested Clinical Privileges shall be consulted for their respective recommendations.

Following its review, the Department shall transmit (together with the application and all supporting materials) a report and recommendation (which, in all cases, shall include specific recommendations concerning the scope of any Clinical Privileges to be granted) to the Credentials Committee for consideration and action.

6.4-6 CREDENTIALS COMMITTEE ACTION

The Credentials Committee shall review the application, supporting documentation, Department’s report and recommendation and any other relevant information available concerning the applicant’s candidacy for Medical Staff membership and Clinical Privileges. As a part of such review, the applicant may be required to appear for an interview and/or to supply additional information and documentation.

Following its review, the Credentials Committee shall transmit a report and recommendation (together with the application and all supporting materials) directly to the Medical Executive Committee for consideration and action.
6.4-7 MEDICAL EXECUTIVE COMMITTEE ACTION

The Medical Executive Committee shall review the application, supporting documentation, Credentials Committee’s report and recommendation, Department’s report and recommendation (if any) and any other relevant information available concerning the applicant’s candidacy for Medical Staff membership and Clinical Privileges. Following such review, the Medical Executive Committee shall proceed as follows:

a) **Deferral:** The Medical Executive Committee may defer making a recommendation regarding an application whenever additional time is needed to interview the applicant, to gather further information and/or otherwise to allow for further consideration of the matter, whether by the Medical Executive Committee, Credentials Committee, Department, or any designated ad hoc Committee. Following such a deferral, the Medical Executive Committee must take action upon the application and must transmit a recommendation to the Governing Body.

b) **Recommendation:** If the Medical Executive Committee does not defer making a recommendation, it shall transmit its recommendation to the Governing Body.

c) **Adverse Recommendation:** If the Medical Executive Committee’s recommendation is adverse, in whole or part, and gives rise to procedural rights under the Bylaws, the Chief of Staff also shall give the applicant written notice of the Medical Executive Committee’s recommendation in accordance with Article IX.

6.4-8 ACTION BY THE GOVERNING BODY

a) **Favorable Recommendation by the Medical Executive Committee:** When the Medical Executive Committee’s recommendation, or any portion thereof, does not give rise to procedural rights under the Bylaws, the Governing Body may take the following action with regard to the recommendation, or the favorable portion thereof:

1) Adopt the Medical Executive Committee’s recommendation;

2) Refer the matter back to the Medical Executive Committee for further review and recommendation, and set a time limit within which a subsequent recommendation shall be made by the Medical Executive Committee to the Governing Body.

3) Modify or reject a Medical Executive Committee’s recommendation, in which case the Governing Body should refer the matter to the Joint Conference Committee and proceed as described in Article XII.

b) **Adverse Recommendation by the Medical Executive Committee:** When the Medical Executive Committee’s recommendation, or any portion thereof, gives rise to procedural rights under the Bylaws, the Governing Body shall take no action with regard to the recommendation, or the adverse portion thereof, until the applicant has either exhausted or waived any such procedural rights.
6.4-9 NOTICE OF FINAL ACTION

a) The Chief Executive shall give written notice of the Governing Body's final action concerning an applicant's candidacy for Medical Staff membership and Clinical Privileges to the applicant, the Medical Executive Committee and the Chairman of each Department concerned. If the Governing Body's final action gives rise to any procedural rights under the Bylaws, such notice shall be given in accordance with Article IX, and the action shall not become effective until such rights have been exhausted or waived.

b) Any decision and notice of appointment shall identify the Medical Staff category to which the applicant has been appointed, the Department to which the applicant has been assigned, the Clinical Privileges that the applicant has been granted, and any special condition(s) that have been attached to the applicant's appointment. If any special condition(s) give rise to any procedural rights under the Bylaws, such notice shall be given in accordance with Article IX.

6.5 REAPPOINTMENT

6.5-1 APPLICATION FOR REAPPOINTMENT

Each Medical Staff Member shall submit a completed reappointment application to the Medical Staff Office at least ninety (90) days prior to the expiration date of the Member's current appointment period. Each application for reappointment shall be in writing, signed by the Member, and submitted on a form developed by the Credentials Committee and approved by the Medical Executive Committee.

The reappointment application form shall require the same information as an application for appointment, except that the reappointment application form shall concentrate on information concerning possible changes in a Member's qualifications since the last reappointment, rather than information which cannot change over time (e.g., premedical and medical education). Additionally, the reappointment application shall require each Member to identify whether or not any change in Medical Staff category, membership status, and/or Clinical Privileges is being requested. If a Member requests additional Clinical Privileges, the request shall be treated as an initial application for the newly requested Clinical Privileges.

6.5-2 APPLICANTS' BURDEN DURING REAPPOINTMENT

All Members applying for reappointment shall have the burden of producing accurate and adequate information to ensure a proper evaluation of their fitness for reappointment to the Medical Staff and for the Clinical Privileges being requested.

Any falsification, misrepresentation, omission, and/or failure to sustain the burden of producing information shall be grounds for denial of the reappointment application, unless the failure to have sustained the burden described above affects only certain Clinical Privileges requested, in which case such failure shall constitute grounds for the denial of those specific Clinical Privileges.

6.5-3 REAPPOINTMENT PROCESS

The Reappointment Process shall be conducted in the same manner as set forth in Section 6.4 for initial applications to the Medical Staff.
6.5-4 BASIS FOR REAPPOINTMENT

Each recommendation concerning a Member’s reappointment to the Medical Staff and the Clinical Privileges to be granted in conjunction therewith shall be based upon whether such Member meets the Minimum Qualifications for Membership and all other standards, requirements and criteria specified elsewhere within the Bylaws, Rules and Regulations, and Policies, including Ongoing Professional Performance Evaluations, Focused Professional Performance Evaluations, and any and all performance improvement activities.

6.5-5 FAILURE TO SUBMIT A REAPPOINTMENT APPLICATION

All Members who have not submitted a reappointment application within ninety (90) days prior to the expiration date of their current appointment period shall be issued a written notice of delinquency, which shall specify that they have thirty (30) days from the date of the notice to return a reappointment application to the Medical Staff Office, or their Medical Staff membership and Clinical Privileges will expire at the end of their current Medical Staff appointment period. A Member’s failure to timely file a reappointment application shall not give rise to any procedural rights under the Bylaws.

ARTICLE VII

CLINICAL PRIVILEGES

7.1 EXERCISE OF CLINICAL PRIVILEGES

Except as otherwise provided in the Bylaws and Rules and Regulations, any Member providing direct clinical services within this Hospital shall be entitled to exercise only those Clinical Privileges specifically granted by the Governing Body.

7.2 DELINEATION OF CLINICAL PRIVILEGES -- GENERAL PROVISIONS

7.2-1 REQUESTS

Each application for appointment or reappointment to the Medical Staff must include a Privilege Control Card that identifies the specific Clinical Privileges being requested. Each request for initial privileges received from an applicant, and each request for additional privileges received from a Member, must be supported by documentation of the requisite training, experience, qualifications and competency necessary for the exercise of such Clinical Privileges.

Except as otherwise provided elsewhere within these Bylaws, Members may request, at any time, that their Clinical Privileges be modified. The processing of such a request, at a time other than in connection with a reappointment review, shall have no effect on the timing of any regularly-scheduled reappointment review.

7.2-2 BASIS FOR DETERMINATION OF CLINICAL PRIVILEGES

Clinical Privilege determinations for both initial applicants and Members shall take into account all pertinent information concerning clinical performance obtained from any source, particularly other institutions and health care settings in which the Practitioner exercise(s)/(d) Clinical Privileges.

a) Initial Request for Clinical Privileges: Requests for initial Clinical Privileges by an applicant shall be evaluated on the basis of the applicant's education, training,
experience and demonstrated ability and judgment, and shall include assessment of patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and system-based practice.

b) Request for Additional Clinical Privileges: Requests for additional Clinical Privileges by a Member (whether or not in connection with a reappointment review) shall be evaluated on the basis of the Member’s:

1) education, training and observed clinical performance and judgment;

2) performance of a sufficient number of procedures each year in order to have developed and maintained the requisite knowledge and skills necessary for the exercise of such Clinical Privileges; and

3) documented results of any relevant patient care assessment or other quality review, evaluation and monitoring activities that may have been performed within the Hospital, including but not limited to Ongoing Professional Performance Evaluations, Focused Professional Performance Evaluations, and any peer review or quality assessment.

7.2-3 PROCEDURE FOR PROCESSING

Except as otherwise provided in the Bylaws, all requests for Clinical Privileges shall be processed in accordance with the procedures outlined within Article VI.

7.3 TELEMEDICINE CLINICAL PRIVILEGES

7.3-1 MEMBERSHIP NOT REQUIRED

Notwithstanding any other provision of the Bylaws, Rules and Regulations, and/or Policies, a Practitioner may be granted Telemedicine Clinical Privileges without also becoming a Member of the Medical Staff (“Telemedicine-Only Practitioners”). All Telemedicine-Only Practitioners:

a) Shall agree to abide by the Bylaws, Rules and Regulations, and/or Policies to the extent they pertain to the exercise of any Telemedicine Clinical Privileges, regardless of their non-Member status; and

b) Shall be entitled only to consult on patients at the Hospital, and to exercise only the Telemedicine Clinical privileges granted them.

7.3-2 INITIAL TELEMEDICINE CLINICAL PRIVILEGES

Each application for initial Telemedicine Clinical Privileges may be processed in one of the following manners:

a) The applicant may obtain Medical Staff membership and Clinical Privileges at the Hospital in full compliance with the Bylaws, Rules and Regulations, and Policies;

b) The Credentials Committee, Medical Executive Committee and Governing Body may rely solely upon information provided by any other hospital(s) at which the applicant is a member of the medical staff and has clinical privileges, or any telemedicine entity providing telemedicine services with which the applicant is affiliated, in accordance with a written agreement with such hospital or
telemedicine entity, in order to make a credentialing decision based upon this Hospital's standards; or

c) The Credentials Committee, Medical Executive Committee and Governing Body may rely fully on the membership and clinical privileging decisions made by any other hospital(s) in which the Practitioner is a member of the medical staff and has clinical privileges, as long as such hospital(s) is/are accredited by The Joint Commission, or any telemedicine entity providing telemedicine services with which the applicant is affiliated, in accordance with a written agreement with such hospital or telemedicine entity.

7.3-3 RECRECREDENTIALING OF TELEMEDICINE CLINICAL PRIVILEGES

Each application for renewed Telemedicine Clinical Privileges shall be based upon the Practitioner's performance at the Hospital, and upon information from any hospital(s) where the Practitioner is a member of the medical staff and has clinical privileges, as well as from any telemedicine entity with which the Practitioner is affiliated.

7.3-4 TERMINATION OF TELEMEDICINE CLINICAL PRIVILEGES

a) Privileges granted to Telemedicine-Only Practitioners may be revoked or limited at any time, for any reason, by the Governing Body on the recommendation of the Medical Executive Committee.

b) Telemedicine Clinical Privileges granted in full reliance on the membership and clinical privileging decisions of another hospital shall terminate automatically in the event that: (1) the Practitioner's medical staff membership and/or clinical privileges at such hospital are revoked, suspended, limited or voluntarily relinquished; (2) the Practitioner's license to practice medicine in this State is revoked, expired, suspended, or restricted; or (3) such hospital no longer has a valid written agreement with this Hospital.

c) Telemedicine Clinical Privileges granted in full reliance on the credentialing and clinical privileging decisions of a telemedicine entity providing telemedicine services in accordance with a written agreement with the Hospital shall terminate automatically in the event that: (1) the Practitioner's affiliation with and/or clinical privileges at the telemedicine entity are revoked, suspended, limited or voluntarily relinquished; (2) the Practitioner's license to practice medicine in this State is revoked, expired, suspended, or restricted; or (3) the telemedicine entity no longer has a valid written agreement with the Hospital.

7.3-5 NO PROCEDURAL RIGHTS

Practitioners who are not granted Telemedicine Clinical Privileges at the Hospital, or whose Telemedicine Clinical Privileges are revoked, suspended or limited in any manner, shall not be entitled to any procedural rights under the Bylaws.

7.4 TEMPORARY CLINICAL PRIVILEGES

7.4-1 CIRCUMSTANCES

a) Pendency of Application: Applicants and Members with pending applications for Medical Staff Membership and/or initial or additional Clinical Privileges may request Temporary Clinical Privileges once sufficient information is available which supports a favorable determination regarding the applicant’s or Member’s
qualifications, ability and judgment to exercise the Clinical Privileges requested. Temporary Privileges may be granted upon approval of the Chair of the Credentials Committee, the Chief of Staff, the applicable Department Chair, and the Chief Executive or a designee thereof. Such temporary Clinical Privileges may be granted on an “as-needed” basis, for one case at a time, or for an initial period of up to ninety (90) days. The initial period may be extended by the Credentials Committee for thirty (30) additional days, for a total period not to exceed one hundred and twenty (120) days. Notwithstanding the preceding sentence, any Temporary Clinical Privileges granted shall automatically expire upon either (1) the issuance of a favorable decision on the pending application by the Governing Body, or (2) their Termination, as set forth below.

b) **Locum Tenens:** A Practitioner who is serving as a locum tenens for one of the Members of the Hospital and who also is a medical staff member in good standing at another accredited hospital in the community may request Temporary Clinical Privileges without applying for membership at this Hospital. Such Temporary Clinical Privileges may be granted by the Credentials Committee for an initial period of up to thirty (30) days, which initial period then may be extended by the Credentials Committee for sixty (60) additional days but in no case shall extended beyond the Practitioner’s period of service as a locum tenens. Locum tenens Practitioners shall not be entitled to admit their own patients to the Hospital despite the grant of Temporary Clinical Privileges.

c) **Experts:** In the case of an important patient care, treatment or service need, an Expert may be granted Temporary Clinical Privileges. For this purpose an “Expert” shall be defined as a Practitioner who holds skills and/or knowledge that is not available from any Member. Use of such Experts must be approved by the Department Chair, Chief of Staff and Chief Executive.

7.4-2 **REQUIRED VERIFICATION FOR THE GRANTING OF TEMPORARY CLINICAL PRIVILEGES**

Verification of the following is required before any Temporary Clinical Privileges may be granted:

a) Current licensure;

b) Professional liability insurance coverage in an amount that meets or exceeds the current Medical Staff requirements;

c) Any report filed with the National Practitioner Data Bank or the applicant’s respective state licensing agency;

d) AMA profile;

e) Whether the Practitioner has been excluded by Medicare, Medi-cal or any other federal- or state funded program; and

f) Documentation of current clinical competence and ability to perform the privileges requested, which shall be verified by a physician-to-physician telephone call.
7.4-3 EXCEPTION TO GRANTING TEMPORARY PRIVILEGES

Temporary Clinical Privileges may not be granted if:

a) The applicant's or Member's professional licensure or registration has ever been terminated, suspended or limited, or any such action is currently pending;

b) The applicant's or Member's medical staff membership at another health care facility or organization has ever been involuntarily terminated; or

c) The applicant's or Member's Clinical Privileges at this or any other health care facility have ever been involuntarily denied, suspended or limited.

7.4-4 CONDITIONS

a) Temporary Clinical Privileges may be granted only when the information available reasonably supports the conclusion that the applicant's or Member's license is valid and current, and that he or she possesses the qualifications, ability and judgment necessary to exercise the privileges being requested, and has satisfied the professional liability insurance requirements of the Bylaws, Rules and Regulations, or Policies.

b) Before Temporary Clinical Privileges may be granted, all necessary credentialing forms must be completed, and the applicant must have executed a written acknowledgment that he or she has received (or been given access to), read, and agrees to be bound by the terms of the Bylaws, Rules and Regulations, Policies, and any Hospital policies as they may be amended from time to time, regardless of whether the applicant is ultimately granted Medical Staff membership and the Clinical Privileges requested. No failure by the Hospital to request or receive such an acknowledgment shall result in any waiver of its right to enforce the Bylaws, Rules and Regulations, Policies, and any Hospital policies.

c) Practitioners who are granted Temporary Clinical Privileges shall be assigned to a Department, and their performance shall be supervised by the Department's Chair or designee. Each Department Chair shall have the discretionary right to impose, at any time, special requirements (e.g., consultation and/or reporting requirements) upon any Practitioner with Temporary Clinical Privileges who has been so assigned.

d) There is no right to Temporary Clinical Privileges. A determination to grant Temporary Clinical Privileges shall not be binding or conclusive with respect to an applicant's or Member's pending application.

7.4-5 TERMINATION OF TEMPORARY CLINICAL PRIVILEGES

a) All or any portion of a Practitioner's Temporary Clinical Privileges may be summarily terminated whenever, because of information discovered or other circumstances or events, any doubt shall have arisen concerning such a Practitioner's professional qualifications, ability to exercise all or any portion of the Temporary Clinical Privileges granted and/or compliance with any Bylaws, Rules and Regulations, or Policies, or any other standard, criterion, requirement (including any special requirement that may have been imposed upon the grant of temporary Clinical Privileges), policy or rule of the Hospital. The Chief Executive or the Chief of Staff may impose such a summary termination after
consultation with the appropriate Department Chair (or designee); however, whenever the conduct of any Practitioner with Temporary Clinical Privileges is such that immediate action must be taken in order to reduce a substantial likelihood of imminent impairment to the health or safety of any patient, prospective patient, employee or other person present in the Hospital, such a Practitioner’s Temporary Clinical Privileges may be summarily terminated by any person authorized to impose a summary suspension pursuant to Section 8.2.

b) If not summarily terminated, any Temporary Clinical Privileges granted shall automatically terminate upon recommendation by the Medical Executive Committee to the Governing Body that the requested Clinical Privileges be denied.

c) Whenever Temporary Clinical Privileges are terminated, the Chief of Staff shall assign a Member to assume responsibility for the care of the Practitioner’s patients. The wishes of the patient and Practitioner shall be considered in the choice of a replacement Member.

7.4-6 PROCEDURAL RIGHTS

All Practitioners requesting or receiving Temporary Clinical Privileges shall be bound by the Bylaws, Rules and Regulations, and Policies. If a Practitioner’s request for Temporary Clinical Privileges is denied, or Temporary Clinical Privileges that have been granted are subsequently terminated, the Practitioner shall not be entitled to any procedural rights unless the action gives rise to procedural rights under Article IX.

