

**THE BYLAWS OF  
THE MEDICAL STAFF OF**



**HEALTHBRIDGE CHILDREN'S  
HOSPITAL**

*Revised 1/2009*

# THE BYLAWS OF THE MEDICAL STAFF OF



## HEALTHBRIDGE CHILDREN'S HOSPITAL

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# THE BYLAWS OF THE MEDICAL STAFF OF

## HEALTHBRIDGE CHILDREN'S HOSPITAL

### P R E A M B L E

WHEREAS, HealthBridge Children's Hospital, a licensed Medical Specialty Hospital ("Hospital"), is a privately held company organized under the laws of the State of California; and

WHEREAS, the purpose of the Hospital is to serve as a children's specialty hospital that provides services for children who require ongoing medical care following catastrophic illness, injury or pre-term birth; and

WHEREAS, it is recognized that the Medical Staff has oversight responsibility for physician activity and the quality of medical care provided in the Hospital and must therefore accept and discharge this responsibility, pursuant to authority delegated by the Hospital's governing body; and

WHEREAS, the cooperative efforts of the Medical Staff, CEO, and the Governing Board are necessary to fulfill the Hospital's obligations to its patients and the community.

NOW, THEREFORE, the licensed practitioners practicing in the Hospital hereby organize themselves into a Medical Staff in conformity with these Bylaws.

## ARTICLE 1 - DEFINED TERMS

The following terms, when capitalized, shall have the meanings indicated when used in these medical staff bylaws.

- 1.1. "**Active Staff**" means those medical staff members who recognize the hospital as one of their primary hospitals for the practice of medicine, dentistry, podiatry and other related hospital activities, and who have been recognized by the medical staff by formal review processes to be members in good standing clinically and in all other ways referred to in these bylaws.
- 1.2. "**CEO**" means the individual approved by the governing board, or any interim appointee, to act on their behalf in the overall management of the hospital.
- 1.3. "**Adversely Affect(ing)**" means a professional review action or recommendation which reduces, restricts, suspends, revokes, denies or fails to renew clinical privileges or membership in the hospital. The term also includes any recommendation or action which grants or recommends the granting of privileges or membership to a practitioner that are inferior to the privileges or membership status originally sought by the practitioner. Such action or recommendation shall entitle the practitioner to the hearing procedures provided for in Article 10 of these bylaws.
- 1.4. "**Advocate**" means an individual selected by the CEO to present a professional review action or recommendation before a hearing officer. Such presentation shall include making a reasonable effort to obtain the facts, present the evidence, call and examine and cross examine witnesses and respond to questions propounded by the hearing officer. The advocate may be an attorney duly licensed in the State of California or an attorney may serve as counsel to the advocate.
- 1.5. "**Affected Practitioner**" means a practitioner who's subject to an adverse or corrective action or recommendation, summary suspension or professional review action or recommendation.
- 1.6. "**Allied Healthcare Professional**" or "**AHP**" includes advanced practice nurses (i.e., nurse practitioners), physician assistants (P.A. or P.A.-C), and other select healthcare professionals specifically determined to further the goals and mission of the hospital, and who are licensed or certified by the State and who perform special examinations or treatments or render other services under the direction and supervision of a member. AHPs are not members of the medical staff and the term does not include medical students, residents or employees of the hospital.
- 1.7. "**Application**" means an application for appointment or reappointment to the medical staff.
- 1.8. "**Applicant**" means anyone qualified to, and who does, submit a complete application for medical staff membership to the hospital.
- 1.9. "**Appointment**" means approval of membership and specific clinical privileges by the Appointment/Privileges committee, pursuant to recommendations by the medical executive committee.
- 1.10. "**Appointment/Privileges Committee of the Governing Board**" or "**Credentialing Committee**" means the standing committee created by the governing board, that includes the hospital CEO and the President of the Medical Staff, which has been specifically delegated the authority to, *among other things*, render decisions regarding appointment, reappointment, and renewal or modification of

clinical privileges.

- 1.11. "**Board**" means the governing board of the hospital, the body appointed by the shareholders, who, in collaboration with other integral administrative and clinical personnel, are responsible for establishing the overall goals and direction of the hospital.
- 1.12. "**Bylaws**" means the bylaws of the medical staff of the hospital and any and all written amendments or revisions thereto, which have been duly adopted by a quorum of the medical executive committee and approved by the governing board.
- 1.13. "**Chair**" or "**Chairperson**" means the President of the Medical Staff of the hospital sitting as the chair of a meeting of the medical executive committee or any individual selected by the President of the Medical Staff to chair a committee created under the authority of these bylaws.
- 1.14. "**Clinical Privileges**" means the written authorization granted by the Credentialing committee to a practitioner to perform specified procedures or otherwise participate in patient care within specified limits at the hospital. At no time shall a practitioner exceed the privileges granted him by the Credentialing committee.
- 1.15. "**Complete Application**" means a completed application meeting the requirements of these bylaws and the hospital. The medical staff coordinator shall notify an applicant in writing when his application is deemed complete.
- 1.16. "**Consulting Staff**" means those practitioners who possess certain skills needed at the hospital for a specified project or upon an occasional basis when requested by authorized medical staff members.
- 1.17. "**Contract Practitioner**" means a practitioner who is or will be providing professional medical services at the hospital for patients pursuant to a written contract. Such a practitioner shall fulfill the requirements of these bylaws and any staff category to which he may be assigned.
- 1.18. "**Corrective Action**" means any action taken against a member of the medical staff by the medical executive committee, the CEO and/or the board in response to conduct which is deemed (i) detrimental to patient care, (ii) detrimental to the best interests of the hospital, and/or (iii) in violation of these bylaws or any rule or regulation promulgated pursuant hereto or any law or regulation applicable to such member's practice. A professional review action or recommendation shall entitle the member to a hearing, as provided for in Article 10 of these bylaws.
- 1.19. "**Courtesy Staff**" means those practitioners who do not intend to use the hospital as one of their primary hospitals for practicing medicine, but who upon occasion, because of their association with active staff members and/or as a result of their practice location, need access to the hospital to accommodate their patients and colleagues.
- 1.20. "**Credentialing Committee**" means the medical executive committee meeting as a whole or as a sub-committee to consider matters of appointment and reappointment to the medical staff and matters of membership or clinical privileges, all pursuant to these bylaws, and forwarding its recommendation to the Credentialing committee.
- 1.21. "**Day(s)**" means, unless otherwise specified, calendar days.

- 1.22. "**Dentist**" means a dentist possessing an unrestricted license to practice dentistry in the State of California.
- 1.23. "**Ex-Officio**" means committee membership by virtue of an office or position held. Unless otherwise expressly provided, an ex-officio committee member shall have full voting rights.
- 1.24. "**Good Standing**" means a member who fulfills and maintains the requirements for his specific category of medical staff membership.
- 1.25. "**Governing Board Representative**" or "**Board Representative**" means any active member of the medical staff desiring to represent the medical staff at meetings of the governing board, with such purpose authorized by the medical executive committee. Unless determined otherwise by the governing board, representation at such meeting(s) is limited to attendance and voice, but not voting membership on the governing board.
- 1.26. "**He**," "**Him**" or "**His**," when used herein, is gender neutral and shall mean both "he" and "she," as well as "him," "her," "his" and "hers," and as may otherwise be required by the context, herein.
- 1.27. "**Health Care Quality Improvement Act of 1986 for Peer Review Activities**" or "**The Act**" means the federal act codified at Title 42 U.S.C. §§ 11101 et. seq., that, *among other things*, encourages good faith professional review actions, as provided in Article 10 of these bylaws.
- 1.28. "**Hearing**" means the opportunity given to an affected practitioner before a neutral hearing officer to respond to a professional review action or recommendation that was made in the reasonable belief that it was in the furtherance of quality health care, which provides the affected practitioner with an opportunity to:
- 1.28.1. hear all the facts supporting the professional review action or recommendation and present evidence on his behalf;
  - 1.28.2. be represented and/or assisted by legal counsel at his expense to defend any professional review action or recommendation;
  - 1.28.3. obtain a record of the proceedings;
  - 1.28.4. submit a written statement at the close of the hearing; and
  - 1.28.5. receive a written recommendation of the hearing officer and the final decision of the hospital or governing body.
- 1.29. "**Hearing Officer**" means a neutral individual selected by the CEO and the President of the Medical Staff, who is not in direct economic competition with the practitioner subject to review, to conduct hearing on a proposed professional review action or recommendation, in accordance with state and federal law and these bylaws. The hearing officer may be an outside practitioner retained for such an exclusive purpose.
- 1.30. "**Hospital**" means HealthBridge Children's Hospital, a children's specialty hospital located at 393 South Tustin Street, Orange, California, or at any other future location, or whether identified by any other name.
- 1.31. "**The Joint Commission**" means the recognized accrediting body for healthcare organizations, located in Oakbrook Terrace, IL.
- 1.32. "**Licensed Independent Practitioner**" Any individual permitted by law and by the organization to provide care and services, without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges, i.e. a doctor of medicine, doctor of

osteopathy, doctor of podiatry or a doctor of dentistry possessing an unrestricted license to practice in the State of California, who is either an applicant for membership or a member of the medical staff.

- 1.33. **"Medical Executive Committee"** means the medical executive committee of the medical staff, serving as a committee of the whole. The medical executive committee shall be comprised of the President of the Medical Staff, who shall chair the committee, and all members of the medical staff. The medical executive committee is empowered to act for the medical staff in all matters except as may otherwise be noted in these bylaws.
- 1.34. **"Medical Staff"** means all duly licensed physicians, dentists, and podiatrists holding a current unlimited California license to practice their respective professions, who have been credentialed and been given clinical privileges to admit and/or attend and/or consult on patients in the hospital.
- 1.35. **"Medical Staff Bylaws"** means these bylaws and shall have the same meaning as **"Bylaws"** and may be used interchangeably, herein.
- 1.36. **"Medical Staff Coordinator"** means the individual tasked by the CEO to serve as the liaison between hospital administration and the medical staff, who shall assist the medical staff by, *among other things*, overseeing Credentialing matters on behalf of the hospital and the medical staff. The position of medical staff coordinator may be performed as a full-time or a collateral duty.
- 1.37. **"Medical Staff Member(s)"** means a member of the medical staff in good standing, in any category or status, and excludes applicants and affiliated healthcare professionals.
- 1.38. **"Medical Staff Membership"** or **"Membership"** means becoming and/or remaining a member of the hospital's medical staff in good standing.
- 1.39. **"Medical Staff Officer"** means the chair of the medical executive committee and any member of the medical staff serving in an official capacity on behalf of the committee, either within or without the hospital.
- 1.40. **"Medical Staff Year"** means a calendar year, commencing January 1st each year and ending December 31st.
- 1.41. **"Member"** shall have the same meaning as medical staff member.
- 1.42. **"Peer Review Committee"** or **"Professional Review Body"** means not only members of such a committee or body, but also employees, representatives, agents, attorneys, investigators, assistants, clerks, staff, and any other person or organization who serves in any capacity, whether such person is acting as a member or under a contract or other formal agreement with the committee or body, and any person who participates with or assists the committee or body with respect to its actions.
- 1.43. **"Performance Improvement Committee"**, **"Quality Council"** or **"PI Committee"** means any committee or joint committee of the hospital or medical staff charged with reviewing matters of utilization review, performance review, infection control, pharmacy and therapeutics, medical records, and any other health care quality and delivery issues, policies and practices.
- 1.44. **"Physician(s)"** means both allopathic (M.D.) and osteopathic (D.O.) physicians possessing an

unrestricted license to practice medicine in the State of California.

- 1.45. "**Plan**" means the formal professional review activity adopted by the hospital to determine the competence or professional conduct of a practitioner (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the practitioner.
- 1.46. "**Podiatrist**" means a podiatrist possessing an unrestricted license to practice podiatry in the State of California.
- 1.47. "**Practitioner**" means any individual who is licensed and qualified to practice a health care profession and is engaged in the provision of care, treatment or services.
- 1.48. "**President of Medical Staff**" means the Chief Officer of the Medical Staff (or designee) elected by members of the Medical Staff. The President of the Medical Staff is a physician duly licensed in the State of California serving as the chief officer of the medical staff. The President of the Medical Staff is appointed and approved by the board, and serves as the chair for the medical executive committee. The President of the Medical Staff also serves as a voting member of the governing board
- 1.49. "**Privileges**" shall have the same meaning as "*Clinical Privileges*."
- 1.50. "**Proctoring**" means the monitoring, by direct or indirect observation, of patient care being administered by another medical staff member with privileges in the specialty area being proctored. Also known as Focused Professional Practice Evaluation.
- 1.51. "**Professional Review Action**" means an action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual practitioner (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the practitioner. Such term includes a formal decision of a professional review body not to take an action or make a recommendation described herein and also includes professional review activities relating to a professional review action. An action is not considered to be based on the competence or professional conduct of a practitioner if the action is primarily based on:
  - 1.51.1. the practitioner's association, or lack of association, with a professional society or association,
  - 1.51.2. the practitioner's fees or the practitioner's advertising or engaging in other competitive acts intended to solicit or retain business,
  - 1.51.3. the practitioner's participation in prepaid group health plans, salaried employment, or any other manner of delivering health services whether on a fee-for-service or other basis,
  - 1.51.4. a practitioner's association with, supervision of, delegation of authority to, support for, training of, or participation in a private group practice with, a member or members of a particular class of health care practitioner or professional, or
  - 1.51.5. any other matter that does not relate to the competence or professional conduct of a practitioner.
- 1.52. "**Professional Review Activity**" means an activity of the hospital with respect to an individual practitioner:
  - 1.52.1. to determine whether the practitioner may have clinical privileges with respect to, or

membership in, the entity,

1.52.2. to determine the scope or conditions of such privileges or membership, or

1.52.3. to change or modify such privileges or membership.

1.52.4. Any activity performed within or without the hospital which could adversely affect a practitioner is a professional review activity.

1.53. "**Professional Review Body**" means the hospital, the governing board or any committee of the hospital or governing board specifically formed to conduct professional review activity, and includes any committee of the medical staff of such an entity when assisting the governing body in a professional review activity. Such committees, and all personnel of such peer review committees or professional review committees, shall and hereby do claim all privileges and immunities afforded to them by the Act, as may hereafter be amended.

1.54. "**Reappointment**" means the reappointment of a member in good standing to the medical staff, immediately following a prior period of appointment.

1.55. "**Resident(s)**" means the individual or individuals participating in an approved residency or fellowship program of a medical school or dental school, and whose presence in the hospital has been approved in advance by the resident's program director and the hospital's President of the Medical Staff; and who has completed the necessary paperwork required by the hospital and agrees to abide by the terms of the agreement between their program and this hospital; and, who shall work under the supervision of the President of the Medical Staff and members of the active medical staff. Residents are not members of the medical staff and may not attend medical staff meetings.

1.56. "**Rules and Regulations**" means the rules and regulations and all amendments thereto duly adopted by the medical staff and approved by the governing board, and which are affixed to these bylaws as *Addendum "A."*

1.57. "**Special Notice**" means a written notification either (i) personally delivered, or (ii) sent via U.S. certified or registered mail, return receipt requested, postage prepaid, to the address of the intended recipient, as that address is reflected in the records of the hospital.

1.58. "**State**" means the State of California.

Terms not otherwise defined herein shall be given their common meaning, unless required otherwise by the context.

## ARTICLE 2 - NAME AND APPLICATION

2.1. These are the Bylaws for the Medical Staff of HealthBridge Children's Hospital. The entities governed by these Bylaws are the Medical Staff and all Medical Staff committees and Medical Staff activities occurring in the Hospital.

## ARTICLE 3 - PURPOSES OF THE MEDICAL STAFF

The purposes of the Medical Staff shall include, but not be limited to the following:

3.1. Serving as a professional collegial body, providing for its Members' and the Residents' mutual education

and training, consultation and professional support, consistent with recognized standards of practice in the community - given the current state of the healing arts and the available resources.

