Medical Staff Bylaws and Rules

Revised and Approved on April 27, 2017

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MEDICAL STAFF BYLAWS

PREAMBLE

These Bylaws are adopted to provide a framework for the Medical Staff to discharge its responsibilities in matters involving the quality of patient care, treatment, and services; to govern the orderly resolution of issues and the conduct of Medical Staff functions supportive of those purposes; and to account to the Board of Trustees for the effective performance of Medical Staff responsibilities. These Bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Board of Trustees, and relations with applicants to and Members of the Medical Staff.

DEFINITIONS

1. **Allied Health Practitioner** or **AHP** means an individual, other than a licensed physician, dentist, or podiatrist, who exercises independent judgment within the areas of his or her professional competence and the limits established by the Board of Trustees, the Medical Staff, and the applicable State Practice Act, who is qualified to render direct or indirect medical, dental, podiatric care under the supervision or direction of a Medical Staff Member possessing Privileges and/or practice prerogatives to provide such in the Hospital, and who may be eligible to exercise practice prerogatives in conformity with these Bylaws and the Medical Staff Rules. AHPs are not eligible for Medical Staff membership.

2. **Attending Physician** means the physician of record providing care.

3. **Board of Trustees** (see **Governing Body** below).

4. **Chief Executive Officer (CEO)** means the person appointed by the Board of Trustees to serve in an administrative capacity, or his or her designee.

5. **Date of Receipt** means the date any Notice, Special Notice, or other communication was delivered personally; or, if such Notice, Special Notice, or communication was sent by mail, it shall mean seventy-two (72) hours after the Notice, Special Notice, or communication was deposited, postage pre-paid, in the United States mail (see also definitions of **Notice** and **Special Notice** below).

6. **Ex-Officio** means service by virtue of office or position held. An **ex-officio** appointment is with vote unless specified otherwise.

7. **Governing Body** means the **Board of Trustees** of Good Samaritan Hospital. As appropriate to the context and consistent with Good Samaritan Hospital's Bylaws, it may also mean any Governing Body committee or individual authorized to act on behalf of the Governing Body.

8. **Hospital** means Good Samaritan Hospital.

9. **Medical Director** means a **Practitioner** appointed by the **Chief Executive Officer** to provide administrative support and leadership for the Medical Staff and to serve as a liaison between the Medical Staff and administration on particular issues.

10. **Medical Executive Committee** or **Executive Committee** means the Executive Committee of the Good Samaritan Hospital Medical Staff.

11. **Medical Staff** means the organizational component of Good Samaritan Hospital that includes all physicians (MD or DO), dentists (DDS or DMD), and podiatrists (DPM) that have been granted recognition as **Members** pursuant to these Bylaws.

12. **Medical Staff Year** means the period between January 1 and December 31.

13. **Member** means any **Practitioner** who has been appointed to the **Medical Staff**.

14. **Notice** means a written communication delivered personally to the addressee or sent by the United States mail, postage pre-paid, addressed to the addressee at the last address as it appears in the official records of the Medical Staff or the Hospital (see **Date of Receipt** above and **Special Notice** below).

15. **Physician** means an individual with an MD or DO degree who is currently licensed to practice medicine in the state of California.

16. **Practitioner** means, unless otherwise expressly limited, any currently licensed physician (MD or DO), dentist (DDS or DMD), or podiatrist (DPM).

17. **Privileges** mean the permission granted to a **Medical Staff Membe**r or **AHP** to render specific patient services.

18. **Rules** refer to the **Medical Staff** and/or Department Rules adopted in accordance with these Bylaws unless specified otherwise.

19. **Special Notice** means a **Notice** sent by certified or registered mail, return receipt requested (see **Date of Receipt** and **Notice** above).

NAME AND PURPOSE

Name

The name of this organization shall be the Good Samaritan Hospital Medical Staff.

Purposes and Responsibilities

To assure that all patients admitted or treated in any of the Hospital's services receive a uniform standard of care at a level of quality and efficiency consistent with generally accepted standards attainable within the Hospital's means and circumstances.

To provide for a level of professional performance that is consistent with generally accepted standards attainable within the Hospital's means and circumstances.

To organize and support professional education and community health education and support services.

To initiate and maintain Rules and policies for the Medical Staff to carry out its responsibilities for the professional work performed in the Hospital, pursuant to the authority delegated by the Board of Trustees.

To provide a means for the Medical Staff, Board of Trustees, and administration to discuss issues of mutual concern.

To provide for accountability of the Medical Staff to the Board of Trustees for the quality of the medical care, treatment, and services provided to patients.

To support the mission and vision of Good Samaritan Hospital.

Health Entity Affiliation

The Hospital and the Medical Staff may affiliate with other healthcare entities and provider groups, including independent practice associations, for the purpose of improving care in the community by establishing cooperative credentialing, peer review, corrective action, and procedural review programs. Such programs shall be carried out in accordance with the following guidelines:

Credentialing

The Medical Staff may enter into arrangements with other healthcare entities and provider groups to assist each other in credentialing activities by sharing information from credentials and peer review files and sharing medical or professional staff support resources, or to process or assist in processing applications for appointment and reappointment.

Peer Review

The Medical Staff may enter into arrangements with other healthcare entities and provider groups to assist each other in peer review activities. This may include, without limitation, sharing information from each other's credentials and peer review files, and utilizing each other's medical or professional staff support resources to conduct or assist in conducting peer review activities.

Corrective Action

The Medical Staff may work cooperatively with other healthcare entities and provider groups at which a Medical Staff Member holds privileges to develop and impose coordinated, cooperative or joint corrective action measures as deemed appropriate to the circumstances. This may include, but is not limited to, giving timely notice of emerging or pending problems, as well as notice of corrective actions imposed and/or reciprocal effectiveness of such corrective actions as provided in these Bylaws and the Rules.

Joint Hearings and Appeals

The Medical Staff and Board of Trustees are authorized to participate in joint hearings and appeals, provided the applicable procedures are substantially comparable to those set forth in the hearing and appellate review procedures established in these Bylaws.

ARTICLE I: MEDICAL STAFF MEMBERSHIP

1.1 Nature of Medical Staff Membership

Membership on the Medical Staff and/or Privileges may be extended to and maintained by only those professionally competent Practitioners who continually meet the qualifications, standards, and requirements set forth in these Bylaws and the Rules. A Practitioner, including one who is employed by and/or has a contract with the Hospital to provide medical-administrative services, may admit or provide services to patients in the Hospital only if the Practitioner is a Member of the Medical Staff or has been granted temporary privileges in accordance with these Bylaws and the Rules. Appointment to the Medical Staff shall confer only such Privileges and practice prerogatives as have been granted by the Board of Trustees in accordance with these Bylaws.

1.2 Qualifications for Membership

Membership on the Good Samaritan Hospital Medical Staff shall be extended only to Practitioners who are professionally competent and continuously meet the qualifications, standards, and requirements set forth in the Medical Staff Bylaws and Rules. The fact that a Practitioner meets such qualifications, standards, and requirements does not, by itself, entitle such Practitioner to membership on the Medical Staff, which shall be determined through the credentialing process in accordance with the Medical Staff Bylaws and Rules. Medical Staff membership (except Emeritus Staff) shall be limited to Practitioners who are currently licensed or qualified to practice medicine, podiatry, or dentistry in California.

1.3 Effect of Other Affiliations

No Practitioner shall be entitled to Medical Staff membership merely because he or she holds a certain degree, is licensed to practice in this or any other state, is a member of any professional organization, is certified by any clinical board, or because he or she had, or presently has, staff membership or privileges at another healthcare facility.

1.4 Nondiscrimination

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

1.5 Conduct Guidelines

Upon receiving Medical Staff membership and/or Privileges or practice prerogatives at the Hospital, Members and other individuals who exercise Privileges or practice prerogatives at the Hospital enter a common goal with all members of the Hospital to maintain quality patient care, a culture of safety, and appropriate professional conduct. Members and other individuals who exercise Privileges or practice prerogatives at the Hospital are expected to behave in a professional manner at all times and with all people, including, but not limited to, patients, professional peers, Hospital staff, visitors, and others in and affiliated with the Hospital. Interactions with all persons shall be conducted in a professional manner consistent with the Medical Staff Code of Conduct/Behavioral and Practice Expectations. Aberrant, disruptive, or unprofessional behavior, as defined in the Code of Conduct/Behavioral and Practice Expectations, will not be tolerated. All allegations of aberrant, disruptive, or unprofessional behavior shall be investigated and addressed as set forth in the Medical Staff Disruptive Physician Behavior Policy.

1.6 Basic Responsibilities of Medical Staff Membership

Except for Emeritus Members (see Article II of these Bylaws regarding Categories of the Medical Staff), each Medical Staff Member and each Practitioner exercising temporary privileges shall continuously meet all of the responsibilities set forth in the Bylaws and Rules.

1.7 Performance Evaluation and Monitoring of Members

1.7.1 Performance Monitoring Generally

1.7.1.1 The credentialing and privileging processes described in Article III and Article IV require that the Medical Staff develop Ongoing Professional Practice Evaluation activities and Focused Professional Practice Evaluation activities to ensure that decisions regarding appointment to membership on the Medical Staff and granting or renewing of Privileges are, among other things, detailed, current, accurate, objective, and evidence-based. Additionally, performance evaluations and monitoring activities help assure timely identification of problems that may arise in the ongoing provision of services in the Hospital. Problems identified through performance evaluation and monitoring activities may be addressed via the appropriate corrective actions set forth in Article XI.

1.7.1.2 Except as otherwise determined by the Medical Executive Committee and the Board of Trustees, the Medical Staff shall regularly monitor all Members' clinical activity in accordance with the provisions set forth in these Bylaws, the Rules, and such performance monitoring policies as may be developed by the Medical Staff and approved by the Medical Executive Committee and the Board of Trustees, including Ongoing Professional Practice Evaluation and Focused Professional Practice Evaluation.

1.7.1.3 Performance monitoring is not viewed as a disciplinary measure, but rather is an information gathering activity. Performance monitoring does not give rise to the procedural rights described in Article XI, unless the form of performance monitoring is an involuntary imposition of significant mandatory consultation and/or proctoring as described in Section 11.2.2.4.

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

1.7.1.5 Performance monitoring activities and reports shall be integrated into other quality improvement activities.

1.7.1.6 The results of any Practitioner specific performance monitoring shall be considered when granting, renewing, revising, or revoking Privileges of the Practitioner.

1.7.2 Ongoing Professional Practice Evaluations (OPPE)

1.7.2.1 Each Department of the Medical Staff shall recommend, for Medical Executive Committee and Board of Trustees approval, the criteria to be used in the conduct of Ongoing Professional Practice Evaluations.

1.7.2.2 Methods that may be used to gather information for Ongoing Professional Practice Evaluations include, but are not limited to: (a) periodic chart review, (b) direct observation, (c) monitoring of diagnostic and treatment techniques, (d) use of valid data from health information systems, and (e) discussions with other individuals involved in the care of each patient, including consulting physicians, assistants, nursing and administrative personnel.

1.7.2.3 Ongoing performance reviews shall be factored into the decision to maintain, revise, or revoke a Practitioner's existing Privileges.

1.7.3 Focused Professional Practice Evaluations (FPPE)

1.7.3.1 The Medial Staff is responsible for developing a Focused Professional Practice Evaluation process that will be used in predetermined situations as set forth in these Bylaws, the Rules, and the Medical Staff Professional Practice Evaluation, Focused and Ongoing Policy, and to evaluate, for a time-limited period, a Practitioner's competency in performing specific Privilege(s).

1.7.3.2 The Medical Staff may supplement these Bylaws with Rules and policies, for approval by the Medical Executive Committee and the Board of Trustees, that will clearly define the circumstances when a focused evaluation will occur, what criteria and methods should be used for conducting the focused evaluation, the duration of the evaluation period, requirements for extending the evaluation period, and how the information gathered during the evaluation process will be analyzed and communicated.

1.7.3.3 Information for a focused evaluation process may be gathered through a variety of measures, including, but not limited to: (a) retrospective or concurrent chart review, (b) monitoring of clinical practice patterns, (c) simulation, (d) external peer review, (e) discussion with other individuals involved in the care of each patient, and (f) proctoring, as more fully described in Article IV.

1.7.3.4 A Focused Professional Practice Evaluation may be used in at least the following situations:

a. All initial appointees to the Medical Staff and all Members granted new Privileges shall be subject to a period of Focused Professional Practice Evaluation in accordance with these Bylaws, the Rules, and the Medical Staff Professional Practice Evaluation, Focused and Ongoing Policy. Such focused evaluation will include a period of proctoring as set forth in Article IV.

b. In special circumstances, focused evaluation will be imposed as a condition of renewal of Privileges (for example, when a Member requests renewal of a Privilege that has been performed so infrequently that it is difficult to assess the Member's current competency in that area).

c. When questions arise regarding a Practitioner's competency in performing specific Privileges at the Hospital as a result of specific concerns or circumstances, a Focused Professional Practice Evaluation may be initiated.

d. As otherwise defined in these Bylaws, the Rules, the Medical Staff Professional Practice Evaluation, Focused and Ongoing Policy, or other applicable Focused Professional Practice Evaluation policies.

e. Nothing in the foregoing precludes the use of other Focused Professional Practice Evaluation tools, in addition to or in lieu of proctoring, as deemed warranted by the circumstances.

ARTICLE II: CATEGORIES OF THE MEDICAL STAFF

2.1 Categories

There are five (5) categories of Medical Staff membership: Provisional, Active, Courtesy, Emeritus, and Refer and Follow. At the time of appointment and each reappointment, a Practitioner's Medical Staff category shall be determined.

2.1.1 Assignment and Transfer in Staff Category

Each Medical Staff Member shall be assigned to a Medical Staff category based upon the qualifications set forth below. The members of each Medical Staff category shall have the prerogatives and carry out the duties set forth below. The Medical Executive Committee shall approve assignments to and transfers to or from a Medical Staff category, which shall be evaluated in accordance with the Medical Staff Bylaws and Rules. Action may be initiated to change the Medical Staff category or terminate the membership of any Member who fails to meet the qualifications or fulfill the duties, as described. Changes in Medical Staff category shall not be grounds for a hearing unless they affect a Member's Privileges and are based upon a medical disciplinary cause or reason.

In assigning Practitioners to the proper Medical Staff category, the Medical Staff shall consider whether the Practitioner participated in other aspects of the Hospital's activities, such as serving on committees or in leadership positions.

The Board of Trustees, on recommendation of the Medical Executive Committee, may rescind an automatic transfer to or from a Medical Staff category, but only if the Practitioner clearly demonstrates the unusual circumstances unlikely to occur in his or her practice that caused the failure to meet the minimum or maximum requirements.

2.1.2 General Prerogatives and Responsibilities

2.1.2.1 The prerogatives available to Medical Staff Members depending on Medical Staff category are:

a. Admit patients consistent with approved Privileges or practice prerogatives.

b. Exercise Privileges or practice prerogatives which have been approved.

c. Vote on any Medical Staff matter including Bylaws amendments, officer selection, and other matters presented at Department meetings.

d. Serve as a general Medical Staff officer.

e. Hold office in the Department to which he or she is assigned.

f. Serve on committees and vote on committee matters.

2.1.2.2 The responsibilities which Medical Staff Members are expected to carry out in addition to the basic responsibilities set forth in Section 1.6 and the Medical Staff Rules, depending on Medical Staff category held, include:

a. Contributing to the organizational and administrative activities of the Medical Staff, including quality improvement, risk management and utilization management, and serving in Medical Staff and Department offices, and on Hospital and Medical Staff committees.

b. Participating equitably in Medical Staff functions, at the request of a Department or other Medical Staff officer, including contributing to the Hospital's medical education programs, service on the on-call roster and accepting responsibility for providing care to any patient requiring on-call coverage in his or her specialty, consulting with other Medical Staff Members consistent with his or her delineated Privileges, proctoring Practitioners, and fulfilling other such Medical Staff functions as may be reasonably required.

c. Attending Medical Staff and Department meetings.

d. Paying Medical Staff dues, application fees, and assessments.

2.1.3 Provisional Staff

2.1.3.1 Qualifications

The Provisional Staff shall consist of Medical Staff Members who:

a. meet the qualifications for Medical Staff membership set forth in the Medical Staff Bylaws and Rules; and

b. are initial appointees to the Medical Staff and plan to qualify for and seek transfer to the Active or Courtesy Staff within twenty-four (24) months.

2.1.3.2 Prerogatives

Members of the Provisional Staff are entitled to:

a. admit patients consistent with approved Privileges or practice prerogatives;

b. exercise Privileges or practice prerogatives which have been approved; and

c. attend, in a nonvoting capacity, meetings of the Medical Staff, the Department to which they are assigned, and committees to which they have been appointed. Provisional Staff Members may not hold elective or appointed office in the Medical Staff or a Department or chair a committee.

2.1.3.3 Transfer and Advancement

a. In the ordinary course of events, Provisional Staff Members are transferred to Active or Courtesy status after service of at least twelve and not more than twenty-four (24) months in the Provisional Staff category. All transfers shall be done at the time of reappointment. To advance to the Active or Courtesy Staff, Provisional Staff Members must meet all the requirements for Active or Courtesy Staff, including applicable proctoring requirements.

b. Provisional Staff Members are subject to a period of Focused Professional Practice Evaluation in accordance with these Bylaws, the Rules, and the Medical Staff Professional Practice Evaluation, Focused and Ongoing Policy in order to satisfactorily demonstrate their ability to exercise the Privileges initially granted. Such focused evaluation will include a period of proctoring in accordance with Article IV. Such proctoring does not constitute grounds for a hearing as set forth in Section 11.2.2. If the Provisional Staff Member has satisfactorily demonstrated his or her ability to exercise the Privileges granted and otherwise appears qualified for continued Medical Staff membership, the Member shall be eligible for advancement to the Active or Courtesy Staff categories. Advancement from the Provisional Staff does not prohibit continued monitoring related to specific Privileges.

c. Action shall be initiated by the Medical Executive Committee to terminate the Privileges and membership of a Provisional Staff Member who does not qualify for advancement within twenty-four (24) months. The Member shall not be entitled to any hearing and/or appeal under the Bylaws and Rules if advancement was denied because of a failure to maintain a satisfactory level of clinical activity. The Member shall be entitled to the hearing and/or appeal rights under the Bylaws and Rules if

advancement was denied because the Member's clinical performance or professional conduct was unsatisfactory.

2.1.4 Active Staff

2.1.4.1 Qualifications

The Active Staff shall consist of Medical Staff Members who:

a. meet the qualifications for Medical Staff membership set forth in the Medical Staff Bylaws and Rules;

b. have been a Member in good standing in the Provisional Staff category for at least twelve months ; and

c. are regularly involved in caring for patients or demonstrate, by way of other substantial involvement in Medical Staff or Hospital activities, a genuine concern and interest in the Hospital. For Practitioners to maintain Active Staff status, regular involvement in patient care shall mean admitting inpatients, treating outpatients, referring, or consulting on at least twenty (20) cases at the hospital in a two (2) year period. Exceptions to these performance requirements may be made for good cause by the Medical Executive Committee, subject to approval by the Board of Trustees. Service as a Medical Staff officer, Department Chief, or committee member shall also be considered in classifying Medical Staff Members.

2.1.4.2 Prerogatives

Members of the Active Staff are entitled to:

a. admit patients consistent with approved Privileges or practice prerogatives;

b. exercise Privileges or practice prerogatives which have been approved;

c. attend and vote on matters within the scope of their licensure, Privileges, and practice prerogatives, including Bylaws amendments, officer selection, and other matters presented at meetings of the Medical Staff, the Department to which they are assigned, and committees to which they have been appointed;

d. serve as a general Medical Staff officer;

e. hold office in the Department to which they are assigned; and

f. serve on and chair committees and vote on committee matters.

2.1.4.3 Transfer and Failure to Meet Requirements

Active Staff Members who fail to achieve a minimum activity for one reappointment cycle shall be deemed to have requested transfer to the Courtesy Staff category unless the doctor specifically request assignment to the Refer and Follow Staff category and, accordingly, shall be automatically transferred to that category. All transfers shall be done at the time of reappointment. Action shall be initiated to evaluate and possibly terminate the Privileges and membership of any Active Staff Member who has failed to have any activity during one reappointment cycle.

2.1.5 Courtesy Staff

2.1.5.1 Qualifications

The Courtesy Staff shall consist of Members of the Medical Staff who:

a. meet the qualifications for Medical Staff membership set forth in the Medical Staff Bylaws and Rules;

b. have been a Member in good standing in the Provisional Staff category for at least twelve months;

c. admit, refer, or otherwise provide services for less than the minimum number of patients required for Active Staff category status; and

d. prior to reappointment, provide evidence of current clinical performance at the hospital where they are most active. A Practitioner must submit a list of clinical activity and outcomes directly to the Medical Staff Management Department with a letter from the Department Chief attesting to the Courtesy Staff reapplicant's current clinical competency.

2.1.5.2 Prerogatives

Except as otherwise provided, members of the Courtesy Staff shall be entitled to:

a. admit patients consistent with approved Privileges or practice prerogatives;

b. exercise Privileges or practice prerogatives which have been approved; and

c. attend, in a voting capacity, meetings of the Medical Staff, the Department to which they are assigned, and committees to which they have been appointed. Courtesy Staff Members may not hold elective or appointed office in the Medical Staff or a Department or chair a committee.

2.1.5.3 Transfer and Advancement

a. A Courtesy Staff Member who has exceeded the maximum activity permitted for one reappointment cycle shall have the option to request transfer to the Active Staff category. All transfers shall be done at the time of reappointment.

b. Action shall be initiated to evaluate and possibly terminate the Privileges and membership of any Courtesy Staff Member who has failed to have any activity during one reappointment cycle.