7.5 EMERGENCY SITUATIONS

For the purposes of this Section, an “emergency” shall be defined as a situation in which a patient is in imminent danger of serious or permanent harm or death and in which any delay in administering treatment likely would add to such danger. In the case of such an emergency, a Practitioner (regardless of Medical Staff category, membership status, Department assignment or Clinical Privileges) shall be permitted to do everything possible (within the scope of his or her license) to save the patient from such danger. Following such an emergency, it shall be necessary for the involved Practitioner to request the necessary Clinical Privileges in order to be able to continue to care for the patient. If such Clinical Privileges either are not requested or are denied, the Chief of Staff (or designee) shall assign the patient to another Member, when indicated. If possible, the wishes of the patient shall be considered in the selection of a substitute Member.

7.6 GENERAL OVERVIEW OF PERFORMANCE EVALUATION AND MONITORING ACTIVITIES

The credentialing and privileging processes described in Article VI and Article VII require that the Medical Staff develop ongoing performance evaluation and monitoring activities to ensure that decisions on requests for Medical Staff membership and Clinical Privileges are detailed, current, accurate, objective and evidence-based. Additionally, performance evaluation and monitoring activities help assure timely identification of problems that may arise in the ongoing provision of services in the hospital. Problems identified through performance evaluation and monitoring activities shall be addressed via the appropriate performance improvement and/or remedial actions as described in Article VIII.

7.7 PERFORMANCE MONITORING GENERALLY

7.7-1 Except as otherwise determined by the Medical Executive Committee and Governing Body, the Medical Staff shall regularly monitor all Members’ exercise of Clinical Privileges
in accordance with the provisions set forth in the Bylaws, Rules and Regulations and Policies.

7.7-2 Performance monitoring is not a disciplinary measure; it is an information-gathering activity. Performance monitoring does not give rise to the procedural rights described in Article IX.

7.7-3 The Medical Staff shall clearly define how information gathered during performance monitoring shall be shared in order to effectuate change and support additional action, if necessary.

7.7-4 Performance monitoring activities and reports shall be integrated into other quality improvement activities.

7.7-5 The results of any Practitioner-specific performance monitoring shall be considered when granting, renewing, revising or revoking Clinical Privileges of that Practitioner.

7.8 ONGOING PROFESSIONAL PERFORMANCE EVALUATIONS (OPPE)

7.8-1 Each Department shall recommend, for Medical Executive Committee and Governing Body approval, the criteria to be used in the conduct of Ongoing Professional Performance Evaluations for its Practitioners.

7.8-2 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.

7.8-3 Ongoing performance reviews shall be factored into the decision to maintain, revise or revoke a Practitioner's existing Clinical Privilege(s).

7.8-4 Failure of a Practitioner to maintain sufficient activity to evaluate the Practitioner's professional practice or to provide documentation from the Chair of the Department at another facility in which the Practitioner maintains clinical privileges comparable to those maintained at the Hospital will be considered a voluntary resignation. Such a voluntary resignation does not grant the Practitioner any procedural rights under the Bylaws.

7.9 FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

7.9-1 The Medical Staff is responsible for developing a focused professional practice evaluation process that will be used in predetermined situations to evaluate, for a time-limited period, a Practitioner's competency in performing specific privilege(s). The Medical Staff may supplement these Bylaws with policies, for approval by the Medical Executive Committee and the Governing Body, 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.

7.9-2 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 in Section 7.10, below.

7.9-3 A Focused Professional Practice Evaluation ("FPPE") may be used in at least the following situations:

a) All initial appointees to the Medical Staff and all Members granted new Clinical Privileges shall be subject to a period of focused professional practice evaluation in accordance with the Bylaws and the Rules and Regulations and/or Policies of the Department in which the applicant or Member will be exercising those Clinical Privileges.

b) In special instances, focused evaluation will be imposed as a condition of renewal of Clinical 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).

c) When questions arise regarding a Practitioner's competency in performing specific Clinical Privilege(s) at the Hospital as a result of specific concerns or circumstances, a focused evaluation may be imposed.

d) As otherwise defined in these Bylaws or applicable FPPE policies.

e) Nothing in the foregoing precludes the use of other FPPE tools, in addition to or in lieu of proctoring, as deemed warranted by the circumstances.

7.10 PROCTORING REQUIREMENT

7.10-1 INITIAL APPOINTEES

Except as otherwise recommended by the Medical Executive Committee and approved by the Governing Body, each initial appointee to the Medical Staff shall complete a period of proctoring, which may include direct observation of the appointee’s performance and/or chart review. Such proctoring shall be structured to ensure that an informed determination can be made regarding the appointee’s eligibility for continued Medical Staff membership and Clinical Privileges.

Each initial appointee shall be proctored by the Department Chair(s) (or designee(s)) of the Department to which the appointee is assigned, and any other Department(s) in
which the appointee is granted Clinical Privileges, for the duration of the Department(s) respective period(s) of proctoring.

No initial appointee shall be removed completely from proctoring until the Medical Executive Committee has received and approved a recommendation from each of the Departments to which the initial appointee is assigned or granted Clinical Privileges, stating that the initial appointee need not remain on proctoring based on:

a) The type and the number of cases that have been proctored;
b) The initial appointee’s clinical performance while under proctorship; and
c) An assessment that the initial appointee satisfactorily has demonstrated the ability to exercise all of the Clinical Privileges tentatively granted within the Department.

7.10-2 MEDICAL STAFF MEMBERS REQUESTING ADDITIONAL PRIVILEGES

Except as otherwise recommended by the Medical Executive Committee and approved by the Governing Body, each Member who is granted additional Clinical Privileges shall complete a period of proctoring in accordance with the procedures outlined for initial appointees.

7.10-3 PERIOD OF PROCTORING

The maximum allowable period of proctoring is twenty-four (24) months. The requirements of proctoring applicable to each Practitioner shall be set in the Rules and Regulations of each Department to which a Practitioner is assigned or granted Clinical Privileges.

7.11 RESIDENTS

Residents who are practicing at the Hospital only in connection with training programs shall not be Members of the Medical Staff. Their Clinical Privileges and duties at the Hospital shall be defined by their training programs, subject to the Hospital's approval. Residents who wish to practice independently of their training programs must apply for and obtain Medical Staff membership and Clinical Privileges.

7.12 DISASTER PRIVILEGES

Disaster privileges may be granted by the Chief of Staff (or designee), Department Chair or Department Vice Chair when the Hospital’s emergency management plan has been activated and the Hospital is unable to handle the immediate patient needs. Such Disaster Privileges will be granted in accordance with the Bylaws, Rules and Regulations, and Policies.

7.12-1 PROCEDURE

a) The Practitioner or AHP must present to the Hospital.
b) The Practitioner or AHP shall be directed to the person or persons designated in the Hospital disaster policies to process Disaster Privileges.
c) The Practitioner or AHP must present at least one of the following:
1) A current license to practice, photo identification, and the name and telephone number of the hospital(s) where the Physician or AHP currently practices;

2) ID that certifies the individual is a member of a disaster medical assistance team;

3) ID that certifies a state, federal, or municipal entity (i.e., FEMA) has granted the individual the authority to administer patient care under emergency circumstances; and/or

4) Presentation by a current Hospital employee or Medical Staff Member who can vouch for the Practitioner’s identity.

d) After viewing the documents, the Hospital representatives must record the date and time of the request for Disaster Privileges, the California license number and expiration date, and/or the type, identification number and expiration date of the photo ID. Two Polaroid photos ID’s will be taken. One will be retained with the copies of documents and one will be utilized as hospital ID.

e) If at all possible, copies should be made of the license and/or photo identification.

f) The Hospital representative should immediately do the following:

1) Contact the facility where the person has recently practiced to verify that the person is in good standing.

2) Call or query the licensing board to verify that the person is in good standing.

IN THE EVENT THESE CALLS CANNOT BE COMPLETED IMMEDIATELY, DISASTER PRIVILEGES MAY STILL BE ISSUED PENDING LATER VERIFICATION OF THE PERSON’S GOOD STANDING.

g) The Practitioner should be paired with a similarly licensed Member. The AHP should be paired with a similarly licensed AHP. It is recommended that this pairing be recorded along with the licensing information.

h) A Practitioner’s and AHP’s Disaster Privileges will be immediately terminated by the Chief of Staff or designee in the event any information is received that suggests the person is not capable of rendering services in a disaster. Termination of such Disaster Privileges, regardless of the reason, shall not give rise to any procedural rights under the Bylaws.

Within 72 hours following such a disaster, it shall be necessary for the involved Practitioner to request the necessary Clinical Privileges in order to be able to continue to care for the patient. All current credentialing standards must be met. Temporary Clinical Privileges may be granted during the pendency of the application, as long as the standards therefor are met.

i) If post-disaster Clinical Privileges either are not requested or are denied, the Chief of Staff (or designee) shall assign the patient to another Practitioner. If possible, the wishes of the patient shall be considered in the selection of a substitute Practitioner.
j) A list of all patients treated by any such Practitioner or AHP shall be maintained and all cases will be retrospectively reviewed by the appropriate Department as soon as possible.

ARTICLE VIII

CORRECTIVE ACTION

8.1 ROUTINE CORRECTIVE ACTION

8.1-1 CRITERIA FOR INITIATION

An Investigation or corrective action may be requested, and ultimately initiated, against any Member with Medical Staff membership and/or Clinical Privileges who engages in, makes, or exhibits acts, statements, demeanor or professional conduct (either within or outside of the Hospital) that is, or is reasonably likely to:

a) Be detrimental to patient safety or to the delivery of quality patient care within the Hospital;

b) Be disruptive to Hospital or Medical Staff operations;

c) Be unethical, fraudulent, or abusive;

d) Be contrary to the Bylaws, Rules and Regulations, and/or Policies;

e) Be an improper use of Hospital resources; or

f) Result in the imposition of sanctions by any governmental authority.

8.1-2 INITIATION

a) A proposal for corrective action or a request for an Investigation (collectively, a “Request for Investigation”) may originate with the Medical Executive Committee, acting on its own initiative, or as a written request, to the Medical Executive Committee, submitted by a Medical Staff Officer, Chair of any Department in which the Practitioner holds membership or Clinical Privileges, Chair of any Medical Staff Committee, the Governing Body, or the Chief Executive.

b) Any written Request for Investigation submitted to the Medical Executive Committee shall identify the alleged activities or conduct giving rise to the Request for Investigation. The Chief of Staff shall promptly notify the Chief Executive and Governing Body any time a Request for Investigation has been received by the Medical Executive Committee, and shall keep the Chief Executive and Governing Body fully informed of the Medical Executive Committee’s response.

c) Following the receipt of a Request for Investigation, the Medical Executive Committee may, but is not required to, initiate an Investigation or take action.

8.1-3 INVESTIGATION

a) The Medical Executive Committee may conduct the Investigation or assign the Investigation to a Medical Staff Officer, or any standing or ad hoc committee of the Medical Staff. The Investigation process shall not constitute a hearing nor be
conducted pursuant to Article IX. During the Investigation, the affected Member shall be notified that an Investigation is being conducted, and shall be given an opportunity to provide information. The affected Member may be required to appear for an interview and/or supply additional information. Any request by the Member for an interview shall be granted.

b) Unless an Investigation is conducted by the Medical Executive Committee, the individual or committee performing the Investigation shall submit a written report to the Medical Executive Committee at the conclusion of the Investigation, unless requested otherwise by the Medical Executive Committee. The Medical Executive Committee shall have sole discretion to terminate the Investigation at any time and take action pursuant to Section 8.1-4.

c) It is within the sole discretion of the Medical Executive Committee to conduct an Investigation. Nothing in this Section prevents the Medical Executive Committee from conducting an informal inquiry or requesting that the Well-Being Committee inquire into the affected Member’s circumstances. Such an informal inquiry shall not constitute an Investigation under this Article.

8.1-4 MEDICAL EXECUTIVE COMMITTEE ACTION

Within sixty (60) days after the Medical Executive Committee has received a Request for Investigation, the Medical Executive Committee shall take action, which may include, without limitation, the following:

a) Formally closing the Request for Investigation without conducting or assigning any Investigation;

b) Formally deferring any action on the Request for Investigation, on the basis that additional time is needed to complete the Investigation process. Following such a deferral, the Medical Executive Committee shall take action pursuant to this section by the deadline specified at the time of the deferral or, if no such deadline was specified, within forty-five (45) days of the date of the deferral;

c) Closing the Investigation without taking or recommending any corrective action;

d) Sending the Practitioner a letter of admonition, censure, reprimand, or warning, which shall be placed in the Practitioner’s credentials file. In such event, the affected Member may provide a written response, which also shall be placed in his credentials file. Nothing herein shall preclude Department Chairs from issuing informal written or oral warnings outside the mechanism for corrective action, which warnings (and any response thereto) shall be documented in the Member’s credentials file;

e) Recommending the imposition of probation or special limitations upon continued Medical Staff membership or exercise of Clinical Privileges, including without limitation, requirements for co-admissions, mandatory consultations or monitoring;

f) Recommending reduction of membership status or limitation of any Prerogatives directly related to the Member’s delivery of patient care;

g) Recommending reduction or revocation of Clinical Privileges;

h) Recommending revocation of Medical Staff membership;
i) Summarily suspending the Practitioner’s Clinical Privileges and/or Medical Staff membership; or

j) Any other action deemed appropriate by the Medical Executive Committee.

Nothing set forth herein shall in any way limit the Medical Executive Committee’s right to impose a summary suspension, at any time, pursuant to Section 8.2.

8.1-5 PROCEDURAL RIGHTS

If the Medical Executive Committee’s action or recommendation under Section 8.1-4 gives rise to procedural rights under the Bylaws, the Chief of Staff shall give the Member written notice of the Medical Executive Committee’s action or recommendation and the Member’s right to request a hearing pursuant to Article IX.

8.1-6 ACTION OR RECOMMENDATION REQUIRING IMMEDIATE REPORT

Notwithstanding Section 8.1-5, if, after a formal investigation, the Medical Executive Committee determines that a Practitioner may have engaged in any of the acts set forth in paragraphs (a) through (d) below, and on that basis takes an action or makes a recommendation regarding any of the disciplinary actions set forth in Section 8.1-4 (d) through (j), and if such action would be permanent or would last for a cumulative total of 30 days or more in any 12-month period, then the Chief of Staff or Hospital Administration shall file a report with the relevant state licensing agency having jurisdiction over the Practitioner within 15 days of taking such action or making such recommendation. Such a report shall be filed regardless of whether a hearing is held pursuant to Article IX, and in addition to any other report required to be filed with any regulatory body.

A report must be filed under this subsection when the Medical Executive Committee’s action or recommendation is based on the following:

a) Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients, to the extent or in such a manner as to be dangerous or injurious to any person or to the public;

b) The use of, or prescribing for or administering to himself or herself, any controlled substance, dangerous drug (as defined in California Business & Professions Code Section 4022), or alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the Practitioner, any other person, or the public, or to the extent that such use impairs the ability of the Practitioner to practice safely;

c) Repeated acts of clearly excessive prescribing, furnishing or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith effort prior to examination of the patient and medical reason therefore. However, in no event shall a Practitioner prescribing, furnishing, or administering controlled substances for intractable pain, consistent with lawful prescribing, be reported for excessive prescribing and prompt review of the applicability of this provision shall be made in any complaint that may implicate this provision; and

da) Sexual misconduct with one or more patients during a course of treatment or an examination.
8.1-7 GOVERNING BODY ACTION

a) The Governing Body shall be notified of any corrective action taken or recommended by the Medical Executive Committee pursuant to Section 8.1-4 (e) through (i), but shall not conduct any review or take any action with regard to the action or recommendation until the Member has either exhausted or waived all procedural rights available under the Bylaws.

b) If the Member exercises any procedural rights, the final decision of the Governing Body shall be determined as set forth in Article IX.

c) If the Medical Executive Committee’s action or recommendation does not give rise to procedural rights under the Bylaws, or if the Member waives all such rights, the Governing Body may take the following action:

1) Adopt the Medical Executive Committee’s action or recommendation;

2) Refer the matter back to the Medical Executive Committee for further review and recommendation, and set a time limit within which a subsequent recommendation shall be made by the Medical Executive Committee to the Governing Body.

3) Modify or reject a Medical Executive Committee’s action or recommendation, in which case the Governing Body should refer the matter to the Joint Conference Committee and proceed as described in Article XII. If following a review by the Joint Conference Committee, the Governing Body takes a final action that independently gives rise to procedural rights under the Bylaws, the Chief Executive Officer shall give notice to the Member in accordance with Article IX, and the action shall not become effective until such rights have been exhausted or waived.

8.1-8 FAILURE TO ACT BY THE MEDICAL EXECUTIVE COMMITTEE

If the Medical Executive Committee does not (1) act in a reasonable period of time on a Request for Investigation, (2) investigate when investigation is warranted, or (3) take or recommend disciplinary action, contrary to the weight of the evidence, the Governing Body may proceed as follows:

a) Submit the matter to the Joint Conference Committee and set a reasonable timetable for the Medical Executive Committee to take action;

b) Direct the Medical Executive Committee to initiate an Investigation or disciplinary action, but only after consultation with the Joint Conference Committee; and

c) If the Medical Executive Committee does not adhere to the timetable or fails to take action in response to the Governing Body’s direction, the Governing Body may initiate corrective action in compliance with Articles VIII and IX.

If the Governing Body’s final action gives rise to any procedural rights under the Bylaws, such notice shall be given in accordance with Article IX, and the action shall not become effective until such rights have been exhausted or waived.

If the Governing Body’s final action is based on one of the acts listed in Section 8.1-6 (a) through (d), a report shall be filed in accordance therewith.
8.2 SUMMARY RESTRICTION OR SUSPENSION

8.2-1 CRITERIA FOR INITIATION

a) All Members’ Medical Staff membership and/or all or any portion of their Clinical Privileges may be summarily restricted or suspended whenever their conduct is such that immediate action must be taken in order to reduce a substantial risk of imminent impairment of the health or safety of any patient, prospective patient, employee or other person present in the Hospital.

b) Such a summary restriction or suspension may be imposed by the Governing Body, the Chief Executive, the Medical Executive Committee, the Chief of Staff, or the Chair of the Department in which the Member holds membership or Clinical Privileges.

c) If a summary restriction or suspension is initiated by the Governing Body or the Chief Executive, such a suspension is subject to ratification by the Medical Executive Committee. If the Medical Executive Committee does not ratify such a summary suspension within two (2) working days, excluding weekends and holidays, the summary suspension shall terminate automatically.

d) A summary restriction or suspension shall become effective immediately upon imposition. The individual or body responsible for the restriction or suspension shall promptly give the affected Member verbal, and, whenever possible, written notice of the summary action in addition to providing notice to the Governing Body, Medical Executive Committee, and Chief Executive.

e) The notice of the summary restriction or suspension to the Medical Executive Committee shall constitute a Request for Investigation under Section 8.1-2.

f) Following the imposition of a summary restriction or suspension, the Department Chair and/or the Chief of Staff shall assign the affected Member’s hospitalized patients to another Member. If possible, the wishes of the patients and the affected Member shall be considered.

