

SUTTER MEDICAL CENTER OF SANTA ROSA

MEDICAL STAFF BYLAWS

Revised: December 2009

PREAMBLE

The Medical Staff recognizes and acknowledges that providing quality medical care in the Hospital depends on the mutual accountability, interdependence and responsibility of the Medical Staff and the Governing Body for the proper performance of their respective obligations. These Medical Staff Bylaws provide a framework for Medical Staff's self government and certain rights and are intended to assure an organization of the Medical Staff that permits the Medical Staff to discharge its responsibilities in matters involving the quality of patient care in the Hospital.

Accordingly, these Bylaws address the Medical Staff's responsibility to establish criteria and standards for Medical Staff membership and Privileges as well as criteria and standards for Allied Health Professional status and Privileges. The Bylaws also address the Medical Staff's right and responsibility to enforce those criteria and standards; to establish clinical criteria and standards to oversee and manage quality management, utilization review, and other Medical Staff activities; they describe the standards and procedures for selecting and removing Medical Staff officers; and they address the respective rights and responsibilities of the Medical Staff and the Governing Body. The Bylaws also codify a process for the Medical Staff and Governing Body to meet and confer in good faith regarding any disputes that may arise.

In adopting these Bylaws, the Medical Staff acknowledges the Governing Body's duty and responsibility to act to protect the quality of medical care provided and the competency of the Medical Staff to ensure the responsible governance of the Hospital in the event that the Medical Staff fails in any of its substantive duties and responsibilities. In that regard, the Medical Staff commits to exercise its responsibilities with diligence and in good faith and the Governing Body commits to allowing the Medical Staff independence in conducting the affairs of the Medical Staff. The final authority of the Governing Body may be exercised for the responsible governance of the Hospital or for the conduct of the business affairs of the Hospital. However, that final authority may only be exercised with a reasonable and good faith belief that the Medical Staff has failed to fulfill a substantive duty or responsibility in matters pertaining to the quality of patient care and the Governing Body will not assume a duty or responsibility of the Medical Staff precipitously, unreasonably, or in bad faith.

DEFINITIONS

ALLIED HEALTH PROFESSIONAL OR “AHP” means an individual, other than a licensed physician, dentist, podiatrist, or clinical psychologist who exercises independent judgment within the areas of his or her professional competence and the limits established by the Governing Body, the Medical Staff, and the applicable State Practice Act, who is qualified to render direct or indirect care under the supervision or direction of a Medical Staff Member possessing Privileges to provide such care in the Hospital, and who may be eligible to exercise Privileges and prerogatives in conformity with the rules adopted by the Governing Body, these Bylaws, and the Medical Staff Rules and Regulations. AHPs are not eligible for Medical Staff membership.

ATTENDING PHYSICIAN means the physician who is a Medical Staff Member who maintains overall responsibility for each patient admitted.

BEHAVIOR DISRUPTIVE TO HOSPITAL OPERATIONS means behavior which compromises the quality of patient care, either directly or because it disrupts the ability of other professionals to provide quality care.

CHIEF EXECUTIVE OFFICER means the individual appointed by the Governing Body to act on its behalf in the overall management of the Hospital. The term “Chief Executive Officer” includes the Chief Executive Officer’s designee. The Medical Staff may rely upon all actions of the Chief Executive Officer as being the actions of the Governing Body taken pursuant to a proper delegation of authority from the Governing Body.

CHIEF OF STAFF means the chief officer of the Medical Staff elected by the Medical Staff.

CLINICAL PRIVILEGES OR PRIVILEGES means the permission granted, including temporary Privileges, to Medical Staff Members or Allied Health Professionals to provide specific patient care services.

CORE PRIVILEGES means those procedures as defined by the relevant department that anyone trained in a specialty area would be expected to be qualified to perform.

DATE OF RECEIPT means the date any Notice, Special Notice or other communication was delivered personally; or if such Notice, Special Notice or communication was sent by mail, it shall mean seventy two (72) hours after the Notice, Special Notice or communication was deposited, postage prepaid, in the United States mail. [See also, the definitions of **NOTICE** and **SPECIAL NOTICE**, below.]

DAYS means calendar days unless otherwise specified.

DEPARTMENT means a clinical department.

DISTANT SITE when used in the context of a discussion regarding Telemedicine, means the location at which the Telemedicine equipment is located and from which the Telemedicine Provider delivers his/her patient care services.

EX OFFICIO means service by virtue of office or position held. An Ex Officio appointment is with vote unless specified otherwise.

GOOD STANDING means a Medical Staff Member is in good standing when, at the time of the assessment of standing, his/her membership and/or Privileges are not voluntarily or involuntarily limited, restricted, suspended, or otherwise encumbered for medical disciplinary cause or reason (excluding medical leaves of absence and participation in a Diversion Program).

GOVERNING BODY means Board of Directors of Sutter Health West Bay Hospitals. As appropriate to the context and consistent with the Hospital's Bylaws, it may also mean any Governing Body committee or individual authorized to act on behalf of the Governing Body.

HOSPITAL means Sutter Medical Center of Santa Rosa.

INVESTIGATION means a process specifically instigated by the Medical Executive Committee to determine the validity, if any, to a concern or complaint raised against a Member of the Medical Staff and does not include the activities of the Physicians' Health Committee.

MEDICAL DIRECTOR means a physician appointed by the Governing Body, after conferring with the Medical Executive Committee, to perform administrative services and to oversee the medical aspects of various clinical service lines within the Hospital.

MEDICAL EXECUTIVE COMMITTEE means the governing unit of the Medical Staff, as described in these Bylaws.

MEDICAL STAFF means those physicians (MD or DO or their equivalent (i.e. foreign)), as recognized by the Medical Board of California (MBC) or the Osteopathic Medical Board of California (OMBC) who are licensed by either the MBC or the OMBC; dentists; podiatrists; and clinical psychologists, who have been granted recognition as Members of the Medical Staff pursuant to the terms of these Bylaws.

MEDICAL STAFF YEAR means the period from January 1 through December 31.

MEMBER means, unless otherwise expressly limited, any physician (MD or DO or their equivalent (i.e. foreign)), as recognized by the Medical Board of California (MBC) or the Osteopathic Medical Board of California (OMBC); dentist; podiatrist; and clinical psychologist, holding a current license to practice within the scope of that license who holds an appointment on the Medical Staff.

NOTICE means a written communication delivered personally to the addressee or sent by United States mail, first-class postage prepaid, addressed to the addressee at the last address as it appears in the official records of the Medical Staff or the Hospital. [See also, the definitions of **DATE OF RECEIPT** above and **SPECIAL NOTICE** below.]

ORIGINATING SITE when used in the context of discussion regarding Telemedicine means the location at which the patient is located.

PATIENT ENCOUNTER means admitting or attending the patient, performing a procedure on the patient (inpatient or Hospital outpatient), consulting on a patient, or assisting at surgery.

PHYSICIAN means an individual with an M.D. or D.O. degree or the equivalent degree (i.e., foreign) as recognized by the Medical Board of California (MBC) or the Osteopathic Medical Board (OMBC), who is licensed by either the MBC or the OMBC.

PRACTITIONER means an appropriately licensed physician, dentist, clinical psychologist, osteopath, or podiatrist. In the context of corrective action and fair hearings pursuant to Article

VII, it shall also include those categories of licentiates described at California Business and Professions Code Section 809(b).

PRECEPTOR means physician who is a Medical Staff Member who has prerequisite credentialing in a relevant discipline and has been granted clinical instructor or clinical professor status by the University of California at San Francisco.

PRIMARY SOURCE means the original source of specific credential which can verify the accuracy of a qualification reported by an individual health care Practitioner.

RESIDENCY PROGRAM means the Family Practice Residency Program at Sutter Medical Center of Santa Rosa, affiliated with the University of California at San Francisco.

RESIDENT means an individual who is enrolled in the Family Practice Residency Program at Sutter Medical Center of Santa Rosa.

RULES means the Medical Staff and/or department Rules adopted in accordance with these Bylaws, unless specified otherwise.

SECTION means a subcommittee of the Department.

SPECIAL NOTICE means a Notice sent by certified or registered mail, return receipt requested. [See also definitions of **DATE OF RECEIPT** and **NOTICE** above.]

SPECIAL PRIVILEGES means those Clinical Privileges which are not Core Privileges.

SMCSR means Sutter Medical Center of Santa Rosa.

TELEMEDICINE means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. Neither a telephone conversation nor an electronic mail message between a health care practitioner and patient constitutes “telemedicine” for the purposes of these Bylaws. The Medical Staff recommends to the Governing Body which clinical services are appropriately delivered through this medium, according to commonly accepted quality standards.

TELEMEDICINE PROVIDER means the individual provider who uses the Telemedicine equipment at the Distant Site to render services to patients who are located at the Originating Site. The Telemedicine Provider is generally a physician, but other health professionals may also be involved as Telemedicine Providers. The Telemedicine Provider would generally contract with (or in the case of nonphysicians, be employed by) the entity that serves as the Distant Site.

ARTICLE I

NAME AND PURPOSES

1.1 Name.

The name of the organization is “The Medical Staff of Sutter Medical Center of Santa Rosa.”

1.2 Purposes and Responsibilities.

1.2-1 The Medical Staff’s purposes are:

- (a) To assure that all patients admitted or treated in any of the Hospital services, including patients treated via Telemedicine, receive care at a uniform level of quality and efficiency consistent with generally accepted standards attainable within the Hospital’s means and circumstances;
- (b) To assume a leadership role in Hospital performance improvement activities to improve quality of care, treatment, services and patient safety;
- (c) To provide for a level of professional performance that is consistent with generally accepted standards attainable within the Hospital’s means and circumstances;
- (d) To organize and support professional education and community health education and support services;
- (e) To initiate, develop and maintain Bylaws and Rules and Regulations establishing self governance for the Medical Staff with respect to the professional work performed in the Hospital and for establishing processes for the Medical Staff to carry out its responsibilities for the professional work performed in the Hospital, pursuant to the authority delegated by the Governing Body, including periodic meetings of the Medical Staff to review and analyze at regular intervals their clinical experience based on the review of patient medical records;
- (f) To provide a means for the Medical Staff, Governing Body and Administration to discuss issues of mutual concern; and
- (g) To provide for accountability of the Medical Staff to the Governing Body.

1.2-2 The Medical Staff’s rights and responsibilities are:

- (a) To provide quality patient care;
- (b) To account to the Governing Body for the quality of patient care provided by all Members authorized to practice in the Hospital through the following measures:
 - (1) Review and evaluation of the quality of patient care provided through valid and reliable patient care evaluation procedures;

- (2) An organizational structure and mechanisms that allow on-going monitoring of patient care practices;
 - (3) A credentials program, including mechanisms of appointment, reappointment and the matching of Clinical Privileges to be exercised or specified services to be performed with the verified credentials and current demonstrated performance of the Medical Staff applicant or member;
 - (4) A continuing education program based at least in part on needs demonstrated through the medical care evaluation program; and
 - (5) A utilization review program to provide for the appropriate use of all medical services.
- (c) To recommend to the Governing Body action with respect to appointments, reappointments, staff category and department assignments, Clinical Privileges and corrective action;
 - (d) To recommend to the Governing Body for the establishment, maintenance, continuing improvement and enforcement of professional standards related to the delivery of health care within the Hospital;
 - (e) To account to the Governing Body for the quality of patient care through regular reports and recommendations concerning the implementation, operation and results of the quality review and evaluation activities;
 - (f) To initiate and pursue corrective action with respect to Members where warranted;
 - (g) To provide a framework for cooperation with other community health facilities and/or educational institutions or efforts;
 - (h) To develop, administer and recommend amendments to and in compliance with these Bylaws, the Rules and Regulations of the Medical Staff and with Hospital policies and procedures; and
 - (i) To exercise the authority granted by these Bylaws in order to fulfill the foregoing responsibilities.

1.2-3 Medical Staff Right to Self-Governance

The Medical Staff's right to self-governance shall include, but not be limited to, all of the following:

- (a) Establishing in these Bylaws and Rules and Regulations the criteria and standards for Medical Staff membership and Privileges, and enforcing those criteria and standards;
- (b) Establishing in the Bylaws and Rules and Regulations clinical criteria and standards to oversee and manage quality improvement, utilization review and other Medical Staff activities including, but not limited to, periodic meetings of the Medical Staff and its committees and Departments and review and analysis of patient medical records;

- (c) Selecting and removing Medical Staff Officers;
- (d) Assessing Medical Staff dues and utilizing the Medical Staff dues as appropriate for the purposes of the Medical Staff;
- (e) The ability to retain and be represented by independent legal counsel at the expense of the Medical Staff; and
- (f) Initiating, developing and adopting Medical Staff Bylaws, Rules and Regulations, and amendments thereto, subject to the approval of the Governing Body, which approval shall not be unreasonably withheld.

1.2-4 Dispute Resolution.

With respect to any dispute related to the Medical Staff's rights of self-governance and/or discharge of Medical Staff responsibilities, the Medical Staff and Governing Body shall meet and confer in good faith to resolve the dispute. The forum established in these Bylaws for this meet and confer obligation is the Joint Conference Committee; however, the Medical Staff and Governing Body can utilize additional or different forums or processes, such as mediation, so long as both the Medical Staff and Governing Body mutually agree to the forum or process as well as any procedures that would govern the meet and confer function. Whenever any person or entity, including the Governing Body, has engaged in, or it about to engage in, acts or practices that hinder, restrict or obstruct the Medical Staff's ability to exercise its rights, obligations or responsibilities, the Medical Staff may apply for, and the Superior Court of the County in which the Hospital is located, may issue an injunction, writ of mandate or other appropriate order. Prior to seeking judicial relief, the Medical Staff must first make a reasonable effort to resolve the dispute, including the pursuit of any reasonable administrative remedies provided in these Bylaws.

ARTICLE II

MEMBERSHIP

2.1 Nature of Membership.

Membership on the Medical Staff and/or Privileges may be extended to and maintained by only those professionally competent Members who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and the Rules. A Member, including one who has a contract with the Hospital to provide medical-administrative services, may admit, render a diagnosis or otherwise provide clinical treatment to patients in the Hospital only if the Member is a Member of the Medical Staff or has been granted temporary Privileges in accordance with these Bylaws and the Rules. Appointment to the Medical Staff shall confer only such privileges and prerogatives as have been granted by the Governing Body in accordance with these Bylaws.

2.2 Qualifications for Membership.

2.2-1 General Qualifications.

Only physicians, dentists, oral surgeons, podiatrists and clinical psychologists shall be deemed to possess basic qualifications for membership on the Medical Staff, except for the Honorary staff category, in which case these criteria shall only apply as deemed individually applicable by the Medical Staff, and who

- (a) Document their (1) current licensure, (2) adequate experience, education, and training, (3) current professional competence in the care of patients in the hospital, (4) good judgment, and (5) current adequate physical and mental health status (subject to any necessary reasonable accommodation), so as to demonstrate to the satisfaction of the Medical Staff that they are professionally and ethically competent and that patients treated by them can reasonably expect to receive quality medical care;
- (b) Are determined (1) to adhere to the ethics of their respective professions, (2) to be able to work cooperatively with others so as not to adversely affect patient care or jeopardize the ability of the treatment team to provide quality patient care, as determined by the Medical Executive Committee (3) to keep as confidential, as required by law, all information or records received in the physician-patient relationship, and (4) to be willing to participate in and properly discharge those responsibilities determined by the Medical Staff, including peer review;
- (c) Maintain in force professional liability insurance, with an insurer acceptable to the Governing Body and Medical Executive Committee, in not less than the minimum amounts, as from time to time may be jointly determined by the Governing Body and the Medical Executive Committee. The Medical Executive Committee, for good cause shown, may recommend to the Governing Body that this requirement be waived with regard to a Practitioner, and the Governing Body shall not grant or withhold such waiver on an arbitrary, discriminatory or capricious basis. In determining whether an individual exception is appropriate, the following facts may be considered:
 - (1) Whether the Practitioner has applied for the requisite insurance;
 - (2) Whether the Practitioner has been refused insurance, and if so, the reasons for such refusal; and
 - (3) Whether insurance is reasonably available to the Practitioner and, if not, the reasons for its unavailability.
- (d) Must not be currently excluded from participating in Medicare, Medicaid or any other federal health care program when such exclusion has been imposed by government enforcement authorities, or accepted by Practitioner, as a sanction for unlawful conduct; and
- (e) Shall be guided by ethical standards. The codes of ethics as provided by Sutter Medical Center of Santa Rosa, and the code of ethics for the American Medical Association, American Dental Association, American

Osteopathic Association, American Podiatric Association, California Hospital Association, Guiding Principles for Physician-Hospital Relationships of the California Medical Association, and the Medical Staff Bylaws shall guide the professional conduct of the Members of the Medical Staff; and

2.2-2 Particular Qualifications.

(a) (a) Physicians. An applicant for physician membership in the Medical Staff, except for the Honorary Staff, must hold an M.D. or D.O. degree or their equivalent and a valid and unsuspended certificate to practice medicine issued by the Medical Board of California or the Board of Osteopathic Examiners of the State of California. For the purposes of this section, “or their equivalent” shall mean any degree (i.e., foreign) recognized by the Medical Board of California or the Board of Osteopathic Examiners. Except for dentists and clinical psychologists, applicants shall be Board Certified, or have completed an approved residency in their intended field of practice; and have practiced in the applicant’s intended filed of practice in a Joint Commission (or equivalent) accredited acute care hospital for two (2) of the previous four (4) years, or have completed an accredited (by ACGME or AOA or otherwise accepted by the MBC or OMBC) clinical residency or fellowship in the intended field of practice within the previous twenty-four (24) months. Applicants to the Office Based category must satisfy all criteria stated in this section except the recent acute care hospital experience requirement. Instead, applicants to the Office Based category shall be eligible to apply if they can demonstrate that they have practiced in a NCQA approved (or acceptable equivalent which includes a demonstrated peer review function, as determined by the Medical Executive Committee) outpatient setting for two (2) of the previous four (4) years or completed an accredited (by ACGME or AOA or otherwise accepted by the MBC or OMBC) clinical residency or fellowship in the intended field of practice within the previous twenty-four (24) months. In lieu of having practiced in an NCQA approved outpatient setting as described above, applicants to the Office Based category will be required to submit a sampling of a minimum of eight (8) office charts for review by the Department Chairperson or his or her designee, or by an outside reviewer, as determined by the Medical Executive Committee. When the review of office charts is required, the types, numbers and selection process for the office charts shall be determined by the Department Chairperson. The costs of such review shall be paid by the applicant.

(b) Limited License Practitioners.

(1) Dentists. An applicant for dental membership in the Medical Staff, except for the Honorary Staff, must hold a D.D.S. or equivalent degree and a valid and unsuspended certificate to practice dentistry issued by the Board of Dental Examiners of California. Oral and maxillofacial surgery applicants shall be Board Certified in their intended field of practice (American Board of Oral and Maxillofacial Surgery (“ABOMS”) or a specialty board recognized by the Commission on Accreditation of the American Dental Association) or have completed an approved (accepted by the Commission on Accreditation of the American Dental Association or otherwise accepted by the Dental Board of California (“DBC”)) residency or fellowship in their intended field of practice; and have practiced in the applicant’s intended field of

practice in a Joint Commission (or equivalent) accredited acute care hospital for two (2) of the previous four (4) years, or have completed an accredited (accepted by the Commission on Accreditation of the American Dental Association or otherwise accepted by the DBC) clinical residency or fellowship in the intended field of practice within the previous twenty-four (24) months.

- (2) Podiatrists. An applicant for Podiatric membership on the Medical Staff, except for the Honorary Staff, must hold a D.P.M. degree and a valid and unsuspended certificate to practice podiatry issued by the Medical Board of California. Podiatric applicants shall be Board Certified in their intended field of practice (American Board of Podiatric Surgery (“ABPS”) or American Board of Podiatric Orthopedics and Primary Podiatric Medicine (“ABPOPPM”)) or have completed an accredited (approved by American Podiatric Medical Association’s (“AMPA”) Council on Podiatric Medical Education or otherwise accepted by the Board of Podiatric Medicine (“BPM”)) residency or fellowship in their intended field of practice; and have practiced in the applicant’s intended field of practice in a Joint Commission (or equivalent) accredited acute care hospital for two (2) of the previous four (4) years, or have completed an accredited (approved by AMPA’s Council on Podiatric Medical Education or otherwise accepted by the BPM) clinical residency or fellowship in the intended field of practice within the previous twenty-four (24) months.
- (3) Clinical Psychologists. An applicant for clinical psychology membership on the Medical Staff, except for the Honorary Staff, must have a Ph.D. degree and a valid and unsuspended certificate to practice clinical psychology issued by the California Board of Psychology and Division of Allied Health Professions of the Medical Board of California.

- (c) Licenses/Registrations. Current California licensure and Drug Enforcement Administration registration may be verified on line. However, if such on line verification can not be obtained, then the Medical Staff members are responsible for assuring that facsimiles of current California licensure and Drug Enforcement Administration (DEA) registration (if applicable) are on file with the Medical Staff Office at the time of initial appointment. Except for Honorary Staff Members, all Members of the Medical Staff shall verify renewal of their DEA registration (if applicable) at the time the registration is renewed by either confirming that on-line verification has been obtained or by submitting a copy of the renewed registration to the Medical Staff Office, unless a letter has been filed with the Medical Staff Office stating that the Practitioner does not have such registration. Because of the acknowledged inability of the Federal Drug Enforcement Administration to process and return these documents in a timely fashion, a ninety (90) day grace period on membership and Privileges will be granted if the Practitioner can demonstrate that he/she has taken the necessary steps to renew his/her DEA certification. A Practitioner whose DEA is expired beyond ninety (90) days shall immediately and automatically be divested of his/her right to prescribe medications covered by such certification.

- (d) Malpractice Insurance. Medical Staff Members are responsible for assuring that their current professional liability carrier supplies the Medical Staff Office with a certificate of insurance or declaration of continuous coverage which meets the minimum requirements of coverage as may be jointly determined by the Governing Body and the Medical Executive Committee. Continuous coverage means current professional liability coverage, as well as evidence of tail or nose coverage for prior periods in the event the Members has changed insurance carriers. Medical Staff Members are also responsible for notifying the Medical Staff Office of any changes in carrier at the time the change is made.
- (e) Dues. The dues for Medical Staff membership shall be payable in such amounts, at such times, and for such periods as the Medical Executive Committee of the Hospital may from time to time establish with the approval of the Medical Staff. Automatic suspension will be instituted if dues are not paid in full after a thirty (30) day period beyond which they are due provided that no Practitioner shall be so suspended except upon failure to pay after at least ten (10) days written notice that payment is due.

A Practitioner who does not meet these basic standards is ineligible to apply for Medical Staff membership, and the application shall not be accepted for review, except that applicants for the Honorary Medical Staff do not need to comply with any of the basic standards. If it is determined during the processing that an applicant does not meet all of the basic qualifications, the review of the application shall be discontinued. An applicant who does not meet the basic standards is not entitled to the procedural rights set forth in these Bylaws, but may submit comments and a request for reconsideration of the specific standards which adversely affected such Practitioner. Those comments and requests shall be reviewed by the Medical Executive Committee and the Governing Body, which shall have the sole discretion to decide whether to consider any changes in the basic standards or to grant a waiver as allowed by Section 2.3.

2.3 Waiver of Qualifications.

Insofar as is consistent with applicable laws, the Governing Body has the discretion to deem a Practitioner to have satisfied a qualification, based upon the recommendation of the applicable clinical Department and the Medical Executive Committee, if it determines that the Practitioner has demonstrated he or she has substantially comparable qualifications and that this waiver is necessary to serve the best interests of the patients and of the Hospital. There is no obligation to grant any such waiver, and Practitioners have no right to have a waiver considered and/or granted. A Practitioner who is denied a waiver or consideration of a waiver shall not be entitled to any hearing and appeal rights under these Bylaws.

2.4 Effect of Other Affiliations.

No person shall be entitled to membership on the Medical Staff merely because that person 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 person had, or presently has, staff membership or privileges at another health care facility. Medical Staff membership or Clinical Privileges shall not be conditioned or determined on the basis of an individual's participation or non-participation in a

particular group, IPA, PPO, PHO, hospital sponsored foundation, or other organization or contracts with a third party which contracts with this Hospital.

2.5 Hospital Sponsored Outpatient Clinics.

Each Practitioner or Allied Health Professional who provides services to patients of Hospital outpatient programs and facilities and programs sponsored by Sutter Medical Center of Santa Rosa must be Members of the Medical Staff of Sutter Medical Center of Santa Rosa with Privileges to provide those services or have Allied Health Professional Status at Sutter Medical Center of Santa Rosa and have the appropriate service authorization to provide such services.