2.1.6 Emeritus Staff

2.1.6.1 Qualifications

The Emeritus Staff shall consist of Medical Staff Members who:

a. are distinguished Members of the Medical Staff retired from active practice (formerly Honorary); or

b. have outstanding reputations which the Medical Staff wishes to honor.

2.1.6.2 Prerogatives

Emeritus Staff shall not be entitled to admit patients or hold or exercise any Privileges. However, they may attend educational programs and attend, in a nonvoting capacity, meetings of the Medical Staff, the Department to which they may be assigned, and committees to which they may be appointed. Emeritus Staff may not hold office or chair a committee.

2.1.7 Refer and Follow Staff

2.1.7.1 Qualifications

The Refer and Follow Staff, shall consist of Members who:

a. refer patients to the Hospital and follow their patients to provide continuity of care, in consultation with the Attending Physician at the Hospital;

b. are not granted clinical or admitting Privileges to independently manage the care of patients in the Hospital; and

c. comply with the Medical Staff Bylaws and Rules as well as any applicable Medical Staff or Hospital policies and procedures.

2.1.7.2 Prerogatives

Members of the Refer and Follow Staff are entitled to:

a. refer patients to the Hospital, follow patients through their Hospital stay, visit their patients who have been admitted to the Hospital, and assist with discharge planning;

b. order outpatient ancillary studies;

d. review their patients' medical records and participate in care coordination (by documentation in their patients' medical records);

e. consult with the Attending Physician of record, communicate with caregivers, and observe diagnostic or surgical procedures with the approval of the Attending Physician of record; and

f. attend meetings of the Medical Staff and educational programs. Members of the Refer and Follow Staff may not vote, hold office, or serve on committees.

2.2 Limitation of Prerogatives

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

2.3 General Exceptions to Prerogatives

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

2.3.1 May not hold any general Medical Staff office.

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

2.3.3 Shall exercise Privileges only within the scope of their licensure and as limited by the Medical Staff Bylaws and Rules.

2.4 Modification of Medical Staff Membership Category

Upon recommendation of the Credentials and Privileging Committee, pursuant to a request by a Member, or upon direction of the Board of Trustees, the Medical Executive Committee may recommend a change in a Member's Medical Staff category consistent with the requirements of these Bylaws and the Rules.

ARTICLE III: PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

3.1 General

The Medical Staff shall consider each application for appointment, reappointment, and Privileges, and each request for modification of Medical Staff category using the procedure and the standards set forth below. The Medical Staff shall investigate each applicant before recommending action to the Board of Trustees. The Board of Trustees shall ultimately be responsible for granting membership and Privileges. The Medical Staff shall perform this function also for Practitioners who seek temporary privileges and for AHPs. By applying to the Medical Staff for appointment or reappointment (or by accepting Emeritus Staff appointment), the applicant agrees that regardless of whether he or she is appointed or granted the requested Privileges, he or she will comply with the responsibilities of Medical Staff membership and with the Medical Staff Bylaws and Rules as they exist and as they may be modified.

3.2 Applicant's Burden

An applicant for Medical Staff appointment, reappointment, advancement, transfer, and/or Privileges shall have the burden of producing accurate and adequate information for a thorough evaluation of his or her qualifications and suitability for the requested Medical Staff category or Privileges, resolving any reasonable doubts about these matters, and satisfying requests for information. The provision of information containing significant misrepresentations or omissions shall result in the immediate termination of the application process. The application shall be deemed incomplete and withdrawn. If the significant misrepresentation or omissions are discovered after the application has been approved, the significant misrepresentation or omissions may be grounds to restrict or terminate Privileges or medical staff membership. Failure to sustain the burden of producing information shall be grounds for denying an application or request. This burden may include submission to a medical or psychological examination as provided for in the Bylaws and Rules.

3.3 Basis for Appointment and Reappointment

Recommendations for appointment and reappointment to the Medical Staff and for the granting and renewal of Privileges shall be based upon the applicant's or Member's professional performance at this Hospital and in other settings, whether the applicant or Member meets the qualifications and can carry out all of the responsibilities specified in the Bylaws and Rules, and upon the Hospital's patient care needs and ability to provide adequate support services and facilities for the Practitioner. Gender, race, creed, and national origin shall not be used in making decisions regarding the granting or denying of Privileges or Medical Staff membership.

3.4 Application Form

3.4.1 Provision and Return of Application

Each Practitioner who expresses formal interest in a recognized and appropriate category of membership and Privileges shall be provided an application form for Medical Staff membership. Upon completion by the Practitioner, the form shall be returned to the Medical Staff Management Department with a non-refundable application fee as required by the Rules.

3.4.2 Application Form

The application form shall be approved by the Medical Executive Committee and the Board of Trustees and, once approved, shall be considered part of the Rules. The application shall request information pertinent to the applicant's qualifications and document the applicant's agreement to abide by the Medical Staff and Hospital Bylaws, Rules, and policies (including the standards and procedures for evaluating applicants contained herein) and to release all persons and entities from any liability that might arise from their investigating and/or acting on the application. The form shall also request information regarding:

3.4.2.1 practice history

3.4.2.2 ~~premedical education~~ (Deleted: Per Bylaws Committee 10/01/2013).

3.4.2.3 medical/professional education

3.4.2.4 internship, residencies, and fellowships

3.4.2.5 board certifications

3.4.2.6 certifications

3.4.2.7 medical license(s) and/or registrations, including voluntary/involuntary relinquishment of licensure and/or registrations

3.4.2.8 professional liability coverage and history

3.4.2.9 current and previous hospital affiliations, including voluntary/involuntary relinquishments of membership or privileges

3.4.2.10 peer references

3.4.2.11 work history

3.4.2.12 physical and mental health issues

3.5 Physical and Mental Capabilities

3.5.1 Obtaining Information

3.5.1.1 The application shall request information pertaining to the condition of the applicant's physical and mental health on a separate page of the form, which can be removed from the remaining application and processed separately. Upon receipt of the application, the page addressing physical and mental disabilities shall be removed and referred to the Well-Being Committee if applicable.

3.5.1.2 When the Medical Staff Management Department verifies information and obtains references, it shall ask for any information concerning physical or mental disabilities to be reported on a confidential form, which can be processed separately from the other information regarding the applicant. This information will also be referred to the Well-Being Committee if applicable.

3.5.1.3 The Well-Being Committee shall be responsible for investigating any Practitioner who has or may have a physical or mental disability that might affect the Practitioner's ability to exercise his or her requested Privileges or practice prerogatives in a manner that meets the Hospital's and Medical Staff's quality of care standards. This may include one of the following:

a. Medical examination to ascertain whether the Practitioner has a physical or mental disability that might interfere with his or her ability to provide care which meets the Hospital's and the Medical Staff's quality of care standards.

b. Interview to ascertain the condition of the Practitioner and to assess if and how reasonable accommodations may be made.

3.5.1.4 Any Practitioner who feels limited or challenged in any way by a qualified mental or physical disability in exercising his or her Privileges or practice prerogatives and in meeting quality of care standards should make such limitations immediately known to the Well-Being Committee. Any such disclosure will be treated with the high degree of confidentiality that attaches to the Medical Staff's peer review activities.

3.5.2 Review and Reasonable Accommodations

3.5.2.1 Any Practitioner who discloses or manifests a qualified physical or mental disability will have his or her application processed in the usual manner without references to the condition.

3.5.2.2 The Well-Being Committee shall not disclose any information regarding any Practitioner's qualified physical or mental disability until the Credentials and Privileging Committee (or, in the case of temporary privileges, the Medical Staff representatives who review temporary privilege requests and the Chief Executive Officer) has determined that the Practitioner is otherwise qualified for membership and/or to exercise the Privileges or practice prerogatives requested. Once the determination is made that the Practitioner is otherwise qualified, the Well-Being Committee may disclose information they have regarding any physical or mental disabilities and the effect those disabilities may have on the Practitioner's application for membership and Privileges. The Well-Being Committee and any other appropriate committee may meet with the Practitioner to discuss if and how reasonable accommodation(s) can be made.

3.5.2.3 As required by law, the Medical Staff and the Hospital will attempt to provide reasonable accommodation(s) to a Practitioner with known physical or mental disabilities if the Practitioner is otherwise qualified and can perform the essential functions of the Medical Staff appointment and Privileges in a manner which meets the Hospital and Medical Staff quality of care standards. If reasonable accommodations are not possible under the standards set forth herein, it may be necessary to withdraw or modify a Practitioner's Privileges and the Practitioner shall have the hearing and appellate rights described in the Bylaws and Rules.

3.6 Effect of Application

3.6.1 By applying for or by accepting appointment or reappointment to the Medical Staff, the applicant:

3.6.1.1 Signifies his or her willingness to appear for interviews in regard to his or her application for appointment.

3.6.1.2 Authorizes the Medical Staff and the Hospital representatives to consult with other hospitals, persons, or entities who have been associated with him or her and/or who may have information bearing on his or her 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.

3.6.1.3 Consents to the inspection and copying by Hospital representatives of all records and documents that may be relevant or lead to the discovery of information that is 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.

3.6.1.4 Certifies that he or she will report any subsequent changes in the information submitted on the application form to the Credentials and Privileging Committee and/or Chief Executive Officer.

3.6.1.5 Releases from any and all liability the Medical Staff and Hospital and their representatives for their acts performed in connection with evaluating the applicant.

3.6.1.6 Releases from any and all liability all individuals and organizations who provide information concerning the applicant, including otherwise privileged and confidential information, to Hospital representatives.

3.6.1.7 Authorizes and consents to Hospital representatives providing other hospitals, professional societies, licensing boards, and other organizations concerned with provider performance and the quality of patient care with relevant information the Hospital may have concerning him or her, and releases the Hospital and its representatives from liability for doing so.

3.6.1.8 Agrees that the Hospital and the Medical Staff may share information with a representative or agent from any hospital, including information obtained from other sources, and releases each person and each entity who received the information and each person and each entity who disclosed the information from any and all liability, including claims of violations of any federal or state law, such as laws forbidding restraints of trade, that might arise from the sharing of information and likewise agrees that the Hospital and any and all Hospital representatives may act upon such information.

3.6.1.9 Consents to undergo and to release the results of a medical, psychiatric, or psychological examination by a practitioner acceptable to the Well-Being Committee at the applicant's expense, if deemed necessary by the Well-Being Committee or the Medical Executive Committee.

3.6.1.10 Signifies his or her willingness to abide by all conditions of membership, as stated on the appointment or reappointment application form and in the Bylaws and the Rules.

3.6.2 For purposes of this section, the term "Hospital representative" includes the Board of Trustees, individual directors and committee members, the Chief Executive Officer, the Medical Staff as a whole, the Medical Staff Management Department, all Medical Staff Department Chiefs 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.

3.7 Verification of Information

3.7.1 Completion of Application and Verification

The applicant shall fill out and deliver an application form to the Medical Staff Management Department, which shall seek to verify the information submitted. The application will be deemed complete when all necessary verifications have been obtained, including current licensure, licensing board disciplinary records, specialty board certification status, National Practitioner Data Bank information, DEA certification (if Privileges to prescribe will be sought), verification of all practice activities from the time of completion of professional school to present, current malpractice liability insurance, and peer reference letters. References shall be obtained from three (3) peers, at least one of which is a practitioner who is familiar with the applicant's current qualifications by virtue of having recently worked with the applicant or having recently reviewed the applicant's cases, and shall include questions to address relevant training and experience, current competence, and any effects of health status on the Privileges requested. The Medical Staff Management Department shall then transmit the completed application and all supporting materials to the Chief of the Department in which the applicant seeks Privileges and to the Credentials and Privileging Committee.

3.7.2 Incomplete Application

3.7.2.1 If the Medical Staff Management Department is unable to verify the information, or if all necessary references have not been received, or if the application is otherwise significantly incomplete, the Medical Staff Management Department may delay further processing of the application, or may begin processing the application based on the available information with a decision that further information will be considered upon receipt.

3.7.2.2 If the processing of the application is delayed due to missing information that is reasonably deemed significant to a fair determination of the applicant's qualifications, the affected Practitioner shall be so informed. He or she shall then be given the opportunity to withdraw his or her application or to request the continued processing of his or her application by providing the missing information. If the applicant does not respond within thirty (30) days, he or she shall be deemed to have voluntarily withdrawn his or her application. If the applicant requests further processing, but then fails within thirty (30) days of being informed of the_missing information (or any other date mutually agreed to when the extension was granted, whichever is later), to provide or arrange for the provision of the information that the Practitioner could obtain using reasonable diligence, the Practitioner shall be deemed to have voluntarily withdrawn his or her application.

3.7.2.3 Any application deemed incomplete and withdrawn under this section may thereafter be reconsidered only if all requested information is submitted and all other information has been updated.

3.8 Action on the Application

3.8.1 Department Action

Upon receipt, the Department Chief shall review the application, supporting documentation, and other relevant information available to him or her. The Department Chief may personally interview the applicant. The Department Chief shall send his or her recommendations to the Credentials and Privileging Committee. The recommendations shall address Medical Staff appointment, Department affiliation, and Privileges.

3.8.2 Credentials and Privileging Committee Action

The Credentials and Privileging Committee, or a subcommittee thereof, shall review the application, supporting documentation, Department Chief's recommendation, and other relevant information available to it. The Credentials and Privileging Committee shall send the Medical Executive Committee a written report and recommendations regarding Medical Staff appointment, Department affiliation, and Privileges.

3.8.3 Medical Executive Committee Action

3.8.3.1 Preliminary Recommendation

At its next regularly scheduled meeting after receiving the recommendations of the Credentials and Privileging Committee and the Department Chief, the Medical Executive Committee shall consider all relevant information available to it. The Medical Executive Committee shall then formulate a preliminary recommendation. 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 accommodations(s), the necessary functions of Medical Staff membership.

3.8.3.2 Final Recommendation

Thereafter, a final recommendation shall be formulated and the Medical Executive Committee shall forward to the Board of Trustees a written report and recommendations as follows:

a. Favorable Recommendation

Favorable recommendations shall be promptly forwarded to the Board of Trustees together with a report that includes information from the Credentials and Privileging Committee and Department Chief on Medical Staff appointment, Department affiliation, Privileges to be granted, and any special conditions connected to the appointment.

b. Adverse Recommendation

When the recommendation is adverse in whole or in part, the Medical Staff Chairman shall immediately inform the Practitioner by Special Notice, and the Practitioner shall be entitled to the hearing and appeal rights provided in these Bylaws and the Rules. The Board of Trustees 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.

For the purpose of this section, an "adverse" recommendation by the Medical Executive Committee is as defined in Section 11.2.2.

c. Deferral

The Credentials and Privileging Committee, Department Chief, and/or 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 sixty (60) days with a recommendation for appointment and Privileges, or an adverse recommendation in whole or in part.

3.8.4 Board of Trustees Action

3.8.4.1 On Favorable Medical Executive Committee Recommendation

The Board of Trustees shall adopt, reject, or modify a recommendation of the Medical Executive Committee, or shall refer the recommendation back to the Medical Executive Committee for further consideration, stating the reasons for referral and setting a time limit within which the Medical Executive Committee shall respond. If the Board of Trustees' action is grounds for a hearing under Section 11.2.2, the Chief Executive Officer shall promptly inform the applicant by Special Notice, and he or she shall be entitled to the hearing and appeal rights provided for in Section 11.2.

3.8.4.2 Without Benefit of a Medical Executive Committee Recommendation

If the Board of Trustees does not receive a recommendation from the Medical Executive Committee within the time specified below, it may, after giving the Medical Executive Committee written notice and a reasonable period of time to act, take action on its own initiative. If such recommendation is favorable, it shall become effective as the final decision of the Board of Trustees. If the recommendation is grounds for a hearing under Section 11.2.2, the Chief Executive Officer shall give the applicant Special Notice of the tentative adverse recommendation and of the applicant's right to request a hearing. The applicant shall be entitled to the hearing and appeal rights provided in Section 11.2 before any final adverse action is taken.

3.8.4.3 After Procedural Rights

In the case of an adverse Medical Executive Committee recommendation or an adverse Board of Trustees decision, the Board of Trustees shall take final action in the matter only after the applicant has exhausted or has waived his or her Section 11.2 procedural rights. Action thus taken shall be the conclusive decision of the Board of Trustees, except that the Board of Trustees may defer final determination by referring the matter back to the Medical Executive Committee for reconsideration. Any such referral shall state the reason(s), shall set a reasonable time limit in which reply to the Board of Trustees shall be made, and may include a directive that additional hearings be conducted to clarify issues which are in doubt. After receiving the new recommendation and any new evidence, the Board of Trustees shall make a final decision.

3.8.4.4 Conflict Resolution

The Board of Trustees shall give great weight to the actions and recommendations of the Medical Executive Committee and in no event shall act in an arbitrary and capricious manner.

3.8.5 Notice of Final Decision

The Chief Executive Officer shall give notice of the Board of Trustees' final decision to the Medical Executive Committee and to the applicant. If the decision is adverse, the notice to the applicant shall be by Special Notice. A decision and notice to appoint shall include:

3.8.5.1 the Medical Staff category to which the applicant has been appointed;

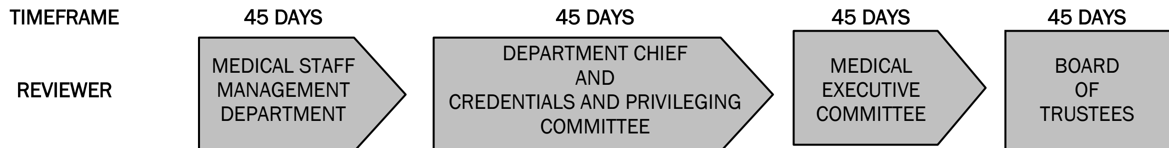
3.8.5.2 the Department and section, if any, to which the applicant has been assigned;

3.8.5.3 the Privileges the applicant may exercise; and

3.8.5.4 any special conditions attached to the appointment.

3.8.6 Guidelines for Time of Processing an Applicant

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



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 Medical Staff Chairman or the Chief Executive Officer. If action is not completed within one hundred and eighty (180) days from the time the first reference was received, an update on the references shall be requested.

3.8.7 Expedited Action

If the Medical Staff Management Department determines an applicant has no negative information in the credentials file, that file may be referred to the Credentials and Privileging Committee Chair or his or her designee, who may determine whether the application qualifies for expedited action. If he or she determines the file qualifies for expedited action, the file shall be forwarded to the Chief of the Department in which the applicant seeks membership. If they agree the applicant qualifies for expedited action, the file shall be referred to the Chief Executive Officer, who will decide whether to act on behalf of the Board of Trustees to grant membership and Privileges on an expedited basis. The expedited action processing will be terminated and routine processing resumed if anyone who reviews the file finds that expedited action is not warranted. If expedited approval is given, the file will nevertheless be submitted to the Credentials and Privileging Committee, Medical Executive Committee, and the Board of Trustees at their regularly scheduled meetings for ratification. Any of those bodies may act to rescind an expedited approval for Privileges and return the application for routine processing. There will be no right to expedited action and no hearing and appeal rights if expedited action is not taken or if approval given under the expedited action process is rescinded.

3.8.7.1 Criteria that would disqualify an applicant from the expedited action process are:

a. The applicant submits an incomplete application.

b. The Medical Executive Committee makes a final recommendation that is adverse or has limitations.

3.8.7.2 Criteria that needs to be evaluated on a case-by-case basis and may result in ineligibility are:

a. There is a current challenge or a previously successful challenge to licensure or registration.

b. The applicant has received an involuntary termination of medical staff membership at another hospital.

c. The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges.

d. The Hospital determines that there has been either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

3.9 Duration of Appointment

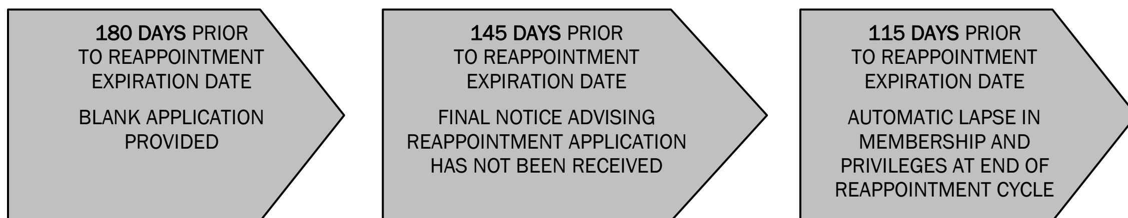
3.9.1 All new Medical Staff Members shall be appointed to the Provisional Staff category. Provisional Staff category appointments are for a period of not more than twenty-four (24) months.

3.9.2 Reappointments to any Medical Staff category other than Provisional shall be for a maximum period of twenty-four (24) months.

3.10 Reappointment Process

3.10.1 Schedule for Reappointment

3.10.1.1 At least one hundred and eighty (180) days prior to the expiration of each Medical Staff Member's appointment (except those granted temporary privileges), the Medical Staff Management Department shall provide the Member with a reappointment application form. If the reappointment application form is not completed and returned to the Medical Staff Management Department within thirty-five (35) days after it was initially mailed, a final Notice shall be promptly sent to the Member advising him or her that the application has not been received. Failure, without good cause, to return the reappointment application form and all requested documentation within thirty (30) days after the final Notice was mailed shall result in an automatic lapse of membership and Privileges as described in Section 3.10.9.



3.10.1.2 A Member may request a change in membership category or Privileges when he or she is not scheduled for a biennial review and such a request will be processed when it is received by the Medical Staff Management Department. The Member shall also be reviewed in accordance with the standard reappointment schedule.