8.2-2 MEDICAL EXECUTIVE COMMITTEE ACTION

A Member who has been summarily restricted or suspended may request an interview with the Medical Executive Committee. Such an interview shall be convened as soon as possible and no more than ten (10) days from the date of the suspension. In no event shall any meeting of the Medical Executive Committee, with or without the Member, constitute a hearing nor shall any procedural rules under Article IX apply. Following such an interview, the Medical Executive Committee shall either continue, modify or terminate the summary restriction or suspension, and shall give written notice of its decision to the affected Member, the Governing Body and the Chief Executive.

8.2-3 PROCEDURAL RIGHTS

a) If a summary restriction or suspension is not terminated by the Medical Executive Committee, it shall remain in effect (as originally imposed or subsequently modified) during the pendency and completion of both the corrective action process under this Article and any hearing and appellate review process under Article IX.
b) The affected Member shall not be entitled to any procedural rights provided in Article IX unless the summary action constitutes grounds for a hearing as set forth in Section 9.2.

c) In the event that a report is filed with the affected Member's licensing body pursuant to California Business & Professions Code Section 805, and the summary action is subsequently overturned as a result of the procedural rights provided in these Bylaws, a letter shall be sent to the affected Member's licensing body notifying it of such action.

8.3 AUTOMATIC SUSPENSION, TERMINATION, RESTRICTION, AND DIVESTMENT

8.3-1 LICENSE

a) Revocation or Expiration: Whenever a Member's license to practice in this State is revoked or has expired, the Member's Medical Staff membership and Clinical Privileges shall be immediately and automatically terminated. Such an automatic termination shall not give rise to any procedural rights provided in Article IX.

b) Restriction: Whenever a Member's license to practice in this State is limited, restricted, or placed on probation, those Clinical Privileges that fall within the scope of such limitation or restriction shall be immediately and automatically restricted. In addition, the terms of any probation shall be applied to the Member's activity in the Hospital. Such an automatic restriction shall not give rise to any procedural rights provided in Article IX.

c) Suspension: Whenever a Practitioner's license to practice in this State is suspended, the Member's Medical Staff membership and Clinical Privileges shall be immediately and automatically terminated. Such an automatic termination shall not give rise to any procedural rights provided in Article IX.

8.3-2 DRUG ENFORCEMENT ADMINISTRATION ("DEA") CERTIFICATE

a) Revocation, Suspension or Expiration: Whenever a Member's DEA certificate is revoked, suspended, or expired, the Member shall automatically and correspondingly be divested of the right to prescribe, dispense or administer any medications covered by such certificate within the Hospital. Such an automatic divestment shall not give rise to any procedural rights set forth in Article IX.

b) Restriction: Whenever a Member's DEA certificate is limited or restricted, the Member shall automatically and correspondingly be divested of the right to prescribe, dispense or administer any medications covered by such a restriction on that certificate within the Hospital. Such an automatic divestment shall not give rise to any procedural rights set forth in Article IX.

8.3-3 FAILURE TO SATISFY SPECIAL APPEARANCE REQUIREMENT

If a Member should fail to appear and satisfy the requirements of Section 13.7-3 without first having been excused by the Medical Executive Committee for good cause, the Member's Clinical Privileges shall be automatically suspended. Such a suspension shall remain in effect during the pendency and completion of any corrective action ordered by the Medical Executive Committee, and any hearing and appellate review process required under Article IX.
a) If a Member fails to complete any medical records within the time limit(s) established by the Rules and Regulations, Policies, or any other standards, policies or rules of the Hospital, local government, state government or federal government, the Member shall be issued a written notice of delinquency, which shall specify that, unless all delinquent medical records are completed within fourteen (14) days of the Notice, the Member’s Clinical Privileges and right to admit patients and to provide any other professional services within the Hospital shall be suspended immediately and automatically. There are two exceptions to this rule:

1) The Member will be allowed to continue to treat patients already admitted to the Hospital; and

2) The Member MUST continue any Emergency Department call responsibilities and, if necessary, may admit and treat any emergency room patient within the hospital.

b) Operative reports must be completed immediately following surgery. A Member who fails to complete the operative report immediately shall be issued a verbal notice of delinquency followed by a confirmatory fax and written notice, which shall specify that, unless all delinquent operative reports are completed immediately, the Member’s Clinical Privileges and right to admit patients and to provide any other professional services within the Hospital shall be suspended immediately and automatically.

c) History and physical examinations must be completed within the time frame specified in Section 3.6-13. A Member who fails to complete the history and physical examination within the required time frames shall be issued a verbal notice of delinquency followed by a confirmatory fax and written notice, which shall specify that, unless all delinquent history and physical examinations are completed immediately, the Member’s Clinical Privileges and right to admit patients and to provide any other professional services within the Hospital shall be suspended immediately and automatically.

GENERALLY

A complete history and physical examination must be recorded in the chart or dictated within 24 hours after admission of the patient. If dictated, the chart must contain an admission note within 24 hours that provides pertinent findings from the history and physical examination. The attending practitioner must personally write an admission note also within 24 hours of admission, indicating the reason for hospitalization and the diagnostic/therapeutic plan. The history and physical examination report must include the chief complaint, details of the present illness, all relevant past medical, social and family histories, the patient's emotional, behavioral and social status when appropriate, and all pertinent findings resulting from a comprehensive, current assessment of all body systems. (Rev. 8/97; Rev 3/08

USE OF REPORTS PREPARED PRIOR TO CURRENT ADMISSION

1) **External to Hospital:** If a qualified member of the hospital's medical staff has obtained a complete history or has performed a complete physical examination
within thirty (30) days prior to the patient's admission to the hospital, a durable, legible copy of the report may be used in the patient's hospital medical record, provided that an interval admission note is recorded immediately on admission that includes all additions to the history and any changes in the physical findings subsequent to the original report. *(Revised 1/21/92)* In the case of Obstetrical patients being admitted for normal delivery, the attending physician shall submit the original or a legal copy of his/her patient's prenatal record in the Delivery Suite thirty (30) days prior to the expected delivery. The attending physician shall complete an admission note at the time of his/her patient's admission, detailing any interval changes in history, physical examination, or clinical course which may have occurred since the last entry of such information on to the patient's prenatal record. *(Added 4/97, Rev 3/08, Rev 3/08)*

2) **On Prior Admission:** When a patient is readmitted to this hospital within 30 days for the same or a related problem, an interval history and physical examination reflecting subsequent history and changes in physical findings may be used, provided the original information is readily available, and the update is documented immediately *(Rev 3/08)*

**SHORT FORM**
A short history and physical examination form may be used for patients admitted for minor surgical procedures and for patients whose hospital stay is not expected to exceed 24 hours. If the patient remains over 24 hours, a comprehensive H & P must be initiated and completed.

**INVASIVE PROCEDURES**
Any patient undergoing a procedure requiring admission to the inpatient, short stay, or other unit of the hospital shall undergo a medical history and physical examination or its equivalent. Any patient admitted for a procedure including moderate or deep sedation shall require a history and physical examination per the Moderate Sedation Protocol. *(Rev. 8/97, 2/98, 12/03)*

d) **PERIOPERATIVE DOCUMENTATION (HISTORY AND PHYSICAL EXAMINATION)**

A relevant history and physical examination is required on each patient having surgery. Another report, such as a consultation report (but not ER physician notes or dictations), may serve as the pre-operative history and physical if it contains the required elements. If this is completed more than twenty-four (24) hours prior to surgery (and in no event more than thirty (30) days prior to surgery), a preoperative interval note detailing any changes since the original history and physical must be written or dictated, immediately, even if there are no changes (in which case it is sufficient to so state in the medical record or progress notes). Except in an emergency so certified in writing by the operating practitioner, surgery or any other potentially hazardous procedure shall not be performed until after the pre-operative diagnosis, history, physical examination, and required laboratory tests have been recorded in the chart. If the history and physical examination have been dictated but are not on the chart at the time of surgery, a written note must be entered before surgery stating the basic nature of the proposed surgery/procedure and the condition for which it is to be done, the condition of the heart and lungs, allergies known to be present, other pertinent pathology and information relating to the patient, and that the history and physical have been dictated. If not recorded, the anesthesiologist (or other licensed independent professional responsible for the patient's anesthesia care)
shall not allow the surgery to proceed. In cases of emergency, the responsible practitioner shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of the procedure, and the history and physical examination shall be recorded immediately after the emergency surgery has been completed. All cases in which the requirements of this section are not met shall be acted upon in accordance with Article VIII, Section 8.3-5 of the Medical Staff Bylaws. (Rev. 12/97; Rev 5/04; Rev 3/08)

History and physical examinations must be completed within the time frame specified in Section 3.6-13. A Member who fails to complete the history and physical examination within the required time frames shall be issued a verbal notice of delinquency followed by a confirmatory fax and written notice, which shall specify that, unless all delinquent history and physical examinations are completed immediately, the Member's Clinical Privileges and right to admit patients and to provide any other professional services within the Hospital shall be suspended immediately and automatically.

If a suspension should take effect pursuant to subsections (a)-(c) above, it shall remain in effect until all delinquent medical records have been completed. Whenever such suspension(s) shall accumulate to a total of sixty (60) suspension days, whether consecutively or intermittently, in any twelve (12) month period, the Member shall be deemed voluntarily to have resigned his or her Medical Staff Membership and Clinical Privileges, effective immediately.

8.3-5 MALPRACTICE INSURANCE

Any Member who fails to comply with the professional liability insurance required by the Bylaws, Rules and Regulations, or Policies shall be issued a written notice of noncompliance, which shall specify that the Member's Clinical Privileges and right to admit patients and to provide any other professional services within the Hospital are suspended immediately and automatically. 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 (6) months after the date of automatic suspension shall be deemed a voluntary resignation of the Member from the Medical Staff. Such an automatic suspension and voluntary resignation shall not give rise to any procedural rights set forth in Article IX.

8.3-6 ANNUAL DUES

Any Member who fails to pay annual Medical Staff dues within thirty (30) days of initial notice shall be issued a second notice requesting dues payment. A Member who fails to pay annual dues within thirty (30) days of the second notice shall receive a final notice of delinquency, which shall specify that the Member's Medical Staff membership and Clinical Privileges are suspended immediately and automatically. A Member who fails to pay annual dues within thirty (30) days of the date of the final notice of delinquency shall be considered to have voluntarily resigned his or her Medical Staff membership and Clinical Privileges, effective immediately. Such an automatic suspension and voluntary resignation shall not give rise to any procedural rights set forth in Article IX.

8.3-7 NOTICE OF AUTOMATIC SUSPENSION OR TERMINATION; TRANSFER OF PATIENTS

Whenever an automatic suspension or termination takes effect, notice of such suspension or termination shall be given to the affected Member, the Medical Executive
Committee, the Chief Executive and the Governing Body. However, such a notice is not required for an automatic suspension or termination to become effective. Whenever indicated due to an automatic suspension or termination, the Department Chair and/or the Chief of Staff shall assign the suspended or terminated Member's hospitalized patients to another Member. If possible, the wishes of such patients and the affected Member shall be considered.

8.4 INTERVIEWS

Interviews shall neither constitute, nor be deemed, a “hearing” as that term is used in Article IX, and shall not be conducted according to the procedural rules set forth in Article IX. The Medical Executive Committee shall be required to grant a Member's request for an interview only when this Article VIII so specifies. In the event an interview is granted, the Member 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.

ARTICLE IX

HEARING AND APPELLATE REVIEW PROCEDURE

9.1 PREAMBLE

9.1-1 CHALLENGES TO BYLAWS, RULES AND REGULATIONS OR POLICIES

The hearing and appeal rights established in the Bylaws are strictly adjudicative, rather than legislative, in structure and function. The hearing committees have no authority to adopt or modify the Bylaws, Rules and Regulations, or Policies, nor to decide questions regarding the merits or substantive validity thereof. The Governing Body may, in its discretion, entertain challenges to the merits or substantive validity of Bylaws, Rules and Regulations, or Policies and decide those questions. If the only issue in a case is whether a Bylaw, Rule and Regulation, or Policy is lawful or meritorious, the Practitioner is not entitled to a hearing or appellate review. In such cases, the Practitioner must submit any challenges directly to the Governing Body, which shall give the Medical Executive Committee an opportunity to respond. Only after a decision by the Governing Body is rendered may the challenger seek judicial intervention.

Notwithstanding the above, and separate from any of its quasi-judicial activities and responsibilities, the Governing Body, after consultation with the Medical Staff, shall have continuing, independent power and authority to make legislative determinations and to hold legislative, notice and comment type hearings, as it shall see fit.

9.1-2 EXHAUSTION OF REMEDIES

If an adverse action as described in Section 9.2 is taken or recommended, the Practitioner must first exhaust the remedies afforded by these Bylaws before resorting to legal action.

9.2 GROUNDS FOR A HEARING

Except as otherwise provided elsewhere within these Bylaws, any one or more of the following actions or recommended actions shall constitute grounds for a hearing under the Bylaws if the actions or recommended actions are the result of a Medical Disciplinary Cause or Reason:

9.2-1 Denial of initial Medical Staff membership and/or Clinical Privileges;
9.2-2 Denial of requested advancement in Medical Staff membership category;
9.2-3 Denial of reappointment of Medical Staff membership and/or Clinical Privileges;
9.2-4 Restrictions imposed on Medical Staff membership and/or Clinical Privileges for a cumulative total of 30 days or more in any twelve (12) month period;
9.2-5 Involuntary reduction of Medical Staff membership and/or Clinical Privileges;
9.2-6 Suspension of Medical Staff membership and/or Clinical Privileges; or
9.2-7 Termination of Medical Staff membership and/or Clinical Privileges;
9.2-8 Any other action that requires a report to the Practitioner’s licensing agency under California Business & Professions Code Section 805.

9.3 EXCEPTIONS TO FAIR HEARING RIGHTS

9.3-1 LIMITED/CLOSED-STAFF OR EXCLUSIVE-USE DEPARTMENTS

The hearing and procedural rights of these Bylaws shall not apply whenever the Medical Executive Committee recommends the denial of an application for Medical Staff membership and Clinical Privileges on the basis that any Department to which the Practitioner has applied and/or requested Clinical Privileges is a limited/closed-staff or exclusive-use Department. However, the Practitioner may request that the Governing Body review the adverse recommendation or action, which request the Governing Body may grant or deny in its sole discretion. If the request for review is granted, the Governing Body shall determine whether the Practitioner may appear personally before it and/or may submit a written memorandum. Whatever right(s) are afforded to the Practitioner shall also be afforded to the Medical Executive Committee. A Practitioner must request such review and, if the request is granted, the Governing Body must make a final determination, before the Practitioner may seek judicial review in a court of law.

9.3-2 MEDICO-ADMINISTRATIVE OFFICERS

The removal of a medico-administrative officer from his or her medico-administrative position shall be governed by the terms and conditions of his or her Medico-Administrative Contract with the Hospital and such an action shall not give rise to the hearing and procedural rights contained within this Article. However, if an action is taken which must be reported under California Business & Professions Code Section 805 and/or the Practitioner’s Medical Staff membership status or Clinical Privileges that are independent of the Practitioner’s Contract are removed or suspended, then the procedural rights set forth in this Article apply to that particular action.

9.3-3 ALLIED HEALTH PROFESSIONALS

Nothing contained within the Bylaws, Rules and Regulations or Policies shall be interpreted as providing to any AHP the procedural rights set forth in this Article. An AHP may request a review of an adverse decision in accordance with Article V.

9.4 REQUESTS FOR A HEARING

9.4-1 NOTICE OF ACTION OR PROPOSED ACTION

In all cases in which an adverse recommendation or action is made pursuant to Section 9.2, the Practitioner shall be given a Notice of Action or Proposed Action, which states:
9.4-2 REQUEST FOR HEARING

The Practitioner shall have thirty (30) days following receipt of the Notice of Action or Proposed Action within which to request a hearing. Such a request must be addressed to the Chief of Staff, who shall forward a copy to the Chief Executive.

If the Practitioner does not request a hearing in such time and manner, he or she shall be deemed to have waived all rights to any hearing or appellate review to which he or she otherwise was entitled under these Bylaws, and shall be deemed to have accepted the adverse recommendation or action, which shall become the final recommendation of the Medical Executive Committee. Such final recommendation shall be considered and acted upon by the Governing Body within forty-five (45) days thereafter.

9.4-3 NOTICE OF HEARING

Upon receipt of a request for a hearing, the Chief of Staff shall schedule a hearing and, within thirty (30) days from the date of receipt of the request, shall send a Notice of Hearing to the Practitioner, stating the time, place and date of the hearing. The date set for the commencement of the hearing shall be not less than thirty (30) days nor more than sixty (60) days from the date the Chief of Staff received the request for a hearing.

9.4-4 NOTICE OF CHARGES

a) As part of, or together with, the Notice of Hearing, the Chief of Staff shall provide a written Notice of Charges, which sets forth the acts or omissions with which the Practitioner is being charged, or the reason(s) for the adverse recommendation or action, including, whenever applicable and feasible, a list of the patient charts involved.

b) The Notice of Charges may be amended at any time. Such amendments may delete or modify the acts, omissions, charts, or reasons specified in the original Notice of Charges. Notice of each amendment shall be given to the Practitioner.

