PREAMBLE

These Bylaws are adopted to provide a framework for self-government for the organization of the Medical Staff of Saint Joseph Hospital of Orange that permits the Medical Staff to discharge its responsibilities in matters involving the quality of patient care, treatment and services, to govern the orderly resolution of issues and the conduct of Medical Staff functions supportive of those purposes, and to account to the Governing Body for the effective performance of Medical Staff responsibilities. These Bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Governing Body, and relations with applicants to and Members of the Medical Staff.

The Medical Staff acknowledges that the Governing Body must act to protect the quality of medical care provided and the competency of the Medical Staff, and to ensure the responsible governance of the hospital. In adopting these Bylaws, the Medical Staff commits to exercise its responsibilities with diligence and good faith, and in approving these Bylaws, the Governing Body commits to supporting the Medical Staff's self-governance and independence in conducting the affairs of the Medical Staff. Accordingly, the Governing Body will not assume a duty or responsibility of the Medical Staff precipitously, unreasonably, or in bad faith; and will do so only in the 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.

DEFINITIONS

1. **ALLIED HEALTH PRACTITIONER OR AHP** means an individual who is a nonemployee brought into the hospital by a licensed independent practitioner to provide care, treatment, or services, and who have the same qualifications and competencies required of employed individuals performing the same or similar services at the hospital. Categories of AHPs permitted to work under this definition are set forth in the Rules. For the purposes of these bylaws, AHPs do not include nurse practitioners and physician assistants. AHPs are not eligible for Medical Staff membership.

2. **"ADVANCED PRACTICE PROVIDER" OR "APP"** means an individual who exercises independent judgment within the areas of his 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 medical, dental, or podiatric 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 scope of practice and prerogatives in conformity with the rules adopted by the Governing Body, these Bylaws, and the Medical Staff Rules. Categories of APPs that can qualify for practice prerogatives under this definition are Nurse Practitioners and Physician Assistants. APPs are not eligible for Medical Staff membership.

3. **AHP or APP PRACTICE PREROGATIVES** means the permission granted to an Allied Health Practitioner or Advanced Practice Provider to participate in the provision of certain patient care services.

4. **CHIEF EXECUTIVE OFFICER (CEO)** means the person appointed by the Board of Trustees of St. Joseph Health System to act on its behalf in the overall management of the Hospital, or his duly authorized representative.

5. **CHIEF OF STAFF** or **PRESIDENT** means the chief officer of the Medical Staff. An alternate designation is President of the Medical Staff.

6. **CLINICAL PRIVILEGES or PRIVILEGES** means the permission granted to a Medical Staff member to render specific diagnostic, therapeutic, medical, dental, podiatric, surgical, or psychological services.

7. **CONFLICT OF INTEREST** means a personal, professional or financial interest or conflicting fiduciary obligation that may make it difficult or impossible, as a practical matter, for an individual to act in the best interests of the Medical Staff or patient care in a particular matter over which the individual has decision making authority or influence. Such a conflict may also be attributed to the

individual if the interest is held by an immediate family member of that individual, including that individual's spouse, domestic partner, child or parent.

8. **DATE OF RECEIPT** means the date any Notice, Special Notice or other communication was delivered personally, by facsimile or by electronic mail (e-mail); or if such Notice, Special Notice or communication was sent by mail, it shall mean 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.)

9. **EX OFFICIO** means service by virtue of office or position held. An Ex Officio appointment is without vote unless specified otherwise by the Bylaws or Rules.

10. **EXECUTIVE COMMITTEE** or **MEDICAL EXECUTIVE COMMITTEE** means the Executive Committee of the Medical Staff.

11. **GOVERNING BODY** means the hospital's Board of Trustees. As appropriate to the context and consistent with the corporate Bylaws, it may also mean any Governing Body committee or individual authorized to act on behalf of the Governing Body.

12. **HOSPITAL** means St. Joseph Hospital of Orange.

13. **INVESTIGATION** means a process specifically instigated by formal action of the Medical Executive Committee, pursuant to Article 13 of these bylaws, to determine the validity, if any, to a concern or complaint raised against a member of the Medical Staff and does not include activity of the Committee on Physician Health.