- 3.2. Establishing a healthcare treatment environment where all pediatric patients admitted to or treated in the Hospital receive an appropriate level of care, regardless of race, sex, color, creed, disability, national origin, religion, sexual preference or payor source.
- 3.3. Serving as the primary means for accountability to the Governing Board for the appropriateness of Medical Staff Members' professional performance and ethical conduct through use of peer review and analysis.
- 3.4. Collaborating with Hospital administration to develop an organizational structure reflected in the Medical Staff Bylaws, Rules and Regulations and other protocols adopted pursuant there from, which adequately defines responsibility and concomitant authority and accountability of every organizational component. Such structure shall further be designed to assure that each Medical Staff Member exercises responsibility and authority and is subject to appropriate accountability commensurate with His current clinical competence to provide patient care in the Hospital.
- 3.5. Making recommendations to the Credentialing Committee concerning Appointments and Reappointments to the Medical Staff, including Membership category and delineation of Clinical Privileges.
- 3.6. Fostering a high level of professional performance and ethical conduct of all Medical Staff Members by the appropriate delineation of Clinical Privileges in the Hospital and the continuous review of the activities of all individuals granted these Clinical Privileges.
- 3.7. Participating in the Hospital's performance improvement program by conducting all required and necessary activities for assessing and improving the effectiveness and efficiency of medical care provided in the Hospital, including without limitation the following:
  - 3.7.1. evaluating Practitioners and their performance through valid and reliable criteria;
  - 3.7.2. engaging in the ongoing monitoring of aspects of patient care and enforcement of Medical Staff and Hospital policies;
  - 3.7.3. evaluating Practitioners' credentials for Appointment and Reappointment to the Medical Staff and for the delineation of Clinical Privileges in the Hospital;
  - 3.7.4. arranging for Medical Staff participation in programs designed to meet the educational needs of its Members and Residents; and
  - 3.7.5. assuring that medical and health care services at the Hospital are appropriate for meeting patients' medical, psychological, social and emotional needs, consistent with sound healthcare resource utilization and continuous performance improvement practices.
  - 3.7.6. Performance indicators as established by the hospital
- 3.8. Initiating and maintaining rules and regulations for self-governance and orderly functioning of the Medical Staff that can be enforced.
- 3.9. Reviewing and evaluating care provided by Members in relation to cost effectiveness and other factors necessary to meet accreditation and licensure standards, federal and state law, and peer review standards and report to the Board through the President of the Medical Staff and/or Board Representative.
- 3.10. Establishing procedures for Professional Review Action in the Hospital designed to fairly review the competence or professional conduct of a Practitioner in a timely manner.

- 3.11. Participating and promoting activities designed to improve and protect the general health of the community served by the Hospital.
- 3.12. Providing an orderly and systematic means to identify, discuss and resolve issues concerning the Medical Staff and the Hospital that may be discussed internally, in a collegial and cooperative manner, or with the Governing Board and/or the CEO.
- 3.13. Accomplishing such other purposes as described in these Bylaws, or as may otherwise be determined by the Credentialing Committee or the Governing Board of the Hospital.

## ARTICLE 4 - MEDICAL STAFF MEMBERSHIP

- 4.1. **Medical Staff Membership.** Membership on the Medical Staff of the Hospital is a privilege and not a vested interest or right. Every practitioner who seeks or enjoys appointment to the Medical Staff must, at the time of appointment and continuously thereafter, demonstrate to the satisfaction of the appropriate authorities of the Medical Staff the following qualifications and any additional qualifications and procedural requirements as are set forth in these Bylaws and rules and regulations and other protocols adopted pursuant hereto.
  - 4.1.1. Membership on the Medical Staff and/or Clinical Privileges shall be extended only to qualified Practitioners who are professionally competent and the Member shall participate only such Clinical Privileges and prerogatives as have been granted by the CREDENTIALING Committee in accordance with the Bylaws.
  - 4.1.2. No Practitioner, including those Practitioners holding medical administrative positions by virtue of a written contract with the Hospital, shall admit or provide service to patients in the Hospital until or unless He is a Member of the Medical Staff or has been granted temporary privileges in accordance with the procedures set forth in these Bylaws.
  - 4.1.3. No individual shall be entitled to Membership on the Medical Staff merely because that individual holds a certain degree, is licensed to practice in this or in any other state, is a member of any professional organization, is certified by any clinical board, or because such individual had, or presently has, staff membership or privileges at another healthcare facility.
- 4.2. **Licensure.** Only qualified Physicians, Podiatrists and Dentists currently licensed to practice in the State, who can document their background, experience, training, demonstrated competence, and adherence to the ethics of their professions shall be qualified for Medical Staff Membership and be granted Privileges to practice. Practitioners applying or continuing Medical Staff Membership and/or Clinical Privileges:
  - 4.2.1.1.1 must possess and demonstrate a good reputation, sound professional judgment, adequate physical and mental competencies, a willingness to participate in the timely discharge of Staff responsibilities, the ability to work with others with sufficient adequacy to reasonably assure the Medical Staff that any patient treated by them in the Hospital will be given medical care consistent with the recognized standard of practice in the community.
  - 4.2.1.1.2 Will be granted Privileges by the CREDENTIALING Committee and shall be directly related to (i) the delivery of quality patient care, (ii) professional ability and judgment, and (iii) community need.
  - 4.2.1.1.3 Must demonstrate graduation from an approved school of medicine, osteopathy, dentistry or podiatry, or certified by the Educational Council for Foreign medical Graduates; and if a physician, satisfactory completion of an approved residency; and if a dentist or podiatrist, satisfactory completion of at least two years in a post graduate/residency training program.
- 4.3. **Clinical Performance.** Practitioners applying or continuing Medical Staff Membership and/or Clinical

privilege must demonstrate current experience, clinical results and utilization practice patterns, documenting a continuing ability to provide patient care services at an acceptable level of quality and efficiency given are consistent with available resources.

- 4.4. **Attitude and Cooperativeness.** Practitioners applying or continuing Medical Staff Membership and/or Clinical Privileges most demonstrate ability to work with and relate to other staff appointees, members of other health disciplines, Administration and Medical Leadership, employees, visitors and the community in general, in a cooperative, professional manner that is essential for maintaining an environment appropriate to quality and efficient patient care.
- 4.5. **Professional Conduct.** Practitioners applying or continuing Medical Staff Membership and/or Clinical Privileges shall be of high moral character and to adhere to generally recognized standards of medical and professional ethics. Specifically, but without limitation, this includes refraining from: paying or accepting commissions or referral fees for professional services; delegating the responsibility for diagnosis or care of patients to a practitioner or allied health professional not qualified to undertake that responsibility; failing to reveal to the patient the identity of the practitioners involved in providing services; failing to seek appropriate consultation when medically indicated; failing to provide or arrange for appropriate and timely medical coverage and care for patients for whom the practitioner is responsible; and failing to obtain informed patient consent to treatments. Practitioners should not treat themselves or members of their families.
- 4.6. **Basic Obligations of Medical Staff Membership.** Acceptance of Membership on the Medical Staff shall constitute the Practitioner's expressed agreement to:
  - 4.6.1. strictly abide by the principles of the Practitioner's professional and/or ethical code, as such code may be amended or modified from time to time;
  - 4.6.2. provide patients with care at the level consistent with recognized standards of practice in the community and consistent with the Practitioner's professional responsibility for medically appropriate and fiscally efficient facility and resource utilization;
  - 4.6.3. abide by the Medical Staff Bylaws and all other lawful standards, policies and rules of the Hospital;
  - 4.6.4. discharge such Medical Staff, committee, clinical service and Hospital functions for which He is responsible due to Medical Staff assignment or appointment;
  - 4.6.5. prepare and complete, according to regulation, standards and/or hospital policy, the medical and other required records for all patients admitted to or cared for in the Hospital;
  - 4.6.6. satisfy the continuing education requirements established by the Practitioner's licensing body and the Medical Staff and participating in continuing education requirements as requested or required, necessary to maintain clinical skills and current competence; (*Note: Physicians need to complete at least 24 hours of continuing medical education, at least half of which must be in formal courses. These hours should be counted from expiration date to expiration date. Documentation of CME courses shall be made available upon request.*)
  - 4.6.7. review these Bylaws and agree that throughout any period of His Membership He will timely comply with the obligations and requirements of Medical Staff Membership and with these Bylaws and the rules, regulations and other protocols adopted and modified from time to time pursuant hereto;
  - 4.6.8. work cooperatively with Medical Staff Members, nurses, Hospital employees and Hospital administration to promote positive patient care;
  - 4.6.9. immediately advise the Hospital of any change in such Member's licensure status; and
  - 4.6.10. provide all information necessary to insure that a current and up-to-date Credentialing file is always maintained at the Hospital.

- 4.7. **Nondiscrimination.** No Practitioner shall be denied Membership to the Medical Staff and/or practice privileges because of His race, religion, age, creed, color, ethnic origin, nationality, disability, sex, sexual preference or any other bases proscribed by law.
- 4.8. **Disability.** Practitioners shall be free of or have adequately accommodated any occupationally relevant physical or behavioral impairment that interferes with, or presents a substantial probability of interfering with, the qualifications required in these Bylaws, in such a way that patient care is not likely to be compromised or adversely affected.
- 4.8.1. **“Ability-to-Perform” Statement.** Each Applicant shall submit a written Ability-to-Perform Statement or another similar statement, in which He shall swear or affirm that He does not have any physical or mental health disability (including, but not limited to, any form of illegal substance addiction) that affects, or is reasonably likely to affect, His ability to perform His obligations to His patients and/or His duties as a Member of the Medical Staff.
- 4.9. **Specific Qualifications for Membership.** Only Practitioners meeting the following criteria shall be considered for Membership:
- 4.9.1. maintains an unrestricted license to practice in the State;
  - 4.9.2. maintains State controlled substance registration and DEA registration;
  - 4.9.3. can document his academic and employment background, experience, training, current competence, and adherence to the ethics of their profession;
  - 4.9.4. can document their professional reputation;
  - 4.9.5. whose physical and mental health will not be detrimental to the care and/or well being of the patients or their responsibility to meet the obligations imposed by these Bylaws and would be willing to submit to a physical and/or mental examination, as may be requested by the Medical Executive Committee or the Credentialing Committee for such purpose, if deemed necessary;
  - 4.9.6. can satisfactorily demonstrate appropriate utilization of services at the Hospital or other healthcare facility where the Practitioner has Privileges;
  - 4.9.7. can satisfactorily demonstrate ability to interface effectively and harmoniously with others;
  - 4.9.8. has an acceptable professional liability record, including past and pending professional liability claims, suits, settlements and judgments;
  - 4.9.9. prepares medical record entries , according to regulation, standards and/or hospital policy, and legible manner in accordance with Hospital policy and Medical Staff Rules and Regulations with sufficient adequacy that convinces the Medical Executive Committee and the Credentialing Committee that any patient treated by them in the Hospital will be given medical care at or above the level which is consistent with that being currently provided in the Hospital;
  - 4.9.10. maintains professional liability insurance in amounts determined adequate by the Governing Board. Compliance with this policy shall be evidenced by filing with the Chief Executive Officer written evidence from the Medical Staff member or applicant that his malpractice insurance coverage is equal to or greater than that required by the Board. All physicians and allied health professionals must carry medical professional liability insurance with limits of at least \$1,000,000 per claim and \$3,000,000 annual aggregate. *(a copy of the certificate of insurance must be submitted to the Medical Staff Coordinator with the initial application; at the time of re-application, the Applicant must update all professional liability insurance information, including the name of the insurance carrier, the policy number and the policy’s expiration date.);*
  - 4.9.11. adheres to applicable state and federal laws, rules and regulations and regulatory standards, including those which permit payment to the Hospital for services ordered or provided by the Members;
  - 4.9.12. is able to read and understand English, and communicate effectively in writing and verbally in English; and

- 4.9.13. has not been convicted of Medicare or Medicaid fraud or abuse related violations or been expelled from participation.
  - 4.9.14. maintains CPR/PALS licensure and TB screening for practitioners that practice in care on-site. PALS certification required for all pediatricians.
  - 4.9.15. immediately reports any voluntary or involuntary termination of medical staff appointment, limitation or reduction, or loss of privileges at any hospital or any restriction of practice or severance from employment by a medical practice employing more than twenty five physicians.
  - 4.9.16. Prepares and compete, according to regulation, standards and/or hospital policy, the medical and other required records for all patients for whom the practitioner is responsible.
  - 4.9.17. failure to satisfy any of these basic obligations is grounds , as warranted by the circumstances, for non–reappointment or for such disciplinary action as deemed appropriate as noted in these Bylaws including the Medical Staff Rules and Regulations.
- 4.10. **Board Certification.** An Applicant for Membership must be able to document board certification or board eligibility.
- 4.11. **Duration and Limitation of Appointment.** Appointment and Reappointment to the Medical Staff shall be made by the Credentialing Committee according to procedures set forth in these Bylaws and the Hospital’s Credentialing policies.
- 4.11.1. **Appointment and Reappointment Periods.** Initial Appointment shall be for a period of not less than one (1) year or more than two (2) years, and shall include a sufficient review process. Reappointments shall be for a period of not more than two (2) years.
  - 4.11.2. **Privileges Granted in Accordance with Bylaws.** Appointment to the Medical Staff shall confer on the Practitioner only such Clinical Privileges as have been approved by the Credentialing Committee in accordance with these Bylaws.
- 4.12. **Evaluation of Applications.** Mechanisms for evaluating Applications for initial Appointment and for conducting periodic reappraisals for Reappointment to the Medical Staff are outlined in the hospital’s Credentialing policies and are incorporated herein by reference.
- 4.12.1. The decision to grant or deny a privilege(s), and/or to renew an existing privilege(s), is arrived at by an objective, evidence-based process.
    - 4.12.1.1. Each of the criteria used are consistently evaluated for all practitioners holding that privilege.
    - 4.12.1.2. The evaluation shall consist of information regarding the practitioner’s current:
      - 4.12.1.2.1. medical/clinical knowledge
      - 4.12.1.2.2. technical and clinical skills
      - 4.12.1.2.3. interpersonal skills
      - 4.12.1.2.4. communication skills
      - 4.12.1.2.5. professionalism
    - 4.12.1.3. Before recommending privileges, the following will be evaluated:
      - 4.12.1.3.1. challenges to any licensure or registration
      - 4.12.1.3.2. voluntary and involuntary relinquishment of any license or registration
      - 4.12.1.3.3. voluntary and involuntary termination of medical staff membership
      - 4.12.1.3.4. voluntary and involuntary limitation, reduction, or loss of clinical privileges
      - 4.12.1.3.5. any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant
      - 4.12.1.3.6. documentation as to the applicant’s health status
      - 4.12.1.3.7. relevant practitioner-specific data as compared to aggregate data, when available
      - 4.12.1.3.8. morbidity and mortality data, when available

- 4.13. **Burden of Providing Information.** In connection with all applications for Appointment or Reappointment, the Practitioner shall have the burden of providing information for an adequate evaluation of His qualifications and suitability for the Clinical Privileges and category requested, of resolving any reasonable doubts about these matters, and of satisfying any and all requests for information. The Practitioner's failure to sustain this burden shall be grounds for denial of the Application, which denial is not a Professional Review Action and shall **not** entitle the Practitioner to a Hearing. This burden may include submission to a medical or psychological examination limited in scope to matters occupationally relevant to the Membership status and/or Privileges sought, *at the Practitioner's expense*, if deemed appropriate by the Medical Executive Committee. The Medical Executive Committee may select the examining physician. All Practitioners seeking Medical Staff Appointment shall agree to acknowledge in writing the Hospital's obligation to query and report adverse actions to the State licensing agency pursuant to the Act, as the same has been, and may be, amended from time to time.
- 4.14. **Acknowledgments by Practitioner.** Every Application for Medical Staff Appointment or Reappointment shall be signed by the Practitioner and shall contain the Practitioner's acknowledgment to provide for the continuous care and supervision of His patients, and His willingness to abide by these Bylaws, the Rules and Regulations adopted by the Medical Staff and other laws or regulations applicable to their particular practice in the Hospital. By applying for Membership, each Practitioner shall acknowledge His:
- 4.14.1. willingness to appear for interviews;
  - 4.14.2. authorization to consult with others who have been associated with Him, who may have information bearing on His competence, qualifications and performance, and authorizes such individuals and organizations to candidly provide all such information;
  - 4.14.3. consent to inspection of records and documents that may be material to an evaluation of His qualifications and ability to carry out Clinical Privileges requested, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying;
  - 4.14.4. release from any liability, to the fullest extent permitted by law, all persons for acts performed in connection with investigating and evaluating the Practitioner;
  - 4.14.5. release from any liability, to the fullest extent permitted by law, all individuals and organizations who provide information regarding the Practitioner, including otherwise confidential information;
  - 4.14.6. consent to the disclosure to other hospitals, medical associations, licensing boards, and to other similar organizations as required by law, any information regarding the Practitioner's professional or ethical standing that the Hospital or Medical Staff may have, and releases the Medical Staff and the Hospital from liability for so doing to the fullest extent permitted by law;
  - 4.14.7. pledge to endeavor to provide for the continuous quality care for patients;
  - 4.14.8. pledge to maintain an ethical practice, including refraining from illegal inducements for patient referral, providing continuous care of His patients, seeking consultation whenever necessary, refraining from providing "ghost" medical services, and refraining from delegating patient care responsibility to non-qualified or inadequately supervised Practitioners; and
  - 4.14.9. understanding of the Hospital's obligation to query and report actions Adversely Affecting Applicants and Practitioners to the State licensing agency pursuant to the Act, as the same has been and may be amended from time to time.
- 4.15. **Exclusion From Medicare or Medicaid.** No Practitioner shall be eligible for Medical Staff Membership if He has been excluded from the Medicare or Medicaid program. This criterion is not a Professional Review Action and does not entitle the Practitioner to a Hearing.
- 4.16. **Contract Practitioners.** Contract Practitioners may be retained by the Hospital for any purpose

permitted by and consistent with these Bylaws and Rules and Regulations. The CEO may seek the input of the Medical Executive Committee regarding recommendations concerning quality of care issues related to Contract Practitioners in the following situations:

- 4.16.1. whether to execute an exclusive contract;
  - 4.16.2. whether to renew or modify an exclusive contract; and/or
  - 4.16.3. whether to terminate an exclusive contract.
- 4.17. **Privileges Required to Admit, Attend Patients for Contract Practitioners.** A Practitioner under any written contract with Hospital supervisory or administrative duties may not admit or provide service to Hospital patients unless that Practitioner becomes a Member of the Medical Staff, with delineated Privileges, in accordance with these Bylaws.
- 4.18. **Termination of Contract.** Termination of a contract between a Practitioner and the Hospital shall not terminate the Practitioner's Membership; provided, however, that such contract termination does not include a written provision mandating the termination of such Membership or Privileges concurrent with the contract termination. Any contractual termination of Membership or Clinical Privileges does not entitle the Practitioner to a Hearing.
- 4.19. **Termination of a Practitioner's Medical Staff Membership.** Termination of a Practitioner's Medical Staff Membership or revocation of His Clinical Privileges in accordance with these Bylaws is grounds for termination of the contract between the Practitioner and the Hospital, notwithstanding any contractual provision to the contrary.
- 4.20. **Opportunity for Administrative Input.** Any Medical Staff Member in any category, holding either status, may attend meetings of the Governing Board as a Governing Board Representative, or request and obtain a meeting with the CEO, to adequately communicate concerns regarding the Medical Staff and/or Hospital administration.