2.6 Nondiscrimination.

No aspect of Medical Staff membership or particular Clinical Privileges shall be denied on the basis of sex, race, age, creed, religion, color, national origin, or physical or mental impairment that does not pose a threat to the quality of patient care.

2.7 Basic Responsibilities of Medical Staff Membership.

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

- (a) Providing patients with the quality of care meeting the professional standards of the Medical Staff of this Hospital;
- (b) Abiding by the Medical Staff Bylaws and Rules and Regulations and all other lawful standards, policies and rules of the Medical Staff as well as those Hospital policies required by state or federal law or by the standards of national accrediting organizations such as the Joint Commission (or equivalent at the discretion of the Medical Executive Committee);
- (c) Discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the Member by virtue of Medical Staff membership, including committee assignments and peer review activities;
- (d) Preparing and completing in a timely fashion medical records for all the patients to whom the Member provides care in the Hospital, in accordance with the Medical Staff Rules and Regulations;
- (e) Abiding by the lawful ethical principles of the California Medical Association;
- (f) Aiding in any Medical Staff approved educational programs for medical students, interns, resident physicians, resident dentists, Staff physicians, podiatrists, oral surgeons and dentists, nurses, and other personnel;
- (g) Working cooperatively with Members, nurses, Hospital administration, and others so as not to adversely affect patient care or jeopardize the ability of the treatment team to provide quality patient care;
- (h) Making appropriate arrangements for coverage for his or her patients as determined by the Medical Staff;

- (i) Refusing to engage in improper inducements for patient referral;
- (j) Participating in continuing education programs as determined by the Medical Staff;
- (k) Discharging such other Medical Staff obligations as may be lawfully established from time to time by the Medical Staff or Medical Executive Committee;
- (l) Every application or reapplication for Medical Staff appointment shall constitute the applicant's specific willingness to participate in such emergency service coverage or panels as may be determined by the Medical Staff and Hospital. Any Medical Staff Member, regardless of staff category, who agrees to cover the practice of another Medical Staff Member, shall be obligated to take calls from the Emergency Room if he/she is covering for someone who is on-call to the Emergency Department;
- (m) Reporting to his/her clinical Department Chairperson any extended illness, disability, or absence which will prevent him/her from participating in Hospital practice and/or Medical Staff business;
- (n) Reporting to the Chief of Staff promptly in the event of any formal action taken by government enforcement authorities to exclude the Practitioner from participating in Medicare, Medicaid, or any other federal health care program as a sanction for unlawful conduct;
- (o) Reporting to his/her clinical Department Chairperson any reduction, restriction, suspension, or revocation of his/her Clinical Privileges, for medical disciplinary cause or reason, at another hospital or surgicenter, or any termination, restriction, reduction or suspension, for medical disciplinary cause or reason, of his/her status as a contracted provider for a managed care organization or any licensing agency's accusation, action or settlement;
- (p) Reporting to the Chief of Staff within five (5) days any criminal conviction;
- (p) Providing information to and/or testifying on behalf of the Medical Staff or an accused Practitioner regarding any matter under an investigation pursuant to Section 6.1-4, and those which are the subject of a hearing pursuant to Article VII;
- (q) Upon request, providing information from his or her office records or from outside sources as necessary to facilitate the care of or review of the care of specific patients;
- (r) Attending meetings of a Medical Staff peer review committee at which the Member's practice or conduct is scheduled for discussion, if the Member's attendance has been requested at least seven (7) days prior to the meeting, or responding within thirty (30) days to a written request on behalf of any such committee, identifying questions or concerns pertaining to a Member's practice or conduct and requesting that he/she review and

respond to the applicable committee meeting minutes and medical records;
and

- (s) Continuously meet the qualifications for membership as set forth in these Bylaws.

A Member may be required to demonstrate continuing satisfaction of any of the requirements of these Bylaws upon the reasonable request of the Medical Executive Committee.

2.8 Harassment Prohibited.

Harassment by a Medical Staff Member against any individual, e.g., against another Medical Staff Member, Hospital employee or patient, on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex, gender or sexual orientation, or for any other reason, shall not be tolerated.

"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 (such as unwelcome touching, assault or interference with movement or work), and visual harassment (such as the display of derogatory cartoons, drawing or posters).

Sexual harassment includes unwelcome advances, requests for sexual favors and any other verbal, visual or physical conduct of a sexual nature when (1) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion or other aspects of employment; or (2) this conduct substantially interferes with the individual's employment or creates an intimidating, hostile or offensive work environment. Sexual harassment also includes conduct which indicates that employment and/or employment benefits are conditioned upon acquiescence in sexual activities.

All allegations of harassment by a Medical Staff Member, including, but not limited to, sexual harassment, shall be immediately investigated by the Medical Staff and, if confirmed, will result in appropriate corrective action from reprimands up to and including termination of Medical Staff Privileges or membership, if warranted by the facts.

2.9 HIPAA

All Members of the Medical Staff will be deemed to be members of the Hospital's Medical Staff Organized Healthcare Arrangement ("MSOHCA") as such term is defined by the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and all implementing regulations, as amended from time to time ("HIPAA"). The Hospital will issue a Joint Notice of Privacy Practices ("JNPP") to its patients, and will obtain acknowledgement of patient's receipt of the JNPP, on behalf of the MSOHCA; Medical Staff Members shall not issue a separate notice of privacy practices to hospitalized patients. MSOHCA members are individually responsible for compliance with the terms of the JNPP. The JNPP does not fulfill Practitioners' obligations when seeing patients outside of the Hospital or in their private offices.

ARTICLE III

CATEGORIES OF MEMBERSHIP

3.1 The Medical Staff.

The categories of the Medical Staff shall include the following: Active, Courtesy, Consulting, Provisional, Office Based, Honorary, Temporary, and Telemedicine Affiliate. At appointment and each time of reappointment, the Member's staff category shall be determined by the Medical Executive Committee.

3.2 Active Staff.

3.2-1 Qualifications.

The Active Staff shall consist of Members who:

- (a) Meet the general qualifications for membership set forth in section 2.2;
- (b) Have offices or residences which, in the opinion of the Medical Executive Committee, are located close enough to the Hospital to provide appropriate continuity of quality care;
- (c) regularly care for patients in the hospital or are regularly involved in medical staff functions, as determined by the medical staff;
- (d) Pay dues to the Medical Staff;
- (e) Participate in continuing evaluation of the clinical care and adherence to the standards established by the Medical Staff; and
- (f) Except for good cause shown as determined by the Medical Executive Committee, have satisfactorily completed their designated term in the Provisional Staff category.

3.2-2 Prerogatives.

Except as otherwise provided, the prerogatives of an Active Medical Staff Member shall be to:

- (a) Admit patients and exercise such Clinical Privileges as are granted pursuant to Article V (i.e., the Medical Staff Bylaws provisions on Clinical Privileges);
- (b) Attend and vote on matters presented at general and special meetings of the Medical Staff and the Department and committees to which the Member is duly appointed; and
- (c) Hold Staff, section, or Department office and serve as a voting member of committees to which the Member is duly appointed or elected by the Medical Staff or duly authorized representative thereof.

3.2-3 Transfer of Active Staff Member.

After two (2) consecutive years in which a Member of the Active Staff fails to regularly care for patients at the Hospital, or be regularly involved in medical staff

functions as determined by the Medical Staff, that Member may be transferred to the appropriate category, if any, for which the Member is qualified, with approval of the Medical Executive Committee. The transfers shall be done at the time of reappointment. A Member who does not wish to be transferred has the burden to clearly demonstrate that unusual circumstances unlikely to occur again in his or her practice caused the failure to meet the minimum or maximum requirements.

3.3 The Courtesy Medical Staff.

3.3-1 Qualifications.

The Courtesy Staff shall consist of Members who:

- (a) Meet the general qualifications for membership set forth in section 2.2;
- (b) Have offices or residences which, in the opinion of the Medical Executive Committee, are located close enough to the Hospital to provide appropriate continuity of quality care;
- (c) Pay dues to the Medical Staff;
- (d) Do not regularly care for patients in the Hospital or are not regularly involved in Medical Staff functions as determined by the Medical Staff;
- (e) Are Members in Good Standing of the Active Medical Staff of another hospital licensed in the State of California and approved by The Joint Commission, although exceptions to this requirement may be made by the Medical Executive Committee for good cause; and
- (f) Except for good cause shown as determined by the Medical Executive Committee, have satisfactorily completed their designated term in the Provisional Staff category.

3.3-2 Prerogatives.

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

- (a) Admit patients to the Hospital with the limitations of Section 3.3-1(d) and exercise such Clinical Privileges as are granted pursuant to Article V; (i.e., the Medical Staff Bylaws provisions on Clinical Privileges); and
- (b) Attend meetings of the Medical Staff and the Department and committees to which the Member is duly appointed, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment.

Courtesy Members shall not be eligible to hold office in the Medical Staff organization, and shall not be permitted to serve as the chairperson of any committee to which they are assigned.

3.4 The Office Based Staff

3.4-1 Qualifications.

The Office Based Staff shall consist of those applicants or existing Members who:

- (a) Have met all the requirements set forth in Section 2.2 to qualify for Clinical Privileges except for the requirement that the applicants have practiced in the applicant's intended field of practice in a Joint Commission (or equivalent) accredited acute care hospital for two (2) of the previous four (4) years. Office Based Members must be involved in the care of outpatients at least twenty (20) hours per week in the outpatient or office based setting. Office Based Members shall not be granted Clinical Privileges or be allowed to write orders. An applicant may be appointed directly to the Office Based Category without first completing an appointment to the Provisional Staff.

3.4-2 Prerogatives.

- (a) Office Based Staff Members may attend meetings of the Medical Staff and the Department and/or section to which that person is assigned, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment.
- (b) Office Based Staff Members shall not be eligible to hold office in the Medical Staff organization, but may serve on committees, as appointed by the Department chair, Chief of Staff or Medical Executive Committee.
- (c) Office Based Members shall pay dues.
- (d) Office Based Staff Members who wish to apply for Clinical Privileges must demonstrate current competence in the care of acute inpatients and to exercise the specific Privileges requested as recommended by the appropriate clinical Department, the Credentials Committee and the Medical Executive Committee. This required demonstration will likely require the Practitioner to obtain recent education and training from a program approved by the appropriate clinical Department, the Credentials Committee and the Medical Executive Committee, and which is specifically designed to enable the Practitioner to demonstrate current competence in the care of acute inpatients. Office Based Staff Members applying for Clinical Privileges may be required to have an interview with the Credentials Committee. Successful applicants will be approved for provisional staff category and must satisfactorily complete all proctoring requirements before advancing to any other staff category.
- (e) Office Based Staff Members must provide documentation identifying a Medical Staff Member who shall be responsible for admitting and managing the care of the Office Based Staff Member's patients who present to the Hospital for admission.
- (f) At the time of reappointment, Practitioners seeking reappointment to the Office Based Staff must provide documentation acceptable to the Credentials Committee and Medical Executive Committee that he or she has been involved in the care of outpatients at least twenty (20) hours per week in the outpatient or office based setting. Additionally, the

3.-5 The Provisional Medical Staff.

3.5-1 Qualifications.

The Provisional Staff shall consist of Members who:

- (a) Meet the general Medical Staff membership qualifications set forth in Sections 2.2.
- (b) Immediately prior to their application and appointment were not Members (or were no longer Members) in Good Standing of this Medical Staff (except for Members of the Office Based Category); and
- (c) Pay dues to the Medical Staff.

3.5-2 Prerogatives.

The Provisional Staff Member shall be entitled to:

- (a) Admit patients and exercise such Clinical Privileges as are granted pursuant to Article V; (i.e., the Medical Staff Bylaws provisions on Clinical Privileges); and
- (b) Attend meetings of the Medical Staff and committees to which the Member is duly appointed, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment.

Provisional Staff Members shall not be eligible to hold office in the Medical Staff organization, but may serve on committees. They shall not be permitted to serve as chairperson of any committee to which they are assigned.

3.5-3 Observation of Provisional Staff Member.

Each Provisional Staff Member shall undergo a period of observation by designated monitors as described in Section 5.3 as approved by the Medical Executive Committee. The purpose of observation shall be to evaluate the Member's (1) proficiency in the exercise of Clinical Privileges initially granted and (2) overall eligibility for continued staff membership and advancement within staff categories. Observation of Provisional Staff Members shall follow whatever frequency and format each Department deems appropriate in order to adequately evaluate the Provisional Staff Member including, but not limited to, concurrent or retrospective chart review, mandatory consultation, and/or direct observation. Appropriate records shall be maintained. The results of the observation shall be communicated, in writing, by the Department chairpersons of the Hospital to the Credentials Committee.

3.5-4 Term of Provisional Staff Status.

A Member shall remain in the Provisional Staff for a period of one (1) year, unless that status is extended by the Medical Executive Committee for an additional one (1) year period, upon a determination of good cause; which determination shall not be subject to review pursuant to Article VII (the corrective action and fair hearings provisions). However, in no event shall the Member remain in the Provisional Staff for a period in excess of two (2) years.

3.5-5 Action at Conclusion of Provisional Staff Status.

- (a) If the Provisional Staff Member has satisfactorily complied with the proctoring requirements and satisfactorily demonstrated the ability to exercise the Core Privileges initially granted and otherwise appears qualified for continued Medical Staff membership, the Member shall be eligible for placement in the Active, Courtesy, or Consulting staff as appropriate, upon the recommendation of the Medical Executive Committee; and
- (b) In all other cases, the appropriate Department shall advise the Credentials Committee which shall make its report to the Medical Executive Committee which, in turn, shall make its recommendation to the Governing Body regarding a modification or termination of Clinical Privileges or termination of Medical Staff membership. The failure of a Provisional Staff Member to advance from Provisional Staff status shall be deemed a termination of his/her staff appointment. An appointee whose membership is so terminated shall have the rights accorded by these Bylaws to any Member of the Medical Staff who has failed to be reappointed except where the failure to advance is based solely on the appointee not meeting the minimum number of cases required according to the applicable Department policies/procedures.

3.5-6 Failure to Complete Proctoring for Special Privileges.

The failure to complete proctoring for any Special (i.e., as distinguished from Core Privileges) Privilege shall not, of itself, preclude advancement from Provisional Staff. If advancement is approved prior to completion of proctoring, the proctoring will continue for the Special Privileges. The Special Privileges may be voluntarily relinquished or terminated if proctoring is not completed thereafter within a reasonable time as established by the Department with the approval of the Medical Executive Committee.

3.6 The Consulting Staff.

3.6-1 Qualifications.

Any Member of the Medical Staff in Good Standing may consult in that Member's area of expertise; however, the Consulting Staff shall consist of such Practitioners who:

- (a) Are not otherwise Members of the Medical Staff, who possess an expertise that is not adequately represented on the Medical Staff, are Board certified in their specialty, and who meet the general qualifications set forth in Section 2.2-1, except that this requirement shall not preclude an out of state Practitioner from appointment as may be permitted by law if that Practitioner is otherwise deemed qualified by the Medical Executive Committee;
- (b) Possess qualifications for Medical Staff membership and adequate clinical and professional credentials in an expertise which the Medical Executive Committee determines is under represented on the Medical Staff;
- (c) Shall be a Member in Good Standing of the Active Staff of another Joint Commission (or equivalent) approved acute care hospital acceptable to the Medical Executive Committee, although exceptions to this requirement may be made by the Medical Executive Committee for good cause; and
- (d) Shall have satisfactorily completed appointment in the Provisional Staff category. At the time of application, Practitioners seeking appointment to the Consulting Staff must provide documentation that he or she has satisfactorily completed a proctor program at their primary hospital. Such documentation may be accepted in lieu of actual observation and or other proctor program requirement, at the discretion of the chairperson of the Department to which the Practitioner is assigned.

3.6-2 Prerogatives.

The Consulting Staff Member shall be entitled to:

- (a) Exercise such Clinical Privileges as are granted pursuant to Article V; (i.e., the Medical Staff Bylaws provisions on Clinical Privileges); and
- (b) Be appointed to a specific Department, be eligible to serve on specific committees when appointed and vote on matters before such committees. They may attend Medical Staff meetings, including open committee meetings and educational programs, and meetings of the Department to which the Practitioner is assigned, but shall have no right to vote at such meetings. They shall not pay dues.

Members of the Consulting Staff shall not have admitting Privileges. Members of the Consulting Staff shall not be eligible to hold office in the Medical Staff and may not serve as chairperson of any committees to which they are assigned.

3.7 The Honorary Staff.

3.7-1 Qualifications.

- (a) The Honorary Staff. The Honorary Staff shall consist of physicians, dentists, oral surgeons, podiatrists and clinical psychologists who are retired or who do not actively practice at the Hospital but are deemed deserving of membership by virtue of their outstanding reputation, noteworthy contributions to the health and medical sciences, or their previous long-standing service to the Hospital, and who continue to exemplify high standards of professional and ethical conduct.

3.7-2 Prerogatives.

Honorary Staff Members are not eligible to admit patients to the Hospital or to exercise Clinical Privileges in the Hospital, or to vote or hold office in this Medical Staff organization, but they may serve upon committees with or without vote at the discretion of the Medical Executive Committee. They may attend Medical Staff and Department meetings, including open committee meetings and educational programs. They shall not pay dues.

3.8 Temporary Staff.

3.8-1 Qualifications.

The Temporary Staff shall consist of Physicians, Dentists, Oral Surgeons, Podiatrists and Clinical Psychologists who do not actively practice at the Hospital but are important resource individuals for Medical Staff performance improvement activities. Such persons shall be qualified to perform the functions for which they are made temporary members of the Medical Staff.

3.8-2 Prerogatives.

Temporary Staff Members shall be entitled to attend all meetings of committees to which they have been appointed for the limited purpose of carrying out performance improvement functions. They shall have no Privileges to perform clinical services in the Hospital. They may not admit patients to the Hospital, or hold office in the Medical Staff organization. They may, however, serve on designated committees with or without vote at the discretion of the Medical Executive Committee, but may not serve as the chairperson of any committees to which they are assigned. They may attend Medical Staff meetings outside of their committees, upon invitation. They shall not pay dues.

3.9 Residents.

Resident physicians may be permitted to provide patient care services at the Hospital in accordance with training protocols and pursuant to the conditions stated in these Bylaws and in the Rules and Regulations. Medical licensure usually occurs during post-graduate education, but it is not required by law to perform duties as described in training protocols applicable to Residents in program approved by the Hospital.

- (a) Residents shall not be Members of the Medical Staff, shall not be granted Clinical Privileges and shall not be entitled to any rights afforded to Medical Staff Members, including the hearing and appeal rights under Article VII of these Bylaws.
- (b) Participation by residents in a training program at the Hospital shall be governed exclusively by the terms and conditions of the written affiliation

- (c) Residents may perform only those services set forth in the training protocols developed by the applicable training program to the extent that such services do not exceed or conflict with the Rules and Regulations of the Medical Staff or Hospital policies and procedures. Residents shall be responsible and accountable at all times to a Member of the Medical Staff. Residents shall comply with the Medical Staff Bylaws, Rules and Regulations and applicable Hospital policies and procedures.
- (d) Residents shall attend Medical Staff meetings if required to do so and may be appointed to Medical Staff Committees but shall have no voting rights.

3.10 Telemedicine Affiliate Staff

3.10-1 Qualifications.

The Telemedicine Affiliate Staff shall consist of Physicians who meet the basic and particular qualifications for Medical Staff membership and who provide diagnostic or treatment services to Hospital patients via Telemedicine devices (i.e., interactive (involving real time (synchronous) or near real time (asynchronous) two-way transfer of medical data and information) audio, video, or data communications (but not to include telephone or electronic mail communications)) between Physician and patient.

3.10-2 Prerogatives.

- (a) Telemedicine Affiliate Staff Members may not admit patients to the Hospital or exercise Clinical Privileges whatsoever in the Hospital. Members of this staff category may only provide patient care services from a Distant Site.
- (b) Telemedicine Affiliate Staff Members may attend Medical Staff and Department meetings, including open committee meetings and educational programs. However, they may not vote at Department or general Medical Staff meetings or hold any office in the Medical Staff organization. Telemedicine Affiliate Staff Members may, however, be appointed by the Medical Executive Committee to serve on committees and they may vote in those committees if the right to vote is specified at the time of appointment.
- (c) Telemedicine Affiliate Staff Members shall pay dues.

3.11 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 by the Medical Staff Rules and Regulations.

3.12 General Exceptions to Prerogatives.

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

- (a) Shall only have the right to vote on matters within the scope of their licensure. In the event of a dispute over voting rights, that issue shall be determined by the chair of the meeting, subject to final decision by the Medical Executive Committee; and
- (b) Shall exercise Clinical Privileges only within the scope of their licensure and as set forth in Section 5.4.

3.13 Modification of Membership.

On its own, upon recommendation of the Credentials Committee, or pursuant to a request by a Member under Section 4.7, or upon direction of the Governing Body as set forth in Section 6.1-7, the Medical Executive Committee may recommend a change in the Medical Staff category of a Member consistent with the requirements of the Bylaws.

ARTICLE IV

APPOINTMENT AND REAPPOINTMENT

4.1 General.

Except as otherwise specified herein, no person (including persons engaged by the Hospital in administratively responsible positions and persons using Telemedicine to prescribe, render a diagnosis or otherwise provide clinical treatment to a patient) shall exercise Clinical Privileges in the Hospital unless and until that person applies for and receives appointment to the Medical Staff, is granted temporary Privileges as set forth in these Bylaws, or, with respect to Allied Health Professionals, has been granted a service authorization or Privileges under applicable Medical Staff Bylaws, Rules and Regulations and policies. By applying to the Medical Staff for appointment or reappointment (or, in the case of Members of the Honorary Staff, by accepting an appointment to that category), the applicant acknowledges responsibility to first review these Bylaws and agrees that throughout any period of membership that person will comply with the responsibilities of Medical Staff membership and with the Bylaws and Rules and Regulations and policies of the Medical Staff as they exist and as they may be modified from time to time. Appointment to the Medical Staff shall confer on the appointee only such Clinical Privileges as have been granted in accordance with these Bylaws.

4.2 Burden of Producing Information.

In connection with all applications for appointment, reappointment, advancement, or transfer, the applicant shall have the burden of producing information for an adequate evaluation of the applicant's qualifications and suitability for the Clinical Privileges and staff category requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information. The applicant's failure to sustain this burden shall be grounds for denial of the application. To the extent consistent with law, this burden may include submission to a medical or psychological examination, at the applicant's expense, if deemed appropriate by the Medical Executive Committee which may select the examining physician. The provision of information containing significant misrepresentations or omissions and/or failure to sustain the burden of producing adequate information shall be grounds for denial of the application.

4.3 Appointment Authority.

Appointments, denials, and revocations of appointments to the Medical Staff shall be made as set forth in these Bylaws, but only after there has been a recommendation from the Medical Executive Committee, or as set forth in Section 6.1-7.

4.4 Duration of Appointment and Reappointment.

Initial appointments to the Medical Staff shall be for a period not to exceed two (2) years. Reappointments shall be for a period not to exceed two (2) years.

4.5 Qualifications.

Each new applicant shall meet the following threshold application criteria in order for the application to be accepted:

- (a) Be licensed in the State of California and have a federal DEA certificate, if applicable. Applicants whose license to practice in the State of California is restricted or encumbered by the Medical Board of California, the Osteopathic Medical Board of California or any other licensing agency, shall not be considered for initial appointment to the Medical Staff.
- (b) Except for dentists and clinical psychologists, be Board Certified or have completed an approved residency in their intended field of practice; and have practiced in the applicant's field of practice in a Joint Commission (or equivalent) accredited acute care hospital for two (2) of the previous four (4) years, or have completed an accredited (by ACGME or AOA or otherwise accepted by the MBC or OMBC) clinical residency or fellowship in the intended field of practice within the previous twenty-four (24) months.
- (c) Have continuous liability insurance coverage, with an insurer acceptable to the Governing Body and Medical Executive Committee, at minimum coverage limits as from time to time may be jointly determined by the Medical Executive Committee and the Governing Body. Continuous coverage means current professional liability coverage, as well as evidence of tail or nose coverage for prior periods of Medical Staff membership in the event that the Member has changed insurance carriers.
- (d) Except Consulting Staff applicants and physicians assigned specific times to be at the facility (e.g., emergency department physicians), resides in a geographic location that allows the applicant to provide for continuous care and supervision of patients.
- (e) Must not be currently excluded from participating in Medicare, Medicaid, or any other federal healthcare program when such exclusion has been imposed by government enforcement authorities, or accepted by Practitioner, as a sanction for unlawful conduct.