3.10.2 Content of the Reappointment Application Form

3.10.2.1 The reappointment application form shall be approved by the Medical Executive Committee and the Board of Trustees, and once approved, shall be considered part of the Rules. The form shall seek information concerning the changes in the applicant's qualifications since his or her last review. Specifically, the form shall request an update of all of the information and certification requested in the appointment application form, with the exception of that information which cannot change over time, such as information regarding the Member's pre-medical and medical education, date of birth, and so forth. The form shall also require information as to whether the applicant requests any change in his or her Medical Staff category and/or his or her Privileges, including any reduction, deletion, or additional Privileges. Requests for additional Privileges must be supported by the type and nature of evidence which would be necessary to be granted in an initial application.

3.10.2.2 If the Member's level of clinical activity at this Hospital is not sufficient to permit the Medical Staff and the Board of Trustees to evaluate his or her competency to exercise the Privileges requested, the Member shall have the burden of providing evidence of clinical performance at his or her principal institution in whatever form as the Medical Staff may require.

3.10.3 Verification and Collection of Information

The Medical Staff shall, in a timely fashion, verify the additional information made available on each reappointment application and collect any other materials or information deemed pertinent by the Medical Executive Committee, the Credentials and Privileging Committee, or the Chief of the Department to which the Member belongs. The information shall address without limitation:

3.10.3.1 Patterns of care, professional performance including clinical and technical skills and utilization management as demonstrated in the findings of quality improvement, risk management and resource management activities, including, when available, Practitioner specific data compared with relevant aggregate data.

3.10.3.2 Participation in relevant continuing education activities.

3.10.3.3 Level/amount of clinical activity (patient care contacts) that can indicate current competence and ability to perform the procedures for which Privileges are requested.

3.10.3.4 Sanctions imposed or pending and other problems.

3.10.3.5 Health status, including completion of a physical examination or psychiatric evaluation by a physician who is mutually accepted by the affected Practitioner and the Medical Staff, when requested by the Credentials and Privileging Committee or Medical Executive Committee and subject to the standards set forth in Section 3.5 pertaining to physical and mental capabilities.

3.10.3.6 Participation as a Medical Staff leader and/or committee member/chair.

3.10.3.7 Timely, accurate, and legible completion of medical records.

3.10.3.8 Cooperativeness and general demeanor in relationships with other Practitioners, Hospital personnel, and patients.

3.10.3.9 Professional liability claim experience, including being named as a party in any professional liability claims and the disposition of any pending claims.

3.10.3.10 Compliance with all applicable Medical Staff and Hospital Bylaws, Rules, and policies.

3.10.3.11 If there is significant peer review information available, professional references from at least one practitioner who is familiar with the Member's current qualifications by virtue of having recently worked with the Member or having recently reviewed the Member's cases and which address relevant training and experience, current competence, and any effects of health status on the Privileges requested.

3.10.3.12 Any other pertinent information including the Member's activities at other hospitals and his or her medical practice outside the Hospital.

3.10.3.13 Information concerning the Member from the state licensing board and the National Practitioner Data Bank.

The Medical Staff Management Department shall transmit the completed reappointment application form and supporting documentation to the Chief of each Department to which the Member belongs or requests Privileges, and to the Credentials and Privileging Committee.

3.10.4 Department Action

The Department Chief's designee shall review the application and all other relevant available information. He or she shall transmit to the Department Chief his or her written recommendations, which are prepared in accordance with Section 3.10.7. Upon receipt of an application from a Department Chief's designee, or the Medical Staff Management Department, the Department Chief shall review the application and all other relevant available information. He or she shall transmit to the Credentials and Privileging Committee his or her written recommendations, which are prepared in accordance with Section 3.10.7.

3.10.5 Credentials and Privileging Committee Action

The Credentials and Privileging Committee, or a subcommittee thereof, shall review the application, the Department Chief's recommendation, and all other relevant available information. The Credentials and Privileging Committee shall transmit to the Medical Executive Committee written recommendations, which are prepared in accordance with Section 3.10.7.

3.10.6 Medical Executive Committee Action

3.10.6.1 The Medical Executive Committee shall review the Credentials and Privileging Committee's and Department Chief's recommendations and all other relevant information available to it and shall forward to the Board of Trustees its favorable recommendations, which are prepared in accordance with Section 3.10.7.

3.10.6.2 When the Medical Executive Committee recommends an adverse action, as defined in Section 11.2.2, either with respect to reappointment or Privileges, the Medical Staff Chairman shall give the applicant Special Notice of the adverse recommendation and of the applicant's right to request a hearing in the manner specified in Section 11.2. The applicant shall be entitled to the Section 11.2 hearing and appeal rights. The Board of Trustees shall be informed of, but not take action on the pending recommendation until the applicant has exhausted or waived his or her procedural rights.

3.10.6.3 Thereafter the procedures specified for applicants in Section 3.8.4 (Board of Trustees Action), Section 3.8.5 (Notice of Final Decision), and Section 3.12 (Waiting Period After Adverse Action) shall be followed. The Medical Executive Committee may also defer action; however, any deferral must be followed-up within seventy (70) days with a recommendation.

3.10.7 Reappointment Recommendations

Reappointment recommendations shall be written and shall specify whether the applicant's appointment should be renewed, renewed with modified membership category, Department affiliation, and/or Privileges, or terminated. The reason for any adverse recommendation shall be described. The Medical Staff may require additional proctoring of any Privileges that are used so infrequently as to make it difficult or unreliable to assess current competency without additional proctoring. Such proctoring requirements imposed for lack of activity shall not result in any hearing rights.

3.10.8 Basis for Reappointment

Reappointment recommendations (including Privilege recommendations) shall be based upon whether the Medical Staff Member has met all of the qualifications and carried out all of the responsibilities set forth in the Medical Staff and Hospital Bylaws, Rules, and policies.

3.10.9 Failure to File Reappointment Application

Failure to file a complete application for reappointment within sixty-five (65) days of the initial mailing of the reappointment application shall result in the automatic lapse of a Member's membership and Privileges at the expiration of the Member's current term. Members whose membership automatically lapses will be processed as new applicants should they wish to reapply. In the event membership lapses for the reasons set forth herein, the Member is not entitled to any hearing or review.

3.11 Relinquishment of Privileges

A Medical Staff Member who wishes to relinquish or limit particular Privileges shall send written notice to the Medical Staff Chairman and the appropriate Department Chief identifying the particular Privileges to be relinquished or limited. A copy of this notice shall be forwarded to the Medical Staff Management Department for inclusion in the Medical Staff Member's credentials file.

3.12 Waiting Period After Adverse Action

3.12.1 Who Is Affected

3.12.1.1 A waiting period of twenty-four (24) months shall apply to the following Practitioners:

a. An applicant who:

i. has received a final adverse decision regarding appointment; or

ii. withdrew his or her application or request for membership and Privileges following an adverse recommendation by the Medical Executive Committee or the Board of Trustees.

b. A former Medical Staff Member who:

i. received a final adverse decision resulting in termination of Medical Staff membership and/or Privileges;

ii. resigned from the Medical Staff or relinquished Privileges while an investigation was pending or following the Medical Executive Committee or Board of Trustees issuing an adverse recommendation; or

c. A Medical Staff Member who has received a final adverse decision resulting in:

i. termination or restriction of his or her Privileges; or

ii. denial of his or her request for additional Privileges.

3.12.1.2 Ordinarily, the waiting period shall be twenty-four (24) months; however, for Practitioners whose adverse action included a specified period or condition of retraining or additional experience, the Medical Executive Committee may exercise its discretion to allow earlier reapplication upon completion of the specified conditions. Similarly, the Medical Executive Committee may exercise its discretion, with approval of the Board of Trustees, to waive the objective measures, if changed circumstances warrant earlier consideration of an application.

3.12.1.3 An action is considered adverse only if it is based on the type of occurrence(s) which might give rise to corrective action. An action is not considered adverse if it is based upon reasons that do not pertain to medical or ethical conduct, such as actions based on a failure to maintain a practice in the area (which can be resolved by a move), to pay dues (which can be resolved by paying dues), or to maintain professional liability insurance (which can be resolved by obtaining the insurance).

3.12.2 Date When Action Becomes Final

The action is considered final on the latest date on which the application or request was withdrawn, a Medical Staff Member's resignation became effective, or upon completion of (i) all Medical Staff and Hospital hearings and appellate review and (ii) all judicial proceedings pertinent to the action served within two (2) years after the completion of the Hospital proceedings.

3.12.3 Effect of the Waiting Period

Except as otherwise permitted in Section 3.12.1.2, Practitioners subject to waiting periods cannot reapply for Medical Staff membership or the Privileges affected by the adverse action for at least twenty-four (24) 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 shall 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 completed any specific training or other conditions which were imposed.

3.13 Confidentiality and Impartiality

To maintain confidentiality and to assure the unbiased performance of appointment and reappointment functions, participants in the credentialing process shall limit their discussion of the matters involved to the formal avenues provided in the Medical Staff Bylaws and Rules for processing applications for appointment and reappointment.

3.14 Healthcare Entity Cooperation

3.14.1 General Rules for Healthcare Entity Cooperation for Appointments and Reappointments

Practitioners desiring to exercise clinical privileges through more than one affiliated healthcare entity member are subject to the following provisions regarding affiliated healthcare entity appointments and reappointments.

3.14.2 Healthcare Entity Application Form

A single application form shall be developed for all participating affiliated healthcare entity members to use. The applicant shall indicate those affiliated healthcare entity members in which he or she desires to exercise clinical privileges together with the departments to which the applicant will apply and the clinical privileges desired.

3.14.2.1 An applicant requesting appointment and clinical privileges with an affiliated medical group or entity must first demonstrate a contractual or employment relationship with such a medical group or entity.

3.14.2.2 An applicant requesting clinical privileges in a facility or clinical department subject to an exclusive contracting arrangement must first demonstrate a contractual or employment relationship with the party holding the exclusive contract.

3.14.2.3 Clinical privileges at any healthcare entity member shall be limited by the scope of clinical privileges normally available at that affiliated healthcare entity member.

3.14.3 Healthcare Entity Investigation

3.14.3.1 A coordinated investigation shall be conducted in accordance with the Hospital's credentialing process. Investigatory responsibility may be delegated to one or more participants in the affiliated healthcare entities.

3.14.3.2 The results of the investigation shall be reported to the Credentials and Privileging Committee for processing in the manner described above. The Credentials and Privileging Committee

shall render its recommendations to the Medical Executive Committee, as well as to each participating healthcare entity member's medical executive committee or equivalent committee, or if there is no such committee then directly to each healthcare entity member's governing body for independent determination of appointment and/or clinical privileges in accordance with each entity's bylaws or other applicable credentialing policies and procedures.

3.15 Leave of Absence

3.15.1 Members may obtain a voluntary leave of absence from the Medical Staff upon submitting written notice to the Medical Executive Committee stating the approximate period of leave desired, which cannot exceed the present term of appointment. During the period of the leave of absence, the Member shall not exercise Privileges at the Hospital, and membership rights and responsibilities shall be inactive, but the obligation to pay dues, if any, shall continue unless waived by the Medical Executive Committee. Provisional Members are not eligible to request a leave of absence.

3.15.2 A Member on leave of absence may request reinstatement to the Medical Staff by submitting a written notice to that effect to the Medical Executive Committee and applying for reappointment. Reinstatement at the end of the leave of absence must be approved in accordance with the applicable standards and procedures set forth in these Bylaws and the Rules for reappointment review. The Member must also provide information regarding his or her professional activities during the leave of absence and his or her health status.

3.15.3 Failure, without good cause, to request reinstatement at least thirty (30) days prior to the expiration of the leave of absence, to submit a completed reappointment application, or to provide requested information concerning the Member's activities during the leave of absence and his or her health status shall be deemed a voluntary resignation from the Medical Staff and shall result in an automatic termination of Medical Staff membership and Privileges with no hearing rights.

ARTICLE IV: PRIVILEGES

4.1 Exercise of Privileges

Except as otherwise provided in these Bylaws or the Rules, every Practitioner or AHP providing direct clinical services at the Hospital shall be entitled to exercise only those Privileges specifically granted to him or her. Privileges shall be reviewed for initial granting and renewal subject to the standards and procedures set forth in these Bylaws and the Rules.

4.2 Emergency Privileges

In the event of an emergency, any Member of the Medical Staff or credentialed AHP shall be permitted to do everything reasonably possible to save the life of a patient or save a patient from serious harm. The Member or AHP shall promptly yield such care to a qualified Member once one becomes available.

An emergency is defined as a condition where the life and/or limb of a patient is in immediate danger, and in which delay in administering proper treatment would increase this danger.

4.3 Delineation of Privileges in General

4.3.1 Requests

4.3.1.1 Each application for appointment and reappointment to the Medical Staff must contain a request for the specific Privileges desired by the applicant. A request for a modification of Privileges must be supported by documentation of training and/or experience supportive of the request.

4.3.1.2 Each Department will be responsible for developing criteria for granting Privileges and including those criteria in the Department's delineation of Privileges forms, which shall be a part of the Department rules and subject to approval by the Credentials and Privileging Committee, Medical Executive Committee, and Board of Trustees.

4.3.2 Basis for Privilege Delineation

Requests for Privileges shall be evaluated on the basis of the Practitioner's education, training, experience, demonstrated professional competence and judgment, clinical performance, the documented results of patient care and other quality improvement review and monitoring activities, performance of a sufficient number of procedures during the immediate-past two (2) years to develop and maintain the Practitioner's skills and knowledge, and compliance with any specific criteria applicable to the Privileges. Privilege determinations shall also be based on pertinent information concerning clinical performance activities obtained from other sources, especially other institutions and healthcare settings where a Practitioner exercises privileges.

4.4 Conditions for Privileging of Limited License Practitioners

4.4.1 Admissions

4.4.1.1 Dentist, oral and maxillofacial surgeon, and podiatrist Members may admit patients only if a Physician Member assumes responsibility for care of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside of the limited license Practitioner's lawful scope of practice.

4.4.1.2 When evidence of appropriate training and experience is documented, an oral and maxillofacial surgeon may perform the history or physical on his or her own patient. Otherwise, a Physician Member must conduct or directly supervise the admitting history and physical examination (except the portion related to dentistry or podiatry).

4.4.2 Medical Appraisal

All patients admitted for care in the Hospital by a dentist, oral and maxillofacial surgeon, or podiatrist shall receive the same basic medical appraisal as patients admitted to other services, and a Physician Member or a limited license Practitioner with appropriate Privileges shall determine the risk and effect of any proposed treatment or surgical procedure on the general health status of the patient. Where a dispute exists regarding proposed treatment between a Physician Member and a limited license Practitioner based upon medical or surgical factors outside of the scope of licensure of the limited license Practitioner, the treatment will be suspended insofar as possible while the dispute is resolved by the appropriate Department(s).

4.5 Temporary Privileges

Temporary privileges may be granted only in those situations provided in these Bylaws and the Rules, after the Practitioner or AHP has satisfied the requirements set forth in these Bylaws and the Rules.

4.5.1 Circumstances

4.5.1.1 Temporary privileges can be granted on a case by case basis when there is an important need that mandates an immediate authorization for practice, for a limited period of time, while the full credentials information is verified and approved. This would include a situation where there are no Members of the Medical Staff available to provide necessary coverage of services. Such temporary privileges shall not exceed one hundred and twenty (120) days in duration and shall be limited to the care of four (4) patients in a calendar year. Practitioners desiring clinical privileges to care for additional patients shall be required to apply for Medical Staff membership and request the appropriate clinical privileges.

4.5.1.2 Temporary privileges may also be granted when an application for Medical Staff membership or Privileges is waiting for a review and recommendation by the Medical Executive Committee and approval by the Board of Trustees. Temporary privileges under these circumstances may be granted for a limited period of time, not to exceed one hundred and twenty (120) days, provided:

a. there is verification of:

i. current licensure

ii. relevant training and experience

iii. current competence

iv. ability to perform the privileges requested

v. other such criteria as may be required by the Medical Staff Bylaws and/or Rules

b. the results of the National Practitioner Data Bank query have been obtained and evaluated

c. the applicant has:

i. a complete application

ii. no current or previously successful challenge(s) to licensure or registration

iii. not been subject to involuntary termination of medical staff membership at another organization

iv. not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges

4.5.2 Application

Practitioners seeking temporary privileges must complete the appropriate request for temporary privileges application and pay an application fee for Medical Staff membership (if temporary privileges are sought during the pendency of an application or to serve as locum tenens).

4.5.3 Granting Temporary Privileges

4.5.3.1 Temporary privileges may be granted by the Chief Executive Officer, or his or her designee, on the recommendation of the Medical Staff Chairman or the Chair of the Credentials and Privileging Committee.

4.5.3.2 Temporary privileges shall automatically terminate at the end of the designated period.

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

4.5.3.4 Members whose membership was automatically terminated for a failure to complete medical records shall not be eligible for temporary privileges except in an emergency, as determined by the person asked to grant the temporary privileges.

4.5.4 Deferral, Denial, or Termination

4.5.4.1 There is no right to temporary privileges. Accordingly, temporary privileges are not granted unless the available information supports, with reasonable certainty, a favorable determination regarding the requesting Practitioner's or AHP's qualifications, ability, and judgment to exercise the clinical privileges or practice prerogatives requested, and only after the Practitioner or AHP has demonstrated compliance with these Bylaws and the Rules.

4.5.4.2 If the available information is inconsistent or casts any reasonable doubts on the applicant's qualifications, action on the request for temporary privileges may be deferred until the doubts have been satisfactorily resolved or the request is denied.

4.5.4.3 Temporary privileges must be terminated if information is received later suggesting the Practitioner or AHP may not be qualified.

4.5.4.4 Temporary privileges may be terminated with or without cause at any time by the Medical Staff Chairman, the responsible Department Chief, or the Chief Executive Officer after conferring with the Medical Staff Chairman or the responsible Department Chief. A person shall be entitled to the procedural rights afforded by the Bylaws and Rules only if a request for temporary privileges is refused based upon, or if all or any portion of temporary privileges are terminated or suspended for, a medical disciplinary cause or reason. In all other cases (including a deferral in acting on a request for temporary privileges), the Practitioner shall not be entitled to any procedural rights based upon an adverse action involving temporary privileges.

4.5.4.5 Whenever temporary privileges are terminated, the appropriate Department Chief or, in their absence, the Medical Staff Chairman shall assign a Member to assume responsibility for the care of the Practitioner's patient(s). The wishes of the patient and affected Practitioner shall be considered in the choice of a replacement Member.

4.6 Telemedicine Privileges

4.6.1 Definition of Telemedicine and the Privileges Required

Telemedicine involves the use of electronic communication or other communication technologies to provide or support clinical care at a distance. Practitioners who render a diagnosis or otherwise provide clinical treatment of a patient by telemedicine are subject to the Medical Staff credentialing and privileging process.

4.6.2 Services Provided via Telemedicine must be recommended by the Department and approved by the Medical Executive Committee.

4.6.3 Qualifications for Privileges to Provide Services via Telemedicine

In order to qualify for telemedicine privileges, the Practitioner must meet all the requirements set forth in the Bylaws and Rules for Privileges (either temporary or granted in connection with membership).

4.7 Proctoring

4.7.1 General

4.7.1.1 The imposition of proctoring does not give rise to the hearing rights described in Article XI when required for initial appointees and for Members granted probationary or additional Privileges. Only when proctoring is involuntarily imposed under Section 11.2.2.4 shall the Practitioner be entitled to the hearing rights described in Article XI.

4.7.1.2 All Medical Staff Members initially granted Privileges shall be proctored. All Practitioners granted temporary privileges during the pendency of their application, on a probationary basis, or as locum tenens shall be proctored. Practitioners granted Privileges to care for a specific patient, , shall not be proctored, but shall comply with any special supervision required by the Department Chief.

4.7.1.3 A clinical privilege request form shall be completed for each Practitioner who is granted Privileges. A copy of the clinical privilege request form indicating the approved Privileges shall be sent to the Practitioner, Department Chief, and any service in which Privileges were granted (e.g., the Operating Room, ICU, or Radiology). A copy of the clinical privilege request form shall also be maintained in the Practitioner's credentials file. The clinical privilege request form shall indicate the Privileges for which the Practitioner must be proctored.

4.7.1.4 Whenever proctoring is imposed, the number or duration and types of procedures to be proctored shall be delineated.

4.7.1.5 During proctoring, the initial applicant or Member must demonstrate he or she is qualified to exercise the Privileges that were granted and is carrying out the duties of his or her Medical Staff category.

4.7.2 Assignment of Proctor

4.7.2.1 The proctor must have unrestricted Privileges to perform the procedures that he or she will proctor. If no Medical Staff Members who have the necessary expertise are available to proctor, special arrangements may be made for proctoring by non-Medical Staff Members (at sites other than the Hospital) and/or by Medical Staff Members who have related Privileges. Special

arrangements must be approved by the Medical Executive Committee. All Active, Courtesy, and Provisional Members who have completed proctoring must assist in proctoring.

4.7.2.2 The Department Chief shall oversee proctoring.

4.7.2.3 If an assigned proctor is unable to fulfill the responsibilities of a proctor, he or she shall notify the Department Chief.

4.7.3 Function and Responsibility of the Proctor

4.7.3.1 All Members who act as proctors of initial appointees, Members of the Medical Staff, and/or Practitioners with temporary privileges are acting at the direction of and as an agent for the Member's respective Department, the Medical Executive Committee, and the Board of Trustees.

4.7.3.2 The proctor shall be responsible for evaluating the proctored Practitioner's performance from the time of the patient's admission until discharge and shall evaluate the indications for admission, discharge, diagnostic work-up, and therapy management.