14. **LICENSED INDEPENDENT PRACTITIONERS (LIP)** means any practitioner permitted by law and by the organization to provide care and services, without direction or supervision, within the scope of the practitioner

15. **LIMITED LICENSE PRACTITIONERS** means dentists, psychologists, and podiatrists.

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

17. **MEDICAL STAFF** means the organization of all physicians, dentists, psychologists and podiatrists who have been granted membership by the Governing Body.

18. **MEDICAL STAFF YEAR** means the period from January 1 to December 31.

19. **MEMBER** means any Practitioner who has been appointed to the Medical Staff.

20. **NOTICE** means a written or electronically transmitted 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.)

21. **PHYSICIAN** means an individual with a M.D. or D.O. degree who is licensed to practice medicine.

22. **PRACTITIONER** means, unless otherwise expressly limited, any currently licensed physician (M.D. or D.O.), dentist, psychologist, or podiatrist.

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

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

ARTICLE 1

NAME AND PURPOSES

1.1 Name

The name of this organization shall be the Medical Staff of St. Joseph Hospital of Orange.

1.2 Purpose

The purposes of this organization are:

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

1.2.2. To assure a level of professional performance that is consistent with generally accepted and uniform standards of care for all practitioners and APPs authorized to practice in the Hospital through the appropriate delineation of the clinical privileges that each practitioner may exercise in the Hospital and of the practice prerogatives that each APP may exercise in this Hospital; and through an ongoing review and evaluation of each practitioner's and APP's performance in the Hospital;

1.2.3. To initiate and maintain Bylaws and Rules for the Medical Staff to carry out its responsibility to be self-governing with respect to the professional work performed in the Hospital, as required under the law;

1.2.4. To provide a forum whereby issues concerning the Medical Staff and the Hospital may be discussed by the Medical Staff with the Governing Body and the CEO;

1.2.5. To provide education that will lead to the continuous advancement of professional knowledge and skill of its members and trainees in various disciplines;

1.2.6. To encourage clinical research;

1.2.7. To provide for accountability of the Medical Staff to the Governing Body for the quality of the medical care, treatment and services provided to patients and for the effective performance of Medical Staff Responsibilities; and

1.2.8. To support the mission and vision of the Hospital.

1.3 Healthcare Entity Affiliation

The Hospital and its Medical Staff may affiliate with Regional Ministries and Children's Hospital of Orange County (CHOC), for the purpose of improving care in the community by establishing cooperative credentialing, peer review, corrective action, and procedural review programs. Such programs must be approved by the Executive Committee and provide for Practitioners to have the chance to opt out prospectively of any cooperative program and otherwise shall be carried out in accordance with the following guidelines;

1.3.1. **Credentialing**

The Medical Staff may enter into arrangements with Regional Ministries and Children's Hospital of Orange County (CHOC) to assist each other in credentialing activities by sharing information from credentials and peer review files and sharing medical or professional staff support resources to process or assist in processing applications for appointment and reappointment.

1.3.2. **Peer Review**

The Medical Staff may enter into arrangements with Regional Ministries and Children's Hospital of Orange County (CHOC) to assist each other in peer review activities. This may include, without limitation, sharing information from each other's credentials and peer review files, and utilizing each other's medical or professional staff support resources to conduct or assist in conducting peer review activities.

1.3.3. **Corrective Action**

The Medical Staff may work cooperatively with Regional Ministries and Children's Hospital of Orange County (CHOC) to develop and impose coordinated, cooperative, or joint corrective action measures as deemed appropriate to the circumstances. This may include, but is not limited to, giving timely notice of emerging or pending problems, as well as notice of corrective actions imposed and/or reciprocal effectiveness of such corrective actions as provided in these Bylaws and the Rules.

1.3.4. **Joint Hearings and Appeals**

The Medical Staff and Governing Body are authorized to participate in joint hearing and appeal associated with Regional Ministries and Children's Hospital of Orange County (CHOC), provided the applicable procedures are substantially comparable to the Hearing and Appellate Review Procedures established in these Bylaws.