4.6 Application for Initial Appointment.

New applicants must meet the threshold membership criteria (See section 4.5, above) in order for an application to be accepted. If a new applicant fails to satisfy the threshold criteria, the application will not be processed and will be returned to the applicant.

4.6-1 Application Form.

The form shall require detailed information which shall include, but not be limited to, information concerning:

- (a) The applicant's qualifications, including, but not limited to, professional training and experience, current licensure (verified at the time of initial granting, renewal and revision of Privileges and at the time of license expiration), current DEA registration (if applicable), and continuing medical education information related to the Clinical Privileges to be exercised by the applicant;
- (b) Peer reference letters (minimum of three (3)), preferably from the applicant's specialty area and preferably not including relatives, current partners or associates in practice. All peer reference letters must be from individuals who are directly familiar with the applicant's professional competence in the care of patients in the hospital and ethical character, either through direct clinical observation or through close working relationships;
- (c) Current government issued photograph (e.g., passport, driver's license, military identification) sufficient to verify that the applicant requesting approval is the same individual identified in the application and credentialing documents;
- (d) Application fee;
- (e) Verified plans to provide continuous coverage for the Practitioner's patients, subject to the approval of the Medical Executive Committee;
- (f) Written clarification of any lapse in time, (subsequent to graduation from medical school) exceeding sixty (60) days;
- (g) Requests for membership categories, Departments and Clinical Privileges;
- (h) Past or pending professional disciplinary action, voluntary or involuntary denial, revocation, suspension, restriction, reduction or relinquishment of medical staff membership or Privileges, or any licensure or registration, termination of participating provider status in any managed care organization for medical disciplinary cause or reason, and related matters;
- (i) Information detailing any prior or pending government agency or third party payor, investigation, proceeding, or litigation challenging or sanctioning the Practitioner's patient admission, treatment, discharge, charging, collection, or utilization practices, including, but not limited to, Medicare or Medi-Cal fraud and abuse proceedings or convictions;
- (j) Current physical and mental health status;
- (j) Final judgments or settlements or other awards rendered in or outside the United States made against the applicant in professional liability cases, and any open or closed malpractice lawsuits filed in or outside the United States;

- (k) Professional liability coverage;.
- (l) Completion of such other certifications or statements as required by law, the Joint Commission, Medicare, Medi-Cal or other government payor or bond financing programs; and

Each application for initial appointment to the Medical Staff shall be in writing, submitted on the prescribed form with all provisions completed (or accompanied by an explanation of why answers are unavailable), dated and signed by the applicant. A complete application is one which provides responsive information to each inquiry on the application form and provides supplementary information reasonably necessary to enable the Medical Staff to make a sound recommendation regarding the application. Unresolved disciplinary action or malpractice litigation or the inability to verify information may render an application incomplete. When an applicant requests an application form, that person shall be given a copy of these Bylaws, the Medical Staff Rules and Regulations, and, as deemed appropriate by the Medical Executive Committee, copies of summaries of any other applicable Medical Staff policies relating to clinical practice in the Hospital.

4.6-2 Effect of Application.

In addition to the matters set forth in Section 4.1, by applying for appointment to the Medical Staff each applicant:

- (a) Signifies willingness to appear for interviews in regard to the application;
- (b) Authorizes consultation with others who have been associated with the applicant and who may have information bearing on the applicant's competence, qualifications, and performance, and authorizes such individuals and organizations to candidly provide all such information;
- (c) Consents to inspection of records and documents that may be material to an evaluation of the applicant's 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;
- (d) Certifies that he/she will report to the Medical Executive Committee any changes in the information submitted on the application form which may subsequently occur;
- (e) Releases from any liability, to the fullest extent permitted by law, all persons for their acts performed in connection with investigating and evaluating the applicant;
- (f) Releases from any liability, to the fullest extent permitted by law, all individuals and organizations who provide information regarding the applicant, including otherwise confidential information;
- (g) Consents to the disclosure to other hospitals, medical associations, licensing boards, health care service plans, managed care organizations, and to other similar organizations as authorized by law, any information regarding the applicant's professional or ethical standing that the Hospital

or Medical Staff may have, and releases the Medical Staff and Hospital from liability for so doing to the fullest extent permitted by law;

- (h) Agrees that the Hospital and Medical Staff may share information with a representative or agent of any other affiliated hospital or affiliated medical group, skilled nursing facility or outpatient clinic, including information obtained from other sources, and releases each person and each entity who received the information from any and all liability, including any claims of violations of any federal or state laws, including laws regarding restraints of trade, and agrees that the person or entity to whom the information is disclosed may act upon such information;
- (i) Consents to undergo and to release the results of a medical, psychiatric, or psychological examination by a practitioner acceptable to the Medical Executive Committee, at the applicant's expense, if deemed necessary by the Medical Executive Committee;
- (j) If a requirement then exists for Medical Staff dues, acknowledges responsibility for timely payment (see Section 2.2-2(e));
- (k) Pledges to provide for continuous quality care for patients;
- (l) Pledges to maintain an ethical practice, including refraining from illegal inducements for patient referrals, providing continuous care of his or her patients, seeking consultation whenever necessary, and refraining from delegating patient care responsibility to non-qualified or inadequately supervised practitioners;
- (m) Pledges to be bound by the Medical Staff Bylaws, Rules and Regulations and policies; And

4.6-3 Applicant's Responsibility to Produce Complete Information.

The applicant shall have the burden of producing adequate and complete information in a timely fashion for a proper evaluation of his/her competence, character, ethics, and other basic qualifications for membership. Only complete applications will receive consideration. An application which is not deemed complete in accordance with Section 4.6-1 shall not be considered. An application which remains incomplete after one hundred twenty (120) days, unless an exception is made for good cause by the Credentials Committee, will be deemed to have been withdrawn. The failure to consider applications deemed incomplete shall not entitle the applicant to due process rights pursuant to Article VII. Applicants whose license to practice in the State of California is restricted or encumbered by the Medical Board of California, the Osteopathic Medical Board of California or any other licensing agency, shall not be considered for initial appointment to the Medical Staff.

4.6-4 Submission of Application and Verification of Information.

The applicant shall deliver a completed, signed, and dated application and supporting documents to the Medical Staff Office along with an advance payment of the application fee. The Medical Staff Office shall expeditiously seek to collect or verify the references, licensure status, and other evidence submitted in support of the application. The Medical Staff Office shall query the Medical Board of California and the National Practitioner Data Bank regarding the applicant and submit any resulting information for inclusion

with the applicant's or Member's credentials file. The Medical Staff Office may verify licensure and DEA certification status on-line with the Primary Source. The applicant shall be notified of any problems in obtaining the information required, and it shall be the applicant's obligation to obtain any reasonably requested information. When collection and verification of information is accomplished, the application shall be considered complete and shall be processed as described below.

4.6-5 Department Action.

The completed application and all supporting materials shall be transmitted to the Chairperson of the appropriate Department of the Hospital. The Chairperson or designee shall review the application and supporting documentation, and may conduct a personal interview with the applicant at the Chairperson's or designee's discretion. The Department Chairperson or designee shall evaluate all matters deemed relevant to a recommendation, including information concerning the applicant's provision of services within the scope of Privileges requested, and the applicant's participation in relevant continuing education, and shall transmit to the Credentials Committee a written report and recommendation as to appointment and, if appointment is recommended, as to membership category, Department affiliation, Clinical Privileges to be granted, and any special conditions to be attached. The chair may also request of the Credentials Committee that further action on the application be deferred for good cause.

4.6-6 Credentials Committee Action.

The Credentials Committee shall review the application, evaluate and verify the supporting documentation, the Department chairpersons' report(s) and recommendations, and other relevant information. The Credentials Committee, or a subcommittee thereof, may elect to interview the applicant and seek additional information. As soon as practicable, the Credentials Committee shall transmit to the Medical Executive Committee(s), a written report and its recommendations as to appointment and, if appointment is recommended, as to membership category, Department affiliation, Clinical Privileges to be granted, and any special conditions to be attached to the appointment. The Credentials Committee may also recommend that the Medical Executive Committee(s) defer action on the application.

4.6-7 Medical Executive Committee Action.

At its next regular meeting (or as soon thereafter as is practicable) after receipt of the Credentials Committee report (including a complete application file) and recommendation and the Department report and recommendation, the Medical Executive Committee shall consider the reports and recommendations any other relevant information. The Medical Executive Committee may request additional information, return the matter to the Credentials Committee or Department for further investigation, and/or elect to interview the applicant. The Medical Executive Committee shall forward to the Governing Body, a written report and recommendation as to Medical Staff appointment and, if appointment is recommended, as to membership category, Department affiliation(s), Clinical Privileges to be granted, and any special conditions to be attached to the appointment. The Medical Executive Committee may also defer action on the application. The reasons for each recommendation shall be stated. All requests for privileges by an applicant shall go to the Medical Executive Committee.

4.6-8 Effect of Medical Executive Committee Action.

- (a) Favorable Recommendation: When the recommendation of the Medical Executive Committee is favorable to the applicant, it shall be promptly forwarded, together with supporting documentation, to the Governing Body.
- (b) Unfavorable Recommendation: When a final recommendation of the Medical Executive Committee is unfavorable to the applicant, the Governing Body and the applicant shall be promptly informed by written notice. The applicant shall then be entitled to the procedural rights as provided in Article VII.

4.6-9 Action On The Application.

The Governing Body may accept the recommendation of the Medical Executive Committee or may refer the matter back to the Medical Executive Committee for further consideration, stating the purpose for such referral and setting a reasonable time limit for making a subsequent recommendation. The following procedures shall apply with respect to action on the application:

- (a) If the Medical Executive Committee issues a favorable recommendation, the Governing Body shall affirm the recommendation of the Medical Executive Committee if the Medical Executive Committee's decision is supported by substantial evidence.
 - (1) If the Governing Body concurs in that recommendation, the decision of the Board of Directors shall be deemed final action.
 - (2) If the tentative final action of the Governing Body is unfavorable, the Chief Executive Officer shall give the applicant written notice of the tentative adverse recommendation and the applicant shall be entitled to the procedural rights set forth in Article VII. If procedural rights are waived by the applicant, the decision of the Governing Body shall be deemed final action.
- (b) In the event the recommendation of the Medical Executive Committee, or any significant part of it, is unfavorable to the applicant, the procedural rights set forth in Article VII shall apply.
 - (1) If procedural rights are waived by the applicant, the recommendations of the Medical Executive Committee shall be forwarded to the Governing Body for final action, which shall affirm the recommendation of the Medical Executive Committee if the Medical Executive Committee's decision is supported by substantial evidence.
 - (2) If the applicant requests a hearing following the adverse Medical Executive Committee recommendation pursuant to Section 4.6-9(b) or an adverse Governing Body tentative final action pursuant to Section 4.6-10(a)(2), the Governing Body shall take final action only after the applicant has exhausted all procedural rights as established by Article VII. After exhaustion of the procedures set forth in Article VII, the Governing Body shall make a final decision and shall affirm the decision of the Judicial Review Committee if the Judicial Review Committee's decision is

supported by substantial evidence, following a fair procedure. The Governing Body's decision shall be in writing and shall specify the reasons for the action taken.

4.6-10 Expedited Process and Action by Committee of Governing Body.

To expedite appointment, reappointment, or renewal or modification of Clinical Privileges, the Governing Body, pursuant to its Bylaws, may elect to delegate the authority to render initial appointment, reappointment and renewal or modification of Clinical Privileges decisions to a committee ("Board Committee") of the Governing Body consisting of at least two (2) members of the Governing Body. Following a favorable recommendation from the Medical Executive Committee on application, the Board Committee shall review and evaluate the qualifications and competence of the Practitioner applying for appointment, reappointment, or renewal or modification of Clinical Privileges, and renders its decision in accordance with Section 4.6-10, above. A positive decision by the Board Committee results in the status or Privileges as requested. The Governing Body, at its next regularly scheduled meeting, shall consider and, if appropriate, ratify all positive Board Committee decisions. If the Board Committee's decision is adverse to the applicant, the matter is referred back to the Medical Executive Committee for further evaluation. An applicant is usually ineligible for the expedited process if, at the time of appointment or if since the time of reappointment, any of the following has occurred:

- (a) The applicant submits an incomplete application;
- (b) The Medical Executive Committee makes a final recommendation that is adverse or with limitation;
- (c) There is a current challenge or a previously successful challenge to licensure or registration;
- (d) The applicant has received an involuntary termination of medical staff membership at another organization;
- (e) The applicant has received involuntary or voluntary limitation, reduction, denial or loss of clinical privileges at another organization, medical group, PPO, HMO or other medical organization for medical disciplinary cause or reason; or
- (f) There has been a final judgment adverse to the applicant in a professional liability action.

4.6-11 Notice of Final Decision.

- (a) Notice of the final decision shall be given to the Chief of Staff and Medical Executive Committee, the applicant, and the Chief Executive Officer.
- (b) A decision and notice to appoint or reappoint shall include, if applicable: (1) the staff category to which the applicant is appointed; (2) the Department to which that person is assigned; (3) the Clinical Privileges granted; and (4) any special conditions attached to the appointment.

4.6-12 Reapplication After Adverse Appointment Decision.

An applicant who has received a final adverse decision regarding appointment shall not be eligible to reapply to the Medical Staff for a period of two (2) years. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as may be required to demonstrate that the basis for the earlier adverse action no longer exists.

4.6-13 Timely Processing of Applications.

Applications for staff appointments shall be considered in a timely manner by all persons and committees required by these Bylaws to act thereon. While special or unusual circumstances may constitute good cause and warrant exceptions, the following maximum time periods provide a guideline for routine processing of applications:

- (a) Evaluation, review, and verification of application and all supporting documents by the Medical Staff Office: thirty (30) days from receipt of all necessary documentation;
- (b) Review and recommendation by Department chairperson: thirty (30) days after receipt of all necessary documentation from the Medical Staff Office;
- (c) Review and recommendation by Credentials Committee: thirty (30) days after receipt of Department report and recommendation, or at its next meeting;
- (d) Review and recommendation by the Medical Executive Committee: thirty (30) days after receipt of all necessary documentation from the Credentials Committee, or at its next meeting; and
- (e) Final action: thirty (30) days after receipt of recommendation from Medical Executive Committee or seven (7) days after conclusion of hearings.

Best efforts will be made to expedite a completed and verified application and applicant presented to the Credentials Committee within thirty (30) days when there is an urgent need to do so, as determined by the Medical Executive Committee.

4.7 Reappointment and Requests For Modifications of Staff Status or Privileges.

4.7-1 Application for Reappointment.

- (a) At least three (3) months prior to the expiration date of the current staff appointment (except for temporary appointments), a reapplication form developed by the Credentials Committee and approved by the Medical Executive Committee shall be mailed or delivered to the member. If an application for reappointment is not received at least sixty (60) days prior to the expiration date, written notice shall be promptly sent to the applicant advising that the application has not been received and that the member will have only an additional thirty (30) days to submit it. At least sixty (60) days prior to the expiration date, each Medical Staff Member shall submit to the Medical Staff Office the completed application form with supporting or requested documentation for renewal of appointment to the staff for the coming year and for renewal or modification of Clinical

Privileges. The reapplication form shall include all information necessary to update and evaluate the qualifications of the applicant including, but not limited to, the matters set forth in Section 4.6-1, as well as other relevant matters. Should the Member's tardiness result in the Medical Staff's inability to process the application through all the evaluation and approval levels up to and including final action by the Governing Body, automatic suspension will occur as set forth in Section 4.7-4. Upon receipt of the application, the information shall be processed as set forth commencing at Section 4.6-4. The information requested may include, but not be limited to, the following:

- (1) Professional and clinical performance, including his/her patterns of practice, based at least in part on the findings of performance improvement measures, such as peer review, utilization management, infection control activities, tissue review, medical record review, and pharmacy and therapeutics activities;
- (2) Current Privileges and the basis for any requested modifications;
- (3) Health status (subject to any necessary reasonable accommodation);
- (4) Evidence of participation in continuing education programs relevant to the applicant's field of practice;
- (5) Service on Medical Staff and Hospital Committees;
- (6) Timely completion of medical records;
- (7) Compliance with applicable Hospital policies and with Medical Staff Bylaws, Rules and Regulations and policies;
- (8) The recommendations of any Department or Section to which the Member has been assigned or in which the Member exercises Privileges;
- (9) peer reference letters [minimum of two (2)], preferably not including relatives, current partners or associates in practice. All peer reference letters must be from individuals who are directly familiar with the applicant's professional competence in the care of patients in the hospital and ethical character, either through direct clinical observation or through close working relationships;
- (10) Current California Medical license;
- (11) Current continuous professional liability insurance, as defined in previous sections;
- (12) Current DEA registration, if applicable;
- (13) Radiography X-ray Supervisor's and Operator's Permit, if applicable;

- (14) Reports from Medical Board of California and National Practitioner Data Bank inquiries;
- (15) Judgments, settlements, other awards rendered in or outside the United States since previous appointment; malpractice lawsuits filed in or outside the United States since previous appointment; and other matters as set forth in section 4.6-1(j) and (k), updated from previous appointment;
- (16) Letter from Primary Hospital (in case of Courtesy Staff members) or letter from other area facility (in case of Active Staff members);
- (17) Completion of such other certifications or statements as required by law, the Joint Commission, Medicare, Medi-Cal or other government payor or bond financing programs; and

Upon receipt of the application for reappointment and supporting data, the application shall be processed as set forth commencing at Section 4.6-4, et seq.

- (b) A Medical Staff Member who seeks a change in Medical Staff status or modification of Clinical Privileges may submit such a request at any time upon a form developed by the Credentials Committee and approved by the Medical Executive Committee, except that such application may not be filed within one (1) year of the time a similar request has been denied. All requests for expansion or addition of Privileges will be processed in the same manner as requests for initial Privileges.

4.7-2 Effect of Application.

The effect of an application for reappointment or modification of staff status or Privileges is the same as that set forth in Section 4.6-2.

4.7-3 Standards and Procedures for Review.

When a Medical Staff Member submits the first application for reappointment, and every two (2) years thereafter, or when the Member submits an application for modification of staff status or Clinical Privileges, the Member shall be subject to an in-depth review generally following the procedures set forth in Sections 4.6-3 through 4.6-12.

4.7-4 Failure to File Reappointment Application.

Failure without good cause to file, on or before the date specified by the Medical Staff Office, a completed application for reappointment shall result in the automatic suspension of the member's admitting privileges. Such failure shall also result in expiration of other practice Privileges and prerogatives at the end of the current staff appointment period. Failure to submit a completed application for reappointment with all supporting or requested documentation by the expiration of the current appointment period shall result in the automatic termination of the member's medical staff membership and Clinical Privileges. In the event membership terminates for the reasons set forth herein, this will not be considered an adverse decision regarding reappointment, the procedures set forth in Article VII shall not apply. A Member who requests reappointment to the Medical Staff within sixty (60) days following an automatic termination under this Section shall not be required to complete a new application form.

4.8 Reapplication After Adverse Reappointment Decision.

An applicant who has received a final adverse decision regarding reappointment shall not be eligible to reapply to the Medical Staff for a period of two (2) years following the final decision. As used in this subsection 4.8, final decision means the final decision of the Governing Body or the decision of a reviewing trial or appellate court, whichever occurs last. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as may be required to demonstrate that the basis for the earlier adverse action no longer exists.

4.9 Leave Status.

Any Member of the Medical Staff who is unable to participate in Hospital practice and/or Medical Staff business due to extended illness, disability, or absence must report this to his/her Department chairperson. At the discretion of the Medical Executive Committee, a Medical Staff Member may obtain a voluntary leave of absence from the staff upon submitting a written request to the Medical Executive Committee stating the approximate period of leave desired, which may not exceed one (1) year. During the period of the leave, the Member shall not be required to pay dues, attend meetings or to participate in other Medical Staff business. Members on leave of absence shall not be eligible to admit, care for, or consult on patients, or vote or hold office, serve on Medical Staff committees or advance in staff category. Members on leave of absence shall not be required to maintain continuous professional liability insurance, but must have appropriate "tail" coverage providing coverage for acts which occurred prior to the leave of absence and must provide evidence of such tail coverage as part of any request for a leave of absence. Any Practitioner who commences a leave of absence without providing such evidence will be deemed to have voluntarily resigned from the Medical Staff.

4.10 Termination of Leave.

At least thirty (30) days prior to the termination of the leave of absence, or at any earlier time, the Medical Staff Member may request reinstatement of Privileges by submitting a written notice to that effect to the Medical Executive Committee. The Medical Staff Member shall submit a summary of relevant activities during the leave, if the Medical Executive Committee so requests. The Medical Executive Committee shall make a recommendation concerning the reinstatement of the Member's Privileges and prerogatives, and the procedure provided in Sections 4.1 through 4.6-14 shall be followed. If a Member's appointment expired during the time that he/she was on leave of absence, the Member must submit a completed application for reappointment prior to reinstatement. Assuming favorable action on the reappointment application, the Member shall be assigned to the reappointment cycle which existed prior to the leave of absence.

4.11 Failure to Request Reinstatement.

Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of membership, Privileges, and prerogatives. A Member whose membership is automatically terminated shall be entitled to the procedural rights provided in Article VII for the sole purpose of determining whether the failure to request reinstatement was unintentional or excusable, or otherwise. A request for Medical Staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

4.12 Request for Reinstatement After Voluntary Resignation.

A Practitioner who requests reinstatement after voluntary resignation shall not be required to complete a new application form if the request is received within sixty (60) days of the effective date of the resignation. However, the Practitioner will be expected to respond to requests for additional information, if any, from the Medical Staff relative to the request for reinstatement.

ARTICLE V

CLINICAL PRIVILEGES

5.1 Exercise of Privileges.

Except as otherwise provided in these Bylaws, a Member providing clinical services at this Hospital shall be entitled to exercise only those Clinical Privileges specifically granted. Said Privileges and services must be granted on a hospital specific basis, within the scope of any license, certificate or other legal credential authorizing practice in this state and consistent with any restrictions thereon, and shall be subject to the rules and regulations of the clinical Department and the authority of the department chair and the Medical Staff. Medical Staff Privileges may be granted, continued, modified or terminated by the Governing Body of this Hospital based upon recommendation of the Medical Staff, only for reasons directly related to quality of patient care and other provisions of the Medical Staff Bylaws, and only following the procedures outlined in these Bylaws.

5.2 Criteria for General Competencies.

The Medical Staff, in addition to criteria for Privileges, also develop areas of “general competencies” by which all Hospital Practitioners shall be measured for current proficiency. Each Department shall define how to measure these general competencies as applicable to that Department and use them to regularly monitor and assess each Practitioner’s current proficiencies. Examples of general competencies that the Medical Staff may establish include, but are not limited to, patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems based practice.

5.3 Development of Criteria for Clinical Privileges.

Subject to approval of the Medical Executive Committee and Governing Body, each Department will be responsible for developing criteria for granting Clinical Privileges, including, but not limited to, identifying and developing criteria for any Privileges that may be appropriately performed via Telemedicine. The criteria shall be designed to facilitate uniform quality patient care, treatment and services. Insofar as feasible, affected categories of Allied Health Professionals shall participate in developing criteria for Privileges to be exercised by Allied Health Professionals. Each Department’s approved criteria for granting Privileges shall be included in the Department’s rules.

5.4 Delineation of Privileges in General.

5.4-1 Requests.

Each application for appointment and reappointment to the Medical Staff must contain a request for the specific Clinical Privileges desired by the applicant. A request by a Member for a modification of Clinical Privileges may be made at any time, but such requests must be supported by documentation of training and/or experience supportive of the request. The Medical Staff Office shall query the National Practitioner Data Bank in connection whenever the Practitioner seeks to expand Privileges or to add new Privileges.

Each department will be responsible for developing criteria for granting Privileges.

5.4-2 Bases for Privileges Determination.