4.7.3.3 If surgery or an invasive procedure is performed, the proctor shall evaluate the indication for the procedure, the technique, how the procedure is performed, and the pre-operative, operative, and post-operative care of the patient. He or she shall utilize the patient's chart, discussions with the Practitioner, and actual observation as the basis for the review. If medical care is provided, the proctor shall review the care of the patient, utilizing the patient's chart, discussions with the Practitioner, and actual observation, as necessary, as the basis for the review. Invasive medical procedures will be proctored by observation unless the case is an emergency or as otherwise specified in the Department Rules.

4.7.3.4 For each case that is proctored, the proctor shall complete a proctoring report and submit it to the Department Chief through the Medical Staff Management Department.

4.7.3.5 Non-invasive surgical or procedural proctoring reports shall be completed fully and in a timely manner after the patient's discharge.

4.7.3.6 The proctor's primary responsibility is to evaluate the proctored Practitioner's performance. However, if the proctor believes that intervention is warranted in order to avert harm to a patient, he or she may take any action he or she finds reasonably necessary to protect the patient.

4.7.3.7 If the proctor and the proctored Practitioner disagree on the appropriate treatment of a patient, the dispute shall be referred to the Department Chief for resolution.

4.7.3.8 A proctor may or may not act as the assistant in a surgical procedure. Except when the proctor acts as a surgical assistant, no fee shall be charged by the proctor.

4.7.4 Responsibility of the Proctored Practitioner

4.7.4.1 The proctored Practitioner shall be responsible for notifying an assigned proctor regarding each patient whose care is to be evaluated. For surgical or invasive medical procedures that will be observed, the proctored Practitioner shall be responsible for arranging the time of the procedure with the proctor.

4.7.4.2 The proctored Practitioner shall provide the information that is requested by the assigned proctor regarding the patient and the planned course of treatment.

4.7.5 Proctoring Duration

Each Practitioner granted Privileges must be proctored on at least three (3) cases, or such higher minimum number of cases as may be identified in the Rules.

4.7.6 Extension of Proctoring

If at the time of completion of the minimum number of cases required for Privileges, the Department concludes that the Practitioner should be proctored on additional cases, the Department Chief shall notify the proctored Practitioner. Proctoring shall be extended for three (3) additional cases at a time, for a maximum of twenty-four (24) cases. Failure to satisfactorily complete proctoring shall have the consequences set forth in the Medical Staff Bylaws and Rules. This provision does not, however, preclude the initiation of corrective action at an earlier time.

4.7.7 Reciprocal Proctoring

4.7.7.1 Reciprocal proctoring may be accepted to supplement actual observation on the premises, pursuant to the applicable provisions of the Medical Staff Professional Practice Evaluation, Focused and Ongoing Policy.

4.7.7.2 Reciprocal proctoring may be acceptable when initial applicant has Privileges at a neighboring hospital where Members of this Hospital's Medical Staff are familiar with the Member to be proctored, and familiar with that neighboring hospital's peer review standards, privileging and proctoring information from the neighboring hospital.

4.7.7.3 Reciprocal proctoring is acceptable only if all of the following conditions are met:

a. The proctor is a member of the medical staff at both hospitals, and is eligible to serve as a proctor at both hospitals.

b. The Practitioner has requested the same range and level of clinical privileges at both hospitals.

c. The proctor has the same range and level of Privileges as requested by the Practitioner.

d. Copies of a proctoring report shall be provided to the Hospital.

4.7.8 Proctoring Review

When the Department is considering whether to terminate proctoring requirements and grant a Practitioner unrestricted Privileges, it may have the Medical Staff Management Department first verify that the Practitioner remains in good standing at other hospitals where he or she is actively practicing. The information secured as a result of this review shall be taken into consideration by the Department in making its final recommendations.

4.7.9 Effect of Failure to Complete Proctoring

4.7.9.1 Failure to Complete Necessary Volume

Any Practitioner or Member undergoing proctoring, who is not afforded procedural rights as provided in Article XI as a result of such proctoring, who fails to complete the required number of proctored cases within the time frame established in the Bylaws and Rules and any applicable policy shall be deemed to have voluntarily withdrawn his or her request for the relevant Privileges, and he or she shall not be afforded the procedural rights provided in Article XI. However, the Medical Staff has the discretion to extend the time for completion of proctoring in appropriate cases subject to approval by the Department Chief, the Medical Executive Committee and the Board of Trustees. The inability to obtain such an extension shall not give rise to the procedural rights described in Article XI.

4.7.9.2 Failure to Satisfactorily Complete Proctoring

If a Practitioner completes the necessary volume of proctored cases but fails to perform satisfactorily during proctoring, the relevant Privileges may be revoked, and he or she shall be afforded the procedural rights as provided in Article XI. In the event procedural rights are invoked, the Practitioner who has not successfully completed proctoring shall be deemed an "initial applicant" for purposes of Article XI.

4.7.9.3 Effect on Advancement

The failure to complete proctoring for any specific Privilege shall not, by itself, preclude advancement from the Provisional Staff. If advancement is approved prior to completion of proctoring, the proctoring will continue for the specified Privileges. The specific Privileges may be voluntarily relinquished or terminated, if proctoring is not completed thereafter within a reasonable time. Whenever such privileges are voluntarily relinquished or terminated because proctoring is not completed within a reasonable time, the Practitioner shall not be entitled to any procedural rights as provided in Article XI.

4.8 Disaster Privileges

4.8.1 General

4.8.1.1 Disaster privileges may be granted to a volunteer licensed independent practitioner, volunteer_LIP by the Chief Executive Officer or designee and the Medical Staff Chairman MSC) or designee when the Hospital's emergency management plan has been activated and the Hospital is unable to handle the immediate patient needs.

4.8.1.2 Before granting disaster privileges, the volunteer LIP must present a valid government-issued photo identification issued by a state or federal agency and one of the following:

a. Current picture hospital ID card with professional designation.

b. Current license to practice or primary source verification of license by Medical Staff Management.

c. Identification indicating the volunteer LIP has been granted authority to render patient care, treatment, and services during a disaster, or is a member of a Disaster Medical Assistance Team, the Medical Reserve Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, or another recognized organization either federal or of the state of California, or the city of Los Angeles/county of Los Angeles.

4.8.1.3 In the absence of one of the three (3) forms of verification noted above, a current Hospital employee or Medical Staff Member with personal knowledge of ability to act as an volunteer LIP during a disaster may attest to the identity of the volunteer LIP.

4.8.1.4 Medical Staff Management will attempt to verify licensure upon request for disaster privileges. Should this not be possible, verification will occur as soon as practical after the immediate situation is under control, and, except in extraordinary circumstances, will be completed within seventy-two (72) hours from the time when the volunteer LIP presents to the organization. The time the privileges were granted will be documented, and the Hospital- Chief Executive Officer or designee and the Medical Staff Chairman MSC) or designee will make a decision within seventy-two (72) hours regarding whether to continue the privileges.

4.8.1.5 The patient care, treatment, and services provided by volunteer LIPs will be monitored and overseen by the applicable Department Chief in which services are provided.

4.8.1.6 Disaster privileges shall automatically terminate once the state of emergency no longer exists or when the volunteer LIP's services are no longer required, as determined by the Hospital Chief Executive Officer or designee. Disaster privileges may be revoked at any time. The termination of disaster privileges shall be final, and the Medical Staff's hearing and appellate review procedures shall not apply.

4.8.2 Declaration of Emergency

4.8.2.1 The Chief Executive Officer, or designee, shall declare an emergency once the Hospital's emergency management plan has been activated.

4.8.2.2 After activation, the Medical Staff Chairman or his designee will determine if the Hospital requires additional (volunteer) LIPs to handle its immediate patient care needs.

4.8.2.3 Volunteer LIPs will be directed to the Physician Pool (located in the Physician Dining Room, Hospital basement or Physician Lounge, Hospital first floor) and Medical Staff Management Personnel, or their designee, (MSMP) will manage disaster credentialing activities from the Physician Pool and Medical Staff Management Office (next to Physician Lounge).

4.8.2.4 A Volunteer Staff Registration form will be used by MSMP stationed inside the Physician Pool to record all solicited and unsolicited volunteer LIPs who apply for temporary disaster privileges.

4.8.2.5 One employee from Medical Staff Management will remain inside the Physician Pool at all times as a "message center" to inform volunteer LIPs of the current situation, in coordination with the Support Branch Director, Situation Unit Leader, and IT/IS Unit Leader. He/she will also observe volunteers for signs of stress and inappropriate behavior. Concerns will be reported to the Employee Health and Well-Being Unit Leader.

4.8.2.6 Other priorities shall cease in order to expedite the processing of volunteer LIPs for disaster privileges.

4.8.3 Request for Disaster Privileges

4.8.3.1 A "Temporary Disaster Privileges Request" form must be completed in person and submitted to MSMP with the following:

a. Current license to practice medicine in California

b. DEA certificate (if feasible)

c. Proof of malpractice insurance (if feasible)

d. Valid government-issued photo identification issued by a state or federal agency

e. Any one of the following:

i. Current picture hospital ID card with professional designation.

ii. Current license to practice or primary source verification of license by MSMP.

iii. Identification indicating the volunteer LIP has been granted authority to render patient care, treatment, and services during a disaster, or is a member of a Disaster Medical Assistance Team, the Medical Reserve Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, or another recognized organization either federal or of the state of California, or the city of Los Angeles/county of Los Angeles.

iv. In the absence of any one of the three (3) forms of verification noted above, a current Hospital employee or Medical Staff Member with personal knowledge of ability to act as a volunteer LIP during a disaster may attest to the identity of the volunteer LIP.

4.8.4 Credentialing of Volunteer Practitioners

4.8.4.1 The following shall be verified/queried, documented, filed, and completed within seventy-two (72) hours from the time the volunteer LIP begins working at the Hospital, by MSMP, upon receipt of a completed "Temporary Disaster Privileges Request" form:

a. California license/sanctions via website or telephone

b. Current competence

i. Telephone or fax "primary hospital affiliation" for confirmation of privileges, standing, status, restriction of privileges.

c. National Practitioner Data Bank (NPDB)

d. Sanctions by the Office of Inspector General (OIG) and the General Services Administration's Excluded Parties Listing Service

4.8.4.2 In the event that none of the above items are available via internet, hospitals unaffected by the disaster will be contacted via telephone and assistance with verifications requested.

4.8.5 Granting and Continuation of Disaster Privileges

4.8.5.1 Upon completion of the abbreviated credentialing process described above, MSMP shall notify the Medical Staff Chairman, who shall recommend temporary disaster privileges on a case-by-case basis.

4.8.5.2 At the discretion of the Medical Staff Chairman, volunteer LIPs shall be paired with a Practitioner currently on the Medical Staff, preferably of the same specialty. "Buddy" practitioners shall immediately report any concern regarding the volunteer LIP's competency to the Medical Staff Chairman and/or MSMP. The name of the "buddy" will be documented on the "Temporary Disaster Privileges Request" form.

4.8.5.3 Within seventy-two (72) hours from the time the volunteer LIP began working at the Hospital, the Chief Executive Officer, or a designee, will decide if the volunteer LIP's temporary disaster privileges should be continued.

4.8.5.4 The Chief Executive Officer or designee, at his/her sole discretion, may grant temporary disaster privileges.

4.8.6 Identification of Volunteer Practitioners

4.8.6.1 Once temporary disaster privileges have been granted to the volunteer LIP, his/her photo will be taken via digital camera (if feasible) and he/she will be issued a "Disaster Volunteer Practitioner" badge.

4.8.6.2 MSMP will affix the photo to the "Temporary Disaster Privileges Request" form and file, and record the badge and number in the "Disaster Volunteer Physician Badge Log."

4.8.6.3 MSMP shall notify appropriate Hospital departments (nursing, health information management, admitting, pharmacy, etc.) immediately (via telephone, email, etc.) of the approved volunteer LIP. A list of approved volunteer LIPs shall be maintained and published as feasible by MSMP.

4.8.7 Termination of Disaster Privileges

4.8.7.1 The Chief Executive Officer or designee at his/her discretion may terminate a volunteer LIP's temporary disaster privileges at any time without cause or reason.

4.8.7.2 The declaration of the Chief Executive Officer or designee that the emergency is over will automatically terminate all temporary disaster privileges.

4.8.7.3 Termination of temporary disaster privileges shall not give rise to hearing or appeal rights under the Medical Staff Bylaws, Rules, or any other authority.

4.8.8 Long-term, After-the-Fact Credentialing

4.8.8.1 As soon as the immediate emergency situation is under control, MSMP shall verify current competency and licensure for all volunteer LIPs, as if the volunteer LIPs were being granted one-time temporary privileges, if not already completed (see Section 4.5). MSMP shall report any irregularities immediately to the Medical Staff Chairman and the Chief Executive Officer. MSMP shall complete credentialing for volunteers no longer than three (3) months after the emergency is declared over.

4.8.8.2 All charts of patients cared for by volunteer LIPs shall be peer reviewed and results reported through the Multidisciplinary Peer Review Committee.

4.8.9 Medical Staff Management Specific Duties Related to Emergency Management

4.8.9.1 MSMP will maintain a paper roster to ensure that in cases of power failure, current roster information is available.

4.8.9.2 In the event of a disaster, all Medical Staff leadership will be contacted (Officers, Chiefs, Chairs, and Medical Directors) by MSMP. Medical Unit Directors, Department Chiefs, and Medical Staff officers shall be authorized to discharge patients in consult with the Incident Commander.

4.8.9.3 MSMP may maintain a primary emergency call tree roster of credentialed Practitioners who live within a ten (10)-mile radius at the beginning of each month. Active Staff Members will be contacted first. A secondary emergency call tree roster of credentialed Practitioners whose primary offices are within a ten (10) mile radius may also be maintained. Active Staff Members will be contacted first.

4.8.10 National Incident Management System "Credentialing Unit Leader"

4.8.10.1 In the event of a disaster, the Director and/or Manager of the Medical Staff Management Department will report to the Incident Commander or Operations Section Chief, as assigned, put on position identification, and meet with the Operations Section Chief and other Operations Section directors for briefing and development of an initial action plan.

4.8.10.2 The Director and/or Manager of Medical Staff Management will next meet with the Medical Staff Unit Leader (Medical Staff Chair, Vice Chair, or Secretary/Treasurer) who will determine if the Hospital requires all available credentialed Practitioners to come to the Hospital, per the

call tree priority listed above, or if additional (volunteer) LIPs are needed to handle immediate patient care needs.

4.8.10.3 In addition to the procedures related to temporary disaster privilege credentialing, MSMP shall inventory the number of medical and Allied Health Practitioner staff in-house as follows:

a. Physicians (critical and general care)

b. Medical Students, Residents, and Fellows

c. Physician-employed Allied Health Practitioners

4.8.10.4 MSMP will next inventory the number of Medical Staff per the primary and secondary emergency call tree rosters.

4.8.10.5 MSMP will distribute a list of approved voluntary LIPs as feasible every twelve (12) hours, and the ability to meet workload demands will be evaluated by the Medical Staff Chairman every twenty-four (24) hours.

4.8.10.6 A debriefing report on lessons learned and procedural/equipment changes needed will be reviewed at the next Medical Executive Committee meeting.

ARTICLE V: ALLIED HEALTH PRACTITIONERS

5.1 Qualifications of Allied Health Practitioners

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

5.2 Categories

The Board of Trustees shall determine, based upon comments of the Medical Executive Committee and such other information as it has before it, those categories of AHPs that shall be eligible to exercise practice prerogatives in the Hospital. Such categories are set forth in the Medical Staff Rules.

Such AHPs shall be subject to the supervision requirements developed in each Department and approved by the Interdisciplinary Practices Committee, the Medical Executive Committee, and the Board of Trustees.

5.3 Practice Prerogatives, Responsibilities, and Procedural Rights

The practice prerogatives and responsibilities of AHPs shall be established and reviewed as provided in the Rules. AHP procedural rights shall be those specified in the Rules.

ARTICLE VI: MEDICAL STAFF OFFICERS, DEPARTMENT CHIEFS, AND MEDICAL DIRECTORS

6.1 Identification

6.1.1 Medical Staff General Officers

The general officers of the Medical Staff shall be the (1) Medical Staff Chairman, (2) Vice Chairman, (3) Immediate Past Chairman, and (4) Secretary-Treasurer.

6.1.2 Qualifications

All Medical Staff general officers shall:

6.1.2.1 Understand the purposes and functions of the Medical Staff and demonstrate willingness to assure that patient welfare always takes precedence over other concerns;

6.1.2.2 Understand and be willing to work towards attaining the Hospital's lawful and reasonable policies and requirements;

6.1.2.3 Have administrative ability as applicable to the respective office;

6.1.2.4 Be able to work with and motivate others to achieve the objectives of the Medical Staff and the Hospital;

6.1.2.5 Demonstrate clinical competence in his or her field of practice;

6.1.2.6 Be an Active Medical Staff Member (and remain in good standing as an Active Medical Staff Member while in office); and

6.1.2.7 Not have any significant conflict of interest.

6.1.3 Disclosure of Conflict of Interest

All nominees for election or appointment to a Medical Staff office (including those nominated by petition of the Medical Staff pursuant to the Bylaws and the Rules) shall, at least twenty (20) days prior to the date of the election or appointment, disclose in writing to the Medical Executive Committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware that could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff. The Medical Executive Committee shall evaluate the significance of such disclosures and discuss any significant conflicts with the nominee. If a nominee with significant conflict of interest remains on the ballot, the nature of his or her conflict shall be disclosed in writing and circulated with the ballot.

6.2 Method of Selection of General Officers

6.2.1 Nominations

A Nominating Committee shall be appointed by the Chairman of the Medical Staff no later than the first of July each year. The committee shall consist of one (1) member of the Medical Executive Committee and two (2) members of the Active Staff who are not Medical Executive Committee members.

The Nominating Committee will propose a slate of candidates for each open office. The Nominating Committee will present its slate of officer candidates to the Medical Executive Committee at least eight (8) weeks prior to the election. The Medical Staff Management Department will mail the slate of candidates to the Active Staff along with the process for additional nominations within ten (10) days following the Medical Executive Committee meeting. Additional nominations may be made by a petition signed by at least ten (10) Active Staff

Members that is submitted to the chairman of the Nominating Committee at least thirty (30) days prior to the day of the annual Medical Staff meeting. The slate of candidates (nominees and petitioner candidates) shall be distributed to the Active Staff Members at least twenty-one (21) days prior to the date of the annual Medical Staff meeting. Nominations from the floor and write-in nominations will not be accepted.

6.2.2 Election

Officers shall be elected by a written mail ballot and the results shall be announced at the annual Medical Staff meeting of the Medical Staff. Only Active Staff Members shall be eligible to vote. Voting shall be by secret written ballot.

The ballots shall be mailed at least twenty-one (21) days prior to the annual Medical Staff meeting to the Active Staff Members. The ballots must be received in the Medical Staff Management Department no later than 16:30 on the day prior to the day of the annual Medical Staff meeting.

A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate for the office receives a majority vote on the first ballot, a runoff election shall be held promptly between the two (2) candidates receiving the highest number of votes.

If the candidates are unopposed, there will be no need to have an election and the officers will be deemed elected.

6.2.3 Immediate Past Chairman

The Medical Staff Chairman, upon expiration of his term, immediately succeeds to the office of Immediate Past Chairman.

6.2.4 Term of Office –

Each officer shall serve a one (1) year term, commencing on the first day of the Medical Staff Year following his or her election. Each officer shall serve until the end of his or her term and until a successor is elected, unless he or she shall sooner resign or be removed from office. No general officer (with the exception of Secretary-Treasurer) shall hold the same office for more than three (3) consecutive terms).

6.3 Removal from Office

A Medical Staff officer may be removed from office for any valid cause, including, but not limited to, failure to carry out the duties of his or her office. Removal of a general officer may be initiated by a majority vote of the Medical Executive Committee, a majority vote of the Board of Trustees, or upon the written request of one third (1/3) of the Active Staff Members. Removal shall be considered at a special Medical Staff meeting called for that purpose. Such removal may be effected by a two-thirds (2/3) vote of the ballots from Active Staff Members. Voting on removal of an elected officer shall be by secret written ballot which shall be distributed and collected at the special Medical Staff meeting. The ballots shall be counted by the Secretary-Treasurer of the Medical Staff (except when he or she is the subject of the balloting, in which case the Medical Staff Chairman shall count the ballots) and the Director of Medical Staff Management.

6.4 Filling Vacancies

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

6.4.1 a vacancy in the office of the Medical Staff Chairman shall be filled by the Vice-Chairman;

6.4.2 a vacancy in the office of the Vice-Chairman or Secretary-Treasurer shall be filled by appointment by the Medical Executive Committee; and

6.4.3 a vacancy in the office of the Immediate Past Chairman need not be filled, except that the Medical Executive Committee may appoint qualified successors to serve as chair of or as a member of any committee that the Immediate Past Chairman is automatically appointed to pursuant to the Bylaws and the Rules.

6.5 Duties of Officers

6.5.1 Medical Staff Chairman

The Medical Staff Chairman shall serve as the chief officer of the Medical Staff. The duties of the Medical Staff Chairman shall include, but not be limited to:

6.5.1.1 maintain constructive communication with the Chief Executive Officer in all matters of mutual concern with the Hospital;

6.5.1.2 call, preside at, and be responsible for the agenda of all Medical Staff meetings;

6.5.1.3 serve as chair of the Medical Executive Committee;

6.5.1.4 serve as an ex-officio member of all other Medical Staff committees without vote, unless his or her membership on a particular committee is required by the Bylaws and/or the Rules;

6.5.1.5 be responsible for the enforcement of the Medical Staff Bylaws and Rules, implementing sanctions where indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a Practitioner;

6.5.1.6 appoint, with Medical Executive Committee approval, committee members to all standing and special Medical Staff committees, except where otherwise provided by the Bylaws and/or the Rules;

6.5.1.7 serve as a member of the Board of Trustees in such capacity as may be permitted or required by the Hospital's corporate bylaws;

6.5.1.8 represent the views, policies, needs, and grievances of the Medical Staff to the Board of Trustees and to the Chief Executive Officer;

6.5.1.9 interpret the policies of the Board of Trustees to the Medical Staff;

6.5.1.10 be a spokesman for the Medical Staff in external professional and public relations; and

6.5.1.11 perform such other functions as may be assigned to him or her by the Bylaws and the Rules, by the Medical Staff, by the Medical Executive Committee, or by the Board of Trustees.

