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DIVISION 1: MEDICAL STAFF STRUCTURE

ARTICLE 1

INTRODUCTION

1.1 Name

The name of this organization is the Good Samaritan Hospital Medical Staff and is referred to here as “the Medical Staff.”

1.2 Organization and Purpose

1.2.1 The Medical Staff is organized for the purpose of maintaining a high quality of medical care provided in the Hospital and assuring the competency of the Hospital’s Medical Staff. These Bylaws provide a framework for self-governance, assuring an organization of the Medical Staff that permits it to discharge its responsibilities in matters involving the quality of medical care, to govern the orderly resolution of issues and the conduct of Medical Staff functions supportive of those purposes, and to account to the Governing Body for the effective performance of Medical Staff responsibilities. These Bylaws also provide the professional and legal structure for Medical Staff operations and a framework for the relationship between the Medical Staff and the Governing Body, and between the Medical Staff and its members and applicants.

1.2.2 The Medical Staff acknowledges that the Governing Body is ultimately responsible for everything at the Hospital, including the quality and safety of care, the competency of the Medical Staff, and the responsible governance of the Hospital. The Medical Staff commits to exercising its responsibilities with diligence and good faith, and acknowledges that if it does not fulfill its responsibilities, the Governing Body may act to do so; however, the Governing Body will not assume a Medical Staff duty or responsibility precipitously, unreasonably, or in bad faith. If the Governing Body acts to fulfill a Medical Staff responsibility, it will do so only in the reasonable and good faith belief that the Medical Staff has failed to fulfill that substantive duty or responsibility.

1.3 Definitions

1.3.1 ADVERSE ACTION and ADVERSE RECOMMENDATION mean actions and recommendations, respectively, that constitute grounds for a hearing pursuant to the Hearing and Appeals Article of the Medical Staff Bylaws.

1.3.2 ADMINISTRATOR or CHIEF EXECUTIVE OFFICER or PRESIDENT means the person appointed by the Governing Body to serve in an administrative capacity for the Hospital or his or her designee.

- 1.3.3** ADVANCED PRACTICE PROFESSIONAL (“APP”) means an Allied Health Practitioner whose license or other legal credential permits the professional to provide health care services at a medical level of care, whether independently or under the supervision or order of a physician, podiatrist, dentist, or clinical psychologist. Advanced Practice Professionals are ineligible for Medical Staff membership, but are eligible for privileges.
- 1.3.4** ALLIED HEALTH PRACTITIONER (“AHP”) means a health care professional, other than a physician, dentist, clinical psychologist or podiatrist, who holds a license or other legal credential, as required by California law, that (a) permits the professional to provide health care services, and (b) has been designated by the Governing Body as a profession that is eligible for Allied Health Status. Allied Health Practitioners are ineligible for Medical Staff membership. However, they are eligible for privileges if they are Advanced Practice Professionals, and for practice prerogatives if they are not Advanced Practice Professionals.
- 1.3.5** ALLIED HEALTH STAFF means (a) those Allied Health Practitioners who are not employees of the Hospital but have been granted privileges or practice prerogatives to provide certain clinical services; and (b) all Advanced Practice Professionals, whether employed by the Hospital or not, who have been granted privileges to provide certain clinical services.
- 1.3.6** CHIEF MEDICAL OFFICER or VICE PRESIDENT OF MEDICAL AFFAIRS means a physician appointed by the Governing Body as an administrator who, among other duties, is a liaison between the Medical Staff and Hospital administration.
- 1.3.7** CHIEF OF STAFF means the chief officer of the Medical Staff elected by the Medical Staff.
- 1.3.8** CLINICAL PRIVILEGES or PRIVILEGES means the permission granted by the Governing Body to individual Medical Staff members and Advanced Practitioner Practitioners to render specific patient services.
- 1.3.9** COMPLETED APPLICATION means an application that includes all the information requested by the Medical Staff at any time during the application process by any person or committee charged with evaluating the application.
- 1.3.10** CONFLICT OF INTEREST means a personal or financial interest or conflicting fiduciary obligation on the part of an individual or an immediate family member of that individual (including a spouse, domestic partner, child or parent) that may negatively impact, as a practical matter, the individual’s ability to act in the best interests of the Medical Staff without regard to the individual’s private or personal interest, or creates the impression of such a conflict.
- 1.3.11** DAYS means calendar days, unless otherwise indicated.

- 1.3.12** DISTANT SITE HOSPITAL means a Medicare-certified hospital where a Telehealth Provider is located.
- 1.3.13** DISTANT SITE ENTITY means an entity that provides telemedicine services and is not a Medicare-certified hospital.
- 1.3.14** EX OFFICIO means service by virtue of office or position held. An ex officio appointment is with vote unless specified otherwise.
- 1.3.15** GOVERNING BODY means the Governing Board for the Hospital. As appropriate to the context and consistent with the Hospital's Bylaws, it may also mean any Governing Body committee or individual authorized to act on behalf of the Governing Body.
- 1.3.16** GOVERNING DOCUMENTS means the documents that create a system of rights, responsibilities, and accountability between the Medical Staff and the Governing Body, and between the Medical Staff and its members; they include the Hospital and Medical Staff Bylaws, Rules and Regulations, Policies and Procedures, Department or Section Rules and Policies and Procedures, and any other document adopted by the Hospital or Medical Staff directly applicable to Medical Staff operations, the granting of membership or privileges on the Medical Staff, or the exercise of privileges at the Hospital.
- 1.3.17** **HOSPITAL means Good Samaritan Hospital and includes all inpatient, outpatient and rural health clinic locations and services operating under the Hospital's license.**
- 1.3.18** IN GOOD STANDING means a member currently meets all membership requirements (including, but not limited to, meeting attendance requirements and payment of dues or assessments) and is not currently under any limitation of any Medical Staff rights or privileges. "Limitation" may include, but is not limited to, suspension, concurrent proctoring unrelated to initial privileges, or consultation requirement.
- 1.3.19** INVESTIGATION means the formal process initiated by the Medical Executive Committee, as set forth in the Investigations Article of these Bylaws. To constitute an investigation, this formally commenced process generally must be the precursor to a decision regarding whether or not to take corrective action, and is ongoing until either formal action is taken, or the investigation is closed. Except as otherwise provided in these Bylaws, only the Medical Executive Committee or Governing Body may take or recommend corrective action as the result of an investigation. An investigation does not include activity of the Medical Staff Wellbeing Committee, which lacks the authority to take or recommend corrective action.

Notwithstanding the above, for the purposes of complying with applicable reporting requirements under Business and Professions Code Sections 805 and 805.01 or the National Practitioner Data Bank (collectively, "the Reporting

Requirements”), the Medical Executive Committee will, as needed and on a case-by-case basis, evaluate whether a focused professional practice evaluation falls within the definition or description of “investigation” under the statutes, regulations, or guidance that govern the Reporting Requirements.

- 1.3.20** MEDICAL EXECUTIVE COMMITTEE means the executive committee of the Medical Staff.
- 1.3.21** MEDICAL STAFF means the organizational component of the Hospital that includes all Practitioners who have been granted recognition as Members pursuant to these Bylaws.
- 1.3.22** MEDICAL STAFF LEADER means any Medical Staff officer, department chair or vice chair, or committee chair.
- 1.3.23** MEDICAL STAFF YEAR means the period from January 1 through December 31.
- 1.3.24** MEMBER means, unless otherwise indicated in the Bylaws, Rules, or Policies, any Practitioner appointed to the Medical Staff.
- 1.3.25** MONTHLY or ONCE A MONTH means, for the purpose of Medical Staff committee meeting requirements, meeting at least once during at least eight months a year.
- 1.3.26** NOTICE means a written communication (1) sent by United States mail, first-class postage prepaid, addressed to the addressee at the last address as it appears in the official records of the Medical Staff or the Hospital, (2) sent by an electronic means approved by the Medical Executive Committee as an appropriate manner of communication, but only if directed to the Medical Staff as a whole, a Department as a whole, or a committee as a whole, and not directed toward an individual member, or (3) by any manner identified in the Special Notice definition.
- 1.3.27** PATIENT CONTACT means any provision of medical care by a Practitioner to a patient at the Hospital, including but not limited to, admission, consultation, surgical or other procedure, and care management, performed in any facility included on the Hospital’s license or provided through a telemedicine link. The provision of medical care to a patient during a discrete admission at the Hospital is one patient contact, regardless of the extent of medical care provided during that admission.
- 1.3.28** POLICIES AND PROCEDURES means those documents adopted as Medical Staff policies in accordance with these Bylaws, unless specified otherwise. “Department Policies” or “Section Policies” means the department or section policies adopted in accordance with applicable Bylaws, Rules, or policy.

- 1.3.29** PRACTITIONER means a physician, podiatrist, dentist, or clinical psychologist.
- 1.3.30** RULES AND REGULATIONS or RULES means the Medical Staff Rules and Regulations adopted in accordance with these Bylaws unless specified otherwise. “Department Rules” or “Section Rules” means the department or section rules adopted in accordance with applicable Bylaws, Rules, or policy.
- 1.3.31** SPECIAL NOTICE means a notice sent by (1) certified or registered mail, return receipt requested, (2) via a courier delivery service that documents delivery (such as, but not limited to, FedEx or UPS), or (3) hand-delivery, with a signed receipt (or, if there is a refusal to sign, documentation that it was delivered).
- 1.3.32** SYSTEM means Good Samaritan Hospital.
- 1.3.33** SYSTEM MEMBER means a facility or entity (such as an rural health clinic, urgent care center, surgery center, foundation or other entity) that is part of the system.
- 1.3.34** TELEHEALTH means the mode, as defined by law, of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient’s health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth includes synchronous (real time) interactions and asynchronous store and forward transfers of patient information without the presence of the patient.
- 1.3.35** TELEMEDICINE means that subset of Telehealth services delivered to Hospital patients by Practitioners or Allied Health Staff.
- 1.3.36** TELEHEALTH PROVIDER or TELEMEDICINE PROVIDER means Practitioners or Allied Health Staff who have been granted privileges by this Hospital to provide services only via Telehealth modalities.

1.4 Delegation of Tasks

- 1.4.1** The Governing Body, the Hospital administration, or a Medical Staff Leader may delegate the tasks assigned to them by the Governing Documents to appropriate designees, unless the Governing Documents express otherwise, or such delegation is contrary to law or accreditation requirement.
- 1.4.2** When a Medical Staff Member is unable to perform an assigned task, a Medical Staff Leader may perform the task or delegate it to another appropriate designee. If there are any questions as to who should perform the task, the Chief of Staff shall make the assignment.

- 1.4.3 Any member who acts in the name of this Medical Staff without proper authority shall be subject to disciplinary action.

1.5 Medical Staff Responsibilities

The Medical Staff is responsible to the Governing Body for the following:

- 1.5.1 The adequacy and quality of care rendered to patients;
- 1.5.2 Initiating, developing, and adopting Medical Staff Bylaws, rules, and regulations, and amendments thereto, subject to the approval of the Governing Body, which approval shall not be unreasonably withheld;
- 1.5.3 Assuring that the Bylaws provide formal procedures for the evaluation of staff applications and credentials, appointments, reappointments, assignment of clinical privileges, appeals mechanisms and such other subjects or conditions which the Medical Staff and Governing Body deem appropriate;
- 1.5.4 Abiding by and establishing a means of enforcement of its Bylaws;
- 1.5.5 Establishing clinical criteria and standards for Medical Staff membership and privileges, and enforcing those criteria and standards;
- 1.5.6 Making recommendations regarding granting membership and delineating privileges;
- 1.5.7 Establishing clinical criteria and standards to oversee and manage quality assurance, utilization review, and other Medical Staff activities including, but not limited to, periodic meetings of the Medical Staff and its committees and departments and review and analysis of patient medical records;
- 1.5.8 Organizing committees to fulfill the functions required by state and federal law or accreditation standards, or as otherwise requested by the Governing Body;
- 1.5.9 Providing leadership to departments/services;
- 1.5.10 Providing ongoing evaluation of care;
- 1.5.11 Organizing and supporting professional education and community health education and support services;
- 1.5.12 Investigating, when authorized by these Bylaws, members or Allied Health Staff and taking corrective action where warranted;
- 1.5.13 Providing processes for fair hearings;

- 1.5.14 Operating in a manner that permits the Hospital to meet its obligations to the community, as well as to comply with state and federal law and accreditation standards;
- 1.5.15 Exercising its rights and responsibilities in a manner that does not jeopardize the Hospital's license, Medicare and Medi-Cal provider status, accreditation, or [tax exempt status].

1.6 Self Governance and Independent Rights

1.6.1 The Medical Staff's right to self-governance includes:

- (a) Establishing, in Medical Staff Bylaws, rules, or regulations, criteria and standards for Medical Staff membership and privileges, and enforcing those criteria and standards.
- (b) Establishing, in Medical Staff Bylaws, rules, or regulations, clinical criteria and standards to oversee and manage quality assurance, utilization review, and other Medical Staff activities including, but not limited to, periodic meetings of the Medical Staff and its committees and departments and review and analysis of patient medical records.
- (c) Selecting and removing Medical Staff officers.
- (d) Assessing Medical Staff dues and utilizing the Medical Staff dues as appropriate for the purposes of the Medical Staff.
- (e) The ability to retain and be represented by independent legal counsel at the expense of the Medical Staff.
- (f) Initiating, developing, and adopting Medical Staff Bylaws, rules, and regulations, and amendments thereto, subject to the approval of the Governing Body, which approval shall not be unreasonably withheld.

1.6.2 The Medical Staff has certain independent rights with which the Governing Body may not interfere. Those rights are:

- (a) Right to counsel. Upon the authorization of the Medical Executive Committee, the Medical Staff may retain and be represented by independent legal counsel, who shall be compensated through Medical Staff funds.
- (b) Right to dues. The Medical Staff has the ability to assess dues and use them for its own purposes.
- (c) Right to select officers. The Medical Staff may select and remove Medical Staff officers without interference.

1.7 Meet and Confer

The Medical Staff and the Governing Body shall meet and confer in good faith to resolve any disputes regarding the Medical Staff's rights and responsibilities and any disputes regarding the operation or outcome of the processes detailed in the Governing Documents; if necessary, the Medical Staff and Governing Body shall follow the conflict resolution process referenced in the Rules.

ARTICLE 2

OFFICERS, MEMBERS AT LARGE, AND CHIEF MEDICAL OFFICER

2.1 Identification of Officers

The officers of the Medical Staff are:

- 2.1.1 Chief of Staff
- 2.1.2 Vice Chief
- 2.1.3 Department/Committee Chairs

2.2 Qualifications

Officers of the Medical Staff must:

- 2.2.1 Be a physician, dentist, clinical psychologist or podiatrist;
- 2.2.2 Have served on the Active Staff for at least (1) one year prior to nomination;
- 2.2.3 Understand the purposes and functions of the Medical Staff and demonstrate willingness to assure that patient welfare always takes precedence over other concerns;
- 2.2.4 Be members of the Active Staff in good standing at the time of nomination and election, and remain members of the Active Staff in good standing throughout their term;
- 2.2.5 At the time of nomination and election, not be subject to any adverse recommendations that, if become final, would limit the Practitioner's appointment or privileges;
- 2.2.6 Disclose all conflicts of interests, as defined in the Governing Documents, and not have any disqualifying conflict of interest as defined in the Governing Documents; and
- 2.2.7 Demonstrate an understanding of the Medical Staff's purposes and functions, including the Medical Staff's responsibilities to the Governing Body.
- 2.2.8 Be willing to faithfully discharge the duties and responsibilities of the position.

2.3 Terms of Office

2.3.1 Elections are held in the fall of odd-numbered years and Officers shall take office the following January.

2.3.2 The term of office shall be two years. No officer shall serve consecutive terms in the same position.

2.4 General Responsibilities

All officers of the Medical Staff are representatives of the Medical Staff and must:

2.4.1 Understand and work toward the fulfillment of the Medical Staff purpose and responsibilities, as described in Article 1;

2.4.2 Promote compliance with the Governing Documents by all Medical Staff members;

2.4.3 Represent the needs of Medical Staff members; and

2.4.4 Comport themselves in a responsible, professional, and collegial manner.

2.5 Specific Duties

2.5.1 Chief of Staff. The Chief of Staff serves as the chief officer of the Medical Staff. The Chief of Staff's duties include, but are not limited to:

- (a) Being responsible for the organization and conduct of the Medical Staff;
- (b) Enforcing the Governing Documents;
- (c) Promoting quality of care, implementing sanctions when indicated, and promoting compliance with procedural safeguards when corrective action has been requested or initiated;
- (d) Calling, presiding at, and being responsible for the agenda of all meetings of the Medical Staff;
- (e) Serving as Chair of the Medical Executive Committee with vote;
- (f) Serving as an ex officio member of all other Medical Staff committees without vote, unless otherwise provided in the Governing Documents;
- (g) Appointing, in consultation with the Medical Executive Committee, committee members for all standing, ad hoc, and special Medical Staff, liaison, or multi-disciplinary committees, except where otherwise provided by the Governing Documents, and designating the Chairs of

these committees, except where otherwise provided by the Governing Documents;

- (h) Serving as, or appointing members of the Medical Staff to serve as, a Medical Staff liaison to participate in the development of Hospital policies;
- (i) In the interim between Medical Executive Committee meetings, performing those responsibilities of the committee that, in his or her reasonable opinion, must be accomplished prior to the next regular or special meeting of the committee;
- (j) Being a spokesperson for the Medical Staff in external professional and public relations;
- (k) Consulting directly with the Governing Body periodically (and at least twice) throughout the year about, at a minimum, the quality of medical care provided to Hospital patients;
- (l) Serving on liaison committees with the Governing Body and Hospital administration, as well as outside licensing or accreditation agencies;
- (m) Interacting with the Chief Executive Officer and Governing Body in all matters of mutual concern within the Hospital and communicating to the Medical Staff any concerns expressed by the Governing Body;
- (n) Representing the views and policies of the Medical Staff to the Governing Body and to the Chief Executive Officer and serving as an ex-officio member of the Governing Body [without vote];
- (o) Regularly reporting to the Governing Body on the performance of Medical Staff functions;
- (p) Being accountable to the Governing Body, in conjunction with the Medical Executive Committee, for the Medical Staff's effective performance of its responsibilities; and
- (q) Performing such other functions as may be assigned to him or her by these Bylaws, the Medical Staff, or the Medical Executive Committee.

2.5.2 Vice Chief. The Vice Chief's duties include, but are not limited to:

- (a) Assuming the duties of the Chief of Staff and acting with full authority as Chief of Staff in his or her absence;
- (b) Serving on the Medical Executive Committee;

- (c) Performing other duties as assigned by the Chief of Staff or the Medical Executive Committee, or as delineated in the Governing Documents; and
- (d) Automatically succeeding the Chief of Staff at the beginning of the next Medical Staff term or sooner should the office become vacant for any reason during the Chief of Staff's term of office.

2.5.3 Immediate Past Chief of Staff. The Immediate Past Chief of Staff's duties include, but are not limited to:

- (a) Serving on the Medical Executive Committee;
- (b) Serving as an advisor to other Medical Staff Leaders; and
- (c) Performing other duties as are assigned by the Chief of Staff or the Medical Executive Committee, or as are delineated in the Medical Staff Bylaws, Rules, or policies.

2.6 At-Large Members

- 2.6.1** The Medical Staff shall select (2) two members-at-large. Members-at-large are not officers.
- 2.6.2** At the time of nomination, election, and throughout their term, members-at-large must be in good standing and not be subject to any adverse recommendation that, if it were to become final, would limit the Practitioner's appointment or privileges.
- 2.6.3** Candidates for member-at-large positions must disclose all conflicts of interests, as defined in the Governing Documents, and not have any disqualifying conflict of interest as defined in these Medical Staff Bylaws, Rules, or policy.
- 2.6.4** Members-at-large shall serve on the Medical Executive Committee.

2.7 Nominations

Nominations for office or member-at-large positions are made by the nominating committee or by petition, as described below. Due to the requirement to determine the qualifications of candidates and to disclose conflicts of interests prior to elections, nominations from the floor shall not be accepted during any election.

2.7.1 By Committee

- (a) At least 150 days prior to an election being held, the Medical Executive Committee shall appoint a nominating committee. The nominating committee will include the Chief of Staff, the Immediate Past Chief of Staff, and at least two other members selected by the Medical Executive Committee. The nominating committee shall meet at least 120 days prior to the scheduled election.
- (b) At least 90 days prior to the election, the nominating committee shall request names of potential candidates from members of the Medical Staff. Such request can be made either by mail, email, or by posting the request in Medical Staff common areas, or any combination of those means. The nominating committee is not obligated to include any names it receives as a result of this request on the slate of candidates submitted to the Medical Staff.
- (c) The nominating committee shall confirm that any potential candidate meets the qualifications set forth in this Article, is willing to serve if elected, and fulfills the conflicts of interest obligations as defined in the Governing Documents.
- (d) At least 60 days before the election, the nominating committee shall develop a slate of candidates meeting the qualifications for the position

for which they are being nominated. At least one candidate shall be nominated for each of the following positions:

- (i) Chief of Staff
- (ii) Vice Chief of Staff
- (iii) Member-at-large, if any positions are open for election

2.7.2 By Petition

The Medical Staff can nominate candidates for any open office or member-at-large position by petition signed by at least 25% of members eligible to vote. The candidate must meet the qualifications detailed in this Article, and the candidate's name and proposed office must appear on each page of the petition where signatures appear. The candidate must submit a statement signifying a willingness to run. Such nominations must be received by the Chief of Staff at least 30 days prior to ballots being distributed.

2.8 Election

- 2.8.1** The election may be held either by mail ballot or by an electronic means approved by the Medical Executive Committee and the Governing Body at least six months prior to the election. Any approved electronic means shall provide for voter security and confidentiality and shall be detailed in a written policy that is distributed to the Medical Staff.
- 2.8.2** At least 15 days prior to the deadline to return the ballots or vote electronically, the ballot with the slate of candidates and the conflicts of interest form filled out by each candidate pursuant to the Governing Documents shall be sent to the voting members of the Medical Staff. The ballot may be sent by mail or by an electronic means and shall identify the deadline for the return of ballots or for voting electronically. Ballots received after the deadline shall not be counted.
- 2.8.3** The Chief of Staff shall appoint a Medical Staff member who is not a candidate for office to monitor and validate the election process.
- 2.8.4** The candidate receiving a simple majority of votes shall be elected. If there are three or more candidates and none receive a simple majority, there shall be a run-off election between the two candidates receiving the highest number votes. The Medical Executive Committee shall approve a process for a timely run-off election.
- 2.8.5** In an election or run-off where each of two candidates receive 50% of the vote, the majority vote of the Medical Executive Committee shall decide the election by secret written ballot at its next meeting or a special meeting called for that purpose.

2.9 Recall of Officer or Member-at-Large

2.9.1 A Medical Staff officer or member-at-large may be recalled from office for any of the following:

- (a) Failing to comply with the Governing Documents;
- (b) Failing to perform the duties of the position held;
- (c) Failing to demonstrate a willingness to promote patient safety over all other concerns;
- (d) Demonstrating an unwillingness to work with the Hospital toward attaining its lawful and reasonable goals;
- (e) Conduct detrimental to the interests of the Medical Staff or the Hospital;
- (f) Demonstrating an inability to work with and motivate others to achieve the objectives of the Medical Staff organization in the context of the Hospital's lawful and reasonable objectives.
- (g) Any condition that renders the individual incapable of fulfilling the duties of that office; or
- (h) Failure to continuously meet the qualifications for the office or position.

2.9.2 Recall of a Medical Staff officer or member-at-large may be initiated by a majority of the Medical Executive Committee or by a petition signed by at least one-third of the Medical Staff members eligible to vote for officers. On each page where signatures appear, the petition must include the name and office of the person proposed to be subject to the recall and state that the purpose of the petition is to call for a recall vote.

2.9.3 Upon the initiation of the recall process, the Medical Executive Committee shall set a date for the vote on recall by those Medical Staff members eligible to vote for officers. The date of the vote shall be no later than 45 days after the initiation of the recall process. The individual subject to the recall vote shall be given at least 15 days' Special Notice prior to the recall vote and may submit a written statement to the Medical Executive Committee and to the Medical Staff prior to the vote.

2.9.4 Recall shall require a two-thirds vote in favor of recall by those Medical Staff members eligible to vote for officers and who timely cast a ballot.