The Medical Staff shall make an objective and evidence based decision with regard to each request for Privileges. Requests for Clinical Privileges shall be evaluated on the basis of the Member's education, training, experience, current demonstrated professional competence and judgment, evidence of current proficiency in Hospital's general competencies, applicant specific information regarding applicant's clinical performance at this Hospital and in other settings, comparison's made to aggregate information (when available) about performance, judgment and clinical and technical skills; morbidity and mortality data (when available); current health status, the documented results of patient care and other quality review and monitoring which the Medical Staff deems appropriate, performance of a sufficient number of procedures to develop and maintain the Practitioner's skills and knowledge and compliance with any specific criteria applicable to the Privileges. Privilege determinations may also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a Member exercises Clinical Privileges. The decision to grant or deny a Privilege and/or to renew an existing Privilege shall be based on peer recommendations which address the applicants: (i) medical/clinical knowledge; (ii) technical and clinical skills; (iii) clinical judgment; (iv) interpersonal skills; (v) communication skills; (vi) professionalism; and (vii) health status. When available, relevant Practitioner specific data as compared to aggregate data and mortality and morbidity data shall be considered. When considering a request from a Practitioner who practices Telemedicine, credentialing information from another Joint Commission accredited facility may be used so long as the decision to delineate Privileges is made at the Hospital receiving the Telemedicine services. Consideration of appropriate utilization of Telemedicine equipment by the Telemedicine Practitioner shall also be considered in decisions regarding Clinical Privileges.

Information regarding each Practitioner's scope of Privileges shall be updated as changes in Clinical Privileges for each Practitioner are made.

5.4-3 Telemedicine Privileges.

(a) The initial appointment of individuals to the Telemedicine Affiliate Staff may be based upon (i) the individual's full compliance with the Hospital's credentialing and privileging standards; or (ii) by using the Hospital's standards but relying on information provided by the hospital(s) or other Joint Commission accredited organizations at which the individual practices.

(b) Reappointment of a Telemedicine Affiliate Staff Member's Privileges may be based upon performance at the Hospital, and, if the information from the Hospital is not sufficient, from the other Joint Commission accredited organizations where the individual practices.

5.5 Proctoring.

5.5-1 General Provisions.

Except as otherwise determined by the Medical Executive Committee, all initial appointees to the Medical Staff and all Members granted new Clinical Privileges shall be subject to a period of proctoring. In addition, Members may be required to be proctored as a condition of renewal of Privileges (for example, when a Member requests renewal of a Privilege that has been performed so infrequently that it is difficult to assess the Member's current competence in that area). Proctoring may also be implemented whenever the Medical Executive Committee determines that additional information is needed to assess a Practitioner's performance. Each appointee or recipient of new Clinical Privileges shall be assigned to a Department where performance on an appropriate number of cases as established by the Medical Executive Committee, or the Department as designee of the Medical Executive Committee, shall be observed by the chair of the Department, or the chair's designee, during the period of proctoring specified in the Department's rules and regulations, to determine suitability to continue to exercise the Clinical Privileges granted in that Department. The exercise of Clinical Privileges in any other Department shall also be subject to direct observation by that Department's chair or the chair's designee. The Member shall remain subject to such proctoring until the Medical Executive Committee has been furnished with:

- (a) A report signed by the chair of the Department(s) to which the Member is assigned describing the types and numbers of cases observed and the evaluation of the applicant's performance, a statement that the applicant appears to meet all of the qualifications for unsupervised practice in that Department, has discharged all of the responsibilities of staff membership, and has not exceeded or abused the prerogatives of the category to which the appointment was made; and
- (b) A report signed by the chair of the other Department(s) in which the appointee may exercise Clinical Privileges, describing the types and number of cases observed and the evaluation of the applicant's performance and a statement that the Member has satisfactorily demonstrated the ability to exercise the Clinical Privileges initially granted in those Departments.

5.5-2 Failure to Successfully Complete Proctoring.

If an initial appointee fails within the time of provisional membership to satisfactorily complete his or her proctoring requirements, or if a Member exercising new Clinical Privileges fails to satisfactorily complete his or her proctoring requirements, within the time allowed by the Department, those specific Clinical Privileges shall automatically terminate, and, if the termination is based upon medical disciplinary cause or reason, the Member shall be entitled to a hearing, upon request, pursuant to Article VII.

5.5-3 Completion of Proctoring.

Proctoring shall be deemed successfully completed when the Practitioner completed the required number of proctored cases within the time frame established in the Bylaws and Rules and Regulations, and the Practitioner's professional performance in the cases meets the standard of care of the Hospital.

5.5-4 Effect of Failure to Complete Proctoring.

- (a) Failure to Complete Necessary Volume: Any Member who fails to complete the required number of proctored cases within the time frame established in the Bylaws and Rules shall be deemed to have voluntarily withdrawn his or her request for membership (or the relevant Privileges), and he or she shall not be afforded the procedural rights provided in Article VII. However, the Department has the discretion to extend the time for completion of proctoring in appropriate cases subject to ratification by the Medical Executive Committee. The inability to obtain such an extension shall not give rise to procedural rights described in Article VII. Any Practitioner terminated pursuant to this section may not reapply to the Medical Staff for one (1) year, unless the Medical Executive Committee makes an exception for good cause.
- (b) Failure to Satisfactorily Complete Proctoring: If a Practitioner completes the necessary volume of proctored cases but fails to perform satisfactorily during proctoring, he or she may be terminated (or the relevant Privileges may be revoked), and he or she shall be afforded the procedural rights as provided in Article VII.

5.5-5 Medical Staff Advancement.

The failure to complete proctoring for any Special Privilege (i.e., as distinguished from Core Privilege) shall not, of itself, preclude advancement from Provisional Staff. If advancement is approved prior to completion of proctoring, the proctoring will continue for the Special Privileges. The Special Privileges may be voluntarily relinquished or terminated if proctoring is not completed thereafter within a reasonable time as established by the Department with the approval of the Medical Executive Committee.

5.6 Conditions For Privileges of Non-physician Practitioners.

5.6-1 Admissions.

- (a) When Dentists, Oral Surgeons, and Podiatrists who are Members of the Medical Staff admit patients, a physician Member of the Medical Staff must conduct or directly supervise the admitting history and physical examination (except the portion related to dentistry or podiatry or unless the podiatrist has been granted Privileges to perform a complete history and physical), and assume responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside of the non-physician practitioner's lawful scope of practice. It is the responsibility of the non-physician practitioner to secure the services of a physician to perform these functions prior to admitting the patient to the Hospital.
- (b) Oral and maxillofacial surgeons who have successfully completed a postgraduate program in oral and maxillofacial surgery accredited by a nationally recognized accrediting body approved by the U.S. Office of Education and have been determined by the Medical Staff to be competent to do so, may perform a history and physical examination and determine the ability of their patient to undergo surgical procedures the oral and maxillofacial surgeon proposed to perform. Completion of a history and physical by a qualified oral and maxillofacial surgeon under this

subsection (b) shall satisfy the appraisal portion of the requirement of Section 5.6-3, below. For patients with existing medical conditions or abnormal findings beyond the surgical indications, a physician Member of the Medical Staff must conduct or directly supervise the admitting history and physical examination, except the portion related to oral and maxillofacial surgery, and assume responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside of the limited license practitioner's lawful scope of practice.

5.6-2 Surgery.

Surgical procedures performed by Dentists, Oral Surgeons, and Podiatrists shall be under the overall supervision of the chair of the Department of surgery or the chair's designee.

5.6-3 Medical Appraisal.

All patients admitted for care in a hospital by a Dentist, Oral Surgeon, or Podiatrist shall receive the same basic medical appraisal as patients admitted to other services, and the dentists, oral surgeons and podiatrists shall seek consultation with a physician Member to determine the patient's medical status and need for medical evaluation whenever the patient's clinical status indicates the development of a new medical problem. Consultation shall be obtained for circumstances defined by the Medical Staff. Where a dispute exists regarding proposed treatment between a physician Member and a limited license practitioner based upon medical or surgical factors outside of the scope of licensure of the limited license practitioner, the treatment will be suspended insofar as possible while the dispute is resolved by the appropriate Department(s).

5.7 Temporary Clinical Privileges.

Temporary Privileges may be granted in two circumstances. First, to meet an important patient care need and only after the Medical Staff verifies current licensure and current competence. Secondly, temporary Privileges may be granted when a new application with a complete application that raises no concerns is awaiting review and approval by the Medical Executive Committee and Governing Body. There is no right to temporary Privileges. Accordingly, temporary Privileges should not be granted unless all of the information requested and obtained supports, with reasonable certainty, a favorable determination regarding the Practitioner's qualifications, ability, current competency and judgment to exercise the Privileges requested. If the available information is inconsistent of casts any reasonable doubts on the applicant's qualifications, action on the request for temporary Privileges may be deferred until the doubts have been satisfactorily resolved. Temporary Privileges may be granted by the Chief Executive Officer (or his or her designee when the Chief Executive Officer is unavailable) on the recommendation of the Chief of Staff or the Department chair where the Privileges will be exercised, or either's designee. A determination to grant temporary Privileges shall not be binding or conclusive with respect to an applicant's pending request for appointment to the Medical Staff. Temporary Privileges may not be granted for periods beyond one hundred twenty (120) days.

5.7-1 Request from Applicants.

Temporary Privileges may be granted when a new applicant with a complete application that raises no concerns is awaiting review and approval by the Medical Executive Committee and the Governing Body. Upon receipt of a completed application for Medical Staff membership from an appropriately licensed Practitioner, including verification of all data (including current licensure, relevant training or experience, current competence, ability to perform the procedures requested, a query and evaluation of the NPDB information, no previously successful challenges to licensure or registration, no subsection to involuntary termination of Medical Staff membership at another organization, and no subsection to involuntary limitation, reduction, denial or loss of Clinical Privileges), completion of the interview (if required) with the Credentials Committee, and a favorable recommendation by the Credentials Committee, the Chief Executive Officer, (or his or her designee when the Chief Executive Officer is unavailable) with the approval of the Chief of Staff or the Chairperson of the appropriate Department, or their respective designees, may grant temporary Privileges for a period of one hundred twenty (120) days, to a Practitioner who is not a Member of the Medical Staff.

5.7-2 Temporary Privileges - Special Consultant.

Should the unique situation arise where a Practitioner with specific expertise is required for the care of a specific patient and the Practitioner is not a Member of the Medical Staff, then temporary Privileges may be granted by the Chief Executive Officer (or his/her designee when the Chief Executive Officer is unavailable), with the approval of the Chief of Staff or the Department chairperson. Such temporary Privileges shall be restricted to the treatment of not more than an aggregate of three (3) patients in any one (1) calendar year by any Practitioner, after which such Practitioner shall be required to apply for membership on the Medical Staff before being allowed to attend additional patients. Except for general dentistry, the Practitioner requesting temporary Privileges under this section must have Active Staff Privileges at another Joint Commission (or equivalent) - accredited acute care facility.

5.7-3 Temporary Privileges - Assisting at Surgery.

Temporary Privileges for assisting at surgery only may be granted by the Chief Executive Officer (or his/her designee when the Chief Executive Officer is unavailable), with the approval of the Chief of Staff or the Department chairperson. Such temporary Privileges shall be restricted to the treatment of not more than three (3) patients in any one (1) calendar year by any Practitioner, after which such Practitioner shall be required to apply for membership on the Medical Staff before being allowed to attend additional patients. Except for general dentistry, the Practitioner requesting temporary Privileges must have Active Staff Privileges at another Joint Commission (or equivalent) accredited acute care facility.

In cases 5.7-2 and 5.7-3 above, the Medical Staff Office shall verify and document current California licensure, current membership and Privileges in Good Standing at another Joint Commission (or equivalent) accredited hospital, DEA registration (if applicable) and current and continuous professional liability insurance and shall obtain a report from the Medical Board of California and query the National Practitioners' Data Bank. (Appropriate licensure and DEA status may be verified on-line.) The Practitioner must also submit his/her signed acknowledgment that he/she has received the Medical Staff Bylaws and Rules and Regulations and that he/she agrees to be bound by the terms thereof in all matters relating to his/her exercise of temporary Privileges. To facilitate the

necessary documentation, including verification of license and current and continuous professional liability insurance coverage, the request should be made at least forty-eight (48) hours in advance of the procedure or consultation.

5.7-4 Temporary Privileges - Locum Tenens.

Temporary Clinical Privileges may be granted to a person serving as a locum tenens for a current Member of the Medical Staff, provided that the procedure described in Section 5.7-1 has been completed. Under exceptional circumstances, as determined by the Chief of Staff and the Chair (or his or her designee) of the Credentials Committee, the application process for locum tenens Privileges, including approval by the Credentials Committee, shall be completed within twenty-one (21) days. When this expedited process is utilized, the applicant for locum tenens Privileges shall be expected to work closely with the Medical Staff Office in the verification process and to promptly respond to all requests for information. A person granted locum may attend only patients of the Member for whom that person is providing coverage for a period not to exceed one hundred twenty (120) days, unless the Medical Executive Committee recommends a longer period for good cause.

5.7-5 General Conditions.

In the exercise of any such temporary Privileges, the Practitioner shall be subject to the oversight of the chairperson, or designee, of the Department to which the applicant is assigned, and shall be subject to any special requirements of supervision and reporting as may be imposed by the chairperson or designee. Temporary Privileges shall automatically terminate at the end of the designated period unless earlier terminated or affirmatively renewed as provided in the Bylaws or the Rules and Regulations. Additionally, temporary Privileges may be terminated, with or without cause, at any time by the Chief of Staff, the responsible Department chairperson or the Chief Executive Officer with the approval of the Chief of Staff or the responsible Department chairperson. A Practitioner shall be entitled to the procedure rights afforded by Article VII only if a request for temporary Privileges is refused based upon, or if all or any portion of temporary Privileges are terminated, restricted or suspended, for a medical disciplinary cause or reason. In all other cases (including deferral in acting on a request for temporary Privileges), the Practitioner shall not be entitled to any procedural rights based upon any adverse action involving temporary Privileges. Whenever temporary Privileges are terminated, the appropriate Department chairperson, or in the chairperson's absence, the Chief of Staff shall assign a Member of the Medical Staff to assume responsibility for the care of a Practitioner's patients. The wishes of the patient shall be considered in the choice of a replacement Practitioner. All persons requesting or receiving temporary Privileges shall be bound by the Bylaws and the Rules and Regulations.

5.8 Disaster Privileges.

When the emergency management plan has been activated, the Chief Executive Officer or the Chief of Staff, or their respective designees, may grant disaster privileges to volunteer licensed independent practitioners. The individuals covered by this section shall be collectively referred to as "Volunteers." Any privileges and/or responsibilities granted pursuant to this section shall exist only for the duration of the disaster as determined by the Hospital.

- (a) Disaster privileges may be granted upon presentation of government-issued photo identification (e.g. driver's license or passport) and at least one of the following:

- (1) A current picture Hospital identification card that clearly identifies professional designation;
 - (2) A current license to practice;
 - (3) Primary source verification of licensure;
 - (4) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT) or Medical Reserve Corp (MRC);
 - (5) 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;
 - (6) Confirmation by current Hospital or Medical Staff member(s) with personal knowledge regarding the practitioner's ability to act as a licensed independent practitioner during a disaster;
- (b) Persons granted disaster privileges shall wear identification badges.
- (c) The Medical Staff Office shall begin verification process of the credentials and privileges of individuals who received disaster privileges within 72 hours or as soon as the immediate situation is under control, using a process identical to that described in Section 5.7 (except that the individual is permitted to begin rendering services immediately, as needed).
- If primary source verification cannot be completed within 72 hours of the individual's arrival, the Chief Executive Officer or the Chief of Staff or their respective designees shall determine whether the individual's disaster privileges will be continued, modified or terminated.
- (d) The responsible Department chair shall arrange for appropriate concurrent or retrospective monitoring of the activities of Practitioners granted disaster Privileges.

5.9 Emergency Privileges.

In the case of an emergency, any Member of the Medical Staff, to the degree permitted by the scope of the applicant's license and regardless of Department, Staff status, or Clinical Privileges, shall be permitted to do everything reasonably possible to save the life of a patient or to save a patient from serious harm. The Members shall make every reasonable effort to communicate promptly with the Department chair concerning the need for emergency care and assistance by Members of the Medical Staff with appropriate Clinical Privileges, and once the emergency has passed or assistance has been made available, shall defer to the Department chair with respect to further care of the patient at the Hospital unless granted temporary Privileges.

In the event of an in-hospital patient emergency, any person shall be permitted to do everything reasonably possible to save the life of a patient or to save a patient from serious harm. Such persons shall promptly yield such care to a qualified Member of the Medical Staff when one becomes available.

5.10 Modification of Clinical Privileges or Department Assignment.

On its own, upon recommendation of the Credentials Committee, or pursuant to a request under Section 4.7-1(b), the Medical Executive Committee may recommend a change in the Clinical Privileges or Department assignment(s) of a Member. The Medical Executive Committee may also recommend that the granting of additional Privileges to a current Medical Staff Member be made subject to monitoring in accordance with procedures similar to those outlined in Section 5.5-1. All requests for expansion or addition of Clinical Privileges shall be processed in the same manner as requests for initial Clinical Privileges.

5.11 Lapse of Application.

If a Medical Staff Member requesting a modification of Clinical Privileges or Department assignments fails to timely furnish the information necessary to evaluate the request, the application shall automatically lapse, and the applicant shall not be entitled to a hearing as set forth in Article VII.

ARTICLE VI

CORRECTIVE ACTION

6.1 Corrective Action.

6.1-1 Routine Monitoring and Evaluation.

The Departments and committees are responsible for carrying out delegated review and performance improvement functions. They may counsel, educate, issue letters of warning or censure, or institute retrospective or concurrent monitoring (so long as the Practitioner is only required to provide reasonable notice of admissions and procedures) in the course of carrying out their duties without initiating formal corrective action. Comments, suggestions and warnings may be issued orally or in writing. The Practitioner shall be given an opportunity to meet with the Department or committee. Any informal actions, monitoring, or counseling shall be documented in the Practitioner's file. Medical Executive Committee approval is not required for such actions, although the actions shall be reported to the Medical Executive Committee. The actions shall not constitute a restriction of Privileges or grounds for any formal hearing or appeal rights under Article VII.

6.1-2 Criteria for Initiation.

Any person may provide information to the Medical Staff about the conduct, performance or competence of its Members. A corrective action investigation may be initiated whenever reliable information indicates that a Medical Staff Member may have engaged in, made, or exhibited acts, statements, demeanor, or professional conduct, either within or outside of the Hospital, and the same is or is reasonably likely to be: (a) detrimental to patient safety or to the delivery of quality patient care; (b) disruptive to Hospital operations; (c) unethical conduct; (d) in contravention of these Bylaws, the

Rules and Regulations of the Medical Staff, Departmental policies and procedures and those policies of the Hospital required by state or federal law or by the standards of national accrediting organizations such as the Joint Commission (or equivalent); or (e) the Member has sustained a summary suspension or limitation of Privileges at another hospital, for medical disciplinary cause reason.

6.1-3 Initiation.

- (a) Any person who believes that corrective action may be warranted may provide information to the Chief of Staff, any other Medical Staff Officer, any Department chair, the chair of any Medical Staff committee, the Governing Body, or the Chief Executive Officer.
- (b) If the Chief of Staff, any other Medical Staff Officer, any Department chair, the chair of any Medical Staff committee, the Governing Body or the Chief Executive Officer determines that corrective action may be warranted under Section 6.1-2, that person, entity or committee may request the initiation of a formal corrective action investigation or may recommend particular corrective action. Such requests may be conveyed to the Medical Executive Committee orally or in writing.

6.1-4 Investigation.

If the Medical Executive Committee concludes an investigation is warranted, it shall direct an investigation to be undertaken. The Medical Executive Committee may conduct the investigation itself, or may assign the task to an appropriate Medical Staff Officer, Medical Staff Department, or standing or ad hoc committee of the Medical Staff. The Medical Executive Committee in its discretion may appoint Practitioners who are not Members of the Medical Staff as temporary Members of the Medical Staff for the sole purpose of serving on a standing or ad hoc committee, and not for the purpose of granting these Practitioners temporary Clinical Privileges under Section 5.7, should circumstances warrant. If the investigation is delegated to an officer of a committee other than the Medical Executive Committee, such officer or committee shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the Medical Executive Committee as soon as practicable. The report may include recommendations for appropriate corrective action. The Member shall be notified that an investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The individual or body investigating the matter may, but is not obligated to, conduct interviews with persons involved; however, such investigation shall not constitute a "hearing" as that term is used in Article VII, nor shall the procedural rules with respect to hearings or appeals apply. Despite the status of any investigation, at all times the Medical Executive Committee shall retain authority and discretion to take whatever action may be warranted by the circumstances, including summary restriction or suspension, termination of the investigative process, or other action.

6.1-5 Medical Executive Committee Action.

As soon as practicable after the conclusion of the investigation, the Medical Executive Committee shall take action which may include, without limitation:

- (a) Determining no corrective action be taken and, if the Medical Executive Committee determines there was no credible evidence for the complaint in

the first instance, removing any adverse information from the Member's file;

- (b) Deferring action for a reasonable time where circumstances warrant;
- (c) Issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude the Medical Executive Committee or Department chairs from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letters are issued, the affected Member may make a written response which shall be placed in the Member's file;
- (d) Recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of Clinical Privileges, including, without limitation, requirements for co-admission, mandatory consultation, or monitoring;
- (e) Recommending reduction, modification, suspension or revocation of Clinical Privileges. If suspension is recommended, the terms and duration of the suspension and the conditions that must be met before the suspension is ended shall be stated;
- (f) Recommending reductions of membership status or limitation of any prerogatives directly related to the Member's delivery of patient care;
- (g) Recommending suspension, revocation or probation of Medical Staff membership; and
- (h) Taking other actions deemed appropriate under the circumstances.

6.1-6 Subsequent Action.

- (a) If the Medical Executive Committee's recommended action is to recommend no corrective action, such recommendation, together with such supporting documentation as may be required by the Governing Body, shall be transmitted thereto.
- (b) If corrective action as set forth in Section 7.1-7 (a) - (l) is recommended by the Medical Executive Committee, that recommendation shall be transmitted to the Governing Body. So long as the recommendation is supported by substantial evidence the recommendation of the Medical Executive Committee shall be adopted by the Board as final action unless the member requests a hearing, in which case the final decision shall be determined as set forth in Article VII.
- (c) If the Medical Executive Committee recommends an action that constitutes grounds for a hearing under Section 7.1-7 (a) - (l), the Chief of Staff shall give the Practitioner Special Notice of the adverse recommendation and of the right to request a hearing. The Governing Body may be informed of the recommendation, but shall take no action until the Practitioner has either waived his or her right to a hearing or completed the hearing.

6.1-7 Initiation by Governing Body.

If the Medical Executive Committee fails to investigate or take disciplinary action, contrary to the weight of the evidence, the Governing Body may direct the Medical Executive Committee to initiate investigation or disciplinary action, but only after consultation with the Medical Executive Committee. The Governing Body's request for Medical Staff action shall be in writing and shall set forth the basis of the request. If the Medical Executive Committee fails to take action in response to that Governing Body direction, the Governing Body, after giving the Medical Executive Committee two (2) working days written notice, excluding weekends and holidays, may initiate corrective action, but this corrective action must comply with Articles VI and VII of these Medical Staff Bylaws. The Governing Body shall inform the Medical Executive Committee in writing of what it has done.

6.2 Summary Restriction or Suspension.

6.2-1 Initiation.

Whenever a Member's conduct appears to require that immediate action be taken to protect the life or well-being of patient(s) or to reduce a substantial and imminent likelihood of significant impairment of the life, health, safety of any patient, prospective patient, or other person, or a Member is placed under summary suspension or there is a limitation of Privileges at another hospital, the Chief of Staff, the Medical Executive Committee, the Chair (or the Vice Chair, if the Chair is unavailable) of the Department in which the Member holds Privileges, or the Chief Executive Officer may summarily restrict or suspend the Medical Staff membership or Clinical Privileges of such Member. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition, and the person or body responsible shall promptly give written notice to the Governing Body, the Medical Executive Committee and the Chief Executive Officer. In addition, the affected Medical Staff Member shall be provided with a written notice of the action which notice fully complies with the requirements of Section 6.2-2, below. The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary restriction or suspension, the Member's patients shall be promptly assigned to another Member by the Department chair or by the Chief of Staff, considering where feasible, the wishes of the patient in the choice of a substitute Member.

6.2-2 Written Notice of Summary Suspension.