6.5.2 Vice Chairman

The Vice Chairman, in the absence of the Medical Staff Chairman, shall assume all duties and authority of the Chairman; perform such other supervisory duties as the Chairman may assign to him or her; and carry out such other functions as may be delegated to him or her by the Bylaws and the Rules, by the Medical Staff, by the Medical Executive Committee, or by the Board of Trustees. He or she shall automatically succeed the Chairman when the latter fails to serve for any reason.

6.5.3 Immediate Past Chairman

The Immediate Past Chairman shall be a member of the Medical Executive Committee; be the representative to the Hospital Medical Staff Sections of the American Medical Association, California Medical Association, and the Los Angeles County Medical Association; perform such other duties as the Medical Staff Chairman may assign him-or her; and carry out other such functions as may be delegated to him or her by the Bylaws and the Rules, by the Medical Staff, by the Medical Executive Committee, or by the Board of Trustees.

6.5.4 Secretary-Treasurer

The Secretary-Treasurer shall be a member of the Medical Executive Committee; keep accurate and complete minutes of all Medical Executive Committee and Medical Staff meetings; call meetings on the order of the Medical Staff Chairman; attend to all correspondence; receive, safeguard, and be accountable for all funds of the Medical Staff; and perform such other duties as ordinarily pertain to his or her office or as may be delegated to him or her by the Bylaws and the Rules, by the Medical Staff, by the Medical Executive Committee, or by the Board of Trustees.

6.5.5 Compensation

The Chairman of the Medical Staff, the Vice Chairman, and the Secretary-Treasurer shall receive monetary compensation in an amount to be determined annually by the Medical Executive Committee.

6.6 Medical Directors

6.6.1 Appointment

Medical Directors for special units (such as the intensive care unit, or others as defined by California Code of Regulations, Title 22) and Departments may be appointed by the Chief Executive Officer after consulting with the Board of Trustees and the Medical Executive Committee.

6.6.2 Responsibilities

6.6.2.1 The duties of Medical Directors shall be delineated by the Chief Executive Officer in keeping with the general provisions set forth below. The Medical Executive Committee shall approve any Medical Director duties that relate to authority to perform functions on behalf of the Medical Staff or that directly affect the performance or activities of the Medical Staff.

6.6.2.2 In keeping with the foregoing, Medical Directors may:

a. serve as administrative liaison among Hospital administration, the Board of Trustees, outside agencies, and the Medical Staff; and

b. assist the Medical Staff in performing its assigned functions and coordinating such functions with the responsibilities and programs of the Hospital.

6.7 Department Chiefs

6.7.1 Qualifications

Each Department Chief shall:

6.7.1.1 be willing and able to faithfully discharge the functions of his or her office;

6.7.1.2 be board certified or board admissible in his or her particular specialty;

6.7.1.3 have demonstrated clinical competence in his or her field of practice sufficient to maintain the respect of the members of his or her Department;

6.7.1.4 have an understanding of the purposes and functions of the Medical Staff organization and a demonstrated willingness to promote patient safety over all other concerns;

6.7.1.5 have an understanding of and willingness to support and promote the Hospital's efforts toward attaining its lawful and reasonable goals;

6.7.1.6 have an ability 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 goals;

6.7.1.7 be (and remain during tenure in office) a Member of the Medical Staff in good standing; and

6.7.1.8 not have any significant conflict of interest.

6.7.2 Procedures for Selecting Department Chiefs

Department Chiefs are appointed by the Medical Staff Chairman subject to the approval of the Medical Executive Committee and the Board of Trustees.

6.7.3 Term of Office

All Department Chiefs shall serve a one (1) year term commencing on the first day of the Medical Staff Year following their appointment and until their successors are chosen, unless they shall sooner resign, be removed from office, or lose their Medical Staff membership or Privileges in that Department. Department Chiefs are eligible to succeed themselves.

6.7.4 Resignation and Grounds for and Procedures for Removing Department Chiefs

6.7.4.1 Resignation

Unless the Practitioner's contract or employment arrangement with the Hospital provides otherwise, a Department Chief may resign at any time by giving written notice to the Medical Executive Committee and the Chief Executive Officer. A resignation and takes effect on the date of receipt of the written notice or at any later time specified in such written notice.

6.7.4.2 Removal (Contract or Employment Arrangement)

The grounds and procedure for removing a Department Chief who has a contract or employment arrangement with the Hospital are governed by the terms of the contract or employment arrangement. Where the terms of the contract or employment arrangement do not address such grounds and procedure, the provisions of Section 6.7.4.3 shall apply.

6.7.4.3 Removal (Non-Contract or Non-Employment Arrangement)

A Department Chief may be recalled from office for any good cause, including, but not limited to, failure to carry out the duties of his or her office. Removal of a Department Chief from office may be initiated by the Medical Executive Committee, the Board of Trustees, or by written request from twenty percent (20%) of the members of the Department who are eligible to vote. Such removal may be effected by a two-thirds (2/3) vote of the Department members eligible to vote on Department matters, but is not final until ratified by the Medical Executive Committee. All voting shall be conducted by written secret mail ballot, which shall be sent to those eligible to vote within forty-five (45) days after the initiation of removal pursuant to this section. Completed ballots must be received no later than twenty-one (21) days after they are mailed and shall be counted by the Medical Staff Chairman, Secretary-Treasurer, and the

Director of Medical Staff Management. No removal shall be effective unless and until it is ratified by the Medical Executive Committee.

6.7.5 Filling Vacancies

A vacancy in a Department leadership position shall be filled in the same manner in which the leader was originally selected.

6.7.6 Responsibilities of Department Chiefs

Each Department Chief shall be responsible for:

6.7.6.1 All Department clinical activities.

6.7.6.2 All administrative activities of the Department (unless otherwise provided for by the Hospital).

6.7.6.3 Working with the Administrative Vice-President on matters that affect the Department.

6.7.6.4 Integrating the Department into the primary functions of the Hospital.

6.7.6.5 Coordinating and integrating interdepartmental and intradepartmental services.

6.7.6.6 Developing and implementing policies and procedures that guide and support the provision of services in the Department.

6.7.6.7 Recommending a sufficient number of qualified and competent persons to provide care/services in the Department.

6.7.6.8 Continuing surveillance of the professional performance of all individuals who have delineated Privileges and practice prerogatives in the Department.

6.7.6.9 Recommending the criteria for Privileges and practice prerogatives in the Department.

6.7.6.10 Recommending Privileges and practice prerogatives for each member of the Department and each Medical Staff Member desiring to exercise Privileges and practice prerogatives in the Department.

6.7.6.11 Evaluating the qualifications and competence of Allied Health Practitioners who provide patient care services within the purview of the Department.

6.7.6.12 Continuously assessing and improving the quality of care and services provided in the Department.

6.7.6.13 Investigating, when necessary, professional conduct of Department members and/or cases that may require corrective action.

6.7.6.14 Maintaining quality control programs, as appropriate, in coordination with the Performance Improvement Council.

6.7.6.15 Overseeing the orientation and continuing education of all persons in the Department, in coordination with the Medical Staff committee(s) responsible for continuing medical education.

6.7.6.16 Making recommendations regarding space and other resources needed by the Department.

6.7.6.17 Making recommendations to the relevant Hospital authority with respect to off-site sources needed for patient care services not provided by the Department or Hospital.

6.7.6.18 Deciding when to convene Department meetings and chairing those meetings.

6.7.6.19 Service as an ex-officio member of all committees of his or her Department and attending such committee meetings as deemed necessary.

6.7.6.20 Assuring that records of performance are maintained and current for all members of his or her Department.

6.7.6.21 Reporting on activities of the Department and/or the Medical Staff to the Board of Trustees when called upon to do so by the Medical Staff Chairman or the Chief Executive Officer.

6.7.6.22 Performing such additional responsibilities as may be delegated to him or her by the Medical Executive Committee or the Medical Staff Chairman.

6.7.6.23 Determining the qualifications and competence of Department personnel who are not licensed independent practitioners and who provide patient care, treatment, and services.

ARTICLE VII: COMMITTEES

7.1 General

7.1.1 Designation

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

7.1.2 Appointment of Members and Conduct of Business

Unless otherwise specified in these Bylaws, the chair and members of all committees shall be appointed as provided in the Rules. The business of committees shall be conducted as provided in the Rules.

7.1.3 Term of Committee Members

Unless otherwise specified in these Bylaws, committee members shall be appointed for the term specified in the Rules.

7.1.4 Removal of Committee Members

Unless otherwise specified in these Bylaws, committee members shall be removed as provided in the Rules.

7.1.5 Vacancies

Unless otherwise specified in these Bylaws, vacancies on any committee shall be filled as provided in the Rules.

7.1.6 Conduct and Record of Meetings

Committee meetings shall be conducted and documented as provided in the Rules.

7.2 Medical Executive Committee

7.2.1 Composition

The Medical Executive Committee shall be composed of the Medical Staff officers, the Department Chiefs, and chairs of the Credentials and Privileging Committee, Performance Improvement Council, and Utilization Management Committee. The Chief Executive Officer and Vice-President of Patient Care Services shall serve as ex-officio members without vote. The chair may appoint additional members (practitioners/individuals) up to eight (8) additional members. Such appointed members are entitled to vote on committee matters. The Medical Staff Chairman shall chair the Medical Executive Committee. The Vice-Chairman shall chair the committee if the Chairman is absent. The Chairman of the Good Samaritan Board of Trustees may attend the meeting without vote.

7.2.2 Duties

With assistance from the Medical Staff Chairman, the Medical Executive Committee shall:

7.2.2.1 Supervise the performance of Medical Staff functions, which shall include:

a. requiring regular reports and recommendations from the Medical Staff officers, Hospital officers, Department Chiefs, and Medical Staff committees concerning discharge of assigned functions;

b. issuing such directives as appropriate to assure effective performance of all Medical Staff functions; and

c. following-up to assure implementation of all directives.

7.2.2.2 Coordinate the activities of all Medical Staff committees and Department Chiefs.

7.2.2.3 Based on input from the Department Chiefs and the Credentials and Privileging Committee, make recommendations regarding all applications for Medical Staff or AHP appointment, reappointment, Privileges, and practice prerogatives.

7.2.2.4 When indicated, initiate and/or pursue disciplinary or corrective actions affecting Medical Staff Members or AHPs.

7.2.2.5 Supervise the Medical Staff's compliance with:

a. the Medical Staff Bylaws, Rules, and policies;

b. the Hospital Bylaws, Rules, and policies;

c. state and federal laws and regulations; and

d. accreditation requirements.

7.2.2.6 Oversee the development of Medical Staff policies, approve (or amend) all such policies, and oversee the implementation of such policies.

7.2.2.7 Implement, as it relates to the Medical Staff, the approved policies of the Hospital.

7.2.2.8 With the Department Chiefs, set Department objectives for establishing, maintaining, and enforcing professional standards within the Hospital, and for the continuing improvement of the quality of care rendered in the Hospital, and assist in developing programs to achieve these objectives.

7.2.2.9 Regularly report to the Board of Trustees through the Medical Staff Chairman and Chief Executive Officer on at least the following:

a. the outcomes of quality improvement programs with sufficient background and detail to assure the Board of Trustees that quality of care is consistent with professional standards; and

b. the general status of any Medical Staff or AHP disciplinary or corrective action in progress.

7.2.2.10 Make recommendations to the Board of Trustees regarding the structure of the Medical Staff, the mechanism used to review credentials and to delineate individual clinical privileges, the organization of the quality assessment and improvement activities of the Medical Staff as well as the mechanism used to conduct, evaluate, and revise such activities, the mechanism by which membership on the Medical Staff may be terminated, and the mechanism for hearing procedures (this responsibility may be satisfied by way of Medical Staff Bylaws and Rules addressing such issues).

7.2.2.11 Review and make recommendations to the Chief Executive Officer regarding quality of care and utilization review issues related to exclusive contract arrangements for professional medical services. In addition, the Medical Executive Committee shall cooperate in providing relevant input to notice-and-comment proceedings or other mechanisms that may be implemented by Hospital administration in making exclusive contract decisions.

7.2.2.12 Establish, as necessary, such ad hoc committees that will fulfill particular functions for a limited time and will report directly to the Medical Executive Committee.

7.2.2.13 Establish the date, place, time, and program of the regular meetings of the Medical Staff, including the annual Medical Staff meeting.

7.2.2.14 Act on behalf of the Medical Staff in the intervals between its (regular) meetings.

7.2.3 Meetings

The Medical Executive Committee shall meet at least ten times during the Medical Staff Year.

7.2.4 The authority delegated pursuant to this section may be removed by amendment of these Bylaws.

7.3 Ad Hoc Dispute Resolution Committee

All disputes between the Board of Trustees/Hospital administration and the Medical Staff (Parties) relating to the Medical Staff's rights of self-governance as set forth in California Business and Professions Code Section 2282.5 (Disputes), which have not been resolved by informal meetings and discussions, shall be addressed and resolved in accordance with the meet and confer process of an Ad Hoc Dispute Resolution Committee (AHDRC), as described in this section.

7.3.1 Invoking the Dispute Resolution Process

The Medical Executive Committee may invoke this dispute resolution process upon its own initiative. If the Medical Executive Committee declines to invoke this dispute resolution process, such process may be invoked upon written petition signed by at least twenty percent (20%) of the voting Members of the Medical Staff. In the event a Party determines a dispute exists, such Party shall give written notice to the other Party, stating the nature of the dispute. Within three (3) business days following receipt of such notice, both Parties shall appoint representatives to an AHDRC, as provided below. Neither Party shall initiate any legal action related to the dispute until this committee has completed its efforts to resolve the dispute.

7.3.2 Composition

The AHDRC shall be composed of two (2) members appointed by the Board of Trustees and two (2) members appointed by the Medical Executive Committee. The four (4) members shall appoint a fifth member. Appointees shall not include Medical Staff officers and shall not include individuals with direct administrative responsibility at the Hospital. In even numbered years, the chair of the AHDRC shall be designated by the Board of Trustees and in odd numbered years, the chair of the AHDRC shall be designated by the Chief of Staff.

7.3.3 Duties

When formed, the AHDRC shall within thirty (30) days, receive and review written requests for initiation of the meet and confer/dispute resolution process, and gather information relevant to the dispute. The AHDRC, with such assistance and input as it may request, shall then meet and work in good faith to manage and, if possible, recommend a resolution of the dispute. Such efforts shall continue, as necessary, for up to sixty (60) days. The AHDRC shall report the results of its efforts and its recommendations to both the Medical Executive Committee and the Board of Trustees. Unless requested by the Parties to continue its deliberations, the AHDRC shall dissolve thirty (30) days following the reporting of its results and recommendations. Approval of the report on the recommendations from the AHDRC requires a majority vote of the committee. The Board of Trustees shall make its final determination giving great weight to the actions and recommendations of the

Medical Executive Committee and the ADHRC. In such instances, the Board of Trustees' determination shall not be arbitrary or capricious, and shall be consistent with its legal responsibilities to ensure responsible and effective governance of the Hospital and to protect the quality of medical care provided to its patients.

7.4 Organization of Departments

Each Department shall be organized as an integral part of the Medical Staff and have a Chief who is selected and delegated authority, duties, and responsibilities specified in these Bylaws and the Rules. Additionally, each Department may appoint a Department committee and other such standing or ad hoc committees as it deems appropriate to perform its required functions. The composition and responsibilities of each standing Department committee shall be specified in the Rules.

7.5 Designation

Current Departments shall be designated in the Rules. The Medical Executive Committee will periodically restudy the designation of the Departments and recommend to the Board of Trustees what action is desirable in creating, eliminating, or combining Departments for better organizational efficiency and improved patient care. Action shall be effective upon approval by the Medical Executive Committee and the Board of Trustees without any need of amendment of these Bylaws.

7.6 Assignment to Departments

Each Medical Staff Member shall be assigned membership in at least one Department, but may be granted membership and/or Privileges in other Departments.

7.7 Functions of Departments

The Departments shall fulfill the clinical, administrative, quality improvement, risk management, utilization management, collegial, and education functions described in the Rules. When the Department or any Department committee meets to carry out the duties described in the Rules, the meeting body shall constitute a peer review body, which is subject to the standards and entitled to the protections and immunities afforded by federal and state law for peer review bodies.

ARTICLE VIII: MEETINGS

8.1 Medical Staff Meetings

8.1.1 Regular Meetings

There shall be at least one meeting of the Medical Staff during each Medical Staff Year. The date, place, and time of the meeting(s) shall be determined by the Medical Staff Chairman. The Medical Staff Chairman shall present a report on significant actions taken by the Medical Executive Committee during the time since the last Medical Staff meeting and on other matters to be of interest and value to the membership.

8.1.2 Special Meetings

Special meetings of the Medical Staff may be called at any time by the Medical Staff Chairman, Medical Executive Committee, or the Board of Trustees, or upon the written request of ten percent (10%) of the voting Members of the Medical Staff. The meeting must be called within thirty (30) days after receipt of such request. No business shall be transacted at any special Medical Staff meeting except that stated in the Notice calling the meeting.

8.1.3 Combined or Joint Medical Staff Meetings

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

8.2 Department and Committee Meetings

8.2.1 Regular Meetings

Departments and committees may provide, by resolution, the day(s) and the time(s) that regular meetings shall be held. Whenever so provided, no additional Notice of regular meetings shall be required. Each Department shall meet at the request of the Department Chief as necessary to review and discuss patient care activities and to fulfill other Department responsibilities.

8.2.2 Special Meetings

A special meeting of any Department or committee may be called by, or at the request of the Department Chief or the committee chair, the Medical Executive Committee, the Medical Staff Chairman, or by thirty-three and one-third percent (33 1/3%) of the Department or committee's current voting members, but not fewer than three (3) members. No business shall be transacted at any special meeting except that stated in the Notice calling the meeting.

8.2.3 Combined or Joint Department or Committee Meetings

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

8.3 Notice of Meetings

Written Notice stating the date, place, 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 either personally, by mail, by facsimile, or by e-mail to each person entitled to be present not less than two (2) business days before the date of such meeting. Personal attendance at a meeting shall constitute a waiver of Notice of such meeting.

8.4 Quorum

8.4.1 Medical Staff Meetings

The presence of twenty-five percent (25%) of the voting Medical Staff Members at any regular or special meeting, either in person or through written mail ballot, shall constitute a quorum.

8.4.2 Committee Meetings

The presence of fifty percent (50%) of the voting members shall be required for Medical Executive Committee meetings. For other committees, a quorum shall consist of two (2) voting committee members, unless otherwise specified in the Rules.

8.4.3 Department Meetings

The presence of at least ten percent (10%) and no less than three (3) of the voting members of the Department at a meeting shall constitute a quorum, unless otherwise specified in the Rules.

8.5 Manner of Action

8.5.1 Action at a Meeting

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. Where good cause exists and upon prior approval by the meeting chair, a member may participate in a meeting by telephone and be considered present. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be required by these Bylaws or the Rules. The meeting chair shall refrain from voting except when necessary to break a tie.

8.5.2 Telephonic and Virtual Meetings

Department or committee action may be conducted by telephone conference, which shall be deemed to constitute a meeting for the matters discussed in that telephone conference. Notice of such telephone conference shall be provided to each Department or committee member, as set forth in Section 9.3. The quorum requirements for a meeting conducted by telephone will be the same as if the meeting were conducted in person. When cause exists, a Department Chief or committee chair may hold a virtual meeting using e-mail. E-mail meetings will only be used when members are being asked to vote on one or more specific issues. Each specific issue will be clearly defined in the e-mail Notice. Members will have forty-eight (48) hours after the e-mail Notice has been sent to respond to the meeting chair or designee, with their votes regarding the specific issues. The quorum requirements for voting by e-mail will be the same as if the meeting were conducted in person, which means action may be taken only if votes are received from at least the minimum number of members required for a quorum. Votes submitted after forty-eight (48) hours will not be considered. A record of such telephonic or virtual meetings and any action taken shall be maintained within the appropriate permanent minute file.

8.5.3 Action by Written Consent

Valid action may be taken without a meeting if a consent to the action is signed by at least simple majority of the members entitled to vote. A record of such action and consent shall be maintained within the appropriate permanent minute file.

8.5.4 Action by Written Mail Ballot

Unless otherwise specified in these Bylaws and the Rules, whenever required by the Medical Staff Bylaws or ordered by the Medical Executive Committee, a matter may be submitted for Medical Staff action by written mail ballot. When voting is to be conducted by written mail ballot, the Medical Staff Management Department shall issue ballots. To be valid, each written mail ballot must be received by the Medical Staff Management Department by the return date designated on the ballot, which shall be at least twenty-one (21) days from the date the ballot is issued, unless otherwise specified in these Bylaws and the Rules. The Medical Staff Chairman or Vice Chairman, or their designees, shall count the ballots, unless otherwise specified in these Bylaws and the Rules. An action by written mail ballot shall be effected by a majority vote of the valid ballots actually cast, provided ballots are received from at least the minimum number of members that would be required for a quorum if the action had been taken at a meeting or such greater number as may be specifically required. Whenever a matter is acted upon by written mail ballot, a record of such action shall be maintained within the appropriate permanent minutes file.