9.5 FAIR HEARING PROCEDURE

9.5-1 SELECTING THE TRIER OF FACT

a) The Medical Executive Committee shall determine whether the hearing will be conducted before an arbitrator or a hearing panel.

b) If the hearing is being held before an arbitrator, then the arbitrator shall be selected using a process mutually accepted by the peer review body and the Practitioner. The arbitrator need not be either a health professional or an attorney. The arbitrator shall carry out all of the duties assigned herein to the Hearing Officer and Judicial Review Committee.
c) If the hearing is being held before a Judicial Review Committee, the Chief of Staff shall appoint at least three (3) panel members and, whenever indicated, at least two (2) alternates. The individuals selected to serve on the Judicial Review Committee, whether as panel members or as alternates, shall gain no direct financial benefit from the outcome of the hearing, and shall not have acted as accusers, investigators, fact finders or initial decision makers in the matter at any previous level. Where feasible, the Judicial Review Committee shall include an individual practicing the same specialty as the Practitioner. Knowledge of the issues involved shall not preclude an individual from serving as a panel member or alternate on the Judicial Review Committee.

d) Both the Medical Executive Committee and the Practitioner have the right to a reasonable opportunity to voir dire, and to challenge the impartiality of, each Judicial Review Committee panel member and alternates. The Hearing Officer may question the panel members and/or alternates directly regarding their service on the Judicial Review Committee. Any challenges to the impartiality of any panel member or alternate will be ruled upon by the Hearing Officer.

9.5-2 THE HEARING OFFICER

a) If the hearing is being held before a Judicial Review Committee, the Chief of Staff shall appoint a Hearing Officer to preside over the hearing.

b) The Hearing Officer shall be an attorney at law who is qualified to preside over a quasi-judicial hearing and has experience in medical staff matters. Attorneys from a law firm that are regularly utilized by the Hospital, Medical Staff or the affected Practitioner for legal advice regarding their affairs and activities are not eligible to serve as the Hearing Officer. Any attorney who has served as a Hearing Officer on behalf of the Hospital in the past two (2) years also shall not be eligible to serve as the Hearing Officer. The Hearing Officer shall gain no direct financial benefit from the outcome and must not act as a prosecuting officer or as an advocate. The Hearing Officer may participate in the deliberations of the Judicial Review Committee and serve as its legal advisor; however, he or she shall not be entitled to vote.

c) Both the Medical Executive Committee and the Practitioner have the right to a reasonable opportunity to voir dire, and challenge the impartiality of, the Hearing Officer. Such challenges will be ruled upon by the Hearing Officer.

d) The Hearing Officer shall:

1) Assure that all hearing participants shall have a reasonable opportunity to be heard and to present all relevant oral and documentary evidence;

2) Ensure that proper decorum is maintained throughout the hearing by all participants;

3) Determine the order of, and the procedure for, the presentation of evidence and arguments during the hearing; and

4) Make all rulings on questions that pertain to matters of law, procedure or the admissibility of evidence, including, but not limited to, requests and objections pertaining to the production of documents, requests for continuances, designation and exchange of proposed evidence, evidentiary disputes, witness issues including disputes regarding expert
witnesses, and setting reasonable schedules for the timing and/or completion of all matters related to the hearing.

9.5-3 FAILURE TO APPEAR AND PROCEED

a) If the Practitioner, without good cause, does not personally attend and proceed at the hearing or any session thereof, in an efficient and orderly manner, he or she shall be deemed to have waived all further procedural rights to which he or she otherwise was entitled under these Bylaws, and shall be deemed to have accepted the adverse recommendation or action, which shall become the final recommendation of the Medical Executive Committee. Such final recommendation shall be considered and acted upon by the Governing Body within forty-five (45) days thereafter.

b) If the Hearing Officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the Hearing Officer may take such discretionary action as seems warranted by the circumstances, including, but not limited to, limiting the scope of examination and cross-examination and setting fair and reasonable time limits on either side’s presentation of the case.

Under extraordinary circumstances, the Hearing Officer’s discretionary action includes, to the extent permitted by law, termination of the hearing at the direction of the Judicial Review Committee. When the Judicial Review Committee deems that termination of the hearing is necessary and orders termination, then:

1) If the order is against the MEC, the charges against the Practitioner will be dropped; or

2) If the order is against the Practitioner, the Practitioner will be deemed to have waived his or her right to a hearing.

Such an extraordinary action may be immediately appealed to the Governing Body.

9.5-4 POSTPONEMENTS, CONTINUANCES AND EXTENSIONS

Any requests for a postponement, continuance, or extension of time beyond the time permitted in these Bylaws shall be ruled upon by the Hearing Officer and only granted upon a showing of good cause for the postponement, continuance or extension of time. However, the parties can agree to a postponement, continuance, and extension of time at any time.

9.5-5 DISCOVERY

a) Rights of Inspection and Copying

1) The Practitioner shall have the right to inspect and copy, at his or her own expense, any documents relevant to the charges in the possession or control of the Medical Staff.

2) The Medical Executive Committee shall have the right to inspect and copy, at its expense, any documents relevant to the charges in the possession or control of the Practitioner.
3) The failure by either party to provide access to this information at least thirty (30) days before the hearing shall constitute good cause for a continuance.

b) **Limits on Discovery**

   The right by either party to inspect and copy documents does not extend to confidential information referring to individually identifiable Practitioners other than the Practitioner under review, and does not create any obligation to modify or create documents in order to satisfy a request for information.

c) **Discovery Disputes**

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

   1) Whether the information sought may be introduced to support or defend the charges;

   2) The exculpatory or inculpatory nature of the information sought, if any;

   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.

9.5-6 **PRE-HEARING DOCUMENT AND WITNESS EXCHANGE**

   At the request of either party, the parties must exchange all documents that will be introduced at the hearing, and a list of all witnesses expected to testify, at least ten (10) days prior to the start of the hearing. A failure to comply with this rule is good cause for the Hearing Officer to grant a continuance.

9.5-7 **PROCEDURAL DISPUTES**

   Both parties have a duty to exercise reasonable diligence in notifying the Hearing Officer of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, so that decisions concerning such matters may be made expeditiously. Objection to any such prehearing decisions shall be raised at the hearing, and shall be preserved for consideration during any appellate review, if applicable.

9.5-8 **RECORD OF THE HEARING**

   A certified shorthand reporter shall be present to maintain a record of the hearing. The cost of such a reporter's presence shall be borne by the Hospital; however, the cost of any transcript shall be borne by the party requesting it. The Judicial Review Committee may, but shall not be required to, order that oral evidence be taken only under oath administered by a properly authorized individual.
9.5-9 LEGAL REPRESENTATION

a) The hearings provided for in these Bylaws shall be for the purpose of intra-professional resolution of matters bearing upon conduct or professional competency. Neither party shall be entitled to representation by legal counsel at the hearing unless the Judicial Review Committee, in its sole discretion, permits both parties to be represented by legal counsel, at each party’s own expense. The foregoing shall not be deemed to deprive any party of its right to the assistance of legal counsel for the purpose of preparing for the hearing.

b) The Medical Executive Committee shall not be represented by an attorney at the hearing unless the Practitioner is represented by an attorney.

c) Regardless of legal representation, the Practitioner shall be entitled to be accompanied by another Practitioner, licensed to practice in the State of California, who is not also an attorney, and who is, preferably, a Member in good standing of the Medical Staff.

9.5-10 RIGHTS OF THE PARTIES

During a hearing, each party shall have the right to: call, examine, and cross-examine witnesses for relevant testimony; introduce and rebut relevant exhibits or other documents; present oral opening and closing statements; submit a written memorandum concerning any issue of procedure, law or fact at any time prior to the conclusion of oral testimony, which shall become part of the hearing record; and to submit a closing written statement.

9.5-11 PRESENTING EVIDENCE

a) The Practitioner may be called at any time as a witness for the Medical Executive Committee and be examined as if under cross-examination.

b) The members of the Judicial Review Committee may examine the witnesses during the hearing. The Judicial Review Committee may, at its sole discretion, request the voluntary presence of additional witnesses for examination.

c) The Medical Executive Committee may object to the introduction of evidence that was not provided by the Practitioner, despite requests for such information, during the appointment, reappointment or corrective action process underlying the adverse recommendation or action. The evidence 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 at the time it was requested.

d) The rules of law relating to the examination of witness and to the presentation of evidence shall not apply during any hearing conducted under this Article. Any relevant evidence, including hearsay, shall be admitted by the Hearing Officer if it is the sort of evidence upon which reasonable persons customarily rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. It is the intent of this provision that evidentiary disputes, with the exception of disputes involving privileged or otherwise confidential information, be resolved in favor of admissibility, with the Judicial Review Committee deciding the appropriate weight to be accorded all of the evidence.
9.5-12 BURDEN OF PROOF

a) The Medical Executive Committee shall have the initial duty to present evidence which supports the Notice of Charges.

b) Initial Applicants: The applicant shall bear the burden of persuading the Judicial Review Committee by a preponderance of the evidence of his or her qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning his or her current qualifications for staff privileges, membership, or employment. Initial applicants shall not be permitted to introduce information not produced upon request during the application process, unless the initial applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

c) All Other Hearings: The Medical Executive Committee shall bear the burden of persuading the Judicial Review Committee, by a preponderance of the evidence, that its actions or recommendations were reasonable and warranted.

9.5-13 ADJOURNMENT AND CONCLUSION

The Hearing Officer may adjourn the hearing and may reconvene the same, without special notice. Following the presentation of all oral and written evidence and argument by both the Medical Executive Committee and the Practitioner, the hearing shall be closed. Closing written arguments, if any, shall be due to the Judicial Review Committee within thirty (30) days of the final hearing session.

9.5-14 DECISION OF THE HEARING COMMITTEE

a) Deliberations

Following the adjournment and conclusion of the hearing, the Judicial Review Committee shall conduct its deliberations outside the presence of any other parties, except the Hearing Officer.

b) Basis for the Decision

The decision of the Judicial Review 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.

c) Decision of the Hearing Committee

Within thirty (30) days after final adjournment of the hearing, or the receipt of closing written arguments, if any, the Judicial Review Committee shall render a written Decision and Report. The Decision and Report shall include findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached by the Judicial Review Committee. Copies of such Decision and Report shall be delivered to the Medical Executive Committee, Chief Executive, Governing Body, and Practitioner. The Decision and Report shall provide a written explanation of the procedure for appealing the Judicial Review Committee’s Decision. The Decision of the Judicial Review Committee shall be considered final, subject only to such rights of appeal or Governing Body review as described in the Bylaws.
9.6 APPELLATE REVIEW

9.6-1 TIME FOR APPEAL

Within thirty (30) days after receiving the decision of the Judicial Review Committee, either party may request an appellate review. A written request for such a review shall be delivered to the Chief of Staff, Chief Executive, and other party to the hearing and specify the ground(s) for appeal. If an appellate review is not requested within such time period, the action or recommendation of the Judicial Review Committee shall become the final action of the Medical Staff. The Governing Body shall consider the Judicial Review Committee’s decision and take final action within forty-five (45) days.

9.6-2 GROUNDS FOR APPEAL

The grounds for appeal from the hearing shall be:

a) Substantial non-compliance with the procedures required by these Bylaws or applicable law, so as to deny a fair hearing;

b) The decision was not supported by substantial evidence based on the hearing record; and/or

c) Action was taken arbitrarily, unreasonably, or capriciously.

9.6-3 TIME, PLACE AND NOTICE

Within thirty (30) days of receiving a request for appellate review, the Governing Body shall schedule a review date and cause each side to be given notice of the time, place, and date of the appellate review.

The appellate review shall commence no earlier than thirty (30) days and no more than ninety (90) days from the date of receipt of the appellate review request. However, when a request for appellate review concerns a Member who is under summary suspension that is currently in effect, the appellate review should commence as soon as practically possible, but no later than forty-five (45) days from the date of receipt of the request for appellate review.

9.6-4 APPEAL BOARD

The full Governing Body shall sit as an Appeal Board during any appellate review, unless the Governing Body appoints an ad hoc committee, which shall consist of at least four (4) members of the Governing Body. Knowledge of the matter involved shall not preclude any person from serving as a member of the Appeal Board, so long as that person did not take part in a prior hearing on the same matter. The Appeal Board may select an attorney to assist it in the proceeding. If an attorney is selected, he or she may act as an appellate Hearing Officer and shall have all the authority of and carry out all the duties assigned to a Hearing Officer as described in Section 9.5-2. That attorney shall not be entitled to vote with respect to the appeal. The Appeal Board shall have such powers as are necessary to discharge its responsibilities.

9.6-5 APPELLATE REVIEW PROCEDURE

The proceeding by the Appeal Board shall be an appellate hearing based upon the record of the hearing before the Judicial Review Committee, provided that the Appeal Board may accept additional oral or written evidence, subject to a foundational showing
that such evidence could not have been made available in the exercise of reasonable
diligence, and subject to the same rights of cross-examination or confrontation provided
at the hearing. Each party shall have the right to be represented by legal counsel or any
other representative designated by that party on appeal. The appealing party shall submit
a written statement concisely stating the specific grounds for appeal. In addition, each
party shall have the right to present a written statement in support of his, her or its
position on appeal, in accordance with reasonable time frames that may be established
by the appellate Hearing Officer or, if there is no Hearing Officer, the Appeal Board.
Each party has the right to personally appear and make oral argument. The Appeal
Board may then deliberate outside the presence of both parties.

9.6-6 DECISION OF THE APPEAL BOARD

Within forty-five (45) days, or if the Practitioner is currently under summary suspension,
within thirty (30) days, after the appeal has been submitted to the Appeal Board for
deliberation and decision, the Appeal Board shall render a written Decision, affirming,
modifying or reversing the Decision and Report of the Judicial Review Committee. The
Appeal Board may, in its sole discretion, remand the matter to the Judicial Review
Committee or to some other committee or person for further review and recommendation.
A copy of the Decision of the Appeal Board shall be delivered to the Medical Executive
Committee and the Practitioner.

9.6-7 FINAL DECISION OF THE GOVERNING BODY

a) Unless the Appeal Board remands the matter for further review and
recommendation, the Decision of the Appeal Board shall not be subject to any
further intra-organizational review. If the matter is remanded for further review
and recommendation, the remand process (including the time required for a
Remand Report to be returned to the Governing Body) shall take no longer than
forty-five (45) days, unless the parties stipulate, or the Governing Body orders,
that the process may take some longer period of time.

b) Upon receipt of the Appeal Board’s Decision, or a Remand Report, as applicable,
the Governing Body shall have fifteen (15) days within which to render a final
written decision affirming, modifying or reversing the Appeal Board Decision or
Remand Report. The Governing Body’s written decision shall be final, effective
immediately, and shall not be subject to any further intra-organizational review.
A copy of the Governing Body’s Final Decision shall be delivered to the
Practitioner, Medical Executive Committee, and Chief Executive.

9.6-8 POSTPONEMENTS AND EXTENSIONS

Postponements and extensions of time beyond the time expressly permitted within
Section 9.6 may be requested by either party and shall be authorized by the Appeal
Board upon a showing of good cause.

9.7 INDEPENDENT ACTION BY THE GOVERNING BODY

If any action of the Governing Body gives rise to any procedural rights under these Bylaws, all
Notice and fair hearing requirements set forth in this Article IX shall be afforded the Practitioner
by the Governing Body rather than the Medical Executive Committee. In such instance, there
shall be no right of Appellate Review, as set forth in Section 9.6. Rather, the Decision and Report
of the Judicial Review Committee shall be transmitted to the Governing Body and considered for
a Final Decision as set forth in Section 9.6-7.
9.8 **RIGHT TO ONE HEARING**

Notwithstanding any other provision of these Bylaws, no Practitioner shall be entitled, as a matter of right, to more than one evidentiary hearing and/or one appellate review on any matter which shall have been the subject of an adverse recommendation or action.

**ARTICLE X**

**DEPARTMENTS AND DIVISIONS**

10.1 **ORGANIZATION OF DEPARTMENTS**

The Medical Staff shall be divided into Departments. Each Department shall be organized as an integral unit of the Medical Staff and shall have a Chair and a Vice-Chair who shall be selected and have the authority, duties and responsibilities, specified in this Article and the Rules and Regulations. The creation, elimination or combination of any Department(s) is subject to the requirements for amending these Bylaws, as set forth in Article XVI. Departments may also form Divisions, as described below.

10.2 **CURRENT DEPARTMENTS**

The current Departments are as follows:

10.2-1 The Department of Medicine (including all recognized medical subspecialties and also including, but not limited to, dermatology, family medicine, radiology, emergency medicine, physical medicine, and rehabilitation).

10.2-2 The Department of Surgery (including all recognized surgical subspecialties and also including, but not limited to, podiatry, dentistry, oral surgery, anesthesiology and pathology).

10.2-3 The Department of Obstetrics-Gynecology.

10.2-4 The Department of Pediatrics.

10.3 **ASSIGNMENT TO DEPARTMENTS AND DIVISIONS**

Each Member shall be assigned to one Department and one Division, if applicable, within the Department. However Members may be granted Clinical Privileges within other Departments and/or Divisions. The exercise of Clinical Privileges within each Department and Division shall be subject to the Rules and Regulations thereof, and the authority of the Department Chair and, where applicable, the Division Chief.

10.4 **FUNCTIONS OF DEPARTMENTS**

The Departments shall fulfill the clinical, administrative, quality improvement/risk management/utilization management, and collegial and educational functions set forth below.

When the Department, any of its committees, and/or any of its Divisions meet to carry out their duties, the meeting body shall constitute a peer review committee, which is subject to the standards and entitled to all the protections and immunities afforded by federal and state law for peer review committees. Each Department, its committees, and/or its Divisions must meet regularly to carry out their assigned duties.

A Department’s specific functions shall include:
10.4-1 Formulating Departmental Rules and Regulations in accordance with Section 15.1-2.

10.4-2 Conducting concurrent and retrospective patient care reviews, including blood usage review and surgical indications monitoring. Each Department shall review all of the clinical care performed under its jurisdiction by all Department members and non-members holding Clinical Privileges or Practice Privileges therein. If concerns about the provision of patient care are identified, each Department shall take corrective action, and shall evaluate the effectiveness of such action once taken.

10.4-3 Convening at least six (6) meetings each year, to review and act upon reports of the Department’s clinical performance review and other activities, and the activities of the Medical Staff.

10.4-4 Submitting regular reports to the Medical Executive Committee on the Department's: (a) clinical performance review activities, (b) recommendations for maintaining and improving quality of care in the Department and the Hospital, and (c) any other Departmental activities.

10.4-5 Establishing criteria for obtaining Clinical Privileges or Practice Privileges in the Department, and submitting the Departmental recommendations described by these Bylaws, such as recommendations about a Practitioner’s appointment, reappointment, privileging and/or corrective action.

10.4-6 Coordinating the patient care provided by those exercising Clinical Privileges or Practice Privileges in the Department with the nursing, ancillary patient care, and administrative support services.

10.4-7 Monitoring Departmental adherence to: (a) Medical Staff and Hospital policies and procedures, (b) requirements for alternate coverage and consultations, and (c) sound principles of clinical practice.