Within one (1) working day of imposition of a summary suspension or restriction, the affected Medical Staff Member shall be provided with written notice of such restriction or suspension. This initial written notice shall include a statement of facts demonstrating that the restriction or suspension was necessary because failure to restrict or suspend the Member's Privileges summarily could reasonably result in an imminent danger to the health of an individual. The statement of facts provided in this initial notice shall also include a summary of one or more particular incidents giving rise to the assessment of imminent danger. This initial notice shall not substitute for, but is in addition to, the notice required under Section 7.2-1 (which applies in all cases where the Medical Executive Committee does not immediately terminate the summary suspension.) The Notice under Section 7.2-1 may supplement the initial notice provided under this Section by including any additional relevant facts supporting the need for summary suspension or other corrective action.

6.2-3 Medical Executive Committee Action.

In those cases where the Medical Executive Committee did not impose the initial summary action, a meeting of the Medical Executive Committee shall be convened within ten (10) calendar days to review and consider the action. Upon request, the Member may attend that meeting and make a statement concerning the issues under investigation, on such terms and conditions as the Medical Executive Committee shall impose, although in no event shall any meeting of the Medical Executive Committee, with or without the Member, constitute a hearing within the meaning of Article VII, and none of the procedural rules shall apply. In those cases where the Medical Executive Committee imposed the initial summary action, the Member may request a meeting with the Medical Executive Committee for the same purposes and on the same terms and conditions as described above. The Medical Executive Committee shall hold such meeting within one (1) week of receipt of the request. The Medical Executive Committee may modify, continue, or terminate the summary restriction or suspension, but in any event it shall furnish the member with notice of its decision within two (2) working days of its meeting.

6.2-4 Procedural Rights.

Unless the Medical Executive Committee promptly terminates the summary restriction or suspension, the Member shall be entitled to the procedural rights afforded by Article VII. The summary restriction or suspension shall remain in effect during the pendency and completion of the corrective process and of the hearing and appellate review process. When a summary action is continued, the affected Practitioner shall be entitled to the procedural rights afforded by Article VII, but the hearing may be consolidated with the hearing on any corrective action that is recommended so long as the hearing commences within sixty (60) days after the hearing on the summary action was requested.

6.2-5 Initiation by Governing Body.

If the Chief of Staff, the Medical Executive Committee and the Chair of the Department, (or the Vice Chair if the Chair is unavailable), in which the Member holds Privileges are not available to summarily restrict or suspend the Member's membership or Clinical Privileges, the Governing Body (or designee) may immediately suspend a Member's Privileges if a failure to suspend those Privileges is likely to result in an imminent danger to the health of any patient, prospective patient, or other person, provided that the Governing Body (or designee) made reasonable attempts to contact the Chief of Staff, the Medical Executive Committee, and the Chair of the Department (or the Vice Chair, if the Chair is unavailable) before the suspension.

Such a suspension is subject to ratification by the Medical Executive Committee. If the Medical Executive Committee does not ratify such a summary suspension within two (2) working days, excluding weekends and holidays, the summary suspension shall terminate automatically. If the Medical Executive Committee does ratify the summary suspension, all other provisions under Section 6.2 of these Bylaws will apply. In this event, the date of imposition of the summary suspension shall be considered to be the date of ratification by the Medical Executive Committee for purposes of compliance with notice and hearing requirements.

6.2-6 Notice of Pending Investigations And/Or Corrective Action.

The Chief of Staff, or designee, shall be authorized to notify their counterpart officers at other Sutter Health West Bay Hospitals whenever an ad hoc investigatory committee is

convened to review an application for appointment or reappointment; to investigate the qualifications, competence, behavior or suitability for continued Medical Staff membership or Clinical Privileges of an existing Medical Staff Member; whenever there is a peer review recommendation that membership and/or Clinical Privileges of a Medical Staff Member be terminated, suspended (including summary suspensions), restricted, limited or subjected to conditions of any kind, regardless of whether the action or restriction is reportable to the Medical Board of California or the National Practitioner Data Bank.

The effect of such action on the involved Practitioner's Medical Staff membership or Privileges at another Sutter Health West Bay Hospital shall be determined by the Medical Staff Bylaws or other applicable policies of that Sutter Health West Bay Hospital Medical Staff and in accordance with the direction of the Medical Executive Committee of that Sutter Health West Bay Hospital.

6.2-7 Effect of Actions Taken By Other Entities.

Whenever the Chief of Staff or Medical Executive Committee receives information about an action taken at another Sutter Health West Bay Hospital and involving a Practitioner holding Privileges at the Hospital, the Chief of Staff or Medical Executive Committee shall independently assess the facts and circumstances to ascertain whether to take comparable action. However, when a Practitioner was summarily suspended or restricted at the other Sutter Health West Bay Hospital, any person authorized under these Bylaws to impose a summary suspension or restriction is authorized to immediately impose a comparable summary suspension or restriction at the Hospital, subject to review by the Medical Executive Committee in accordance with the provisions of these Bylaws.

6.3 Automatic Suspension or Revocation.

In the following instances, the Member's Privileges or membership may be suspended or limited as described, and a hearing, if requested, shall be limited to the question of whether the grounds for automatic suspension, limitation or revocation, as set forth below have occurred.

6.3-1 Licensure.

- (a) Revocation, Suspension or Expiration. Whenever a Member's license or other legal credential authorizing practice in this state is revoked, suspended or expired without an application pending for renewal, Medical Staff membership and Clinical Privileges shall be automatically revoked as of the date such action becomes effective. Such Member shall not be entitled to the procedural rights afforded by Article VII.
- (b) Restriction. Whenever a Member's license or other legal credential authorizing practice in this state is limited or restricted by the applicable licensing or certifying authority, any Clinical Privileges which the Member has been granted at the Hospital which are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

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

6.3-2 Exclusive Contracts.

The Privileges of a Practitioner who is a Member of, a subcontractor of, or otherwise affiliated with, a Practitioner or group which holds an exclusive contract, shall be automatically terminated or restricted as to those Privileges covered by the exclusive contract if his or her membership in, subcontract with or affiliation with the exclusive contractor is terminated or if his or her Privileges with the group are restricted by the group.

6.3-3 Controlled Substances.

- (a) Revocation, Suspension and Expiration. Whenever a Member's DEA certificate is revoked, limited, suspended, or expired, the Member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.
- (b) Probation. Whenever a Member's DEA certificate is subject to probation, the Member's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

6.3-4 Failure to Satisfy Special Appearance or Response Requirement.

Failure of a Member without good cause to appear at a peer review meeting and/or respond to a peer review inquiry pursuant to Section 2.7(r) and satisfy the requirements of Section 12.6-3 shall result in the Member being automatically suspended from exercising all or such portion of Privileges as the Medical Executive Committee determines.

6.3-5 Failure to Report.

A Member shall have five (5) days from the date of imposition to report any restrictions on Privileges, loss of staff membership at a hospital or other institutional provider, loss of contracting status with a managed care organization or medical group based upon medical disciplinary cause or reason, or any other form of adverse action against the Member, when the actions taken were based upon medical disciplinary cause or reason. Failure to so report will result in automatic suspension of privileges.

6.3-6 Medical Records.

Members of the Medical Staff are required to complete medical records within such reasonable time as may be prescribed by the Medical Executive Committee in accordance with the requirements of the licensing regulations. A limited suspension in the form of withdrawal of admitting and other related Privileges until medical records are completed, shall be imposed by the Chief of Staff, or the Chief of Staff-Elect, if the Chief of Staff is unavailable, after notice of delinquency for failure to complete medical records within

such period. For the purpose of this Section, “related privileges” means voluntary on-call service for the emergency room, scheduling surgery, assisting in surgery, consulting on hospital cases, and providing professional services within the Hospital for future patients. Bona fide vacation or illness may constitute an excuse subject to approval by the Medical Executive Committee. Members whose Privileges have been suspended for delinquent records may admit patients only in life-threatening situations. The suspension shall continue until lifted by the Chief of Staff or the Chief of Staff’s designee.

6.3-7 Failure to Pay Dues/Assessments.

Failure without good cause as determined by the Medical Executive Committee, to pay dues or assessments, as required under Section 2.2-2(e), shall be grounds for automatic suspension of a Member’s Clinical Privileges, and if within sixty (60) days after written warnings of the delinquency the Member does not pay the required dues or assessments, the Member’s membership shall be automatically terminated.

6.3.8 Professional Liability Insurance.

Failure to maintain current and continuous professional liability insurance, shall be grounds for automatic suspension of a Member’s Clinical Privileges, and if within thirty (30) days after written warnings of the delinquency the Member does not provide evidence of required professional liability insurance, the member’s membership shall be automatically terminated.

6.3-9 Failure to Submit Reappointment Application in Timely Manner.

Failure to submit the completed reappointment application in accordance with the provisions of Section 4.7-4 shall constitute grounds for an automatic suspension of Privileges at the end of the member’s current appointment period.

6.3-10 Exclusion from Participation in Federal Health Care Program.

Whenever a Member is excluded from participation in Medicare, Medicaid, or any other federal health care program as a sanction for unlawful conduct, Medical Staff membership and Clinical Privileges shall be automatically and immediately suspended as of the effective date of exclusion, pending final action by the Governing Body, based upon the recommendation of the Medical Executive Committee, which final action may include lifting the suspension following official reinstatement of eligibility to participate in the federal health care program.

6.3-11 Medical Executive Committee Deliberation.

- (a) As soon as practicable after action is taken or warranted as described in Section 6.3-1 (licensure revocation, suspension, expiration, restriction or probation), Section 6.3-3 (DEA certificate revocation, suspension, expiration, or probation), or Section 6.3-4 (failure to satisfy a special appearance), the Medical Executive Committee shall convene to review and consider the facts, and may recommend such further corrective action as it may deem appropriate in accordance with these Bylaws. There is no need for the Medical Executive Committee to act on automatic suspensions for failure to complete medical records (Section 6.3-6), maintain professional liability insurance (Section 6.3-8), or to pay dues (Section 6.3-7). The Medical Executive Committee review and subsequent hearings and reviews shall not address the propriety of the

licensure or DEA action, but instead shall address what action should be taken by the Hospital.

- (b) Practitioners whose Privileges are automatically revoked or suspended and/or who have been deemed to have resigned their Medical Staff membership shall be entitled to a hearing only if the suspension is reportable to the Medical Board of California or the National Practitioner Data Bank.

6.3-12 Automatic Termination.

If a Practitioner is suspended for more than six (6) months, his or her membership (or the affected Privileges, if the suspension is a partial suspension) shall be automatically terminated. Thereafter, reinstatement to the Medical Staff shall require application and compliance with the appointment procedures applicable to applicants. However, a Practitioner who is involuntarily terminated for administrative reasons need not complete a new application form if they request reinstatement within sixty (60) days of Governing Body action on the termination.

ARTICLE VII

HEARINGS & APPELLATE REVIEWS

7.1 Hearing and Appeal Procedures.

7.1-1 Exhaustion of Remedies.

If an adverse action as described in Section 7.1-6 below is taken or recommended, the Practitioner must exhaust the administrative remedies afforded by these Bylaws before resorting to legal action.

7.1-2 Intra-Organizational Remedies.

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

7.1-3 Definitions.

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

- (a) “Body whose decision prompted the hearing” refers to the Medical Executive Committee in all cases where the Medical Executive Committee or authorized Medical Staff Officers, members or committees took the action or rendered the decisions which resulted in a hearing being

requested. It refers to the Governing Body in those cases where the Governing Body or its authorized officers, directors, agents or committees took the action or rendered the decision which resulted in a hearing being requested.

- (b) “Practitioner” as used in this Article refers to the applicant or Member who has requested a hearing pursuant to this Article.

7.1-4 Substantial Compliance.

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

7.1-5 Final Action.

Recommended adverse action described in Section 7.1-6 shall become final only after the hearing and appellate rights set forth in these Bylaws have either been exhausted or waived, and only upon being adopted as final actions by the Governing Body.

7.1-6 Grounds for Hearing.

In any case in which any member of the Medical Staff, or any applicant for such membership (both hereafter for purposes of this Article VII “Practitioner”), receives notice of a specific recommendation of the Medical Executive Committee to the Governing Body outlined in this Section 7.1-6 which recommendation, if approved by the Governing Body, would adversely affect Practitioner’s exercise of Clinical Privileges (“adverse recommendation”), or if a Practitioner is otherwise entitled by these Bylaws to a hearing and review under these Bylaws, the Practitioner shall be entitled to a hearing before a Judicial Review Committee, and if the Judicial Review Committee also makes an adverse recommendation, to appellate review by the Governing Body prior to its final decision on the matter.

Except as otherwise specified in these Bylaws (including those Exceptions to Hearing Rights specified in Section 7.5-9) any one or more of the following actions, if taken for medical disciplinary cause or reason, as defined in Business and Professions Code Section 805 or its successor statute, shall be deemed adverse and shall constitute grounds for a hearing:

- (a) Denial of initial appointment to Medical Staff;
- (b) Denial of reappointment to Medical Staff;
- (c) Suspension of Medical Staff membership;
- (d) Revocation of Medical Staff Membership;
- (e) Denial of requested Clinical Privileges;
- (f) Reduction in Clinical Privileges;
- (g) Suspension of Clinical Privileges;
- (h) Revocation of Clinical Privileges;

- (i) Requirement of consultation or other conditions of Clinical Privileges including mandatory consultation, assistants or special conditions of admission or treatment (excluding monitoring incidental to provisional status and Section 5.3-1);
- (j) Termination of a contract between Hospital and a Member of the Medical Staff, if undertaken for a medical disciplinary cause or reason as defined in Business and Professions Code Section 805 or its successor statute;
- (k) Denial, reduction, suspension or termination of temporary, special or locum tenens Privileges, if undertaken for a medical disciplinary cause or reason as defined in Business and Professions Code Section 805 or its successor statute; and
- (l) Any other disciplinary action or recommendation that must be reported to the Medical Board of California.

7.2 Request for Hearing.

7.2-1 Notice of Action or Proposed Action.

In all cases in which any action or recommendation has been taken or made constituting grounds for hearing as set forth in Section 7.1-6, the applicant or Medical Staff Member shall promptly be given Special Notice of the recommendation or action and of the right to request a hearing pursuant to this Article. The Notice shall in all instances include the following information:

- (a) A description of the action or recommendation;
- (b) That the Practitioner has the right to request a hearing within thirty (30) days after receipt of Special Notice as defined herein;
- (c) A summary of the Practitioner's rights in the hearing; and
- (d) A concise statement of the reasons for the action or recommendation. (When deemed necessary and in the event a hearing is requested, a more detailed Notice of the Reasons or Charges may be provided subsequently.)

In the event the action or recommendation is the type of action which will be reportable to the Medical Board of California pursuant to Section 805 of the Business and Professions Code, and/or the National Practitioners Data Bank, if adopted or implemented, then the notice should also explain that the action, if adopted or implemented, will be reportable to Medical Board pursuant to Business and Professions Code 805 and/or the National Practitioner Data Bank.

7.2-2 Request for Hearing.

The Practitioner shall have thirty (30) days following the receipt of such Special Notice to request a hearing. The request shall be in writing, addressed to the Medical Executive Committee with a copy to the Governing Body. The Practitioner shall state, in writing, his or her intentions with respect to attorney representation at the time he or she files the request for a hearing. Notwithstanding the foregoing and regardless of whether the Practitioner elects to have attorney representation at the hearing, the parties shall have the right to consult with legal counsel to prepare for a hearing or an appellate review.

7.2-3 Time and Place of Hearing.

Upon receipt of a request for hearing, the Medical Executive Committee shall schedule a hearing and, within thirty (30) days but in no event less than ten (10) days prior to the hearing, give written notice to the Practitioner of the time, place and date of hearing, and the reasons for the proposed action or recommendation including the acts or omissions with which the Practitioner is charged and a list of the charts in question, where applicable. A supplemental Notice may be issued at any time, provided the Practitioner is given sufficient time to prepare to respond. The date of the commencement of the hearing shall be not less than fifteen (15) days, nor more than sixty (60) days from the date of receipt of the request by the Medical Executive Committee for a hearing; provided, however, that when the request is received from a Practitioner who is under summary suspension, the hearing shall be held as soon as the arrangements may reasonably be made, so long as the Practitioner has at least thirty (30) days from the date of notice of the hearing to prepare for the hearing or waives this right. The date of the hearing may be delayed only upon agreement of the parties or upon written decision issued by the hearing officer pursuant to Section 7.3.

7.2-4 Waiver of Hearing.

In the event the Practitioner does not request a hearing within the time and in the manner described, the Practitioner shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved.

7.2-5 Pre-hearing Discovery.

The Practitioner shall have the right to inspect and copy at his or her expense any documentary information or other evidence upon which the charges are based as well as other evidence relevant to the charges which the Medical Executive Committee has in its possession or under its control, as soon as practicable after the Practitioner's request for such inspection. The Medical Executive Committee, or the body whose decision prompted the hearing, shall have the right to inspect and copy at its expense any documentary information relevant to the charges which the Practitioner has in his or her possession or control as soon as practicable after receipt of the Medical Executive Committee's request for such inspection. The requests for discovery shall be fulfilled as soon as practicable. The failure by either party to provide access to this information at least thirty (30) days before the hearing shall constitute good cause for a continuance. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable Practitioners, other than the Practitioner under review.

The hearing officer shall consider and rule upon any dispute or controversy concerning a request for access to information, and may impose any safeguards for the protection of the peer review process and justice requires, pursuant to California Business and Professions Code Section 809.2. When ruling upon requests for access to information and determining the relevancy thereof, the hearing officer shall consider, among other factors, the following:

- (a) Whether the information sought may be introduced to support or defend the charges.
- (b) The exculpatory or inculpatory nature of the information sought, if any; i.e., whether there is a reasonable probability that the result of the hearing

would be influenced significantly by the information if received into evidence.

- (c) The burden imposed on the party in possession of the information sought, if access is granted.
- (d) Any previous requests for access to information submitted or resisted by the parties to the same proceeding.

7.2-6 Witness Lists.

If either side to the hearing requests in writing a list of witnesses, within fifteen (15) days of receipt of such request, and in no event less than ten (10) days before commencement of the hearing, each party shall furnish to the other a written list of the names and addresses of the individuals, so far as is reasonable known or anticipated, who are anticipated to give testimony or evidence in support of that party at the hearing. Nothing in the foregoing shall preclude the testimony of additional witnesses whose possible participation was not reasonably anticipated. The parties shall notify each other as soon as they become aware of the possible participating of such additional witnesses. The failure to have provided the name of any witness at least ten (10) days prior to the hearing date at which the witness is to appear shall constitute good cause for a continuance.

7.2-7 Pre-Hearing Document Exchange.

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

7.2-8 Objections to Introduction of Evidence Previously Not Produced for the Medical Staff.

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

7.3 Judicial Review Committee.

7.3-1 Judicial Review Committee.

When a hearing is requested, the Medical Executive Committee shall appoint a Judicial Review Committee which shall be composed of not less than three (3) Members of the Medical Staff who shall not have acted as accusers, investigators, fact finders or initial decision makers in connection with or active participants in the same matter, provided such persons shall gain no direct financial benefit from the outcome nor shall any be in direct economic competition with the Practitioner who requested the hearing. Membership on a Judicial Review Committee shall consist of one (1) member who shall have the same healing arts licensure as the accused, and where feasible, include an individual practicing the same specialty as the Practitioner. Such appointment shall

include designation of the chairman. Knowledge of the matter involved shall not preclude a Member of the Active Medical Staff from serving as a member of the Judicial Review Committee. In the event that it is not feasible to appoint a fully qualified Judicial Review Committee from the Medical Staff, the Medical Executive Committee may appoint qualified physicians who are not Members of the Medical Staff. Such appointment shall include designation of the Chair. The Medical Executive Committee shall appoint alternates who meet the standards described above and who can serve if a Judicial Review Committee member becomes unavailable.

7.3-2 The Hearing Officer.

The Medical Executive Committee shall appoint a hearing officer to preside at the hearing. The hearing officer shall be an attorney at law qualified to preside over a quasi-judicial hearing, but attorneys from a firm regularly utilized by the Hospital, the Medical Staff or the involved Medical Staff Member or applicant for membership, for legal advice regarding their affairs and activities shall not be eligible to serve as hearing officer. The hearing officer shall gain no direct financial benefit from the outcome and must not act as a prosecuting officer or as an advocate. The hearing officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The hearing officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure or the admissibility of evidence. If the hearing officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the hearing officer may take such discretionary action as seems warranted by the circumstances. If requested by the Judicial Review Committee, the hearing officer may participate in the deliberations of such committee and be a legal advisor to it, but the hearing officer shall not be entitled to vote. The hearing officer shall assist in preparation of the Judicial Review Committee's report and recommendations. In the absence of the appointment of a hearing officer by the Medical Executive Committee, the Chairperson of the Judicial Review Committee shall serve as the presiding officer and all references to a "hearing officer" in these Bylaws will refer to such presiding officer.

7.3-3 Failure to Appear or Proceed.

Failure without good cause of the Practitioner to personally attend and proceed at the Judicial Review Committee hearing in an efficient and orderly manner shall be deemed a waiver of any right to a hearing and shall constitute voluntary acceptance of the recommendations or actions involved.

7.4 Conduct of Hearing by Judicial Review Committee.

7.4-1 Personal Presence Mandatory.

Under no circumstances shall the hearing be conducted without the presence of the Practitioner unless Practitioner has waived such appearance or has failed without good cause to appear after appropriate notice.

7.4-2 Representation.

The hearings provided for in these Bylaws are for the purpose of intra-professional resolution of matters bearing on conduct, professional competency or character. Accordingly, the Practitioner requesting the hearing has a right to representation by an

attorney in any phase of the hearing. In the absence of legal counsel, the Member shall be entitled to be accompanied by and represented at the hearing only by a practitioner licensed to practice in the State of California who is not also an attorney at law, and the Medical Executive Committee shall appoint a representative who is not an attorney to present its action or recommendation, the materials in support thereof, examine witnesses and respond to appropriate questions. The Medical Executive Committee shall not be represented by an attorney if the Practitioner is not so represented.

7.4-3 Record of Hearing.

The Judicial Review Committee shall maintain a record of the hearing. A shorthand reporter shall be present to make a record of the hearing proceedings and the pre-hearing proceedings, if deemed appropriate by the hearing officer. The cost of attendance of the shorthand reporter shall be borne by the Hospital. The cost of the transcript, if any, shall be borne by the party requesting it. The Judicial Review Committee may, but shall not be required to, order that oral evidence shall be taken only on oath administered by any person lawfully authorized to administer such oath.

7.4-4 Conduct of Hearing.

At a hearing, each side shall, within reasonable limits, have the following rights: to ask the Judicial Review Committee members and the hearing officer questions which are directly related to determining whether they are impermissibly biased and to challenge their impartiality; to call, examine and cross-examine witnesses for relevant testimony; to introduce relevant exhibits or other documents; to impeach any witness who shall have testified orally on any matter relevant to the issues, and otherwise rebut evidence; to receive all information made available to the Judicial Review Committee; and to submit a written statement at the close of the presentation of evidence, as long as these rights are exercised in an efficient and expeditious manner. The hearing officer shall make all necessary rulings on the foregoing. The Practitioner may be called by the body whose decision prompted the hearing or the Judicial Review Committee and examined as if under cross-examination.

7.4-5 Miscellaneous Rules.

Judicial rules of evidence and procedure relevant to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under this Article. Any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. At its discretion, the Judicial Review Committee may request or permit both sides to file written arguments. The Judicial Review Committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate. The hearing process shall be completed within a reasonable time after the notice of the action is received, unless the hearing officer issues a written decision that the Practitioner or the Medical Executive Committee failed to provide information in a reasonable time or consented to the delay.

7.4-6 Burdens of Presenting Evidence and Proof.

- (a) At the hearing, the Medical Executive Committee, or the body whose decision prompted the hearing, shall have the initial duty to present evidence in support of its action or recommendation. The Member shall be obligated to present evidence in response.

- (b) An applicant shall bear the burden of persuading the Judicial Review Committee, by a preponderance of the evidence, of the applicant's qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning the applicant's current qualifications for membership and Privileges. An applicant shall not be permitted to introduce information not produced upon request of the Medical Executive Committee during the application process, unless the initial applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.
- (c) Except as provided above for applicants, throughout the hearing, the Medical Executive Committee, or the body whose decision prompted the hearing shall bear the burden of persuading the Judicial Review Committee by a preponderance of the evidence, that its action or recommendation was reasonable and warranted.

7.4-7 Adjournment And Conclusion.

After consultation with the chair of the Judicial Review Committee, the hearing officer may adjourn the hearing and reconvene the same without special notice as such times and intervals as may be reasonable and warranted, with due consideration for reaching an expeditious conclusion to the hearing. Both the Medical Executive Committee and the Practitioner may submit a written statement at the close of the hearing. Upon conclusion of the presentation of oral and written evidence, or the receipt of closing written arguments, if submitted, the hearing shall be closed.