ARTICLE 2

MEDICAL STAFF MEMBERSHIP

2.1 Nature Of Medical Staff Membership

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

2.2 Qualifications For Membership

2.2.1. **General Qualifications**

Medical Staff membership (except Emeritus Medical Staff) shall be limited to Practitioners who are currently licensed or qualified to practice medicine, podiatry, clinical psychology or dentistry in California. Membership and privileges shall be granted, revoked or otherwise restricted or modified based only on the quality, competence, behavior, and professional training and experience criteria as set forth in these bylaws.

2.2.2. Specific Qualifications

A Practitioner must demonstrate compliance with all the basic standards set forth in this Section in order to have an application for Medical Staff membership accepted for review. The Practitioner must:

a. Be licensed to practice medicine, dentistry, psychology, or podiatry in California or qualify under California law to practice with an out-of-state license.

b. If practicing medicine, dentistry, psychology, or podiatry and having privileges to prescribe controlled substances, have a federal DEA number with full schedules excluding Schedule 1, except for good cause. All exceptions for good cause will be considered on a case-by-case basis and must be approved by the Medical Executive Committee, which shall have sole discretion in granting or denying exceptions.

c. For physicians and podiatrists, to have successfully completed a residency approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association or the Council on Podiatric Medical Education that provided complete training in the specialty or subspecialty that the Practitioner will practice at the Hospital; or can demonstrate exceptional qualifications or that they possess skills not otherwise available at the Hospital. Individual Department Rules may require board certification in particular specialties or subspecialties as prerequisites to assignment to the Department or to the granting of particular clinical privileges.

d. Have professional liability insurance or equivalent coverage meeting the standards specified in the Rules.

e. Be located close enough (office and residence) to the Hospital to provide the continuum of care according to the quality-of-care response times defined by department or Section to which the practitioner belongs or is applying. The distance to the Hospital may vary depending upon the Medical Staff category and Privileges which are involved and the feasibility of arranging alternative coverage

and may be defined in the Rules. This provision shall not apply to Telemedicine Staff.

f. If requesting Privileges in a Department or service operated under an exclusive contract, be a member, employee, or subcontractor of the group or person that has the contract.

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 Emeritus Medical Staff need not 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 and the Rules 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 Executive Committee and the Governing Body, which shall have sole discretion to decide whether to consider any changes in the basic standards or to grant a waiver as allowed by Section 2.5 below.

2.2.3. **Qualifications for Membership**

In addition to meeting the basic qualifications, the Practitioner must:

a. Document his or her (i) experience, education, and training in the requested Privileges; (ii) current professional competence; (iii) good judgment; and (iv) physical and mental health status (subject to any necessary reasonable accommodation) to demonstrate to the satisfaction of the Medical Staff that he or she is professionally and ethically competent so that patients can reasonably expect to receive the generally recognized high professional level of quality of care for this community; and

Be determined (i) to adhere to the lawful ethics of his or her profession; (ii) to be able to work cooperatively with others in the Hospital setting so as not to adversely affect patient care or Hospital operations to the degree that patient care is, or is likely/reasonably to be, adversely affected; and (iii) to be willing to participate in and properly discharge Medical Staff responsibilities.

2.3 Effect Of Other Affiliations

No practitioner shall be automatically entitled to Medical Staff membership or to exercise any particular clinical privileges because he holds a certain degree; is licensed to practice in California or any other state; is a member of any professional organization; is certified by any clinical board; had Staff membership or privileges at this Hospital; or had or presently has 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, or other organization or in contracts with a third party which contracts with this Hospital. Except in the case of exclusive contracts, Medical Staff membership or clinical privileges shall not be revoked, denied, or otherwise infringed based on the member's professional or business interests. Neither the existence of an actual or potential conflict of interest, nor the disclosure thereof, shall affect a member's Medical Staff membership or clinical privileges.

2.4 Non-Discrimination

No aspect of Medical Staff membership or particular clinical privileges shall be denied on the basis of sex, marital status, sexual orientation, race, age, creed, color, national origin, or handicap or disability (except to the extent the handicap or disability prevents the practitioner from performing essential functions or poses a health or safety risk to the practitioner or others and the handicap or disability cannot be reasonably accommodated).

2.5 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, after consulting with the 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.