## ARTICLE 5 - CATEGORIES AND STATUS OF THE MEDICAL STAFF

- 5.1. **Medical Staff Categories and Status.** The Medical Staff of the Hospital shall be organized into three (3) categories: ***Active, Courtesy*** and ***Consulting***.
- 5.2. **Medical Staff Status.** Each Member shall also have status, which shall be either ***Provisional*** or ***Regular***.
- 5.2.1. All Practitioners shall successfully complete a period of time in provisional status during their initial period of Appointment. During their initial Reappointment, they shall automatically be placed in regular status, upon final approval of their Reappointment by the Credentialing Committee.
  - 5.2.2. Practitioners in provisional status shall enjoy all the Clinical Privileges granted to them and the prerogatives enjoyed by Members of the category to which they have been duly admitted.
- 5.3. **Proctoring.** While in provisional status, or if determined appropriate afterwards, a Practitioner's performance shall be subject to Proctoring.
- 5.3.1. If the President of the Medical Staff determines that Proctoring is appropriate, a proctor shall be appointed from the Medical Staff by the President of the Medical Staff. The proctor shall, through direct and indirect observation, evaluate the Practitioner's clinical skills, medical judgment

and compliance with these Bylaws and provide a report at (i) the close of the Practitioner's initial period of Appointment, or (ii) at a time determined in advance by the President of the Medical Staff for Practitioners in regular status. The proctor's report shall be reduced to writing and may be delivered via live testimony at the election of the President of the Medical Staff.

5.3.2. The decision to assign a proctor does not entitle the Practitioner to a Hearing.

5.4. **Active Staff.**

5.4.1. Qualifications. The Active Staff shall consist of Practitioners who, in the best judgment of the Medical Executive Committee and Credentialing Committee, are:

5.4.1.1. Located in sufficient proximity to the Hospital to provide continuous care of their patients; and

5.4.1.2. Who assume all of the functions and responsibilities of appointment to the Active Staff in compliance with these Bylaws; and

5.4.1.3. Anticipate admitting at least six (6) patients annually to the Hospital.

5.4.2. Prerogatives and Obligations. A Member of the Active Medical Staff shall have the following prerogatives and obligations:

5.4.2.1. Admit patients appropriate for admission to the Hospital, except as otherwise provided in these Bylaws or any rules or regulations adopted pursuant hereto;

5.4.2.2. Vote on all matters presented at general and special meetings of the Medical Staff, any committee of which He is a member, and to otherwise participate in all Medical Staff affairs;

5.4.2.3. Meet the minimum guidelines for clinical activity during Reappointment periods as outlined in the Hospital's Credentialing policy;

5.4.2.4. Exercise such Clinical Privileges as are granted to Him;

5.4.2.5. Accept Medical Staff committee appointments, as assigned;

5.4.2.6. Assist in the clinical, administrative and quality management work conducive and necessary to the professional and efficient operation of the Hospital;

5.4.2.7. Attend the minimum number of required regular Medical Staff and committee meetings, as provided in these Bylaws;

5.4.2.8. Participate in Performance Improvement activities; and

5.4.2.9. Consult freely with other Medical Staff Members concerning medical cases and challenging healthcare concerns.

5.4.3. Noncompliance/Discipline. Failure to comply with any of the above obligations may subject a Practitioner to corrective action, as outlined herein. After two consecutive years during which an Active Staff Member fails to care regularly for patients in the Hospital, or to be involved regularly in Medical Staff functions as determined by the Medical Executive Committee, the Member shall be removed from the Medical Staff or transferred to the appropriate Staff category, if any, for which the Member is qualified. A Practitioner removed from the Active category because He no longer meets the criteria is NOT based on competence or conduct and does not entitle Him to a Hearing under Article 10 of these Bylaws. A Practitioner removed from the Active category for any other reason may be a Professional Review Activity and would entitle the Practitioner to a Professional Review Action.

5.5. **Courtesy Staff.**

5.5.1. Qualifications. The Courtesy Staff shall be comprised of those Practitioners who anticipate admitting less than six (6) patients annually to the Hospital and who:

5.5.1.1. meet the general qualifications for Medical Staff Membership; and

5.5.1.2. are located in the same proximity to the Hospital as Active Staff Members, or demonstrate arrangements that are satisfactory to the Credentials Committee for alternative medical coverage for patients for whom He is responsible; and

- 5.5.1.3. demonstrate that they are members of the Active or Courtesy Staff at another licensed hospital in California, if a Practitioner's primary practice location is not at the Hospital, but is within Hospital's service area and such other hospital observes quality management procedures consistent with those of the Hospital; and
  - 5.5.1.4. agree to fulfill the obligations of Active Staff Membership specified in these Bylaws and to participate in Performance Improvement activities.
  - 5.5.2. Prerogatives and Obligations. Courtesy Medical Staff Members shall have the following prerogatives and obligations:
    - 5.5.2.1. Courtesy Staff Members may admit patients in the same manner as Active Staff Members, subject to any other requirements of these Bylaws. At such times as the CEO may determine that the Hospital is operating at full occupancy, or that there is otherwise a shortage of Hospital beds and/or other facilities, the elective patient admissions of Courtesy Staff members shall be subordinated to those of Active Staff Members.
    - 5.5.2.2. Courtesy Staff Members shall exercise those Clinical Privileges which have been granted to them. Courtesy Staff Members may, but are not obligated to, attend Medical Staff meetings, including open committee meetings and educational programs. Courtesy Staff Members shall be eligible to vote for the President of the Medical Staff.
  - 5.5.3. Noncompliance/Discipline. Failure to comply with any of the above obligations may subject a Practitioner to corrective action, as outlined herein. After two consecutive years during which a Courtesy Staff Member fails to care regularly for patients in the Hospital, or to be involved regularly in Medical Staff functions as determined by the Medical Staff, such Member shall, at the discretion of the Medical Staff, be removed from the Medical Staff or transferred to the appropriate Staff category, if any, for which the Member is qualified. A Practitioner removed from the Courtesy category because He no longer meets the criteria is NOT based on competence or conduct and does not entitle Him to a Hearing under Article 10 of these Bylaws. A Practitioner removed from the Courtesy category for any other reason may be a Professional Review Activity and would entitle the Practitioner to a Professional Review Action.
- 5.6. **Consulting Staff.**
- 5.6.1. Definitions and Qualifications. A Consulting Medical Staff Member primarily provides consultations for patients admitted and attended by other Members of the Medical Staff and must:
    - 5.6.1.1. possess specialized skills needed at the Hospital in a specific project or on an occasional basis in consultation when requested by a Medical Staff Member; and
    - 5.6.1.2. demonstrate active participation on the Medical Staff in the Active or Courtesy category at another hospital requiring performance improvement activities of a substance and character similar to those at this Hospital or agrees to fulfill the obligations of the Courtesy Staff membership specified in these Bylaws or Hospital policies concerning participation in Performance Improvement activities at the Hospital.
  - 5.6.2. Prerogatives and Obligations. A Consulting Medical Staff member may exercise such Clinical Privileges as are granted by the Credentialing Committee. Consulting Staff members are not eligible to admit patients to the Hospital, hold office in the Medical Staff, or vote at meetings of the Medical Staff. Consulting Medical Staff members may, however, participate and vote in Medical Staff committees. Further obligations of Consulting Staff are provided in Section 4.3 of these Medical Staff Bylaws.
  - 5.6.3. Noncompliance/Discipline. Any action taken or made during a professional review activity based on a Practitioner's competence or professional conduct that affects or could adversely Affect a Practitioner in the Courtesy category would entitle the Practitioner to a Hearing under these Bylaws.

5.7. **Hospital Based Medical Staff.**

5.7.1. **Definitions and Qualifications.** Hospital based Medical Staff are those Practitioners under contract to the Hospital who are Members of the Active Medical Staff. Hospital based Medical Staff Members are required to comply with these Bylaws, however, all other rights are controlled by the contractual agreement. Hospital based Medical Staff shall remain in Good Standing in the Active Staff category.

5.7.2. **Prerogatives and Obligations.** A Member of the Hospital based Medical Staff may admit patients without limitation and exercise those clinical privileges granted to Him by the Credentialing Committee. These Members are eligible to attend all meetings of the Medical Staff as a voting member and serve on Medical Staff committees, with the same obligations imposed on Active Medical Staff Members.

5.8. **Emergency-Non-Disaster Privileges & Courtesy Staff Membership.** In the event that the President of the Medical Staff becomes aware of a medical emergency or other situation which might require the treatment of a Hospital patient(s) by a Practitioner who is not a member of the Medical Staff, or who otherwise does not have Clinical Privileges at the Hospital, the President of the Medical Staff may grant *emergency non-disaster privileges and courtesy staff membership* to the Practitioner(s) at issue. As soon as possible, the President of the Medical Staff shall report any activity taken to the Medical Executive Committee. The duration of any privileges and/or Membership granted hereunder *shall not exceed thirty (30) Days*, but such duration may be extended by fifteen (15) Days when deemed medically necessary **and** when approved in writing by the President of the Medical Staff.

5.9. **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 and/or by the Medical Staff Rules and Regulations.

5.10. **Leaves of Absence.** A Member in any category may request a leave of absence, as further provided in these Bylaws and Rules and Regulations. It is intended that leaves of absence be granted only for compelling reasons. A leave of absence is not a category or a status of Medical Staff Membership.

5.11. **Procedure for Leaves of Absence.** To initiate a request for a leave of absence, a Member must submit His request in writing for a voluntary leave of absence to the President of the Medical Staff via the Medical Staff Coordinator. The term of the leave of absence may not extend beyond the Member's current term of Appointment. At a minimum, the request must include the following:

5.11.1. basis or bases for the request;

5.11.2. date of departure and anticipated date of return; and

5.11.3. unambiguous arrangements in writing for physician coverage of current patients in the Hospital.

5.12. **Review and Consideration.** The President of the Medical Staff shall review the request for leave of absence, including an emergency leave of absence, along with comments and recommendations submitted therewith. The President of the Medical Staff may make additional inquiries prior to reaching a determination. If approved, the leave of absence shall commence and expire on the dates, and upon the conditions, approved.

5.13. **Restrictions During Leave of Absence.** During a leave of absence, a Practitioner may not exercise Clinical Privileges or any of the privileges of Medical Staff Membership, and may not treat patients at, or

admit patients to, the Hospital.

- 5.14. **Terminating a Leave of Absence.** Not later than thirty (30) Days before the date of expiration of a leave of absence, or any earlier time, a Practitioner shall request reinstatement by submitting a written request to the President of the Medical Staff via the Medical Staff Coordinator. The Practitioner must include a written summary of all *relevant* activities that occurred during the period of the leave of absence that might adversely impact His ability to resume His role on the Medical Staff. If any issues arise, the Practitioner may be called upon to demonstrate that He is still clinically competent to exercise His Clinical Privileges and is otherwise qualified for Medical Staff Membership.
- 5.15. **Request for Reinstatement.** The President of the Medical Staff shall review a Practitioner's request for reinstatement and shall act on such request within fourteen (14) Days from receipt of said request. The President of the Medical Staff may convene the Medical Executive Committee if any issues have been raised by the Member in His request for reinstatement which the President of the Medical Staff feels requires additional input from the Medical Executive Committee. The Medical Staff Coordinator shall ensure that the Practitioner receives the decision via Special Notice.
- 5.16. **Result of Untimely Reinstatement Request.** If a Practitioner's term of Appointment expires before He returns from His leave of absence, He must submit a new Application for Medical Staff Membership and request for Clinical Privileges.
- 5.17. **Leave Request Due to Impairment.** Where a Member has requested and taken a leave of absence due to impairment (e.g., drug, alcohol, mental impairment or any other recognized impairment), the Medical Staff Rules and Regulations shall apply. In addition, other qualifications for Reinstatement may be imposed by the Medical Executive Committee for the protection of the patients and the Hospital.

**5.18. Committee on Physician Health**

5.18.1. Assisting Impaired Medical Staff Members

- 5.18.1.1. All Medical Staff members should share their concerns about chemical dependence, or mental or physical impairment, or behavior problems in themselves or other members, in confidence, with the Committee on Physician Health. The Committee on Physician Health is dedicated to helping the members identify chemical abuse, and mental and physical impairments, and behavior problems and helping members to obtain treatment to alleviate the problem. Even though the Committee's mission is to assist Medical Staff members, patient safety must be primary. Thus, if the Committee on Physician Health finds a risk of harm or danger to patients and the practitioner does not willingly enter treatment and/or withdraw from clinical practice, the Committee will suggest to the President of the Medical Staff to initiate corrective action.

5.18.2. Composition

- 5.18.2.1. The Committee on Physician Health shall be composed of no fewer than three Active or Courtesy Medical Staff Members. A psychiatrist or psychologist will be a participant whenever possible.
- 5.18.2.2. The associate President of the Medical Staff will chair the physician well-being committee.
- 5.18.2.3. Whenever possible, members of this committee may not actively participate on other peer review committees while serving on this committee. Members of the committee may not participate in any corrective action against any physician being assisted by the committee.
- 5.18.2.4. Should a conflict of interest be perceived by the reporter (self / other) a sealed envelope clearly marked as "Confidential" / Wellbeing Committee may be given to the Medical Staff

Coordinator. The Medical Staff Coordinator will immediately notify the President of the Medical Staff whom shall appoint a chair other than the associate President of the Medical Staff. A MEC meeting will be called within 24 business hours to appoint committee membership.

5.18.2.5. Should a conflict of interest be identified by the Chair ( including the alternate chair ) of the committee , he shall request from the President of the Medical Staff to be relieved of his duty and the President of the Medical Staff will appoint an alternate chair.

5.18.2.6. Should a member of the committee identify a conflict of interest after the report is revealed he/she shall request to be removed from the committee and the chair will appoint an alternate.

### 5.18.3. Duties

5.18.3.1. The Medical Staff Coordinator will serve as administrative support and recording.

5.18.3.2. Receive reports related to health, well-being, or impairment of Medical Staff members.

5.18.3.3. Investigate such reports as it deems appropriate.

5.18.3.4. Consult with individual staff members when required.

5.18.3.5. Provide advice, counseling or referrals on a voluntary basis, as may seem appropriate.

5.18.3.6. Respond or make recommendations to the referral source and the concerned physician.

5.18.3.7. Develop and recommend individualized monitoring plans for affected Practitioners.

5.18.3.8. Compile lists of physicians and programs with special expertise that can monitor a physician's compliance with a plan, for consideration of the President of the Medical Staff.

5.18.3.9. Present educational programs as directed to the Medical Executive Committee.

5.18.3.10. The committee is an advisory body, and its activities are confidential, concerned primarily with the needs of the physician in question. The committee shall not actively seek out instances of impairment, nor shall it provide treatment or supervision of clinical practice.

5.18.3.11. If the Committee receives information that demonstrates that the health or impairment of a Medical Staff member may pose a risk of harm to the Hospital's patients (or prospective patients), that information shall be referred to the President of the Medical Staff immediately.

5.18.3.12. Any recommendations or action steps will be implemented within the State and AMA guidelines.

5.18.3.13. When a monitoring plan has been developed and a monitor assigned, the monitor will report to the President of the Medical Staff periodically on the physician's compliance with the plan.

5.18.3.14. The effectiveness of the committee shall be evaluated annually by the M.E.C.

### 5.18.4. Confidentiality

5.18.4.1. The Committee on Physician Health shall maintain strict confidentiality. It will release information only, as needed to carry out Medical Staff duties, or as required by law.

5.18.4.2. The Committee on Physician Health shall annually report on its activities to the Medical Executive Committee and the Board, without identifying individuals.

5.18.4.3. The Committee on Physician Health shall report directly to the President of the Medical Staff on the status of particular cases.

### 5.18.5. Reporting and Investigating Procedure

5.18.5.1. The Committee on Physician Health will investigate all reports of impairment to determine whether a problem exists. This protocol applies to Members who have impairments, as well as applicants who have a history of impairment.