10.4-8 Establishing such committees or other mechanisms as required for the Department to perform its duties.

10.4-9 Conducting, participating and making recommendations regarding Continuing Medical Education programs relevant to Departmental clinical practice.

10.5 DEPARTMENT CHAIR AND VICE CHAIR

10.5-1 QUALIFICATIONS

Each Department Chair and Vice-Chair 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, and shall be willing and able to faithfully discharge the functions of his or her office.

10.5-2 RESPONSIBILITIES OF THE DEPARTMENT CHAIR

The duties of each Department Chair are as follows:

a) Oversee and report to the Medical Executive Committee and the Chief of Staff regarding all clinically related and administrative activities within the Department;

b) Act as the presiding officer at all Department meetings;
c) Be a member of the Medical Executive Committee, give guidance on the overall medical policies of the Hospital, and make specific recommendations and suggestions regarding the Department;

d) Ensure continual review of the professional performance of those holding Clinical Privileges or Practice Privileges in the Department, maintain quality control programs, and report regularly thereon to the Medical Executive Committee;

e) Submit the Departmental recommendations as required by the Bylaws or Rules and Regulations including, without limitation, appointment/reappointment, privileging and corrective action recommendations, as well as criteria for Clinical Privileges or Practice Privileges that are relevant to the care provided in the Department;

f) Develop and implement policies and procedures that guide and support the provision of care, treatment, and services, and oversee the Department’s compliance with, and enforcement of, the Bylaws, Rules and Regulations and Policies of the Hospital;

g) Implement, within the Department, actions taken by the Medical Executive Committee or the Governing Body;

h) Participate in every phase of the administration of the Department, and work cooperatively with the nursing service, Hospital administration, and other Departments and services, on all matters that affect the quality and efficiency of patient care provided within the Department and the Hospital;

i) Make recommendations regarding space requirements, staffing levels, performance of personnel, supplies, special regulations, standing orders and techniques;

j) Ensure orientation of personnel in the Department and recommend continuing medical education programs that will ensure improvements in the quality of patient care at the Hospital;

k) Recommend to organizational authorities external care, treatment, and service facilities for patients, if necessary; and

l) Perform other such duties as may be delegated under the Bylaws.

10.5-3 RESPONSIBILITIES OF THE VICE-CHAIR

The duties of each Department Vice-Chair are to assist the Chair in the duties described above, and any other such duties as may be delegated under these Bylaws. In the absence of a Department Chair, the Vice-Chair shall assume the Chair’s authority, duties and responsibilities.

10.5-4 SELECTION

a) The Department Chair shall be elected every two (2) years, in an election conducted as follows:

1) At least sixty (60) days prior to the Department meeting at which the election will commence, the Department Chair shall appoint a
Nominating Committee of three (3) members. The Nominating Committee shall identify one or more nominees for the position of Chair.

2) At least twenty (20) days prior to the Department meeting at which the election will commence, the Nominating Committee shall circulate its nominee(s) to the Department Members eligible to vote.

3) At the Department meeting at which the election will commence, nominations may be made from the floor by Department Members eligible to vote, as long as the nominee is present and consents to the nomination.

4) Immediately following such Department meeting, a written mail ballot shall be sent to each Department Member eligible to vote. Such ballots shall bear an authenticating mark, shall include a self-addressed return envelope, and shall identify the date by which the ballot must be returned, which date shall be at least fifteen (15) days from the date the ballot is issued.

5) Only ballots bearing the authenticating mark that are returned on or before the stated return date shall be counted. In order for the vote to be tallied, valid ballots must be received from at least one-half (1/2) of the Department Members eligible to vote.

6) A nominee shall be elected upon receiving a majority of the valid votes cast. If no nominee receives a majority vote on the first ballot, a run-off ballot shall be held promptly between the two nominees receiving the highest number of votes. In the case of a tie on the second ballot, a majority vote of the Medical Executive Committee shall decide the election by secret written ballot at a special meeting called for that purpose.

7) Election of Department Chairs shall be subject to ratification by the Medical Executive Committee.

b) The Department Vice-Chair shall be selected by the newly elected Department Chair within each Department.

10.5-5 TERM OF OFFICE

Each Department Chair and Vice Chair shall serve a two (2) year term coinciding with the Medical Staff year or until his or her successor is chosen, unless he or she shall sooner resign, be removed from office, or lose his or her Medical Staff membership or Clinical Privileges in that Department, which shall result in the automatic termination of the Officer’s term of service. Department Chairs shall be eligible to succeed themselves.

10.5-6 REMOVAL FROM OFFICE

a) 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 petition of at least one-third (1/3) of the Department Members eligible to vote.
b) If removal is initiated by the Medical Executive Committee, it may choose to put the removal to a vote by the Department, or it may remove the Officer by majority vote.

c) If removal is to be voted on by the Department, such vote shall be conducted by written mail ballot, which shall be sent to each Department Member eligible to vote within 45 days after removal has been sought. Such ballots shall bear an authenticating mark, shall include a self-addressed return envelope, and shall identify the date by which the ballot must be returned, which date shall be at least twenty-one (21) days from the date the ballot is issued. The removal of a Department Officer shall become effective if valid ballots are received from at least one-half (1/2) of the Department Members eligible to vote, and if such removal is approved by two-thirds (2/3) of the valid ballots cast.

10.5-7 VACANCIES IN OFFICE

a) Department Chair

If a vacancy occurs in the office of Chair, the Vice-Chair shall complete the term as Department Chair for a maximum interim period of ninety (90) days until a special election can be held. The interim Chair shall remain eligible for nomination to the office of Chair for the next term. When the Department Vice-Chair must fill a vacancy in the office of Department Chair, he or she shall immediately appoint a new Department Vice-Chair to complete his or her term.

b) Department Vice-Chair

If a vacancy occurs in the office of Vice-Chair, the Chair shall appoint a new Vice-Chair to complete the term.

10.6 DEPARTMENTAL DIVISIONS

10.6-1 ORGANIZATION OF DIVISIONS

The delineation of Division(s) in a Department, if any, shall be set forth in that Department’s Rules and Regulations. The creation, elimination or combination of any Division(s) is subject to the requirements for amending the Departmental Rules and Regulations, as set forth in Section 15.1-2.

10.6-2 FUNCTIONS OF DIVISIONS

Each Division shall perform the functions delegated to it, which may include, without limitation: retrospective patient care assessment, continuous monitoring of patient care practices, conduct of continuing education programs, and recommendation to the Department Chair regarding requests for Clinical Privileges or Practice Privileges. Each Division shall transmit regular reports to its Department Chair regarding the conduct of its assigned functions.

10.6-3 DIVISION CHIEFS

a) Qualifications

Each Division Chief shall be an active Medical Staff Member; a member of the Division; qualified by training, experience and demonstrated ability in the clinical area covered by the Division; and willing and able to faithfully discharge the functions of his or her office.
b) Responsibilities

1) The duties of each Division Chief are as follows: Oversee and report to the Department Chair regarding the operation of, and the clinical work performed in, the Division.

2) Develop and implement programs to carry out the quality review, assessment and monitoring functions delegated to the Division.

3) Transmit to the Department Chair the Division’s recommendations regarding such things as the delineation of Clinical Privileges and Practice Privileges in the Division.

4) Preside over all Division meetings.

5) Perform such other duties as may be delegated in accordance with the Bylaws.

c) Selection

Each Division Chief shall be appointed by the Department Chair after first consulting with the members of the Division.

d) Term of office; removal; vacancies

Each Division Chief shall serve a two (2) year term coinciding with the Medical Staff year or until a successor has been appointed, unless he or she shall sooner resign, be removed from office, or lose his or her Medical Staff membership or Clinical Privileges in that Department or Division, which shall result in the automatic termination of the Chief’s term of service.

Division Chiefs may serve up to two (2) successive full terms, after which they may not serve for at least one (1) intervening term. The Medical Executive Committee may grant exceptions to such term limits, in its sole discretion.

A Division Chief may be removed by a majority vote of either the Department’s Supervisory Committee or the Medical Executive Committee. If a vacancy should occur in the office of a Division Chief, a new Division Chief immediately shall be appointed by the Department Chair after first consulting with the members of the Division.

ARTICLE XI

MEDICAL STAFF OFFICERS

11.1 OFFICERS OF THE MEDICAL STAFF

11.1-1 IDENTIFICATION

The Officers of the Medical Staff shall be the Chief of Staff, the Immediate Past Chief of Staff or the Chief of Staff-Elect (whichever is in office), and the Secretary-Treasurer.
11.1-2 QUALIFICATIONS

a) Officers must be Members of the Active Staff at the time of nomination and election, and must remain Active Staff members in Good Standing during the entire term of office. Failure to maintain such status shall create an immediate vacancy in that office.

b) Medical Staff Officers shall not have any significant conflict of interest with regard to their activities or responsibilities to act/serve on behalf of the Medical Staff. All nominees for election or appointment as Medical Staff Officers shall, at least twenty (20) days prior to the date of election or appointment, disclose in writing to the MEC 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 to act on behalf of the Medical Staff. The MEC shall evaluate the significance of such disclosures and discuss them with the nominee. If a candidate for a Medical Staff Officer position is nominated from the floor during the General Medical Staff Meeting, then that candidate shall verbally disclose his or her conflicts at the meeting. The MEC shall have the opportunity to verbally comment on such a conflict at the General Medical Staff Meeting. 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.

11.1-3 ELECTIONS

Each year, an election shall be held to fill the Medical Staff Officer positions and Medical Executive Committee Member-at-Large positions that will become vacant at the end of the year. Such elections shall be conducted as follows:

a) A Nominating Committee composed of the Chief of Staff, the Chief of Staff-Elect or Immediate Past Chief of Staff (whichever is in office) and the Chair of each Department shall nominate at least two candidates to fill each Medical Staff Officer and Medical Executive Committee Member-at-Large position that will become vacant. The Nominating Committee’s slate of nominees shall be mailed to each Member of the Active Staff at least twenty-one (21) days prior to the third general Medical Staff meeting of the year, which shall be held no later than the first (1st) day of November.

b) During the third general Medical Staff meeting of the year, any additional nominations shall be received from the floor.

c) Immediately following the third general meeting, a written mail ballot shall be sent to each Active Staff member and the votes shall be tallied in accordance with Section 13.5-3.

d) A nominee shall be elected upon receiving a majority of the valid votes cast. If, for any position, no nominee receives a majority vote on the first ballot, a run-off ballot shall be held promptly between the two nominees receiving the highest number of votes. In the case of a tie on the second ballot, a majority vote of the Medical Executive Committee shall decide the election by secret written ballot at a special meeting called for that purpose.

e) Chief of Staff:
The Chief of Staff shall not be selected by election, as set forth in this section. Rather, the Chief of Staff-Elect, upon completion of the term of office in that position, immediately shall ascend to the office of Chief of Staff.

Should a currently seated Chief of Staff wish to serve a second term in that position, he or she shall run for the Chief of Staff-Elect position in the election occurring during year one of his or her first term as Chief of Staff. A Chief of Staff who is elected for a second term shall serve as both Chief of Staff and Chief of Staff-Elect during year two of his or her first term as Chief of Staff, and then as Chief of Staff for an additional two-year term.

f) Immediate Past Chief of Staff: The Immediate Past Chief of Staff shall not be selected by election, as set forth in this section. Rather, the Chief of Staff, upon completion of the term of office in that position, immediately shall ascend to the office of Immediate Past Chief of Staff.

Should the Chief of Staff who succeeds the Immediate Past Chief of Staff be re-elected for a second term as Chief of Staff, the Immediate Past Chief of Staff shall continue to serve until another Chief of Staff-Elect takes office.

11.1-4 TERM OF OFFICE

Except as otherwise provided in these Bylaws, all Medical Staff Officers and Medical Executive Committee Members-at-Large shall begin their term on the first day of the Medical Staff Year following their election, and shall serve until the end of the term listed below, or until a successor has been elected, unless they sooner have resigned or been removed from office.

The term of each elected position is as follows:

a) Chief of Staff: Two (2) years.

b) Immediate Past Chief of Staff: One (1) year, and until a Chief of Staff-Elect takes office.

c) Chief of Staff-Elect: One (1) year.

d) Secretary-Treasurer: Two (2) years.

e) Medical Executive Committee Member-at-Large: Two (2) years.

Except as otherwise provided in these Bylaws, no Officer may serve more than two successive terms in any particular office.

11.1-5 REMOVAL OF OFFICERS

a) Medical Staff Officers may be removed from office for valid cause, including but not limited to, failure to carry out the duties of his or her office, gross neglect or misfeasance of office, or serious acts of moral turpitude.

b) Except as otherwise provided, the removal of a Medical Staff Officer may be initiated by the Medical Executive Committee or by a written petition of at least one-third (1/3) of Active Staff members eligible to vote for Officers. Prior to calling for a vote on the proposed removal, a special meeting of the Medical Staff shall be called for consideration thereof.
c) Any vote on the removal of Officers must be conducted by written mail ballot. In order for the vote to be tallied, valid ballots must be received from at least a quorum of the Active Staff in accordance with Section 13.5-3.

d) Removal shall be effected by a majority vote of the valid ballots actually cast.

11.1-6 VACANCIES IN OFFICE

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

a) A vacancy in the office of Chief of Staff shall be filled by the Chief of Staff-Elect, or the Immediate Past Chief of Staff (whichever is in office). Whenever the vacancy is filled by the Chief of Staff-Elect, he or she shall continue to serve as the Chief of Staff for the next term.

b) A vacancy in the office of Chief of Staff-Elect, shall be filled by a special election conducted in accordance with the requirements for annual elections of Medical Staff Officers, including nomination by the Nominating Committee.

c) A vacancy in the office of Secretary-Treasurer or any Member-at-Large position of the Medical Executive Committee shall be filled by the Medical Executive Committee.

d) A vacancy in the office of Immediate Past Chief of Staff need not be filled, except that the Medical Executive Committee may appoint one or more qualified successors to serve as the Chair or a member of any committee to which the Immediate Past Chief of Staff automatically is appointed pursuant to these Bylaws.

11.2 DUTIES OF MEDICAL STAFF OFFICERS

11.2-1 CHIEF OF STAFF

The Chief of Staff shall serve as the Chief Executive Officer of the Medical Staff. The duties of the Chief of Staff shall include, but are not limited to:

a) Coordinate and cooperate with the Chief Executive in all matters of mutual concern within the Hospital;

b) Call, preside at, and be responsible for the agenda of, all general meetings of the Medical Staff;

c) Serve as Chair of the Medical Executive Committee and the Nominating Committee;

d) Serve as an ex-officio member of all other Medical Staff committees, without a vote, unless his or her membership on a particular committee is required by these Bylaws;

e) Ensure the Medical Staff's compliance with, and enforcement of, the Bylaws, Rules and Regulations, Policies, and all other standards, policies and rules of the Hospital;

f) Appoint the Chairs of any Medical Staff committees, except as otherwise provided in these Bylaws;
g) Serve as a member of the Governing Body in such capacity as may be permitted or required by the Hospital’s Bylaws;

h) Present the views, policies, needs and grievances of the Medical Staff to the Governing Body and Chief Executive;

i) Present the policies of the Governing Body to the Medical Staff;

j) Be a spokesperson for the Medical Staff in external professional and public relations;

k) Oversee the interaction of performance improvement and peer review functions of the Medical Staff;

l) Be accountable to the Governing Body, in conjunction with the Medical Executive Committee, for the effective performance, by the Medical Staff, of its responsibilities with respect to quality and efficiency of clinical services within the Hospital and for the effectiveness of the quality assurance and utilization review programs; and

m) Perform other such functions as may be assigned to him or her by these Bylaws, the Medical Staff or the Medical Executive Committee.

11.2-2 CHIEF OF STAFF-ELECT

The Chief of Staff-Elect, in the absence of the Chief of Staff, shall assume all duties and all authority of the Chief of Staff. The Chief of Staff-Elect shall be a member of the Medical Executive Committee, the Nominating Committee and the Joint Conference Committee, and shall perform such other duties as may be delegated by the Bylaws and/or the Medical Executive Committee.

11.2-3 IMMEDIATE PAST CHIEF OF STAFF

Until a Chief of Staff-Elect takes office, the Immediate Past Chief of Staff, in the absence of the Chief of Staff, shall assume all duties and all authority of the Chief of Staff. The Immediate Past Chief of Staff shall be a member of the Medical Executive Committee, the Nominating Committee and the Joint Conference Committee, and shall perform such other duties as may be delegated by the Bylaws and/or the Medical Executive Committee.

11.2-4 SECRETARY-TREASURER

The Secretary-Treasurer shall be a member of the Medical Executive Committee. The Secretary-Treasurer’s duties shall include, but are not limited to:

a) Maintain a Medical Staff membership roster;

b) Keep accurate and complete minutes of all Medical Executive Committee and Medical Staff meetings;

c) Call meetings on the order of the Chief of Staff;

d) Attend to correspondence;

e) Receive, safeguard, and be accountable for, all funds of the Medical Staff;
f) Supervise the Medical Executive Committee’s formulation of an annual Medical Staff budget;

g) Assume all duties and all authority of the Chief of Staff in the event both the Chief of Staff, and the Chief of Staff-Elect or the Immediate Past Chief of Staff (whichever is in office), are absent; and,

h) Perform such other duties as ordinarily pertain to the office or as may be delegated by the Bylaws and/or the Medical Executive Committee.

ARTICLE XII

COMMITTEES

12.1 GENERAL

12.1-1 DESIGNATION

a) The MEC and other committees described in these Bylaws and the Rules and Regulations shall be the standing committees of the Medical Staff. Special or ad hoc committees may be created by the MEC to perform specified tasks. Any committee that is carrying out any function or activity required by these Bylaws is deemed a duly appointed and authorized committee of the Medical Staff. Medical Staff committees shall be responsible to the Medical Executive Committee.

b) Any standing committee may use subcommittees to help carry out its duties. The MEC shall be informed when a subcommittee is appointed. The committee chair may appoint individuals in addition to, or instead of, members of the standing committee to the subcommittee, after consulting the Chief of Staff regarding Medical Staff members and the Chief Executive regarding hospital staff.