2.10 Vacancies

Vacancies in office occur upon resignation, removal, death, or failure to continuously meet the qualifications of office. Vacancies shall be filled as follows:

- 2.10.1** If there is a vacancy in the office of Chief of Staff, the Vice Chief will serve until the end of the unexpired term of the Chief of Staff. If the unexpired term is less than one year, then the Vice Chief who served out that term shall continue to serve as Chief of Staff for the following two-year term.
- 2.10.2** If there is a vacancy in the office of Vice Chief, the Medical Executive Committee will appoint an individual who satisfies the officer qualifications set forth in in this Article to the office if the vacancy is for a period of less than one year. If the vacancy occurs one year or more prior to the next term, the MEC shall hold a special election for Vice Chief. The Vice Chief elected in the special election shall automatically succeed the Chief of Staff at the beginning of the next Medical Staff term.
- 2.10.3** If there is a vacancy of a member-at-large of the Medical Executive Committee, the Medical Executive Committee will appoint an individual who satisfies the qualifications for the position in issue set forth in this Article until a special election can be held at the discretion of the Medical Executive Committee.
- 2.10.4** Vacancies in the office of Immediate Past Chief of Staff will not be filled.

2.11 Chief Medical Officer

2.11.1 Appointment

The Chief Medical Officer shall be appointed by the Governing Body after soliciting input from the Medical Executive Committee. The Medical Executive Committee shall participate in the interview process for the selection of a Chief Medical Officer.

2.11.2 Responsibilities

- (a) The Chief Medical Officer's duties are delineated by the Governing Body in keeping with the general provisions set forth in subparagraph (b) below. The Medical Executive Committee approval is required for any Chief Medical Officer duties that relate to authority to perform functions on behalf of the Medical Staff or directly affect the performance or activities of the Medical Staff.

ARTICLE 3

DEPARTMENTS/SERVICES

3.1 Organization of Clinical Departments

- 3.1.1 The Medical Staff shall be organized into clinical departments.
- 3.1.2 The departments shall fulfill the clinical, administrative, quality improvement, risk management, utilization management, and collegial and education functions as described in the Governing Documents.
- 3.1.3 Subject to the Governing Body's approval, the Medical Executive Committee may create, eliminate, or combine departments for better organizational efficiency, or may divide them into sections or divisions.
- 3.1.4 Each member shall be assigned membership in at least one department and shall comply with the responsibilities of membership in any department or any section or division to which he or she is assigned.

3.2 Identification of Departments

The departments of the Medical Staff are identified in the Medical Staff Rules.

3.3 Functions of Departments

The Departments shall be responsible for the following, in accordance with the Governing Documents:

- 3.3.1 Conducting performance evaluations and monitoring of all department members and APPs exercising privileges in the department and continuous assessment and improvement of the quality of care, treatment and services (including periodic demonstrations of ability).
- 3.3.2 Credentials review.
- 3.3.3 Recommending to the Medical Executive Committee criteria for granting clinical privileges and performing specified services within the department.
- 3.3.4 Initiating and assisting in the conduct of performance improvement and corrective action, when indicated.
- 3.3.5 Conducting orientations and continuing education consistent with any relevant Governing Documents.
- 3.3.6 Planning and budget review, including making recommendations regarding space and other resources needed by the department.

3.3.7 Meeting regularly to perform its functions and reporting to the Medical Executive Committee regarding its activities and recommendations for improvement.

3.3.8 Any additional responsibility assigned by the Medical Executive Committee.

3.4 Department Meetings and Committees

The department may develop committees to fulfill the department's functions. These committees constitute Medical Staff committees. Each department or its committees, if any, must meet regularly to carry out its duties.

3.5 Sections

Within each department, the Practitioners of the various specialty groups may organize themselves as a clinical section, subject to the approval of the Medical Executive Committee and Governing Body. Each section may develop rules specifying the section's purpose and responsibilities, the qualifications for section leaders, its method of selecting section leaders, and section leaders' responsibilities. These rules shall be effective when approved by the Department, Medical Executive Committee, and Governing Body. Section leaders report directly to the Department Chair. While sections may assist departments in performance of departmental functions, responsibility and accountability for performance of departmental functions shall remain at the departmental level.

3.6 Department/Service Officers

3.6.1 Qualifications

Each department shall have a chair and vice-chair. The chair and vice chair shall:

- (a) Be members of the Active Staff in good standing at the time of nomination and election and remain members of the Active Staff in good standing throughout their term;
- (b) At the time of nomination and election, not be subject to any adverse recommendation that, if it becomes final, would limit the Practitioner's appointment or privileges;
- (c) Disclose all conflicts of interests, as defined in the Governing Documents, and not have any disqualifying conflict of interest as defined in the Governing Documents;
- (d) Be qualified by licensure and have demonstrated ability in at least one of the clinical areas covered by the department.
- (e) Be certified by an appropriate specialty board, unless no one so certified is available;

- (f) Be willing to faithfully discharge the duties and responsibilities of the position.

3.6.2 Responsibility of Chair

The department chair's roles and responsibilities include at least the following:

- (a) Clinically-related activities of the department.
- (b) Administratively-related activities of the department, unless otherwise provided by the Hospital.
- (c) Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges.
- (d) Recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the department.
- (e) Recommending clinical privileges for each member of the department.
- (f) Assessing and recommending to the relevant Hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization.
- (g) Integration of the department or service into the primary functions of the organization.
- (h) Coordination and integration of interdepartmental and intradepartmental services.
- (i) Development and implementation of policies and procedures that guide and support the provision of care, treatment, and services.
- (j) Recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services.
- (k) Determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services.
- (l) Continuous assessment and improvement of the quality of care, treatment, and services.
- (m) Maintenance of quality control programs, as appropriate.
- (n) Orientation and continuing education of all persons in the department.
- (o) Recommending space and other resources needed by the department or service.

- (p) Chairing all department meetings.
- (q) Serving as an ex officio member of all committees of his or her department and attending such committee meetings as deemed necessary for adequate information flow.
- (r) Assuring that records of performance are maintained and updated for all members of his or her department.
- (s) Reporting on activities of the Medical Staff to the Governing Body when called upon to do so by the Chief of Staff or the Chief Executive Officer.
- (t) Serving as a member of the Medical Executive Committee, if identified as a Medical Executive Committee member.
- (u) Performing such additional responsibilities as may be delegated to him or her by the Medical Executive Committee or the Chief of Staff.

3.6.3 Responsibility of Vice Chair

Each Vice Chair shall assist the Department Chair to perform his or her duties and, in the absence or disability of the Department Chair, be responsible for performing the duties of the Department Chair. This includes, but is not limited to, assuming the Chair's voting rights on all Medical Staff or Department Committees. The Vice Chair also shall perform any other duties assigned by the Department Chair or the Medical Executive Committee.

3.6.4 Nominations

- (a) Unless otherwise specified, the Chair and members of all committee shall be appointed by, and may be removed by, the Chief of Staff, subject to consultation with and approval by the Medical Executive Committee. Medical Staff committee shall be responsible to the Medical Executive Committee.

3.6.5 Term of Office

- (a) The term of office shall be (2) two years.

3.6.6 Recall

Department Chairs and Vice Chairs may be recalled for the reasons identified for the recall of Medical Staff Officers, and in a manner consistent with the process for the recall of Medical Staff Officers, except that (a) for recall not initiated by the Medical Executive Committee, only members of the department eligible to vote may sign the petition to initiate the recall and vote in the recall election; (b) the department leader's written statement, if any, shall be sent only to department members, and (c) no removal shall be effective until

it is ratified by the Medical Executive Committee.

3.6.7 Vacancies

Vacancies in the office of Department Chair shall be filled by the Vice Chair. Vacancies in the office of Vice Chair shall be filled via special election if a year or more is left in the term, and by appointment by the Chair after consultation with the Department members if less than a year is left in the term.

ARTICLE 4
COMMITTEES

4.1 Designation

- 4.1.1 Medical Staff committees include, but are not limited to, any committee described in the Governing Documents; meetings of a Department; meetings of a Section; any ad hoc, special, or sub-committee created by a (a) committee described in the Governing Documents, (b) Department, or (c) Section; any meeting that takes place pursuant to the meeting provisions of these Bylaws; or any meeting of the Medical Staff as a whole.
- 4.1.2 Any meeting or activities related to the business of Medical Staff committees shall be considered Medical Staff committee proceedings and shall be entitled to the protections and immunities afforded to peer review committees under state and federal law.
- 4.1.3 All Medical Staff committees shall be responsible to the Medical Executive Committee.

4.2 Creation

- 4.2.1 The Medical Staff's standing committees shall be those identified in these Bylaws or in the Rules, and those designated as standing committees by the Departments or Sections.
- 4.2.2 Subject to the available resources of the Medical Staff Administration, any committee can create a subcommittee, such as a special committee or ad hoc committee, to perform specified tasks. The committee chair shall inform the Medical Executive Committee when a subcommittee is created. The committee chair may appoint individuals in addition to, or other than, members of the standing committee to the subcommittee after consulting with the Chief of Staff regarding Medical Staff member appointees, and the Chief Executive Officer regarding Hospital Staff appointees.
- 4.2.3 No committee shall create a special committee or ad hoc committee to perform a task already assigned to another committee. Committees shall, as appropriate, attempt to coordinate their efforts to maximize efficiency and minimize redundancy.

4.3 Appointment and Nonmembers

- 4.3.1 Unless otherwise specified in the Governing Documents, the chair and members of all committees shall be appointed by, and may be removed by, the Chief of Staff, subject to consultation with and approval by the Medical Executive Committee; however, the Chief of Staff may not remove persons who are ex

officio members of the committee or whose membership is required by the Governing Documents.

- 4.3.2 A Medical Staff committee is composed as stated in the description of the committee in the Governing Documents. Unless provided otherwise in the Bylaws or Rules, Medical Staff committees may include persons who are not Medical Staff members or otherwise affiliated with the Hospital, depending on the committee's functions.
- 4.3.3 Each Medical Staff member who serves on a committee participates with vote unless the Governing Documents designate the position as nonvoting.
- 4.3.4 The Chief of Staff, subject to the approval of the Chief Executive Officer or his or her designee, shall appoint any non-Medical Staff members who serve in non-ex officio capacities.
- 4.3.5 Unless otherwise provided in the Bylaws or Rules, terms of appointment shall be for (2) two years, subject to earlier resignation or removal. Committee members may be appointed for consecutive terms, without limit. Insofar as possible, terms in any individual committee shall be staggered to achieve continuity.
- 4.3.6 A committee chair may, in his or her discretion, allow a Medical Staff member or Allied Health Staff member who is not a committee member to attend a portion of a committee meeting that is of importance to the member. The committee chair will exercise his or her judgment regarding whether any guest is permitted to attend a portion of the committee meeting in which confidential information regarding another Practitioner or Allied Health Staff member is discussed. Committee guests must abide by the confidentiality and other rules that apply to committee members.

4.4 Ex Officio Members

Unless otherwise provided in the Governing Documents, the Chief of Staff and the Chief Executive Officer or their respective designees are ex officio members of all standing and special committees of the Medical Staff, except the Well-Being Committee, and shall serve without vote.

4.5 Committee Chairs

- 4.5.1 In appointing committee chairs, the Chief of Staff's goal shall be to appoint individuals who:
 - (a) Have demonstrated a commitment to the Medical Staff's responsibilities,
 - (b) Support the mission of the Hospital,
 - (c) Understand how the committee's duties and actions impact the Medical Staff's and Hospital's legal and credentialing obligations, and are

committed to lead in a manner that promotes compliance with those obligations; and

(d) Are knowledgeable about the committee's area of focus.

- 4.5.2 Committee chairs are expected to conduct committee meetings in an efficient and expeditious manner and to ensure that proper decorum is maintained. Committee chairs also are responsible for ensuring that the committee functions in a manner designed to achieve and fulfill the committee's duties.
- 4.5.3 Committee chairs may call on outside consultants or special advisors, but only after obtaining approval from the Chief of Staff and, if the Hospital is to pay for any portion of the consultant or special advisor's fee, approval from the Chief Executive Officer.
- 4.5.4 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.
- 4.5.5 Each committee chair or other authorized person chairing a meeting has the right to discuss and to vote on issues presented to the committee.

4.6 Conflicts of Interest

Every committee member, regardless of whether the person serves as an ex officio member, must disclose all conflicts of interests, as defined in the Governing Documents, and not have any disqualifying conflict of interest as defined in the Governing Documents. In addition, committee members must orally identify any conflicts of interest relating to a particular subject matter when that subject is discussed in committee. The member, either upon his or her own initiative or upon direction from the Chair, shall recuse himself or herself from any discussion or action that may be impacted by the conflict of interest.

4.7 Representation on Hospital Committees and Participation in Hospital Functions

Upon the Governing Body's approval, the Medical Staff may discharge its duties relating to accreditation, licensure, certification, disaster planning, facility and services planning, financial management and physical plant safety by providing Medical Staff representation on Hospital committees established to perform such functions.

4.8 Charters

The composition, duties, and meeting frequency of each standing committee shall be described in the Bylaws or the Rules. All committees are accountable to the Medical Executive Committee.

4.9 Medical Executive Committee

The Medical Executive Committee is the executive committee of the Medical Staff.

4.9.1 Composition

- (a) A majority of the members of the Medical Executive Committee shall be doctors of medicine or doctors of osteopathy. The Medical Executive Committee shall be composed of:
 - (i) The Medical Staff Officers;
 - (ii) The member(s)-at-large;
 - (iii) The Department Chairs;
 - (iv) The chairs of the Quality Improvement and Pharmacy & Therapeutics
 - (v) The Chief Executive Officer or designee as ex officio;
 - (vi) The Chief Nursing Executive or designee as ex officio.
- (b) If at any time the composition requirements in (a) above result in less than a majority the members of the Medical Executive Committee not being doctors of medicine or doctors of osteopathy, then notwithstanding any other provision in these Bylaws, the Medical Staff will hold a special election for sufficient additional members-at-large to serve on the Medical Executive Committee. In such special elections, only doctors of medicine or doctors of osteopathy shall be eligible for election as at-large members. The Medical Executive Committee shall set a date for the election that is later more than 90 days from the date that the need for a special election is identified. The special election shall, to the extent feasible, comply with the election procedures identified in these Bylaws for at-large members, except that (i) the Medical Executive Committee may stand in the place of the Nominating Committee, (ii) the Medical Executive Committee may modify the deadlines and dates as needed to facilitate an efficient process, as long as that process remains fair, and (iii) such number of at-large members shall be elected as to result in a majority of the members of the Medical Executive Committee being doctors of medicine or doctors of osteopathy.

4.9.2 Duties

The Medical Staff delegates to the Medical Executive Committee broad authority to oversee the operations of the Medical Staff. This includes, but is not limited to, the authority and responsibility over the matters identified below, as well as anything else identified throughout these Bylaws as being within the

Medical Executive Committee's authority. The Medical Staff may delegate additional authority to, or remove authority from, the Medical Executive Committee through amendment of these Bylaws.

The Medical Executive Committee shall:

- (a) Assure that the Medical Staff fulfills each of its purposes and responsibilities, as described in Article 1 and elsewhere in these Bylaws.
- (b) Supervise the performance of all Medical Staff functions, which shall include:
 - (i) Requiring regular reports and recommendations from the departments, committees and officers of the Medical Staff concerning their discharge of assigned functions;
 - (ii) Issuing directives as appropriate to assure effective performance of all Medical Staff functions; and
 - (iii) Following up to assure implementation of all directives.
- (c) Review and make recommendations to the Governing Body on reports of Medical Staff committees, departments, and other assigned activity groups.
- (d) Oversee the coordination of the activities of the committees and departments.
- (e) Make recommendations to the Governing Body on Medical Staff membership, the Medical Staff structure, the process used to review credentials and delineate privileges, and the delineation of privileges for each Practitioner and APP privileged through the Medical Staff process.
- (f) Oversee and ensure that the Medical Staff establishes criteria and standards for Medical Staff membership and privileges, and enforce those criteria and standards in reviewing the qualifications, credentials, performance, and professional competence and character of applicants and staff members.
- (g) Oversee and ensure that the Medical Staff establishes 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.
- (h) Evaluate the performance of Practitioners exercising clinical privileges whenever there is doubt about the ability of an applicant, member, or Allied Health Practitioner to perform requested privileges.

- (i) Based upon input from the departments and Credentials Committee, make recommendations regarding all applications for Medical Staff appointment, reappointment, and privileges.
- (j) When indicated, initiate Focused Professional Practice Evaluations and/or pursue disciplinary or corrective actions affecting Medical Staff members or APPs.
- (k) With the assistance of the Chief of Staff, supervise the Medical Staff's compliance with:
 - (i) The Governing Documents;
 - (ii) The Hospital's Bylaws, Rules, and policies;
 - (iii) State and federal laws and regulations; and
 - (iv) Applicable accreditation requirements.
- (l) Adopt and amend rules and regulations, and do so in a manner consistent with these Bylaws.
- (m) Oversee the development and amendment of Medical Staff policies, approve (or disapprove) all such policies, and oversee the implementation of those policies.
- (n) Implement, as they relate to the Medical Staff, the Hospital's approved policies.
- (o) Confer and meet in good faith with the Governing Body or its designee to resolve disputes with the Governing Body, or delegate that meeting to another committee;
- (p) With the Department Chairs, set departmental objectives for establishing, maintaining, and enforcing professional standards within the Hospital and for continually improving 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.
- (q) Regularly report to the Governing Body through the Chief of Staff and the Chief Executive Officer on at least the following:
 - (i) The outcomes of Medical Staff quality improvement programs, providing sufficient background and detail to assure the Governing Body that quality of care is consistent with professional standards; and

- (ii) The general status of any Medical Staff disciplinary or corrective actions in progress.
- (r) Promote the ethical and collegial practice of all Practitioners and APPs.
- (s) Assist the Hospital in reviewing and advising on sources of clinical services provided by consultation, contractual arrangements, or other agreements; in evaluating the safety and quality of services provided via consultation, contractual arrangements, or other agreements; and in providing relevant input to notice-and-comment proceedings or other mechanisms that may be implemented by Hospital administration in making exclusive contracting decisions.
- (t) Prioritize and assure that Hospital-sponsored educational programs incorporate the recommendations and results of Medical Staff quality assessment and improvement activities.
- (u) Establish, as necessary, ad hoc committees to fulfill particular functions for a limited time; such committees will report directly to the Medical Executive Committee.
- (v) Establish the date, place, time, and program of the regular meetings of the Medical Staff.
- (w) Represent and act on behalf of the Medical Staff between meetings of the Medical Staff.
- (x) Take such other actions as may reasonably be deemed necessary in the best interests of the Medical Staff and the Hospital.

4.9.3 Meetings

The Medical Executive Committee shall meet regularly, and at least quarterly, during the calendar year. A record of its proceedings and actions shall be maintained.

ARTICLE 5

MEETINGS AND VOTING

5.1 Medical Staff Meetings

5.1.1 Regular Meetings

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

5.1.2 Special Meetings

Special meetings of the Medical Staff may be called at any time by the Chief of Staff, Medical Executive Committee, or Governing Body, or upon the written petition of 10 percent of the voting members. A petition requesting a special meeting shall state the reasons for the meeting on each page where signatures appear. The meeting must be called within 30 days after receipt of such request, and notice shall be provided to the Medical Staff at least 15 days before the meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

5.1.3 Combined or Joint Medical Staff Meetings

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

5.2 Department and Committee Meetings

5.2.1 Regular Meetings

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

5.2.2 Special Meetings

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

5.2.3 Combined or Joint Department or Committee Meetings

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

5.3 Notice of Meetings

Written notice stating the place, day, and time of any regular or special Medical Staff meeting or of any regular or special department or committee meeting not held pursuant to resolution shall be delivered electronically, personally, or by mail to each person entitled to attend. Such notice shall be given not fewer than two working days nor more than 30 days before the date of the meeting. Personal attendance at a meeting shall constitute a waiver of notice.

5.4 Quorum

5.4.1 Medical Staff Meetings

The presence of the greater of 25 percent of the voting members, or three voting members, at any regular or special meeting of the Medical Staff shall constitute a quorum.

5.4.2 Committee Meetings

The presence of 50 percent of the voting members shall be required for Medical Executive Committee meetings. For other committees, a quorum shall consist of 30 percent of the committee's voting members, but in no event less than three voting committee members.

5.4.3 Department Meetings

The presence of the greater of 25 percent of the voting members, or three voting members, at any regular or special department meeting shall constitute a quorum.

5.5 Manner of Action

- 5.5.1** Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members so long as any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be required by these Bylaws.
- 5.5.2** Committee and Department meetings may be held in person, telephonically, via internet conference, or other electronic systems, so long as the quorum requirements are met and the meeting is held in a manner that allows all committee members the opportunity to hear, participate, and (if a voting member) vote. The validity of actions does not depend on whether the meeting was held in person, telephonically, via internet conference, or other electronic systems.
- 5.5.3** Valid action may be taken without a meeting if at least [10] days' notice of the proposed action has been given to all members entitled to vote, and the proposed action is thereafter approved in writing or via email by at least two thirds of the members entitled to vote, with such writing or email specifying the proposed action the member is approving.

5.6 Minutes

Minutes of all meetings shall be prepared. Minutes shall include a record of the attendance of members, the vote taken on each matter, and the names of any individuals who recused themselves from discussion or vote on any matter. A meeting report will be forwarded to the Medical Executive Committee or other designated committee and Governing Body. Each committee shall maintain a permanent file of the minutes of each meeting. When meetings are held with outside entities, access to minutes shall be limited as necessary to preserve the protections from discovery, as provided by California law.

5.7 Attendance

5.7.1 Attendance Requirements

- (a) Each member of a Medical staff is encouraged to attend department or section meetings during the two-year reappointment period.

5.7.2 Special Appearance

- (a) A committee or department may require a Practitioner or APP to appear at any meeting where the Practitioner's or APP's clinical performance or professional conduct is being discussed. When possible, the meeting chair should give the Practitioner at least [10] days advanced written notice of the time, place, and subject of the meeting. The notice shall inform the Practitioner or APP that his or her

appearance is mandatory and that his or her failure to appear may result in an automatic suspension of privileges and referral to the Medical Executive Committee for possible corrective action.

- (b) If a Practitioner or APP fails to attend the meeting after being notified that his or her appearance is mandatory, and the failure to appear is not excused by the Medical Executive Committee, then his or her privileges shall be automatically suspended pursuant to the Automatic Suspension, Termination, and Limitation provisions of the Corrective Action Article of these Bylaws, and he or she shall be referred to the Medical Executive Committee for possible corrective action.

5.8 Conduct of Meetings

Unless otherwise specified, the chair of meetings shall use Robert's Rules of Order as a reference for conducting the meeting; however, failure to follow these rules shall not invalidate action taken at the meeting.

5.9 Electronic Voting

Unless otherwise provided in these Bylaws, any vote for an election, adoption, or amendment process may be accomplished through an electronic voting process approved by the Medical Executive Committee, so long as the Medical Executive Committee has determined that the electronic voting process has sufficient safeguards to protect the integrity of the vote and the process has been approved by the Governing Body. "Electronic voting process" includes, but is not limited to, email and web-based voting processes.

ARTICLE 6

GOVERNING DOCUMENTS

6.1 Identification of Governing Documents

- 6.1.1** The documents that govern the Medical Staff's operations and its responsibilities, as well as the responsibilities and practices of the members, other Practitioners, and Allied Health Staff at the Hospital, include the Hospital and Medical Staff Bylaws, Rules and Regulations, Policies and Procedures, Department or Section Rules and Policies and Procedures, and any other document adopted by the Hospital or Medical Staff directly applicable to Medical Staff operations, the granting of membership on the Medical Staff, or the exercise of privileges at the Hospital. Applicants, Medical Staff members, and any other person holding privileges shall be governed by any Governing Document that is properly adopted.
- 6.1.2** The Medical Staff Bylaws describe the fundamental principles of Medical Staff self-governance and accountability to the Governing Body. The key standards for Medical Staff membership, appointment, reappointment, privileging, corrective action, and hearings and appeals are set out in the Bylaws. Additional provisions may be set out in other Governing Documents.
- 6.1.3** Amendments to the Medical Staff Governing Documents shall be made in good faith and be consistent with the Medical Staff's legal, accreditation, and ethical obligations. Under no circumstance may the Medical Staff amend a Governing Document in a manner that conflicts with the Hospital's Bylaws or that would jeopardize the Hospital's licensure, Medicare certification, accreditation status, or not-for-profit status.

6.2 Bylaws

6.2.1 Adoption

The Medical Staff Bylaws may be adopted by (a) an affirmative vote of greater than 50% of the members voting, as long as at least 30% of the members eligible to vote cast ballots, followed by (b) the approval of the Governing Body, which approval shall not be unreasonably withheld. The Medical Staff Bylaws shall be effective immediately upon the Governing Body's approval, unless the Medical Staff Bylaws specify, at the time of vote and adoption, a later effective date.

The Medical Staff Bylaws shall be reviewed on an as-needed basis, but at least once every two years. Additionally, Hospital administration may develop and recommend proposed Bylaws, and should be consulted as to the impact of any proposed Bylaws on Hospital operations and feasibility.