8.6 Minutes

Minutes of all meetings shall be prepared and shall include a record of the attendance of members and the vote taken on all matters. A summary of the action items shall be forwarded to the Medical Executive Committee and Board of Trustees. Each committee and Department 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 protection from discovery as provided by federal and state law.

8.7 Attendance Requirements

Medical Staff Members are encouraged, but not required, to attend Medical Staff, Department, and committee meetings. Committee members who fail to attend sixty percent (60%) of the meetings may be removed from the committee.

8.8 Special Appearance

A committee or Department, at its discretion, may require a Practitioner to respond to specific questions concerning the care of a patient or professional behavior, either in writing or by appearing at a meeting. If appearance at a meeting is required, the committee chair or Department Chief should try to give the Practitioner at least ten (10) business_days advance written Special_Notice of the date, place, and time of the meeting. In addition, whenever a written response or an appearance is requested because of an apparent or suspected deviation from standard clinical practice, Special Notice shall be given and shall include a statement of the issue involved and inform the Practitioner that his or her response or appearance, as applicable, is mandatory. Failure of a Practitioner to respond in writing by the specified deadline date or to appear at any meeting with respect to which he or she was given Special Notice, absent an approved postponement for good cause, shall be cause for the Medical Executive Committee to impose an automatic suspension of all or such portion of the Practitioner’s Privileges as the Medical Executive Committee may direct_until an appearance is made or other action is taken by the Medical Executive Committee.

8.9 Conduct of Meetings

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

ARTICLE IX: CONFIDENTIALITY, IMMUNITY, AND RELEASES

9.1 Authorization and Conditions

By applying for and/or exercising Privileges or practice prerogatives within this Hospital, a Practitioner or AHP:

a. Authorizes representatives of the Hospital and the Medical Staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the Practitioner or AHP's professional ability and qualifications.

b. Authorizes persons and organizations to provide information, including otherwise privileged or confidential information, concerning the Practitioner or AHP to the Hospital and the Medical Staff.

c. Agrees to be bound by the provisions of this Article and to waive all legal claims against any representative of the Hospital or the Medical Staff who acts in accordance with the provisions of this Article to the fullest extent permitted by law.

d. Acknowledges that the provisions of this Article are express conditions to the granting of Medical Staff membership, the continuation of such membership, and the exercise of Privileges or practice prerogatives at this Hospital.

9.2 Confidentiality of Information

9.2.1 General

Medical Staff, Department or committee minutes, files, and records, including information regarding any Member or applicant to this Medical Staff shall, to the fullest extent permitted by law, be confidential. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall become part of the Medical Staff files and shall not become part of any particular patient's file or of any general Hospital records. Dissemination of such information and records shall be made only where expressly required by law, pursuant to officially adopted policies of the Medical Staff, or where no officially adopted policy exists, only with the express approval of the Medical Executive Committee or its designee and the Chief Executive Officer.

9.2.2 Breach of Confidentiality

Inasmuch as effective credentialing, quality improvement, peer review, and consideration of qualifications of Medical Staff Members and applicants to perform specific procedures must be based on free and candid discussions, and inasmuch as Practitioners and others participate in credentialing, quality improvement, and peer review activities with the reasonable expectation that this confidentiality will be preserved and maintained, any breach of confidentiality of the discussions or deliberations of the Medical Staff, Departments, or committees, except in conjunction with another healthcare entity, healthcare facility, professional society, or licensing authority, is outside appropriate standards of conduct for the Medical Staff and will be deemed disruptive to the operations of the Hospital. If determined that such a breach has occurred, the Medical Executive Committee may undertake such corrective action as it deems appropriate.

9.3 Immunity from Liability

9.3.1 Immunity from Liability for Providing Information or Taking Action

The Medical Staff, the Hospital, each representative of the Medical Staff and the Hospital, and all third parties shall be exempt from liability to an applicant, Member, Practitioner, or other individual exercising Privileges or practice prerogatives for damages or other relief by reason of providing information to the Medical Staff, the Hospital, a representative of the Medical Staff or Hospital, or any other healthcare-related organization concerning such person who is, or has been, an applicant to or Member of the Medical Staff or who did, or does, exercise Privileges or provide services at the Hospital or by reason of otherwise participating in a Medical Staff or Hospital credentialing, quality improvement, or peer review activity.

9.3.2 Activities and Information Covered

9.3.2.1 Activities

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

a. applications for appointment, Privileges, or specified services;

b. periodic reappraisals for reappointment, Privileges, or specified services;

c. corrective action;

d. hearings or appellate reviews;

e. quality improvement review, including patient care audit;

f. peer review;

g. utilization reviews;

h. morbidity and mortality conferences; and

i. other Hospital, Department, or committee activities related to monitoring and improving the quality of patient care and appropriate patient conduct.

9.3.2.2 Information

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

9.4 Releases

Each applicant, Member, Practitioner, or other individual exercising Privileges or practice prerogatives shall, upon request of the Hospital, execute general and specific releases in accordance with the tenor and import of this Article; however, execution of such release shall not be deemed a prerequisite to the effectiveness of this Article.

9.5 Cumulative Effect

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

9.6 Indemnification

The Hospital shall indemnify, defend, and hold harmless the Medical Staff and its individual Members (Indemnitees) from and against losses and expenses (including attorney's fees, judgments, settlements, and all other costs, direct or indirect) incurred or suffered by reason of or based upon any threatened, pending or completed action, suit,

proceeding, investigation, or other dispute relating or pertaining to any alleged act or failure to act within the scope of peer review or quality assessment activities, including, but not limited to:

a. as a member of or witness for a Medical Staff Department, committee, or hearing committee;

b. as a member of or witness for the Board of Trustees or any Hospital committee; and

c. as a person providing information to any Hospital or Medical Staff group, officer, Board member, or employee for the purpose of aiding in the evaluation of the qualifications, fitness, or character of a Medical Staff Member or applicant.

The Hospital shall retain responsibility for the sole management and defense of any such claims, suits, investigations or other disputes against Indemnitees, including, but not limited to, selection of legal counsel to defend against any such actions. Indemnification may be provided only if it meets the standards set forth in the Hospital corporate bylaws for indemnification of Hospital officers, agents and representatives.

ARTICLE X: CORRECTIVE ACTION – HEARINGS AND APPEALS

10.1 Corrective Action

10.1.1 Criteria for Initiation

A corrective action investigation may be initiated whenever reliable information indicates a Member may have exhibited acts, demeanor, or conduct, either within or outside of the Hospital, that is reasonably likely to be (a) detrimental to patient safety or to the delivery of quality patient care within the Hospital; (b) unethical; (c) contrary to the Medical Staff Bylaws or Rules; (d) below applicable professional standards; (e) disruptive of Medical Staff or Hospital operations; or (f) an improper use of Hospital resources.

10.1.1.1 Initiation

a. Any person who believes that corrective action may be warranted may provide information to the Medical Staff Chairman, the Medical Staff Management Department, any Department Chief, any Medical Staff committee, the chair of any Medical Staff committee, the Board of Trustees, or the Chief Executive Officer.

b. If the Medical Staff Chairman, the Medical Staff Management Department, any Department Chief, any Medical Staff committee, the chair of any Medical Staff committee, the Board of Trustees, or the Chief Executive Officer determines that corrective action may be warranted, that person, entity, or committee may request the initiation of a corrective action investigation or may recommend particular corrective action. Such requests may be conveyed to the Medical Executive Committee orally or in writing.

c. The Medical Executive Committee chair shall notify the Chief Executive Officer and shall continue to keep him or her fully informed of all actions taken. In addition, the Medical Executive Committee chair shall immediately forward all necessary information to the committee or person that will conduct any investigation provided, however, that the Medical Staff Chairman or the Medical Executive Committee may dispense with further investigation of matters deemed to have been adequately investigated by a committee.

10.1.1.2 Expedited Initial Review

a. Whenever information suggests that corrective action may be warranted, the Medical Staff Chairman or his or her designee may, on behalf of the Medical Executive Committee, immediately investigate and conduct whatever interviews may be indicated. The information developed during this initial review shall be presented to the Medical Executive Committee, which shall decide whether to initiate a corrective action investigation or recommend corrective action.

b. In cases of complaints of harassment or discrimination involving a patient or patient visitor, an expedited initial review shall be conducted on behalf of the Medical Executive Committee by the Medical Staff Chairman or his or her designee, together with representatives of administration or by an attorney for the Hospital. In cases of complaints of harassment or discrimination where the alleged harasser is a Medical Staff Member and the complainant is not a patient or patient visitor, an expedited initial review shall be conducted by the Medical Staff Chairman and the Hospital's Human Resources Director or their designees, or by an attorney for the Hospital. If he or she does not conduct the review, the Medical Staff Chairman shall be kept apprised of the status of the initial review. The information developed during this expedited initial review shall be presented to the Medical Executive Committee,

which shall decide whether to initiate a corrective action investigation or recommend corrective action.

10.1.1.3 Investigation

a. If the Medical Executive Committee concludes an investigation is warranted, it shall direct an investigation be undertaken. The Medical Executive Committee may conduct the investigation itself or may assign the task to an appropriate officer or standing or ad hoc committee. The Medical Executive Committee, in its discretion, may appoint Practitioners who are not Members of the Medical Staff as temporary members of the Medical Staff for the sole purpose of conducting or aiding in the conduct of an investigation. If the investigation is delegated to an officer or committee other than the Medical Executive Committee, such officer or committee shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the Medical Executive Committee as soon as practicable. The report may include recommendations for appropriate corrective action. If the Medical Executive Committee concludes action is indicated but no further investigation is necessary, it may proceed to recommend action.

b. Prior to any adverse action being approved, the Medical Executive Committee shall assure that the Member was given an opportunity to provide information in a manner and upon such terms as the Medical Executive Committee, investigating body, or reviewing committee deems appropriate. The investigating body or reviewing committee may, but is not obligated to, interview persons involved; however, such an interview shall not constitute a hearing as that term is used in these Bylaws and neither the Rules nor shall the hearing and appeal procedures apply.

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

10.1.1.4 Medical Executive Committee Action

As soon as practicable after the conclusion of the investigation, the Medical Executive Committee shall recommend action, including, without limitation:

a. Determining no corrective action should be taken and, if the Medical Executive Committee determines there was no credible evidence for the complaint in the first instance, clearly documenting those findings in the Member's file;

b. Deferring action for a reasonable time;

c. Issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude Department Chiefs or committee chairs from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letters are issued, the affected Member may make a written response which shall be placed in the Member's credentials file;

d. Recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of Privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring;

e. Recommending reduction, modification, suspension, or revocation of Privileges. If suspension is recommended, the terms and duration of the suspension and the conditions that must be met before the suspension is ended shall be stated;

f. Recommending reductions of membership status or limitation of any prerogatives directly related to the Member's delivery of patient care;

g. Recommending suspension, revocation, or probation of Medical Staff membership. If suspension or probation is recommended, the terms and duration of the suspension or probation and the conditions that must be met before the suspension or probation is ended shall be stated; and

h. Taking other actions deemed appropriate under the circumstances.

10.1.1.5 Procedural Rights

a. If the Medical Executive Committee determines that no corrective action is required or only a letter of warning, admonition, reprimand, or censure should be issued, the decision shall be forwarded to the Board of Trustees. The decision shall become final if the Board of Trustees affirms it or takes no action on it within seventy (70) days after being informed of the decision.

b. If the Medical Executive Committee recommends an action that is grounds for a hearing pursuant to Section 11.2.2, the Medical Staff Chairman shall give the Practitioner Special Notice of the adverse recommendation and of the right to request a hearing. The Board of Trustees may be informed of the recommendation, but shall take no action until the Member has either waived his or her right to a hearing or completed the hearing.

10.1.1.6 Initiation by Board of Trustees

If the Medical Executive Committee fails to investigate or take disciplinary action, contrary to the weight of the evidence, the Board of Trustees may direct the Medical Executive Committee to initiate an investigation or corrective action, after consulting with the Medical Executive Committee. If the Medical Executive Committee fails to act in response to the Board of Trustees' direction, the Board of Trustees may initiate corrective action, but must comply with applicable provisions of these Bylaws and Rules. The Board of Trustees shall inform the Medical Executive Committee in writing of what it has done.

10.1.2 Summary Restriction or Suspension

10.1.2.1 Criteria for Initiation

a. Whenever a Practitioner's conduct is such that a failure to take action may result in imminent danger to the health or well-being of any individual, the Medical Staff Chairman, the Medical Executive Committee, or the Chief of the Department in which the Member holds Privileges may summarily restrict or suspend the Medical Staff membership or Privileges of such Member.

b. If the Medical Staff Chairman, the Medical Executive Committee, or the Chief of the Department in which the Member holds Privileges is not available after reasonable efforts are made to contact them, the Chief Executive Officer, Board of Trustees Chair, or the Board of Trustees may summarily restrict or suspend the Member's Medical Staff membership or Privileges. In such cases, if the summary restriction or suspension is not ratified by the Medical Staff Chairman, Medical Executive Committee, or Chief of the Department in which the Member holds Privileges within two (2) business days, excluding weekends and holidays, after the restriction or suspension was imposed, the summary restriction or suspension shall terminate automatically.

c. Unless otherwise stated, such summary restriction or suspension (summary action) shall become effective immediately upon imposition, and the person or body responsible shall promptly give Special Notice to the Member and written Notice to the Board of Trustees, the Medical Executive Committee, and the Chief Executive Officer. The Notice shall generally describe the reasons for the action.

d. The summary action may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary action, the Member's patients shall be promptly assigned to another Member by the Department Chief or by the Medical Staff Chairman considering, where feasible, the wishes of the patient and the affected Practitioner in the choice of a substitute Member.

e. The Notice of the summary action given to the Medical Executive Committee shall constitute a request to initiate corrective action and the procedures set forth in Section 11.1 shall be followed.

10.1.2.2 Medical Executive Committee Action

All summary action will be reviewed at a special meeting of the Medical Executive Committee to determine whether the terms of such summary action shall be continued, modified, or terminated. This special meeting shall be held within five (5) business days following the imposition of the summary action and shall include the person(s) who imposed the summary action. The affected Practitioner may appear at this special meeting, be interviewed, and make a statement concerning the issues under review, on such terms and conditions as the Medical Executive Committee may impose, and shall be given Notice thereof. In no event shall any meeting of the Medical Executive Committee, with or without the affected Practitioner, constitute a hearing as the term is used in these Bylaws nor shall any procedural rule apply. The Medical Executive Committee may thereafter continue, modify, or terminate the terms of the summary action. It shall give the Practitioner Special Notice of its decision, which shall include the information specified in Section 11.2 if the action is adverse.

10.1.2.3 Procedural Rights

Unless the Medical Executive Committee terminates the summary action, it shall remain in effect during the pendency and completion of the corrective action process and of the hearing and appellate review process. When a summary action is continued, the affected Practitioner shall be entitled to the procedural rights afforded by Section 11.2 of these Bylaws. However, the hearing may be consolidated with a hearing on any corrective action that is recommended so long as the hearing commences within sixty (60) days after the hearing on the summary action was requested.

10.1.3 Automatic Suspension or Limitation

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

10.1.3.1 Licensure

a. Revocation, Suspension, Expiration, Surrender, or Relinquishment

Whenever a Member's license or other legal credential authorizing practice in this state is revoked, suspended, expired, surrendered, or relinquished without an application pending for renewal, Medical Staff membership and Privileges shall be automatically revoked as of the date such action becomes effective.

b. Restriction

Whenever a Member's license or other legal credential authorizing practice in this state is limited or restricted by the applicable licensing or certifying authority, any Privileges which are within the scope of such limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

c. Probation

Whenever a Member is placed on probation by the applicable licensing or certifying authority, his or her membership status and Privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

10.1.3.2 Drug Enforcement Agency (DEA) Certificate to Handle Controlled Substances

a. Revocation, Limitation, Suspension, and Expiration

Whenever a Member's DEA certificate is revoked, limited, suspended, or expired, the Member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate as of the date such action becomes effective and throughout its term.

b. Probation

Whenever a Member's DEA certificate is subject to probation, the Member's right to prescribe such medications shall automatically become subject to the same terms of the probation as of the date such action becomes effective and throughout its term.

10.1.3.3 Failure to Pay Dues

Members will be billed for dues in December and will be required to pay the dues promptly. A second notice will be sent thirty (30) days after the initial billing to remind anyone who is delinquent. Members who fail to pay their dues within fifteen (15) days after the date of receipt of the second notice will be automatically suspended. Such suspension shall apply to the Medical Staff Member's right to admit, treat, or provide services to any patients in the Hospital. The suspension shall remain in effect until the dues are paid.

Members who are suspended for failure to pay dues will, in addition to suspension, automatically be assessed the fines as outlined in Medical Staff Rule 6.

A lack of payment after ninety (90) days shall be deemed a voluntary resignation of Medical Staff membership and Privileges.

Thereafter, reinstatement to the Medical Staff shall require payment of the dues, accumulated fines, and an application with processing fee, per the appointment procedures for applicants.

10.1.3.4 Failure to Satisfy Special Appearance Requirement

A Member who fails without good cause to appear and satisfy the requirements of Bylaws Section 9.8_shall automatically be suspended from exercising all or such portion of Privileges as the Medical Executive Committee specifies.

10.1.3.5 Medical Records

a. Medical Staff Members are required to complete medical records per state and federal regulations and within the time prescribed by these Bylaws and Rules, as follows:

i. Medical Records

A medical record must be completed promptly and authenticated by a Practitioner within fourteen (14) days following the patient's discharge.

ii. Operative and/or Procedure Reports

Operative and/or procedure reports must be documented in the medical record immediately following the conclusion of a procedure. If the operative and/or procedure report is not placed in the medical record immediately following the conclusion of a procedure, then an operative progress note must be written within twenty-four (24) hours to provide pertinent information for a caregiver attending to the patient. If the operative progress note is not documented in the medical record after twenty-four (24) hours and/or an operative and/or procedure report is not documented in the medical record within a reasonable time thereafter, the Practitioner will be suspended.

iii. History and Physical Reports

History and Physical reports (H&P) must be on the patient record within twenty-four (24) hours after admission and prior to any procedure. The H&P may be recorded in the progress notes (provided all required elements are present), on an appropriate H&P form, or as a dictated report.

b. Failure to complete records as prescribed above shall result in an automatic suspension four (4) business days after Special Notice is given. Such suspension shall apply to the Medical Staff Member's right to admit, treat, or provide services to any patients in the Hospital. The suspension shall continue until all incomplete medical records are completed. However, the Member may be allowed, if permitted by both the Medical Staff Chairman and the Chief Executive Officer, or their designees, to continue to treat patients already admitted to the Hospital or to provide emergency patient care.

10.1.3.6 Cancellation of Professional Liability Insurance

Failure to maintain professional liability insurance as required by these Bylaws shall be grounds for automatic suspension of a Member's Privileges. Failure to maintain professional liability insurance for certain procedures shall result in the automatic suspension of Privileges to perform those procedures. The suspension shall be effective until appropriate coverage is reinstated, including coverage of any acts or potential liabilities that may have occurred or arisen during the period of any lapse in coverage.

10.1.3.7 Exclusion or Suspension from Federal Programs and Failure to Comply with Government and Other Third Party Payor Requirements

Any Practitioner who has been excluded or suspended from Medicare, Medi-Cal, or other federal or state government programs shall promptly notify the Medical Executive Committee of the exclusion or suspension and shall be automatically suspended from the Medical Staff until the exclusion or suspension is ended.

The Medical Executive Committee shall be empowered to determine that compliance with any other specific third party payor, government agency, and professional review organization

rules or policies is essential to Hospital and/or Medical Staff operations and that compliance with such requirements can be objectively determined. Any Practitioner who fails to comply with such rules or policies that have been deemed essential shall be automatically suspended. The suspension shall be effective until the Practitioner complies with such requirements.

10.1.3.8 Automatic Termination

If a Practitioner remains suspended under an automatic suspension provision for more than three (3) months, his or her membership (or the affected Privileges if the suspension is a partial suspension) shall be automatically terminated.

10.1.3.9 Medical Executive Committee Deliberation and Procedural Rights

a. As soon as practicable after action is taken or warranted as described in Section 11.1.3.1 (licensure revocation, suspension, expiration, surrender, relinquishment, restriction, or probation), Section 11.1.3.2 (DEA certificate revocation, limitation, suspension, expiration, or probation), or Section 11.1.3.4 (failure to satisfy a special appearance requirement), the Medical Executive Committee shall review and consider the facts and may recommend such further corrective action as it may deem appropriate.

   There is no need for the Medical Executive Committee to act on automatic suspensions for failures to pay dues (Section 11.1.3.3), complete medical records (Section 11.1.3.5), maintain professional liability insurance (Section 10.1.3.6), or comply with government and other third party payor rules and policies (Section 11.1.3.7).

   The Medical Executive Committee review and any subsequent hearings and reviews shall not address the propriety of the licensure or DEA action, but instead shall address what action should be taken by the Hospital.

b. Practitioners whose Privileges or practice prerogatives are automatically suspended and/or who have been deemed to have automatically resigned their Medical Staff membership shall not be entitled to hearing rights set forth in this Article, unless the suspension must be reported under California Business and Professions Code Section 805 or to the federal National Practitioner Data Bank.