2.6 Administrative and Contract Practitioners

2.6.1. Practitioners with No Clinical Duties

A Practitioner engaged in a purely administrative capacity with the hospital with no clinical duties or Privileges is subject to the regular personnel policies and to the terms of his or her contract or other conditions of affiliation.

2.6.2. Practitioners Who Have Clinical Duties

A Practitioner who is engaged as an independent contractor who will be providing specified clinical services pursuant to a contract or agreement with the Hospital (a "hospital contract physician") or who is engaged by the Hospital in a full or part time administrative capacity, whose activities include providing or supervising clinical care (a "medico-administrative officer") must be a Medical Staff Member, achieving this status by the procedures provided in the Bylaws and Rules.

2.6.3. Subcontractors

All hospital contract physicians and medico-administrative officers shall provide in their contracts or agreements with their partners, employees, subcontractors and agents (hereinafter referred to as "subcontractors") that privileges granted in connection with or under an exclusive hospital contract will be automatically terminated if the hospital contract physician's or medico-administrative officer's agreement with the Hospital is terminated or the hospital contract physician or medico-administrative officer terminates his employment of, association with, or partnership with the subcontractor. The Hospital may enforce such an automatic termination even if the subcontractor's agreement failed to include such provision. To the degree termination of certain specific privileges, but not all privileges, of a Medical Staff member are warranted by commencement of an exclusive contract, whether in the same or different specialty within the hospital as covered by the exclusive contract, other privileges of that member not exclusively reserved to physicians under the contract by the contract’s scope of services shall remain granted and unchanged.

2.7 Basic Responsibilities of Medical Staff Membership

Each Medical Staff Member, and each Practitioner exercising temporary privileges, shall continuously meet all of the following responsibilities:

2.7.1. Provide his or her patients with care of generally recognized professional level of quality and efficiency.

2.7.2. Actively help educate patients and families regarding the medical condition for which the patients are receiving care and their treatment.

2.7.3. Delegate responsibility for diagnosis or care of hospitalized patients only to a Practitioner, practitioner in training, or APP who is qualified to undertake this responsibility and who is adequately supervised.

2.7.4. Coordinate care, treatment and services with other practitioners and Hospital staff, as relevant to the care, treatment and services for individual patients.

2.7.5. Make appropriate arrangements for coverage of his or her patients.

2.7.6. Seek consultation whenever warranted by the patient's condition or when required by the Rules.

2.7.7. Prepare and complete in an accurate, legible and timely manner the medical and other required records for all patients to whom the Practitioner in any way provides services in the Hospital.

2.7.8. Maintain confidentiality of patient-identifiable information.

2.7.9. Upon request, provide 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.

2.7.10. Abide by the ethical principles of his or her profession.

2.7.11. Abide by the Medical Staff Bylaws and Rules and all other lawful standards, policies, and rules of the Medical Staff and of the Hospital (to the extent that the Hospital's standards, Bylaws, and policies do not conflict with or adversely affect the Medical Staff's self-governance and independent rights).

2.7.12. Pay dues and other fees as required by these Bylaws and the Medical Staff Rules.

2.7.13. Abide by all applicable laws and regulations of governmental agencies.

2.7.14. Comply with applicable standards of The Joint Commission or other accrediting organizations with which the Hospital may be affiliated.

2.7.15. Refrain from unlawful fee splitting or unlawful inducements relating to patient referral.

2.7.16. Recognize the importance of communicating with appropriate Department officers and/or Medical Staff officers when he or she obtains credible information indicating that a fellow Medical Staff Member may have engaged in unprofessional or unethical conduct or may have a health condition which poses a significant risk to the well-being or care of patients and then cooperate as reasonably necessary toward the appropriate resolution of any such matter.

2.7.17. Actively participate in and regularly cooperate with the Medical Staff in assisting the Hospital to fulfill its obligations related to patient care, including, but not limited to, continuous quality improvement, peer review, utilization management, quality evaluation and related monitoring activities required of the Medical Staff, and in discharging such other functions as may be required from time to time.

2.7.18. Discharge such Medical Staff, Department, committee, and service functions for which he or she is responsible by appointment, election, or otherwise.

2.7.19. Participate in Medical Staff proctoring in accordance with the Rules.

2.7.20. Complete continuing medical education ("CME") that meets all licensing requirements and is appropriate to the Practitioner's specialty.