6.2.2 Amendment

- (a) Any proposal to amend or repeal these Bylaws shall be requested by the Medical Executive Committee, the Chief of Staff, or a committee charged with reviewing the Medical Staff Bylaws, or upon written petition submitted to the Medical Executive Committee signed by at least 25% of the members of the Medical Staff in good standing who are entitled to vote. Any petition from the Medical Staff must include the exact wording of the proposed amendment or repeal on every page on which signatures appear.
- (b) Proposed amendments meeting the above parameters shall be submitted to the Governing Body for comment at least 30 days before they are distributed to the Medical Staff for a vote. If the Governing Body has any concerns regarding any proposed amendment, it will contact the Chief of Staff within 21 days after receiving the proposed amendments for discussion. If the Governing Body has comments on the proposed amendments after its discussion with the Chief of Staff, its comments will be circulated with the proposed amendments at the time they are distributed to the Medical Staff for a vote.
- (c) Proposed amendments meeting the above parameters shall be submitted to the Medical Staff for vote only after the Medical Executive Committee has determined that the proposed amendment does not conflict with existing Hospital Bylaws.
- (d) Voting shall be conducted at a special meeting called for that purpose, via a mail ballot, or via an electronic voting process, as described elsewhere in these Bylaws. The ballot, in whatever form, must specify what language in the Bylaws is proposed to be added, amended, moved, or deleted.
- (e) Amendments shall require (i) an affirmative vote of greater than 50% of the members voting, as long as at least 30% of the members eligible to vote cast ballots, followed by (ii) the approval of the Governing Body, which approval shall not be unreasonably withheld.
- (f) Amendments shall be effective immediately upon approval of the Governing Body, unless the ballot specifies a later effective date.

6.2.3 Technical and Editorial Corrections

The Medical Executive Committee shall have the power to adopt such amendments to the Bylaws that are, in its judgment, technical modifications or clarifications, reorganization or renumbering of the Bylaws, or amendments made necessary because of punctuation, spelling or other errors of grammar or expression or inaccurate cross-references. No substantive amendments are permitted pursuant to this section. The action to amend may be taken by motion

and acted upon in the same manner as any other motion before the Medical Executive Committee. After approval, such amendments shall be communicated in writing or electronically to the Medical Staff and to the Governing Body. Such amendments are effective upon adoption by the Medical Executive Committee; provided however, that they may be rescinded by vote of the Medical Staff or Governing Body within 120 days of the date of adoption by the Medical Executive Committee. Such vote of the Medical Staff will be held in the same manner as a vote on an amendment of the Bylaws.

6.2.4 Legal and Accreditation Compliance

The Medical Staff agrees to work cooperatively with the Governing Body to assure that the Bylaws comply with legal and accreditation standards on an ongoing basis. As part of its legal and accreditation responsibilities, the Medical Staff acknowledges and agrees that it will, in a timely manner, amend the Medical Staff Bylaws in order to assure compliance with state or federal law, Medicare requirements, court order, or accreditation standards. If the Medical Staff unreasonably fails to exercise its responsibility to adopt or amend the Bylaws to make these types of non-discretionary amendments, the Governing Body may take such actions that are within its authority.

6.3 Rules and Regulations

6.3.1 Identification

The Medical Staff adopts rules and regulations necessary to implement more specifically the general principles found within these Bylaws, subject to the Governing Body's approval. If there is a conflict between these Bylaws and the Rules and Regulations, the Bylaws shall prevail. The Rules and Regulations shall be reviewed regularly, and at least every two years, and the mechanism described in these Bylaws shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff Rules and Regulations.

6.3.2 Adoption and Amendment

The Medical Staff delegates to the Medical Executive Committee the authority to initiate and adopt such general rules and regulations as it may deem necessary for the proper conduct of the Medical Staff's work and to periodically review and revise the rules and regulations. Additions or changes to the general Medical Staff rules and regulations (Proposed Rules) may be proposed by the Medical Executive Committee, the Chief of Staff, or by petition submitted to the Medical Executive Committee and signed by at least 25% of members of the Medical Staff in good standing who are entitled to vote. Any petition from the Medical Staff must include the names of the Medical Staff members who are contact persons for the petition and the exact wording of the Proposed Rule on every page on which signatures appear. Proposed Rules shall be reviewed and acted upon as follows:

- (a) Except with respect to circumstances requiring urgent action, as described below, the Medical Executive Committee shall not act on any Proposed Rule until members of the Medical Staff and the Governing Body have had a reasonable opportunity to review and comment on the Proposed Rule. Notice regarding a Proposed Rule shall be communicated electronically or through mail to members of the Medical Staff and to the Governing Body at least 30 days prior to the scheduled Medical Executive Committee meeting where the vote is to take place, together with instructions on how to communicate comments to the Medical Executive Committee.
- (b) The Medical Executive Committee shall inform the Medical Staff regarding whether it has approved or rejected the Proposed Rule.
- (c) If the Medical Executive Committee fails to approve a Proposed Rule that has been submitted by petition as described above, the members of the Medical Staff identified as contact persons on the petition may invoke the Conflict Management process described in the Rules.
- (d) If, after the Conflict Management process, the Medical Executive Committee does not adopt the Proposed Rule, the Medical Staff may petition to have the Proposed Rule submitted to the Medical Staff for a vote. The petition to hold the vote must be supported by signatures from at least 25% of members of the Medical Staff who are entitled to vote and must include the purpose of the petition on every page on which signatures appear. The vote shall be held in a manner consistent with the process used for the amendment of the Medical Staff Bylaws, including the distribution of Governing Body comments, if any.
- (e) Following approval by the Medical Executive Committee or by a vote of the Medical Staff, the Proposed Rule shall be forwarded to the Governing Body for approval, which approval shall not be withheld unreasonably. The Rule shall become effective immediately following the approval of the Governing Body.

6.3.3 Urgent Revisions

- (a) Notwithstanding the above, in cases of a documented need for an urgent amendment to rules and regulations necessary to comply with law or regulation, the Medical Executive Committee may provisionally adopt, and the Governing Body may provisionally approve, an urgent amendment without prior notification of the Medical Staff. In such cases, the Medical Executive Committee shall provide notice to the Medical Staff as soon as practicable about the amendment.
- (b) The Medical Staff shall have the opportunity for retrospective review of and comment on the provisional amendment. If no petition is submitted as described in the next sentence, the provisional

amendment stands and is no longer provisional. The provisional amendment shall be challenged by submitting a petition requesting repeal of the amendment to the Medical Staff Administration within 30 days after the Medical Executive Committee provides notice of the change; such petition shall be signed by more than 50% of the members of the Medical Staff who are entitled to vote and shall have the names of contact persons for the petition and the purpose of the petition included on every page on which signatures appear. In the event of such challenge, the Conflict Management process detailed in the Rules is implemented. The provisional amendment shall remain in effect during the Conflict Management process. At the conclusion of that process, a revised amendment may be, if necessary, submitted to the Medical Executive Committee and Governing Body for action consistent with the amendment process described above.

6.4 Policies and Procedures

6.4.1 Adoption

The Medical Executive Committee may adopt and amend policies and procedures as necessary for the accomplishment of Medical Staff processes, subject to the Governing Body's approval, which approval shall not be unreasonably withheld. If there is a conflict between these Bylaws and a policy, the Bylaws shall prevail. If there is a conflict between the Rules and Regulations and a policy, the Rules and Regulations shall prevail. Proposed new or revised policies (proposed policies) for the Medical Executive Committee's consideration may arise from any responsible committee, department, Medical Staff officer, or by petition signed by at least 25% of members of the Medical Staff who are entitled to vote. Any petition from the Medical Staff must include the names of the Medical Staff members who are contact persons for the petition and the exact wording of the proposed policy on every page on which signatures appear.

- (a) If the Medical Executive Committee fails to approve a proposed policy that has been submitted by petition as described above, the members of the Medical Staff identified as contact persons on the petition may invoke the Conflict Management process described in the Rules. If, after the Conflict Management process, the Medical Executive Committee does not adopt the proposed policy, the Medical Staff may petition to have the proposed policy submitted to the Medical Staff for a vote. The petition to hold the vote must be supported by signatures from at least 25% of members of the Medical Staff who are entitled to vote and must include the purpose of the petition on every page on which signatures appear. The vote shall be held in a manner consistent with the process used for the amendment of the Medical Staff Bylaws, including the distribution of Governing Body comments, if any.

- (b) Following approval of a proposed policy by the Medical Executive Committee or by a vote of the Medical Staff, the Medical Executive Committee shall inform the Medical Staff of the approval of the proposed policy and shall forward the proposed policy to the Governing Body for approval, which approval shall not be withheld unreasonably. The policy shall become effective immediately following the approval of the Governing Body.

6.5 Department and Section Rules

- 6.5.1** Subject to the approval of the Medical Executive Committee and Governing Body, each department may formulate its own rules for conducting its affairs and discharging its responsibilities. Hospital administration also may develop and recommend proposed department rules, and in any case should be consulted as to the impact of any proposed department rules on Hospital operations and feasibility. Such rules shall not be inconsistent with the Medical Staff or Hospital Bylaws, Rules, or other policies.
- 6.5.2** Subject to the approval of the department that oversees the section, the Medical Executive Committee, and the Governing Body, each section may formulate rules for conducting its affairs and discharging its responsibilities. Hospital administration also may develop and recommend proposed section rules, and in any case should be consulted as to the impact of any proposed section rules on Hospital operations and feasibility. Such rules shall not be inconsistent with the Medical Staff or Hospital Bylaws, Rules, or policies.

6.6 Forms

Forms necessary for use in connection with Medical Staff appointments, reappointments, delineation of privileges, corrective action, notices, recommendations, reports and other matters shall be approved by, and may be amended by, the Medical Executive Committee, subject to approval by the Governing Body.

6.7 Non-Contractual Nature of Governing Documents

- 6.7.1** The Bylaws, Rules and Regulations, and Policies and Procedures and other Governing Documents are not, and shall not be deemed to be, contracts of any kind between the Governing Body, the Hospital, the Medical Staff and/or any individual (including any Medical Staff member, applicant, or AHP), unless the document provides that it is a contract, agreement, or release.
- 6.7.2** Application for, the conditions of, and the duration of appointment to the Medical Staff, or the granting of privileges to a Practitioner or to an AHP, shall not be deemed contractual in nature. The consideration of applications and the granting and continuance of any privileges at this Hospital are based solely upon a Practitioner's or AHP's continued ability to justify the exercise of privileges. The granting of privileges does not obligate the Practitioner or AHP to practice at the Hospital.

6.7.3 Notwithstanding the above, all rights, responsibilities, and obligations of Medical Staff membership are enforceable as a condition of membership.

6.8 Notice by Posting on Medical Staff Website

For the notice requirements relating to Proposed Rules and to policies, the Medical Executive Committee may meet those obligations by posting the Proposed Rule or the policy on the Medical Staff website, as long as the Medical Executive Committee sends a notice electronically or through mail within the time frames provided above informing those members of the Medical Staff who are entitled to vote that the Proposed Rule or the policy is available on the Medical Staff website. The electronic or mailed notice must include the web address for the Medical Staff website.

ARTICLE 7

Dues and Additional Provisions

7.1 Dues and Assessments

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

7.1.2 The Medical Executive Committee may develop policies, subject to the Governing Body's approval, for the assessment of fines for noncompliance with Medical Staff Governing Documents or Hospital policy, including, but not limited to, fines for noncompliance with medical record requirements.

7.2 Compensation of Medical Staff Leaders

The Medical Staff may compensate Medical Staff Leaders for work performed pursuant to their duties as officers, department leaders, or committee chairs. The amounts of such compensation shall be determined by the Medical Executive Committee and shall be paid from the Medical Staff's own funds. The amounts and form of compensation must comply with any applicable federal or state laws regarding physician compensation. If the Hospital contributes funds to the Medical Staff, the Hospital shall have the authority to review any compensation arrangement to determine its compliance with state and federal laws and shall have the authority to approve or withhold approval of the compensation arrangement. Compensation is contingent on the Medical Staff Leader's fulfillment of his or her duties, which shall be determined by the Medical Executive Committee.

7.3 No Retaliation

7.3.1 Neither the Medical Staff, its members, committees, or department heads; nor the Governing Body, the Chief Executive Officer, or any other employee or agent of the Hospital or Medical Staff, shall discriminate or retaliate, in any manner, against any patient, Hospital employee, member of the Medical Staff, or any other health care worker of the facility because that person has done either of the following:

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

- 7.3.2** The proper exercise of the Medical Staff's and Hospital's responsibilities, including, but not limited to, those responsibilities relating to quality assessment and corrective action, does not constitute retaliation and is not precluded by this section.

7.4 Authorizations, Releases, Immunity, Confidentiality, and Indemnity

Applicants, members, Practitioners, and AHPs, by virtue of applying for or accepting membership, clinical privileges, or other permissions to practice, agree to comply with and be bound by the provisions in the Rules addressing authorizations to obtain and release information, releases, immunities, confidentiality, and indemnity. Compliance with those provisions is a condition of appointment to, and continued membership on, the Medical Staff, and a condition to any clinical privilege or other permissions to practice granted.

DIVISION 2: MEMBERSHIP AND PRIVILEGES

ARTICLE 8

MEMBERSHIP QUALIFICATIONS AND RESPONSIBILITIES

8.1 General Qualifications

- 8.1.1** Only Practitioners and APPs who are professionally competent, conduct themselves professionally, and continuously meet the qualifications and requirements for Medical Staff membership and privileges set forth in these Bylaws and other Governing Documents may be granted and may maintain Medical Staff membership and/or privileges.
- 8.1.2** Only Practitioners who are appointed to the Medical Staff may exercise Medical Staff membership rights and responsibilities, and only to the extent and in the manner described in these Bylaws for the staff status the Practitioner holds.
- 8.1.3** Only Practitioners who are granted privileges to do so under the processes detailed in these Bylaws may admit or provide services in this Hospital.
- 8.1.4** No Practitioner is entitled to Medical Staff membership or privileges merely because he or she holds a certain degree; is licensed to practice in any jurisdiction; is a member of any professional organization; is a party to, or a beneficiary of, a contract with the Hospital; is certified by any clinical board; or currently has, or has had, staff membership or privileges at another health care facility.
- 8.1.5** AHPs are not eligible for Medical Staff membership but may be granted privileges or other permissions to practice pursuant to the processes defined in the Medical Staff's Governing Documents.

8.2 Nondiscrimination

Medical Staff membership or privileges shall not be denied on the basis of sex, gender identity, gender expression, age, religion, race, creed, color, national origin, sexual orientation, genetic information, military or veteran status, political affiliations or activities, marital status, or any other legally-protected status. Medical Staff membership or privileges shall not be denied on the basis of any physical or mental disability if the applicant meets the standards set forth in the Governing Documents with or without reasonable accommodation.

8.3 Minimum Qualifications

In order to have an application accepted for processing, an applicant must meet each of the requirements set forth in this section. A Practitioner who does not meet these minimum qualifications is ineligible to apply for Medical Staff membership, and the application shall not be accepted for processing unless these Bylaws provide that the category to which the Practitioner is applying does not require the qualification to be met. If it is determined at any time during processing that an applicant does not meet

all the minimum qualifications, the Medical Staff shall discontinue review of the application. An applicant who does not meet the minimum qualifications is not entitled to the procedural rights set forth in these Bylaws but may request a waiver to a qualification, as detailed in the waiver provisions below.

The minimum qualifications each applicant must meet include:

- 8.3.1** Holding one of the following:
 - (a) A license to practice medicine from the Medical Board of California or the Osteopathic Medical Board of California;
 - (b) A license to practice dentistry from the Dental Board of California;
 - (c) A license to practice podiatry from the California Board of Podiatric Medicine; or
 - (d) A license to practice clinical psychology by the California Board of Psychology.
- 8.3.2** If practicing medicine, dentistry, or podiatry, having a federal Drug Enforcement Administration number, if requesting privileges that involve prescribing.
- 8.3.3** For physicians and podiatrists, having completed a residency approved by the Accreditation Council for Graduate Medical Education or the Council on Podiatric Medical Education that provided complete training in the specialty or subspecialty that the Practitioner will practice at the Hospital.
- 8.3.4** For dentists, having completed a residency approved by the Commission of Dental Accreditation if the Department in which the dentist is assigned requires such a residency.
- 8.3.5** Being certified by a board recognized by the American Board of Medical Specialties or the American Osteopathic Association, the American Board of Foot and Ankle Surgeons, or the American Dental Association's Council on Dental Education and Licensure, as described in further detail in the Board Certification Section below. Such certification must be in the specialty or subspecialty that the Practitioner will practice at the Hospital.
- 8.3.6** Being eligible to receive Medicare and Medicaid payments.
- 8.3.7** Having liability insurance or equivalent coverage, including nose or tail coverage, meeting the standards approved by the Medical Staff and the Governing Body.
- 8.3.8** Meeting the clinical activity requirements specified by the Department as necessary to demonstrate current competence for the privileges requested.
- 8.3.9** Being located close enough (office and residence) to the Hospital to provide continuous care to his or her patients and to fulfill any emergency call

requirements. The distance to the Hospital may vary depending upon the Medical Staff category and privileges that are involved and the feasibility of arranging alternative coverage, and may be defined in the Rules.

- 8.3.10** If requesting privileges only in departments operated under an exclusive contract, be a member, employee, or subcontractor of the group or person that holds the contract.

8.4 Additional Qualifications

In addition to meeting the minimum qualifications described above, each applicant and member must:

- 8.4.1** Document his or her:

- (a) Adequate experience, education, and training in the requested privileges;
- (b) Current professional competence;
- (c) Good judgment; and
- (d) Adequate physical and mental health status (subject to any necessary reasonable accommodation) to demonstrate to the satisfaction of the Medical Staff that patients can reasonably expect to receive the generally-recognized professional level of quality and safety of care for this community. If the Medical Staff receives information suggesting that the applicant cannot meet this standard, it will sequester this information until it has completed its initial review of the application and the Medical Executive Committee is prepared to make a recommendation on the application.

- 8.4.2** Demonstrate an ability and commitment to:

- (a) Adhere to the lawful ethics of his or her profession;
- (b) Work cooperatively with others in the Hospital setting so as not to adversely affect patient care or Hospital operations; and
- (c) Participate in and properly discharge Medical Staff responsibilities.

- 8.4.3** If applying after previously holding membership and/or privileges, or if applying for reappointment, pay all outstanding dues, fees, and/or assessments, if any, from the prior or current appointment.

8.5 Board Certification

- 8.5.1** “Specialty board,” as used in this section, means a national specialty board of, or recognized by, the American Board of Medical Specialties or the American Osteopathic Association, the American Board of Foot and Ankle Surgeons, or the American Dental Association’s Council on Dental Education and Licensure.
- 8.5.2** Unless the individual qualifies for an exemption to this requirement pursuant to the guidelines set forth in the Rules and Regulations, a Practitioner applying for appointment or reappointment to the Medical Staff and/or for the granting or extension of clinical privileges must, at the time of application, be certified by the specialty board pertaining to the Practitioner’s clinical privileges.
- 8.5.3** Unless the member qualifies for an exemption to this requirement pursuant to the guidelines set forth in the Rules and Regulations, all Medical Staff members are required to maintain board certification throughout their membership on the Medical Staff. Medical Staff members must obtain recertification from the specialty board pertaining to the Practitioner’s clinical privileges if recertification is required in order to maintain board certification. Failure of a Practitioner to maintain board certification shall result in the automatic termination of his or her Medical Staff membership and privileges. A Practitioner whose Medical Staff membership and privileges are terminated for failing to maintain board certification is not entitled to the hearing and appeal rights in these Bylaws.
- 8.5.4** If a Practitioner’s membership and privileges are subject to termination for failure to attain or maintain board certification, the Medical Executive Committee, in its sole discretion, subject only to the approval of the Governing Body, may extend the date of termination of the Practitioner’s membership and privileges for up to six weeks if the Medical Executive Committee determines that such extension is necessary for the health and wellbeing of patients at the Hospital. The Medical Executive Committee’s decision not to extend a Practitioner’s membership and/or privileges, or to extend them for less than six weeks, is not subject to the hearing and appeal rights in these Bylaws.
- 8.5.5** Board certification must correspond to the clinical privileges requested and training program completed. An applicant or member need not be certified in a general specialty for which he or she is requesting privileges if he or she is certified in a subspecialty for which he or she is also requesting privileges.

8.6 Waiver

Any applicant who does not satisfy one or more of the qualifications or criteria identified in this Article or in any document describing the criteria for membership or privileges may request that the qualification or criteria be waived, subject to the following:

- 8.6.1** It is the Medical Staff and Governing Body’s intent that waivers to any eligibility criteria be granted rarely. Waivers are never granted for qualifications that are required by law or accreditation standard.

- 8.6.2 Waivers of any eligibility criteria are disfavored and are granted only in extreme circumstances when necessary to address an identifiable patient care need and only if the waiver is found to be in the best interests of the Hospital and its patients' health and wellbeing. The needs or circumstances of the applicant are irrelevant to such determination.
- 8.6.3 The Governing Body, with a recommendation from the Medical Executive Committee, is the sole determiner of whether a waiver is in the best interest of the Hospital and its patients' health and wellbeing.
- 8.6.4 A determination that a waiver is, or is not, in the best interest of the Hospital and its patients' health and wellbeing is not a determination as to whether the Practitioner is otherwise qualified to hold membership or privileges, and does not entitle the Practitioner to the hearing and appeal rights in these Bylaws.
- 8.6.5 Once the Board determines that a waiver is in the best interests of the Hospital and its patients, the Practitioner requesting the waiver bears the burden of demonstrating exceptional circumstances and that his or her qualifications are equivalent to, or exceed, the criterion in question.
- 8.6.6 A determination to grant a waiver does not mean that appointment will be granted, only that processing of the application can begin.
- 8.6.7 A determination to grant a waiver in a particular instance is not intended to set a precedent.

8.7 General Responsibilities of Membership

Except as otherwise provided in these Bylaws, each Medical Staff member and Practitioner with privileges must continuously meet all of the following responsibilities:

- 8.7.1 Provide patients with quality of care meeting the professional standards of the Medical Staff.
- 8.7.2 Abide by the Governing Documents of the Medical Staff and the Hospital.
- 8.7.3 Abide by all applicable laws and government regulations and comply with applicable accreditation standards.
- 8.7.4 Discharge in a responsible and cooperative manner the Medical Staff, department, section, committee and service functions for which he or she is responsible.
- 8.7.5 Complete and document history and physicals in a timely manner consistent with these Bylaws and other Governing Documents.
- 8.7.6 Appropriately inform patients and obtain consent, in a manner consistent with Hospital and Medical Staff requirements.

- 8.7.7 Prepare and complete, in a timely and accurate manner, the medical and other required records for all patients to whom the Practitioner in any way provides services in the Hospital, in the manner consistent with Hospital policy and procedure.
- 8.7.8 Abide by the ethical principles of his or her profession.
- 8.7.9 Refrain from unlawful fee splitting or unlawful inducements relating to patient referral.
- 8.7.10 Refrain from harassment or discrimination against any person (including any patient, Hospital employee, Hospital independent contractor, Medical Staff member, volunteer, or visitor) based upon the person's sex, gender identity, gender expression, age, religion, race, creed, color, national origin, sexual orientation, genetic information, military or veteran status, political affiliations or activities, marital status, or any other legally-protected status, or the person's health status, ability to pay, or source of payment.
- 8.7.11 Refrain from delegating the responsibility for diagnosis or care of hospitalized patients to a Practitioner or Allied Health Professional who is not qualified to undertake this responsibility or not adequately supervised.
- 8.7.12 Provide for appropriate coverage of his or her patients.
- 8.7.13 Coordinate individual patients' care, treatment and services with other Practitioners and Hospital personnel, including, but not limited to, seeking consultation whenever warranted by the patient's condition or when required by the Rules or policies and procedures of the Medical Staff or applicable Department.
- 8.7.14 Actively participate in, and regularly cooperate with, the Medical Staff in assisting the Hospital to fulfill its obligations related to patient care, including, but not limited to, continuous organization-wide quality measurement, assessment, and improvement; peer review, including providing information during corrective action investigations and testimony during hearings; utilization management; quality evaluation; Ongoing and Focused Professional Practice Evaluations and related monitoring activities required of the Medical Staff; and in discharging other such functions as may be required from time to time.
- 8.7.15 Upon request, provide information from his or her office records or from outside sources as necessary to facilitate the care, or review of the care, of specific patients.
- 8.7.16 Communicate with appropriate Department officers and/or Medical Staff Officers when he or she obtains credible information indicating that a fellow Medical Staff member may have engaged in unprofessional or unethical conduct or may have a health condition which poses a significant risk to the well-being

or care of patients, and then cooperate as reasonably necessary toward the appropriate resolution of any such matter.