10.1.3.10 Notice of Automatic Suspension or Action

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

10.1.3.11 Automatic Action Based Upon Actions Taken by Another Peer Review Body

a. The Medical Executive Committee shall be empowered to automatically impose any adverse action that has been taken by another peer review body (as that term is used in federal or California laws) after a hearing that meets the requirement of the

federal and state laws. Such an adverse action may be any action taken by the original peer review body, including, but not limited to, denying membership and/or Privileges, restricting Privileges, or terminating membership and/or Privileges. The action may be taken automatically only if the original hospital took action based upon standards that were essentially the same as those in effect at this Hospital at the time the automatic action is taken. The action that is the basis of the automatic action may have become final within the past thirty-six (36) months. The action may be taken once the Practitioner has completed the hearing and any appeal. It is not necessary to await a final disposition in any judicial proceeding that may be brought challenging the action.

b. The Practitioner shall not be entitled to any hearing or appeal unless the Medical Executive Committee takes an action that is more restrictive than the final action taken by the original peer review body. Any hearing and appeal that is requested by the Practitioner shall not address the merits of the action taken by the original peer review body, which were already reviewed at the original peer review body's hearing, and shall be limited to only the question of whether the automatic action is more restrictive than the original peer review body's action. The Practitioner shall not be entitled to challenge the automatic peer review action unless he or she successfully overturns the original peer review action in court.

c. Nothing in this section shall preclude the Medical Staff or Board of Trustees from taking a more restrictive action than another peer review body based upon the same facts or circumstances.

10 .1.3.12 Automatic suspension of privileges to issue orders

Any Practitioner or AHP who fails to complete the Hospital's Computerized Provider Order Entry (CPOE) training on or before June 1, 2014, (and who does not qualify for an exception as defined in Rule 8.10.1.6, shall be subject to losing all privileges to issue orders. Such privileges shall remain automatically suspended until such time as the Practitioner or AHP has successfully completed the CPOE training. A Practitioner or AHP whose privileges to issue any orders remain automatically suspended for more than 120 days shall be automatically terminated from the Medical Staff or AHP Staff. Automatic actions imposed pursuant to this Section do not give rights to any hearing or appeals rights.

10.1.4 Interview

Interviews shall neither constitute nor be deemed a hearing as described in the Bylaws and Rules, shall be preliminary in nature, and shall not be conducted according to the procedural rules applicable with respect to hearings. The Medical Executive Committee shall be required, at the Practitioner's request, to grant an interview only when so specified in these Bylaws and the Rules. When an interview is granted, the Practitioner shall be informed of the general nature of the reasons for the recommendation and may present information relevant thereto. The Practitioner may not be represented by an attorney at the interview. A record of the matters discussed and the findings resulting form an interview shall be made.

10.1.5 Confidentiality

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

10.1.6 Coordinated Corrective Action

10.1.6.1 Notice of Pending Investigations/Joint Investigations

a. The Medical Staff Chairman and the Chief Executive Officer each shall have the discretion to notify their counterpart officers at affiliated healthcare entities with

whom the Hospital has agreed to coordinate peer review whenever a request for corrective action has been received.

b. In addition, the Medical Executive Committee may authorize a coordinated investigation and may appoint other affiliated healthcare entities' medical staff members to assist in the coordinated investigation.

c. The Medical Staff Chairman and the Chief Executive Officer are authorized to disclose to another affiliated healthcare entity's member's peer review body (or an authorized representative of that body) information from Hospital and Medical Staff records to assist in the other affiliated healthcare entity's independent or joint investigation of any Practitioner.

d. The results of any joint investigation shall be reported to each affiliated healthcare entity's peer review body for its independent determination of what, if any, corrective action should be taken.

10.1.6.2 Notice of Actions

a. In addition to the discretionary reporting and joint investigation provisions set forth in Section 11.1.6.1, the Medical Staff Chairman and the Chief Executive Officer are authorized to inform their counterpart officer at any other affiliated healthcare entity where the Practitioner is known to hold clinical privileges whenever any of the following actions has been taken:

i. Summary suspension of clinical privileges should be reported promptly upon imposition (other than automatic suspensions for failure to complete medical records or pay dues).

ii. Other corrective actions may be reported at any time the Medical Staff Chairman or Chief Executive Officer determines such a report to be appropriate, and should be reported promptly upon final action by the Board.

b. The effect of such action on the involved Practitioner's clinical privileges at another affiliated healthcare entity shall be determined by the medical staff bylaws or other applicable policies of that other affiliated healthcare entity; or if there are no applicable bylaws or policies, the information shall be deemed transmitted for the receiving affiliated healthcare entity's independent review and action.

c. The Medical Staff Chairman and Chief Executive Officer are authorized to disclose to another affiliated healthcare entity's peer review body (or an authorized representative of that body) information from the Hospital and Medical Staff records regarding such a Practitioner or Allied Health Practitioner.

10.1.6.3 Effect of Actions Taken by Other Entities

Except as provided in Section 11.1.6.1, whenever the Medical Staff Chairman or Medical Executive Committee receives information about an action taken at another affiliated healthcare entity and involving a Practitioner or Allied Health Practitioner holding Privileges or practice prerogatives at the Hospital, the Medical Staff Chairman or Medical Executive Committee shall, if time permits, independently assess the facts and circumstances to ascertain whether to take comparable action. However, when the Practitioner or Allied Health Practitioner was summarily suspended or restricted at the other affiliated healthcare entity, any person authorized under Section 11.1.2 to impose a summary action is authorized to immediately impose a comparable suspension or restriction at this Hospital, subject to review in accordance with the provisions of Section 11.1.2.

10.2 Hearings and Appellate Reviews

10.2.1 General Provisions

10.2.1.1 Review Philosophy

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

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

10.2.1.2 Exhaustion of Remedies

If an adverse action as described in Section 11.2.2 is taken or recommended, the Practitioner must exhaust the remedies afforded by these Bylaws before resorting to legal action.

10.2.1.3 Intra-Organizational Remedies

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

10.2.1.4 Joint Hearings and Appeals

The Medical Staff and Board of Trustees are authorized to participate in joint hearings and appeals in accordance with Section 11.2.10.

10.2.1.5 Definitions

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

a. **Body whose decision prompted the hearing** refers to the Medical Executive Committee in all cases where the Medical Executive Committee or authorized Medical Staff officers, Members, or committees took the action or rendered the decision which resulted in a hearing being requested. It refers to the Board of Trustees in all cases where the Board of Trustees or its authorized officers, directors, or committees took the action or rendered the decision which resulted in a hearing being requested.

b. **Practitioner** as used in this Section refers to the Practitioner who has requested a hearing pursuant to Section 11.2.3.

10.2.1.6 Substantial Compliance

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

10.2.2 Grounds for Hearing

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

10.2.2.1 Denial of initial Medical Staff membership and/or Privileges.

10.2.2.2 Denial of reappointment of Medical Staff membership and/or Privileges.

10.2.2.3 Revocation, suspension, restriction, involuntary reduction of Medical Staff membership and/or Privileges.

10.2.2.4 Involuntary imposition of significant consultation or proctoring requirements (excluding proctoring incidental to Provisional Staff status or the granting of new Privileges or imposed because of insufficient activity, or proctoring or consultation that does not restrict the Practitioner's Privileges).

10.2.2.5 Restriction or suspension of Medical Staff membership and/or Privileges for a cumulative total of thirty (30) days or more in any twelve (12) month period.

10.2.2.6 Summary suspension of Medical Staff Membership and/or Privileges during the pendency of corrective action and hearings and appeals procedures, where such summary suspension must be reported under California Business and Professions Code Section 805

10.2.2.7 Any other medical disciplinary action or recommendation that must be reported to the Practitioner's licensing agency under California Business and Professions Code Section 805, or to the National Practitioner Data Bank.

10.2.3 Requests for Hearing

10.2.3.1 Notice of Action or Proposed Action

In all cases in which action has been taken or a recommendation made as set forth in Section 11.2.2, the Practitioner shall be given Special Notice of the action or recommendation and of the right to request a hearing pursuant to this section. The Special Notice must state:

a. what action has been proposed against the Practitioner;

b. that the action, if adopted, must be reported under California Business and Professions Code Section 805; if the action was based upon medical disciplinary cause or reason.

c. a brief indication of the reasons for the action or proposed action;

d. that the Practitioner may request a hearing;

e. that a hearing must be requested within thirty (30) days; and,

f. that the Practitioner has the hearing rights described in the Medical Staff Bylaws and Rules .

10.2.3.2 Request for Hearing

The Practitioner shall have thirty (30) days following receipt of Special Notice of such action to request a hearing. The request shall be in writing addressed to the Medical Staff Chairman with a copy to the Chief Executive Officer. If the Practitioner does not request a hearing within the time and in the manner prescribed, the Practitioner shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved. Such final recommendation shall be considered by the Board of Trustees within seventy (70) days and shall be given great weight by the Board of Trustees although it is not binding on the Board of Trustees.

10.2.4 Hearing Procedure

10.2.4.1 Hearing Prompted by Board of Trustees Action

If the hearing is based upon an adverse action by the Board of Trustees, the chair of the Board of Trustees shall fulfill the functions assigned in this section to the Medical Staff Chairman or the Medical Executive Committee.

10.2.4.2 Notice of Hearing

Upon receipt of a request for hearing, the Medical Staff Chairman shall schedule a hearing and, within thirty (30) days from the date he or she received the request for a hearing, give Special Notice to the Practitioner of the time, place, and date of the hearing. The date of the commencement of the hearing shall be not less than thirty (30) days nor more than sixty (60) days from the date the Medical Staff Chairman received the request for a hearing.

10.2.4.3 Notice of Charges

Together with the Special Notice stating the time, place, and date of the hearing, the Medical Staff Chairman shall state clearly and concisely in writing the reasons for the adverse proposed action taken or recommended, including the acts or omissions with which the Practitioner is charged and a list of the charts in question, where applicable. A supplemental Notice of Charges may be issued at any time, provided the Practitioner is given sufficient time to prepare to respond. A supplemental Notice of Charges may delete or modify the acts, omissions, charts, or reasons specified in the original Notice of Charges.

10.2.4.4 Selecting the Trier of Fact

a. When a hearing is requested, the Medical Executive Committee shall determine whether the hearing will be conducted before a Hearing Committee or an arbitrator.

b. If the hearing is conducted before a Hearing Committee, the Medical Staff Chairman shall appoint a Hearing Committee, which shall be composed of not less than three (3) Members who shall gain no direct financial benefit from the outcome and who have not acted as accuser, investigator, fact finder, initial decision maker, or otherwise actively participated in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude a Member of the Medical Staff from serving as a member of the Hearing Committee. In the event that it is not feasible to appoint a Hearing Committee from the Active Medical Staff, the Medical Staff Chairman may appoint Members from other Medical Staff categories or Practitioners who are not Medical Staff Members. Such appointment shall include designation of the chair. When feasible, the Hearing Committee shall include at least one Member who has the same healing arts licensure as the Practitioner and who practices the same specialty as the Practitioner. The Medical Staff Chairman may appoint alternates who meet the

standards described above and who can serve if a Hearing Committee member becomes unavailable.

c. Both the body whose decision prompted the hearing and the Practitioner have the right to a reasonable opportunity to voir dire, and to challenge the impartiality of, each Hearing Committee member and/or alternate. The Hearing Officer may question the Hearing Committee members and/or alternates directly regarding their service on the Hearing Committee. Any challenges to the impartiality of any Hearing Committee member and/or alternate will be ruled upon by the Hearing Officer.

d. In limited circumstances and where good cause exists, the Medical Executive Committee may delegate the authority to appoint a Hearing Committee and all responsibilities and decisions regarding the appointment of a Hearing Committee to the Board of Trustees.

e. If the hearing is conducted before an arbitrator, the arbitrator shall be selected using a process mutually accepted by the body whose decision prompted the hearing and the Practitioner. The arbitrator need not be either a health professional or an attorney. The arbitrator shall carry out all of the duties assigned to the Hearing Officer and to the Hearing Committee.

f. The Hearing Committee or the arbitrator, as applicable, shall have such powers as are necessary to discharge its or his or her responsibilities.

10.2.4.5 The Hearing Officer

a. If the hearing is conducted before a Hearing Committee, the Medical Staff Chairman shall appoint a Hearing Officer to preside at the hearing. In limited circumstances and where good cause exists, the Medical Executive Committee may delegate the authority to appoint the Hearing Officer and all responsibilities and decisions regarding the appointment of the Hearing Officer to the Board of Trustees.

b. The Hearing Officer shall be an attorney at law who is qualified to preside over a quasi-judicial hearing and has experience in medical staff matters. The Hearing Officer shall not be an attorney regularly utilized by the Hospital, Medical Staff, or the affected Practitioner. The Hearing Officer shall not be biased for or against any party, shall gain no direct financial benefit from the outcome, and must not act as a prosecuting officer or as an advocate. The Hearing Officer may participate in the deliberations of the Hearing Committee and be a legal advisor to it, but the Hearing Officer shall not be entitled to vote.

c. Both the body whose decision prompted the hearing and the Practitioner have the right to a reasonable opportunity to voir dire, and to challenge the impartiality of, the Hearing Officer. Such challenges shall be ruled upon by the Hearing Officer.

d. The Hearing Officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The Hearing Officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure, or the admissibility of evidence that are raised prior to, during, or after the hearing, including deciding when evidence may not be introduced, granting continuances, ruling on disputed discovery requests, and ruling on challenges to Hearing Committee members or himself or herself serving as the Hearing Officer. If the Hearing Officer determines that either side in a hearing is not proceeding in an

efficient and expeditious manner, the Hearing Officer may take such discretionary action as seems warranted by the circumstances.

10.2.4.6 Representation

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

b. The body whose decision prompted the hearing shall not be represented by an attorney at the hearing unless the Practitioner is represented by an attorney.

c. When attorneys are not allowed, the Practitioner and the body whose decision prompted the hearing may be represented at the hearing only by a Practitioner licensed to practice in the state of California who is not also an attorney at law.

10.2.4.7 Failure to Appear or Proceed

Failure without good cause of the Practitioner to personally attend and proceed at a hearing in an efficient and orderly manner shall be deemed to constitute waiver of all further procedural rights to which he or she otherwise was entitled under these Bylaws, and shall be deemed to constitute voluntary acceptance of the recommendations or actions involved.

10.2.4.8 Postponements and Extensions

Once a request for a hearing is initiated, postponements and extensions of time beyond the times permitted in these Bylaws and Rules may be permitted by the Hearing Officer within his or her discretion, on a showing of good cause.

10.2.4.9 Discovery

a. Rights of Inspection and Copying

The Practitioner may inspect and copy (at his or her expense) any documentary information relevant to the charges that the Medical Staff has in its possession or under its control. The body whose decision prompted the hearing may inspect and copy (at its expense) any documentary information relevant to the charges that the Practitioner has in his or her possession or under his or her control. The requests for discovery shall be fulfilled as soon as practicable. Failures to comply with reasonable discovery requests at least thirty (30) days prior to the hearing shall be good cause for a continuance of the hearing.

b. Limits on Discovery

Discovery may be denied when justified to protect peer review or in the interest of fairness and equity. Further, the right to inspect and copy by either party does not extend to confidential information referring to individually identifiable Practitioners other than the Practitioner under review, nor does it create or imply any obligation to modify or create documents in order to satisfy a request for information.

c. Discovery Disputes

The Hearing Officer shall consider and rule upon any request for access to documentary information and may impose any safeguards the protection of the peer review process and justice requires. When ruling upon requests for access to information and determining the relevancy thereof, the Hearing Officer shall, among other factors, consider:

1. whether the information sought may be introduced to support or defend the charges;

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

3. the burden imposed on the party in possession of the information sought, if access is granted; and

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

d. Objections to Introduction of Evidence Previously Not Produced for the Medical Staff

The body whose decision prompted the hearing may object to the introduction of evidence that was not provided during an appointment, reappointment, or Privilege application review or during corrective action despite the requests of the peer review body for such information. The information will be barred from the hearing by the Hearing Officer unless the Practitioner can provide he or she previously acted diligently and could not have submitted the information.

10.2.4.10 Pre-Hearing Document Exchange

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

10.2.4.11 Witness Lists

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

10.2.4.12 Procedural Disputes

a. It shall be the duty of the parties to exercise reasonable diligence in notifying the Hearing Officer of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible in order that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be succinctly made at the hearing.

b. The parties shall be entitled to file motions as deemed necessary to give full effect to rights established by the Bylaws and Rules and to resolve such procedural matters as the Hearing Officer determines may properly be resolved outside the presence of the full Hearing Committee. Such motions shall be in writing and shall specifically state the motion, all relevant factual information, and any supporting authority for the motion. The moving party shall deliver a copy of the motion to the opposing party, who shall submit a written response to the Hearing Officer, with a copy to the moving party. The Hearing Officer may establish reasonable time frames for the moving party to submit a motion and for the opposing party to respond. The Hearing Officer shall also determine whether to allow oral argument on any such motions. The Hearing Officer's ruling shall be in writing and shall be provided to the parties promptly upon its rendering. All motions, responses, and rulings thereon shall be entered into the hearing record by the Hearing Officer.

10.2.4.13 Record of the Hearing

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

10.2.4.14 Rights of the Parties

Within reasonable limitations, both sides at the hearing may call and examine witnesses for relevant testimony, introduce relevant exhibits or other documents, cross-examine or impeach witnesses who shall have testified orally on any matter relevant to the issues, and otherwise rebut evidence, receive all information made available to the Hearing Committee, and submit a written statement at the close of the hearing, as long as these rights are exercised in an efficient and expeditious manner. The Practitioner may be called by the body whose decision prompted the hearing or the Hearing Committee and examined as if under cross-examination. The Hearing Committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate.

10.2.4.15 Rules of Evidence

Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under 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.

10.2.4.16 Burdens of Presenting Evidence and Proof

a. At the hearing, the body whose decision prompted the hearing shall have the initial duty to present evidence for each case or issue in support of its action or recommendation. The Practitioner shall be obligated to present evidence in response.

b. An initial applicant for membership and/or Privileges shall bear the burden of persuading the Hearing Committee, by a preponderance of the evidence, that he or she is qualified for membership and/or the denied Privileges. The Practitioner must produce information which allows for adequate evaluation and resolution of

reasonable doubts concerning his or her current qualifications for membership and Privileges. Initial applicants shall not be permitted to introduce information not produced upon request of the body whose decision prompted the hearing 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 body whose decision prompted the hearing shall bear the burden of persuading the trier of fact by a preponderance of the evidence that the action or recommendation is reasonable and warranted.

10.2.4.17 Adjournment and Conclusion

The Hearing Officer may adjourn the hearing and reconvene the same without Special Notice at such times and intervals as may be reasonable and warranted with due consideration for reaching an expeditious conclusion to the hearing.

10.2.4.18 Deliberations

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

10.2.4.19 Basis for Decision

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

10.2.4.20 Presence of Hearing Committee Members and Vote

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

10.2.4.21 Decision of the Hearing Committee

Within thirty (30) days after final adjournment of the hearing, the Hearing Committee shall render a written decision. If the Practitioner is currently under suspension, however, the time for the decision and report shall be fifteen (15) days after final adjournment. Final adjournment shall be when the Hearing Committee has concluded its deliberations. A copy of the decision shall be forwarded to the Chief Executive Officer, the Medical Executive Committee, the Board of Trustees, and to the Practitioner. The decision shall contain the Hearing Committee's findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached. Both the Practitioner and the body whose decision prompted the hearing shall be provided a written explanation of the procedure for appealing the decision. The decision of the Hearing Committee shall be considered final, subject only to such rights of appeal or Board of Trustees review as described in the Bylaws and Rules.

10.2.5 Appeal

10.2.5.1 Time for Appeal

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

10.2.5.2 Grounds for Appeal

The grounds for appeal from the hearing shall be:

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

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

c. action was taken arbitrarily, unreasonably, or capriciously.

10.2.5.3 Time, Place, and Notice

If an appellate review is to be conducted, the Appeal Board shall, within thirty (30) days after receiving a request for appellate review, schedule a review date and cause each party 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 sixty (60) days from the date of such Notice provided, however, when a request for appellate review concerns a Member who is under suspension which is then in effect, the appellate review should commence within forty-five (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.

10.2.5.4 Appeal Board

The Board of Trustees may sit as the Appeal Board, or it may appoint an Appeal Board which shall be composed of not less than three (3) members of the Board of Trustees. Knowledge of the matter involved shall not preclude any person from serving as a member of the Appeal Board, so long as that person did not take part in a prior hearing on the same matter. The Appeal Board may select an attorney to assist it in the proceeding who will act as an appellate Hearing Officer and have all of the authority of and carry out all of the duties assigned to a Hearing Officer as described in Section 11.2. The Hearing Officer shall not be entitled to vote with respect to the appeal. The Appeal Board shall have such powers as are necessary to discharge its responsibilities.

10.2.5.5 Appeal Procedure

The proceeding by the Appeal Board shall an appellate hearing based upon the record of the hearing before the Hearing Committee, provided that the Appeal Board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the hearing; or the Appeal Board may remand the matter to the Hearing Committee for the taking of further evidence and for decision. Each party shall have the right to be represented by legal counsel or any other representative designated by that party in connection with the appeal. The appealing party shall submit a written statement concisely stating the specific grounds for appeal. In addition, each party shall have the right to present a written statement in support of his, her, or its position on the

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.

10.2.5.6 Decision

a. Within thirty (30) days after the adjournment of the appellate review proceeding, the Appeal Board shall render a final decision in writing. Final adjournment shall not occur until the Appeal Board has completed its deliberations.

b. The Appeal Board may affirm, modify, reverse the decision, or remand the matter for further review by the Hearing Committee or any other body designated by the Appeal Board.

c. The Appeal Board shall give great weight to the Hearing Committee recommendation, and shall not act arbitrarily or capriciously. The Appeal Board may, however, exercise its independent judgment in determining whether a Practitioner was afforded a fair hearing, whether the decision is reasonable and warranted, and whether any Bylaw, Rule, or policy relied upon by the Hearing Committee is unreasonable or unwarranted. The decision shall specify the reasons for the action taken and provide findings of fact and conclusions articulating the connection between the evidence produced at the hearing and the appeal (if any), and the decision reached, if such findings and conclusions differ from those of the Hearing Committee.

d. The Appeal Board shall forward copies of the decision to each party involved in the hearing.

e. The Appeal Board may remand the matter to the Hearing Committee or any other body the Appeal Board designates for reconsideration or may refer the matter to the full Board of Trustees for review. If the matter is remanded for further review and recommendation, the further review shall be completed within thirty (30) days unless the parties agree otherwise or for good cause as determined by the Appeal Board.