12.1-2 TERM OF SERVICE AND APPOINTMENT/REMOVAL OF COMMITTEE MEMBERS

a) Term of Service

Except as otherwise provided in these Bylaws, committee members (including committee chairs) shall serve for a term of one year, unless they have resigned or been removed from the committee. The term shall begin on the first day of the Medical Staff Year following their appointment. Committee members shall be entitled to serve for successive terms.

b) Appointment of Members

1) Any Medical Staff committee is created and composed in accordance with the Bylaws and Rules and Regulations. Except as otherwise provided in the Bylaws, committees established to perform Medical Staff functions required by the Bylaws may include Practitioners in any category of Medical Staff membership, AHPs, representatives from Hospital Departments such as administration, nursing services, or health information services, representatives of the community, and persons with special expertise, as deemed necessary to discharge the functions of the committee.
2) Unless otherwise specified, the Chair and members of any standing committee shall be appointed by the Chief of Staff, subject to consultation with and approval by the Medical Executive Committee. In the case of ad-hoc committees, the Chief of Staff shall appoint the Chair, who shall appoint the rest of the committee members.

3) Unless otherwise specified, the Chair and the members of the committee shall have full voting rights.

4) The Chief Executive or his or her designee, in consultation with the Chief of Staff, shall appoint any non-Medical Staff members, as deemed necessary to discharge the functions of the committee.

5) The Committee Chair, after consulting with the Chief of Staff and Chief Executive may use outside consultants or special advisors, as deemed necessary to discharge the functions of the committee.

6) 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.

7) The Chief of Staff and Chief Executive, or their respective designees, are ex officio members of all standing and special committees of the Medical Staff, with voting rights, unless otherwise stated in the Bylaws, Rules and Regulations or resolution creating the committee.

c) Removal of Committee Members:

1) General Rule: Any committee member, including the Committee Chair, may be removed by a majority vote of the Medical Executive Committee.

2) Exceptions:

Any committee member, including the Committee Chair, who is appointed by a Department Chair may be removed by a majority vote of either the respective Department or the Medical Executive Committee.

Any committee member who is appointed by the Chief Executive may be removed by the Chief Executive or a majority vote of the Medical Executive Committee.

Any subcommittee member who is appointed by a Committee Chair may be removed by the Committee Chair or a majority vote of the Medical Executive Committee.

12.1-3 VACANCIES

Unless otherwise specified in these Bylaws, vacancies on any Committee shall be filled in the same manner in which the original appointment to the committee was made.

12.1-4 CONDUCT AND RECORDS OF MEETINGS

Committee meetings shall be conducted and documented in the manner specified in Article XIII.
12.2  MEDICAL EXECUTIVE COMMITTEE

12.2-1  COMPOSITION

The Medical Executive Committee shall be composed of:

a)  The Officers of the Medical Staff;

b)  The Chairs of the Departments;

c)  Four Members-at-Large, elected from the Active Staff in staggered terms, such that two are elected each year;

d)  A representative from each of the following Hospital services: anesthesiology, pathology, radiology, pulmonary medicine, emergency medicine, cardiology, and hospitalist:

   1)  Each year, the Chief of Staff shall designate, on a rotating basis, which one of the representatives from anesthesiology, pathology or radiology, and which one of the representatives from pulmonary medicine, emergency medicine, cardiology or the hospitalist service, will serve as full voting members of the Medical Executive Committee;

   2)  The remaining representatives not so designated shall serve in a non-voting capacity; and

e)  The Director of Continuing Medical Education and the physician members of the Governing Body (each of whom shall serve in a non-voting capacity).

The Chair of the Quality Management Committee and the Chief Executive may attend each meeting of the Medical Executive Committee in a non-voting capacity.

The Chief of Staff shall serve as the chair of the Medical Executive Committee.

12.2-2  OFFICERS

The Chief of Staff, the Chief of Staff-Elect or the Immediate Past Chief of Staff (whichever is in office), and the Secretary-Treasurer of the Medical Staff shall serve as the Chair, Vice-Chair and Secretary-Treasurer, respectively, of the Medical Executive Committee.

12.2-3  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 the broad delegation of authority, the Medical Executive Committee shall perform in good faith the duties listed below

a)  Representing, and acting on behalf of, the Medical Staff between Medical Staff meetings;

b)  Receiving and acting upon Department and Committee reports and recommendations;

c)  Coordinating and implementing the professional and organizational activities and policies of the Medical Staff;
d) Providing liaison between the Medical Staff and both the Chief Executive and the Governing Body;

e) Making recommendations to the Chief Executive regarding action(s) to be taken on medico-administrative matters;

f) Making recommendations to the Governing Body (through the Chief Executive and the Joint Conference Committee) regarding Hospital management (including long-range planning) matters;

g) Being responsible/accountable on behalf of the Medical Staff to the Governing Body for the adequacy and the quality of the medical care rendered to patients in the Hospital;

h) Keeping the Medical Staff informed regarding the accreditation program, and the accreditation status, of the Hospital;

i) Conducting the review, and making the recommendations, required under Articles V, VI and VII;

j) Reviewing periodically all information available concerning such things as the performance and the clinical competence of Medical Staff members, other Practitioners, and AHPs with Practice Privileges, and, based upon such reviews, making recommendations regarding reappointment and renewal, or changes in, Clinical or Practice Privileges;

k) Taking all reasonable steps to assure professionally ethical conduct and competent clinical performance on the part of all Medical Staff members, other Practitioners and AHPs with practice privileges including, whenever necessary, initiating, and/or participating in, Medical Staff reviews and/or the taking of corrective measures;

l) Making the determinations regarding dues, fees and expenditures described in Section 15.3;

m) Formulating each year (under the supervision of the Secretary-Treasurer) a Medical Staff budget;

n) Making a report at all general meetings of the Medical Staff;

o) Performing such other duties as may be delegated to it by the Medical Staff or the Bylaws;

p) Taking reasonable steps to develop continuing medical education (CME) activities and an overall CME program for the Medical Staff;

q) Designating such Committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the Medical Staff;

r) Appointing such special or ad hoc Committees as may be necessary or appropriate to assist the Medical Executive Committee in carrying out its functions and those of the Medical Staff;

s) With the Department Chairs, set departmental objectives for establishing, maintaining and enforcing professional standards within the hospital and for the
continuing improvement of the quality of care rendered in the hospital; assist in developing programs to achieve these objectives including, but not limited to, Ongoing Professional Practice Evaluations, Performance Evaluation and Monitoring;

t) Affirmatively implementing, enforcing and safeguarding the self-governance rights of the Medical Staff to the fullest extent permitted by law. Such rights of the Medical Staff include, without limitation:

1) Initiating, developing and adopting Bylaws, Rules and Regulations, and amendments thereto, subject to the approval of the Governing Body, which approval shall not be unreasonably withheld;

2) Selecting and removing Medical Staff Officers;

3) Assessing Medical Staff dues and utilizing such funds as appropriate for the purposes of the Medical Staff;

4) Retaining and being represented by independent legal counsel at the expense of the Medical Staff;

5) Establishing, in the Bylaws and Rules and Regulations, criteria and standards for Medical Staff membership and Clinical Privileges, and for enforcing those criteria and standards;

6) Establishing, in the Bylaws and Rules and Regulations, clinical criteria and standards to oversee and manage quality assurance, utilization review and other Medical Staff activities including, but not limited to, periodic meetings of the Medical Staff and its committees and Departments and review and analysis of patient medical records;

7) Taking such action as appropriate to prohibit against retaliation directed towards a Member;

8) Taking such other steps as appropriate to meet and confer in good faith to resolve disputes with the Governing Body, or any other person or entity, regarding any self-governance rights of the Medical Staff; and

9) After having met and conferred in good faith to remedy any dispute under subsection(s) of this section, exercising its discretion as appropriate to resolve the dispute, up to and including resort to resolution of the matter in the courts as permitted by law.

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

12.2-4 MEETINGS

The Medical Executive Committee shall meet at least ten (10) times each calendar year. A permanent record of its proceedings and actions shall be maintained.
12.3 DEPARTMENT SUPERVISORY COMMITTEES

12.3-1 COMPOSITION

Each Department designated in Section 10.2 shall have a Department Supervisory Committee, which shall consist of at least three Active Staff Members of the Department. The Department Chair shall chair the committee and shall appoint the other members thereof.

12.3-2 DUTIES

The Department Supervisory Committee shall assist the Department Chair in the performance of the functions described in Section 10.4.

12.3-3 MEETINGS

Each Department’s regularly scheduled meetings shall also constitute the regular meetings of the Department Supervisory Committee. A Department Chair may call special meetings of the committee at any time.

12.4 CREDENTIALS COMMITTEE

12.4-1 COMPOSITION

The Credentials Committee shall consist of at least eight (8) Active Staff Members appointed in a manner that will ensure, insofar as feasible, representation of the major clinical specialties and each Department. Committee members shall serve in staggered two (2)-year terms.

12.4-2 DUTIES

The committee shall:

a) Review and evaluate the qualifications of each Practitioner applying for appointment or reappointment to the Medical Staff and/or initial or modified Clinical Privileges, and submit to the Medical Executive Committee the reports and recommendations as set forth in Article VI.

b) Investigate, review and report on matters referred by the Chief of Staff or the Medical Executive Committee regarding the qualifications, conduct, professional character or competence of any applicant or current Member of the Medical Staff.

c) Submit periodic reports to the Medical Executive Committee on its activities and the status of pending applications.

12.4-3 MEETINGS

The committee shall meet as often as necessary at the call of its chair. The Committee shall maintain a record of its proceedings and actions and shall report to the Medical Executive Committee.
12.5 BYLAWS COMMITTEE

12.5-1 COMPOSITION

The Bylaws Committee shall consist of at least four (4) Active Staff Members, who shall serve in two (2)-year terms.

12.5-2 DUTIES

The committee shall:

a) Conduct, at a minimum, a biennial review of the Bylaws and the Rules and Regulations.

b) Submit to the Medical Executive Committee any amendments to the Bylaws and the Rules and Regulations it deems necessary.

c) Analyze and comment upon any proposed amendments to the Bylaws and the Rules and Regulations that are referred by the Medical Executive Committee as a result of a proposal by the Medical Executive Committee, Medical Staff, Governing Body, or Hospital Administration.

12.5-3 MEETINGS

The Bylaws Committee shall meet at least annually. Additional meetings may be called from time to time by the Chair of the Committee.

12.6 JOINT CONFERENCE COMMITTEE

12.6-1 COMPOSITION

a) The Joint Conference Committee shall consist of five (5) members from the Governing Body (whose appointment and tenure shall not be governed by these Bylaws) and five (5) members from the Medical Executive Committee. In addition, the Chief Executive shall serve in a non-voting capacity.

b) The Medical Staff representatives to the committee shall include the Chief of Staff, the Chief of Staff-Elect or the Immediate Past Chief of Staff (whichever is in office), and three other Medical Executive Committee members appointed by the Chief of Staff. The chair of the committee shall be alternated annually between the Governing Body and the Medical Staff.

12.6-2 DUTIES

a) The Joint Conference Committee shall serve as a forum for discussion, interaction and recommendation between the Governing Body and the Medical Staff regarding matters of Hospital and Medical Staff policy, practice and planning, or regarding any other matter(s) that might be referred for the committee’s consideration (by the Governing Body, the Medical Staff or the Medical Executive Committee or according to these Bylaws).

b) In those cases in which the Governing Body shall submit a matter to the Joint Conference Committee for review and recommendation prior to the Governing Body making its final decision, the procedure shall be as follows:
1) Once the Joint Conference Committee has completed its review and has made its recommendation to the Governing Body, the Governing Body may, before making its final recommendation, refer the matter back to the Joint Conference Committee stating the reasons for such referral and setting a time limit within which a subsequent recommendation shall be made by the Joint Conference Committee to the Governing Body.

2) Following any review by the Joint Conference Committee, the Governing Body shall give great weight to the recommendation of the Joint Conference Committee when making its final decision.

12.6-3 MEETINGS

The Joint Conference Committee shall meet as needed and shall transmit a written report of its activities to both the Medical Executive Committee and the Governing Body.

12.7 QUALITY MANAGEMENT COMMITTEE

12.7-1 COMPOSITION

The Quality Management Committee shall consist of at least one representative from each Department, the nursing service and Administration.

12.7-2 DUTIES

The Quality Management Committee shall:

a) Recommend to the Medical Executive Committee mechanisms for maintaining the quality and safety of patient care within the Hospital, which may include: (1) establishing systems to identify potential problems in patient care, (2) setting priorities for action to correct problems, (3) referring priority problems for assessment and corrective action to appropriate Departments or committees, and/or (4) monitoring the results of the quality management/performance improvement activities of the Medical Staff.

b) Submit regular confidential reports to the Medical Executive Committee on the quality of medical care provided in the Hospital, and on the quality review activities conducted by the committee.

c) Review and monitor: (1) blood utilization, (2) drug utilization including antibiotics, (3) surgical outcomes, (4) morbidity and mortality, (5) infection control activities, (6) medical records, (7) risk management activities, and (8) utilization review/case management activities within the Hospital.

12.7-3 MEETINGS

The Quality Management Committee shall meet as needed, but not less than quarterly, and shall transmit written reports of its activities to the Medical Executive Committee and the Governing Body.
12.8 PHYSICIAN WELL BEING COMMITTEE

12.8-1 PURPOSE

The Medical Staff and Hospital leaders have an obligation to protect patients, Practitioners, AHPs, employees, visitors, and all other individuals present in the hospital from harm. The Physician Well Being Committee has been established to identify and manage matters of individual health for any individual permitted to provide care, treatment, and services, without direction or supervision (collectively, “Licensed Independent Practitioners”), which is separate from actions taken for disciplinary purposes.

12.8-2 COMPOSITION

The Physician Well Being Committee shall consist of at least three Active Staff Members, a majority of whom, including the Chair shall be physicians. The Medical Executive Committee shall appoint the members of the committee and designate the chair. Committee members shall serve in staggered two (2)-year terms.

12.8-3 DUTIES

The Physician Well Being Committee shall:

a) Address the education of Licensed Independent Practitioners and other organization staff about illness and impairment recognition issues specific to Licensed Independent Practitioners (at-risk criteria).

b) Receive referrals related to the health, well-being, or impairment of Licensed Independent Practitioners, which may include self-referrals or referral by others. In the case of referral by others, the committee shall maintain informant confidentiality.

c) As necessary, refer Licensed Independent Practitioners to appropriate professional internal or external resources for evaluation, diagnosis, and treatment of the condition or concern.

d) Maintain the confidence of any Licensed Independent Practitioner seeking referral or referred for assistance, except as limited by applicable law, ethical obligation, or when the health and safety of a patient is threatened.

e) Assess and evaluate the credibility of any complaint, allegation, or concern.

f) Monitor any Licensed Independent Practitioners for whom credible concerns have been identified, and the safety of such Practitioners’ patients, until the rehabilitation is complete and periodically thereafter, if required.

g) Report to the Chief of Staff or Medical Executive Committee instances in which a Licensed Independent Practitioner is providing unsafe treatment.

h) Initiate appropriate actions when a Licensed Independent Practitioner fails to complete the required rehabilitation program.

i) Consider general matters related to the health and well-being of the Medical Staff.
12.8-4 MEETINGS
The Physician Well Being Committee shall meet as often as necessary, at the call of its chair. It shall maintain only such record of its proceedings as it deems advisable, but shall report its activities to the Medical Executive Committee, at minimum, on a quarterly basis.

12.9 PHARMACY AND THERAPEUTICS COMMITTEE

12.9-1 COMPOSITION
The Pharmacy and Therapeutics Committee shall include at least three (3) Medical Staff Members, including representatives from the Departments of Medicine, Surgery, Obstetrics/Gynecology, and Pediatrics, and the Division of Pathology. The committee also shall include a representative from the pharmaceutical service, and an individual employed in a surveillance or epidemiological capacity. The committee also shall include, in a non-voting capacity, representatives from the nursing service and Hospital Administration.

12.9-2 DUTIES
The Pharmacy and Therapeutics Committee shall:

12.9-1.1 Assist in formulating professional practices and policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs in the Hospital, including use of antibiotics;

12.9-1.2 Advise the Medical Staff and the pharmaceutical service on matters pertaining to the choice of available drugs;

12.9-1.3 Make recommendations concerning drugs to be stocked on the nursing unit floors and by other services;

12.9-1.4 Delegates authority for formulary decision-making to the centralized PH&S formulary process, led by a representative PH&S formulary committee of experts in medicine, pharmacy, and nursing throughout the system and continuum of care, that ensures patients of Providence and its affiliates are provided with safe, high-quality, and affordable medications throughout the continuum of care.

12.9-1.5 The committee and its providers will be engaged in the centralized PH&S formulary determination process, which ensures patients of Providence and its affiliates are provided with safe, high-quality, and affordable medications throughout the continuum of care.

12.9-1.6 Accepts and adheres to the outcomes of the centralized PH&S formulary process.

12.9-1.7 The committee, or an individual provider in coordination with a P&T lead pharmacist, may petition a PH&S formulary decision through the centralized PH&S formulary appeal process with the understanding the burden of proof of value (safety, efficacy, cost) is on those who advocate the alternative.

12.9-1.8 Evaluate clinical data concerning new drugs or preparations requested for use in the Hospital;
12.9-1.9 Establish standards concerning the use and control of investigational drugs and research in the use of recognized drugs;

12.9-1.10 Maintain a record of all activities relating to pharmacy functions and submit periodic reports and recommendations to the Medical Executive Committee concerning those activities;

12.9-1.11 Will include and document decisions of the PH&S formulary committee, which is comprise of representatives from medicine, pharmacy, and nursing throughout the system and continuum of care.

12.9-1.12 Review untoward drug reactions and medication errors.

12.9-3 MEETINGS

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

12.10 INFECTION CONTROL COMMITTEE

12.10-1 COMPOSITION

The Infection Control Committee shall include at least three (3) Medical Staff Members, including representatives from the Departments of Medicine, Surgery, Obstetrics/Gynecology, and Pediatrics, and the Division of Pathology. The committee also shall include a representative from the nursing service and Administration, and an individual employed in a surveillance or epidemiological capacity. The committee also may include, in a non-voting capacity, consultants in microbiology and representatives from other relevant hospital services.