5.18.5.1.1. The investigation may include evaluation of written reports; peer references; interviews of associates, relatives, and others at the Hospital, office or home (when authorized by the doctor); and chart review of records at this or other hospital for the purpose of identifying impairment rather than assessing quality of care.

5.18.5.1.2. If a problem may exist, the Practitioner in question will be invited to meet with

the Committee, to discuss the problem and the findings from the investigation. The interview will be informal.

- 5.18.5.1.3. The Committee may ask the practitioner to be evaluated by a practitioner, including a psychiatrist, or other psychotherapist, or substance abuse specialist. The Committee will ask the practitioner to sign a form authorizing disclosure of the results of the evaluation to the Committee. The practitioner should be given a list of professionals acceptable to the Committee on Physician Health. The report should address the diagnosis, prognosis, and treatment program recommendation, and the practitioner's ability to continue practice.
- 5.18.5.1.4. Practitioners who have substance abuse will be referred to the Medical Board of California Diversion program, and/or a treatment program of the practitioner's choice approved by the Committee on Physician Health. Practitioners who have other types of impairment will be referred for treatment approved by the Committee on Physician Health.
- 5.18.5.1.5. The Committee on Physician Health will draw up a contract between it and the practitioner, delineating the Committee's expectations for treatment and monitoring. The contract, as a minimum, will require the member to agree to the following conditions, depending upon the nature of the impairment:
  - 5.18.5.1.5.1. To provide documentation from an evaluating or treating professional that initial treatment is being provided and when the member may safely continue practice or return to practice.
  - 5.18.5.1.5.2. To abstain from using any medications or drugs or alcohol, except as approved by the treatment program and the Committee on Physician Health. If such is prescribed by another physician, the subject physician shall report immediately to the Committee on Physician Health: the substance, amount, and purpose of the prescription; and provide the name and telephone number of the prescribing physician, and permission for him to confer with the Committee on Physician Health.
  - 5.18.5.1.5.3. To participate in an ongoing treatment program approved by the Committee on Physician Health. Any specific terms, such as continuing psychiatric counseling, securing medical treatment or attending physician recovery groups two nights a week and Alcoholics Anonymous or Narcotics Anonymous two nights a week, should be stated.
  - 5.18.5.1.5.4. To agree to any random testing of bodily fluids, by the treatment program or as directed by the Committee on Physician Health.
  - 5.18.5.1.5.5. To meet regularly, and at least quarterly, with a monitor appointed by the Committee on Physician Health.
  - 5.18.5.1.5.6. To allow free and open communication between the treating professionals, the recovery support network, those persons responsible for verifying compliance with the re-entry agreement, and the Committee on Physician Health.
  - 5.18.5.1.5.7. To request a medical leave of absence in the event the Committee on Physician Health finds that the impairment or failure to comply with the re-entry agreement presents a risk to patients.
  - 5.18.5.1.5.8. To sign whatever forms are needed to authorize release of information from the treatment programs to the Committee on Physician Health, and request that reports shall be made regularly, at defined time intervals, such as quarterly.
  - 5.18.5.1.5.9. To acknowledge that any failure to comply with the conditions will result in immediate referral to the President of the Medical Staff, with suggestions for corrective action.
  - 5.18.5.1.5.10. To provide for post treatment monitoring of a sufficient duration (up to

five (5) years).

- 5.18.5.1.5.11. To participate in a regular review of the agreement, and to modify it as necessary to achieve the goals of continued recovery.
- 5.18.5.1.5.12. To notify the Committee on Physician Health at any time he is applying for membership at another hospital, and to authorize disclosure of impairment and monitoring status to the equivalent committee of the hospital to which application is being made.
- 5.18.5.1.6. When the treating program or the Committee on Physician Health concludes that the member cannot practice safely, the member shall request a leave of absence. Discontinuance of the leave shall be contingent upon the member satisfying the Committee on Physician Health he or she can return safely to practice (if the member still chooses to comply voluntarily with the Physician Health Program).
- 5.18.5.1.7. When indicated based upon the severity and duration of the mental or physical impairment, the member may be required to (1) pass an oral or written test administered by a designated committee member or (2) proctored on at least 20 cases and for at least 3 months, and have reports of satisfactory performance on these cases.
- 5.18.5.2. The investigation may be closed at any time if it is deemed unsubstantiated.
- 5.18.5.3. If the Practitioner refuses to cooperate at any stage, the matter will be referred to the President of the Medical Staff, together with a statement that the Practitioner is not participating in the investigation or in the monitoring plan and the Committee has reason to suspect that the Member may be impaired as a result of a physical or mental impairment. The President of the Medical Staff will refer the matter to the Medical Executive Committee, which may initiate its own corrective action investigation. Insofar as is feasible, the Medical Executive Committee shall not ask the Committee on Physician Health to share the confidential information that was gathered during an investigation or while the Member was fulfilling his or her Agreement with the Committee on Physician Health. The Committee on Physician Health should be asked only to indicate what action may be necessary to protect patients. Whenever possible, evidence should be developed independently in order to preserve the integrity of the Committee on Physician Health's promises of confidentiality.
- 5.18.5.4. After successful completion of the treatment program for a minimum period, the Committee on Physician Health shall close the active cases. It will open a monitoring case for a defined period of time, such as 3 years, and review the Practitioner's status every 6 months.

## ARTICLE 6 - DELINEATION OF CLINICAL PRIVILEGES

- 6.1. **Exercise of Privileges.** A Practitioner providing clinical services at this Hospital by virtue of Medical Staff Membership, or otherwise, may exercise, in connection with such practice, only those Clinical Privileges specifically granted to Him by the Credentialing Committee. Regardless of the level of Privileges granted, each Practitioner must obtain consultation when it's deemed prudent for the safety and well being of a patient, or when required by the Rules and Regulations or other policies of the Medical Staff or the Hospital.
- 6.2. **Bases for Determination of Privileges.** Privileges governing clinical practice are Hospital specific and are granted pursuant to training, experience, demonstrated current competence, clinical judgment, and prior and continuing education, as documented and verified in each Practitioner's credentials file, and in accordance with the criteria in these Bylaws and the resources and services available at the hospital. The bases for Privileges' determinations for Members, or any person granted practice Privileges in connection with Reappointment or a requested change in Privileges must include clinical

performance, attitude & cooperativeness, professional conduct reviews and documented results of the Hospital's performance improvement activities.

- 6.3. **System and Procedure for Granting and Delineating Privileges.** The various levels of Clinical Privileges, the specific qualifications for the exercise of Privileges at each level, and the procedures by which requests for Clinical Privileges are processed, are provided in detail in the Hospital's Credentialing policies.
- 6.4. **Special Conditions for Physician Members.** A physician Member of the Medical Staff shall be responsible for the care of any medical problem that may be present upon admission, or that may arise during hospitalization, including the care provided by Allied Health Professionals and such findings shall be recorded in the medical chart.
- 6.5. **Emergency Situation.** In case of an emergency in which serious permanent harm or aggravation of injury or disease is imminent, or in which the life of a patient is in immediate danger, and any delay in administering treatment could add to that danger, any Medical Staff Member, assisted as necessary, is authorized to do everything possible to save the patient's life or to save the patient from serious harm, to the degree permitted by the Member's license and training, but regardless of the Member's Medical Staff category, status or delineated privileges. In such an emergency situation the Practitioner is expected to summon the consultative assistance deemed necessary.
- 6.6. **Temporary Privileges.**
  - 6.6.1. **Conditions.** Temporary Privileges are granted when the Practitioner's highly specialized services are needed by a patient in the Hospital and the Applicant has submitted a Complete Application per state law, including supportive required documentation for primary source verification.
  - 6.6.2. **Qualified Candidate.** An Applicant shall not be considered qualified for temporary privileges until the application for privileges is complete, which includes primary source verification of the candidate's professional license; and hospital privileges elsewhere are in good standing; that his malpractice insurance is in the proper amounts required and available to the Hospital; a completed "ability to perform" health statement; and he has agreed to abide by these Bylaws.
  - 6.6.3. **Approval and Duration.** Temporary privileges shall be granted for a specific period of time, not to exceed ninety (90) Days, and may not be extended beyond this period of time *unless* an additional request for temporary privileges is made by the Applicant, showing good cause for such extension. If an extension is granted, such extension shall not exceed thirty (30) additional Days. Under no circumstances shall the total time for temporary privileges extend beyond one hundred twenty (120) Days, including any extension time granted. A candidate may exercise temporary privileges immediately upon the written approval of the CEO and President of the Medical Staff or Associate President of the Medical Staff.
  - 6.6.4. **Supervision.** When temporary privileges are granted, the President of the Medical Staff, or where applicable, an Associate President of the Medical Staff, shall be responsible for supervision of the candidate during the period specified.
  - 6.6.5. **Notify Medical Executive Committee.** When temporary privileges have been granted, such information shall be reported at the next meeting of the Medical Executive Committee.
  - 6.6.6. **No Hearing Available.** The inability to obtain temporary privileges, failure of renewal of such privileges, or the expiration of such privileges is not a Professional Review Action and does not entitle the individual to a Hearing.
- 6.7. **Expiration or Termination of Temporary Privileges.** In the event Temporary Privileges expire or are terminated, the Practitioner's patients in the Hospital shall immediately be assigned to another

Practitioner by the President of the Medical Staff. When feasible, the wishes of the patient or responsible party shall be considered in selecting a replacement Practitioner. The bases for terminating temporary privileges includes:

- 6.7.1. Any event of a professional or personal nature which casts doubt on the candidate's qualifications or ability to exercise the temporary privileges granted, the CEO and the President of the Medical Staff / Associate President of the Medical Staff may modify or terminate the temporary privileges.
- 6.7.2. If the life or well-being of a patient is determined to be endangered, then termination may be effected by any one possessing Summary Suspension authority, (as provided in Article 9 of these Bylaws: Whenever the conduct or competence of a Practitioner may require that immediate action be taken to protect the life of any patient(s) or other person or to reduce the substantial likelihood of immediate injury or damage to the health or safety of any patient, employee or other person, either the CEO, President of the Medical Staff, Medical Executive Committee or the Governing Board shall have the authority to **summarily suspend** the Practitioner's Medical Staff Membership and/or all or any portion of the Clinical Privileges of such Practitioner.) ; or
- 6.7.3. By a mutual decision made by the CEO and the President of the Medical Staff, with or without cause.

6.8. **Rights of Practitioner Upon Termination or Expiration.** A candidate is not entitled to a Professional Review Activity because His request for temporary privileges is refused or expires. If temporary privileges are terminated based on the conduct or competence of a Practitioner, the Practitioner is entitled to a Hearing under Article 10.

6.9. **Delineation of Privileges Under Conditions Identified as "Disaster."** Disaster privileges may be granted only when the hospital's emergency management plan has been activated and the hospital is unable to adequately meet the immediate needs of its patients. During such a disaster, the CEO may grant disaster privileges.

6.9.1. The CEO may, either individually or upon the request of the Medical Staff Coordinator, grant disaster privileges to practitioners deemed essential to meet patients' needs during a recognized area disaster. The granting of privileges under this Section 6.9 shall be performed on a case-by-case basis, upon the discretion of the CEO.

6.9.2. Granting disaster privileges shall be done using the DISASTER PRIVILEGES APPLICATION (attached hereto), which shall be accompanied by the presentation of any of the following forms of verification:

- 6.9.2.1. a current picture hospital ID card;
- 6.9.2.2. a current license to practice and a valid picture ID issued by a state, federal, or regulatory agency.
- 6.9.2.3. identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT);
- 6.9.2.4. identification indicating that the individual has been granted authority to render patient care in emergency circumstances such authority having been granted by a federal, state, or municipal entity; or
- 6.9.2.5. presentation by a current hospital or medical staff member(s) with personal knowledge regarding practitioner's identity.
- 6.9.2.6. The practitioner granted disaster privileges under this Section shall remain under the direct supervision of the Medical Staff Director or his designee.

6.9.3. Following the granting of disaster privileges, the Medical Staff Coordinator / Medical Staff Service Specialist shall commence the verification process as a priority, as soon as the situation causing the underlying disaster has been deemed under control by the CEO.

A decision to continue the disaster privileges initially granted must be made within 72 hours. The privileging process used in these Bylaws to grant temporary privileges shall be sufficient to meet this requirement. Such privileges shall thereafter terminate, as further provided herein.

- 6.9.4. Volunteer practitioners that have been granted disaster privileges shall be issued a temporary identification
  
- 6.10. **Locum Tenens.** The CEO may permit a Practitioner serving in a *locum tenens* capacity to become a Member of the Medical Staff and to attend patients without applying for Membership for a period not to exceed ninety (90) Days, only if the agency supplying the Practitioner has completed its own Credentialing process, which is current, and its findings have been made available to the Hospital. Any anticipated extension beyond 90 days require the Locum Tenens to complete an Application for temporary privileges within 30 days of his initial start date for processing to be complete within 90 days at which point Temporary privileges will be granted by the Medical Executive Committee for up to 120 days.. Exercising temporary privileges the Practitioner in a *locum tenens* capacity shall be under the oversight authority of the President of the Medical Staff / Associate President of the Medical Staff. Specifically, the *locum tenens* Practitioner must:
  - 6.10.1. acknowledge in writing that He has received and will read a copy of these Bylaws and the Rules and Regulations of the Medical Staff;
  - 6.10.2. agree to be bound by the terms thereof in all matters relating to His temporary privileges; and
  - 6.10.3. satisfy the insurance requirements imposed by these Bylaws.

## **ARTICLE 7 - APPOINTMENT AND REAPPOINTMENT**

- 7.1. **Appointment/Reappointment to the Medical Staff.** The granting, denial or revocation of Medical Staff Membership and Clinical Privileges at the Hospital is done by the Credentialing Committee; as such function has been delegated by the Governing Board. A period of focused professional practice evaluation shall be implemented for all initially requested privileges.
  - 7.1.1. The Medical Executive Committee shall evaluate the performance of practitioners when issues affecting the provision of safe, high quality patient care are identified.
  
- 7.2. **Period of Appointment.** The period of initial Appointment for Applicants with provisional status shall not be less than twelve (12) months or more than twenty-four (24) months. The period of Reappointment for all other Applicants with regular status shall not exceed twenty-four (24) months. In calculating a period of initial Appointment, the period of time in which any temporary privileges were granted shall be counted. At the completion of the twelve (12) month provisional status period the applicants professional license, DEA certificate, liability insurance, NPDB, criminal background, OIG/GSA shall be re-verified and the President of the Medical Staff shall be contacted to verify clinical performance.
  
- 7.3. **Hospital's Non-Discrimination Policy.** A Practitioner shall not be denied such Membership or Clinical Privileges on the basis of sex, race, religion, color, national origin, disability, sexual preference or any other basis prohibited by law.
  
- 7.4. **Application Process for Appointment and Reappointment.** The Medical Executive Committee, with the assistance of Hospital administration, shall investigate and consider each Application for Appointment or Reappointment to the Medical Staff, including all requests for modification of Privileges, and forward all findings and recommendations to the Credentialing Committee. Only those Practitioners eligible for Medical Staff Membership, as provided within these Bylaws and the Hospital's Credentialing

Policy, shall be provided an Application for Membership.