7.4-8 Basis of Decision.

The decision of the Judicial Review Committee shall be based on the evidence introduced at the hearing, including all logical and reasonable inferences from the evidence and testimony.

7.4-9 Presence of Judicial Review Committee Members And Vote.

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

7.4-10 Decision of The Judicial Review Committee.

Within thirty (30) days after final adjournment of the hearing, the Judicial Review Committee shall render a decision which shall be accompanied by a report in writing and shall be delivered to the Medical Executive Committee. If the Practitioner is currently under suspension, however, the time for the decision and report shall be fifteen (15) days after final adjournment. The report and recommendation shall include the Judicial Review Committee's findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached. Both the Practitioner and the Medical Executive Committee, or the body whose decision prompted the hearing, shall be provided a written explanation of the procedure for appealing the

decision. The decision of the Judicial Review Committee shall be subject to the rights of appeal or review as described in these Bylaws, but shall otherwise be affirmed by the Governing Body as the final action if it is supported by substantial evidence, following a fair procedure.

7.5 Appeal.

7.5-1 Time for Appeal.

Within ten (10) days after receipt of the decision of the Judicial Review Committee, either the Practitioner or the Medical Executive Committee may request an appellate review. A written request for review shall be delivered to the Chief of Staff, the Chief Executive Officer, and the other party in the hearing. If appellate review is not requested within such time period, that action or recommendation shall be affirmed by the Governing Body as the final action if it is supported by substantial evidence, following a fair procedure.

7.5-2 Grounds for Appeal.

A written request for an appeal shall include an 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 Judicial Review Committee decision shall be: (a) substantial non-compliance with the procedures required by these Bylaws or applicable law which has created demonstrable prejudice; or, (b) the decision was not supported by substantial evidence based upon the hearing record or such additional information as may be permitted pursuant to Section 7.5-5.

7.5-3 Time, Place and Notice.

If an appellate review is to be conducted, the Appeal Board shall, within thirty (30) days after receiving a notice of appeal, schedule a review date and cause each side to be given notice of the time, place and date of the appellate review. The appellate review shall commence within thirty (30) days of the date of such notice provided, however, when a request for appellate review concerns a Practitioner 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 provided. The time for appellate review may be extended by the appeal board for good cause.

7.5-4 Appeal Board.

The Governing Body may sit as the appeal board or it may appoint an appeal board which shall be composed of not less than three (3) members of the Governing Body. Knowledge of the matter involved shall not preclude any person from serving as a member of the appeal board, so long as that person did not take part in a prior hearing on the same matter. The appeal board may select an attorney to assist it in the proceeding, but that attorney shall not be entitled to vote with respect to the appeal. The attorney firm selected by the Governing Body shall be neither the attorney firm that represented either party at the hearing before the Judicial Review Committee nor the attorney who assisted the hearing panel or served as hearing officer.

7.5-5 Appeal Procedure.

The proceedings by the appeal board shall be in the nature of an appellate hearing based upon the record of the hearing before the Judicial Review Committee, provided that the

appeal board may accept such additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the Judicial Review Committee in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the Judicial Review Committee hearing; or the appeal board may remand the matter to the Judicial Review Committee for the taking of further evidence and for decision. Each party shall have the right to be represented by legal counsel, or any other representative designated by that party in connection with the appeal, to present a written statement in support of that party's position on appeal, and to personally appear and make oral argument. The appeal board may thereupon conduct, at a time convenient to itself, deliberations outside the presence of the appellant and respondent and their representatives. The appeal board shall present to the Governing Body its written recommendations as to whether the Governing Body should affirm, modify, or reverse the Judicial Review Committee decision, or remand the matter to the Judicial Review Committee for further review and decision.

7.5-6 Decision.

- (a) Except as provided in Section 7.5-6(b), within thirty (30) days after the conclusion of the appellate review proceedings, the Governing Body shall render a final decision and shall affirm the decision of the Judicial Review Committee if the Judicial Review Committee's decision is supported by substantial evidence, following a fair procedure.
- (b) Should the Governing Body determine that the Judicial Review Committee decision is not supported by substantial evidence, the Board may modify or reverse the decision of the Judicial Review Committee and may instead, or shall, where a fair procedure has not been afforded, remand the matter to the Judicial Review Committee for reconsideration, stating the purpose for the remand. If the matter is remanded to the Judicial Review Committee for further review and recommendation, the Judicial Review Committee shall promptly conduct its review and make its recommendations to the Governing Body. This further review and the time required to report back shall not exceed thirty (30) days in duration except as the parties may otherwise agree or for good cause as jointly determined by the chair of the Governing Body and the Judicial Review Committee.
- (c) The decision shall be in writing and shall specify the reasons for the action taken and provide findings of fact and conclusions articulating the connection between the evidence produced at the hearing and the appeal (if any), and the decision reached, if such findings and conclusions differ from those of the Judicial Review Committee.

7.5-7 Right to One Hearing.

Except in circumstances where a new hearing is ordered by the Governing Body or a court because of procedural irregularities or for other reasons not the fault of the Practitioner, no Practitioner shall be entitled to more than one evidentiary hearing and one appellate review on any matter which shall have been the subject of unfavorable recommendation or action.

7.5-8 Confidentiality.

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

7.5-9 Exceptions to Hearing Rights.

- (a) Automatic Suspension or Limitation of Practice Privileges.
- (b) No hearing is required when a Practitioner's license or legal credential to practice has been revoked or suspended as set forth in Section 6.3-1(a). In other cases described in Section 6.3-1 and 6.3-3, the issues which may be considered at a hearing, if requested, shall not include evidence designed to show that the determination by the licensing or credentialing authority or certifying authority was unwarranted, but only whether the Practitioner may continue practice in the Hospital with those limitations imposed.
- (c) Practitioners whose Privileges are automatically suspended and/or who have resigned their Medical Staff membership for failing to satisfy a special appearance (Section 6.3-4), failing to complete medical records (Section 6.3-6), failing to timely file an application for reappointment (Section 4.7-4), failing to maintain malpractice insurance (Section 6.3-8), or failing to pay dues (Section 6.3-7) are not entitled under Article VII to any hearing or appellate review rights except when a suspension for failure to complete medical records will exceed thirty (30) days in an 12-month period, and it must be reported to the Medical Board of California.
- (d) A Practitioner who is automatically suspended pursuant to Section 6.3-10 shall be entitled to a hearing under Article VII; however, the issues which may be considered at a hearing shall not include evidence designed to show that the determination by the government enforcement authorities was unwarranted. Rather, the only issue considered at the hearing shall be whether the Practitioner may continue to practice in the Hospital while under the exclusion.

7.5-10 Exclusive Contracts.

- (a) The fair hearing rights of Article VII do not apply to a Practitioner whose application for Privileges was denied, in whole or in part, on the basis that the Privileges sought are covered by an exclusive contract.
- (b) The fair hearing rights of Article VII do not apply to a Practitioner whose Privileges are terminated, or suspended, or restricted following the decision to enter into an exclusive contract for the provision of the subject services.
- (c) The fair hearing requirements of Article VII do not apply to a Practitioner whose Privileges are terminated, suspended or restricted because he or she is terminated, suspended or restricted by, or he or she is no longer affiliated with, the physician or group holding the exclusive contract.

7.5-11 Failure to Meet Minimum Activity Requirements.

Practitioners shall not be entitled to the hearing and appellate review rights if their membership or Privileges are denied, restricted, or terminated or their Medical Staff categories are changed or not changed because of a failure to meet any existing minimum activity requirements set forth in the Medical Staff Bylaws or Rules and Regulations. In such cases, the only review shall be provided by the Medical Executive Committee through a subcommittee consisting of at least three (3) Medical Executive Committee members. The subcommittee shall give the Practitioner notice of the reasons for the intended denial or change in membership, Privileges, and/or category and shall schedule an interview with the subcommittee to occur no less than thirty (30) days and no more than one hundred (100) days after the date the notice was given. At this interview, the Practitioner may present evidence concerning the reasons for the action, and thereafter the subcommittee shall render a written decision within forty-five (45) days after the interview. A copy of the decision shall be sent to the Practitioner, Medical Executive Committee and the Governing Body. The subcommittee decision shall be final unless it is reversed or modified by the Medical Executive Committee within forty-five (45) days after the decision was rendered or the Governing Body within ninety (90) days after the decision was rendered.

ARTICLE VIII

ALLIED HEALTH PROFESSIONALS

8.1 Medical Staff Role.

- (a) The Medical Staff shall have responsibility for reviewing and making recommendations to the Governing Body regarding the credentials and Privileges of each Allied Health Professional seeking or exercising Privileges, including those employed by or seeking employment with the Hospital. This will occur at the time of initial application and each time the Allied Health Professional seeks reappointment or renewal of Privileges. The Medical Staff shall have general responsibility for monitoring the quality of care provided in the Hospital by health care professionals who are neither employed by the Hospital nor eligible for Medical Staff membership, but who are permitted to treat patients at the Hospital by virtue of Allied Health Professional status. The Medical Staff may cede the monitoring responsibility, in accordance with applicable laws and accreditation standards, to Hospital Administration in the case of individual Allied Health Professionals who are employed by the Hospital, where oversight by the Medical Staff would not be efficient or practicable. However, all Allied Health Professionals, including employees of the Hospital, shall be bound by the applicable Medical Staff Bylaws and Rules and Regulations governing the practice of Allied Health Professionals.
- (b) The Medical Staff shall fulfill its responsibilities under this Section by performing the following functions with respect to Allied Health Professional categories under its jurisdiction:
 - (1) Making recommendations to the Governing Body regarding the categories of Allied Health Professionals who will be permitted to render patient care services in the Hospital.
 - (2) Establishing standards of practice for the category;

- (3) Credentialing and privileging Allied Health Professionals from the category who apply for Privileges or renewal of Privileges as an Allied Health Professional;
- (4) Undertaking peer review of Allied Health Professionals in the category; and
- (5) Establishing appropriate standards and procedures for carrying out its functions.

ARTICLE IX

OFFICERS

9.1 General Officers of the Staff.

The Medical Staff's right of self-governance includes the right to select and remove Medical Staff Officers.

9.1-1 Identification.

The officers of the Medical Staff shall be the Chief of Staff, Chief of Staff-Elect, and Immediate Past Chief of Staff.

9.1-2 Qualifications.

Officers must be Members of the Active Medical Staff at the time of their nominations and election and must remain Members in Good Standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

9.1-3 Nominations.

- (a) The Medical Staff election year shall be each odd numbered Medical Staff year. A nominating committee shall be appointed by the Medical Executive Committee not later than one hundred twenty (120) days prior to end of the calendar year that the elections will be held or at least forty-five (45) days prior to any special election. The nominating committee shall consist of the current Chief of Staff, the Chief of Staff-Elect, one other member of the Medical Executive Committee, and two (2) members from among the Active Medical Staff who are not then members of the Medical Executive Committee. The nominating committee shall nominate at least two (2) nominees for the office of Chief of Staff-Elect and for the Medical Executive Committee members-at-large. The nominations of the committee shall be reported to the Medical Executive Committee at least sixty (60) days prior to the date set for the ballots to be mailed out and shall be delivered or mailed to the Active Staff Members of the Medical Staff at least forty (40) days prior to the date set for the submission of the completed written ballots to the Medical Staff Office.
- (b) Further nominations may be made for any office by any Active Member of the Medical Staff, provided that the name of the candidate is submitted in writing to the chair of the nominating committee, is endorsed by the signature of at least five percent (5%) of other Members who are eligible

to vote, and bears the candidate's written consent. These nominations shall be delivered to the chair of the nominating committee as soon as reasonably practicable, but not later than fourteen (14) days prior to the ballot being sent out. Such further nominations shall be included in the mailed written ballot.

9.1-4 Elections.

The Chief of Staff-Elect and one (1) to six (6) members-at-large, as determined by the Medical Executive Committee, shall be elected by mailed ballot. All voting shall be by authenticated secret written ballot. Written ballots shall include handwritten signatures on the envelope or pre-printed labels. A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate for the office receives a majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes. In the case of a tie on the second ballot, the majority vote of the Medical Executive Committee shall decide the election by secret written ballot at its next meeting or a special meeting called for that purpose. The results of the election will be communicated to the Medical Staff membership.

9.1-5 Term of Elected Officers.

Each officer shall serve a two (2) year term, commencing on the first day of the Medical Staff year following the election. Each officer shall serve in his/her office until the end of that officer's term, or until a successor is elected, unless that officer shall sooner resign or be removed from office. At the end of that officer's term, the Chief of Staff shall automatically assume the office of Immediate Past Chief of Staff and the Chief of Staff-Elect shall automatically assume the office of Chief of Staff.

9.1-6 Removal of Elected Officers.

Any Medical Staff officer may be removed from office for valid cause, including, but not limited to, neglect or malfeasance in office, or acts of moral turpitude. Recall of a Medical Staff officer may be initiated by the Medical Executive Committee or shall be initiated by a petition signed by at least one-third (1/3) of the Members of the Medical Staff eligible to vote for officers. Recall shall be by authenticated secret written mailed ballot. Recall shall require a two-thirds (2/3) vote of the Medical Staff Members eligible to vote for Medical Staff officers who actually cast votes by mailed ballot.

9.1-7 Vacancies in Elected Office.

Vacancies in office occur upon the death or disability, resignation, or removal of the officer, or such officer's loss of membership on the Medical Staff. Vacancies, other than that of the Chief of Staff, shall be filled by appointment by the Medical Executive Committee until the next regular election. If there is a vacancy in the office of Chief of Staff, then the Chief of Staff-Elect shall serve out that remaining term (in addition to serving out his/her own term as Chief of Staff) and shall immediately appoint an ad hoc nominating committee to decide promptly upon nominees for the office of Chief of Staff-Elect. Such nominees shall be reported to the Medical Executive Committee and to the Medical Staff. A special election to fill the position shall occur at the next regular Staff meeting. If there is a vacancy in the office of Chief of Staff-Elect, that office need not be filled by election, but the Medical Executive Committee shall appoint an interim officer to fill this office until the next regular election, at which time the election shall also include the office of Chief of Staff.

9.2 Duties of General Officers.

9.2-1 Chief of Staff.

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

- (a) Enforcing the Medical Staff Bylaws and Rules and Regulations, implementing sanctions where indicated, and promoting compliance with procedural safeguards where corrective action has been requested or initiated;
- (b) Calling, presiding at, and being responsible for the agenda of all meetings of the General Medical Staff;
- (c) Chairing the Medical Executive Committee, without vote except in the event of a tie vote, and calling, presiding at, and being responsible for the agenda of all meetings thereof;
- (d) Serving as an ex officio member of all other Medical Staff committees, except hearing committees, with vote;
- (e) Serving as a member of the Hospital Performance Improvement Committee;
- (f) Interacting with the Chief Executive Officer and Governing Body in all matters of mutual concern within the Hospital;
- (g) Appointing, in consultation with the Medical Executive Committee, committee members for all standing committees other than the Medical Executive Committee and all special Medical Staff, liaison, multi-disciplinary committees and ad hoc investigatory committees, except where otherwise provided by these Bylaws and, except where otherwise indicated, designating the chairs of these committees;
- (h) Representing the views and policies of the Medical Staff to the Governing Body and to the Chief Executive Officer;
- (i) Being a spokesperson for the Medical Staff in external professional and public relations;
- (j) Serving on liaison committees with the Governing Body and administration, as well as outside licensing or accreditation agencies;
- (k) In the interim between Medical Executive Committee meetings, performing those responsibilities of the Committee that, in his or her reasonable opinion, must be accomplished prior to the next regular or special meeting of the Medical Executive Committee; and
- (l) Performing such other functions as may be assigned to the Chief of Staff by these Bylaws, the Medical Staff, or by the Medical Executive Committee.

9.2-2 Chief of Staff-Elect.

The Chief of Staff-Elect shall assume all duties and authority of the Chief of Staff in the absence of the Chief of Staff. The Chief of Staff-Elect shall be a member of the Medical Executive Committee, and the Hospital Performance Improvement Committee. The Chief of Staff-Elect shall also perform such other duties as the Chief of Staff may assign or as may be delegated by these Bylaws, or by the Medical Executive Committee.

Duties shall include, but not be limited to:

- (a) Maintaining a roster of members;
- (b) Keeping accurate and complete minutes of all Medical Executive Committee and general Medical Staff meetings;
- (c) Calling meetings on the order of the Chief of Staff or Medical Executive Committee;
- (d) Attending to all appropriate correspondence and notices on behalf of the Medical Staff;
- (e) Receiving and safeguarding all funds of the Medical Staff;
- (f) Excusing absences from meetings on behalf of the Medical Executive Committee; and
- (g) Performing such other duties as ordinarily pertain to the office or as may be assigned from time to time by the Chief of Staff or Medical Executive Committee.

9.2-3 Immediate Past Chief of Staff.

The immediate past Chief of Staff shall be a member of the Medical Executive Committee, and shall perform such other duties as may be assigned by the Chief of Staff or delegated by these Bylaws, or by the Medical Executive Committee. The Immediate Past Chief of Staff shall assume all duties and authority of the Chief of Staff in the absence of the Chief of Staff and the Chief of Staff-Elect.

ARTICLE X

CLINICAL DEPARTMENTS AND SECTIONS

10.1 Organization of Clinical Departments.

The Medical Staff shall be divided into clinical Departments. Each Department shall be organized as a separate component of the Medical Staff and shall have a chair selected and entrusted with the authority, duties, and responsibilities specified in Section 10.7. A Department may be further divided, as appropriate, into Sections which shall be directly responsible to the Department within which it functions, and which shall have a Section chief selected and entrusted with the authority, duties and responsibilities specified in Section 10.8. The Department may make recommendations for Sections to the Medical Executive Committee, which shall have the authority to approve such recommendations, subject to the ultimate approval of the Governing Body. The Medical Executive

Committee may recommend to the Medical Staff the creation, elimination, modification or combination of Departments.

10.2 Clinical Departments.

The clinical departments are: Anesthesia, Family Practice, Medicine, Ob/Gyn and Pediatrics, Psychiatry, Surgery, and Ancillary Services (Emergency Medicine, Pathology and Radiology).

10.3 Assignment to Departments.

Each Member shall be assigned membership in at least one Department, and to a Section, if any, within such Department, but may also be granted membership and/or Clinical Privileges in other Departments or Sections consistent with practice Privileges granted.

10.4 Sections.

Within each Department, the Members of the various specialty groups may organize themselves as a Section, subject to a two-thirds (2/3) vote of approval of the votes cast of both the Department and the Medical Executive Committee. Responsibility and accountability of departmental functions shall remain at the Department level.

10.5 Functions of Departments.

The general functions of each Department shall include:

- (a) Conducting patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the Department. The number of such reviews to be conducted during the year shall be as determined by the Medical Executive Committee in consultation with other appropriate committees. The Department shall routinely collect information about important aspects of patient care provided in the Department, periodically assess this information, and develop objective criteria for use in evaluating patient care. Patient care reviews shall include all clinical work performed under the jurisdiction of the Department, regardless of whether the Member whose work is subject to such review is a member of that Department;
- (b) Recommending to the Medical Executive Committee guidelines for the granting of Clinical Privileges and the performance of specified services within the Department;
- (c) Evaluating and making appropriate recommendations regarding the qualifications of applicants seeking appointment or reappointment and Clinical Privileges within that Department;
- (d) Conducting, participating and making recommendations regarding continuing education programs pertinent to departmental clinical practice;
- (e) Reviewing and evaluating departmental adherence to: (1) Medical Staff policies and procedures and (2) sound principles of clinical practice;
- (f) Coordinating patient care provided by the Department's Members with nursing and ancillary patient care services;
- (g) Submitting written reports to the Medical Executive Committee concerning: (1) the Department's review and evaluation activities, actions taken thereon, and the results of such action; and (2) recommendations for maintaining and improving the quality of care provided in the Department and the Hospital;
- (h) Meeting at least quarterly for the purpose of considering patient care review findings and the results of the Department's other review and

evaluation activities, as well as reports on other Department and staff functions or otherwise create a mechanism (acceptable to the Medical Executive Committee) for the performance of the functions and dissemination of the information;

- (i) Establishing such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring protocols;
- (j) Taking appropriate action when important problems in patient care and clinical performance or opportunities to improve care are identified;
- (k) Accounting to the Medical Executive Committee for all professional and Medical Staff administrative activities within the Department;
- (l) Appointing such committees as may be necessary or appropriate to conduct Department functions;
- (m) Formulating recommendations for departmental rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to the approval by the Medical Executive Committee; and
- n) Assessing and recommending to the relevant Hospital authority off-site sources for needed patient care services not provided by the Department or the organization.

10.6 Department Executive Committee.

The Department may decide to create an Executive Committee of the Department. The Executive Committee of the Department shall be comprised of the officers of the Department and specialty representatives at the discretion of the Department chair. The Executive Committee shall function on behalf of the Department in the interval between Department meetings, including, but not limited to, performing peer review and quality management activities and conducting whatever business the Department chair determines to be necessary to the efficient operation of the Department.

10.7 Functions of Sections.

Subject to approval of the Medical Executive Committee, each Section shall perform the functions assigned to it by the Department chair. Such functions may include, without limitation, retrospective patient care reviews, evaluation of patient care practices, credentials review and Privileges delineation, and continuing education programs. The Section shall transmit regular reports to the Department chair on the conduct of its assigned functions.

10.8 Department Chairs.

10.8-1 Qualifications.

Each Department shall have a chair and vice-chair who shall be Members of the Active Medical Staff and shall be either board certified by an appropriate specialty board or affirmatively establish comparable competence through the credentialing process. If the Department chair and/or vice chair is not board certified, he or she must establish comparable competence through documented training, experience and demonstrated

ability in at least one of the clinical areas covered by the Department, as determined by the Medical Executive Committee.

10.8-2 Selection.

Department chairs and vice-chairs shall be elected every two (2) years by those Active Staff Members of the Department who are eligible to vote for general officers of the Medical Staff. For the purpose of this election, each Department chair shall appoint a nominating committee of three (3) members at least sixty (60) days prior to the date set for return of the completed ballots by the voting Members. The Medical Executive Committee shall approve the Department nominee(s) for the chair and vice-chair prior to the names being circulated to the voting Members of each Department. The names of nominees shall be circulated to the voting Members at least twenty (20) days prior to the date set for return of the completed ballots by the voting Members. All voting shall be by mailed ballot, in the same manner as voting for general officers of the Medical Staff. Election of Department chairs and vice-chairs shall be subject to ratification by a majority vote of the Medical Executive Committee. If for any reason the chair does not complete his or her term, the vice-chair shall automatically assume the office of the chair. Vacancies in the vice-chair position shall be filled for the unexpired term through special election by the respective Department with such mechanisms as that Department may adopt.

10.8-3 Term of Office.

Each Department chair and vice-chair shall serve a two (2) year term which coincides with the Medical Staff year, unless they shall sooner resign, be removed from office, or lose their Medical Staff membership or Clinical Privileges in that Department. Department officers shall be eligible to succeed themselves.

10.8-4 Meeting Attendance by Chair and Vice-Chair.

The Department chairs and vice-chairs must each attend at least one-half (1/2) of the Department meetings. Failure to satisfy this attendance requirement shall constitute grounds for removal from office in accordance with the provisions governing removal.

10.8-5 Removal.

After election and ratification, removal of Department chairs and vice-chairs from office may occur for cause including, but not limited to, neglect or malfeasance in office or acts of moral turpitude or failure to attend meetings, by a two-thirds (2/3) vote of the Medical Executive Committee or a two-thirds (2/3) vote of the Department Members eligible to vote on departmental matters who cast votes.

10.8-6 Duties.

Each chair shall have the following authority, duties and responsibilities, and the vice-chair, in the absence of the chair, shall assume all of them and shall otherwise perform such duties as may be assigned. In the absence of the chair and vice-chair, a representative may be appointed by the chair or the Medical Executive Committee to act on their behalf.