12.10-2 DUTIES

The Infection Control Committee shall:

a) Develop a Hospital-wide infection control program and maintain surveillance over the program;

b) Develop a system for reporting, identifying and analyzing the incidence and cause of hospital-acquired infections, including assignment of responsibility for the ongoing collection and analytic review of such data, and follow-up activities;

c) Develop and implement a program to minimize infection hazards, including establishing, reviewing and evaluating aseptic, isolation and sanitation techniques;

d) Develop written policies defining special indications for isolation requirements;

e) Coordinate action on findings from the Medical Staff's review of the clinical use of antibiotics;

f) Act upon recommendations related to infection control received from the Chief of Staff, the Medical Executive Committee, Departments and other committees;

 g) Review the sensitivities of organisms specific to the facility.
12.10-3 MEETINGS

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

12.11 CANCER COMMITTEE

12.11-1 COMPOSITION

a) The Chair of the Cancer Committee shall be an Active Staff Member qualified by training, experience and demonstrated ability for the position.

b) The Cancer Committee shall include additional Medical Staff Members appointed by the Chair. In selecting such members, the Chair shall endeavor to appoint board certified physicians who represent all, or as many as is feasible, medical specialties involved in the care of patients with cancer. At a minimum, the committee shall include board certified physicians representing the specialties of surgery, medical oncology, diagnostic radiology, radiation oncology, and pathology. Representatives of other disciplines may be included as appropriate, with consideration of the types of cancers treated at the Hospital, and may include internal or family medicine, Cancer Liaison Physician, gynecology, urology and thoracic surgery.

c) The Cancer Committee also shall include the cancer registrar, an oncology nurse, a social worker, a representative from quality management and Hospital administration.

12.11-2 DUTIES

The Cancer Committee shall:

a) Provide leadership in the cancer program activities of the Hospital;

b) Ensure that patients have access to consultative services in all disciplines and provide for the establishment of Tumor Board meetings;

c) Assure that educational programs, conferences, and other clinical activities cover the entire spectrum of cancer;

d) Oversee the operation of the Cancer Registry for quality control, research programs, follow-up, and reporting of statistical information to the Medical Staff;

e) Serve as a resource to the Medical Staff for information on current modalities and therapies in the treatment of cancer patients;

f) Liaise with other Hospital committees, the Commission on Cancer of the American College of Surgeons, and other appropriate organizations;

g) Perform audits of patient care, either directly or by review of audit data;

h) Obtain or generate criteria for the diagnosis, treatment, follow-up and rehabilitation of patients with neoplasms according to site, and assure that patient care conforms such criteria;
i) Make recommendations regarding personnel, facilities, equipment, and other administrative matters of the cancer program;

j) Consider the entire spectrum of care for cancer patients admitted to the Hospital;

k) Publish and distribute an annual report of cancer program activities.

12.11-3 MEETINGS

The Cancer Committee is a standing committee of the Hospital. This committee must meet at least quarterly and preferably monthly as an entity separate from conferences or Tumor Boards. Minutes of the meeting shall be recorded, held confidential, and reports shall be submitted on a regular basis to the Medical Executive Committee.

12.12 CONTINUING MEDICAL EDUCATION COMMITTEE

12.12-1 COMPOSITION

a) The Medical Executive Committee shall appoint a Director of Medical Education, who shall serve as chair of the Continuing Medical Education Committee, for a term of up to two years. Directors of Medical Education may succeed themselves for consecutive terms.

b) The chair of the Continuing Medical Education Committee shall appoint at least two (2) other committee members, who may be Medical Staff Members and other health professionals affiliated with or employed by the Hospital who are particularly interested and suited for establishing a program of medical education that will improve the quality of care provided at the Hospital.

12.12-2 DUTIES

The Continuing Medical Education Committee shall:

a) Plan, implement, coordinate and promote ongoing special clinical and scientific programs for the Medical Staff. This includes:

1) Identifying the educational needs of the Medical Staff;

2) Formulating clear statements of objectives for each program;

3) Assessing the effectiveness of each program;

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

5) Documenting staff attendance at each program.

b) Assist in developing processes to assure optimal patient care and contribute to the continuing education of each practitioner;

c) Liaise with the quality assurance program of each department in order to be apprised of problem areas in patient care, which may be addressed by a specific continuing medical education activity;
d) Liaise with other Hospital, Medical Staff and Department committees concerned with patient care;

e) Make recommendations to the Medical Executive Committee regarding library needs of the Medical Staff; and

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

12.12-3 MEETINGS

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

12.13 CRITICAL CARE COMMITTEE

12.13-1 COMPOSITION

The Critical Care Committee shall be a multidisciplinary committee consisting of at least six (6) representatives of the Medical Staff and nursing service, each of whom are frequently involved in caring for critically ill patients.

12.13-2 DUTIES

The Critical Care Committee shall:

a) Establish and implement policies for appropriate patient care within the Critical Care Areas;

b) Initiate processes to monitor and evaluate the quality of care provided in the Critical Care Areas;

c) Recommend education programs to the Continuing Medical Education Committee; and

d) Recommend to the Bylaws Committee additions or changes to the General Medical Staff Rules & Regulations.

12.13-3 MEETINGS

The Critical Care Committee shall meet as often as necessary at the call of its chair but at least quarterly. It shall maintain a record of its proceedings and shall report its activities and recommendations to the Medical Executive Committee. The chair or a designee shall be invited to present the committee’s report to the Medical Executive Committee on a quarterly basis.

12.14 INSTITUTIONAL REVIEW BOARD

12.14-1 COMPOSITION

The Institutional Review Board (IRB) shall consist of at least six (6) members, including representatives from the Medical Staff, Pharmacy, Chaplaincy, legal counsel and one community member who is not otherwise affiliated with the Hospital or part of the immediate family of a person who is affiliated with the Hospital.
12.14-2 DUTIES

The Institutional Review Board shall:

a) Review all research activities conducted at the Hospital to assure the scientific merit of the research and that patients' rights are protected;

b) Assure that proposed changes in an approved research activity shall not be initiated without the IRB approval except when necessary to prevent immediate harm to patients or others;

c) Assure prompt reporting to the IRB of unanticipated risks to patients or others;

d) Assure timely reporting to the appropriate Department or the Medical Executive Committee of non-compliance by investigators with the requirements and determinations of the IRB;

e) Review, at least semi-annually, all research projects underway at the hospital, which review shall include a complete report by investigators of the results of their research;

f) Require that information given to patients as part of the informed consent process and that documentation of informed consent complies with applicable law or regulations; and

g) Suspend or terminate research that is not in accordance with the IRB’s requirements or that has been associated with unexpected harm to patients or others.

12.14-3 MEETINGS

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

12.15 INTERDISCIPLINARY PRACTICE COMMITTEE

12.15-1 COMPOSITION

a) The Interdisciplinary Practice Committee (IDPC) shall include the Chief Nursing Executive or designee, the Chief Executive or designee, and an equal number of physicians appointed by the Medical Executive Committee and registered nurses appointed by the Chief Nursing Executive or designee.

b) Licensed or certified health professionals other than registered nurses who perform functions requiring standardized procedures also shall be included in the committee.

c) The Medical Executive Committee shall designate the committee chair, who shall be an Active Staff Member, from among the physician members of the committee.

12.15-2 DUTIES

The Interdisciplinary Practice Committee shall:
a) Evaluate and make recommendations regarding the need for, and appropriateness of, the care provided by Allied Health Professionals.

b) Evaluate and make recommendations regarding:

1) Mechanisms to evaluate the qualifications and credentials of AHPs who hold or apply for Practice Privileges;

2) The minimum standards of training, education, character, competence, and overall fitness of AHPs who hold or apply for Practice Privileges;

3) Which services may be performed by an AHP, or category of AHP, and any terms and conditions thereon; and

4) The professional responsibilities of AHPs who have been granted Practice Privileges.

c) Make recommendations regarding monitoring, supervision, and evaluation of AHPs holding Practice Privileges.

d) Evaluate and report whether the care proposed to be provided or actually provided by AHPs is consistent with the rendering of quality medical care and with the responsibilities of the Medical Staff.

e) Evaluate and report on the effectiveness of supervision requirements imposed upon AHPs who hold Practice Privileges.

f) Evaluate and report on the efficiency and effectiveness of the care provided by AHPs.

The Interdisciplinary Practice Committee shall routinely report to the Governing Body through the Medical Executive Committee and, in addition, shall submit an annual report directly to the Governing Body and the Medical Executive Committee.

12.15-3 MEETINGS

The Interdisciplinary Practice Committee shall meet at the call of the chair at such intervals as the chair or the Medical Executive Committee deems appropriate.

12.16 HEALTH INFORMATION MANAGEMENT COMMITTEE

12.16-1 COMPOSITION

The Health Information Management Committee shall consist of at least one representative from each Department, the nursing service, the medical records department, and Hospital Administration.

12.16-2 DUTIES

The Health Information Management Committee shall:

a) Review and evaluate medical records, or a representative sample, to determine whether they comply with the requirements of the General Rules and Regulations;
b) Review and make recommendations for Medical Staff and Hospital Policies, and Rules and Regulations regarding medical records, including completion, forms and formats, filing, indexing, storage, destruction, availability and methods of enforcement; and

c) Liaise with Hospital administration and medical record personnel on matters relating to medical records practices.

12.16-3 MEETING

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

ARTICLE XIII

MEETINGS

13.1 MEDICAL STAFF MEETINGS

13.1-1 GENERAL MEETINGS

General meetings of the Medical Staff shall be held at least three (3) times per year. The Chief of Staff shall determine the date, place and time of the general meetings. The Chief of Staff shall present a report on significant actions taken by the Medical Executive Committee since the prior general meeting, and on any other matters of importance and interest to the Medical Staff. No business shall be transacted at any general meeting except that stated in the notice thereof.

13.1-2 AGENDA

The Chief of Staff shall set the order of business at a general meeting. The agenda for such a general meeting may include:

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

b) Administrative reports from the Chief Executive, the Chief of Staff and any Department and committee chairs;

c) Reports regarding any activities required by these Bylaws; and

d) New business.

Where the Medical Staff is being asked to consider or review a document, a copy of the document shall be appended to the agenda. Drafts of any documents considered or to be considered at any Medical Staff meeting shall be available to any Medical Staff member upon request. Further, any proposal considered at the meeting shall be accompanied by a clear explanation as to the source of the proposal and why that proposal is needed.
13.1-3 SPECIAL MEETINGS

A special meeting of the Medical Staff may be called by the Chief of Staff, Medical Executive Committee, or Governing Body at any time. A special meeting may also be called upon the written request to the Chief of Staff or Medical Executive Committee signed by at least a quorum of Active Staff members; such a meeting must be called within thirty (30) days after receipt of such a request. No business shall be transacted at any special meeting of the Medical Staff except for the business described within the notice calling such a meeting.

13.2 DEPARTMENT AND COMMITTEE MEETINGS

13.2-1 REGULAR MEETINGS

Departments and committees may provide, by resolution, the day(s) and the time(s) that regular meetings shall be held. Whenever so provided, no additional notice of regular meetings shall be required.

13.2-2 SPECIAL MEETINGS

A special meeting of a Department or committee may be called at any time by the Chair, the Medical Executive Committee, Chief of Staff, or one-third (1/3) of the committee or Department’s members, but not fewer than three (3) members. The Chair of the committee or the Department of the requested special meeting shall determine the date, place and time of the meeting. No business shall be transacted at any special meeting of a committee or Department except for that stated in the notice.

13.3 NOTICE OF MEETING

Any required written notice of a meeting and its agenda shall be provided at least seven (7) days prior to the meeting. Personal attendance at a meeting shall constitute a waiver of notice of such meeting. No business shall be transacted at any meeting except for that stated in the notice.

13.4 QUORUM

13.4-1 MEDICAL STAFF MEETINGS

The presence of one-half (1/2) of the Active Staff eligible to vote at any regular or special meeting, either in person or through written mail ballot, shall constitute a quorum for the purpose of adopting or amending the Bylaws or Rules and Regulations, or for the election or removal of Medical Staff Officers. The presence of one-third (1/3) of such Members shall constitute a quorum for all other actions.

13.4-2 COMMITTEE MEETINGS

a) The presence of one-half (1/2) of the committee members eligible to vote shall constitute a quorum of the Medical Executive Committee or Credentials Committee.

b) For all other committees, a quorum shall consist of one-third (1/3), but no less than two (2), of the committee members eligible to vote.
13.4-3 DEPARTMENT MEETINGS

The quorum for Department meetings shall be set forth in the Rules and Regulations of each Department.

13.5 MANNER OF ACTION

13.5-1 ACTION AT A MEETING; IN-PERSON OR TELEPHONIC

a) Except as otherwise specified, the action of a majority of the members present and voting at any meeting at which a quorum is present shall be the action of the group. Notwithstanding the departure of members, business may continue to be transacted at any meeting at which a quorum initially was present, as long as any action taken is approved by a majority of the required quorum for such meeting or such greater number as may be specifically required.

b) Department or committee business may be transacted by telephone conference as long as written notice stating the day and hour of such conference is provided not less than two (2), nor more than five (5), days before the date of such conference to each committee member, and as long as at least a quorum is present and voting in such conference.

13.5-2 ACTION BY UNANIMOUS WRITTEN CONSENT

Action may be taken by a Department or committee without a meeting if a consent to the action is signed by each voting member of the Department or committee. Such consent shall be maintained within the appropriate permanent minutes file.

13.5-3 ACTION BY WRITTEN MAIL BALLOT

a) Notwithstanding any other provision contained herein to the contrary, whenever required by the Bylaws or ordered by the Medical Executive Committee, a matter may be submitted for Medical Staff action by written mail ballot.

b) When voting is to be conducted by written mail ballot, the Medical Staff Office shall issue ballots that bear an authenticating mark, such as the Hospital’s seal, and shall provide a self-addressed return envelope (Attention: Staff Secretary-Treasurer) with each ballot.

c) To be valid, each written mail ballot must be received in the Medical Staff Office by the return date designated on the ballot, which shall be at least fifteen (15) days from the date the ballot is issued, or such greater voting period as may be specifically required.

d) The Chief of Staff (or designee), the Secretary-Treasurer of the Medical Staff and a representative from the Medical Staff Office shall count the ballots. Any ballot returned that does not bear the authenticating mark will not be counted.

e) In order for the vote to be tallied, valid ballots must be received from at least a quorum of the Active Staff.

f) An action by written mail ballot shall be effected by a majority vote of the valid ballots actually cast, or such greater number as may be specifically required.
g) Whenever a matter is acted upon by written mail ballot, the Secretary-Treasurer shall prepare a writing describing the action so taken. Such a writing shall be maintained within the appropriate permanent minutes file.

13.6 MINUTES

Minutes of all meetings, including committee meetings conducted by telephone conference, shall be prepared and include a record of the attendance of members and of the result of the vote taken on each matter. Such minutes shall be signed by the presiding officer and shall be forwarded to the Medical Executive Committee. Each Department and committee shall maintain a permanent file of the minutes of each of their respective meetings. 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.

13.7 ATTENDANCE REQUIREMENTS

13.7-1 REGULAR ATTENDANCE

Each member of the Active and Provisional Staffs shall be required to attend, each year, at least one (1) of the general or special Medical Staff meetings; and at least three (3) Department meetings of which he or she is a member. The attendance of a Division or a committee meeting shall be equivalent to attending a Department meeting.

13.7-2 ABSENCE FROM MEETINGS

a) All Active Staff Members who do not comply with the meeting attendance requirements shall be demoted (regardless of any pending application for reappointment) from the Active to the Courtesy Staff without the procedural rights provided in Article IX. All Courtesy Staff Members who do not comply with the meeting attendance requirements shall not be eligible for elevation to the Active Staff until, at the time of reappointment, such requirements are met.

b) Unless excused for good cause by the Medical Executive Committee, Members who fail to meet the Committee meeting attendance requirements shall be deemed to have resigned from the committee(s) involved, effective immediately.

13.7-3 SPECIAL APPEARANCE

A Practitioner may be asked to attend any regular or special meeting of any Department or committee. Whenever a Practitioner’s attendance at such a meeting is necessary for the Department or committee to discharge its responsibilities under these Bylaws, the Department or committee Chair shall issue a written Special Appearance Notice, at least seven (7) days prior to the meeting. Such Notice shall set forth the time and the place of the scheduled meeting, the reason for the scheduled meeting, and an explicit statement that the Practitioner’s appearance at the scheduled meeting is mandatory. If a Practitioner does not attend any meeting for which he or she received a Special Appearance Notice, the Practitioner shall be suspended pursuant to Section 8.3-3, unless he or she was excused from appearing by the Medical Executive Committee in advance of the scheduled meeting, upon a showing of good cause.

13.8 CONDUCT OF MEETINGS

Unless otherwise specified, meetings shall be conducted according to Robert’s Rules of Order; however, any technical failure to follow such rules shall not invalidate action taken during such a meeting.
ARTICLE XIV
CONFIDENTIALITY, IMMUNITY AND RELEASES

14.1 SPECIAL DEFINITIONS

For purposes of this Article, the following definitions shall apply:

14.1-1 INFORMATION shall mean all acts, communications, records of proceedings, minutes, other records, reports, memoranda, statements, recommendations, data and other disclosures (whether in written, recorded, computerized or oral form) that relate to professional qualifications, clinical ability, judgment, character, physical and mental health, emotional stability, professional ethics or any other matter that, directly or indirectly, might affect patient care.

14.1-2 REPRESENTATIVE shall mean any Board, Director, Committee, or Chief Executive of a hospital or other health care institution or their designee; a Medical Staff entity; an organization of Practitioners or AHPs; a PSRO, PRO, or state or local board of medical or professional quality assurance (i.e., the Medical Board of California), and any member, Officer, Department or Committee thereof; and any individual authorized by any of the foregoing to perform specific information gathering or disseminating functions.

14.1-3 THIRD PARTIES shall mean both individuals and organizations providing information to any Representative.

14.2 AUTHORIZATIONS AND CONDITIONS

By applying for, or exercising, Clinical or Practice Privileges within this Hospital, a Practitioner or AHP:

14.2-1 Authorizes Representatives of this Hospital and its Medical Staff to solicit, to provide and/or to act upon information bearing upon the Practitioner or AHP’s professional ability and qualifications.

14.2-2 Authorizes Third Parties and their Representatives to provide information, including otherwise privileged or confidential information, concerning the Practitioner or AHP to this Hospital and its Medical Staff.

14.2-3 Agrees to be bound by the provisions of this Article and to waive all legal claims against any representative who acts in accordance with the provisions of this Article.

14.2-4 Acknowledges that the provisions of this Article are express conditions to any application for, or acceptance of, Medical Staff membership and to the continuation of such membership, or application for, or acceptance and exercise of, Clinical or Practice Privileges at this Hospital.