- 7.5. **The Application for Medical Staff Membership.** Any Application shall be signed by the Practitioner and submitted to the Medical Executive Committee via the Medical Staff Coordinator. Each Application shall require detailed information concerning the Practitioner's professional qualifications and current clinical competence. An Application for Reappointment must additionally demonstrate that the Practitioner has also met the responsibilities of Medical Staff Membership for the prior period of Appointment. An Application will only be considered complete when the following items have been submitted and verified.
- 7.5.1. Copy of a current unrestricted license to practice medicine, dentistry or podiatry in the State and whether a state licensing board has censured, reprimanded, or placed the Practitioner on probation for reasons relating to the Practitioner's professional competence or professional conduct.
  - 7.5.2. Proof of controlled substance certification and DEA certification to prescribe such substances in the State, and information of any previous denials, suspensions, probations, revocations, or voluntary relinquishments of the privilege to prescribe these substances in any state.
  - 7.5.3. Medical education, residency training and other educational curriculum.
  - 7.5.4. Verification (copies of certificates or copies of letters from appropriate specialty boards) of board admissibility or board certification.
  - 7.5.5. The names of three clinicians, with at least one (1) clinician being licensed in the same field as the Practitioner, who have recently worked with the Practitioner and directly observed His professional performance over a reasonable period of time and who will provide reliable information regarding current clinical ability, ethical character and ability to work well with others.
  - 7.5.6. Continuing Medical Education for the last two (2) years, as required by state laws for license renewal.
  - 7.5.7. Previous and current medical staff memberships at other hospitals or health care entities and any denials, revocations, suspensions, reductions, restrictions, or non-renewals of membership status or clinical privileges or withdrawals of applications for appointments or reappointments at such hospitals or entities.
  - 7.5.8. Any previously successful or currently pending challenges to any of the Practitioner's licensure or registration or a voluntarily relinquishment of such licensure or registration at any hospital of healthcare entity.
  - 7.5.9. Professional Review Activity taken by a hospital or healthcare entity that Adversely Affected the clinical privileges of the Practitioner for a period longer than thirty (30) days.
  - 7.5.10. Acceptance by a hospital or healthcare entity of the surrender of clinical privileges of the Practitioner while the Practitioner was under an investigation relating to the provision of professional services pursuant to the terms of the license held, or improper professional conduct, or in exchange for not conducting an investigation or instigating a proceeding.
  - 7.5.11. Present or past membership in any professional societies and any previous clinical or disciplinary actions, censures or voluntary or involuntary disenrollment in any such a society.
  - 7.5.12. Investigations commenced, charges filed, or final actions taken against the Practitioner by His licensing authority, Department of Health and Human Services, Office of Inspector General, a peer review organization, or any state or federal law enforcement agency or health regulatory agency.
  - 7.5.13. Written certification by the Practitioner (or by a physician, if so requested by the Medical Executive Committee) that His physical and mental health does not impair His ability to care adequately for patients at the Hospital. (*e.g., see Section 4.8(1)*) Each Applicant shall submit a written Ability-to-Perform Statement or another similar statement, in which He shall swear or affirm that He does not have any physical or mental health disability (including, but not limited to, any form

- of illegal substance addiction) that affects, or is reasonably likely to affect, His ability to perform His obligations to His patients and/or His duties as a Member of the Medical Staff.)
- 7.5.14. Information concerning the Practitioner's malpractice experience, including final judgments and settlements, along with a signed authorization consenting to the release of all claims information from His present and past professional liability insurance carrier(s).
  - 7.5.15. Proof that the Practitioner meets the minimum professional liability insurance limits required by the Board at the time of submitting the Application.
  - 7.5.16. Category and Privileges for which the Practitioner wishes to be considered.
  - 7.5.17. A signed Acknowledgment that the Practitioner will comply with these Bylaws and Rules and Regulations, if appointed to the Medical Staff.
- 7.6. **Application Process.** The Medical Staff Coordinator shall collect and verify all documentation necessary to confirm the Applicant's professional qualifications and clinical competence in accordance with the Hospital's Credentialing policy and these Bylaws. When complete, all information obtained and verified shall be then forwarded to the President of the Medical Staff to determine whether:
- 7.6.1. additional information must be obtained or verified;
  - 7.6.2. an interview of the Practitioner is necessary; and
  - 7.6.3. to place the Practitioner on the agenda for the next Committee meeting or whether the Medical Staff Coordinator may present the Practitioner's file to the committee members individually - in lieu of a committee meeting, for their review and determination.
- 7.7. **Practitioner's Burden.** At all times during the Application process the Practitioner maintains the burden of producing adequate information for a proper evaluation of His current licensure, relevant training and/or experience, current competence, character, health status, ethics, and other qualifications, and for resolving any questions about such qualifications on a timely basis. If a Practitioner fails to respond to a request for additional information within sixty (60) days from such request, or fails to complete the Application process within one hundred and twenty (120) days of initiating such application, the Application will be deemed withdrawn and no further activity will be performed on the Application by the Hospital. There shall be no obligation on the Hospital to process an Application deemed incomplete and the withdrawal of the Application under this Section.
- 7.8. **Withholding Information or Submitting False Information.** The falsification or the withholding of substantive information on the Application shall void the Application for initial Applicants, or provide grounds for termination of Medical Staff Membership for Members.
- 7.9. **Medical Executive Committee Review.** The Medical Staff Service Specialist shall thoroughly review each Application and all relevant available information and shall cause a **summary sheet** of the Practitioner's credentials to be prepared for review by the Medical Executive Committee. Following the Medical Executive Committee's review, the Credentialing file shall first be transmitted to the Credentialing Committee. The report of the Medical Executive Committee shall include a recommendation that Appointment or Reappointment be either (i) approved (with or without modifications - and if with modifications, so state), (ii) renewed (with or without modifications - and if with modifications, so state), or (iii) not approved or not renewed. If additional information is required in order to prepare its recommendation, the file shall be returned to the Medical Staff Coordinator to comply with the specific instructions of the Medical Executive Committee. Any action or recommendation Adversely Affecting a Practitioner will entitle the Practitioner to a Hearing, as provided in Article 10.
- 7.10. **Medical Staff Coordinator Follow-Up Action.** If it's determined that additional information is required from a Practitioner, or an interview is necessary, the Medical Staff Coordinator shall contact the Practitioner and apprise Him of the requirements imposed by the Medical Executive Committee via

Special Notice.

- 7.11. **Medical Executive Committee Recommendation to the Credentialing Committee.** Following receipt of the Medical Executive Committee's recommendation regarding Appointment, Reappointment and Privileges, the Credentialing Committee shall promptly act on the matter. If the Credentialing Committee's decision is favorable, the Practitioner will be appointed or reappointed to the Medical Staff, with the Privileges specifically delineated. Any action Adversely Affecting a Practitioner will entitle the Practitioner to a Hearing, as provided in Article 10 of these Bylaws.
- 7.12. **Status.** A Member's status is determined by the bylaws as new members will automatically be placed on Provisional Status for one (1) year (including the temporary privilege time frame) and then will progress to the appropriate status with satisfactory completion of Provisional Status. Re-appointment status will be status based on their original request for Privileges unless other wise stated in a formal communication from the Practitioner to the Medical Staff Coordinator.
- 7.13. **Applying for Membership Following an Adverse Decision.** A Practitioner receiving a decision Adversely Affecting Him may not re-apply for Membership for one (1) full year from the date of the decision. A Practitioner re-applying under this section must include, as part of His Application, the basis for the previous Professional Review Action and why the basis for that decision no longer exists.
- 7.14. **Denial Based Upon Hospital's Inability to Accommodate Applicant.** A decision to deny Medical Staff Membership and/or specific Clinical Privileges because of the Hospital's present inability to provide adequate facilities or support services for the Practitioner and His patients is not based upon professional competence or conduct and shall not entitle the Practitioner to a Hearing, as provided in Article 10 of these Bylaws.
- 7.15. **Waiver of Qualifications.** Any qualification requirements in any Article of these Bylaws not required by law or governmental regulation may be waived at the discretion of the Hospital upon recommendation of the Medical Executive Committee, when done upon a determination that such waiver is done in the best interest of the patients.
- 7.16. **Custody of Medical Staff Applications.** All Applications and other Credentialing documents when tendered to the Hospital are and shall remain the exclusive property of the Hospital and shall not be returned. Production of these documents will only be done pursuant to a validly issued subpoena.

## **ARTICLE 8 - CONFIDENTIALITY, IMMUNITY AND RELEASES**

- 8.1. **Special Definitions Regarding Article 8.** For purposes of this Article 8, the following definitions shall apply:
- 8.1.1. **"Information"** means records of proceedings, minutes, interviews, records, reports, forms, memoranda, statements, recommendations, findings, evaluations, opinions, conclusions, actions, data, and other disclosures or communications whether written or oral, relating to any of the subject matter specified in these Bylaws.
- 8.1.2. **"Malice"** means the dissemination of a known falsehood, or of information with a reckless disregard for whether it is true or false.
- 8.1.3. **"Practitioner"** means a Medical Staff Member or Applicant.
- 8.1.4. **"Representative"** means any of the following individuals or groups: a member of the

Governing Board or the Credentialing Committee, the CEO; registered nurses and other employees of the Hospital; the Medical Staff and any member, officer, or committee thereof; and any individual or private entity authorized by any of the foregoing to perform specific information gathering, reproduction, analysis, use or dissemination functions.

- 8.1.5. **"Third Parties"** mean both individuals and organizations providing information to any Representative.
- 8.2. **Authorizations and Conditions.** By submitting an Application for Membership or by applying for/ or exercising Clinical Privileges or providing specified patient care services in this Hospital, a Practitioner expressly does each of the following:
- 8.2.1. Authorizes Representatives of the Hospital and the Medical Staff to solicit, provide, and act upon information on His professional ability and qualifications.
- 8.2.2. Agrees to be bound by the provisions of these Bylaws and this Article and to waive all legal claims against any Representative or Third Party who acts in accordance with these provisions herein.
- 8.2.3. Acknowledges that the provisions of this Article are express conditions of His Application for or acceptance of Medical Staff Membership and the continuation of such Membership, and His exercise of Clinical Privileges or provision of specified patient services at this Hospital.
- 8.3. **Confidentiality of Information.** Information with respect to any Practitioner or specified professional personnel submitted, collected, or prepared by any Representative of this or any other healthcare facility or organization or Medical Staff for the purpose of evaluating and improving the quality and efficiency of patient care, reducing morbidity and mortality, contributing to teaching or clinical research, determining that healthcare services are professionally indicated or were performed in compliance with the applicable standards of care, or establishing and enforcing guidelines to keep healthcare costs within reasonable bounds shall be confidential to the fullest extent permitted by law, and shall neither be disseminated to anyone other than a Representative, nor be used in any way except as provided herein, or except as otherwise required by law. Such confidentiality shall also extend to information of like kind that may be provided by Third Parties. This information shall not become part of any particular patient's record.
- 8.4. **Immunity From Liability.** The shareholders, Board, Credentialing Committee, each Representative of the Medical Staff and Hospital and any independent contractor used for a similar purpose shall be exempt, to the fullest extent permitted by law, from liability to any Practitioner for damages or other relief for action taken, or statements or recommendations made, within the scope of duties exercised as a Representative of the Medical Staff or Hospital. Each Representative of the Medical Staff and Hospital and all Third Parties shall be exempt, to the fullest extent permitted by law, from liability to any Practitioner for damages or other relief by reason of providing information to a Representative of the Medical Staff or Hospital concerning such person who is, or has been, an Applicant to or Member of the Medical Staff or who did, or does, exercise Clinical Privileges or provide services at this Hospital.
- 8.5. **Activities and Information Covered.** The confidentiality and immunity provided by this Article applies to all acts, communications, proceedings, interviews, reports, records, transcripts, minutes, forms, memoranda, statements, recommendations, findings, evaluations, opinions, conclusions, or disclosures performed or made in connection with this or any other healthcare facility's or organization's activities concerning, but not limited to the following areas:
- 8.5.1. Applications for Appointment, Clinical Privileges, or specified services;
- 8.5.2. periodic reappraisals for Reappointment, Privileges, or specified services;
- 8.5.3. Professional Review Activity and/or summary suspensions;

- 8.5.4. Professional Review Actions
  - 8.5.5. Performance Improvement activities and utilization reviews;
  - 8.5.6. medical care evaluations;
  - 8.5.7. claims reviews;
  - 8.5.8. profiles and profile analysis;
  - 8.5.9. malpractice loss prevention; and
  - 8.5.10. other Hospital and Medical Staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.
- 8.6. **Information.** The information referred to in this article may relate to a Practitioner's qualifications, clinical competence or ability, judgment, character, physical or mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly impact patient care.
- 8.7. **Releases.** In addition to the "Release" language specified herein, each Practitioner shall, upon request of a Representative of the Hospital, execute any and all general and specific releases in accordance with the express provisions and general intent of this Article 8. Execution of such releases are not, and shall not be, deemed a prerequisite to the effectiveness of this Article and these Bylaws.
- 8.8. **Cumulative Effect.** Provisions in these Bylaws and in application forms related to authorizations, confidentiality of information, and immunities from liability are in addition to other protections provided by law and not in limitation thereof.

## ARTICLE 9 - COMPLAINTS OF PRACTITIONER COMPETENCE OR CONDUCT

- 9.1. **Forms of Action.** The Hospital may take action against a Practitioner for either (i) various minor conduct infractions that are not likely to Adversely Affect the Practitioner, or (ii) a Professional Review Action, which potentially may Adversely Affect the Practitioner.
- 9.2. **Corrective Action Due to Minor Infractions.** Whenever the professional competence or professional conduct of any Member represents a minor infraction of these Bylaws or Rules and Regulations, or is disruptive to Hospital operations, for which action or recommendation will reasonably not Adversely Affect the Practitioner, action may be taken or recommended against such Member.
- 9.3. **Source of Complaints.** Complaints of either a minor infraction or one which may Adversely Affect a Practitioner may be made by anyone with direct knowledge.
- 9.4. **Harassment Prohibited.** Harassment by a Member against any other Member, Hospital staff, patient, vendor or visitor on the basis of race, religion, color, national origin, ancestry, age, disability, medical disability, marital status, sex or gender, or sexual orientation shall not be tolerated.
- 9.5. **"Harassment" Defined.** Harassment is verbal or physical conduct that denigrates or shows hostility or aversion toward an individual because of race, religion, color, national origin, ancestry, age, disability, medical disability, marital status, sex or gender, or sexual orientation or that of his/her relatives, friends, or associates, and that has the purpose or effect of (i) creating an intimidating, hostile, or offensive working environment, (ii) unreasonably interfering with an individual's work performance, or that otherwise adversely affects an individual's employment opportunities. Harassing conduct includes epithets, slurs, negative stereotyping, or threatening, intimidating or hostile acts that relate to race, religion, color, national origin, ancestry, age, disability, medical disability, marital status, sex or gender, or sexual orientation; and written or graphic material that denigrates or shows hostility or aversion toward

an individual or group because of race, religion, color, national origin, ancestry, age, disability, medical disability, marital status, sex or gender, or sexual orientation and that is placed on walls, bulletin boards, or elsewhere on the employer's premises, or circulated in the workplace.

- 9.6. **“Sexual Harassment” Defined.** Sexual harassment is unwelcome verbal or physical conduct of a sexual nature which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (e.g., unwelcome touching, assault or interference with movement or work), and visual harassment (e.g., display of derogatory cartoons, drawings, or posters). It includes unwelcome advances, requests for sexual favors or any other verbal, visual or physical conduct of a sexual nature when submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion, benefits or other aspects of employment; training and education or training and educational opportunities; medical treatment; referrals; purchases; etc. It also includes such conduct when the conduct interferes with the individual's employment or education/training, or creates an intimidating, hostile or offensive work, education or treatment or education environment.
- 9.7. **Professional Review Action.** A Professional Review Action is an action or recommendation of a Professional Review Body (see Section 1.52) which is taken or made in the conduct of Professional Review Activity (see Section 1.51), and which is based on the competence or professional conduct of the Affected Practitioner, which conduct affects or could adversely affect the health and welfare of a patient or patients and which affects or may Adversely Affect the Clinical Privileges or Medical Staff Membership of the Affected Practitioner. A Professional Review Action taken must be:
- 9.7.1. performed in the reasonable belief that the action was in the furtherance of quality health care;
  - 9.7.2. after a reasonable effort to obtain the facts of the matter;
  - 9.7.3. after adequate notice regarding the proposed action is sent to the Affected Practitioner, advising Him that He has a right to request a Hearing on the proposed action within thirty (30) Days from receipt of the notice or after such other procedures as are fair to the Affected Practitioner under the circumstances; and
  - 9.7.4. in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after following meeting the requirement of a Hearing in Article 10.
- 9.8. **Requests for Action.** All requests for corrective action or Professional Review Action shall be in writing and under oath, supported by reference to the specific activities or conduct which constitute the grounds for the request, and shall be submitted either to the CEO or the President of the Medical Staff. The CEO or President of the Medical Staff shall, in collaboration with one another, determine whether the matter needs to be addressed as a Corrective Action or a Professional Review Action. If addressed as a Professional Review Action, the matter shall be forwarded to either the Medical Executive Committee, a sub-committee of the Medical Executive Committee or a hospital committee formed for such specific purpose, which shall include at least three (3) members, that includes one (1) Physician. If it's to be addressed as a Corrective Action, the matter shall be forwarded to a hospital committee consisting of at least two (2) members formed for such specific purpose. In either case, the issue to be determined by the committee shall be provided in writing to the committee chair, which includes the Memorandum convening the committee (the “Memorandum”).
- 9.9. **Investigation of the Complaint.** Following selection of the appropriate committee, the matter shall be forwarded to the committee with instructions in the Memorandum to (i) conduct and maintain all aspects of the investigation under strictest confidentiality and to clearly mark each page or all documents prepared as **“PEER REVIEW COMMITTEE: PRIVILEGED & CONFIDENTIAL”** in bold letters and in not less than 14 point size font, (ii) perform a reasonable effort to obtain the facts in the matter complained

of, and (iii) complete the investigation within thirty (30) Days or less, from receipt of the Memorandum. The Affected Practitioner may be invited to meet with the committee investigating the complaint, solely for the purpose of providing information during the investigation. The investigation is not a Hearing and neither the committee members, nor the Affected Practitioner, shall be entitled to legal representation. Following its investigation the committee shall provide its written recommendation to the CEO and President of the Medical Staff.