- 8.7.17** Accept responsibility for participating in proctoring in accordance with the Rules and policies and procedures of the Medical Staff.
- 8.7.18** Complete continuing professional education that meets all licensing requirements and is appropriate to the Practitioner's specialty.
- 8.7.19** Adhere to the Medical Staff Standards of Conduct as described in the Governing Documents so as not to adversely affect patient care or Hospital operations.
- 8.7.20** Work cooperatively with other members, Hospital staff, and Hospital administration so as not to adversely affect patient care or Hospital operations.
- 8.7.21** Participate in emergency service coverage and consultation panels as allowed and required by the Medical Staff or Hospital.
- 8.7.22** Cooperate with the Medical Staff in assisting the Hospital to meet its uncompensated or partially-compensated patient care obligations.
- 8.7.23** Comply with any rules relating to any training program for health care Practitioners and professionals that the Hospital may sponsor or participate in, including residency programs.
- 8.7.24** Participate in patient and family education activities as determined by the Department or Medical Staff Rules, or the Medical Executive Committee.
- 8.7.25** Notify the Medical Staff office in writing promptly, and no later than five calendar days, following any investigations into, or action taken regarding, the member's license, Drug Enforcement Administration registration, board certification, or privileges at other facilities; any changes in liability insurance coverage; any report filed with the National Practitioner Data Bank or licensing board; any arrest or charge for any alleged criminal act with the exception of a traffic violation that does not rise to the level of either a misdemeanor or felony; or any other action or change in circumstances that renders the information previously provided out-of-date or that could affect his/her qualifications for Medical Staff membership and/or clinical privileges at the Hospital.
- 8.7.26** Continuously meet the qualifications for and perform the responsibilities of membership as set forth in the Governing Documents. A member may be required to demonstrate continuing satisfaction of any of the requirements of these Bylaws upon the reasonable request of the Medical Executive Committee. This shall include, but is not limited to, submitting to mandatory physical or mental health evaluation and mandatory drug and/or alcohol testing, the results of which shall be reportable to the Medical Executive Committee, the Well-Being Committee, and/or the Professional Conduct Committee.

8.7.27 Discharge such other obligations as may be lawfully established from time to time by the Medical Staff or Medical Executive Committee.

8.8 Conduct Expectations

8.8.1 The Medical Staff expects Practitioners and AHPs to work cooperatively to create a cohesive, harmonious, and professional environment that respects the entire care team and supports a high level of patient care. The desired care environment will require from each Medical Staff member and AHP teamwork, mutual respect, and a personal commitment to the Medical Staff's and Hospital's behavior expectations.

8.8.2 By applying for, or accepting, membership and/or privileges, each Practitioner and AHP acknowledges and agrees that appropriate conduct and behavior is critical to the delivery of quality patient care, to the Hospital's orderly functioning, and to the Hospital's and Medical Staff's ability to meet their obligations to patients, Practitioners, staff, and the community.

8.8.3 By applying for, or accepting, membership and/or privileges, each Practitioner and AHP acknowledges and agrees that he or she will comply with any Medical Staff rules or policies delineating behavior expectations; will communicate professionally with all individuals in the Hospital, and will not engage in any unacceptable and/or inappropriate conduct, as defined in any Governing Document, while at the Hospital; will not tolerate hostile or threatening behavior against any individual at the Hospital; and will not retaliate against any individual at the Hospital who reports the Practitioner or Allied Health Staff member to the Hospital or Medical Staff regarding the Practitioner or Allied Health Staff member's behavior or clinical practice.

8.8.4 If a Practitioner or Allied Health Staff member has concerns or complaints about any of the following, he or she will address them in a professional manner to the appropriate Medical Staff officer, Department Chair, Department manager, nursing/staff supervisor, administrator, or Governing Body representative:

- Patient care;
- Performance or behavior of a Medical Staff member, Allied Health Staff member, or employee;
- Hospital facilities, operations, policies, governance, administration, action or inaction; or
- Medical Staff operations, governance, Bylaws, Rules and Regulations, policies or procedures, processes, or action.

- 8.8.5** Each Practitioner and AHP acknowledges and agrees that behavior that falls below the Medical Staff's standards can adversely affect patient care and Hospital operations and may be grounds for corrective action.
- 8.8.6** Reports of a Practitioner's or Allied Health Staff member's failure to meet these standards or to comply with any other Medical Staff policy and procedure addressing behavior shall be addressed in the manner outlined in the relevant Medical Staff Rules and Code of Conduct.

ARTICLE 9

MEMBERSHIP STATUS

9.1 Categories of Membership

- 9.1.1** Each Medical Staff member shall be assigned to a Medical Staff category based on his or her qualifications. The member shall have the prerogatives and responsibilities detailed for the membership category in these Bylaws.
- 9.1.2** A member may be assigned to a different membership category by the Medical Executive Committee either during appointment or at reappointment if a change in qualifications occurs. A change in Medical Staff category is not in and of itself grounds for a hearing under these Bylaws.
- 9.1.3** The staff categories are: Provisional, Active, Consulting, Courtesy, Honorary & Retired, Tele Health, and Temporary.

9.2 Description of Prerogatives and Responsibilities

- 9.2.1** Members' prerogatives are based on the membership category they hold and are delineated in the description of each staff category. The available prerogatives and their meaning include the following:
 - (a) Admit patients, if granted privileges to do so.
 - (b) Eligible for clinical privileges: Exercise those clinical privileges that have been approved.
 - (c) Vote on any Medical Staff matter, including Bylaws amendments, officer selection, and other matters presented at any general or special staff meetings and on matters presented at department meetings.
 - (d) Hold office in the Medical Staff and in the department to which he or she is assigned.
 - (e) Serve on committees.
 - (f) Vote on committee matters.
- 9.2.2** In addition to the requirement to continuously comply with the basic responsibilities applicable to all members set forth in the Membership Qualifications and Responsibilities Article, members are expected to carry out additional responsibilities based on the membership category they hold. Those responsibilities are delineated in the description of each staff category, and may include:
 - (a) Medical Staff functions: Contribute to, and participate equitably in, staff functions, as described in the Governing Documents or at the

request of a Department Chair or other officer, including: contributing to quality improvement, risk management and utilization management activities; serving in Medical Staff and department offices and on Hospital and Medical Staff committees; participating in and assisting with the Hospital's medical education programs; proctoring other Practitioners; and fulfilling such other staff functions as may reasonably be required.

- (b) Consulting with other Medical Staff members consistent with his or her delineated privileges.
- (c) Attend meetings: Attend at least the minimum number of Medical Staff and department meetings specified in the Medical Staff Bylaws or department rules.
- (d) Pay fees/dues: Pay application fees, dues, and assessments in the amounts specified in the rules.

9.2.3 In addition to the above, other prerogatives or responsibilities may be identified in each staff category. Prerogatives and responsibilities also may be subject to limitation, as described in the Governing Documents.

9.3 Active Staff

9.3.1 Qualifications

- (a) The Active Staff consists of members of the Medical Staff who are involved in at least 30 patient contacts at the Hospital during the two-year appointment term and who have been members in good standing on the Provisional Staff for at least 12 months, or who demonstrate, by way of other substantial involvement in Medical Staff or Hospital activities, a genuine concern and interest in the Hospital.
- (b) Active Staff members must meet each of the minimum qualifications and additional qualifications detailed in the Membership Qualifications and Responsibilities Article of these Bylaws.

9.3.2 Prerogatives. Active staff members may:

- (a) Admit patients.
- (b) Be eligible for clinical privileges.
- (c) Vote.
- (d) Hold office.
- (e) Serve on committees.

- (f) Vote on committee matters.

9.3.3 Responsibilities. Active Staff members hold the following responsibilities:

- (a) Medical Staff functions.
- (b) Consulting.
- (c) Attend meetings.
- (d) Pay fees/dues.

9.4 Courtesy Staff

9.4.1 Qualifications

- (a) The Courtesy Staff consists of members of the Medical Staff who are involved in at least three patient contact at the Hospital during the two-year appointment term and who have been members in good standing on the Provisional Staff for at least 12 months. Courtesy Staff members with fewer than three patient contacts during the two-year appointment term must also be an active staff member at another accredited hospital.
- (b) Courtesy Staff members must meet each of the minimum qualifications and additional qualifications detailed in Membership Qualifications and Responsibilities Article.

9.4.2 Prerogatives. Courtesy staff members may:

- (a) Admit patients.
- (b) Be eligible for clinical privileges.
- (c) Serve on committees.
- (d) Vote on committee matters.

9.4.3 Responsibilities. Courtesy Staff members hold the following responsibilities:

- (a) Medical Staff functions.
- (b) Consulting.
- (c) Attend meetings.
- (d) Pay fees/dues.

9.5 Community Affiliate

9.5.1 Qualifications

- (a) The Community Affiliate Staff consists of members of the Medical Staff who desire to be associated with the Hospital, but do not intend to practice at the Hospital.
- (b) Community Affiliate Staff members must meet each of the minimum qualifications and additional qualifications detailed in the Membership Qualifications and Responsibilities Article, except they do not need to:
 - (i) Hold a DEA number.
 - (ii) Be board certified.
 - (iii) Be eligible to receive Medicare and Medicaid payments, or qualify as an Ordering, Referring, and Prescribing provider for Medicare and Medicaid; however, they may not be excluded from Medicare or Medicaid.
 - (iv) Meet the location requirements.
 - (v) Pledge to continuous care.

9.5.2 Prerogatives. Community Affiliate Staff members may:

- (a) Refer patients to the Hospital for admission and care, but may not admit or provide clinical services at the Hospital.
- (b) Refer patients to the Hospital's diagnostic facilities and order diagnostic tests.
- (c) Communicate with the clinical staff about the care of patients who they refer; visit those patients, and review the medical records and test results for those patients, but may not admit patients, attend patients, write orders for inpatients, input information into the medical record, perform consultations, assist in surgery, or otherwise participate in the management of clinical care to patients at the Hospital.
- (d) Serve on committees.

- (e) Vote on committee matters.
- (f) Attend Medical Staff meetings and department meetings, without vote.
- (g) Attend educational activities.

9.5.3 Responsibilities. Community Affiliate Staff members hold the following responsibilities:

- (a) Pay fees/dues.

9.6 Telemedicine Staff

9.6.1 The Telemedicine Staff consist of members who solely provide telemedicine services to patients at the Hospital.

- (a) Telemedicine Staff members must meet each of the minimum qualifications and additional qualifications detailed in Membership Qualifications and Responsibilities Article, except they do not need to:
 - (i) Hold a DEA number, unless they request prescribing privileges.
 - (ii) Be board certified.
 - (iii) Meet the location requirements.
 - (iv) Pledge to continuous care.
- (b) Notwithstanding the above, Telemedicine Staff members may be exempted from some or all of the minimum qualifications and additional qualifications if they are credentialed through the Telemedicine Staff Membership And Clinical Privileges provisions found below.

9.6.2 Prerogatives. Telemedicine Staff members may:

- (a) Be eligible for telemedicine clinical privileges.
- (b) Serve on committees.
- (c) Vote on committee matters.
- (d) Attend Medical Staff meetings and department meetings, without vote.
- (e) Attend educational activities.

9.6.3 Responsibilities. Telemedicine Staff members hold the following responsibilities:

- (a) Medical Staff Functions.
- (b) Pay fees/dues.

9.7 Provisional Staff

9.7.1 Qualifications.

- (a) The Provisional Staff consists of members of the Medical Staff who have been appointed to the Medical Staff after applying as an initial applicant and who do not hold, at the time of appointment, other staff status on the Medical Staff.
- (b) Provisional Staff members must meet each of the minimum qualifications and additional qualifications detailed in the Membership Qualifications and Responsibilities Article.

9.7.2 Prerogatives. Provisional Staff members may:

- (a) Admit patients.
- (b) Be eligible for clinical privileges.
- (c) Serve on committees.
- (d) Vote on committee matters.

9.7.3 Responsibilities. Provisional Staff members hold the following responsibilities:

- (a) Medical Staff functions.
- (b) Consulting.
- (c) Attend meetings.
- (d) Pay fees/dues.

9.8 Temporary Staff

9.8.1 Qualifications

- (a) The Temporary Staff consists of Practitioners who have been granted privileges to fulfill an important patient care need under the “Temporary Privileges” section in the Privilege Delineation Article of these Bylaws, and who are not currently applying for membership.

- (b) Temporary Staff must meet each of the minimum qualifications and additional qualifications detailed in the Membership Qualifications and Responsibilities Article, except they do not need to:
 - (i) Be board certified.
 - (ii) Meet the location requirements.

9.8.2 Prerogatives. Temporary Staff Practitioners may:

- (a) Admit patients.
- (b) Be eligible for clinical privileges.

9.8.3 Responsibilities. Temporary Staff Practitioners hold the following responsibilities:

- (a) Medical Staff functions.
- (b) Consulting.
- (c) Pay fees/dues.

9.9 Administrative Staff

9.9.1 Qualifications

- (a) The Administrative Staff consists of California-licensed Practitioners who are not eligible for other staff category and who are retained by the Hospital or appointed by the Medical Staff to perform on-going medical administrative activities.
- (b) Administrative Staff do not have to meet any of the minimum qualifications or additional qualifications for membership, other than to be currently licensed Practitioners.
- (c) Because Administrative Staff appointment is conditioned on the Practitioner's position with the Hospital or Medical Staff, the termination of that position shall result in the automatic termination of staff status, without any hearing and appeal rights described in these Bylaws.

9.9.2 Prerogatives

- (a) Serve on committees.
- (b) Vote on committee matters, if the right to do so is specified by the Medical Executive Committee at time of appointment or within the committee description.

- (c) Attend Medical Staff meetings and department meetings, without vote.
- (d) Attend educational activities.

9.10 Honorary Staff

9.10.1 Qualifications.

- (a) The Honorary Staff consists of members who either (i) have a record of previous service to the Hospital, have retired from the active practice of medicine and, in the discretion of the Medical Executive Committee, are in good standing at the time of initial application for membership on the Honorary Staff; or (ii) are recognized for outstanding or noteworthy contributions to the medical sciences.
- (b) Honorary Staff do not have to meet any of the minimum qualifications or additional qualifications for membership.

9.10.2 Prerogatives. Honorary Staff members may:

- (a) Serve on committees.
- (b) Attend Medical Staff meetings and department meetings, without vote.
- (c) Attend educational activities.

ARTICLE 10

PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

10.1 General

- 10.1.1** Unless otherwise provided in this Article and in the Privilege Delineation Article, “applicant” shall refer to Practitioners applying for appointment, reappointment, and/or privileges.
- 10.1.2** The process for granting Allied Health Staff status and privileges or other permissions to practice to AHPs shall be detailed in the Rules and Regulations.
- 10.1.3** Practitioners may apply for appointment to the Medical Staff by completing an application. Practitioners are appointed to the Medical Staff and/or are granted privileges only after the processes delineated in this Article and the Privilege Delineation Article are completed. Except as otherwise described in these Bylaws, only the Governing Body has the authority to appoint members and to grant privileges. All decisions regarding appointment and the granting of privileges shall be made using the criteria and standards for membership and clinical privileges set forth in the Medical Staff’s Governing Documents. Such decisions shall be objective and evidence-based and shall, where appropriate, reflect the general competencies required by the applicable accrediting body.
- 10.1.4** Initial applicants who, at the time of application or at any time during which the application is being processed, have an accusation against their license in which the licensing body is requesting revocation, limitation, or suspension of the license shall not be eligible to apply for appointment, reappointment, or privileges until the licensing action has been resolved.
- 10.1.5** Any history of revocation, suspension, restriction, or other disciplinary or corrective action by any state licensing authority, professional organization, certification board, peer review body, or health care entity (including an IPA, HMO, PPO, health plan, or private payor) regarding a Practitioner’s license, certificate, membership or clinical privileges, whether contested or voluntarily accepted, may constitute grounds for denial of the applicant’s application for appointment or reappointment for membership and clinical privileges or practice prerogatives. The Medical Staff shall consider the nature and gravity of the charges or allegations and any resulting disciplinary or corrective action; however, the fact of the revocation, suspension, restriction or other disciplinary or corrective action shall independently be sufficient grounds for finding the denial to be reasonable and warranted. The provisions in this paragraph apply only to action taken for reasons related to 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.

10.2 Obligations of Applicants

10.2.1 Agree to Comply with Governing Documents.

By applying to this Medical Staff for membership and/or privileges, whether initial appointment or reappointment, Practitioners agree that they have read the Medical Staff Bylaws and Rules and Regulations, and that they:

- (a) Agree that they will abide by the Medical Staff Governing Documents in effect throughout their term of appointment, and
- (b) Acknowledge that the granting of membership and/or privileges is expressly conditioned on their continued compliance with the Medical Staff Governing Documents in effect throughout their term of appointment or privileges, and that failure to comply may result in corrective action.

10.2.2 Complete Application Required

- (a) Each applicant has the obligation to provide a complete application to the Medical Staff for consideration. An application will not be considered complete unless the application form has been filled in completely, all questions on the application form have been answered, all supporting documentation has been supplied, all entries and attachments are legible, understandable, and substantively responsive on every point of inquiry, and necessary information has been verified from primary sources. Once this occurs, an application shall be considered preliminarily complete and may be processed further as described below.
- (b) If, at any time during the processing, any individual or committee with responsibility for review of the application determines that additional information from or regarding the applicant is needed in order to evaluate the application, the application will be considered incomplete until that information is supplied. If the requested information or materials are in the exclusive possession of another person or entity, the applicant must take the necessary measures to obtain them or to arrange for them to be submitted to the Medical Staff directly by the source. If the applicant fails to provide the information requested within 30 days after being informed of the need for additional information, or within a later deadline if one is specified in writing to the applicant, then the application will be deemed incomplete and voluntarily withdrawn. Withdrawn applications will not be processed further and do not entitle the applicant to the hearing rights in these Bylaws.

10.2.3 Burden of Producing Information

- (a) At all times, applicants for appointment, reappointment, and privileges have the burden of demonstrating to the Medical Staff and the Governing Body that they qualify for membership, Allied Health Staff status, or the requested privileges. Applicants have the burden of producing accurate and adequate information for a thorough evaluation of the applicant's qualifications and suitability for the requested status or privileges, resolving any reasonable doubts about these matters and satisfying requests for information. Failing to sustain this burden, providing false or misleading information, and making significant omissions of information shall each individually be grounds for denial of the application or the request.
- (b) Applicants, at all times during the processing of their applications, have the burden of updating and correcting any information they have provided as part of the application process. An applicant must inform the Medical Staff in writing within 14 days of any change in the information previously provided, regardless of its source. Failure to inform the Medical Staff in writing of changes to the information previously provided may result in the denial of the application or request.
- (c) If the Medical Executive Committee determines it appropriate, the burden to produce information for any individual applicant may include submission to a physical or mental health examination and/or mandatory drug and alcohol testing at the Practitioner's expense, and the submission of the results of the examination to the Medical Executive Committee or designee. The application shall be incomplete until the examination results are submitted to the Medical Executive Committee. If the results are not submitted within the time frame set by the Medical Executive Committee, which shall be no less than 30 days from the date of the request, then the application shall be deemed incomplete and voluntarily withdrawn. Withdrawn applications will not be processed further and do not entitle the applicant to the hearing rights in these Bylaws.

10.3 Processing of Membership/Privileges Applications

10.3.1 General

All applications for appointment and reappointment shall be processed in the manner described in the Medical Staff's Governing Documents, including the Governing Body Action Section of these Bylaws.

10.3.2 Applications

- (a) Applicants may request an application for membership and/or privileges through the Medical Staff Services Administration. The application form shall be approved by the Medical Executive Committee and the Governing Body. The content of applications shall be described in the Medical Staff Rules and Regulations. Completed applications shall be submitted as directed and must be accompanied by the application fee.
- (b) By submitting an application, the applicant has agreed to be bound by the Governing Documents and all the responsibilities and agreements described within throughout both the application period and, if granted, throughout his or her term of Medical Staff membership, privileges, or Allied Health Staff status. In addition, the applicant:
 - (i) Signifies his or her willingness to appear for interviews regarding his or her application for appointment.
 - (ii) Authorizes Medical Staff and Hospital representatives to consult with persons or entities who have been associated with the applicant or who otherwise may have information bearing on the applicant's competence and qualifications or that is otherwise relevant to the pending review, and authorizes such persons to provide all information that is requested orally and in writing.
 - (iii) Consents to the inspection and copying by Medical Staff and Hospital representatives of all records and documents that may be relevant or lead to the discovery of information relevant to the pending review, regardless of who possesses these records, and directs individuals who have custody of such records and documents to permit inspection and/or copying.
 - (iv) Certifies that he or she will report any subsequent changes in the information submitted on the application form to the Medical Staff Services Administration and the Chief Executive Officer.
 - (v) Releases from any and all liability the Medical Staff and the Hospital and its representatives for their acts performed in connection with evaluating the applicant.
 - (vi) Releases from any and all liability all individuals and organizations who provide information concerning the applicant, including otherwise privileged or confidential information, to Medical Staff or Hospital representatives.

- (vii) Authorizes and consents to Medical Staff and Hospital representatives providing other System Members and other health care entities, professional societies, licensing boards and other organizations concerned with provider performance and the quality of patient care with relevant information the Medical Staff or Hospital may have concerning him or her, and releases the Medical Staff and Hospital and their representatives from liability for so doing, including, but not limited to, claims arising from laws forbidding restraint of trade.
- (viii) Consents to undergo, and to release the results of, a physical or mental health examination by a health care professional acceptable to the Medical Executive Committee, as well as to undergo, and release the results of, drug and alcohol testing, at the applicant's expense, if deemed necessary by the Medical Executive Committee.
- (ix) Signifies his or her willingness to abide by all the conditions of membership, as stated in the Bylaws and other Governing Documents.

For purposes of this Article the term "Hospital representative" includes the Governing Body, its individual Directors or Trustees and committee members; the Chief Executive Officer, Hospital employees, the Medical Staff, all Medical Staff Leaders and/or committee members having responsibility for collecting information regarding or evaluating the applicant's credentials; and any authorized representative or agent of any of the foregoing.

10.3.3 Verification of Information

- (a) After the applicant has submitted the application, the Medical Staff shall determine whether the application has been filled out in its entirety and whether all requested documentation, including fees, have been provided. If any information has not been provided, the application will be considered incomplete. The Medical Staff will inform the applicant of what information is missing and that the applicant has 30 days to provide the missing information. If the applicant fails to provide the information within the deadline, then the application shall be deemed incomplete and voluntarily withdrawn. Withdrawn applications will not be processed further and do not entitle the applicant to the hearing rights in these Bylaws.
- (b) Once an application that has been filled out in its entirety and all requested documentation and fees have been provided, the Medical Staff or its designee shall verify the information, including, but not limited to, licensure status, training and education, current proficiency with respect to the Hospital's general competencies (as applicable to the privileges requested), health status, other evidence submitted in

support of the application, professional liability action history, confirmation that the Practitioner is the same individual identified in the credentialing documents (by viewing a current, valid picture Hospital ID card or a valid state or federal agency picture ID card), and at least two written verifications of peer references. The Hospital's authorized representative also shall query the National Practitioner Data Bank, and the Medical Staff shall query the licensing board and the Office of Inspector General Exclusion list. The Medical Staff shall have policies and procedures describing the process for verifying information, as well as which information requires primary source verification and from what sources verification may be obtained.

- (c) If the Medical Staff cannot verify the information, or finds inconsistencies when attempting to verify the information, it shall so inform the applicant. The applicant shall have 30 days to correct the information or explain the inconsistencies to the satisfaction of the Medical Staff. Failure to correct or provide a satisfactory explanation shall result in the application being deemed incomplete and voluntarily withdrawn. Withdrawn applications will not be processed further and do not entitle the applicant to the hearing rights in these Bylaws.
- (d) After the information provided has been verified, the application may be deemed preliminarily complete and submitted to the department for further processing.

10.3.4 Department Review

Upon receipt, the Department Chair or Department Committee shall review the application and supporting documentation, may personally interview the applicant, and may request that the applicant provide additional information. Based upon the criteria for appointment or reappointment (as applicable) described in the Governing Documents, the Chair shall transmit to the Credentials Committee on the prescribed form a written report with recommendations as to staff appointment and clinical privileges. The Department Chair or Department Committee may instead request that the Medical Staff defer action on the application but must provide reasons for this request.

10.3.5 Credentials Committee Action

The Credentials Committee shall review the application, the supporting documentation, the department's report and recommendations, and other such information available to it that may be relevant to its consideration. The Credentials Committee or a subcommittee may personally interview the applicant and may request that the applicant provide additional information. The Credentials Committee shall then transmit to the Medical Executive Committee on the prescribed form a written report with recommendations as to staff appointment, department/section affiliations, and clinical privileges. The

Credentials Committee may instead request that the Medical Staff defer action on the application but must provide reasons for this request.