14.3 CONFIDENTIALITY OF INFORMATION

14.3-1 GENERAL

Information with respect to any Practitioner or AHP submitted, collected or prepared by any Representative for the purpose of achieving and maintaining quality patient care, reducing morbidity and mortality or contributing to clinical research shall be confidential, to the fullest extent permitted by law, and shall not be disseminated to anyone other than
a Representative, nor used in any way, except as provided herein or except as otherwise required by law. Such confidentiality also shall extend to information of like kind that may be provided by Third Parties. This information shall become part of the Medical Staff Committee files and shall not become part of any particular patient's file or part of the general Hospital records.

14.3-2 BREACH OF CONFIDENTIALITY

Inasmuch as effective peer review and consideration of the qualifications of Medical Staff Members and applicants to perform specific procedures must be based on free and candid discussion, any breach of confidentiality of the discussion or deliberations of Medical Staff Departments, Divisions, or committees, except in conjunction with other hospital, professional society, or licensing authority, is outside appropriate standards of conduct for this Medical Staff 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.

14.4 IMMUNITY FROM LIABILITY

14.4-1 FOR ACTION TAKEN

Every Representative of this Hospital (including its Medical Staff Members and AHPs) shall be exempt, to the fullest extent permitted by law, from liability to a Practitioner or AHP for damages or other relief for any action taken, or statement or recommendation made, within the scope of their duties as Representatives.

14.4-2 FOR PROVIDING INFORMATION

Every Representative of this Hospital (including its Medical Staff members and AHPs) and all Third Parties shall be exempt, to the fullest extent permitted by law, from liability to a Practitioner or AHP for damages or other relief by reason of having provided information, including otherwise privileged or confidential information, to another Representative concerning a Practitioner or AHP.

14.5 ACTIVITIES AND INFORMATION COVERED

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

a) Applications for appointment, reappointment, Clinical Privileges, Practice Privileges and prerogatives; and periodic reappraisals of a Practitioner or AHP’s membership, privileges and/or prerogatives;

b) Corrective action;

c) Hearing and appellate review proceedings;

d) Hospital, Department, committee or other Medical Staff activities related to monitoring, maintaining and improving the quality of patient care, to appropriate utilization and to appropriate professional conduct; and

e) Reports of any PRO, licensing agency, professional standards review organization, and the like.
14.6 RELEASES

Every Practitioner or AHP, upon request of the Hospital, shall execute general and specific releases in accordance with the provisions, tenor and import of this Article. Execution of such releases, however, shall not be deemed a prerequisite to the effectiveness of this Article.

ARTICLE XV

GENERAL PROVISIONS

15.1 RULES AND REGULATIONS

15.1-1 MEDICAL STAFF RULES AND REGULATIONS

The Medical Staff shall initiate and adopt general Rules and Regulations of the Medical Staff as it may deem necessary and shall periodically review and revise its Rules and Regulations to comply with current Medical Staff practice. New Rules and Regulations or changes to the Rules and Regulations (“Proposed Rules”) may emanate from any responsible committee, Department, Medical Staff Officer, or by a petition signed by at least thirty percent (30%) of the Active Staff eligible to vote. Additionally, Hospital administration may develop and recommend Proposed Rules, and in any case should be consulted as to the impact of any Proposed Rule on Hospital operations and feasibility. Proposed Rules shall be submitted to the Medical Executive Committee for review and action, as follows:

a) Except with respect to circumstances requiring urgent action, the Medical Executive Committee shall not act on the Proposed Rule until the Medical Staff has had a reasonable opportunity to review and comment on the Proposed Rule.

b) If the Medical Executive Committee approves a Proposed Rule, it shall be forward to the Governing Body for approval, which approval shall not be withheld unreasonably. If the Governing Body should disagree, in whole or in part, with the Proposed Rule, then the procedure provided in these Bylaws for review and recommendation by the Joint Conference Committee shall be followed.

c) If the Proposed Rule is one generated by a petition of at least thirty percent (30%) of the Medical Staff eligible to vote and the Medical Executive Committee rejects the Proposed Rule, it shall notify the Medical Staff. The Medical Executive Committee and the Medical Staff each has the option of invoking or waiving the conflict management provisions of Section 15.11.

1) If the conflict management process is not invoked within thirty (30) days, it shall be deemed waived, and the Medical Staff’s proposed Rule shall be forwarded to the Governing Body for action. The Medical Executive Committee may forward comments to the Governing Body regarding its reasons for declining to approve the Medical Staff’s Proposed Rule.

2) If the conflict management process is invoked, the Medical Staff’s Proposed Rule shall not be forwarded to the Governing Body until the conflict management process has been completed. The results of the conflict management process shall be forwarded to the Governing Body, which shall take action, if necessary.
d) The Proposed Rule shall become effective immediately following approval of the Governing Body or automatically within ninety (90) days if no action is taken by the Governing Body. If there is a conflict between the Bylaws and the Rules and Regulations, the Bylaws shall prevail.

15.1-2 DEPARTMENTAL RULES AND REGULATIONS

Each Department shall formulate its own Rules and Regulations for the conduct of its affairs and the discharge of its responsibilities. Such Departmental Rules and Regulations shall not be inconsistent with these Bylaws, the general Rules and Regulations of the Medical Staff, or any other policies of the Hospital, and shall be subject to the approval of the Medical Executive Committee and the Governing Body.

15.1-3 URGENT AMENDMENTS TO GENERAL RULES AND REGULATIONS

When an urgent action regarding the general Rules and Regulations is necessary in order to comply with a federal or state law or regulation or accreditation requirement, the Medical Executive Committee may provisionally adopt and the Governing Body may provisionally approve the urgent amendment without prior notification of the Medical Staff. Following the provisional adoptions and approval, the Medical Executive Committee shall immediately notify the Medical Staff of the urgent amendment. The Medical Staff has the opportunity to retrospectively review and comment on the urgent amendment. If there is no conflict between the Medical Staff and the Medical Executive Committee, then the urgent amendment will stand as a final action of the Governing Body. If there is a conflict over the urgent amendment, then, to resolve this conflict, the Medical Staff may resolve the conflict in accordance with Section 15.11.

15.2 MEDICAL STAFF POLICIES AND PROCEDURES

15.2-1 Policies of general application to the entire Medical Staff shall be developed as necessary to implement more specifically the general principles found within these Bylaws and the Rules and Regulations. New or revised policies (“Proposed Policies”) may emanate from any responsible committee, Department, Medical Staff Officer, or by petition signed by at least thirty percent (30%) of the Staff who are eligible to vote.

15.2-2 Except with respect to circumstances requiring urgent action, the Medical Executive Committee shall not act on the Proposed Policy until the Medical Staff has had a reasonable opportunity to review and comment on the Proposed Policy.

15.2-3 If the Medical Executive Committee approves the Proposed Policy, it shall be forwarded to the Governing Body for approval, which approval shall not be withheld unreasonably. If the Governing Body should disagree, in whole or in part, with the Proposed Policy, then the procedure provided in these Bylaws for review and recommendation by the Joint Conference Committee shall be followed.

15.2-4 If the Proposed Policy is one generated by a petition of at least thirty percent (30%) of the Staff eligible to vote and the Medical Executive Committee rejects the Medical Staff’s Proposed Policy, it shall notify the Medical Staff. The Medical Executive Committee and the Medical Staff each has the option of invoking or waiving the conflict management provisions of Section 15.11.

a) If the conflict management process is not invoked within thirty (30) days, it shall be deemed waived, and the Medical Staff’s Proposed Policy shall be forwarded to the Governing Body for action. The Medical Executive Committee may
forward comments to the Governing Body regarding its reasons for declining to approve the Medical Staff's Proposed Policy.

b) If the conflict management process is invoked, the Medical Staff's Proposed Policy shall not be forwarded to the Governing Body until the conflict management process has been completed. The results of the conflict management process shall be forwarded to the Governing Body, which shall take action, if necessary.

15.2-5 The Proposed Policy shall become effective immediately following approval of the Governing Body or automatically within ninety (90) days if no action is taken by the Governing Body. Policies shall not be inconsistent with the Medical Staff or Hospital Bylaws, Rules and Regulations, or other policies. If there is a conflict between the policy and the Bylaws or the Rules and Regulations, the Bylaws and the Rules and Regulations shall prevail.

15.3 ANNUAL DUES, APPLICATION FEE AND EXPENDITURE OF MEDICAL STAFF FUNDS

All members of the Medical Staff, with the exception of Members on a Leave of Absence for duration longer than one year and Members of the Honorary Staff, shall be required to pay annual dues. Such dues shall be due and payable no later than thirty (30) days from the date that shall appear at the top of the annual dues statement. A failure to pay such dues shall result in suspension in accordance with Section 8.3-7. The Medical Executive Committee shall have the power to recommend the amount of annual dues or assessments, if any, for each category of Medical Staff membership and to determine the manner of expenditures of such funds received, subject to the approval of the Medical Staff.

15.4 CONSTRUCTION OF TERMS AND HEADINGS

Words used in these Bylaws shall be read as the masculine or feminine gender, and as the singular or plural, as the context and circumstances require. The captions or headings used in these Bylaws are for convenience only and are not intended to limit or to define the scope or effect of any provision of these Bylaws.

15.5 AUTHORITY TO ACT

Any Member(s) who act(s) 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 ACCEPTANCE OF PRINCIPLES

All Members of each Medical Staff category, by making application for membership on this Medical Staff, do thereby agree to be bound by the terms of the Bylaws, Rules and Regulations, and Policies, as they may be amended from time to time. A copy of the Bylaws, and Rules and Regulations shall be delivered to each applicant upon receipt of a request for an initial Medical Staff appointment. Thereafter, a copy of each amendment to the Bylaws, and Rules and Regulations, once adopted, shall be delivered to each Medical Staff applicant and Member. Any violation of the Bylaws, and/or Rules and Regulations shall subject the applicant or Member to such disciplinary action as may be deemed necessary under the Bylaws.

15.7 DIVISION OF FEES

The practice of the division of professional fees, under any guise whatsoever, is forbidden and any such division of fees shall be cause for exclusion or expulsion from the Medical Staff.
15.8 NOTICES

In the case of a notice to the Hospital, Governing Body, Medical Staff, or Officers or Committee thereof, the notice shall be addressed as follows:

(Name and proper title of addressee)
Providence Holy Cross Medical Center
15031 Rinaldi Street
Mission Hills, California 91345

In the case of a notice to a Practitioner, AHP, or other party, the notice shall be sent to the address as it appears within the records of the Hospital by United States Postal Service, first-class postage prepaid, certified or registered mail, return receipt requested. A notice mailed pursuant to this section is deemed received by the addressee effective 48 hours after being deposited in the mail. If the notice is personally delivered, such notice shall be effective immediately upon delivery to the addressee, or any member of his or her office staff who accepts hand delivery at the office, and who signs on behalf, of the addressee.

Any party may change his/its address for the purposes of this Section by giving written notice of such change to the other party in the manner indicated above.

15.9 CONFLICT MANAGEMENT

15.9-1 DISPUTES BETWEEN THE MEDICAL STAFF AND THE MEDICAL EXECUTIVE COMMITTEE

In the event of a conflict between the Medical Executive Committee and the Medical Staff regarding proposals to adopt a rule, regulation, policy, or amendment thereto, the Chief of Staff shall convene a meeting upon receipt of a written petition signed by at least thirty percent (30%) of the Medical Staff who are eligible to vote. The petition shall include the designation of up to five (5) members of the Medical Staff who are eligible to vote to serve as the petitioners’ representatives. The Medical Executive Committee shall be represented by an equal number of Medical Executive Committee members. The Medical Executive Committee’s and petitioners’ representatives 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 representatives in attendance. Unresolved differences shall be submitted to the Governing Body for final resolution.

15.9-2 DISPUTES WITH THE GOVERNING BODY

In the event of a dispute between the Medical Staff and the Governing Body 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) The MEC may invoke formal dispute resolution, upon its own initiative. In the event the MEC declines to invoke formal dispute resolution, such a process shall be invoked upon written petition of at least a quorum of the Active Staff.

b) The initial forum for dispute resolution shall be the Joint Conference Committee, in accordance with Section 12.6.
1) However, upon written request of at least two-thirds (2/3) of the members of the Medical Executive Committee, the meet and confer will be conducted by a meeting of the full MEC and the full Governing Body.

2) Additionally, a neutral mediator acceptable to both the MEC and the Governing Body may be engaged to assist in the dispute resolution process if requested by: a majority of the MEC plus two (2) members of the Governing Body; or a majority of the Governing Body plus two (2) members of the MEC.

c) Both the MEC and the Governing Body must convene as early as possible, gather and share relevant information, and work in good faith to manage and, if possible, resolve the conflict. If the parties are unable to resolve the dispute, the Governing Body shall make a final determination giving great weight to the actions and recommendations of the MEC. The Governing Body’s determination shall not be arbitrary or capricious, and shall be in keeping with its legal responsibility to ensure responsible and effective governance of the Hospital and protect the quality of medical care provided to its patients.

ARTICLE XVI

ADOPTION AND AMENDMENT OF BYLAWS

16.1 MEDICAL STAFF RESPONSIBILITY AND AUTHORITY

16.1-1 The Medical Staff shall have the initial responsibility and delegated authority to formulate, adopt and recommend Medical Staff Bylaws and amendments thereto, and to forward such recommendations to the Governing Body. Such responsibility and authority shall be exercised in good faith and in a reasonable, timely and responsible manner. Additionally, Hospital administration may develop and recommend proposed Bylaws, and in any case should be consulted as to the impact of any proposed Bylaws on Hospital operations and feasibility.

16.1-2 Proposed amendments shall be submitted to the Governing Body for comments at least thirty (30) days before they are distributed to the Medical Staff for a vote. The Governing Body 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 MEC or upon receipt of a petition signed by at least a quorum of the Active Staff. Amendments submitted upon petition of the Active Staff shall be provided to the MEC at least thirty (30) days before they are submitted to the Governing Body for review and comment. The MEC has the right to have its comments regarding the proposed amendments circulated to the Governing Body when the proposed amendments are submitted to the Governing Body 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.

16.2 ADOPTION AND AMENDMENT OF THE BYLAWS

16.2-1 VOTING AT A REGULAR OR SPECIAL MEETING

Proposals to adopt or amend the Bylaws may be acted upon at any regular or special meeting of the Medical Staff where quorum is present and a notice of such proposal was sent to all Active Staff members not later than thirty (30) days before such meeting. The
notice shall include the exact wording of the proposed Bylaws language and the time and the place of the meeting, at which there will be an opportunity to discuss the proposed changes.

In order for any such proposal to be approved, a quorum must be present at the time the vote is taken, and a majority of the Active Staff members present must vote in the affirmative.

16.2-2 VOTING BY WRITTEN MAIL BALLOT

Proposals to adopt or amend the Bylaws may be acted upon by written mail ballot, as follows:

a) Notice of a regular or special meeting at which the proposal will be discussed must be issued to all Active Staff Members at least thirty (30) days prior to the date of such meeting. The notice shall include the exact wording of the proposed Bylaws language, the time and the place of the meeting, and a statement that the proposal will not be acted upon at the meeting.

b) Immediately following the meeting at which the proposed Bylaws language was presented, a written mail ballot shall be sent to each Active Staff member in accordance with Section 13.5-3, and shall include the exact wording of the proposed Bylaws language. Votes shall be tallied, and the proposal shall become effective, in accordance with Section 13.5-3.

16.2-3 APPROVAL BY THE GOVERNING BODY

a) Adoption or amendment of the Bylaws recommended by the Medical Executive Committee shall be effective when approved by the Governing Body, which approval shall not be unreasonably withheld.

b) If the Governing Body disagrees with the proposed changes, in whole or in part, the Governing Body shall follow the conflict resolution provision in Section 15.11.

c) These Bylaws may not be unilaterally amended or repealed solely by the Medical Staff or Governing Body. If these Bylaws are not in compliance with the requirements imposed by law, regulation, order of a Court, or for accreditation purposes, the Governing Body may request an appropriate amendment. If the Medical Staff should disagree with the requested amendment, the Medical Staff shall follow the conflict resolution provision in Section 15.11.

16.3 URGENT AMENDMENTS TO THE BYLAWS

When an urgent amendment to the Bylaws is necessary in order to comply with a federal or state law or regulation or accreditation requirement, the Medical Executive Committee may provisionally adopt and the Governing Body may provisionally approve the urgent amendment without prior notification of the Medical Staff. Following the provisional adoptions and approval, the Medical Executive Committee shall immediately notify the Medical Staff of the urgent amendment. The Medical Staff shall have the opportunity to retrospectively review and comment on the urgent amendment. The Medical Staff may raise an objection to the urgent amendment via a written petition signed by at least a quorum of the Active Staff, in accordance with the conflict management process set forth in Section 15.11. If no such objection is raised within the time set for review and comment then the urgent amendment will stand as a final action of the Governing Body.
16.4 TECHNICAL AND EDITORIAL CORRECTIONS

The Medical Executive Committee shall have the power to approve technical corrections, such as reorganization or renumbering of the Bylaws or to correct punctuation, spelling or other errors of grammar, or expression or inaccurate cross-references. No substantive amendments are permitted. Corrections may be effected by motion and acted upon in the same manner as any other motion before the Medical Executive Committee. After approval, such corrections shall be communicated in writing to the Medical Staff and to the Governing Body. Such corrections are effective upon adoption by the Medical Executive Committee; provided, however, they may be rescinded by vote of the Medical Staff or the Governing Body within 120 days of the date of adoption by the Medical Executive Committee.
ADOPTION

APPROVED BY THE MEDICAL STAFF:
(By written ballot of the ACTIVE Medical Staff)

_________________________________________  __________________________
Chief of Staff  Date

APPROVED BY THE COMMUNITY MINISTRY BOARD/BOARD OF TRUSTEES:

_________________________________________  __________________________
Community Ministry Board  Date

+--------------------------------------------------------------------------------------------------------+

Initially approved:
By the Medical Staff on 11/13/89 (Written Ballot)
By the Board of Trustees on 01/16/90,

Revised:  10/16/90, 07/14/92, 10/13/92, 04/20/93, 4/19/94, 7/19/94, 10/18/94, 1/16/96, 09/05/96, 08/13/97, 08/26/98, 2/23/00, 8/23/00, 5/6/02, 10/13/03, 12/13/04, 12/20/05, 12/20/06, 02/08, 12/08, 11/10, 08/11, 05/13

Amended and Restated:
By the Medical Staff on 05/15/2014 (Written Ballot)
By the Board of Trustees on 10/16/2014