- 9.10. **Investigative Recommendation for Corrective Action.** A recommendation for corrective action that does not Adversely Affect the Practitioner may be (i) accepted, as recommended, (ii) modified in-part, or (iii) modified in-whole (*if supported by appropriate explanation and agree to by both the CEO and the President of the Medical Staff*). The President of the Medical Staff shall implement any corrective action within thirty (30) Days of receipt of the Investigative Recommendation, or shall be barred from proceeding thereon. Any delay occasioned by the non-availability of the Affected Practitioner shall not count towards the thirty Day time limit.
- 9.11. **Investigative Recommendation for Professional Review Action.** A recommendation for Professional Review Action based on the professional competence or professional conduct of the Affected Practitioner, which conduct (i) affects or could affect adversely the health or welfare of a patient or patients, and (ii) which affects or may Affect Adversely the Clinical Privileges or Medical Staff Membership of the Affected Practitioner, shall entitle the Affected Practitioner to the procedural rights for notice and Hearing provided in Article 10. The written report of the investigation shall include at least one or more of the following recommendations, with supporting information:
- 9.11.1. that the request for Professional Review Action is not justified;
  - 9.11.2. issuance of an oral warning (reduced to writing), letter of censure, or a letter of reprimand to the Affected Practitioner is appropriate;
  - 9.11.3. placing the Affected Practitioner on probation, subject to Proctoring or additional continuing professional education;
  - 9.11.4. reducing, suspending or revoking Clinical Privileges for a period not exceeding fourteen (14) Days, during which time a further investigation shall be conducted;
  - 9.11.5. reducing, suspending or revoking Clinical Privileges for a period exceeding fourteen (14) Days; or
  - 9.11.6. suspending or revoking Membership.
- 9.12. **Procedural Rights.** Any recommendation which includes Section 9.7 (3), (5), or (6), or any combination of any other action(s) that Adversely Affect the Practitioner, shall entitle Him to the procedural rights specified in Article 10. A recommendation provided in Section 9.7 (1), (2) or (4) does not entitle the Affected Practitioner to a Hearing.
- 9.13. **Summary Suspension.** Whenever the conduct or competence of a Practitioner may require that immediate action be taken to protect the life of any patient(s) or other person or to reduce the substantial likelihood of immediate injury or damage to the health or safety of any patient, employee or other person, either the CEO, President of the Medical Staff, Medical Executive Committee or the Governing Board shall have the authority to ***summarily suspend*** the Practitioner's Medical Staff Membership and/or all or any portion of the Clinical Privileges of such Practitioner. Such summary suspension shall be in writing and shall become effective immediately. The Practitioner shall be given Special Notice of such action. It shall be conclusively presumed that the Practitioner has received such written notification within three (3) days, not counting Sundays or national holidays, from the date of such mailing. An investigation shall be immediately commenced following a summary suspension.
- 9.14. **Notice of Procedural Rights.** Upon notification of summary suspension or any subsequent

Professional Review Activity which includes an action or recommendation that Adversely Affects the Affected Practitioner, shall entitle Him to receive in writing the procedural rights provided in Article 10 of these Bylaws.

- 9.15. **Bases for Automatic Suspension.** After a practitioner fails to respond to three (3) requests for copy/copies of updated or current certificates, the Practitioner will be automatically suspended. Reinstatement of the practitioner to former medical staff status and clinical privileges will be directly dependent on the reversal of the event that triggered the suspension. However, if the facts that led to the expiration of these documents are related to a sanction imposed by the issuing agency, reinstatement will be allowed or authorized after corrective action by the Medical Executive Committee has been performed. Either of the following shall result in immediate and automatic suspension from the Medical Staff;
- 9.15.1. where a Practitioner's license is suspended or revoked
  - 9.15.2. where a Practitioner's DEA certificate is suspended or revoked
  - 9.15.3. the Practitioner's privileges are revoked or suspended in another healthcare facility;
  - 9.15.4. the Hospital is notified or learns that the Practitioner's professional liability coverage has been terminated and no replacement coverage information has been provided;
  - 9.15.5. wanton indifference regarding either of the following:
  - 9.15.6. disregarding a request to appear at a Medical Executive Committee meeting to discuss an issue involving the Practitioner's conduct, where the Affected Practitioner was given Special Notice of such meeting;
  - 9.15.7. a pattern of failing to timely complete medical records within thirty (30) Days following a patient's discharge from the Hospital (*for the purpose of this Section 9.15(3)(b), a "pattern" exists when a Practitioner fails to timely complete the medical records of more than two (2) patients in any rolling twelve (12) month period*);
  - 9.15.8. refusal of a Physician on-call to attend to one of his patients in the Hospital when properly called or paged by Hospital staff (*shall omission shall result in a one (1) week suspension*); or
  - 9.15.9. conviction of any crime that (i) may adversely affect the Practitioner's ability to attend patients in the Hospital, or (ii) may adversely impact the reputation of the Hospital, or (iii) involves Medicare, Medicaid or and any other state or federal funding source.
  - 9.15.10. Failure to maintain current status.
- 9.16. **Drug Enforcement Administration ("DEA") Number.** A Practitioner whose DEA number is revoked or suspended shall immediately and automatically be divested of His right to prescribe medications covered by such number. As soon as possible after such suspension, the Medical Executive Committee shall convene to review and consider the facts under which the DEA number was revoked or suspended. Further corrective action may be taken, as appropriate, based on the facts disclosed during such investigation.

## ARTICLE 10 - HEARING AND APPEAL PROCEDURE

- 10.1. **General Right to a Hearing.** If a Professional Review Action is taken or made by a Professional Review Body in the conduct of a Professional Review Activity, which is (i) based on the competence or professional conduct of an Affected Practitioner, and (ii) which conduct affects or could affect adversely the health or welfare of a patient or patients, and (iii) which affects or may Affect Adversely the Clinical Privileges or Medical Staff Membership of the Affected Practitioner, the Affected Practitioner ***must*** exhaust the remedies provided in this Article 10. Additionally:
- 10.1.1. the hearing and appeal shall be completed within a reasonable time;

- 10.1.2. the recommended Professional Review Actions described in these Bylaws shall become final *ONLY* after the Hearing and appeal rights set forth in this Article 10 have either been exhausted or waived.
- 10.2. **Notice of Action or Proposed Action.** Where a Professional Review Action has been taken or recommended, the CEO shall provide the Affected Practitioner with the following information, via prompt Special Notice:
- 10.2.1. that a Professional Review Action has been recommended or proposed to be taken against Him and that such action, if adopted and - *if required*, shall be taken and then reported to His licensing board;
- 10.2.2. specific reasons for the proposed action;
- 10.2.3. His right to request a Hearing pursuant to this Article 10;
- 10.2.4. that such Hearing ***must*** be requested within thirty (30) Days from receipt of the Notice of Proposed Action or He has ***waived*** His right to a Hearing;
- 10.2.5. such Notice shall include a copy of Article 10 of these Bylaws representing the Affected Practitioner's rights in the Hearing; and
- 10.2.6. if (i) the recommendation or final Professional Review Action Adversely Affects the Affected Practitioner's Clinical Privileges or Medical Staff Membership for a period longer than thirty (30) Days and (ii) is based on the Member's competence or professional conduct, such written notice shall state that the action, if adopted, will be reported to the State licensing agency and shall state the proposed text of such report.
- 10.2.7. Notice under this Section 10.2 shall be sent via Special Notice and via First Class U.S. Mail, postage prepaid, to the Affected Practitioner's last known address as it appears in His Medical Staff file. It shall be conclusively presumed that the Member has received such notice within three (3) Days of mailing, excluding Sundays and federal holidays.
- 10.3. **Request for Hearing.** The Affected Practitioner shall have thirty (30) Days to request a Hearing, following receipt of the Notice of Proposed Action identified in Section 10.2. If a Hearing is requested, the request shall be in writing and addressed to the CEO, *with a copy to the Medical Staff Coordinator*. In the event the Affected Practitioner does not request a Hearing within the time and in the manner prescribed, the Member shall be deemed to have ***waived*** any right to a Hearing or appeal, and acceptance of the action proposed.
- 10.4. **Notice of Hearing.** Upon receipt of a timely written request for a Hearing as identified in Section 10.3, the CEO shall schedule a Hearing and, within fifteen (15) Days of receiving the Affected Practitioner's request, provide the Affected Practitioner with the ***Notice of Hearing*** via Special Notice. The Notice of Hearing shall include at least:
- 10.4.1. **Hearing Schedule.** Hearing schedule, which includes the time, place and date of the Hearing. Unless shortened or extended by the Hearing Officer upon request of the Affected Practitioner, the date of the Hearing shall be not less than thirty (30) Days, or more than sixty (60) Days from the date of the Notice of Hearing, provided, however, that when the request is received from a Practitioner who is also under summary suspension, the Hearing shall be held as soon as the arrangements may reasonably be made, but in any case not to exceed forty-five (45) Days from the date of the Notice of Hearing.
- 10.4.2. **Witnesses.** A list of witnesses expected to testify at the Hearing
- 10.4.3. **Conduct of Hearing.** The conduct of the Hearing shall also be included in the Notice of Hearing. A copy of this Article 10 may be used in lieu of providing the conduct of the Hearing.
- 10.4.4. **Right to Representation.** Notice that the Affected Practitioner has the right to representation by legal counsel or other person of His choice, and at His expense, in any phase of the Hearing,

- should He so choose.
- 10.4.5. **Hearing Record.** That the Affected Practitioner has a right to obtain a copy of the record made of the proceedings upon payment of any reasonable charges associated with the preparation thereof.
  - 10.4.6. **Examination of Witnesses.** The Affected Practitioner has the right to call, examine and cross-examine witnesses.
  - 10.4.7. **Presentation of Evidence.** The Affected Practitioner has the right to present evidence determined to be relevant by the Hearing Officer, regardless of its admissibility in a court of law.
  - 10.4.8. **Submitting a Statement.** The Affected Practitioner has the right to submit a written statement at the close of the Hearing.
- 10.5. **Hearing Officer.** When a Hearing is timely requested, the CEO shall, at Hospital expense, appoint a Hearing Officer in the same specialty as the Affected Staff Member, but who is not in direct economic competition with the Affected Staff Member. The Hearing Officer shall not have acted as an accuser, investigator, fact finder, initial decision maker or recommendation maker or not actively participated in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude the Hearing Officer from serving in this capacity. In the event that it is not feasible to appoint a Hearing Officer from among the Members of the Active Medical Staff, the CEO and President of the Medical Staff may appoint a Hearing Officer from outside the Hospital's Medical Staff. If the Hearing Officer requests the assistance of legal counsel, separate legal counsel experienced in similar administrative matters, shall be provided by the CEO at Hospital expense.
  - 10.6. **Advocate.** An Advocate shall be selected by the CEO to present the proposed recommendation, the materials in support thereof, examination of all witnesses, and to respond to appropriate questions. The Advocate may be an attorney licensed in the State, experienced in similar administrative matters. If an attorney is selected as the Advocate, the expense shall be borne by the Hospital.
  - 10.7. **Failure to Appear or Proceed.** Failure of the Affected Practitioner without good cause to request a Hearing within the thirty day period provided, or personally appear for a Hearing that was timely requested, shall be a forfeiture of His right, which forfeiture shall be deemed to constitute voluntarily acceptance of the proposed action.
  - 10.8. **Voluntary Waiver.** An Affected Practitioner may voluntarily waive His rights under this Article 10, when done in a writing sent to the Hospital CEO. The Affected Practitioner's signature on the written waiver (i) must not be a stamp of His signature, and (ii) must be notarized.
  - 10.9. **Postponements.** Once a request for a Hearing is submitted timely, postponement and extensions of time beyond the times set forth in these Bylaws may be permitted only by the Hearing Officer upon a showing of good cause. The determination of "good cause" is within the sole discretion of the Hearing Officer, but under no circumstances shall a Hearing be delayed beyond six (6) months from the date the Affected Practitioner's request for Hearing was first received by the CEO. Requests for postponements beyond six months are to be deemed voluntary waivers.
  - 10.10. **Pre-Hearing Procedure.** If not done previously by either party, then not later than twenty (20) Days prior to the scheduled Hearing, each party shall automatically provide to the other party, the following:
    - 10.10.1. A list of the names and addresses of those witnesses reasonably expected to give testimony or evidence in support of that party's case at the Hearing, including a brief statement regarding the expected testimony.
    - 10.10.2. A copy of all documents or other evidence upon which the charges and allegations and/or defenses are based, or any those documents to be presented to the Hearing Officer.

- 10.10.3. Copies of all evidence which was previously considered during the Professional Review Activity in determining whether to make its recommendation and any exculpatory evidence in the possession of the Hospital or the Medical Staff.
- 10.10.4. Each party shall be expected to supplement the aforementioned (1-3) disclosures until the date of the Hearing.
- 10.11. **Failure to Provide Documents.** The failure by either party to provide the information described herein at least twenty (20) Days before the Hearing shall constitute good cause for a continuance requested by the non-compliant party. The right to obtain copies of the aforementioned documents does not extend to privileged information provided by either party's legal counsel. The Hearing Officer shall consider and rule upon any request for information and may impose any safeguards that the Hearing process and justice may require. In so doing, the Hearing Officer shall consider:
- 10.11.1. **Relevance.** Whether the information sought may be used in support of, or to defend, charges.
- 10.11.2. **Importance.** The exculpatory or inculpatory nature of the information sought, if any.
- 10.11.3. **Unduly Burdensome Requests.** Whether an undue burden is imposed on the party in possession of the information sought, if access is granted.
- 10.11.4. **Lack of Cooperation by the Party.** Whether any previous request for information was either (i) submitted, or (ii) resisted by the parties to the same proceeding.
- 10.11.5. **Assessment of Costs.** Whether the conduct of the non-responding party justifies the assessment of costs, such as reasonable attorney's fees.
- 10.12. **Challenge/Recusal.** The Hearing shall represent a fair opportunity to disclose all the facts and reach an unbiased determination. As such, the Affected Practitioner shall be entitled to a reasonable opportunity to question or challenge the impartiality of the Hearing Officer. The Hearing Officer shall recuse himself when conflicts of interest or matters that could interfere with a fair Hearing are brought to his attention. Challenges by the parties to the impartiality of the Hearing Officer shall be ruled on by the Hearing Officer, whose decision in that respect shall be final. Prior to deliberation, if the Hearing Officer subsequently determines that He has become aware of a potential conflict that may cause Him to be less than impartial, He shall bring the matter to the attention of the parties, who then shall determine whether recusal is the appropriate remedy. If recusal or challenge is requested by either or both parties, the CEO shall appoint a new Hearing Officer and the Hearing shall be held in abeyance until such replacement has been identified and a new hearing schedule agreed upon.
- 10.13. **Procedural Disputes.** It shall be the duty of the Affected Practitioner and the Advocate 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 be made in advance of the Hearing. Objections to any pre-Hearing decisions may be raised to the Hearing Officer by the opposing party. In ruling on any procedural disputes, the Hearing Officer may convene the Hearing to permit argument on any issue He feels would be beneficial.
- 10.14. **Right of Alternative Representation.** The Affected Practitioner has a right to representation by legal counsel, or other person, at His expense in any phase of the Hearing.
- 10.15. **Hearing Officer Duties.** The Hearing Officer shall preside at the Hearing and may seek the advice of separate legal counsel in making rulings, but such counsel may not be an attorney regularly utilized by the Hospital for providing legal advice regarding its affairs and activities. The Hearing Officer shall also be responsible for:

- 10.15.1. **Equal Opportunity to be Heard.** Assure that the parties in the Hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner.
  - 10.15.2. **Decorum.** Establish and maintain proper decorum until the Hearing is adjourned.
  - 10.15.3. **Presentation of Evidence.** Determine the procedure for presenting evidence, oral testimony and argument during the Hearing.
  - 10.15.4. **Rulings.** Utilize the authority and discretion to make rulings on all questions which pertain to matters of law, procedure or the admissibility of evidence.
  - 10.15.5. **Maintain Pace.** Maintain an efficient and expeditious pace in the Hearing.
  - 10.15.6. **Decision.** Provide a written decision following the close of the Hearing in a manner prescribed by these Bylaws.
- 10.16. **Record of the Hearing.** A shorthand reporter or court reporter shall be present to create a verbatim record of the proceedings, and the pre-hearing proceedings if deemed appropriate by the Hearing Officer. The cost of attendance of the short hand reporter or court reporter shall be borne by the Hospital, but the cost of any transcript, *if requested*, shall be borne by the requesting party. A copy of the transcript shall be provided to the Hearing Officer at Hospital expense. All oral testimony shall be taken upon oath administered by any person lawfully authorized to administer such oath. Exhibits shall be marked in advance, as decided between the parties and the Hearing Officer.
- 10.17. **Rights of the Parties During Hearing.** Within reasonable limitations, as determined within the discretion of the Hearing Officer, each party may call and examine witnesses for relevant testimony, introduce relevant exhibits or documents, cross-examine or impeach witnesses who shall have testified orally on any matter relevant to the issues, and otherwise rebut evidence, as long as these rights are exercised in an efficient, expeditious and fair manner. The Affected Practitioner may be called by the Advocate and examined, as if under cross-examination.
- 10.18. **Procedural Rules.** The California Rules of Evidence and California Rules of Civil Procedure shall not apply to a Hearing conducted under this Article 10. Any relevant evidence, including hearsay, shall be admitted if it's the sort of evidence on which responsible persons are accustomed to rely on in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The Hearing Officer shall have complete discretion in ruling on the relevance and admissibility of evidence coming before the Hearing. The Hearing Officer may interrogate the witnesses or recall witnesses, if He deems such action appropriate. The Hearing Officer may limit the maximum number of pages filed by the parties in their written statement presented at the close of the Hearing.
- 10.19. **Burden of Presenting Evidence; Inferences.** During the Hearing the Advocate shall have the duty to present evidence in support of the proposed action or recommendation. The Affected Practitioner is not obligated to present evidence in response to matters submitted by the Advocate and the Hearing Officer shall draw no negative inference from such action or inaction. Throughout the Hearing, the Advocate shall maintain the burden of persuading the Hearing Officer by a preponderance (i.e., *more than 50%*) of the evidence, that the proposed action or recommendation was reasonable and warranted.
- 10.20. **Adjournment and Conclusion.** The Hearing Officer may adjourn the Hearing and reconvene it without Special Notice at such time as may be reasonable and warranted, with due consideration for reaching an expeditious conclusion to the Hearing. Both the Advocate and the Affected Staff Member may submit a written statement at the close of the Hearing. Upon conclusion of the presentation of oral and documentary evidence, or the receipt of a written statement - if submitted, the Hearing Officer shall declare the Hearing closed, at which time the Hearing Officer shall commence deliberations immediately or schedule deliberations for a later date, but not later than fifteen (15) Days from adjournment.