10.3.6 Medical Executive Committee Action

- (a) After receipt of the Department and Credentials Committee report and recommendations, the Medical Executive Committee shall consider all relevant information available to it. The Medical Executive Committee may defer its recommendation in order to obtain or clarify information or in other special circumstances. A deferral must be followed up within 60 days of receipt of information with a subsequent recommendation.
- (b) After confirming it has sufficient information to make a recommendation, the Medical Executive Committee shall formulate a preliminary recommendation as to whether the applicant meets the relevant criteria specified in the Governing Documents regarding appointment, reappointment, and privileges. If the preliminary recommendation is favorable, the Medical Executive Committee shall then assess the applicant's health status and determine whether the applicant is able to perform, with or without reasonable accommodation, the necessary functions of a member of the Medical Staff or Allied Health Staff.
- (c) Thereafter, the Medical Executive Committee will formulate a written report with final recommendations to the Governing Body, as follows:
 - (i) **Favorable Recommendation:** Favorable recommendations shall be promptly forwarded to the Governing Body together with the application form, its accompanying information, and the reports and recommendations of the Department and Credentials Committee as to staff appointment, department and section affiliations, clinical privileges to be granted, and any special conditions to be attached to the appointment.
 - (ii) **Adverse Recommendation:** When the recommendation is adverse in whole or in part, the Chief of Staff shall immediately inform the Practitioner by Special Notice, and he or she shall be entitled to such procedural rights as may be provided in these Bylaws. The Governing Body shall be generally informed of, but shall not receive, detailed information, and shall not take action on the pending adverse recommendation until the applicant has exhausted or waived his or her procedural rights.

10.3.7 Governing Body Action

- (a) **On Favorable Medical Executive Committee Recommendation:** Giving great weight to the Medical Executive Committee's recommendation,

and in no event acting in an arbitrary or capricious manner, the Governing Body shall adopt, reject or modify a favorable recommendation of the Medical Executive Committee, or shall refer the recommendation back to the Medical Executive Committee for further consideration, stating the reasons for the referral and setting a time limit within which the Medical Executive Committee shall respond. If the Governing Body's action is itself grounds for a hearing under the Hearings and Appeals Article of these Bylaws, the Chief Executive Officer shall promptly inform the applicant by Special Notice, and he or she shall be entitled to the procedural rights as provided in these Bylaws.

- (b) Without Benefit of Medical Executive Committee Recommendation: If the Governing Body does not receive a Medical Executive Committee recommendation within 270 days of the application being deemed complete, it may, after giving the Medical Executive Committee written notice and a reasonable time to act, take action on its own initiative. If such recommendation is favorable, it shall become effective as the final decision of the Governing Body. If the recommendation is grounds for a hearing under the Hearings and Appeals Article of the Bylaws, the Chief Executive Officer shall give the applicant Special Notice of the adverse decision and of the applicant's right to request a hearing. The applicant shall be entitled to the procedural rights found in the Hearings and Appeals Article before any final adverse action is taken.
- (c) After Procedural Rights: If the Medical Executive Committee's recommendation is adverse and entitles the applicant to a hearing under these Bylaws, the Governing Body shall take final action in the matter only after the applicant has exhausted or has waived his or her procedural rights. Action taken after the applicant has exhausted or has waived his or her procedural rights shall be consistent with the Appeal Procedure provisions in the Hearings and Appeals Article and shall be the Governing Body's final action.
- (d) Expedited Review: The Governing Body may use an expedited process for appointment, reappointment, or when granting privileges when criteria for that process are met. The expedited process involves the Governing Body delegating its appointment authority to a committee of at least two voting members of the Governing Body; however, any final decision of the committee must be subject to ratification by the full Governing Body at its next regularly scheduled meeting. Expedited processing is not available if the Practitioner or member submits an incomplete application or if the Medical Executive Committee's final recommendation is adverse in any respect or has any limitations. The following situations are evaluated on a case-by-case basis and usually result in ineligibility for the expedited process; a determination that expedited process shall not be used is not grounds for a hearing under these Bylaws:

- (i) There is a current challenge or a previously successful challenge to the Practitioner's licensure or registration;
- (ii) The Practitioner has received an involuntary termination of Medical Staff membership at another organization;
- (iii) The Practitioner has received involuntary limitation, reduction, denial, or loss of medical privileges;
- (iv) There has been a final judgment adverse to the Practitioner in a professional liability action.

10.3.8 Notice of Final Decision

A decision and notice to appoint shall be sent, at a minimum, to the applicant, the Chief of Staff, the department chair, and the administrator. The notice shall include the staff category to which the applicant is appointed; the department and section, if any, to which the Practitioner is assigned; the list of clinical privileges the Practitioner may exercise; and any special conditions attached to the appointment.

10.3.9 Guidelines for Time of Processing

All individuals and groups shall act on applications in good faith and in a timely manner. Except when additional information must be secured, or for other good cause, the Medical Staff shall attempt to process each application within the following time guidelines:

- (a) Medical Staff Services Administration review and verification of application: 45 days after the application is deemed preliminarily complete.
- (b) Department review and recommendation: 45 days after receiving application from Medical Staff Services Administration.
- (c) Credentials Committee review and recommendation: 45 days after receiving the report and recommendation from the Department.
- (d) Medical Executive Committee review and recommendation: 45 days after receiving the report and recommendation from the Credentials Committee.
- (e) Governing Body action: 45 days after receiving the Medical Executive Committee recommendation, unless the hearing and appeal rights of the Hearings and Appeals Article apply.
- (f) Notice to the Practitioner: 45 days after the Governing Body's final decision.

These time periods are guidelines and are not directives which create any rights for a Practitioner to have an application processed within these precise periods. If action at a particular step in the process is delayed without good cause, the next higher authority may immediately proceed to consider the application upon its own initiative or at the direction of the Chief of Staff or the Chief Executive Officer (however, the provisions in the Section, Governing Body Action, “Without Benefit of Medical Executive Committee Recommendation” apply).

10.4 Intervention

Notwithstanding the above, if at any time during the process the reviewing body has concerns regarding the application, it may refer the matter to, or ask for assistance from, the Chief of Staff or the Medical Executive Committee.

10.5 Processing of Telemedicine Membership and Privileges

10.5.1 Notwithstanding the other credentialing and privileging provisions in these Bylaws and other Governing Documents, the Medical Staff and Governing Body may use any one of the following processes to evaluate and grant membership and/or privileges to an applicant who practices only Telemedicine at the Hospital.

- (a) The Practitioner’s or AHP’s application may be processed in the manner described above in the Processing of Membership/Privileges Applications Section above.
- (b) The Medical Staff may make its recommendation relying upon information provided by a distant-site hospital(s) at which the applicant is a member of the Medical Staff and has clinical privileges, or a distant-site entity providing telemedicine services with which the applicant is affiliated, in accordance with a written agreement with such hospital or entity, in order to make a credentialing decision based upon this Hospital’s standards. This process may be used only if: (a) the written agreement complies with the requirements detailed in 42 C.F.R. Sections 482.22(a)(3) or (a)(4) and Sections 482.12(a)(8) or (a)(9), and applicable accreditation standards; (b) the Practitioner is privileged at the distant site for those services to be provided to the Hospital; (c) the distant site provides the Hospital with a current list of the applicant’s privileges; and (d) the Hospital performs an internal review of the Practitioner’s performance of these privileges and sends to the distant site information that is useful to assess the Practitioner’s quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse events that result from the telemedicine services provided by the distant-site physician or Practitioner to the Hospital’s patients and all complaints the Hospital has received about the distant-site physician or Practitioner; or

- (c) The Medical Staff may make its recommendation relying on the credentialing and clinical privileging decisions made by a distant-site hospital(s) at which the Practitioner is a member of the Medical Staff and has clinical privileges or the decisions by a distant-site entity providing telemedicine services with which the applicant is affiliated, in accordance with a written agreement with such hospital or entity. This process may be used only if: (a) the written agreement complies with the requirements detailed in 42 C.F.R. Sections 482.22(a)(3) or (a)(4) and Sections 482.12(a)(8) or (a)(9), and applicable accreditation standards; (b) the Practitioner is privileged at the distant site for those services to be provided to the Hospital; (c) the distant site provides the Hospital with a current list of the applicant's privileges; and (d) the Hospital performs an internal review of the Practitioner's performance of these privileges and sends to the distant site information that is useful to assess the Practitioner's quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse events that result from the telemedicine services provided by the distant-site physician or Practitioner to the Hospital's patients and all complaints the Hospital has received about the distant-site physician or Practitioner.

10.5.2 If the applicant applies for privileges that exceed those Telemedicine privileges that he or she has at the distant-site hospital or the distant-site entity, the application for those privileges must proceed through the same privileging and credentialing process applicable to non-Telemedicine Staff applicants.

10.5.3 Regardless of which manner of credentialing the Hospital uses for Telehealth Practitioners, it shall independently query the National Practitioner Data Bank, the Practitioner's licensing board, and the Office of Inspector General for all applicants for Telemedicine Privileges.

10.6 Application for Reappointment

All the above provisions in this article, including, but not limited to, the obligations of applicants, the effect of applications, and the manner in which applications are processed, shall apply to applicants for reappointment or renewal of privileges. In addition, the following provisions apply:

10.6.1 Applications

The Medical Staff shall develop an application for reappointment and renewal of privileges, as described in the Rules and Regulations. The Medical Staff shall send applications for reappointment and renewal of privileges to members at least 120 days prior to the expiration of the current appointment or privileges. A complete application must be returned to the Medical Staff at least 60 days prior to expiration.

10.6.2 Delinquent Reappointment Applications

Failure to return a complete form by the deadline or to otherwise comply with the provisions in this Article regarding the provision of information may result in the Medical Staff's inability to process the reappointment application prior to the end of the applicant's current appointment term. This shall result in the member's automatic resignation of membership and privileges at the end of his or her current appointment term. In such cases, the applicant will not be entitled to a hearing under these Bylaws. If the resigned member submits a written request for appointment and a complete application within 60 days of the resignation, then the Medical Staff will consider his or her application in the same manner as a reappointment application, and will not require the applicant to serve on the Provisional Staff. In such circumstances, the member also may be considered for temporary privileges, pursuant to the Privilege Delineation Article.

10.6.3 Peer and Quality Data

In addition to the other criteria for reappointment found in the Governing Documents, the Medical Staff shall consider an applicant's ongoing professional performance review data and other quality data, as well as information regarding the Practitioner's conduct and adherence to Governing Document requirements, as appropriate, when determining whether or not to grant reappointment and privileges. If a Practitioner has performed any privilege too infrequently to allow the Medical Staff to assess current clinical competence, the Medical Staff may impose proctoring or other focused professional practice evaluation requirements; these requirements shall not entitle the Practitioner to a hearing under these Bylaws. Additionally, the Medical Staff shall consider the Practitioner's conduct and compliance with the Governing Documents when making reappointment determinations.

10.6.4 Participation in Continuing Education

The Medical Staff shall consider an applicant's participation in continuing education when determining whether or not to grant reappointment and privileges.

10.6.5 Verification

The Medical Staff may develop verification processes specific to the consideration of reappointment applications that may differ from the verification process for initial applications. Regardless, the Hospital's authorized representative shall query the National Practitioner Data Bank and the Medical Staff shall query the licensing board and the Office of Inspector General for every reappointment applicant. The Medical Staff also shall confirm current DEA registration.

10.7 Duration of Appointments

- 10.7.1** All new staff members who are granted privileges, other than Telemedicine Staff, shall be appointed to the Provisional Staff. Members shall hold Provisional Staff status for at least 12 months, and no more than 24 months. To move from Provisional Staff status to another staff status with privileges, the Practitioner must meet the standards detailed in the Governing Documents, including the privileging forms.
- 10.7.2** Appointments, reappointments, and the grant of clinical privileges shall be up to a maximum of two years and shall not be extended beyond two years. No Practitioner has the right to a two-year appointment, and appointments may be for periods less than two years.

10.8 Waiting Periods

10.8.1 For Applications Withdrawn as Incomplete

If a Practitioner has had two applications withdrawn for being incomplete within a 12-month period, the Practitioner will be subject to a 12-month waiting period before he or she can submit another application. The Governing Body may waive this waiting period using the same waiver provisions detailed in Membership Qualifications and Responsibilities Article above.

10.8.2 Reapplication After Adverse Membership Decision

- (a) A 36-month waiting period before applying for membership or privileges shall apply to the following Practitioners:
- (i) An applicant who:
 - (1) Has received a final adverse decision regarding appointment or the granting of privileges, or
 - (2) Withdrew his or her application or request for membership or privileges following an adverse recommendation by the Medical Executive Committee or the Governing Body.
 - (ii) A former member who has:
 - (1) Received a final adverse decision resulting in termination of Medical Staff membership and/or privileges or other permissions to practice; or
 - (2) Resigned from the Medical Staff or relinquished privileges or other permissions to practice while an investigation was pending or following the Medical

Executive Committee or Governing Body issuing an adverse recommendation or decision.

- (iii) Subject to (e) below, a member who has received a final adverse decision resulting in:
 - (1) Termination or restriction of privileges; or
 - (2) Denial of his or her request for additional privileges.
- (b) An action is considered adverse only if it is based on the type of occurrences which might give rise to corrective action. For the purposes of this section, automatic suspensions or terminations under the Automatic Suspension, Terminations, and Limitations provisions of the Corrective Action Article of these Bylaws are not “adverse.”
- (c) The action is considered final on the latest date on which the application or request was withdrawn; a member’s resignation became effective; a member waived his or her right to a hearing to challenge an adverse recommendation or action; or upon exhaustion of all Medical Staff and Hospital hearings and appellate reviews.
- (d) Practitioners subject to waiting periods cannot reapply for Medical Staff membership or the privileges affected by the adverse action for at least 36 months after the action became final. After the waiting period, the Practitioner may reapply. The application will be processed like an initial application or request, plus the Practitioner must document that the basis for the adverse action no longer exists, that he or she has corrected any problems that prompted the adverse action, and/or he or she has complied with any specific training or other conditions that were imposed.
- (e) Notwithstanding the above, for Practitioners whose adverse action involved the termination, restriction, or denial of some, but not all, held or requested privileges, the waiting period shall apply only to those privileges that were terminated, restricted, or denied.
- (f) Notwithstanding the above, for Practitioners whose adverse action included a specified period or conditions of retraining, additional experience, or medical or psychological treatment, the Medical Executive Committee, subject to the Governing Body’s approval, may exercise its discretion to allow earlier reapplication upon completion of the specified conditions and any additional conditions that the Medical Executive Committee determines to be necessary.

10.8.3 Waiver of Waiting Period

The Governing Body may waive the waiting periods under the same circumstances and procedure as described for the waiver of qualifications, described the Membership Qualifications and Responsibilities Article. As in that section, such waivers are disfavored, intended to be granted rarely, and are granted only when necessary to address an identifiable patient care need and only if the waiver is found to be in the best interests of the Hospital and its patients' health and wellbeing. The needs of the individual Practitioner are irrelevant to such determination.

ARTICLE 11

PRIVILEGE DELINEATION

11.1 Exercise of Privileges

Practitioners and APPs may only exercise those privileges that have been granted through the processes delineated in the Governing Documents.

11.2 Development of Privileging Criteria

11.2.1 Generally

The Medical Staff, through its departments and committees, and subject to the Governing Body's approval, shall develop criteria for granting initial privileges and reappointment privileges. Those criteria shall be evidence-based and address the general competencies developed by the Medical Staff. Criteria shall be Hospital-specific and may be setting-specific. Criteria may not discriminate between licensees or specialties of Medical Staff members. APPs should, to the extent feasible, participate in the development of criteria for privileges granted to APPs.

11.2.2 New Procedures

The Hospital may only grant privileges for those procedures that are performed at the Hospital. Requests for clinical privileges to perform either a procedure not currently being performed at the Hospital or a new technique to perform an existing procedure ("new procedure") will not be processed until a determination has been made that the new procedure will be offered by the Hospital and criteria for the clinical privileges have been adopted. The Hospital may develop a process to determine whether sufficient space, equipment, staffing, and financial resources are in place or available within a specified time frame to support each requested new procedure. Once the Hospital determines that a new procedure will be performed at the Hospital, the Medical Staff may, subject to the Governing Body's approval, develop privileging criteria for new procedures.

11.2.3 Multi-Specialty Privileges

When a procedure is performed by specialists in different departments, the departments shall collaborate to develop equivalent privileging criteria, while recognizing that practice differences may exist. The Medical Executive Committee has the authority to resolve any significant conflicts or differences in the criteria developed.

11.3 Privilege Delineation

11.3.1 Generally

- (a) Each application for appointment and reappointment to the Active, Courtesy, Provisional, or Telemedicine Staff must contain a request for specific privileges. Members and APPs may request additional privileges during their appointment by submitting an application for those privileges.
- (b) All requests by Practitioners for privileges shall be processed through the appointment and reappointment procedures described in the Procedures for Appointment and Reappointment Article; requests by APPs shall be subject to the procedures delineated in the Rules.
- (c) Privileges shall be granted only to those Practitioners and APPs who satisfy the established criteria, as evidenced by the applicant's current licensure, education, training, experience, demonstrated professional competence, judgment and clinical performance, health status, data from professional practice review by an organization(s) that currently privileges the applicant (if available), the documented results of patient care and other quality improvement review and monitoring, performance of a sufficient number of procedures each year to maintain current clinical competence, and compliance with any other applicable specific criteria detailed in the Governing Documents.
- (d) No privileges shall be granted merely because a Practitioner or APP holds a contract with the Hospital or is part of a group that holds a contract with the Hospital.
- (e) The Medical Staff may develop processes to authorize Practitioners who are not Medical Staff members or who do not hold other privileges to order outpatient services that are within their scope of practice to order.

11.3.2 History and Physical

- (a) All patients shall receive the same basic medical appraisal. A Practitioner with appropriate privileges shall determine the risk and effect of any proposed treatment or surgical procedure on the general health status of the patient.
- (b) Histories and physicals may be performed only by those Practitioners or APPs with privileges to perform them. Any Practitioner who admits patients but does not hold history and physical privileges must assure that a Practitioner or APP with history and physical privileges performs a history and physical in a manner that complies with the Bylaws and any other applicable Governing Document. A Practitioner without

history and physical privileges may not supervise an APP's performance of history and physicals.

- (c) The admitting Practitioner must assure that every patient receives a history and physical within 24 hours after admission, or, if a history and physical was performed within 30 days prior to admission (or registration if an outpatient procedure) and is in the medical record, that the prior history and physical is updated within 24 hours after admission. Every patient admitted for surgery or other procedure requiring anesthesia services must have a history and physical, or the update to the history and physical, prior to the surgery or procedure requiring anesthesia. No patient shall undergo surgery or a procedure requiring anesthesia services without a history and physical or update consistent with this section in his or her medical record.
- (d) History and physicals performed prior to hospitalization may be submitted by practitioners without history and physical privileges, but the update must be performed by someone with history and physical privileges.

11.4 Application to Podiatrists, Dentists, and Oral and Maxillofacial Surgeons

- 11.4.1** For patients admitted by, or upon order of, oral surgeon, clinical psychologist, or podiatrist who is not also a physician, a physician member must assume responsibility for the care of the patient's medical or psychiatric problems that are present at the time of admission, or which may arise during hospitalization, which are outside of the admitting Practitioner's lawful scope of practice or clinical privileges.
- 11.4.2** Where a dispute exists regarding proposed treatment between a physician member and non-physician member based upon medical or surgical factors outside of the scope of licensure of the non-physician member, the treatment will be suspended insofar as possible while the dispute is resolved by the appropriate departments or Chief of Staff.
- 11.4.3** The findings, conclusions, and assessment of risk must be confirmed or endorsed by a physician member with appropriate privileges prior to major high-risk (as defined by the Medical Staff) diagnostic or therapeutic interventions.

11.5 Effect of Contracted Services

- 11.5.1** The Hospital may enter into contracts or arrangements with Practitioners and/or groups of Practitioners for the performance of clinical and administrative services at the Hospital. All individuals that wish to provide clinical services pursuant to such contracts must apply for, be granted, and maintain membership and privileges in accordance with these Bylaws.

- 11.5.2** If a contract or arrangement confers the exclusive right to perform specified services to one or more Practitioners or groups of Practitioners (an “exclusive contract”), no other Practitioners except those authorized by the exclusive contract may exercise clinical privileges to perform the specified services while the contract is in effect. As such, only Practitioners authorized under the contract are eligible to apply for the clinical privileges covered by the contract. No other applications will be processed.
- 11.5.3** Prior to the Hospital entering into any exclusive contract in a specialty area that has not previously been subject to such a contract or arrangement, the Governing Body will initiate a notice-and-comment process consistent with California legal requirements. The Medical Executive Committee shall provide input to the Governing Body as part of this process, and the Medical Staff shall have the opportunity to provide input directly to the Medical Executive Committee or the Governing Body.
- 11.5.4** A decision to operate a department or service pursuant to an exclusive contract, or to transfer an exclusive contract to another Practitioner or group of Practitioners, shall result in the automatic termination of privileges covered by the exclusive contract for those Practitioners who are not a party to, subcontractor of, or third-party beneficiary of, the exclusive contract. A Practitioner who does not hold any privileges as a result of this termination shall have his or her membership terminated as well.
- 11.5.5** The termination or denial of membership and/or privileges as a result of an exclusive contract arrangement shall not entitle any Practitioner to a hearing under these Bylaws.
- 11.5.6** A Practitioner who holds privileges in connection with a contract shall be subject to the terms of that contract, as well as to the Medical Staff Governing Documents. If the contract and the Governing Documents conflict, the terms of the contract will prevail, except that contracts may not grant Medical Staff membership or privileges to any individual and contracts may not reduce any hearing rights granted for an action that must be reported to the Practitioner’s licensing board under Business and Professions Code Section 805 or to the federal National Practitioner Data Bank. The Practitioner shall be entitled to the hearing rights in these Bylaws only if actions taken fall within the definition of grounds for hearing detailed in the Hearings and Appeals Article of these Bylaws.
- 11.5.7** Practitioners who serve under contracts to provide only administrative services are not required to apply for Medical Staff membership and privileges. If a Practitioner’s contractual duties involve formal liaison with or advising the Medical Staff, Hospital Administration, or the Governing Body about Medical Staff activities or performance, the Hospital shall consult with the Medical Executive Committee and provide it reasonable opportunity to review and comment on the scope of responsibilities and the qualifications of the proposed candidate. The Hospital also shall, at least bi-annually, provide the

Medical Executive Committee with a reasonable opportunity to provide input to the Hospital regarding the performance of those contracted Practitioners.

11.6 Temporary Privileges

11.6.1 Temporary privileges may be granted by the Governing Body, pursuant to its own procedures, upon recommendation of the Chief of Staff, as follows:

- (a) To applicants for initial appointment who have submitted a complete application. To be eligible for temporary clinical privileges, an applicant must: (i) have had no current or previously successful challenges to licensure or registration, (ii) have not been subject to involuntary termination of Medical Staff membership at another organization, and (iii) have not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges at another health care facility.
- (b) To non-applicants, to meet an important patient care need, including the following:
 - (i) The care of a specific patient, where care could not be provided by a current member or where the patient has rejected care from current members;
 - (ii) When necessary to prevent a lack of services in a needed specialty area;
 - (iii) Proctoring, where it is not feasible to have current members proctor; or
 - (iv) When serving as a locum tenens for a member or APP, and temporary privileges are necessary to assure continuity of care.

11.6.2 The following information will be verified prior to the granting of any temporary clinical privileges:

- (a) Current licensure (including any peer review or other actions reported to the licensing board),
- (b) Relevant training or experience,
- (c) Current competence,
- (d) Ability to perform the privileges requested,
- (e) Current professional liability coverage acceptable to the Hospital, and
- (f) Results of a query to the National Practitioner Data Bank and the Office of Inspector General.

11.6.3 Grants of temporary clinical privileges will not exceed 120 days.

(a) For non-applicants, the individual may exercise temporary privileges for a maximum of 120 days, consecutive or not, anytime during the 24-month period following the grant of privileges, subject to the following conditions:

(i) The individual must notify the Medical Staff Administration at least 15 days prior to exercising these privileges (exceptions for shorter notice periods may be considered for good cause); and

(ii) The individual must inform the Medical Staff Administration of any change that has occurred to the information provided on the application form for temporary privileges.

11.6.4 By requesting temporary privileges, the individual agrees to be bound by the Bylaws and other Governing Documents, including, but not limited to, the provisions addressing authorizations, releases, immunities, and confidentiality.

11.6.5 Individuals granted temporary privileges shall be subject to the proctoring and supervision requirements specified in the Governing Documents, and shall act under the supervision of the Department Chair of the Practitioner's specialty.

11.6.6 There is no right to temporary privileges. Temporary privileges will not be granted if a Practitioner does not meet the qualifications for temporary privileges. If there is insufficient information regarding the applicant's qualifications, character, judgment, or ability to exercise the privileges requested, the matter will be deferred until the application can be fully processed.