10.2.5.7 Right to One Hearing

No Practitioner shall be entitled to more than one evidentiary hearing and one appellate review on any matter which shall have been the subject of an adverse action or recommendation.

10.2.6 Confidentiality

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

10.2.7 Release

By requesting a hearing or appellate review under the Bylaws and Rules, a Practitioner agrees to be bound by the provisions in the Medical Staff Bylaws and Rules relating to immunity from liability for the participants in the hearing process.

10.2.8 Board of Trustees Committees

In the event the Board of Trustees should delegate some or all of its responsibilities described in this Article to its committees, the Board of Trustees shall nonetheless retain ultimate authority to accept, reject, modify, or return for further action or hearing the recommendations of its committee.

10.2.9 Exceptions to Hearing Rights

10.2.9.1 Exclusive Use Departments, Hospital Contract Practitioners

a. Exclusive Use Departments

The hearing rights of Section 11.2 do not apply to a Practitioner whose application for Medical Staff membership and Privileges was denied or whose Privileges were terminated on the basis that the Privileges he or she seeks are granted only pursuant to an exclusive use policy. Such Practitioners shall have the right, however, to request that the Board of Trustees review the denial or termination, and the Board of Trustees shall have the discretion to determine whether to review such a request and, if it decides to review the request, to determine whether the Practitioner may personally appear before and/or submit a statement in support of his or her position to the Board of Trustees.

b. Hospital Contract Practitioners

The hearing rights of Section 11.2 do not apply to Practitioners who have contracted with the Hospital to provide clinical services. Removal of these Practitioners from office and of any exclusive Privileges (but not their Medical Staff membership) shall instead be governed by the terms of their individual contracts and agreements with the Hospital. The hearing rights of Section_11.2 shall apply if an action is taken which must be reported under the federal or California law and/or the Practitioner's Medical Staff membership status or Privileges, which are independent of the Practitioner's contract, are removed or suspended for medical disciplinary cause or reason.

10.2.9.2 Allied Health Practitioners

Allied Health Practitioners are not entitled to the hearing rights set forth in this Article XI (see Article V for a description of Allied Health Practitioners' procedural ~~hearing~~ rights).

10.2.9.3 Denial of Applications for Failure to Meet the Minimum Qualifications

Practitioners shall not be entitled to any hearing or appellate review if their application for membership or requests for Privileges are denied because of their failure to meet any of the basic qualifications specified in Rule 1.1.1 or to file a complete application.

10.2.9.4 Automatic Suspension or Limitation of Privileges

No hearing is required when a Member's license or legal credential to practice has been revoked or suspended as set forth in Section 11.1.3.1. In other cases described in -Sections 11.1.3.1 and 11.1.3.2, the issues which may be considered at a hearing, if applicable, shall not include evidence designed to show that the determination by the licensing or credentialing authority or the DEA was unwarranted, but only whether the Member may continue to practice in the Hospital with those limitations imposed.

10.2.10 Joint Hearings and Appeals for Affiliated Healthcare Entity Members

10.2.10.1 Joint Hearings

a. Whenever a Practitioner is entitled to a hearing because a coordinated, cooperative, or joint credentialing or corrective action has been taken or recommended pursuant to Section 11.1.6, a single joint hearing may be conducted in accordance with

hearing procedures that have been jointly adopted by the involved entities, provided that such procedures are substantially comparable to those set forth in Article XI and further provided that at least one member of the Hearing Committee is a Member of this Hospital's Medical Staff.

b. In the event there is such a joint hearing, the recommendation of the Hearing Committee shall be reported to this Hospital's Board of Trustees for final action.

10.2.10.2 Joint Appeals

The hearing procedures may also call for joint appeal rights, provided that such procedures are substantially comparable to those set forth in Article XI and, further provided that at least one member of the Appeal Board is a representative of this Hospital's Board of Trustees.

10.2.10.3 Effect of Joint Hearings/Appeals

A joint hearing and/or appeal in accordance with the foregoing shall be deemed to satisfy procedural rights afforded to the Practitioner pursuant to federal and state law.

10.2.10.4 Provision for Separate Hearing

Notwithstanding the foregoing, if a Practitioner can demonstrate to the Medical Executive Committee (in the case of a hearing based on a recommendation of the Medical Executive Committee) or the Board of Trustees (in the case of a hearing based on a recommendation of the Board of Trustees or in the case of an appeal) prior to the initiation of a joint hearing and/or appeal that the benefits of quasi-judicial economy and efficiency are outweighed by particular burdens or unfairness unique to the individual Practitioner's circumstances, the Medical Executive Committee or Board of Trustees, may, in its sole discretion, order that a separate hearing and/or appeal be conducted solely with respect to Privileges at this Hospital, in accordance with this Hospital's hearing and appeal provisions. (Examples of such unique burdens or unfairness would include unavailability of witnesses or documents to the joint proceeding; but the mere fact that the outcome would affect Privileges at more than one facility would not ordinarily be deemed sufficient to preclude a joint hearing.)

ARTICLE XI: GENERAL PROVISIONS

11.1 Rules and Policies

Applicants and Members of the Medical Staff and others holding Privileges or practice prerogatives shall be governed by the Rules and Medical Staff policies that are properly initiated and adopted. If there is a conflict between the Medical Staff Bylaws and Rules, the Bylaws shall prevail. If there is a conflict between the Rules and policies, the Rules shall prevail. The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Rules and policies.

11.1.1 Medical Staff Rules

The Medical Staff shall initiate and adopt such Rules as it may deem necessary and shall periodically review and revise its Rules to comply with current Medical Staff practice. New Rules or changes to the Rules (proposed Rules) may emanate from any responsible committee, Department, Medical Staff officer, or by petition signed by at least ten percent (10%) of the voting Members of the Medical Staff. Additionally, Hospital administration may develop and recommend proposed Rules, and in any case should be consulted as to the impact of any proposed Rules on Hospital operations and feasibility. Proposed Rules shall be submitted to the Medical Executive Committee for review and action as follows:

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

b. Medical Executive Committee approval is required, unless the proposed Rule is one generated by petition of at least ten percent (10%) of the voting Members of the Medical Staff. In this latter circumstance, if the Medical Executive Committee fails to approve the proposed Rule, it shall notify the Medical Staff. The Medical Executive Committee and the Medical Staff each has the option of invoking or waiving the conflict management provisions of Section 12.2.

1. If the conflict management process is not invoked within thirty (30) days, it shall be deemed waived. In this circumstance, the Medical Staff's proposed Rule shall be forwarded to the Board of Trustees for action. The Medical Executive Committee may forward comments to the Board of Trustees regarding the reasons it declined to approve the proposed Rule.

2. If the conflict management process is invoked, the proposed Rule shall not be forwarded to the Board of Trustees until the conflict management process has been completed. The results of the conflict management process shall be communicated to the Board of Trustees, which shall take action, if necessary.

c. Following approval by the Medial Executive Committee or waiver or completion of the conflict management process described, a proposed Rule shall become effective following approval by the Board of Trustees. The Board of Trustees approval shall not be withheld unreasonably, and approval shall occur automatically within ninety (90) days if no action is taken by the Board of Trustees. The Rules shall be deemed an integral part of the Medical Staff Bylaws.

11.1.2 Department Rules

Subject to the approval of the Medical Executive Committee and the Board of Trustees, each Department shall formulate whatever Rules are necessary for conducting its affairs and discharging its responsibilities. Such Rules shall not be inconsistent with the Medical Staff or Hospital Bylaws, Rules, or other policies. The Department Rules shall be deemed an integral part of the Medical Staff Bylaws.

11.1.3 Medical Staff Policies

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

at least ten percent (10%) of the voting Members of the Medical Staff. Proposed policies shall not be inconsistent with the Medical Staff or hospital Bylaws, Rules, or other policies.

b. Medical Executive Committee approval is required, unless the proposed policy is one generated by petition of at least ten percent (10%) of the voting Members of the Medical Staff. In this latter circumstance, if the Medical Executive Committee fails to approve the proposed policy, it shall notify the Medical Staff. The Medical Executive Committee and the Medical Staff each has the option of invoking or waiving the conflict management provisions of Section 12.2.

1. If the conflict management process is not invoked within thirty (30) days, it shall be deemed waived. In this circumstance, the Medical Staff's proposed policy shall be forwarded to the Board of Trustees for action. The Medical Executive Committee may forward comments to the Board of Trustees regarding the reasons it declined to approve the proposed policy.

2. If the conflict management process is invoked, the proposed policy shall not be forwarded to the Board of Trustees until the conflict management process has been completed. The results of the conflict management process shall be communicated to the Board of Trustees, which shall take action, if necessary.

c. Following approval by the Medical Executive Committee or waiver or completion of the conflict management process described, a proposed policy shall become effective following approval by the Board of Trustees. Board of Trustees approval shall not be withheld unreasonably and approval shall occur automatically within ninety (90) days if no action is taken by the Board of Trustees.

d. The Medical Staff shall be notified of a policy approved by the Medical Executive Committee and may, by petition signed by at least ten percent (10%) of the voting Members of the Medical Staff, require the policy to be submitted for possible recall. However, the approved policy shall remain effective until such time as it is repealed or amended.

11.1.4 Urgent Amendments

When an urgent amendment to the Rules or policies is necessary in order to comply with a federal or state law or regulation or accreditation requirement, the Medical Executive Committee may provisionally adopt and the Board of Trustees may provisionally approve the urgent amendment without prior notification to the Medical Staff. The Medical Executive Committee must document the need for the urgent amendment. Following the provisional adoption and approval, the Medical Executive Committee shall immediately notify the Medical Staff of the urgent amendment. The Medical Staff shall have the opportunity to retrospectively review and comment on the urgent amendment. If there is no conflict between the Medical Staff and the Medical Executive Committee, then the urgent amendment will stand as a final action of the Board of Trustees. However, if there is a conflict over the urgent amendment, then the Medical Staff may invoke the conflict management provisions of Section 12.2.

11.1.5 Technical and Editorial Corrections

Notwithstanding Sections 12.1.1 through 12.1.4, the Medical Executive Committee shall have the power to adopt such corrections to the Rules and policies as are, in its judgment, technical modifications or clarifications, reorganization or renumbering, or corrections made necessary because of punctuation, spelling, other errors of grammar or expression, or inaccurate cross-references. No substantive amendments are permitted. Corrections shall be effective immediately and shall be permanent if not disapproved by the Medical Staff or Board of Trustees within ninety (90) days after the adoption by the Medical Executive Committee. The action to make these corrections may be taken by motion and acted upon in the same manner as any other motion before the Medical Executive Committee. After approval, such corrections shall be communicated in writing to the Medical Staff and to the Board of Trustees.

11.2 Conflict Management

In the event of a conflict between the Medical Executive Committee and the Medical Staff regarding a proposed or adopted Rule or policy, the Medical Staff Chairman may convene a meeting upon receipt of a written petition signed by at least twenty percent (20%) of the voting Members of the Medical Staff. If the conflict management process is invoked, the petitioners shall designate up to five (5) Members of the voting Medical Staff who shall serve as the

petitioners' representatives. The Medical Executive Committee shall be represented by an equal number of Medical Executive Committee members. The petitioners' and Medical Executive Committee's representatives shall exchange information relevant to the conflict and shall work in good faith to resolve differences in a manner that respects the positions of the Medical Staff, the leadership responsibilities of the Medical Executive Committee, and the safety and quality of patient care at the Hospital. Resolution at this level requires a majority vote of the petitioners' representatives and the Medical Executive Committee's representatives. Unresolved differences shall be submitted to the Board of Trustees for final resolution.

11.3 Construction of Terms and Headings

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

11.4 Authority to Act

Any Member or Members who act in the name of this Medical Staff without proper authority shall be subject to such disciplinary action as the Medical Executive Committee may deem appropriate.

11.5 Division of Fees

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

11.6 Notices

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

Notice to the Hospital, Board of Trustees, Medical Staff, or officers or committees thereof, shall be addressed as follows:

Name and proper title of addressee
Good Samaritan Hospital
1225 Wilshire Boulevard
Los Angeles, California, 90017

Notices mailed to an applicant, Member, AHP, or other party shall be sent to the address as it last appears in the official records of the Medical Staff or the Hospital.

11.7 Forms

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

11.8 Dues, Application Fees, and Assessments

The amount of dues and application fees for appointment and reappointment to each category of Medical Staff membership shall be specified in the Rules. The Medical Executive Committee shall have the power to recommend special assessments for some or all categories of Medical Staff membership, subject to the Board of Trustees' approval. The Medical Executive Committee shall determine the manner of expenditure of the funds that are received and the proceeds of any special assessments provided; however, such expenditures shall not jeopardize the non-profit status of the Hospital.

11.9 Non-Contractual Nature of the Bylaws and Rules

11.9.1 These Bylaws and the Rules shall not be deemed to be a contract of any kind between the Board of Trustees and the Medical Staff or any individual (including any Medical Staff Member, applicant, or Allied Health Practitioner). 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.

11.9.2 The Board of Trustees and the Medical Staff are obligated to use essential fairness in dealing with Medical Staff Members, AHPs, and applicants for positions and may fulfill that obligation by following the procedures specified in these Bylaws, the Rules, or any other procedures which are fair in the circumstances.

11.10 Medical Staff Role in Exclusive Contracting

The Medical Executive Committee shall review and make recommendations to the Board of Trustees regarding all quality of care and utilization review issues related to exclusive arrangements for physician and/or professional services, prior to action by the Board of Trustees The Board of Trustees shall give great weight to the recommendations of the Medical Executive Committee on quality of care and utilization review issues related to exclusive arrangements.

11.11 Medical Staff Credentials Files

The credentials files of Medical Staff Members and other Practitioners or AHPs who exercise Privileges or practice prerogatives at the Hospital shall be maintained, protected, and accessed as set forth in the Rules.

11.12 History and Physical Examination Report

11.12.1 It is the responsibility of the Medical Staff to assure that a medical history and appropriate physical examination (H&P) is performed on patients being admitted for inpatient care, as well as prior to operative and complex invasive procedures in either an inpatient or outpatient setting.

11.12.2 The H&P must be completed and documented by a physician, an oral and maxillofacial surgeon, or other qualified licensed individuals no more than thirty (30) days prior to, or within twenty-four (24) hours after, the patient's admission, but prior to surgery or a procedure requiring anesthesia services. For an H&P that was completed within thirty (30) days prior to the patient's admission, an update documenting any changes in the patient's condition must be completed within twenty-four (24) hours after the patient's admission, but prior to surgery or a procedure requiring anesthesia services. In cases of emergency procedures that are immediately necessary to save a patient's life or limb, this provision shall not apply.

11.12.3 An H&P shall be dictated or handwritten and include all pertinent positive and negative findings resulting from an inventory of systems. An abbreviated H&P may be used for outpatient cases using only local stand-by anesthesia. A full H&P would be required if the patient subsequently required inpatient admission. Any time a patient has surgery, there must be an interval H&P performed and recorded on the chart within the previous twenty-four (24) hours.

11.12.4 If the patient is readmitted to the Hospital within thirty (30) days of a previous discharge for the same or a related condition, an interval admission note stating the reason for readmission and any changes in the H&P may be written in lieu of a full H&P, provided that a full H&P was completed and documented within thirty (30) days of the patient's readmission. In such instances, a copy of the original full H&P shall be placed in the patient's medical record.

11.12.5 The H&P report shall be prepared by the patient's Attending Physician, unless he or she delegates this responsibility to another Practitioner or AHP or he or she is required by the Medical Staff Bylaws or Rules to delegate or share this responsibility with another Practitioner. (See specifically the Medical Staff Bylaws and Surgery Department Rules pertaining to medical appraisals and the completion of H&P reports when a podiatrist or dentist is the co-admitting Practitioner.)

11.12.6 Use of an H&P provided by a Licensed Independent Practitioner (LIP) who is not a Member of the Medical Staff is permissible provided that the H&P is reviewed by a Medical Staff Member with Privileges, who conducts a

second assessment to confirm the information and findings. The Medical Staff Member must sign and date the outside H&P as well as the second assessment.

11.12.7 Patients requiring an H&P will receive a full H&P, an abbreviated H&P, or an interval H&P as set forth in these Bylaws and the Rules.

11.12.7.1 Oral and Maxillofacial Surgeons

Oral and Maxillofacial surgeons may perform an H&P if they possess the Privileges to do so, as part of the process of assessing the medical, surgical, and/or anesthetic risks of the proposed operative and/or other procedure.

11.12.7.2 Dentists and Podiatrists

a. Doctors of dentistry and podiatry are responsible for that part of the patient's H&P that relate, respectively, to dentistry and podiatry whether or not they are granted Privileges to take a complete history and perform a complete examination. Doctors of dentistry or podiatry may perform a complete H&P if they possess the Privileges to do so.

b. If the Dentist or Podiatrist does not possess such Privileges, then a qualified Physician must perform the H&P.

11.12.7.3 Licensed Dependent Practitioners

If a licensed dependent practitioner is granted Privileges to perform part or all of an H&P, the findings, conclusions, and assessments of risk are confirmed or endorsed by a qualified Physician.

ARTICLE XII: <u>ADOPTION AND AMENDMENT OF THE BYLAWS</u>

12.1 Medical Staff Responsibility and Authority

12.1.1 The Medical Staff shall have the initial responsibility and delegated authority to formulate, adopt, and recommend Medical Staff Bylaws and amendments, which shall be effective when approved by the Board of Trustees, which approval shall not be unreasonably withheld. Such responsibility and authority shall be exercised in good faith and in a reasonable, timely, and responsible manner, reflecting the interests of providing patient care of the generally recognized level of quality and efficiency, and maintaining a harmony of purpose and effort with the Board of Trustees. Additionally, Hospital administration may develop and recommend proposed Bylaws, and in any case should be consulted as to the impact of any proposed Bylaws on Hospital operations and feasibility. Proposals for amendments to these Bylaws may be referred to the Bylaws Committee for review and comment prior to submission for vote.

12.1.2 Amendments to these Bylaws shall be submitted for vote upon the request of the Medical Executive Committee or upon receipt of a petition signed by at least ten percent (10%) of the voting Members of the Medical Staff.

12.2 Methodology

The Medical Staff Bylaws may be adopted, amended, or repealed by the following combined actions:

12.2.1 The affirmative vote of two-thirds (2/3) of the Medical Staff membership who submit ballots: Voting on Bylaws amendments shall be by mailed secret ballot. A ballot shall be mailed to each Member who is eligible to vote and have a return date that is at least twenty-one (21) days after the date the ballot was mailed. The ballot shall be accompanied by the proposed Bylaws and/or amendments. The ballots shall be counted by the Medical Staff Chairman or Vice Chairman or their designees.

12.2.2 The approval of the Board of Trustees, which shall not be unreasonably withheld: If approval is withheld, the reasons for doing so shall be specified by the Board of Trustees in writing, and shall be forwarded to the Medical Staff Chairman, Medical Executive Committee, and the Bylaws Committee.

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

12.3 Urgent Amendments

When an urgent amendment to the Medical Staff Bylaws is necessary in order to comply with a federal or state law or regulation or accreditation requirement, the Medical Executive Committee may provisionally adopt and the Board of Trustees may provisionally approve the urgent amendment without prior notification to the Medical Staff. The Medical Executive Committee must document the need for the urgent amendment. Following the provisional adoption and approval, the Medical Executive Committee shall immediately notify the Medical Staff of the urgent amendment. The Medical Staff shall have the opportunity to retrospectively review and comment on the urgent amendment. If there is no conflict between the Medical Staff and the Medical Executive Committee, then the urgent amendment will stand as a final action of the Board of Trustees. However, if there is a conflict over the urgent amendment, then the Medical Staff may invoke the conflict management provisions of Section 12.2.

12.4 Technical and Editorial Corrections

The Medical Executive Committee shall have the power to adopt such corrections to the Bylaws as are, in its judgment, technical modifications or clarifications, reorganization or renumbering , or corrections made necessary because of punctuation, spelling, other errors of grammar or expression, or inaccurate cross-references. No substantive amendments are permitted. Corrections shall be effective immediately and shall be permanent if not disapproved by the Medical Staff or Board of Trustees within ninety (90) days after the adoption by the Medical Executive Committee.

The action to make these corrections may be taken by motion and acted upon in the same manner as any other motion before the Medical Executive Committee. After approval, such corrections shall be communicated in writing to the Medical Staff and to the Board of Trustees.

12.5 Exclusive Mechanism

The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff Bylaws.

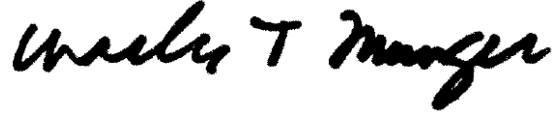
12.6 Compatibility

The Bylaws, Rules and Regulations, and policies of the Medical Staff and the Board of Trustees shall be compatible with each other and will comply with law and regulation.

All Medical Staff contracts made with Physicians and other Practitioners will be compatible with the Medical Staff Bylaws and Rules.

APPROVAL

Approved by the **Medical Executive Committee on**, April 20 2017 and the **Board of Trustees on** April 27, 2017



Medical Staff Chair

Chairman, Board of Trustees

Supersedes: February 25, 2016 Edition

Changes: Article 2.1.4.1 Active Staff requirements for 20 cases <u>at the hospital</u>