- 10.21. **Basis for Decision.** The decision of the Hearing Officer shall be based on the evidence introduced at the Hearing, including all logical and reasonable inferences from the evidence and the testimony received, except any negative inference as described in Section 10.20, above. The decision of the Hearing Officer shall be subject to such rights of appeal as further described in these Bylaws, but shall otherwise be affirmed by the Board as the final action, if it is supported by a preponderance of the evidence following a fair Hearing procedure.
- 10.22. **Decision of the Hearing Officer.** Within fifteen (15) Days after final adjournment of the Hearing or receipt by the Hearing Officer of a transcript of the hearing, (*whichever is later*) the Hearing Officer shall render a decision in writing that shall be delivered to (i) the Affected Practitioner, (ii) the Advocate, and (iii) the CEO. The decision shall contain a concise statement of the reasons in support thereof, including findings of fact and conclusions articulating the connection between the evidence produced at the Hearing and the conclusion(s) reached. If the final proposed action Adversely Affects the Affected Practitioner's Clinical Privileges for a period longer than thirty (30) Days and is based on His competence or professional conduct, the decision shall state that the action - *if adopted*, shall be reported to the State licensing board and shall include the proposed text of the report as agreed upon by the Hearing Officer. Both the Affected Practitioner, or His representative - if so elected, and the Advocate shall be provided a written explanation of the procedure for appealing the decision. The decision of the Hearing Officer shall be subject to such rights of appeal or review, as described in these Bylaws, but shall otherwise be affirmed by the Governing Board as the final action if it is reasonably supported by the evidence, following a fair procedure.
- 10.23. **Appeal.** Within ten (10) Days after receipt of the decision of the Hearing Officer, either the Advocate or the Affected Practitioner may request an appeal of the decision. A written request for such review shall be delivered to the CEO and the non-appealing party in the Hearing. If an appeal is not requested within the ten (10) Day period, the decision of the Hearing Officer shall be affirmed by the Board as the **final action.**
- 10.24. **Grounds for Appeal.** A written request for an appeal shall include a specific identification of the grounds for appeal and a clear and concise statement of the facts in support of the appeal. The grounds for appeal from the Hearing shall be limited to:
- 10.24.1. substantial non-compliance with the procedures required by these Bylaws or applicable law which has created demonstrable prejudice; and/or
  - 10.24.2. the decision was not supported by the preponderance of the evidence based upon the record or the proposed action is arbitrary, capricious and unreasonable; and/or
  - 10.24.3. the text of the report to be filed with Affected Practitioner's licensing board is inaccurate.
- 10.25. **Time, Place and Notice.** If an appeal is to be conducted, the Appeal Board (as defined in 10.26, below) shall, within fifteen (15) Days after receipt of notice of appeal, schedule a review date. The date of appellate review shall not be more than thirty (30) Days from the date of such notice, provided however, that when a request for appellate review concerns a Member who is under suspension which is then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made, not to exceed fifteen (15) Days from the date of the notice. The time for appellate review may be extended by the Appeal Board for good cause.
- 10.26. **Appeal Board.** At least three (3) members of the Governing Board may sit as the Appeal Board, or it may appoint an Appeal Board composed of not less than three (3) members, which may include members of the Governing Board. Knowledge of the matter involved shall not preclude any person from serving as a member of the Appeal Board, so long as that person did not actively participate in a prior

hearing on the same matter. The Appeal Board may select an attorney to assist it, but that attorney (i) shall not be entitled to vote with the respect to the appeal, and (ii) shall not be the attorney that represented either party at the Hearing.

- 10.27. **Appeal Procedure.** The proceeding shall be based upon the record of the Hearing. Each party shall have the right to present a written statement in support of its position on appeal, but not the right to appear before the Appeal Board. Thereafter, the Appeal Board may, at any time convenient to its members, conduct confidential deliberations. If the Appeal Board is not the Governing Board, it shall present its written decision to the Board recommending that it (i) **affirm**, (ii) **modify**, or (iii) **reverse** the Hearing Officer's decision and a brief explanation supporting its decision. If the Governing Board sits as the Appeal Board, its written decision immediately becomes the Board's final decision, as identified in Section 10.28, below.
- 10.28. **Final Decision.** Unless the Governing Board sits as the Appeal Board, within thirty (30) Days following receipt of the Appeal Board's decision, the Board shall render a final decision and shall **affirm** the decision of the Hearing Officer, if the Hearing Officer's decision is supported by the preponderance of evidence following a fair procedure, or **modify** or **reverse** the Hearing Officer's decision should the Governing Board determine that there was either (i) substantial non-compliance with the procedures required by these Bylaws or applicable law that has created demonstrable prejudice, and/or (ii) that the decision was not supported by the preponderance of the evidence based upon the record or the proposed action is arbitrary, capricious and unreasonable. The decision shall be in writing, shall specify the reasons for the determination, shall include the text of the report which shall be made to the State licensing department, if applicable, and shall be forwarded to the Affected Practitioner, the Advocate and the CEO.
- 10.29. **Right to One Hearing.** No Practitioner shall be entitled to more than one evidentiary Hearing and one appeal on any matter which was the subject of Professional Review Activity, except as may be otherwise provided herein.
- 10.30. **Exceptions to Hearing Rights.** If a Medical Staff Member provides professional services under a contract with the Hospital, the Member's Medical Staff Privileges may be terminated upon termination of the contract, if so provided within the contract. Otherwise, His Medical Staff Privileges may only expire by affording Him the same Hearing rights available to all Members of the Medical Staff. No Hearing is required when a Member's license or legal credentials to practice has been revoked or suspended by the issuing Board.

## ARTICLE 11 - ALLIED HEALTH PROFESSIONAL

### 11.1. Appointment and Assignment

11.1.1. **Allied Health Professional:** Allied Health Professionals, sometimes referred to as "specified professional personnel," may be authorized by the Medical Staff to perform their professional services within the Hospital. They shall be individually authorized and shall carry out their professional activities under the supervision of the President of the Medical Staff or an appropriate attending Medical Staff member assigned this responsibility by the President of the Medical Staff under any guidelines issued by an appropriate licensing or certifying body.

11.1.2. **Physician Assistants and Supervising Physicians:** The term "physician assistant" refers specifically to a person who is a graduate of a physician assistant training program accredited by the Committee on Allied Health Education and Accreditation of the Council on Medical Education of the

American Medical Association or a person who has passed the examination given by the National Commission on the Certification of Physician's Assistants. The term "supervising physician" refers to the physician licensed by the California State Board of Medical Examiners either as a doctor of medicine or as a doctor of osteopathy who is assuming responsibility and legal liability for the services rendered by the physician assistant and who has been approved by the California as State Board of Medical Examiners to supervise a specific physician assistant.

11.1.3. Tasks and activities of a physician assistant shall be subject to the following:

11.1.3.1. **Review.** Review of physician assistant activities shall be performed by the Medical Staff and shall be in compliance with the rules adopted by the California State Board of Medical Examiners for physician assistants.

11.1.3.2. **Tasks That May Be Delegated.** Provided that the supervising physician has satisfied himself or herself as to the ability and competence of the physician assistant, and with due regard to the safety of patients in the Hospital and in keeping with sound medical practice, the physician assistant may perform such duties, which do not require the exercise of independent medical judgment, as assigned by his or her supervising physician who is responsible for the performance of such tasks and who retains direct control and supervision of the physician assistant. A supervising physician may delegate authority to a physician assistant to perform such functions as are included with the scope of standing delegation orders as authorized by the rules of the California State Board of Medical Examiners.

11.1.3.3. **Non-Delegable Tasks.** The supervising physician shall neither delegate to nor allow a physician assistant to:

11.1.3.3.1. Perform any task or function without the supervising physician being either physically present or immediately available to provide further guidance, except in life-threatening emergencies where there is no other feasible alternative;

11.1.3.3.2. Make a final or definitive diagnosis of a disease or ailment independent of the supervising physician;

11.1.3.3.3. Independently prescribe any treatment or a regimen;

11.1.3.3.4. Prescribe, order, or dispense medication, sign or stamp prescriptions on behalf of the supervising physician, or order the refilling of a prescription, except as may be authorized by law;

11.1.3.3.5. Replace the supervising physician in making visits in the Hospital;

11.1.3.3.6. Initiate or change any orders on a patient's chart in the Hospital, except at the supervising physician's direction and verifiable request;

11.1.3.3.7. Initiate treatment of any new patient before the supervising physician has seen the patient and ordered the method of treatment, except in life-threatening emergencies or when care is rendered under standing delegation orders as authorized under the rules of the California State Board of Medical Examiners;

11.1.3.3.8. Independently delegate a task assigned to him or her by the supervising physician;

11.1.3.3.9. Allied Health Professionals will remain non-voting members of the medical staff.

11.2. **Other Allied Health Professionals:** Any physician member of the Medical Staff may make a request to the Medical Staff to utilize the services of other categories of Allied Health Professionals to provide an improved level of care to the patients of the Medical Staff member. The Medical Staff member's application shall be approved only under the following conditions:

11.2.3. The physician member of the Medical Staff shall certify in writing to the Executive Committee that the Allied Health Professional shall work only under the medical direction and supervision of the applying Medical Staff member who shall retain full responsibility for all activities of the Allied Health Professional within the Hospital.

11.2.4. An individual Allied Health Professional may be supervised by (or employed by) only one

- physician member of the Medical Staff and shall only provide services to the patients of that physician Medical Staff member.
- 11.2.5. The applying Medical Staff member shall submit to the Executive Committee a detail of all responsibilities which the Allied Health Professional shall be assigned within the Hospital and documentation of the Allied Health Professional's training, education, and qualifications for approval.
  - 11.2.6. In reviewing the application for utilization of the Allied Health Professional, the Executive Committee shall approve the application only if the Executive Committee determines that the documented training, education, and qualifications are sufficient to allow the Allied Health Professional to safely perform the responsibilities detailed to be assigned in paragraph (3) above.
  - 11.2.7. Allied Health Professionals may perform no tasks that require the exercise of independent medical judgment and, except as provided by law, are subject to the limitations detailed in paragraph (3) of this article. The Executive Committee may, at its own discretion, make such additional limitations as it deems appropriate in view of the Allied Health Professional's documented training and experience and the tasks requested to be assigned.
  - 11.2.8. If required for the profession, an Allied Health Professional must have any professional licensure granted by a state or federal licensing or certifying body.
- 11.3. Procedure for Approval of Allied Health Professional Designation**
- 11.3.1. **Application:** All Allied Health Professionals must complete an Allied Health Professional application.
  - 11.3.2. **Checklist:** Allied Health Professionals who practice and bill for their services independently shall complete a privileges checklist, indicating the delineated clinical privileges that the Allied Health Professional is requesting. Allied Health Professionals employed by a Medical Staff member shall complete a scope of services form, indicating the extent of services that the Allied Health Professional wants to perform.
  - 11.3.3. **Certificate:** Allied Health Professionals must provide copies of:
    - 11.3.3.1. Current license/registration/certification, if applicable; and
    - 11.3.3.2. Certificate of professional liability insurance (personally for Allied Health Professionals who practice and bill for their services independently and through employers for Allied Health Professionals employed by a Medical Staff member).
  - 11.3.4. **Complete Application:** If the application for Allied Health Professional designation is satisfactorily completed, the Chief Executive Officer/designee shall collect and verify the references and other materials deemed pertinent, including queries with the National Practitioner Data Bank for those independent Allied Health Professionals requesting delineated clinical privileges. Thereafter, the Chief Executive Officer shall transmit the completed application and all supporting material to the President of the Medical Staff for evaluation.
  - 11.3.5. **Review by President of the Medical Staff:** The President of the Medical Staff shall initially review each application for Allied Health Professional designation and shall, if necessary, seek further evaluation and recommendation by knowledgeable members of the Medical Staff.
  - 11.3.6. **Review by Executive Committee:** The Executive Committee shall then review and make a recommendation regarding each Allied Health Professional's application, subject to final approval or denial by the Board.
- 11.4. Delineation of Clinical Privileges/Scope of Patient Care Services**
- 11.4.1. **Clinical Privileges:** Allied Health Professionals may exercise only those clinical privileges that have been awarded or approved.
  - 11.4.2. **Recommendations:** Recommendations for clinical privileges and for scopes of services are based on the Medical Staff's and the Hospital's need for and ability to accommodate the services

of the classification of the Allied Health Professionals. The general qualifications to be required by members of each category of Allied Health Professionals, if not set forth in these Bylaws, shall be determined by the Executive Committee.

- 11.4.3. **Requests for Additional Privileges:** Requests of Allied Health Professionals to perform additional services in the Hospital must be made in writing to the Chief Executive Officer and be recommended by the President of the Medical Staff. Such requests will be referred to the Executive Committee and to the Board for final approval.

**11.5. Authorized Activities of Allied Health Professionals.**

- 11.5.1. Authorized activities of Allied Health Professionals who practice and bill for their services independently include the following:
- 11.5.1.1. Having access to medical records of patients for whom the Allied Health Professional has been asked to provide care;
  - 11.5.1.2. Visiting patients in whose care the Allied Health Professional is involved;
  - 11.5.1.3. To the extent permitted by law, writing progress notes in the medical records of patients for whom the Allied Health Professional has been asked to provide care; and
  - 11.5.1.4. Performing specific duties ordered by a Practitioner that are within the scope of the Allied Health Professional's delineated clinical privileges.
  - 11.5.1.5. Allied Health Professionals employed by a Medical Staff member may perform such services as may be delegated to them by their employers in accordance with their scope of services form, these Bylaws, and applicable law.

**11.6. Reappraisal**

- 11.6.1. All Allied Health Professionals are reappraised every two years\* by the President of the Medical Staff. The reappraisal shall be completed in accordance with the procedures established for review of the applications of Allied Health Professionals as provided herein.
- 11.6.2. RN's and LVN's employed by the medical staff and assisting medical staff during rounds will practice within the scope of their designated board, follow the job description of the organization and be deemed competent on the schedule set forth by the organization.

**11.7. Conditions of Continued Allied Health Professional Designation**

- 11.7.1. **Limited Rights:** Allied Health Professionals shall not be entitled to the rights, privileges, and responsibilities of members of the Medical Staff and may only engage in acts within the clinical privileges delineated or the scope of services specifically approved by the Board for the individual Allied Health Professional.
- 11.7.2. **Limited Participation:** Allied Health Professionals may participate directly in the management of patients pursuant to an order of a member of the Medical Staff or under the supervision and/or direction of their employer, to the extent permitted by law and as authorized herein.
- 11.7.3. **Orders, Reports, and Progress Notes:** Within the limits established in these Bylaws and in the rules and regulations of the Medical Staff and consistent with State law, appropriately credentialed Allied Health Professionals may write orders and record reports and progress notes in the patient's medical records.
- 11.7.4. **Subject to Authority:** All applicants receiving Allied Health Professional designation shall carry out their activities subject to the policies and procedures of the Hospital and in conformity with these Bylaws and the rules and regulations of the Medical Staff. Allied Health Professionals shall be subject to quality assurance review, and their exercise of clinical privileges or their

performance of services pursuant to their scope of services may be revoked on the basis of adverse results from quality assurance reviews.

- 11.7.5. **No Right to Review:** Requests for Allied Health Professional designation are at the discretion of the Board, may be terminated at will by the Board, and shall not be covered by the provisions of the Plan. Fair Hearing procedures do not apply to Allied Health Professionals.

## **ARTICLE 12 - PRESIDENT OF THE MEDICAL STAFF**

12.1. **President of the Medical Staff's Qualifications.** The President of the Medical Staff shall be a Member of the Active Medical Staff and have sufficient administrative and leadership experience that will enable him to oversee the Medical Staff. The President of the Medical Staff shall be initially confirmed by the Governing Board, upon nomination by the CEO. Every two years thereafter the President of the Medical Staff shall be elected by the voting members of the medical staff. Failure to remain a Member of the Active category, in regular status, shall provide grounds for removal by the Governing Board or CEO, following Special Notice of such proposed removal and failure by the President of the Medical Staff to immediately demonstrate evidence of compliance. Removal from the position of President of the Medical Staff is not an Adverse Action.