- (a) Establishing, together with the Medical Staff and Hospital Administration, the type and scope of services required to meet the needs of the patients and the Hospital, including recommendations for space, a sufficient

number of qualified and competent persons to provide care, treatment and services, and other resources needed by the Department as well as assessing and recommending to the Hospital off-site sources for needed patient care, treatment and services not provided by the Department or the Hospital;

- (b) Act as presiding officer at Departmental meetings;
- (c) Report to the Medical Executive Committee and to the Chief of Staff regarding all professional and administrative activities within the Department;
- (d) Continually monitor, assess and make recommendations regarding improving the quality of patient care and professional performance rendered by Members with Clinical Privileges in the Department through a planned and systematic process; oversee the effective conduct of the patient care, evaluation, and monitoring functions delegated to the Department by the Medical Executive Committee; and take informal remedial or corrective action, such as Practitioner counseling or issuing letters of warning to Department Members;
- (e) Develop and implement Departmental policies and procedures that guide and support the provision of services in the Department, including policies and procedures for retrospective patient care review, on-going monitoring of practice, credentials review and Privilege delineation, medical education, utilization management, and performance improvement;
- (f) Determine the qualifications and competence of Department or service personnel who are not licensed independent practitioners and who provide patient care, treatment and services;
- (g) Participate in the orientation and continuing education of all persons in the Department;
- (h) Maintenance of quality control programs within the Department, as appropriate;
- (i) Be a member of the Medical Executive Committee, and give guidance on the overall medical policies of the Medical Staff and Hospital and make specific recommendations and suggestions regarding the Department, including reporting on all professional and administrative activities within the Department;
- (j) Transmit to the Medical Executive Committee the Department's recommendations concerning Practitioner appointment, Clinical Privileges and classification, reappointment, criteria for Clinical Privileges, monitoring of specified services, and corrective action with respect to persons with Clinical Privileges in the Department;
- (k) Endeavor to enforce the Medical Staff Bylaws, rules, policies and regulations within the Department;
- (l) Implement within the Department appropriate actions taken by the Medical Executive Committee;

- (m) Participate in every phase of administration of the Department, including cooperation with the nursing service and the Hospital administration in matters such as personnel (including assisting in determining the qualifications and competence and numbers of Department personnel who are not licensed independent practitioners and who provide patient care, treatment and services), supplies, special regulations, standing orders and techniques;
- (n) Coordination and integration of interdepartmental and intradepartmental services and integration of the Department or service into the primary functions of the Hospital;
- (o) Assist in the preparation of such annual reports, including budgetary planning, pertaining to the Department as may be required by the Medical Executive Committee;
- (p) Oversee clinically and administratively related activities of the Department, report to the Medical Executive Committee and the Chief of Staff regarding all professional and administrative activities of the Department;
- (p) Recommend delineated Clinical Privileges for each Member of the Department; and
- (q) Perform such other duties commensurate with the office as may from time to time be reasonably requested by the Chief of Staff or the Medical Executive Committee.

10.9 Section Chiefs.

10.9-1 Qualifications.

Each Section shall have a chief who shall be a Member of the Active Medical Staff and a Member of the Section, and shall be qualified by training, experience, and demonstrated current ability in the clinical area covered by the Section.

10.9-2 Selection.

Each Section chief shall be elected by the Section. Vacancies due to any reason shall be filled for the unexpired term by the Department chair's appointment of a Member of the Section to fill the vacancy. Selection of Section chiefs shall be subject to the majority approval of the Medical Executive Committee.

10.9-3 Term of Office.

Each Section chief shall serve a two (2) year term which coincides with the Medical Staff year or until a successor is chosen, unless the Section chief shall sooner resign or be removed from office or lose Medical Staff membership or Clinical Privileges in that Section. Section chiefs shall be eligible to succeed themselves.

10.9-4 Removal.

A Section chief may be removed in either of the following ways:

- (a) For cause, including, but not limited to, neglect or malfeasance in office or acts of moral turpitude, by the Department chair, subject to ratification by a two-thirds (2/3) vote of the members of the Department who are eligible to vote; or
- (b) For cause, including, but not limited to, neglect or malfeasance in office or acts of moral turpitude, by the Medical Executive Committee by a two-thirds (2/3) vote of the members of the Medical Executive Committee who are eligible to vote.

10.9-5 Duties.

Each Section chief shall:

- (a) Act as presiding officer at Section meetings;
- (b) Assist in the development and implementation, in cooperation with the Department chair, of programs to carry out the quality review, and evaluation and monitoring functions assigned to the Section;
- (c) Evaluate the clinical work performed in the Section;
- (d) Conduct investigations and submit reports and recommendations to the Department chair regarding the Clinical Privileges to be exercised within the Section by Members of or applicants to the Medical Staff;
- (e) Attend Department Executive Committee meetings; and
- (f) Perform such other duties commensurate with the office as may from time to time be reasonably requested by the Department chair, the Chief of Staff, or the Medical Executive Committee.

ARTICLE XI

COMMITTEES

11.1 Designation and Appointment.

Medical Staff committees shall include but not be limited to, the Medical Staff meeting as a committee of the whole, meetings of Departments and Sections, meetings of committees established under this Article, and meetings of special or ad hoc committees created by the Medical Executive Committee (pursuant to this Article) or by Departments (pursuant to Sections 10.5 (i) and (l)). The committees described in this Article shall be the standing committees of the Medical Staff. Special or ad hoc committees may be created by the Medical Executive Committee to perform specified tasks. Any committee, whether Medical Staff-wide or Department or other clinical unit, or standing or ad hoc, that is carrying out all or any portion of a function or activity required by these Bylaws, is deemed a duly appointed and authorized committee of the Medical Staff. Unless otherwise specified, the chair and members of all committees shall be appointed by and may be removed by the Chief of Staff, subject to consultation with and approval by a majority vote of the Medical Executive Committee. Medical Staff committees shall be responsible to the Medical Executive Committee. Each Medical Staff Member who

serves on a committee participates with vote unless the statement of committee composition designates the person as non-voting.

11.2 General Provisions.

11.2-1 Terms of Committee Members.

Unless otherwise specified, committee members shall be appointed for a term of two (2) years, and shall serve until the end of this period or until the member's successor is appointed, unless the member shall sooner resign or be removed from the committee.

11.2-2 Removal.

Any committee member who is appointed by the Chief of Staff may be removed in either of the following ways:

- (a) By the Chief of Staff, subject to a majority vote of approval by the members of the Medical Executive Committee who are eligible to vote; or
- (b) By a majority vote of the members of the Medical Executive Committee who are eligible to vote.

Any committee member who is appointed by the Department chair may be removed in either of the following ways:

- (a) By the Department chair, subject to a majority vote of approval of the members present of the Department committee; or
- (b) By a majority vote of the Medical Executive Committee.

11.2-3 Vacancies.

Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made; provided however, that if an individual who obtains membership by virtue of these Bylaws is removed for cause, a successor may be selected by the Medical Executive Committee.

11.2-4 Ex Officio Members.

The Chief of Staff and the Chief Executive Officer, or their respective designees, are ex officio members of all standing and special committees of the Medical Staff and shall serve without vote unless provided otherwise in the provision or resolution creating the committee. The Chief Executive Officer, or his or her designee, attends each Medical Executive Committee meeting.

11.2-5 Action Through Subcommittees.

Any standing committee may use subcommittees to help carry out its duties. The Medical Executive Committee shall be informed when a subcommittee is appointed. The committee chair may appoint individuals in addition to, or other than, members of the standing committee, to the subcommittee after consulting with the Chief of Staff regarding Medical Staff Members, and the Chief Executive Officer regarding Hospital administrative staff.

11.3 Medical Executive Committee.

11.3-1 Composition.

The Medical Executive Committee shall consist of the persons (a majority of whom shall be physicians actively practicing in the Hospital) listed below. All Members of the organized Medical Staff, or any discipline or specialty, are eligible for membership on the Medical Executive Committee.

- (a) The officers of the Medical Staff, including the Immediate Past Chief of Staff;
- (b) The Department chairs;
- (c) Non-voting, ex-officio members appointed at the discretion of the Medical Executive Committee;
- (d) Two (2) at-large physician Members of the Active Medical Staff who shall be nominated and elected for a two-year (2) term in the same manner and at the same time as provided in Sections 9.1-3 through 9.1-4 for the nomination and election of officers;
- (e) The Residency Program Director, ex-officio with vote;
- (f) The Credentials Committee Chair; and
- (g) Other members as may be required to comply with the state licensing regulations and/or Joint Commission (or equivalent) accreditation standards or the standards of comparable accreditation agencies. The majority of voting members of the Medical Executive Committee must be licensed physicians actively practicing in the Hospital.

11.3-2 Duties.

The duties of the Medical Executive Committee shall include, but not be limited to:

- (a) Representing and acting on behalf of the Medical Staff in the intervals between Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws;
- (b) Coordinating and implementing the professional and organizational activities and policies of the Medical Staff;
- (c) Receiving and acting upon reports and recommendations from Medical Staff Departments, Sections, committees, and assigned activity groups;
- (d) Recommending actions to the Governing Body on matters of a medical-administrative nature;
- (e) Adopting and recommending to the Governing Body policies regarding the structure of the Medical Staff, the mechanisms to review credentials and delineate individual Clinical Privileges, the granting of individual staff memberships and Privileges, the organization of the Medical Staff's performance improvement activities including mechanisms to conduct,

evaluate and revise such activities; termination of Medical Staff membership; fair hearing procedures; needed changes to Medical Staff Bylaws; and other matters relevant to the operation of an organized Medical Staff;

- (f) Evaluating the medical care rendered to patients in the Hospital;
- (g) Participating in the development of all Medical Staff and Hospital policy, practice, and planning;
- (h) Reviewing the qualifications, credentials, performance and professional competence, and character of applicants and Medical Staff Members, requiring evaluations of Practitioners and Allied Health Professionals privileged through the Medical Staff process in instances where there is doubt about the person's ability to perform the Privileges requested and making recommendations to the Governing Body at least quarterly regarding Medical Staff appointments and reappointments, assignments to Departments, Clinical Privileges, and corrective action;
- (i) Taking reasonable steps to promote ethical conduct and competent clinical performance on the part of all Members, initiating and participating in Medical Staff corrective or review measures when warranted, including, but not limited to, taking informal corrective action such as counseling a Practitioner or issuing letters of warning or reprimand to a Practitioner;
- (j) Taking reasonable steps to develop continuing education activities and programs for the Medical Staff;
- (k) Designating such committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the Medical Staff and approving or rejecting appointments to those committees by the Chief of Staff;
- (l) Reporting to the Medical Staff at each regular staff meeting;
- (m) Assisting in the obtaining and maintenance of accreditation;
- (n) Developing and maintaining of methods for the protection and care of patients and others in the event of internal or external disaster;
- (o) Appointing such special or ad hoc committees as may seem necessary or appropriate to assist the Medical Executive Committee in carrying out its functions and those of the Medical Staff;
- (p) Reviewing the quality, safety and appropriateness of clinical services provided by contract physicians or through contractual arrangements or other agreement;
- (q) Reviewing and approving the designation of the Hospital's authorized representative for National Practitioner Data Bank purposes;
- (r) Establishing a mechanism for dispute resolution between Medical Staff Members (including limited license practitioners) involving the care of a patient;

- (s) Issuing such directives as appropriate to assure effective performance of all Medical Staff functions and following up to assure implementation of all directives;
- (t) With the assistance of the Chief of Staff, supervise the Medical Staff's compliance with the Medical Staff Bylaws, Rules and Regulations and policies; the Hospital's Bylaws, Rules and policies; state and federal laws and regulations and Joint Commission (or equivalent) accreditation requirements;
- (u) Reviewing and evaluating of Sutter Medical Center Santa Rosa's patient satisfaction data; and
- (v) Providing patient safety leadership.

11.3-3 Meetings.

The Medical Executive Committee shall meet as often as necessary, but at least ten (10) times per year and shall maintain a record of its proceedings and actions. The Chief Executive Officer shall be invited to attend all meetings in a non-voting capacity.

11.4 Credentials Committee.

11.4-1 Composition.

The Credentials Committee shall consist of not less than three (3) Members of the Active Staff selected on the basis that will ensure, insofar as feasible, representation of major clinical specialties and each of the Staff Departments.

11.4-2 Duties.

The Credentials Committee shall:

- (a) Review and evaluate the qualifications of each Practitioner applying for initial appointment, reappointment, or modification of Clinical Privileges, and, in connection therewith, obtain and consider the recommendations of the appropriate Departments;
- (b) Submit required reports and information on the qualifications of each Practitioner applying for membership or particular Clinical Privileges including recommendations with respect to appointment, membership category, Department affiliation, Clinical Privileges, and special conditions;
- (c) Investigate, review and report on matters referred by the Chief of Staff or the Medical Executive Committee regarding the qualifications, conduct, professional character or competence of any applicant or Medical Staff Member; and
- (d) Submit periodic reports to the Medical Executive Committee on its activities and the status of pending applications.

11.4-3 Meetings.

The Credentials Committee shall meet as often as necessary at the call of its chair, but no less than quarterly. The committee shall maintain a record of its proceedings and actions and shall report to the Medical Executive Committee.

11.5 Infection Control Committee

11.5-1 Composition.

The Infection Control Committee shall consist of two (2) representative from the Medical Staff, one voting member infection control practitioner, the Chief of Staff or his/her designee, one voting member who will be the Chief Nursing Officer or his/her representative or the Chief Executive Officer or his/her representative.

11.5-2 Duties.

The duties of the Infection Control Committee shall include:

- (a) Developing a hospital-wide infection control program and maintaining surveillance over the programs;
- (b) Developing a system for reporting, identifying and analyzing the incidence and cause of nosocomial infections, including assignment of responsibility for the ongoing collection and analytic review of such data, and follow-up activities;
- (c) Developing and implementing a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing and evaluating aseptic, isolation and sanitation techniques;
- (d) Developing written policies defining special indications for isolation requirements;
- (e) Coordinating action on findings from the Medical Staff's review of the clinical use of antibiotics;
- (f) Acting upon recommendations related to infection control received from the Chief of Staff, the Medical Executive Committee, Departments and other committees;
- (g) Reviewing sensitivities of organisms specific to the facility; and
- (h) Providing guidance and recommendations related to any construction as it relates to Infection Control.

11.5-3 Meetings.

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

11.6 Pharmacy and Therapeutics Committee

11.6-1 Composition.

The Pharmacy and Therapeutics Committee shall consist of at least two (2) representative from the Medical Staff, one voting pharmacist, the Chief of Staff or his/her representative, one voting member who is the Chief Nursing Officer or his/her representative, or the Chief Executive Officer or his/her representative.

11.6-2 Duties.

The duties of the Pharmacy and Therapeutics Committee shall include:

- (a) Serve in an advisory capacity to the Medical Staff and Hospital Administration in all matters pertaining to the use of drugs;
- (b) Assisting in the formulation of professional practices and policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs in the Hospital, including antibiotic usage;
- (c) Advising the Medical Staff and the pharmaceutical service on matters pertaining to the choice of available drugs based on criteria including indication for use, effectiveness, risks and cost;
- (d) Develop recommendations, policies or procedures to address medication shortages;
- (e) Making recommendations concerning drugs to be stocked on the nursing unit floors and by other services;
- (f) Periodically developing and reviewing a formulary or drug list for use in the Hospital;
- (g) Evaluating clinical data concerning new drugs or preparations requested for use in the Hospital;
- (h) Establishing standards concerning the safe use of drugs in the Hospital, including the use of investigational drugs, hazardous drugs and incompatibilities and of research in the use of recognized drugs;
- (i) Maintaining a record of all activities relating to pharmacy and therapeutics functions and submitting periodic reports and recommendations to the Medical Executive Committee concerning those activities;
- (j) Evaluating the nutritional services of the hospitals and making recommendations as may seem appropriate;
- (k) Reviewing untoward drug reactions;
- (l) Recommend quality measures regarding medication management;
- (m) Review and analyze data on medication safety including reports of adverse drug reactions, medication errors, and sentinel events to identify

- (n) Review recommendations resulting from root cause analyses and failure mode effects analyses and make recommendations for actions to improve medication safety; and
- (o) Review and evaluate literature on technology and practices that have been demonstrated to improve medication safety to identify opportunities for improvement;

11.6-3 Meetings.

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

11.7 Bylaws Committee.

11.7-1 Composition.

The Bylaws Committee shall consist of at least three (3) Members of the Medical Staff, including at least the Chief of Staff-Elect and Immediate Past Chief of Staff as ex-officio members (with vote).

11.7-2 Duties.

The duties of the Bylaws Committee shall include:

- (a) Conducting a review at least annually, and more frequently as necessary, of the Medical Staff Bylaws, as well as the Rules and Regulations and forms promulgated by the Medical Staff and its Departments and Sections;
- (b) Submitting recommendations to the Medical Executive Committee for changes in these documents as necessary to reflect current Medical Staff practices;
- (c) Receiving and evaluating for recommendation to the Medical Executive Committee suggestions for modification of the items specified in subdivision (a).

11.7-3 Meetings.

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

11.8 Medical Staff Well-Being Committee.

11.8-1 Composition.

The Medical Staff Well-Being Committee shall be comprised of no fewer than five (5) members of the Medical Staff, a majority of whom, including the chair, shall be physicians. Except for initial appointments, each member shall serve a term of two (2) years, and the terms shall be staggered as deemed appropriate by the Medical Executive Committee to achieve continuity. Members of this committee shall not serve as active participants on other peer review or performance improvement committees while serving on this committee.

11.8-2 Duties.

The Medical Staff Well-Being Committee shall design and implement a process for identifying and managing matters of individual physician health that is separate from the Medical Staff disciplinary function. The focus of the Medical Staff Well-Being Committee shall be to assist and rehabilitate and to aid a physician in retaining or regaining optimal professional functioning, consistent with protection of patients and the provision of quality patient care. Accordingly, the Medical Staff Well-Being Committee shall perform the following functions:

- (a) Educate the Medical Staff and other Hospital staff about physician (and other Member) health, including prevention of physical, psychiatric, or emotional illness;
- (b) Educate the Medical Staff and other Hospital staff about illness and impairment recognition issue specific to physicians and other Medical Staff Members;
- (c) Educate the Medical Staff at large about options for Member self-referral and/or referral of a Member by other Hospital staff and others as deemed appropriate by the Medical Staff Well-Being Committee;
- (d) Refer the affected Member to the appropriate professional internal or external resources for confidential diagnosis, treatment and rehabilitation of the condition or concern;
- (e) Maintain the confidentiality of the Member seeking referral or referred for assistance, except as limited by law, ethical obligation, or when it is determined that the Member is unable to safely perform the Privileges he or she has been granted such that the safety of patients is threatened;
- (f) Evaluate the credibility of a complaint, allegation, or concern;
- (g) In conjunction with existing Medical Staff mechanisms, monitor the affected Member and the safety of patients until the rehabilitation or any disciplinary process is complete;
- (h) Report to the Chief of Staff, another Medical Staff Officer or the Medical Executive Committee, instances in which a physician is providing unsafe treatment or it is determined that the Member is unable to safely perform the Privileges he or she has been granted such that the safety of patients is threatened; and
- (i) Advise the Medical Executive Committee when a Member of the Medical Staff fails to complete the required rehabilitation program.

11.8-3 Meetings.

The committee shall meet as often as necessary. It shall maintain only such record of its proceedings as it deems advisable, but shall report on its activities on a routine basis, but at least quarterly, to the Medical Executive Committee.

11.9 Interdisciplinary Practice Committee.

11.9-1 Composition.

The Interdisciplinary Practice Committee (IDPC) shall consist of, at a minimum, the Chief Nursing Officer, the Chief Executive Officer or designee, and an equal number of physicians appointed by the Medical Executive Committee and registered nurses appointed by the Chief Nursing Officer. Licensed or certified health professionals other than registered nurses who perform functions requiring standardized procedures shall be included in the committee. The chair of the committee shall be a physician Member of the Active Medical Staff appointed by the Medical Executive Committee. Those committee members required by the licensing regulations shall be voting members.

11.9-2 Duties.

- (a) The IDPC shall oversee the establishment and administration of standardized procedures for registered nurses at the Hospital. Specifically, the IDPC shall:
 - (1) Establish written policies and procedures setting forth the required form of each standardized procedure, including the subjects to be covered;
 - (2) Identify nursing functions which require the adoption of standardized procedures;
 - (3) Review and approve (as to both form and content) all proposed standardized procedures covering registered nurses at the Hospital, with approval to be given by the Chief Executive Officer (or designee), a majority of physician members of the IDPC, and a majority of registered nurse members of the IDPC, after consultation with appropriate persons in the medical and nursing specialties under review;
 - (4) Recommend to the Medical Executive Committee written policies and procedures for the designation of registered nurses who are authorized to perform functions under each standardized procedure;
 - (5) Assume responsibility for identifying and designating registered nurses who are qualified to practice according to standardized procedures, both on an initial and on a continuing basis, or delegate such responsibility to the Chief Nursing Officer; and
 - (6) Insure that the names of registered nurses approved to perform functions according to each standardized procedure are on file in the office of the Chief Nursing Officer or at some other designated place.

- (b) The IDPC shall oversee the practice of Allied Health Professionals at the Hospital. Specifically, the Committee shall:
 - (1) Make recommendations to the Medical Executive Committee concerning any protocols that should be developed to govern the practice of Allied Health Professional at the Hospital and supervise the development of such protocols;
 - (2) Review applications for granting and renewal of clinical privileges, in accordance with governing protocols;
 - (3) Ensure that physician assistants and advanced practice registered nurses and other Allied Health Professionals who practice within the Hospital are credentialed and privileges, both initially and at reappointment, through either the Medical Staff credentialing and privileging process, or an equivalent process that has been approved by the Medical Executive Committee and the Governing Body. At a minimum, an “equivalent process” includes peer review and involves communication with, and input from individuals and committees (including the Medical Executive Committee) in order to make an informed decision regarding the individual’s request for Privileges;
 - (3) Initiate corrective action against Allied Health Professionals at the Hospital, in accordance with governing protocols;
 - (4) Monitor the role of Allied Health Professional categories permitted to practice at the Hospital and make recommendations to the Medical Executive Committee concerning that role; and
 - (5) Serve as liaison between the Allied Health Professionals at the Hospital and the Medical Staff.
- (c) The IDPC shall assist in defining the responsibilities of physicians and of registered nurses in the areas of ambiguity and overlap;
- (d) The IDPC shall serve as a liaison between the registered nurses at the Hospital and the Medical Staff;
- (e) The IDPC shall establish a means of securing recommendations from health care professionals and personnel at the Hospital who practice in the clinical field or specialty under review concerning matters within the Committee’s jurisdiction;
- (f) The IDPC shall establish policies and procedures governing the discharge of the above responsibilities and setting forth the procedure for the approval of any committee recommendation;
- (g) The IDPC may appoint a subcommittee, comprised of a majority of physicians, to make recommendations concerning other matters involving Allied Health Professionals. This subcommittee may make recommendations regarding the following:

- (1) Evaluating and making recommendations regarding the need for and appropriateness of the performance of in-hospital services by Allied Health Professionals;
- (2) Evaluating and making recommendations regarding:
 - (i) The mechanism for evaluating the qualifications and credentials of Allied Health Professionals who are eligible to apply for and provide in-hospital services;
 - (ii) The minimum standards of training, education, character, competence and overall fitness of Allied Health Professionals eligible to apply for the opportunity to apply for in-hospital services;
 - (iii) Identification of in-hospital services which may be performed by an Allied Health Professional or category of Allied Health Professionals as well as any applicable terms and conditions thereon; and
 - (iv) The professional responsibilities of Allied Health Professionals who have been determined eligible to perform in-hospital services.
- (3) Making recommendations regarding appropriate monitoring, supervision, and evaluation of Allied Health Professionals who may be eligible to perform in-hospital services;
- (4) Evaluating and reporting whether in-hospital services proposed to be performed or actually performed by Allied Health Professionals are inconsistent with the rendering of quality medical care and with responsibilities of Members of the Medical Staff;
- (5) Evaluating and reporting on the effectiveness of supervision requirements imposed upon Allied Health Professionals who are rendering in-hospital services;
- (6) Periodically evaluating and reporting on the efficiency and effectiveness of in-hospital services performed by Allied Health Professionals; and
- (7) Coordinating insofar as necessary with the IDPC.

11.9-3 Meetings.

The IDPC shall meet at the call of the chair at such intervals as the chair or the Medical Executive Committee may deem appropriate. It shall maintain a record of its activities and report to the Medical Executive Committee and the Governing Body.

11.10 Continuing Medical Education Committee.

11.10-1 Composition.

The Continuing Medical Education Committee shall consist of at least three (3) Medical Staff Members, the Director of Education, Coordinator of Education and a Medical Staff Services Department representative.

11.10-2 Duties.