11.6.7 Temporary privileges shall terminate when expired or, in the case of applicants to the Medical Staff, if the applicant withdraws his or her application. Temporary privileges also may be suspended or terminated in the manner described in the Corrective Action Article of these Bylaws. Practitioners whose temporary privileges are suspended or terminated shall be entitled to the hearing and appeal rights of these Bylaws only if the action is considered Grounds for Hearing as defined in Hearings and Appeals Article of these Bylaws.

11.6.8 Upon the termination of temporary privileges, the Department Chair or Chief of Staff shall assign a Medical Staff member to assume responsibility for the Practitioner's patients. The wishes of the patient shall be considered in choosing a replacement.

11.7 Disaster Privileges

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

- 11.7.1** Disaster privileges may be granted on a case-by-case basis by the Chief Executive Officer, based upon recommendation of the Chief of Staff, or, in his or her absence, the recommendation of the responsible Department Chair, upon presentation of a valid government-issued photo identification issued by a state or federal agency and at least one of the following:
- (a) A current picture identification card from a health care organization that clearly identifies professional designation;
 - (b) A current license to practice;
 - (c) Primary source verification of licensure;
 - (d) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group;
 - (e) Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances; or
 - (f) Confirmation by a licensed independent practitioner currently privileged by the Hospital or by a staff member with personal knowledge of the volunteer practitioner's ability to act as a licensed independent practitioner during a disaster.
- 11.7.2** Persons granted disaster privileges shall wear identification badges denoting their status as non-members having only disaster privileges.
- 11.7.3** Primary source verification of licensure occurs as soon as the disaster is under control or within 72 hours from the time the volunteer licensed independent practitioner presents themselves to the Hospital, whichever comes first. If primary source verification of a volunteer licensed independent practitioner's licensure cannot be completed within 72 hours of the practitioner's arrival due to extraordinary circumstances, the Hospital documents all the following:
- (a) Reason(s) it could not be performed within 72 hours of the practitioner's arrival;
 - (b) Evidence of the licensed independent practitioner's demonstrated ability to continue to provide adequate care, treatment, and services; and
 - (c) Evidence of the Hospital's attempt to perform primary source verification as soon as possible.

- 11.7.4** If, due to extraordinary circumstances, primary source verification of licensure of the volunteer licensed independent practitioner cannot be completed within 72 hours of the practitioner's arrival, it is performed as soon as possible. However, primary source verification of licensure is not required if the volunteer licensed independent practitioner has not provided care, treatment, or services under the disaster privileges.
- 11.7.5** The responsible Department Chair or the Chief of Staff shall oversee the performance of each volunteer practitioner, and shall arrange for appropriate concurrent or retrospective monitoring of the activities of practitioners granted disaster privileges.
- 11.7.6** Based on the Medical Staff's oversight of each practitioner granted disaster privileges, the Chief Executive Officer, upon recommendation of the Chief of Staff, [or in his or her absence, the recommendation of the responsible department chair,] shall determine within 72 hours of the practitioner's arrival if granted disaster privileges shall continue.

Volunteers who are not licensed independent practitioners may be permitted to provide disaster services as described in the Rules or other Governing Documents.

11.8 Emergency Situations

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

11.9 Transport and Organ Harvest Teams

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

ARTICLE 12

LEAVES OF ABSENCE AND RESIGNATION

12.1 Leaves of Absence

Members may request a leave of absence which, except for military leaves of absence, requires approval by the Medical Executive Committee. During the period of the leave, the member shall not exercise privileges at the Hospital, and membership rights and responsibilities shall be inactive; however, the obligation to pay dues and assessments, if any, shall continue unless waived by the Medical Executive Committee.

12.1.1 Military Leave of Absence

- (a) Requests for leaves of absence to fulfill military service obligations shall be granted upon notice to the Medical Executive Committee.
- (b) Reactivation of membership and clinical privileges previously held shall be granted upon request, except that the following may apply:
 - (i) If the leave of absence has been for more than two years, the member shall be required to submit a reappointment application;
 - (ii) If the request for reactivation occurs in less than two years but after the expiration of the member's current appointment term, the member may be required to update information in his or her credentials file, which may be done by submitting a reappointment application form.

12.1.2 In cases where reactivation from a military leave of absence is requested after the expiration of the member's current appointment term, the member shall be treated as if he or she had been continuously appointed to the Medical Staff for purposes of determining staff status and eligibility for officer or other positions.

12.1.3 Notwithstanding the above, the Medical Staff may take appropriate measures to ensure the current clinical competence of any member requesting a reinstatement from a military leave of absence.

12.1.4 Reinstatement from Non-Military Leaves of Absence

- (a) Non-military leaves cannot exceed two years. Failure to request reinstatement at the end of the leave shall be deemed a voluntary resignation of membership and privileges, which does not entitle the Practitioner to the hearing rights in these Bylaws.
- (b) Requests for reinstatement shall be considered following the same process as the review of reappointment applications. The member must

provide information regarding his or her professional activities during the leave of absence and may be required to provide additional information to demonstrate current clinical competence.

- (c) Even if a member has not yet requested reinstatement from a leave, he or she must submit a reappointment application in a timely manner, prior to the expiration of his or her current appointment term, or his or her membership and privileges shall expire. In such cases, the Practitioner must apply to the Medical Staff as an initial applicant, but at the Medical Executive Committee's discretion, may be placed in a staff status other than Provisional Staff.

12.2 Resignation

12.2.1 Manner of Resignation

A resignation of membership and/or some or all privileges shall be in writing and signed by the Practitioner. If a date is not specified in the written document, then the resignation will be considered effective upon receipt.

12.2.2 Good Standing

- (a) Prior to the effective date of resignation, a Practitioner must complete all medical records; pay any outstanding dues, fees, or assessments; and appropriately discharge or transfer responsibility for the care of any hospitalized patient. Failure to do so will result in the Practitioner being deemed to have been out of good standing at the time of resignation. This designation may be transmitted to querying health care entities.
- (b) If the Practitioner is scheduled for inpatient or call responsibilities prior to resignation, the Practitioner must either: (a) specify a date for resignation that goes into effect after the fulfillment of those responsibilities, or (b) arrange alternative coverage. Failure to fulfill or ensure coverage for call or other scheduled responsibilities shall result in the Practitioner being deemed out of good standing at the time of resignation, and this designation may be transmitted to querying health care entities.

DIVISION 3: QUALITY AND PEER REVIEW

ARTICLE 13

PRACTITIONER PERFORMANCE EVALUATIONS

13.1 General

The Medical Staff is responsible to the Governing Body for the adequacy and quality of patient care services provided at the Hospital, and the Governing Body has ultimate responsibility for those services. To fulfill its responsibility, the Medical Staff will develop processes, subject to the Governing Body's approval, for the evaluation of care provided by Medical Staff members and others with privileges. Those processes will be consistent with state and federal legal and accreditation requirements. Decisions regarding the granting, renewing, and termination of membership or privileges shall be, among other things, detailed, current, accurate, objective, and evidence-based. Ongoing performance evaluation and monitoring will be designed to assure timely identification of matters that may require correction. Concerns regarding professional performance or conduct will be addressed pursuant to the Investigation Article, Corrective Action Article, and the Hearings and Appeal Article of these Bylaws.

13.2 Focused Professional Practice Evaluation for New Privileges

- 13.2.1** All initial grants of clinical privileges, whether at the time of appointment, reappointment, or during the term of an appointment, will be subject to a focused professional practice evaluation (FPPE). That evaluation shall include proctoring, and may include chart review, monitoring, external review, and other forms of review.
- 13.2.2** The Medical Staff, subject to the Governing Body's approval, shall develop the policies and processes it determines necessary to implement FPPE for new privileges. Each Department, subject to the Medical Executive Committee's and Governing Body's approval, shall be responsible for developing FPPE criteria for new applicants and for privileges granted during appointment. In addition, the Medical Staff shall develop criteria for FPPE for conduct at the Hospital.
- 13.2.3** When a Practitioner or APP completes FPPE requirements, the Department shall convey this information to the Medical Executive Committee.
- 13.2.4** If a Practitioner or APP fails to complete the FPPE requirements for any privilege during his or her Provisional Staff status period due to lack of clinical activity, then that privilege shall expire. If all of the Practitioner's or APP's privileges expire, then his or her membership shall automatically terminate. Under these circumstances, the Practitioner and APP shall not be entitled to any hearing and appeal provisions under these Bylaws.
- 13.2.5** If a Practitioner or APP who has been granted a new privilege in the middle of his or her appointment fails to complete the FPPE requirements for that

privilege within two years after being granted the privilege due to lack of clinical activity, then that privilege shall expire. Under these circumstances, the Practitioner and APP shall not be entitled to any hearing and appeal provisions under these Bylaws.

- 13.2.6** If a Practitioner fails to satisfactorily complete FPPE due to a medical disciplinary cause or reason, then the Practitioner will be referred to the Medical Executive Committee for further consideration.

13.3 Ongoing Professional Practice Evaluation

- 13.3.1** All persons with privileges shall be subject to ongoing professional practice evaluations.
- 13.3.2** The Medical Staff and Hospital shall develop clearly defined processes that facilitate the evaluation of each Practitioner's professional practice. Such evaluation shall include evaluation of the Practitioner's interpersonal conduct at the Hospital. Each Department, subject to the Medical Executive Committee's approval, shall be responsible for determining the type of data to be collected.
- 13.3.3** Information resulting from the ongoing professional practice evaluation is used as part of the determination of whether to continue, limit, or revoke any existing privilege.

13.4 Focused Professional Practice Evaluation for Cause

- 13.4.1** The Medical Staff shall develop criteria to be used for evaluating the performance of Practitioners and APPs when issues affecting the provision of safe, high quality patient care are identified.
- (a) The decision to assign a period of performance monitoring is based on the evaluation of a Practitioner's current clinical competence, practice behavior, and ability to perform the requested privilege.
 - (b) An FPPE for cause process is not intended to be an investigation, as that term is defined in these Bylaws.
- 13.4.2** The Medical Staff shall clearly define the performance monitoring process and shall include each of the following elements:
- (a) Criteria for conducting performance monitoring.
 - (b) Method for establishing a monitoring plan specific to the requested privilege.
 - (c) Method for determining the duration of performance monitoring.
 - (d) Circumstances under which monitoring by an external source is required.

13.4.3 The processes also shall identify the triggers that indicate the need for performance monitoring and the criteria that determine the type of monitoring to be conducted.

13.4.4 The FPPE for cause process may result in the following:

- (a) A determination that the FPPE should be concluded without further action;
- (b) A determination that the Practitioner or APP should be subject to a plan that specifies non-restrictive measures designed to improve performance; or
- (c) A referral to the Medical Executive Committee for investigation or corrective action.

13.5 Fitness for Practice Evaluations

At any time, the Medical Executive Committee may require a Practitioner or Allied Health Staff member to submit to a medical or psychological examination, including blood, urine or other biological or physiological testing, and to allow the Medical Executive Committee (and the Wellbeing Committee, if the Medical Executive Committee chooses) to inspect the records of the examination. The Medical Executive Committee shall provide in writing to the Practitioner or Allied Health Staff member a brief description of the reasons for the requirement and identify a deadline for compliance.

13.6 Informal Remediation

At any time when warranted, the Medical Staff may employ informal remediation to address matters related to a Practitioner or Allied Health Staff member's clinical or professional performance. The Medical Staff officers, departments, and committees may counsel, educate, or issue letters of warning or censure without initiating formal corrective action. Such comments, suggestions, and warnings may be issued orally or in writing. The Practitioner shall be given an opportunity to respond in writing and may be given an opportunity to meet with the officer, department, or committee. Any informal actions, monitoring, or counseling shall be documented in the Practitioner or Allied Health Staff member's file. The activities shall be reported to the Medical Executive Committee, but Medical Executive Committee approval is not required. These activities are not a restriction of privileges or grounds for the hearing or appeal rights under these Bylaws. Notwithstanding the availability of informal remediation, the Medical Staff may initiate investigations and/or take corrective action against a Practitioner without first initiating informal remediation.

13.7 Progressive Measures

The Medical Staff may develop progressive measures to address matters related to a Practitioner or Allied Health Staff member's clinical or professional performance. "Progressive measures" means formal interventions that do not constitute investigations or corrective actions. Examples of progressive measures include, but are not limited to, referrals to anger management courses, medical record keeping courses, and continuing education courses on clinical matters. Such interventions, if used, shall be documented in the Practitioner's or Allied Health Staff member's file. The progressive measures shall

be reported to the Medical Executive Committee, but Medical Executive Committee approval is not required for such measures. Progressive measures are not a restriction of privileges or grounds for the hearing or appeal rights under these Bylaws. Notwithstanding the availability of progressive measures, the Medical Staff may initiate investigations and/or take corrective action against a Practitioner without first initiating progressive measures.

ARTICLE 14

INVESTIGATIONS

14.1 Grounds for Investigation

The Medical Staff may initiate an investigation into any Practitioner or APP when reliable information from any source indicates that the Practitioner or APP has done anything that is reasonably likely to have been, or to be:

- 14.1.1 Detrimental to patient safety or to the delivery of quality patient care within the Hospital;
- 14.1.2 Unethical or illegal;
- 14.1.3 Contrary to the Medical Staff Governing Documents;
- 14.1.4 Intimidating or harassing to staff, colleagues, patients, or other persons at the Hospital;
- 14.1.5 Below applicable professional standards;
- 14.1.6 Disruptive of Medical Staff or Hospital operations; or
- 14.1.7 An improper use of Hospital or Medical Staff resources.

14.2 Initial Review

- 14.2.1 Whenever information suggests that an investigation is warranted, the Chief of Staff or his or her designee may, on behalf of the Medical Executive Committee, immediately perform an initial review and conduct whatever interviews may be indicated. The information developed during this initial review shall be presented to the Medical Executive Committee, which shall decide whether to initiate a formal investigation.
- 14.2.2 If the information includes claims of unlawful harassment or discrimination by a Practitioner or APP, the Chief of Staff or his or her designee and representatives from the Hospital, which may include an attorney or other advisor, shall perform an initial review. The reviewers shall attempt to complete the initial fact-gathering process within five days, and within seven days shall decide whether to refer the matter to the Medical Executive Committee for further investigation or corrective action. If the matter is referred to the Medical Executive Committee, the information gathered during the initial review shall be provided to the Medical Executive Committee.

14.3 Initiation of Investigation

The Medical Executive Committee may initiate an investigation upon receiving information suggesting that grounds for an investigation exists. Except as provided in these Bylaws, only the Medical Executive Committee has the authority to initiate an investigation as defined in these Bylaws. The Chief of Staff shall inform the Chief Executive Officer or his or her designee whenever an investigation is initiated and shall continue to keep the Chief Executive Officer or his or her designee fully informed of all action taken. If the investigation involves a patient complaint that constitutes a “patient grievance” pursuant to the Hospital’s grievance policy, the Medical Executive Committee shall cooperate with the Hospital in its process for the resolution of patient grievances.

14.4 Investigative Procedure

Once the Medical Executive Committee initiates an investigation, it will proceed with the understanding that the fundamental purpose of the investigation is to discover facts in order to determine truth. To achieve this, the following will occur:

- 14.4.1** The Medical Executive Committee will inform the Practitioner or APP that it has initiated an investigation. The notice will include a brief description of the reasons for the investigation, will identify the body that is performing the investigation, and will inform the Practitioner or APP that he or she will have an opportunity to provide information to the investigative body pursuant to these Bylaws.
- 14.4.2** The Medical Executive Committee will identify a body to perform the investigation. The investigatory body may be the Medical Executive Committee as a whole, a subcommittee of the Medical Executive Committee, an ad hoc committee, a Medical Staff Officer or Department Chair, or other body that the Medical Executive Committee determines is appropriate to perform the investigation. The Medical Executive Committee will provide the investigatory body with appropriate direction for its assignment. Insofar as feasible, the members of the investigatory body may not be in direct economic competition with the individual being investigated; may not be professionally associated with or a relative of the individual being investigated; and may not have an actual bias, prejudice, or conflict of interest that would or could prevent the individual from fairly and impartially investigating the matter.
- 14.4.3** The investigatory body will evaluate whatever information it determines is reasonably likely to achieve the goal of discovering facts to determine truth. This may include, without limitation, reviewing relevant documents and patient records; conducting interviews; engaging outside consultants, subject to the Medical Executive Committee’s approval; and requiring the Practitioner or APP to submit to a physical or mental health examination and/or mandatory drug and alcohol testing at the Practitioner’s or APP’s expense, subject to the Medical Executive Committee’s approval. The investigatory body may require the Practitioner or APP to submit information as part of the investigation, including patient medical records.

- 14.4.4** The investigatory body shall provide the Practitioner or APP the opportunity to provide information to the body in a manner that the investigatory body determines appropriate. This may include the provision of written information to the investigatory body, attendance at an interview with the investigatory body, or both. Interviews shall not include the presence of attorneys and shall not be considered a “hearing” as the term is used in these Bylaws.
- 14.4.5** The investigatory body will attempt to complete its investigatory tasks within 30 days; however, the investigatory body may take additional time as long as it keeps the Medical Executive Committee informed of its progress.

14.5 Conclusions

- 14.5.1** At the conclusion of its investigation, the investigatory body shall create a report, which it shall submit to the Medical Executive Committee (if the investigatory body was not the Medical Executive Committee). The report shall summarize the investigatory body’s activities during the investigation and shall include its findings and conclusions. The report may include recommendations to the Medical Executive Committee, but the Medical Executive Committee is not required to adopt any investigatory body recommendation.
- 14.5.2** Before acting on any report, the Medical Executive Committee shall confirm that the Practitioner or APP had the opportunity to provide information to the investigatory body in the manner described above.
- 14.5.3** As soon as practicable after the conclusion of the investigation, the Medical Executive Committee shall do one of the following:
- (a) Determine that no corrective action should be taken and, if the Medical Executive Committee determines there was no credible evidence for the complaint in the first instance, clearly document that finding in the Practitioner’s file;
 - (b) Refer the matter back to the investigatory body, with guidance regarding additional investigation that the Medical Executive Committee has determined is necessary;
 - (c) Defer action to a reasonable time; or
 - (d) Impose corrective action in the manner described in the Corrective Action Article.

14.6 Notification of Investigation to System Members

Whenever the Medical Executive Committee initiates an investigation under this Article, it may notify other System Members where the individual also practices or has privileges that an investigation has been initiated and the basis for the investigation. The Medical Executive Committee also may provide any other information it determines to be appropriate regarding the investigation to other

System Members, but will take measures to protect the integrity of the investigation and will not provide preliminary or draft investigatory reports to other entities. The Medical Staff and Hospital will ensure that any information shared complies with Hospital policies regarding patient confidentiality and, at a minimum, with HIPAA and California's laws regarding confidentiality. Any notification should take place within 10 days of the initiation of the investigation, if possible.

14.7 Information Received from Other Entities

If the Hospital or Medical Staff is informed that a Practitioner or Allied Health Staff member is subject to an investigation at another entity, that information will be referred to the Medical Executive Committee for evaluation to determine whether an investigation is warranted by this Medical Staff pursuant to these Bylaws.

14.8 Joint Investigations

This Medical Staff may join with other System Members to jointly investigate an individual who practices at or has privileges with each of the System Members involved in the investigation. In such event, the Medical Executive Committee may delegate the investigation to a joint investigatory body. The joint investigatory body must comply with the investigation provisions detailed in this Article, except that it may engage outside consultants and require mental or physical evaluations without the Medical Executive Committee's approval, as long as a majority of the executive committees of the System Members participating in the investigation agree that the engagement or evaluation is necessary.

14.9 Medical Executive Committee Authority

Despite the status of any investigation, including any joint investigation, the Medical Executive Committee shall, at all times, retain authority and discretion to take whatever action may be warranted by the circumstances, including summary action.

ARTICLE 15

CORRECTIVE ACTION

15.1 Grounds for Action

- 15.1.1** Regardless of whether or not an investigation has taken place, or is taking place, the Medical Executive Committee at all times has the authority to impose corrective action when grounds for action exists. The grounds for corrective action include when the Medical Executive Committee has reasonably verified that events that would constitute grounds for investigation, as identified above, have, in fact, occurred.
- 15.1.2** When appropriate, the Medical Staff should make reasonable attempts at informal remediation or progressive measures, or to conduct a formal investigation, before initiating corrective action; however, such measures are not mandatory conditions to corrective action, which may be initiated whenever circumstances reasonably appear to warrant it.

15.2 Authority to Impose Action

- 15.2.1** By accepting membership and/or privileges, the Practitioner accepts the authority of the Medical Executive Committee to recommend and/or impose corrective action pursuant to these Bylaws. Each Practitioner agrees that he or she will comply with any requirements the Medical Executive Committee imposes on the Practitioner as corrective action once that action is considered a final action or if the action is a summary action. Failure to comply with the requirements of corrective final actions or summary actions shall, in and of itself, be grounds for additional corrective action, including termination of membership and privileges. Invoking the hearing rights under these Bylaws shall not be considered a failure to comply with any corrective action requirement, and no Practitioner shall be penalized for asserting his or her hearing and appeal rights.
- 15.2.2** Nothing within this article shall preclude Department Chairs or committees from issuing informal written or oral warnings that do not constitute corrective action under these Bylaws.

15.3 Effective Dates of Action

- 15.3.1** Unless the Medical Executive Committee designates otherwise, a non-summary corrective action that does not give rise to a hearing right under these Bylaws shall be considered final and effective upon the Governing Body's affirmation of the action.
- 15.3.2** Unless the Medical Executive Committee designates otherwise, summary action shall be effective immediately upon imposition.

- 15.3.3 Corrective action that gives rise to a hearing right under these Bylaws but is not a summary action shall be considered final and effective only after the Practitioner has exhausted or waived his or her hearing rights and only if the action is adopted by the Governing Body.

15.4 Examples of Corrective Action

The Medical Executive Committee has the authority to impose corrective action it determines is likely to achieve peer review goals and is appropriate under the circumstances. Examples of such action include, but are not limited to:

- 15.4.1 Issuing a letter of guidance, counsel, warning, or reprimand;
- 15.4.2 Referring to an appropriate committee, such as the Well-Being Committee or Professional Standards Committee;
- 15.4.3 Imposing terms of probation for continued appointment;
- 15.4.4 Requiring non-restrictive monitoring or retrospective proctoring;
- 15.4.5 Requiring additional training or education;
- 15.4.6 Recommending reduction, suspension (including summary suspension), or other restriction of membership or clinical privileges, including mandatory consultation, concurrent proctoring, or co-admission; or
- 15.4.7 Recommending revocation of membership or clinical privileges.

15.5 Additional Steps

- 15.5.1 The Medical Executive Committee shall provide notice of the corrective action to the Practitioner. When the action gives rise to a hearing under these Bylaws, the notice shall comply with the notice requirements detailed in the Hearing and Appeals Article. When appropriate, the Medical Executive Committee shall identify and inform the member of any terms or conditions that must be met before the corrective action is lifted.
- 15.5.2 Whenever the Medical Executive Committee, Department Chair, or Committee chair issues a written letter of guidance, counsel, warning, or reprimand, whether as formal corrective action or otherwise, the Practitioner or Allied Health Staff member shall have the right to submit a written response, which shall be placed in his or her file.
- 15.5.3 Whenever the Medical Staff takes or recommends an action for a medical disciplinary cause or reason, or based on the Practitioner's professional competence or professional conduct, that adversely affects, or could adversely affect, the health or welfare of a patient, it shall confer with the Hospital administration and with counsel, if any, to determine whether the Medical Staff and Hospital have any reporting obligations under California Business and

Professions Code Sections 805 or 805.01, or to the National Practitioner Data Bank.

15.6 Summary Action

15.6.1 Grounds for Summary Action

The Medical Staff may immediately and summarily suspend or restrict a Practitioner's or Allied Health Staff member's privileges whenever the failure to take that action may result in an imminent danger to the health of any individual.

15.6.2 Summary Actions, Defined

A "summary action" is a suspension or other restriction of privileges that goes into effect before the Practitioner has the opportunity to exercise the hearing and appeal rights in these Bylaws, if any apply.

15.6.3 Procedures for Imposition of Summary Actions

- (a) The Medical Staff authorizes each of the following to impose a summary action on a Practitioner, if grounds for summary action exist: the Medical Executive Committee; the Chief of Staff; the Chair of the Department where the Practitioner holds privileges; the Chief Executive Officer, and the Chief Medical Officer [or any officer of the Governing Body].
- (b) Unless otherwise stated, the summary action shall be effective immediately upon imposition. The summary action may be limited in duration and remain in effect for the period stated or may be of indeterminate length.
- (c) The person or body who imposed the summary action shall provide oral notice to the Practitioner within one working day after imposition, and Special Notice in writing within three working days after imposition. The written notice shall include a brief statement of facts demonstrating that the summary action is reasonable and warranted because it is reasonable to believe that a failure to take the action summarily could result in an imminent danger to the health of any individual. The statement of facts shall also include a summary of one or more particular incidents giving rise to the assessment of imminent danger. This initial notice is in addition to, and not a substitute for, the written notice required under the hearing and appeal procedures in these Bylaws.
- (d) If the Medical Executive Committee was not the body who imposed the summary action, the person or body who imposed it will provide the Medical Executive Committee with oral notice of the summary

action within one working day after imposition and with a copy of the same Special Notice provided to the Practitioner within three working days after imposition. Such notice shall also be considered a request to initiate an investigation and/or corrective action under these Bylaws.