12.2. **Duties of the President of the Medical Staff.** The President of the Medical Staff shall serve as the Director of the Medical Staff and shall maintain responsibility for, or perform, the following duties:

- 12..1. act in coordination and cooperation with the CEO in all matters of mutual concern within the Hospital;
- 12..2. call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;
- 12..3. serve as a voting member of the Hospital's Governing Board;
- 12..4. chair the Medical Executive Committee and all other Medical Executive Committees in the absence of qualified volunteers or available nominees;
- 12..5. serve as an Ex-Officio member with a vote of any other Medical Executive Committees;
- 12..6. maintain responsibility for the impartial enforcement of these Bylaws and Rules and Regulations of the Medical Staff, for the implementation of sanctions as indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested or suggested against a Practitioner;
- 12..7. appoint responsible members to all standing or special Medical Executive Committees, with the exception of the Medical Executive Committee;
- 12..8. appoint responsible Members to designated Hospital committees requiring Medical Staff participation;
- 12..9. zealously represent the views, policies, needs, and grievances of the Medical Staff to the Governing Board and/or the CEO;
- 12..10. be committed to maintaining or improving the level of care provided to patients at the Hospital;
- 12..11. be responsible for the educational activities of the Medical Staff; and
- 12..12. serve as the spokesman for the Hospital's Medical Staff in its external professional and public relations.
- 12..13. responsible for oversight of the administrative functions of the medical staff.
- 12..14. responsible for the annual review and evaluation process of the medical staff.

12.3. **Associate President of the Medical Staff.** With the approval of the CEO, the President of the Medical Staff may select a Member of the Active Medical Staff to serve as the Associate President of the Medical Staff, who shall perform all functions for the President of the Medical Staff in His Absence

except sitting as a member of the Governing Board.

## ARTICLE 13 - COMMITTEES OF THE MEDICAL STAFF

13.1. **Committees, Generally.** Committees exist, and may be designated by the President of the Medical Staff to provide support to the CEO of the Hospital and other Practitioners regarding the administrative and medical matters of the Medical Staff as they pertain to the operation of the Hospital. The Committees of the Medical Staff presently include the Medical Executive Committee and all other committees and that are formed to achieve the purpose and intent of these Bylaws.

13.2. **Medical Executive Committee.** The Medical Executive Committee shall be composed of the President of the Medical Staff, the Associate President of the Medical Staff and Members of the Medical Staff, who shall each have one vote. The elected President of the Medical Staff shall serve as Chair, and the CEO shall be an Ex-Officio non-voting member. The President of the Medical Staff or the Associate President of the Medical Staff will assume the responsibility to chair the Medical Executive Committee in the absence of the President of the Medical Staff. The Director of Clinical Services and the pharmacy representative shall have voting authority in matters related to their specific specialties only. All functions of the Medical Executive Committee shall be carried out by the Medical Staff as a whole; provided, that a majority of this committee consist of physician Members of the Active Medical Staff. At least three (3) physicians shall be in attendance as voting members of a committee, to constitute a quorum at any meeting for those hospitals with fifty (50) or less credentialed physicians on staff. For those hospitals with > than fifty (50) Active members of the Medical Staff a quorum will be defined as at least eight (8) voting members at any given meeting. .

13.3. **Duties of the Medical Executive Committee.** The Medical Executive Committee is empowered by the Organized Medical Staff to represent and act for the Medical Staff in the following duties:

- 13.3.1. Serves as the final decision making body of the Medical Staff in accordance with these Bylaws.
- 13.3.2. Submit recommendations to the Governing Board regarding structure of the Medical Staff; the process to review credentials; to delineate individual Clinical Privileges; and recommend individuals for Medical Staff Membership.
- 13.3.3. Submit recommendations for organization of Performance Improvement and utilization review activities of the Medical Staff.
- 13.3.4. Submit recommendations regarding the process for the hearing; appellate procedures; and termination from the Medical Staff.
- 13.3.5. Determine actions of the Medical Staff that are required by these Bylaws and the Hospital.
- 13.3.6. Coordinate activities and general policies of the Medical Staff.
- 13.3.7. Receive and act in a timely manner on any committee, function, or other Medical Staff reports and recommendations.
- 13.3.8. Prepare, amend and implement policies of the Medical Staff.
- 13.3.9. Work in concert with the CEO and the Governing Board.
- 13.3.10. Recommend actions to the Governing Board and/or the CEO on medical and/or administrative matters.
- 13.3.11. Participate in the long range planning process of the Hospital.
- 13.3.12. Fulfill the Medical Staff's accountability to the Board for the monitoring of the quality of medical care rendered to patients in the Hospital by all Medical Staff Members and Allied Health Professionals.

- 13.3.13. Maintain knowledge of the accreditation status and the factors influencing the accreditation status of the Hospital.
  - 13.3.14. Provide for the preparation of meeting programs, either as a total committee or through a specific person.
  - 13.3.15. Review the credentials of all new Applicants and make recommendations for Medical Staff Membership.
  - 13.3.16. Review annually all information available regarding the performance and clinical competence of all Practitioners and make recommendations for Reappointment or changes in Clinical Privileges.
  - 13.3.17. Review annually the qualifications of Allied Health Professionals practicing in the Hospital and make appropriate recommendations.
  - 13.3.18. Take all reasonable steps to ensure professionally ethical conduct and competence for Clinical Privileges of all Medical Staff Members.
  - 13.3.19. Perform such other duties as may be requested by the CEO and/or the Governing Board.
- 13.4. **Committee Meetings.** The Medical Executive Committee shall meet at least three (3) times per year, and more often as needed, or as called by the President of the Medical Staff or the Board. A written record of the proceedings and actions regarding all functions of the Medical Executive Committee shall be maintained and available for review by all Members to insure the Committee carries out its functions.
- 13.5. **Performance Improvement.** The Medical Executive Committee shall maintain primary responsibility and authority over activities related to the functions of performance improvement of the professional services provided by individuals with Clinical Privileges. This includes organization of the Medical Staff's performance improvement activities and establishing a mechanism designed to conduct, evaluate and revise such activities, as needed.
- 13.6. **Performance Improvement Functions.** The Medical Staff has a leadership role in organization performance improvement activities designed to ensure that the Medical Staff provides leadership for process measurement, assessment and improvement when the performance of a process is dependent primarily on the activities of one or more individuals with Clinical Privileges.
- 13.6.1. The clinical processes include, but are not limited to, those within the:
    - 13.6.1.1. medical assessment and treatment of patients;
    - 13.6.1.2. use of medications;
    - 13.6.1.3. use of blood and blood components;
    - 13.6.1.4. invasive procedures;
    - 13.6.1.5. efficiency of clinical practice patterns; and
    - 13.6.1.6. significant departures from established patterns or clinical practice.
  - 13.6.2. The other patient care processes include, but are not limited to, those within the:
    - 13.6.2.1. education of patients and families;
    - 13.6.2.2. coordination of care with other Practitioners and Hospital personnel, as relevant to the care of an individual patient: and
    - 13.6.2.3. accurate, timely and legible completion of medical records.
- 13.7. **Infection Control Committee.** The Infection Control Committee shall consist of the Infection Control Officer, a member of the Medical Staff; and other members as approved by the President of the Medical Staff and CEO.
- 13.8. **Duties of the Infection Control Committee.** Responsibilities of the Infection Control Committee, with consultation from the President of the Medical Staff, is to maintain an effective Hospital wide

infection control program determining type of surveillance and standard criteria for reporting all types of infections.

- 13.9. **Committee Meetings.** The Infection Control Committee shall meet as needed. Written reports of the conclusions, recommendations, findings, actions taken, and results of actions taken will be presented to the Medical Executive Committee and recorded in the minutes.
- 13.10. **Committees for Special Services and/or Functions.** Special committees may be appointed as needed by the Medical Executive Committee. These committees shall confine their work to the purposes for which they were appointed and report in writing to the Medical Executive Committee as stipulated. The membership, term, and scope of these committees shall be determined jointly by the President of the Medical Staff and CEO.
- 13.11. **Other Functions.** Other functions that may be performed by Medical Staff Members within or without a committee include the following:
  - 13.11.1. **Medical Records Review Function.** The Medical Records Review Function shall be performed at least quarterly by appointed representatives from the Medical Staff, Nursing Service and Hospital administration and shall be responsible for reviewing medical records for their timely completion, clinical pertinence, adequacy for use in quality review studies, and use as a medico-legal document. This review includes, but is not limited to, assuring that each medical record, or a representative sample of records, reflects the diagnosis, results of diagnostic tests, therapy rendered, condition and in-Hospital progress of the patient, and condition of the patient at discharge. The Medical Record Review Function shall also assure that there is documentation in the medical record for the use of all special treatment procedures. Evaluation of medical records shall be applied to inpatient and out-patient medical records as well as to discharge records to determine promptness and adequacy of completion. The Medical Records Review Function is performed concurrently and retrospectively, with a report made at least quarterly to the Medical Executive Committee.
  - 13.11.2. **Drug Usage Evaluation Function.** At specified intervals the Drug Usage Evaluation Function will be carried out by the Pharmacy and Therapeutics Function as a criteria-based, ongoing, planned, and systematic process designed to continuously improve the appropriate and effective use of drugs. The duties of the Drug Usage Evaluation Function include a clinical review by physician Members of the Medical Staff in cooperation with the pharmacy service, the nursing service, and Hospital administration in the prophylactic, therapeutic and empirical use of drugs for in-patients in order to assure that such drugs are used appropriately, safely, and effectively; the establishment of criteria for prophylactic and therapeutic uses of drugs in problem areas; and review of statistical prevalence studies as requested by the Medical Executive Committee or the Infection Control Committee. Written minutes of meetings and reports shall be maintained and reported to the Medical Executive Committee.
  - 13.11.3. **Hospital Committees.** The Medical Staff shall be represented on Hospital based committees as may be required by the Hospital's policies, the CEO or the Board.
- 13.12. **Miscellaneous Provisions Regarding Committee Meetings.**
  - 13.12.1. **Meeting Dates.** A special meeting of any committee may be called by or at the

request of the committee's chair or the President of the Medical Staff.

- 13.12.2. Notice. Written or oral notice stating the place, date, and time of any special meetings or of any regular meetings shall be given to each member of the committee by Special Notice not less than two (2) Days before the time of such meeting, by the person or persons calling the meeting. If mailed, the notice of the meeting shall be deemed delivered three days, excluding holidays and Sundays, after deposit in the United States mail. The attendance of the member at a meeting shall constitute a waiver of notice of such meeting.
- 13.12.3. Quorum: At least three (3) physicians shall be in attendance as voting members of a committee, to constitute a quorum at any meeting for those hospitals with fifty (50) or less credentialed physicians on staff. For those hospitals with > than fifty (50) Active members of the Medical Staff a quorum will be defined as at least eight (8) voting members at any given meeting.
- 13.12.4. Manner of Action. The action of a majority of the members present at the meeting at which a quorum is present shall be the action of a committee. Action may be taken without a meeting by unanimous consent in writing (setting forth the action so taken) signed by each member entitled to vote.
- 13.12.5. Rights of Ex-Officio Members. Unless otherwise provided in these Bylaws, persons serving under these Bylaws as Ex-Officio members of a committee shall have all rights and privileges of regular members except they shall not be counted in determining the existence of a quorum, but shall have the right to vote.

13.13. **Regular Meeting Agenda**. Following a "Call to Order," the agenda at any regular Medical Executive Committee meeting shall include the following items:

- 13.13.1. review of the minutes of the last regular meeting and of all special meetings since the last regular meeting;
- 13.13.2. unfinished business;
- 13.13.3. Credentialing and preparing recommendations on Applicants;
- 13.13.4. report from the CEO;
- 13.13.5. reports from any Medical Executive Committees;
- 13.13.6. new business (including elections, where appropriate); and
- 13.13.7. adjournment.

13.14. **Special Meeting Agenda**. Following a "Call to Order," the agenda at special meetings of the Medical Executive Committee shall include the following items:

- 13.14.1. reading of the notice calling the special meeting;
- 13.14.2. transaction of business for which the special meeting was called; and
- 13.14.3. adjournment.

13.14.4. Approval of Minutes. Minutes shall be signed by the Chair and copies forwarded to the Committee and the Board. A file of the minutes of each meeting shall be maintained. Minutes shall be confidential and stored in a secure area. Copies of minutes shall be accounted for and destroyed after the use for which they were made.

13.14.5. Continuing Medical Education. Where applicable, clinical committees will offer a program featuring new developments in the diagnostic and therapeutic aspects of patient care and refreshing the Medical Staff on various aspects of evidenced based medicine for the population we serve.

13.14.6. Attendance Requirements.

- 13.14.6.1. Number. Each committee member shall be required to attend one-half (½) of all meetings of His committees in each Medical Staff Year. The failure to meet the foregoing annual attendance requirements, unless excused by the committee chair, for good cause shown, shall be grounds for corrective action leading to revocation of Medical Staff Membership in the same manner and to the same effect as provided in Bylaws. The appropriate committee chair shall report such failures to the Medical Executive Committee for action. Attendance is acceptable via conference call if approved by the Committee Chair.
- 13.14.6.2. Failure to Attend Mandatory Meeting. Failure by a Practitioner to attend any meeting with respect to which He was given notice that attendance was mandatory, unless excused by the Committee chair upon a showing of good cause, shall result in an automatic suspension of all or such portion of Practitioner's Clinical Privileges as the Medical Executive Committee may direct, and such suspension shall remain in effect until the matter is resolved through any mechanism that may be appropriate, including corrective action, if necessary. In all other cases, if the Practitioner shall make a timely request for postponement supported by an adequate showing that his absence will be unavoidable, such presentation may be postponed by the President of the Medical Staff, or by the Medical Executive Committee, if the chairman is the Practitioner involved, until not later than the next regular meeting; otherwise the pertinent clinical information shall be presented and discussed as scheduled.

## ARTICLE 14 - RULES AND REGULATIONS

**14.1** The Medical Executive Committee shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the Governing Board. These Rules and Regulations shall relate to the proper conduct of Medical Staff organizational activities, as well as embody the level of practice that is to be required of each Practitioner in the Hospital. Such Rules and Regulations shall be a part of these Bylaws, except that they may be amended or repealed at any regular meeting at which a quorum is present and without previous notice or at any special meeting with notice, by a two-thirds (2/3) vote of those present of the Medical Staff. Such changes shall become effective when approved by the Board.

## ARTICLE 15 - AMENDMENTS

**15.1 Procedure for Amendment.** These Bylaws and/or the Medical Staff Rules and Regulations may be amended after submission of any proposed amendments to the Medical Executive Committee for discussion and evaluation. To be adopted, the amendments shall require a majority vote of the Medical Executive Staff at a meeting at which a quorum is present, provided at least ten (10) Days notice, accompanied by the proposed Bylaws and/or amendments, has been given of the intention to take such action to those members by Special Notice. Amendments so made shall be effective when approved by the Board.

**15.2 Proposal of Amendments.** Amendments may be proposed by any member of the Medical Executive Committee or any committee of the Medical Staff by submitting, in writing, any such proposed change to the Medical Executive Committee. Provided, however, if any amendment to either these Bylaws or rules and regulations of the Medical Staff is required to comply with any federal, state, or local law or regulation or any standard or requirement of any hospital accrediting body, and if the Medical Staff fails to enact this amendment within thirty (30) Days after a request from the Board, the amendment shall become automatic with or without

Committee and Board approval and shall be incorporated herein by reference.

### **ARTICLE 16 - REVIEW OF THE BYLAWS**

**16.1** These Bylaws will be reviewed as needed to assure accuracy, appropriateness, and conformance with legal and industry standards and current practices, but not less often than every three (3) years from the date of Board approval. Approved amendments will be automatically sent to all Members of the Medical Staff.

### **ARTICLE 17 - ADOPTION**

**17.1** These Bylaws, with or without the amended Rules and Regulations, may be adopted at any regular or special meeting of the Medical Staff, provided at least ten (10) Days notice, accompanied by these Bylaws, has been given to those Members by Special Notice. These Bylaws shall become effective when approved by the Board.

### **ARTICLE 18 - PARLIAMENTARY PROCEDURE**

**18.1** Except where it may conflict with procedure stated within these Bylaws, all meetings of the Medical Staff and its committees shall be governed in their procedures by Robert's Rules of Order, as revised. The President of the Medical Staff shall act as parliamentarian.

*(remainder of this page intentionally left blank)*

**★ ADOPTION AND APPROVAL ★**

**ADOPTED** BY THE MEDICAL STAFF ON THE \_\_\_\_ DAY OF \_\_\_\_\_, 200

\_\_\_\_\_  
**DAVID HICKS, M.D., PRESIDENT OF THE MEDICAL  
STAFF**

**APPROVED** BY THE GOVERNING BOARD ON THE \_\_\_\_ DAY OF \_\_\_\_\_, 200

\_\_\_\_\_  
**JOHN W. CASSIDY, M.D.  
CHAIR, GOVERNING BOARD**

**ADDENDUM "A"**

*(remainder of this page intentionally left blank)*