The Continuing Medical Education/Library Committee shall perform the following duties:

- (a) Plan, implement, coordinate and promote ongoing special clinical and scientific programs for the Medical Staff. This includes:
 - (1) Identifying the educational needs of the Medical Staff;
 - (2) Formulating clear statements of objectives for each program;
 - (3) Assessing the effectiveness of each program;
 - (4) Choosing appropriate teaching methods and knowledgeable faculty for each program; and
 - (5) Documenting Medical Staff attendance at each program.
- (b) Assist in developing processes to assure optimal patient care and contribute to the continuing education of each Practitioner;
- (c) Establish liaison with the performance improvement program in order to be apprised of problem areas in patient care, which may be addressed by a specific continuing medical education activity;
- (d) Maintain close liaison with other Hospital Medical Staff and Department committees concerned with patient care;
- (e) Make recommendations to the Medical Executive Committee regarding library needs of the Medical Staff; and
- (f) Advise administration of the financial needs of the continuing medical education program.

11.10-3 Meetings.

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

11.11 Graduate Medical Education Committee.

11.11-1 Composition.

The Graduate Medical Education Committee shall consist of the Family Medicine Residency Program Director, residency coordinators, chief residents and other representatives appointed by the Medical Executive Committee as needed to fulfill the functions of the committee.

11.11-2 Duties.

The duties of the Graduate Medical Education Committee shall be to:

- (a) Advise the Director of the Family Medicine Residency Program in the selection of resident physicians and in the supervision and direction of the residency program;
- (b) Assist the Director of the Family Medicine Residency Program in matters of government and discipline of the resident staff, including investigating complaints against residents and advising on disciplinary matters when requested to perform such functions by the director of the Family Medicine Residency Program;
- (c) Coordinate post-graduate education in cooperation with the director of the Family Medicine Residency Program;
- (d) Facilitate interaction between the Residents and the medical students on one hand and the Medical Staff, Hospital personnel and patients on the other with the ultimate goal of improving or enhancing the quality of patient care at the Hospital;
- (e) Review and implementation of the Accreditation Council for Graduate Medical Education guidelines on graduate medical education;
- (f) Communicate at least annually with preceptors regarding the performance of Residents and others in the graduate medical education program; and
- (g) Approve policies and procedures and guidelines addressing the role of Residents and medical students at the Hospital and outline their appropriate activities at the Hospital.

11.11-3 Meetings.

The committee shall meet as often as necessary at the call of the chair, but at least quarterly. It shall submit reports of its activities and recommendations to the Medical Executive Committee.

11.12 Bioethics Committee

11.12-1 Composition.

The Bioethics Committee shall consist of Physicians and such other Hospital staff members as the Medical Executive Committee may deem appropriate. It may include nurses, lay representatives, social workers, clergy, ethicists, attorneys, administrators and representatives from the Governing Body. Hospital members shall be ex-officio (with vote).

11.12-2 Duties.

The Bioethics Committee may participate in development of guidelines for consideration of cases having bioethical implications; development and implementation of procedures for the review of such cases; development and/or review of institutional policies regarding care and treatment of such cases; retrospective review of cases for the evaluation of bioethical policies; consultation with concerned parties to facilitate communication and aid conflict resolution; and education of the Hospital Staff on bioethical matters.

11.12-3 Meetings.

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

11.13 Joint Conference Committee

11.13-1 Composition.

The Joint Conference Committee shall be comprised of an equal number of members of the Governing Body and of the Medical Executive Committee, but the Medical Staff Members shall at least include the Chief of Staff, The Chief of Staff Elect, and the immediate Past Chief of Staff. The Hospital Chief Executive Officer shall be a non-voting ex officio member. The chairship of the committee shall alternate yearly between the Governing Body (even years) and the Medical Staff (odd years).

11.13-2 Duties.

The Joint Conference Committee shall constitute a forum for the discussion of matters of the Hospital and Medical Staff policy, practice and planning, and a forum for interaction between the Governing Body and the Medical Staff on such matters as may be referred by the Medical Executive Committee or the Governing Body. The Joint Conference Committee shall exercise other responsibilities set forth in these Bylaws.

11.13-3 Meetings.

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

ARTICLE XII

MEETINGS

12.1 Meetings.

12.1-1 Annual Meeting.

There shall be an annual meeting of the Medical Staff. The Chief of Staff, or such other officers, Department or Section heads, or committee chairs, the Chief of Staff or Medical Executive Committee may designate, shall present reports on actions taken during the preceding year and on other matters of interest and importance to the Members. Notice of this meeting shall be given to the members at least thirty (30) days prior to the meeting.

12.1-2 Agenda.

The order of business at a meeting of the Medical Staff shall be determined by the Chief of Staff and Medical Executive Committee. The agenda shall include, insofar as feasible:

- (a) Reading and acceptance of the minutes of the last regular and all special meetings held since the last regular meeting;
- (b) Administrative reports from the Chief of Staff, Departments, and committees, and the Chief Executive Officer;
- (c) Reports by responsible officers, committees and Departments on the overall results of patient care audits and other quality review, evaluation, and monitoring activities of the staff and on the fulfillment of other required staff functions;
- (d) Old business; and
- (e) New business.

12.1-3 Special Meetings.

Special meetings of the Medical Staff may be called at any time by the Chief of Staff or the Medical Executive Committee, or shall be called upon the written request of ten percent (10%) of the Members of the Active Medical Staff. The person calling or requesting the special meeting shall state the purpose of such meeting in writing. The meeting shall be scheduled by the Medical Executive Committee within thirty (30) days after receipt of such request. No later than ten (10) days prior to the meeting, notice shall be mailed or delivered to the Members of the Medical Staff which includes the stated purpose of the meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

12.2 Committee and Department Meetings.

12.2-1 Regular Meetings.

Except as otherwise specified in these Bylaws, the chairs of committees, Departments and Sections may establish the times for the holding of regular meetings. The chairs shall make every reasonable effort to ensure the meeting dates are disseminated to the Members with adequate notice.

12.2-2 Special Meetings.

A special meeting of any Medical Staff committee, Department or Section may be called by the chair thereof, the Medical Executive Committee, or the Chief of Staff, and shall be called by written request of one-third (1/3) of the current Members, eligible to vote, but not less than three (3) Members.

12.3 Quorum.

12.3-1 General Staff Meetings.

The presence of twenty-five percent (25%) of the total Members of the Active Medical Staff at any regular or special meeting in person or through written ballot shall constitute a quorum for all actions to be taken.

12.3-2 Department and Committee Meetings.

A quorum of fifty percent (50%) of the voting members shall be required for Medical Executive and Credentials Committee meetings. For other committees, a quorum shall consist of twenty-five percent (25%) of the voting members of a committee but in no event less than three (3) voting members. For Department and Section meetings, action can be taken by a majority of those persons present and eligible to vote but not less than three (3).

12.4 Voting and Manner of Action.

12.4-1 Voting.

Unless otherwise specified in these Bylaws, only Active Members of the Medical Staff may vote in Medical Staff Departmental or Staff elections, and at Department and Medical Staff meetings and all duly appointed Members of Medical Staff committees are entitled to vote on committee matters, except as may otherwise be specified in these Bylaws.

12.4-2 Manner of Action.

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be specifically required by these Bylaws. Committee action may be conducted by telephone conference which shall be deemed to constitute a meeting for the matters discussed in that telephone conference. Valid action may be taken without a meeting by a committee if it is acknowledged by a writing setting forth the action so taken which is signed by at least two-thirds (2/3) of the members entitled to vote.

12.5 Minutes.

Except as otherwise specified herein, minutes of meetings shall be prepared and retained. They shall include, at a minimum, a record of the attendance of members and the vote taken on significant matters. A copy of the minutes shall be forwarded to the Medical Executive Committee.

12.6 Attendance Requirements.

12.6-1 Special Attendance.

At the discretion of the chair or presiding officer, when a Member's practice or conduct is scheduled for discussion at a regular Department, Section, or committee meeting, the

Member may be requested to attend, or may be requested to submit a written response. If a suspected deviation from standard clinical practice is involved, the notice shall be given at least seven (7) days prior to the meeting and shall include the time and place of the meeting and a general indication of the issue involved. If the Member is requested to file a written response, the deadline for submission of the written response shall be stated. Failure of a Member to appear at any meeting to which notice was given, unless excused by the Medical Executive Committee upon a showing of good cause, or failure to submit a timely written response, shall result in an automatic suspension in accordance with Section 6.3-4.

12.7 Conduct of Meetings.

Unless otherwise specified, meetings shall be conducted according to Robert's Rules of Order; however, technical or non-substantive departures from such rules shall not invalidate action taken at such a meeting.

12.8 Executive Session.

Executive session is a meeting of a Medical Staff committee which only voting Medical Staff committee members may attend, unless others are expressly requested by the committee to attend. Executive session may be called by the presiding officer at the request of any Medical Staff committee member, and shall be called by the presiding officer pursuant to a duly adopted motion. Executive session may be called to discuss peer review issues, personnel issues, or any other sensitive issues requiring confidentiality.

ARTICLE XIII

CONFIDENTIALITY, IMMUNITY & RELEASES

13.1 Authorizations and Conditions.

By applying for, or exercising, clinical privileges, or providing specified patient care services within the Hospital, a Practitioner:

- (a) Authorizes representatives of the Hospital and the Medical Staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the Practitioner's professional ability and qualifications;
- (b) Agrees to be bound by the provisions of this Article and to waive all legal claims against any representative of the Medical Staff or the Hospital who would be immune from liability under Section 13.3 of this Article;
- (c) Acknowledges that the provisions of this Article are express conditions to his or her application for, or acceptance of, Staff membership and the continuation of such membership, and to his or her exercise of Clinical Privileges or provision of specified patient services at the Hospital; and
- (d) Authorizes persons and organizations to provide information concerning such Practitioner to the Medical Staff.

13.2 Confidentiality of Committee Records and Information.

13.2-1 Confidentiality.

Records and proceedings of all Medical Staff committees having the responsibility of evaluation and improvement of quality of care rendered in the Hospital, including, but not limited to, meetings of the Medical Staff as a committee of the whole, meetings of Departments and Sections, meetings of committees established under Article XI, and meetings of special or ad hoc committees created by the Medical Executive Committee (pursuant to Section 11.3-2) or by Departments (pursuant to Section 10.5) and including information regarding any Member or applicant to this Medical Staff shall, to the fullest extent permitted by law, be confidential.

13.2-2 Preservation of Confidentiality.

Members of the Medical Staff shall respect and preserve the confidentiality of all communications and information generated in connection with credentialing, peer review and performance improvement activities as is specifically authorized by these Bylaws, the Medical Staff Rules and Regulations, or by the Medical Executive Committee. Members pledge to invoke the protection of all applicable laws, including California Evidence Code Section 1157 as applicable in legal proceedings, in order to preserve the confidentiality of this information.

13.2-3 Corrective Action for Breach of Confidentiality.

Inasmuch as effective peer review and consideration of the qualifications of Medical Staff Members and applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of Medical Staff Departments, Sections, or committees, except in conjunction with other Hospital, professional society, or licensing authority, is outside appropriate standards of conduct for this Medical Staff, violates the Medical Staff Bylaws, and will be deemed disruptive to the operations of the Hospital. If it is determined that such a breach has occurred, the Medical Executive Committee may undertake such corrective action as it deems appropriate.

13.2-4 Participation by Non-Medical Staff Members.

Individuals who are permitted to attend Medical Staff committee meetings, but who are neither Members of the Medical Staff nor ex-officio members, such as members of Administration and members of the Nursing Staff, may be required to sign the sign-in sheets which shall include pledges of confidentiality consistent with the requirements of these Bylaws. Failure to respect such pledge shall constitute grounds for immediate termination of the individual's right to continue to participate on such committees, and may also constitute grounds for disciplinary action, including, but not limited to, termination of employment, as determined by Administration.

13.3 Immunity from Liability.

13.3-1 For Action Taken.

Each representative of the Medical Staff and the Hospital shall be immune to the fullest extent permitted by law, from liability to an applicant or Member for damages or other relief for any action taken or statements or recommendations made within the scope of duties exercised as a representative of the Medical Staff or the Hospital.

13.3-2 For Providing Information.

Each representative of the Medical Staff and the Hospital and all third parties shall be immune, to the fullest extent permitted by law, from liability to an applicant or Member for damages or other relief by reason of providing information to a representative of the Medical Staff or the Hospital concerning such person who is, or has been, an applicant to, or Member of, the Staff, or who did, or does, exercise Clinical Privileges or provide services at the Hospital.

13.4 Activities and Information Covered.

13.4-1 Activities.

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

- (a) Application for appointment, reappointment, or Clinical Privileges;
- (b) Corrective action;
- (c) Hearings and appellate reviews;
- (d) Utilization management;
- (e) Other Department, or Section, committee, or Medical Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and
- (f) National Practitioner Data Bank queries and reports, peer review organizations, MBC and similar queries and reports.

13.5 Releases.

Each applicant or Member shall, upon request of the Medical Staff or the Hospital, execute general and specific releases in accordance with the express provisions and general intent of this Article. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

13.6 Cumulative Effect.

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

13.7 Indemnification.

The Hospital shall indemnify, defend and hold harmless the Medical Staff and its individual Members from and against losses and expenses (including attorneys' fees, judgments, settlements, and all other costs, direct or indirect) incurred or suffered by reason of or based upon a threatened, pending or completed action, suit, proceeding, investigation, or other dispute relating or pertaining to any alleged act or failure to act

within the scope of peer review, performance improvement or utilization management activities including, but not limited to, (1) as a Member of or witness for a Medical Staff Department, Service, committee, or hearing panel, (2) as a Member of or witness for the Hospital board or any Hospital task force, group or committee, and (3) as a person providing information to any medical staff or hospital group, officer, board member or employee for the purpose of aiding in the evaluation of the qualifications, fitness or character of a Medical Staff Member or applicant. The Medical Staff or Member may seek indemnification for such losses and expenses under this Bylaws provision, statutory and case law, any available liability insurance or otherwise as the Medical Staff or Member sees fit, and concurrently or in such sequence as the Medical Staff or Member may choose. Payment of any losses or expenses by the Medical Staff or Member is not a condition precedent to the Hospital's indemnification obligations hereunder.

ARTICLE XIV

GENERAL PROVISIONS

14.1 Staff Rules and Regulations.

The Medical Executive Committee shall initiate and adopt such Rules and Regulations as it may deem necessary for the proper conduct of the Medical Staff's work and shall periodically review and revise its Rules and Regulations to comply with current Medical Staff practice. Recommended changes to the Rules and Regulations shall be submitted to the Medical Executive Committee for review and approval. Following adoption by the Medical Executive Committee, such Rules and Regulations shall become effective upon approval of the Governing Body, which approval shall not be withheld unreasonably, or automatically after sixty (60) days if no action is taken by the Governing Body. In the latter event, the Governing Body shall be deemed to have approved the Rule(s) and Regulation(s) adopted by the Medical Executive Committee. Rules and Regulations shall be reviewed (and may be revised if necessary) every two (2) years, or more frequently, as needed. Applicants and Members of the Medical Staff shall be governed by such Rules and Regulations as are properly initiated and adopted. If there is a conflict between the Bylaws and the Rules and Regulations, the Bylaws shall prevail. The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff Rules and Regulations.

14.2 Dues or Assessments.

The Medical Executive Committee shall have the power to recommend the amount of annual dues or assessments, if any, for each category of the Medical Staff membership, and to determine the manner of expenditure of such funds received.

14.3 Medical Staff Legal Counsel.

The Medical Staff shall have the right to retain and be represented by independent legal counsel at the expense of the Medical Staff.

14.4 Clinical Department Policies and Procedures.

Departmental policies/procedures may be formulated by each clinical Department for the conduct of its affairs and the discharge of its responsibilities. The Departmental policies/procedures shall be consistent with the Medical Staff Bylaws, Rules and

Regulations. Departmental policies/procedures shall be approved or revised by the affected Department and the Medical Executive Committee.

14.5 Authority to Act.

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

14.6 Division of Fees.

Any division of fees by Members of the Medical Staff is forbidden and any such division of fees shall be cause for exclusion or expulsion from the Medical Staff.

14.7 Notices.

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

Name and proper title of addressee, if known or applicable
Name of department, section or committee
[c/o Medical Staff Services Director, Chief of Staff]
Sutter Medical Center of Santa Rosa
3325 Chanate Road, Santa Rosa, CA 95404

Mailed notice to a Member, applicant or other party, shall be to the addressee at the address as it last appears in the official records of the Medical Staff or the Hospital.

14-8 Disclosure of Interest.

Medical Staff Members who occupy Medical Staff offices, such as Medical Staff Officers, Department and committee chairships and members of the Medical Executive Committee, carry with them a requirement of loyalty and fidelity and must discharge their duties diligently and honestly, exercising their best care, skill and judgment for the sole benefit of the Medical Staff. Accordingly, it is the responsibility of each Medical Staff Member who occupies a Medical Staff office, all Medical Staff Officers, Department and committee chairs, and members of the Medical Executive Committee to make full disclosure of any duality of interest that might result in a possible conflict on his or her part. The subject Medical Staff Member shall refrain from voting on any matter about which he or she has a duality or conflict of interest, and shall be excused from the room while the vote on the matter is taken.

14.9 Nomination of Medical Staff Representatives.

Candidates for positions as Medical Staff representatives to local, state and national Organized Medical Staff Sections should be filled by such selection process as the Medical Executive Committee may determine.

14.10 Medical Staff Credentials Files.

14.10-1 Insertion of Adverse Information.

This section applies to actions relating to requests for insertion of adverse information into the Medical Staff Member's credentials file. For the purposes of this section, "adverse information" is considered to be negative information about a Medical Staff Member which is submitted to the Medical Staff, but which was not solicited or requested by the Medical Staff. Accordingly, information obtained through routine credentialing, peer review and performance improvement activities is not considered "adverse information" for the purposes of this section.

- (a) As stated previously, in Section 6.1-2, any person may provide information to the Medical Staff about the conduct, performance or competence of its Members.
- (b) When a request is made for insertion of adverse information into the Medical Staff Member's credentials file, the respective Department chair and Chief of Staff shall review such a request.
- (c) After such a review a decision will be made by the respective Department chair and Chief of Staff to:
 - (1) Not insert the information;
 - (2) Notify the Member of the adverse information by a written summary and offer the opportunity to rebut this assertion before it is entered into the Member's file; or
 - (3) Notify the Member of the adverse information by written summary and insert the information along with a notation that a request has been made to the Medical Executive Committee for an investigation as outlined in Section 6.1 of these Bylaws.
- (d) This decision shall be reported to the Medical Executive Committee. The Medical Executive Committee, when so informed, may either ratify or initiate contrary actions to this decision by a majority vote.
- (e) A Practitioner shall be entitled to submit a rebuttal to any adverse information or letter of counseling, warning or reprimand placed in his/her credentials file by the department of Medical Executive Committee.

14.10-2 Confidentiality.

The following applies to records of the Medical Staff and its Departments and committees responsible for the evaluation and improvement of patient care:

- (a) The records of the Medical Staff and its Departments and committees responsible for the evaluation and improvement of the quality of patient care rendered in the Hospital shall be maintained as confidential.
- (b) Access to such records shall be limited to duly appointed officers and committees of the Medical Staff for the sole purpose of discharging Medical Staff responsibilities and subject to the requirement that confidentiality be maintained.

- (c) Information which is disclosed to the Governing Body of the Hospital or its appointed representatives -- in order that the Governing Body may discharge its lawful obligations and responsibilities shall be maintained by that body as confidential.
- (d) Information contained in the credentials file of any Member may be disclosed with the Member's consent, or to any Medical Staff or professional licensing board, or as required by law. However, any disclosure outside of the Medical Staff shall require the authorization of the Chief of Staff and the concerned department chair and notice to the Member.
- (e) A Medical Staff member shall be granted access to the individual's credentials file, subject to the following provisions:
 - (1) Timely notice of such shall be made by the Member to the Chief of Staff or the Chief of Staff's designee;
 - (2) The member may review, and receive a copy of, only those documents provided by or addressed personally to the Member. A summary of all other information, including peer review committee findings, letters of reference, proctoring reports, complaints, etc., shall be provided to the Member, in writing, by the designated officer of the Medical Staff, within a reasonable period of time, as determined by the Medical Staff. Such summary shall disclose the substance, but not the source, of the information summarized and shall not be removed from the review site;
 - (3) The review by the Member shall take place in the Medical Staff Office, during normal work hours, with an officer or designee of the Medical Staff present.
- (f) In the event a notice of action or proposed action is filed against a Member, access to that Member's credentials file shall be governed by Section 7.2-5.

14.10-3 Member's Opportunity to Request Correction/Deletion of and to Make Addition to Information File.

- (a) After review of the file as provided under Section 14.1-9 (e), the Member may address to the Chief of Staff a written request for correction or deletion of information in the credentials file. Such request shall include a statement of the basis for the action requested.
- (b) The Chief of Staff shall review such a request within a reasonable time and shall recommend to the Medical Executive Committee, after such review, whether or not to make the correction or deletion requested. The Medical Executive Committee, when so informed, shall either ratify or initiate action contrary to this recommendation, by a majority vote.
- (c) The Member shall be notified promptly, in writing, of the decision of the Medical Executive Committee.

- (d) In any case, a Member shall have the right to add to the individual's credentials file, upon written request to the Medical Executive Committee, a statement responding to any information contained in the file.

14.11 Medical Staff Role in Exclusive Contracting.

The Medical Staff shall review and make recommendations to the Governing Body regarding quality of care issues related to exclusive arrangements for physician and/or professional services, prior to any decision being made, in the following situations:

- (a) The decision to execute an exclusive contract in a previously open Department or service;
- (b) The decision to renew or modify an exclusive contract in a particular Department or service; and
- (c) The decision to terminate an exclusive contract in a particular Department or service.

ARTICLE XV

ADOPTION & AMENDMENT OF BYLAWS

15.1 Procedure

Upon the request of (1) the Medical Executive Committee, or the Chief of Staff or the Bylaws Committee after approval by the Medical Executive Committee, or (2) upon timely written petition signed by at least ten percent (10%) of the Members of the Medical Staff in Good Standing who are entitled to vote, consideration shall be given to the adoption, amendment, or repeal of these Bylaws.

15.2 Action on Bylaw Change.

Such action to change these Bylaws shall be taken by authenticated written ballot. Written ballots shall include handwritten signatures on the envelope for comparison with signatures on file, when necessary. Written notice of the proposed Bylaws change(s) shall be sent to all Members at least thirty (30) days prior to the date set for submission of the ballots. Approval of changes shall require an affirmative vote of fifty-one percent (51%) of the Members voting by written ballot.

15.3 Approval.

Bylaw changes adopted by the Medical Staff shall become effective following approval by the Governing Body, which approval shall not be withheld unreasonably. The Governing Body shall take action on such proposed Bylaws changes within sixty (60) days of receipt of request for such change from the Medical Staff. If no action is taken within sixty (60) days, the Bylaws shall be deemed automatically approved. For purposes of this section, Board action may include approval, rejection, or deferral of action pending receipt of additional information or clarification concerning the proposed changes. In any event, the Governing Body may not defer approval or rejection beyond one hundred twenty (120) days of receipt of the request for change. If approval is withheld, the reasons for doing so shall be specified by the Governing Body in writing, and shall be forwarded to the Chief of Staff, the Medical Executive Committee and Bylaws Committee.

15.4 Technical Amendments.

The Medical Executive Committee shall have the power to approve on behalf of the Medical Staff such amendments to the Bylaws as are, in its judgment, technical modifications or clarifications, reorganization or renumbering of the Bylaws, amendments made necessary because of punctuation, spelling or other errors of grammar or expression, or inaccurate cross-references.

15.5 Exclusivity.

The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff Bylaws. Neither the Medical Staff nor the Governing Body may unilaterally amend the Medical Staff Bylaws.

15.6 Successor in Interest.

These Bylaws, and Privileges of individual Members of the Medical Staff accorded under these Bylaws, will be binding upon the Medical Staff, and the Governing Body of any successor in interest in the Hospital except where the Hospital Medical Staffs are being combined. In the event that the staffs are being combined, the Medical Staff shall work together to develop new Bylaws which will govern the combined Medical Staffs, subject to the approval of the Hospital's Governing Body or its successor in interest. Until such time as the new Bylaws are approved, the existing Bylaws of each Medical Staff will remain in effect.

APPROVALS

Original Signed by Robert R. Wright, M.D. 11/27/2009
Robert R. Wright, M.D., Chief of Staff

Original Signed by Cynthia Nestle. 12/11/2009
Cynthia Nestle, Secretary, Board of Trustees

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