- (e) Patients affected by a summary action shall be assigned to another member by the Department Chair or Chief of Staff. The wishes of the patient and affected Practitioner shall be considered, where feasible, in choosing a substitute member.

15.6.4 Procedures for Ratification of Summary Action

Within one week after a summary action has been imposed, the Medical Executive Committee or a subcommittee appointed by the Chief of Staff shall meet to review and consider the action. Upon request, the member may attend and make a statement, on such terms and conditions as the Medical Executive Committee may impose, concerning the events leading to the summary action. No Medical Executive Committee meeting, with or without the member, shall constitute a “hearing” within the meaning of the Hearings and Appellate Reviews provisions of these Bylaws. After the meeting, the Medical Executive Committee will continue, modify, or terminate the summary action. It shall give the Practitioner Special Notice of its decision within two working days of the meeting.

15.6.5 Imposition of Summary Action by Governing Body

- (a) If no one authorized to take summary action in the Procedures for Imposition of Summary Actions Section is available to take summary action, the Governing Body (or its designee) may immediately suspend a Practitioner’s privileges if failure to summarily suspend those privileges is likely to result in imminent danger to the health of any individual, provided that the Governing Body (or its designee) made reasonable attempts to contact the Chief of Staff and the Chair of the Department to which the member is assigned before acting.
- (b) Such summary action is subject to ratification by the Medical Executive Committee. If the Medical Executive Committee does not ratify the summary action within two working days, excluding weekends and holidays, the summary action shall terminate automatically.

15.7 Governing Body Right to Intercede

15.7.1 The Governing Body has ultimate responsibilities over the care provided at the Hospital and must act to protect the quality of care provided to patients and ensure the competency of the Medical Staff.

15.7.2 If the Medical Executive Committee fails to investigate or to take corrective action contrary to the weight of the evidence, the Governing Body may direct

the Medical Executive Committee to initiate an investigation or disciplinary action, but only after consultation with the Medical Executive Committee.

“Consultation” may include, but is not limited to, written correspondence with the Medical Executive Committee via the Chief of Staff, an in-person meeting with the Medical Executive Committee, or an in-person meeting with the Chief of Staff or his or her designee, as the Medical Executive Committee’s representative. As part of the consultation, the Governing Body shall identify the Practitioner against whom action is requested, shall summarize the basis for the request for action, may identify the action or actions requested, and shall include a deadline for action.

15.7.3 If the Medical Executive Committee fails to take action in response to that Governing Body’s direction, the Governing Body may initiate corrective action after providing written notice to the Medical Executive Committee of the intent to initiate action. The Governing Body shall provide notice of the corrective action to the Practitioner and to the Medical Executive Committee. When the action gives rise to a hearing under these Bylaws, the notice shall comply with the notice requirements detailed in the Hearing and Appeals Article.

15.7.4 Nothing in this subsection shall limit the Governing Body from taking summary action consistent with Imposition of Summary Action by Governing Body Section of this Article when the failure to take immediate action may result in imminent danger to the health of any person.

15.8 Automatic Suspension, Termination, and Limitation

15.8.1 General Terms

- (a) In the circumstances described in the Events Resulting in Automatic Action Section below, a Practitioner’s or AHP’s privileges or membership may be automatically terminated, suspended, or limited as described. If a Practitioner or AHP accumulates a total of 90 days of automatic suspension in a 12-month period, his or her membership and privileges shall be automatically terminated.
- (b) Except as otherwise provided below, an automatic termination, limitation, or suspension of appointment and privileges will be effective immediately upon actual or Special Notice to the individual. Notice also shall be provided to the Medical Executive Committee, Chief Executive Officer, and Governing Body.
- (c) Patients affected by an automatic suspension shall be assigned to another member by the Department Chair or Chief of Staff. The wishes of the patient and affected Practitioner shall be considered, where feasible, in choosing a substitute member.

- (d) A Practitioner whose membership or privileges have been automatically terminated, suspended or limited shall not be entitled to procedural rights afforded under the Hearing and Appeal Article of these Bylaws unless the Medical Staff determines that the Practitioner is entitled to such rights pursuant to Business and Professions Code Section 809 et seq., or under the Health Care Quality and Improvement Act.
- (e) When the Practitioner or AHP is not entitled to the Hearing and Appeal provisions of these Bylaws for an automatic termination, limitation, or suspension, the Medical Executive Committee may provide the Practitioner or AHP with an opportunity to meet with the Medical Executive Committee in any forum or manner that it deems appropriate. Such meeting shall not be considered a hearing and shall not be conducted as a hearing under these Bylaws. The issue before the Medical Executive Committee shall be limited solely to the question of whether or not grounds existed for the automatic termination, suspension, or limitation. The Medical Executive Committee shall immediately rescind any termination, suspension, or limitation that was based on a material mistake of fact as to the basis for such action. If the Medical Executive Committee rescinds an automatic termination, suspension, or limitation based on a material mistake of fact, that automatic termination, suspension, or limitation shall not be grounds for a civil action for damages against the Hospital, Governing Body, Medical Staff, or Medical Staff members.

15.8.2 Events Resulting in Automatic Action

In addition to the other circumstances described elsewhere in these Bylaws as resulting in automatic suspension, termination, or limitation, the following circumstances shall lead to automatic suspension, termination, or limitation:

- (a) Licensure
 - (i) Revocation, Suspension, or Expiration. Whenever a member's license or other legal credential authorizing practice in this state is revoked, suspended or expired, Medical Staff membership and privileges shall be automatically revoked as of the date such action becomes effective.
 - (ii) Restriction. Whenever a member's license or other legal credential authorizing practice in this state is limited or restricted by the applicable licensing or certifying authority, any privileges which are within the scope of such limitation or restriction shall be automatically limited or restricted in a corresponding manner as of the date such action becomes effective and throughout its term.

- (iii) Probation. Whenever a member is placed on probation by the applicable licensing or certifying authority, his or her membership status and privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.
- (b) Drug Enforcement Certificate
 - (i) Revocation, Suspension, or Expiration. Whenever a member's Drug Enforcement Administration certificate is revoked, limited, suspended or expired, the member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate as of the date such action becomes effective and throughout its term [OR: the member's privileges shall be suspended].
 - (ii) Probation. Whenever a member's Drug Enforcement Administration certificate is subject to probation, the member's right to prescribe such medications shall automatically become subject to the same terms of the probation as of the date such action becomes effective and throughout its term.
- (c) Medical Records

Medical Staff members and AHPs are required to prepare, maintain, and complete accurate medical records within the time frame prescribed by the Governing Documents. Failure to do so shall result in an automatic suspension after notice is provided. The suspension shall apply to the Medical Staff member's right to admit, treat, or provide services to new patients in the Hospital; however, members may admit and treat new patients in life-threatening situations. Members and AHPs also shall be allowed to continue to care for patients the Medical Staff member already has admitted or is treating until that patient is discharged. The suspension shall continue until the medical records are completed or until the Practitioner or AHP accumulates sufficient suspension days to result in an automatic termination. Nothing in the foregoing shall preclude the Medical Executive Committee from also implementing monetary fines or a reduction of non-clinical privileges for delinquent medical records.
- (d) Failure to Maintain Professional Liability Insurance

Failure to maintain professional liability insurance as required by these Bylaws shall result in automatic suspension of membership and all privileges. Failure to maintain professional liability insurance for certain procedures shall result in the automatic suspension of privileges to perform those procedures. The suspension shall be effective until appropriate coverage is reinstated, including coverage for the time period for which coverage had lapsed, or until the Practitioner or AHP

accumulates sufficient suspension days to result in an automatic termination.

(e) Failure to Pay Dues or Fines

Failure to pay required dues or fines within 30 days after written warning of delinquency shall result in an automatic suspension of membership and privileges. The Practitioner or AHP shall remain suspended until he or she either pays the delinquent dues or accumulates sufficient suspension days to result in an automatic termination.

(f) Failure to Comply with Government and Other Third-Party Payor Requirements

If a member ceases to be a Medicare or Medi-Cal provider for any reason, the member shall be automatically [suspended][removed from all emergency call activities]. The Medical Executive Committee shall be empowered to determine that compliance with certain specific third-party payor, government agency, or professional review organization rules or policies is essential to Hospital and/or Medical Staff operations. In such cases, a Practitioner who fails to comply with such requirements shall be automatically suspended and shall remain suspended until the Practitioner or AHP either comes into compliance with these requirements or accumulates sufficient suspension days to result in an automatic termination.

(g) Failure to Maintain Board Certification

Failure to maintain board certification, if applicable, throughout the appointment period shall result in the automatic suspension of privileges. The Practitioner or AHP shall remain suspended until board certification is achieved, or until he or she accumulates sufficient suspension days to result in an automatic termination.

(h) Arrests or Convictions

A conviction, plea of guilty, or plea of no contest shall result in an automatic relinquishment of medical staff membership and privileges if the matter pertains to a felony or misdemeanor involving any of the following: (a) Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse; (b) controlled substances, other than marijuana; (c) sexual assault, battery, or rape; (d) child pornography; (e) moral turpitude; or (f) child, dependent adult, or elder abuse.

(i) Failure to Provide Information

An individual's failure to provide information pertaining to his or her qualifications for appointment or clinical privileges in response to a written request from the Credentials Committee, the Medical Executive Committee, or any other Medical Staff committee shall result in the automatic suspension of appointment and clinical privileges. The Practitioner or AHP shall remain suspended until he or she either

provides the information to the satisfaction of the requesting party or accumulates sufficient suspension days to result in an automatic termination.

(j) Failure to Satisfy Special Attendance and Related Peer Review Requirements

Failure without good cause to, when requested by a Medical Staff committee, submit to mental or physical examinations, execute a release as required, or appear at any type of meeting shall result in the automatic suspension of the individual's privileges. The determination whether such failure is without good cause shall rest solely in the discretion of the Medical Executive Committee. The automatic suspension shall remain in effect until the individual either complies with the request in issue or accumulates sufficient suspension days to result in an automatic termination.

(k) Failure to Complete Mandatory Orientation or Training

Failure without good cause, as determined solely by the Medical Executive Committee, to complete in a timely manner any mandatory orientation or training required by the Hospital, the Governing Documents, or the Medical Executive Committee shall result in the automatic suspension of the member's Medical Staff privileges until such time as either the individual has successfully completed the required orientation or training or the Practitioner's or AHP's membership and privileges are automatically terminated. For the purposes of this section, "mandatory training" does not include training ordered as part of an individual determination regarding a Practitioner's competency, such as training ordered as part of an FPPE plan or as a corrective action.

(l) Exclusive Contracts

- (i) If the Hospital closes or continues the closure of a department or service pursuant to an exclusive contract, or if the Hospital transfers an exclusive contract, then the privileges covered by the exclusive contract shall automatically terminate if the Practitioner is not a party to, a subcontractor under, or a third-party beneficiary of the contract.
- (ii) If a Practitioner is no longer a party to, a subcontractor under, or a third-party beneficiary of a contract to provide services to a closed department or service under an exclusive arrangement, the Practitioner's privileges to provide such services shall be automatically terminated.

(m) Telemedicine

If a Practitioner has telemedicine privileges granted through the processes detailed in the Processing of Telemedicine Membership and Privileges Section of the Procedures for Appointment and Reappointment Article, those privileges shall automatically terminate if: (a) the Practitioner no longer has the same privileges at the distant site hospital or entity that the Practitioner has been granted at this Hospital; or (b) if the distant site hospital or entity informs the Hospital that it has terminated or recommended the termination of the Practitioner's privileges and/or membership. If a Practitioner has telemedicine privileges granted through the processes detailed in Processing of Telemedicine Membership and Privileges Section of the Procedures for Appointment and Reappointment Article, those privileges shall be automatically suspended if the distant site hospital or entity informs the Hospital that it has suspended the Practitioner's privileges.

15.9 Information Received From Other Entities

If the Hospital or Medical Staff is informed that a Practitioner or AHP is subject to a corrective action recommendation or action at another entity, that information will be referred to the Medical Executive Committee for investigation. If the Chief of Staff imposes a summary action, it will be reviewed in the same manner as other summary actions.

ARTICLE 16

HEARINGS AND APPEAL

16.1 Scope of Article

16.1.1 Throughout this Article, the term “Practitioner” applies to physicians, podiatrists, dentists, and psychologists who are applicants, members, and/or hold privileges to or on the Medical Staff.

16.1.2 The hearing and appeal procedures set forth in this Article do not apply to AHPs, including APPs [except for clinical psychologists], regardless of whether or not a corrective action must be reported to the AHP’s licensing board.

16.1.3 This Article applies only to actions or recommendations taken for a medical disciplinary cause or reason and that require a report to the Practitioner’s licensing board pursuant to Business and Professions Code Section 805 or to the National Practitioner Data Bank. If the Hospital or Medical Staff takes other actions or recommendations that adversely affect a Practitioner’s ability to practice at the Hospital for more than 14 consecutive days, then the Practitioner may be entitled to the administrative review provisions described in the Rules and Regulations. However, no Practitioner is entitled to a hearing under this Article or to an administrative review in the Rules and Regulations if they are subject to an automatic suspension or automatic termination under these Bylaws, or if they are denied or terminated for failing to meet the minimum or general qualifications found in Bylaws Article 9.

16.1.4 Individual Evaluations v. Requests to Review Rules and Requirements

The hearing and appeal rights established in these Bylaws are strictly “judicial” rather than “legislative” in structure and function. The triers of fact and hearing officer have no authority to adopt or modify rules and standards or to decide questions about the merits or substantive validity of any Governing Document. However, the Medical Executive Committee, in conjunction with the Governing Body may, in its discretion, entertain challenges to the merits or substantive validity of Governing Documents and decide those questions. If the only controversy is whether a Governing Document is lawful or meritorious, the Practitioner is not entitled to a hearing or appellate review. In such cases, the Practitioner must submit his or her challenges first to the Governing Body and only thereafter may he or she seek judicial intervention.

16.1.5 Substantial Compliance

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

16.2 Initiation of Hearing

16.2.1 Governing Body Action

For ease of use, the terms of this Article generally reference hearing rights that arise from adverse actions and recommendations by the Medical Executive Committee. If the Governing Body takes an action without first receiving an adverse recommendation from the Medical Executive Committee, and that action is grounds for a hearing under this Article, any reference in this Article to the “Medical Executive Committee” or “Chief of Staff” will be interpreted as a reference to the “Governing Body” or “Governing Body designee,” respectively, and the Governing Body or its designee will have the responsibilities otherwise granted to the Medical Executive Committee or Chief of Staff.

16.3 Grounds for Hearing

Except as otherwise specified in these Bylaws, any one or more of the following actions or recommendations shall constitute grounds for a hearing, but only if the final imposition of the action would require the Hospital to file a report under California Business and Professions Code Section 805 or to the National Practitioner Data Bank:

- (a) Denial of initial appointment or reappointment to the Medical Staff;
- (b) Denial of requested clinical privileges;
- (c) Suspension of Medical Staff membership and/or privileges for more than 14 consecutive days;
- (d) Restrictions, including suspension and mandatory proctoring, imposed on privileges or membership for a cumulative total of 30 days or more during any 12-month period;
- (e) Termination of Medical Staff membership and/or privileges;
- (f) Any other disciplinary action or recommendation that must be reported to a Practitioner’s licensing board under Business and Professions Code Section 805 or to the National Practitioner Data Bank.

No other recommendation or action will entitle a Practitioner to a hearing detailed in this Article. Voluntary restrictions, leaves of absence, and resignations are not disciplinary actions or recommendations, and do not entitle a Practitioner to a hearing under these Bylaws, regardless of whether or not they must be reported to the licensing board or the National Practitioner Data Bank.

16.4 Notice of Recommendation or Action

When an adverse action or adverse recommendation has been taken or made, the Chief of Staff shall promptly give the Practitioner Special Notice of the recommendation or action and of the right to request a hearing pursuant to this Article. The Notice of Recommendation or Action shall include the following information:

- (a) A description of the recommendation or action;
- (b) A brief statement of the basis for the recommendation or action;
- (c) Whether the action, if adopted, must be reported under Business and Professions Code Section 805, and/or the National Practitioner Data Bank;
- (d) A statement that the Practitioner has the right to request a hearing on the recommendation or action within 30 days of receipt of the notice, and that failure to request such a hearing in a timely manner shall result in the waiver of the right to a hearing; and
- (e) A summary of the Practitioner's rights under this Article and a copy of this Article.

16.4.2 Mediation

At any time before or after making a corrective action recommendation, the Medical Staff may offer the Practitioner the opportunity to mediate the dispute. The mediation shall be conducted in the manner described in the Rules and Regulations. The Practitioner agrees that requesting mediation tolls all the deadlines in this article other than the deadline to request a hearing within 30 days after receiving a Notice of Recommendation or Action described above.

16.4.3 Request for Hearing

- (a) The Practitioner must submit any request for hearing in writing, addressed to the Medical Executive Committee with a copy to the Chief Executive Officer or his/her designee. The request must be received by the Medical Staff Administration within the deadline. The Practitioner shall state in writing within the request his or her intentions with respect to attorney representation.
- (b) In the event the Practitioner does not request a hearing within the time and in the manner described, the Practitioner shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved. In such cases, the Medical Staff's recommendation or action shall be considered by the Governing Body at its next meeting. The Governing Body shall give the recommendation great weight but

may exercise its independent judgment in determining whether or not to adopt the recommendation or action.

16.4.4 Notice of Hearing and Notice of Charges

After receiving a request for hearing, the Chief of Staff will schedule the hearing and, at least 30 days prior to the hearing, provide to the Practitioner by Special Notice:

- (a) The time, place, and date of the hearing;
- (b) A list of the witnesses expected to testify at the hearing on the Medical Executive Committee's behalf, and
- (c) The reasons for the final proposed action taken or recommended, including the acts or omissions with which the Practitioner is charged. This notice shall include a list of patient records (if applicable), and information supporting the recommendation. The notice may be supplemented or amended at any time, including during the hearing, so long as the additional material is relevant to the recommendation or the Practitioner's qualifications and the Practitioner has had a sufficient opportunity (at a minimum, 30 days) to review and respond to this additional material. No prior notice is required if the amendment removes any reasons for the final proposed action taken or recommended, including any of the acts or omissions identified.

16.4.5 Commencement of Hearing

The hearing shall begin no later than 60 days, and no sooner than 30 days, after receipt of the Practitioner's request for the hearing, and be completed within a reasonable time, unless the Hearing Officer issues a written decision finding that the Practitioner failed to comply with the document and witness list exchanges in a timely manner, or consented to the delay. The parties may agree in writing to set an alternative hearing date outside of this time frame, or the Hearing Officer may set an alternative hearing date upon a motion from either party or upon the Hearing Officer's own motion. A hearing is deemed to have commenced at the beginning of the voir dire of the Hearing Officer.

16.5 Appointment of Trier of Fact and Hearing Officer

16.5.1 Trier of Fact

In its sole discretion, the Medical Executive Committee shall select either a Judicial Review Committee, a Dedicated Review Panel, or an Arbitrator to serve as the trier of fact (the "Trier of Fact") at the hearing. The Medical Executive Committee shall inform the Practitioner of its decision at least thirty days prior to the hearing. The Trier of Fact shall have such powers as are necessary to discharge its responsibilities.

- (a) Judicial Review Committee
- (i) When the Medical Executive Committee elects to use a Judicial Review Committee as the Trier of Fact, the Chief of Staff shall appoint its members. Such appointment shall include designation of the Chair. A Hearing Officer who is not a Judicial Review Committee member shall preside over the hearing. The Judicial Review Committee shall carry out all the duties assigned to the Trier of Fact.
 - (ii) The Judicial Review Committee shall be composed of at least three members of the Medical Staff who are in good standing and of good ethics. More than three members can be appointed to the Judicial Review Committee; in such cases, the hearing may continue if any Judicial Review Committee member resigns or is removed from the panel as long as at least three committee members remain. Preference shall be given to Active Staff members, but the Chief of Staff may appoint members from any staff category. If it is not feasible to appoint Medical Staff members, the Chief of Staff may appoint Practitioners who are not Medical Staff members. The Judicial Review Committee members shall gain no direct financial benefit from the outcome of the hearing, shall not be in direct economic competition with the Practitioner, and shall not have acted as accusers, investigators, fact finders, initial decision makers, or otherwise actively participated in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude a Medical Staff member from serving as a member of the Judicial Review Committee.
 - (iii) The Judicial Review Committee shall include at least one member who shall have the same healing arts licensure as the Practitioner and, where feasible, shall include an individual practicing the same specialty as the Practitioner. The failure to include an individual practicing the same specialty as the Practitioner shall not be grounds to invalidate the outcome of the hearing.

16.5.2 Dedicated Hearing Panel

- (a) When the Medical Executive Committee elects to use a Dedicated Hearing Panel as the Trier of Fact, the Chief of Staff shall appoint its members. Such appointment shall include designation of the Chair. A Hearing Officer who is not a Dedicated Hearing Panel member shall preside over the hearing. The Dedicated Hearing Panel shall carry out all the duties assigned to the Trier of Fact.

- (b) Dedicated Hearing Panel members must be willing to commit six or more hours per day on consecutive days, with the exception of weekends and holidays (unless otherwise stipulated by the parties) for the purpose of hearing evidence, engaging in deliberations, and reaching a decision.
- (c) The Dedicated Hearing Panel must be comprised of at least three Practitioners. More than three members can be appointed to the Dedicated Hearing Panel; in such cases, the hearing may continue if any Dedicated Hearing Panel member resigns or is removed from the panel, as long as at least three committee members remain. The Dedicated Hearing Panel members need not be members of the Medical Staff but must be of good reputation and must either currently be practicing in their discipline or have practiced in their discipline within the last two years. The Dedicated Hearing Panel shall include at least one member who shall have the same healing arts licensure as the Practitioner and, where feasible, shall include an individual practicing the same specialty as the Practitioner.
- (d) The Dedicated Hearing Panel members shall gain no direct financial benefit from the outcome of the hearing, shall not be in direct economic competition with the Practitioner, and shall not have acted as accusers, investigators, fact finders, initial decision makers or otherwise actively participated in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude anyone from serving as a member of the Dedicated Hearing Panel.

16.5.3 Arbitrator

- (a) When the Medical Executive Committee elects to use an arbitrator as the Trier of Fact, the Medical Executive Committee and the Practitioner may stipulate to the arbitrator who shall serve, subject to voir dire. Otherwise, the arbitrator shall be selected using the process detailed in this article. By applying for and/or accepting membership or privileges on this Medical Staff, the Practitioner agrees this process is acceptable. The arbitrator shall meet the same qualifications as the Hearing Officer, as detailed in this article. The arbitrator shall carry out all the duties assigned to the Hearing Officer and to the Trier of Fact. If an arbitrator is appointed, no additional Trier of Fact or Hearing Officer shall be appointed, and all references in these Bylaws to the Trier of Fact or Hearing Officer duties and responsibilities shall be read as the arbitrator's duties and responsibilities. The arbitrator shall be selected as follows:
 - (i) Within 21 days of requesting a hearing, the Practitioner must send to the Medical Executive Committee a list of at least three attorneys whom he or she would accept as Arbitrator. If the

Practitioner fails to provide a list, then the Medical Executive Committee shall initiate the Arbitrator selection process as if it had rejected the Practitioner's list of nominees as provided below.

- (ii) The Medical Executive Committee may select the Arbitrator from the Practitioner's list. If the Medical Executive Committee does not accept any of the Arbitrator nominees identified by the Practitioner, the Medical Executive Committee must provide the Practitioner a written list of at least three potential Arbitrators within 10 days after rejection of the Practitioner's list.
 - (iii) The Practitioner shall have 10 days from his/her receipt of the Medical Executive Committee's list to select an Arbitrator from the list. If the Practitioner fails to either select an Arbitrator or to reject all the names on the list within that time, then the Medical Executive Committee may select any person on its list as the Arbitrator.
 - (iv) If the Practitioner timely rejects the Medical Executive Committee's list, then the Practitioner and the Medical Executive Committee shall each designate one name from their respective lists. The persons designated shall, within five days, select an Arbitrator who shall be appointed subject to voir dire. If the persons designated fail to select an Arbitrator timely, the process shall be repeated with other names selected from the parties' respective lists until an Arbitrator is selected.
 - (v) If, for any reason, the person so identified is not available, cannot otherwise serve, or, after voir dire, is unacceptable to both the Medical Executive Committee and the Practitioner, the same process set forth in this section will be followed until an Arbitrator is selected and agrees to serve.
- (b) If the failure or refusal of the Practitioner to agree to an Arbitrator makes it impracticable to commence the hearing within the time frames set forth above, the time for commencement of the hearing shall be extended to thirty days after an Arbitrator is selected.
 - (c) Nothing in the above sections shall be construed as limiting the ability of the Practitioner and Medical Executive Committee to select an arbitrator through a different mutually acceptable process.

16.5.4 Payment and Confidentiality of Patient Information

- (a) Triers of Fact may be paid by the Hospital, by the Medical Staff, or their fees split between the parties. The Medical Staff will refer all such payment arrangements to the Hospital to ensure legal compliance.
- (b) Any Trier of Fact who is not a Medical Staff member shall be required to sign a business associate agreement with the Hospital before serving.

16.5.5 The Hearing Officer

- (a) The Medical Executive Committee shall appoint a Hearing Officer to preside at the hearing before a judicial review committee or a dedicated hearing panel. The Hearing Officer shall be an attorney at law qualified to preside over a quasi-judicial hearing, but attorneys from a firm regularly utilized by the Hospital, the Medical Staff, or the Practitioner for legal advice regarding their affairs and activities shall not be eligible to serve as Hearing Officer. The Hearing Officer shall gain no direct financial benefit from the outcome, shall not be in direct economic competition with the Practitioner, and must not act as a prosecuting officer or as an advocate.
- (b) The Medical Executive Committee will attempt to appoint a Hearing Officer that is acceptable to the Practitioner. In the event that the Medical Executive Committee and the member cannot agree on the Hearing Officer, the Medical Executive Committee may unilaterally appoint a Hearing Officer who meets the Hearing Officer qualifications described in these Bylaws.
- (c) The Hearing Officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The Hearing Officer shall be entitled to determine the order of, and procedure for, presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure, or the admissibility of evidence. These rulings shall be consistent with legal authority and the provisions of this Article.
- (d) When no attorney accompanies a party to the proceedings, the Hearing Officer shall have the authority to interpose and rule on appropriate objections throughout the course of the hearing. The Hearing Officer shall not, however, have the authority to override or revise the Representation section of this Article.
- (e) If the Hearing Officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the Hearing Officer may take such discretionary action as warranted by the circumstances,

including, but not limited to, limiting the scope of examination and cross-examination and setting fair and reasonable time limits on either side's presentation of its case.

- (f) The Hearing Officer may participate in the deliberations of the committee and be a legal advisor to it, but the Hearing Officer shall not be entitled to vote. The Hearing Officer may assist in preparation of the Trier of Fact's report and recommendations.

16.5.6 Voir Dire

The Practitioner and the Medical Executive Committee shall be entitled to a reasonable opportunity to question and challenge the impartiality of Trier of Fact members and the Hearing Officer. Challenges to the impartiality of any Trier of Fact member or the Hearing Officer shall be ruled on by the Hearing Officer.

16.6 Prehearing Process

16.6.1 General Procedures:

The pre-hearing and hearing processes shall be conducted in an informal manner that is consistent with Business and Professions Code Section 809 et seq. Formal rules of evidence or procedure shall not apply.

16.6.2 Witness List

- (a) If either side to the hearing requests in writing a list of witnesses, then at least 10 days before the hearing the parties shall exchange lists of witnesses expected to testify. The list shall include a brief description of the subject(s) about which the witness is expected to testify. The failure to disclose the identity of a witness at least 10 days before the commencement of the hearing shall constitute good cause for a continuance.
- (b) The witness list of either party may be amended or supplemented any time during the course of the hearing. If an addition of a witness to the list occurs after the commencement of the hearing, this shall be good cause for a 10-day continuance prior to the introduction of the additional witness's testimony.
- (c) If the hearing officer allows evidence to be presented on rebuttal, the hearing officer may, in his or her authority to promote an efficient and fair process, find that witnesses who were not previously on the witness list may be presented on rebuttal without requiring 10 days advance notice.

16.6.3 Provision of Relevant Information

- (a) Each party shall have the right to inspect and copy, at its own expense, any documentary information or other evidence relevant to the charges which the other party has in its possession or under its control, as soon as practicable after the party's request for inspection. The requests for discovery shall be fulfilled as soon as practicable. The failure by either party to provide access to this information at least 30 days before the hearing shall constitute good cause for a continuance. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable Practitioners or AHPs, other than the Practitioner under review.
- (b) The Hearing Officer shall consider and rule upon any dispute or controversy concerning a request for access to information and may impose any safeguards for the protection of the peer review process and as justice requires. When ruling upon requests for access to information and determining its relevancy, the Hearing Officer shall consider, among other factors, the following:
 - (i) Whether the information sought may be introduced to support or defend the charges.
 - (ii) The exculpatory or inculpatory nature of the information sought, if any; i.e., whether there is a reasonable probability that the result of the hearing would be influenced significantly by the information if received into evidence.
 - (iii) The burden imposed on the party in possession of the information sought, if access is granted.
 - (iv) Any previous requests for access to information submitted or resisted by the parties to the same proceeding.
- (c) As a condition of membership, the Practitioner agrees that all documents and information disclosed at any time during the peer review process, including information disclosed as part of the hearing process, will be maintained as confidential and will not be disclosed or used for any purpose outside of the hearing. Any inappropriate use by the Practitioner of information disclosed by the Medical Executive Committee during the hearing shall be grounds for the Trier of Fact to find that the Practitioner has committed flagrant or repeated noncompliance with this Article in a manner that prejudices the other party and constitutes a waiver of hearing rights, leading to a termination of the hearing in the Medical Staff's favor. It also shall be grounds for additional corrective action against the Practitioner.
- (d) Prior to receiving any documents, the Practitioner must provide a written representation that his or her counsel or other representative and any experts expected to testify have executed any agreements necessary

to protect Protected Health Information contained in any documents provided.

- (e) No party will have any right to discovery beyond the above information. Civil discovery provisions shall not apply. No confidential information will be provided regarding other Practitioners or Allied Health Staff.
- (f) At the request of either party, the parties must exchange all documents and other evidence that will be introduced at the hearing. The documents must be exchanged at least 10 days prior to the hearing. A failure to comply with this rule shall constitute good cause for a continuance.
- (g) Before a Practitioner, or any person acting on the Practitioner's behalf, may contact any Hospital employee, Medical Staff member, or Allied Health Staff member whose name is on the Medical Executive Committee's witness list or other document exchanged during the pre-hearing process, the Practitioner must: (i) notify the Chief of Staff in writing of his or her intent to contact the individual, (ii) agree in writing to respect any decision by the individual not to discuss the matter with the Practitioner or the Practitioner's representative, and (iii) not contact the individual until seven days after the Medical Executive Committee (or, in the case of a Hospital employee, the Medical Executive Committee and a representative of the Human Resources department jointly) sends the potential witness a letter informing him or her that any decision to, or not to, discuss the matter with Practitioner is voluntary and will not impact the individual's employment or member status. The Medical Executive Committee will send that letter to the individual, with a copy to the Practitioner, within seven days after receiving the required notice and written agreement from the Practitioner. If the Practitioner behaves in a manner that may be considered harassing to the witness, that shall be grounds for the Trier of Fact to find that the Practitioner has committed flagrant or repeated noncompliance with this Article in a manner that prejudices the other party and the Hearing Officer or the Trier of Fact may take appropriate action, up to and including action pursuant to the Conduct of Hearing Section.

16.6.4 Pre-Hearing Conference

- (a) The Practitioner and the Medical Executive Committee shall 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 in advance of the hearing.
- (b) The Hearing Officer may require the Practitioner and the Medical Executive Committee (or a representative of each) to participate in a

pre-hearing conference, which the parties and Hearing Officer shall endeavor to hold no later than two days prior to the hearing.

- (c) At the pre-hearing conference, the Hearing Officer will attempt to resolve all procedural questions, including any objections to exhibits or witnesses.
- (d) Objections to any prehearing decisions may be succinctly made at the hearing, typically outside of the presence of the Trier of Fact, and shall be preserved for consideration in any appellate review proceeding.

16.6.5 Stipulations

The parties will use their best efforts to develop and agree upon stipulations to provide for a more efficient hearing.

16.7 The Hearing

16.7.1 Representation

The hearings provided for in these Bylaws are for the purpose of intra-professional resolution of matters bearing on professional conduct, professional competency, or character, including failure to comply with the Bylaws or Rules and Regulations of the Medical Staff. Accordingly, the Practitioner is entitled to representation at the hearing as follows:

- (a) The Practitioner and the Medical Executive Committee may stipulate to allow greater participation by attorneys in the hearing than the provisions below describe. Otherwise, the provisions below will control.
- (b) If the Practitioner wishes to be accompanied at the hearing by an attorney, he/she shall give notice of such intent in the written Request for Hearing. If the Practitioner changes his or her mind regarding attorney representation at the hearing, he or she must notify the Medical Executive Committee of this change as soon as possible. If the notification occurs within 30 days prior to the start of the hearing, or after the start of the hearing, this shall be good cause for the Medical Executive Committee to be granted a continuance and the Hearing Officer shall, upon request from the Medical Executive Committee, grant the Medical Executive Committee a continuance.
- (c) The Medical Executive Committee representative shall not be accompanied by an attorney at the hearing if the Practitioner is not accompanied by an attorney. However, regardless of whether the Practitioner elects to have attorney representation at the hearing, each party has the right to engage legal counsel to assist in preparing for a hearing or an appellate review.

- (d) Attorneys for either party may accompany their clients in the hearing sessions in order to represent and advise their clients. Attorneys shall not examine witnesses, shall not address the Trier of Fact, and shall not make oral statements in the hearing.
- (e) Whether or not attorneys are present in the hearing pursuant to this Article, the Practitioner and the Medical Executive Committee may be represented at the hearing by a Practitioner licensed to practice medicine, podiatry, dentistry, or psychology in the State of California, who is not also an attorney at law.
- (f) The Hearing Officer shall not allow the presence of attorneys at the hearing to be disruptive or cause a delay in the hearing process.

16.7.2 Burdens of Presenting Evidence and Proof

- (a) At the hearing, the Medical Executive Committee shall have the initial duty to present evidence in support of its action or recommendation.
- (b) An initial applicant shall bear the burden of persuading the Trier of Fact, by a preponderance of the evidence, of the applicant's qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning the applicant's current qualifications for membership and privileges. An applicant shall not be permitted to introduce information not produced upon request of the Medical Staff 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) Except as provided above for initial applicants, the Medical Executive Committee shall bear the burden of persuading the Trier of Fact by a preponderance of the evidence that its action or recommendation is reasonable and warranted. In meeting this burden, the Medical Executive Committee shall not be limited to presenting only that information available to it at the time it imposed or recommended the action, but rather may present any relevant information (within the limits discussed elsewhere in this article) available to it at the time of the hearing.
- (d) The Medical Executive Committee is not required to prove each and every charge or issue in front of the Trier of Fact in order for its actions and/or recommendations to be found reasonable and warranted.
- (e) "Reasonable and warranted" means within the range of alternatives reasonably open to the Medical Executive Committee under the circumstances, and not necessarily that the action or recommendation is the only measure or the best measure that can be taken or formulated in the Trier of Fact's opinion.

16.7.3 Record of Hearing

A court reporter shall make a record of the hearing proceedings and, if deemed appropriate by the Hearing Officer, the pre-hearing proceedings. The cost of the court reporter shall be borne by the Hospital, but the cost of the transcript, if any, shall be borne by the requesting party. The Practitioner is entitled to receive a copy of the transcript upon paying the reasonable cost for preparing the record. The Hearing Officer may, but shall not be required to, order that oral evidence shall be taken only on oath administered by any person lawfully authorized to administer such oath.

16.7.4 Rights of Both Sides at the Hearing

- (a) At a hearing, both sides will have the following rights, subject to reasonable limits determined by the Hearing Officer:
 - (i) To call and examine witnesses, to the extent they are available and willing to testify;
 - (ii) To introduce exhibits;
 - (iii) To cross-examine any witness on any matter relevant to the issues;
 - (iv) To receive all information made available to the Trier of Fact; and
 - (v) To submit a written argument that may include proposed findings, conclusions and recommendations to the Trier of Fact after the conclusion of the hearing sessions.
- (b) If the Practitioner does not testify, he or she may be called by the Medical Executive Committee or the Trier of Fact, or both, and questioned as if the Practitioner was under cross examination.

16.7.5 Conduct of Hearing

- (a) The Trier of Fact may question witnesses, request the presence of additional witnesses, and/or request documentary evidence, all of which must occur during the hearing sessions, subject to objections by either party, which shall be resolved by the Hearing Officer.
- (b) Upon motion of either party or the Hearing Officer, the Trier of Fact may terminate the hearing if it finds that either party has:
 - (i) Exhibited flagrant or repeated noncompliance with this Article in a manner that prejudices the other party or results in repeated delays to the hearing process,

- (ii) Egregiously interfered with the orderly conduct of the hearing, or
 - (iii) Failed to appear at the hearing.
- (c) If the motion to terminate is based on the Practitioner's failure to appear at the hearing, the Trier of Fact shall find that the Practitioner has waived his or her hearing rights if he or she has failed to appear at the hearing, unless the Practitioner can prove that an unforeseen and unanticipated emergency prevented him or her from attending.
 - (d) A finding that the termination results from the Practitioner's noncompliance or egregious conduct shall result in a finding that the Practitioner has waived his or her right to a hearing.
 - (e) The Hearing Officer shall be permitted to advise the Trier of Fact regarding his or her recommendation regarding the disposition of the motion. Evidence of, or a finding that, a party intended to prejudice the other party, delay the hearing process, or interfere with the orderly conduct of the hearing is not necessary to support or grant the motion to terminate the hearing.
 - (f) The party against whom the terminating sanctions have been ordered may appeal the terminating order to the Governing Body. The appeal must be requested within 10 days of the terminating order, and the scope of the appeal shall be limited to reviewing the appropriateness of the terminating order. The appeal procedure shall be in accordance with the appeal provisions of this Article. If the Governing Body, using its independent judgment but giving great weight to the Trier of Fact's determination, finds that the order to terminate the hearing is unwarranted, the Trier of Fact shall reconvene and resume the hearing.

16.7.6 Admissibility of Evidence

- (a) Except as provided below, judicial rules of evidence and procedure relevant to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under this Article. Except as provided in this Article, any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.
- (b) Notwithstanding the above, (1) the attorney-client privilege and the privilege for confidential marital communications shall apply during the hearing; (2) the physician-patient privilege and the psychotherapist-patient privilege shall apply during the hearing, but only if the Practitioner is the patient; and (3) evidence of mediation, compromise, or offers of settlement, as well as any conduct or statements made in

negotiation thereof, is inadmissible to prove either parties' opinion regarding the strength or weakness of evidence supporting the corrective actions or recommendations. Communications that confirm that mediation or settlement discussions were mutually accepted and pursued may be disclosed and admitted as proof that otherwise applicable time frames were tolled or waived or to demonstrate the good faith of the parties in their attempts to resolve the matter.

16.7.7 Presence of Trier of Fact

All the members of the Trier of Fact must be present throughout the hearing and deliberations unless both parties agree that any one member need not attend a particular hearing session or committee meeting. In unusual circumstances when a Trier of Fact member must be absent from any part of the proceedings, he or she shall not be permitted to participate in the deliberations or the decision unless and until he or she confirms that he or she has read the entire transcript of the portion of the hearing from which he or she was absent.

16.7.8 Failure to Appear

Under no circumstances shall the hearing be conducted without the presence of the Practitioner. Failure without good cause of the Practitioner to personally attend and proceed at such a hearing shall be deemed to constitute voluntary acceptance of the recommendations or actions involved.

16.7.9 Postponements and Extensions

Postponements and extensions of time may be requested by either party, the Trier of Fact, or the Hearing Officer, but will be permitted only upon either stipulation by both parties, or by the Hearing Officer on a showing of good cause. Extensions of time necessary to appoint the Trier of Fact or Hearing Officer shall be deemed good cause so long as both parties are proceeding in good faith.

16.8 Hearing Conclusion, Deliberations, and Decision

Within 30 days after final adjournment of the hearing, or 15 days if the Practitioner is currently under summary suspension, the Trier of Fact shall render a decision which shall be accompanied by a written report; this decision and report shall be delivered to the Medical Executive Committee, the Chief Executive Officer or his/her designee, and by Special Notice to the Practitioner. The report and decision shall include the Trier of Fact's findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached. Unless the hearing was before an arbitrator, the final decision of the Trier of Fact must be sustained by a majority vote of the committee. Both the Practitioner and the Medical Executive Committee shall be provided a written explanation of the procedure for appealing the decision. The

decision of the Trier of Fact shall be subject to the rights of appeal or review as described in these Bylaws.

16.9 Appeal Procedure

16.9.1 Time for Appeal

Within 30 days after receiving the decision of the Trier of Fact, either the Practitioner or the Medical Executive Committee may request an appellate review. The appealing party shall submit a written statement concisely stating the specific grounds for appeal. The written request shall be delivered to the Chief of Staff, the Chief Executive Officer, and the other party. If appellate review is not requested within such period, the Trier of Fact's decision shall thereupon become the final recommendation of the Medical Staff. The Governing Body shall consider the decision within 70 days and shall give it great weight.

16.9.2 Grounds for Appeal

The grounds for appeal shall be limited to:

- (a) Substantial non-compliance with the procedures required by these Bylaws or applicable law which has created demonstrable prejudice.
- (b) The decision was arbitrary, capricious, or unsupported by credible evidence.

16.9.3 Time, Place and Notice

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

16.9.4 Appeal Board

- (a) The Governing Body may sit as the Appeal Board, or it may appoint an Appeal Board which shall be composed of not less than three members of the Governing Body.
- (b) 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, investigation, or recommendation on the same matter.

- (c) The Appeal Board may engage an attorney to advise it in the proceeding. If an attorney is selected, and if the Appeal Board so chooses, he or she may act as a presiding officer and shall have the authority, subject to the direction of the Appeal Board, to issue rulings on any procedural matter that arises during the appeal process, as well as any other authority granted by the Appeal Board. Alternatively, the Appeal Board may appoint a hearing officer to preside over the hearing, with the authority to rule on any procedural matter that arises during the appeal process, as well as any other authority granted by the Appeal Board. Regardless of whether the Appeal Board engages an attorney as an advisor or as a hearing officer, that attorney shall not be entitled to vote with respect to the appeal.
- (d) The Appeal Board shall have such powers as are necessary to discharge its responsibilities.

16.9.5 Appeal Procedure

- (a) The proceeding by the Appeal Board shall, at the discretion of the Appeal Board, either be a de novo hearing or an appellate hearing based upon the record before the Trier of Fact.
- (b) If the proceeding is an appellate hearing based on the record before the Trier of Fact, the Appeal Board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available during the hearing in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the hearing. Alternatively, the Appeal Board may remand the matter to the Trier of Fact for the taking of further evidence and for decision.
- (c) Each party shall have the right to present a written statement in support of the party's position on appeal. The appellate Hearing Officer may establish reasonable time frames for the appealing party to submit a written statement and for the responding party to respond. Each party has the right to personally appear and make oral argument. The Appeal Board may then, at a time convenient to itself, deliberate outside the presence of the parties.
- (d) Each party shall have the right to be represented by legal counsel or any other representative designated by that party in connection with the appeal.

16.9.6 Decision

- (a) Within 30 days after the adjournment of the appellate review proceeding, the Appeal Board shall render a final decision in writing. Final

adjournment shall not occur until the Appeal Board has completed its deliberations.

- (b) The Appeal Board may affirm, modify, or reverse the decision, or it may remand the matter for further review by the Trier of Fact or any other body designated by the Appeal Board. If the Appeal Board remands the matter back to the Trier of Fact, it will provide direction to the Trier of Fact for its further consideration and shall set a deadline for the Trier of Fact to complete its further review.
- (c) The Appeal Board shall give great weight to the Trier of Fact decision and shall not act arbitrarily or capriciously. The Appeal Board may, however, exercise its independent judgment in determining whether a Practitioner was afforded a fair hearing and whether the Trier of Fact's decision is reasonable and warranted. The Appeal Board's decision shall specify the reasons for the action taken and provide findings of fact and conclusions articulating the connection between the evidence produced at the hearing and the appeal (if any), and the decision reached, if such reasons, findings, and conclusions differ from those of the Trier of Fact.
- (d) The Appeal Board shall forward copies of its decision to each party.
- (e) If the Governing Body sat as the Appeal Board, the Appeal Board's decision shall be deemed the Governing Body's final decision. If a committee sat as the Appeal Board, then it shall submit its decision to the Governing Body for final action. The Governing Body shall adopt the Appeal Board's decision as its own, which shall become the Governing Body's final decision, unless the Governing Body, on its own motion and exercising its independent judgment, finds that the Practitioner was not afforded a fair hearing in compliance with these Bylaws. In such cases, the matter will be referred back to the Trier of Fact for further proceedings.
- (f) The final decision of the Governing Body shall be effective immediately and shall not be subject to further review.

16.10 Additional Provisions

16.10.1 Right to One Hearing and One Appeal Only

Except in circumstances where a new hearing is ordered by the Governing Body or a court, no Practitioner shall be entitled to more than one evidentiary hearing and one appellate review on any particular adverse action or recommendation, or on any matter that has resulted in an adverse action or recommendation.

16.10.2 Exhaustion of Remedies

If an adverse action is taken or recommended, the Practitioner must exhaust the administrative remedies afforded by these Bylaws before resorting to legal action.

16.11 Joint Hearing

16.11.1 General Provisions

- (a) If (1) the Hospital has an information sharing agreement with another health care entity(ies), as provided in the Rules, (2) the Hospital or Medical Staff takes adverse action or makes an adverse recommendation against a member on the same or similar grounds as an adverse action or adverse recommendation undertaken by that other health care entity(ies), and (3) such adverse action or adverse recommendation provides hearing rights to the member at both the Hospital and the other health care entity(ies), then the Hospital's Medical Executive Committee, the other health care entity(ies), and the Practitioner may agree to hold a single, joint hearing process to address the actions and recommendations at the Hospital and the other health care entity(ies) ("Joint Hearing Process"). If the Practitioner does not agree to the Joint Hearing Process, a Joint Hearing Process will not be held and the Hospital and the other health care entity(ies) will hold individual hearings pursuant to their own Bylaws or policies.
- (b) To the extent that any of the hearing provisions, including the Joint Hearing Process provisions, in the Hospital Medical Staff Bylaws and the other health care entity(ies)'s Bylaws or policies differ, the Medical Executive Committees and the other health care entity(ies) shall jointly determine which entity's hearing provisions shall govern the Joint Hearing Process. At the very least, the agreed upon provisions must comply with the hearing procedures found in California Business & Professions Code Section 809 et seq., and with the Health Care Quality Improvement Act. In the event the Medical Executive Committee and other health care entity(ies) are unable to agree on which Bylaws' hearing procedures, including the Joint Hearing Process procedures, will apply to the hearing, then no Joint Hearing Process will be held and the Hospital and the other health care entity(ies) will hold individual hearings pursuant to their own Bylaws or policies.
- (c) If a Joint Hearing Process is held, it shall commence at such time as the parties agree in writing to have a single, joint hearing.
- (d) Notwithstanding which hearing provisions are agreed upon, if a hearing conducted as part of the Joint Hearing Process is held before a Judicial Review Committee, the Judicial Review Committee shall have at least one participating and voting member from this Medical Staff and at least one participating and voting member from the each of the other health care entity(ies).

16.11.2 Independent Rights

- (a) The Hospital and each of the other health care entity(ies) shall be considered separate parties in the Joint Hearing Process and may be separately represented in a manner permitted by the hearing provisions selected for the Joint Hearing Process.
- (b) The Hospital and the other health care entity(ies) each independently shall have the rights and responsibilities granted to parties in these proceedings, including, but not limited to, the rights to voir dire potential panel members and hearing officers, to call and cross examine witnesses, and to make arguments before the Trier of Fact.
- (c) The Hospital and the other health care entity(ies), in their own discretion, may agree to be jointly represented by a single representative.

16.11.3 Separate Appellate Rights

The Joint Hearing Process does not, and is not intended to, include any appeals or appeal rights relating to the decision of the Trier of Fact. Notwithstanding the preceding sentence, in instances in which a Joint Hearing Process is held, the Hospital and the other health care entity(ies)'s governing bodies may elect, in their sole and absolute discretion, to hold any appellate oral arguments in joint session.

16.11.4 Compliance With Applicable Law and Regulation

- (a) If a Joint Hearing Process is held, the Hospital and the other health care entity(ies) will take appropriate actions to confirm compliance with state and federal laws and regulations governing the privacy and security of personal protected health information.
- (b) A Joint Hearing Process (and appellate oral arguments held in joint session, if any) shall be deemed to satisfy all procedural requirements pursuant to Business & Professions Code Section 809 et. seq., as to both the Hospital and the other health care entity(ies).