2.7.21. Participate in Emergency Department coverage and consultation panels as allowed and as required by the Rules.

2.7.22. Cooperate with the Medical Staff's reasonable requests to assist the Hospital to meet its uncompensated or partially compensated patient care obligations.

2.7.23. Inform the Medical Staff within 10 working days of any significant changes in the information that was submitted in any applications for appointment and reappointment, including, but not limited to, changes in physical or mental health, status at any health facility or group; investigations by any health facility, group or government agency; and changes in status of, or conditions on, licensure or certification.

2.7.24. 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 Executive Committee or Credentials Committee.

2.7.25. Work cooperatively with Members, nurses, Hospital administrative staff, and others so as not to adversely affect patient care, nor affect Hospital operations to the degree it may adversely affect patient care.

2.7.26. Refrain from sexual innuendoes, sexual harassment, racial or ethnic slurs, threats of violence, threats of retribution, intimidating actions, foul language, rudeness, shouting, sarcasm, criticism in inappropriate forums, and any other behavior that may impair the functioning of the health care team or otherwise create a hostile or intimidating work environment.

2.7.27. Treat all staff and patients with courtesy, respect and dignity.

2.7.28. Communicate clearly, honestly and openly.

2.7.29. Respond to patient and staff requests appropriately. Respond to pages in a timely and suitable manner.

2.8 Harassment Prohibited

Harassment by a Medical Staff member against any individual (e.g., against another Medical Staff member, house staff, hospital employee or patient) on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex or sexual orientation, health status, ability to pay or source of payment, shall not be tolerated.

“Sexual harassment” is unwelcome verbal or physical conduct of a sexual or gender-based 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, drawings, 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 and/or perpetuates 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. 28

All allegations of 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 Duration Of Appointment

Initial appointments to the Medical Staff shall be for a period of no less than 12 months and no more than 24 months; thereafter, reappointments shall be based on the Medical Staff year, not to exceed 24 months.

ARTICLE 3

CATEGORIES OF MEMBERSHIP

3.1 Categories

Each Medical Staff Member shall be assigned to a Medical Staff category based upon the qualifications defined below. The categories of the Medical Staff include the following: Active, Associate, Affiliate and Emeritus. Each time membership is granted or renewed, the member's staff category shall be determined. The Members of each Medical Staff category shall have the prerogatives and carry out the duties defined in the Bylaws and Rules. Action may be initiated to change the Medical Staff category or terminate the membership of any Member who fails to meet the qualifications or fulfill the duties described below. Changes in Medical Staff category shall not be grounds for a hearing unless the change would require the Medical Staff to report the change to the Medical Board of California pursuant to Business and Professions Code Section 805 or its successors.

3.2 General Exceptions to Prerogatives

The prerogatives set forth under each Staff category are general in nature and may be limited by special conditions attached to a practitioner's staff appointment, by other Sections of these Bylaws, by the Medical Staff rules, or by other Hospital policies generally applicable to all practitioners in a staff category.

Dentists, podiatrists, and clinical psychologists may not hold any general Medical Staff office (including serving as an officer or Department Chairman) given the nature of their duties in office.

3.2.1. 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 may be set forth in these Bylaws and the Rules & Regulations.

3.3 Prerogatives And Responsibilities

3.3.1. Prerogatives

The prerogatives available to a Medical Staff Member include, depending upon Staff Category as set forth in Section 3.3.3,

a. Admit patients consistent with approved privileges ("Admit Patients");

b. Exercise clinical privileges which have been approved ("Eligible for Clinical Privileges");

c. Vote on any Medical Staff matter including Bylaws amendments, officer selection, and other matters presented at any general or special Staff meetings and on matters presented at Department or Section meetings ("Vote");

d. Hold office in the Medical Staff and Department and Section to which he or she is assigned. ("Hold Office");

e. Serve on Committees and vote on Committee matters ("Serve on Committees").

3.3.2. Responsibilities

The responsibilities Medical Staff Members will be expected to carry out in addition to the basic responsibilities set forth in the Bylaws Section 2.7, and depending upon Staff Category as set forth in Section 3.3.3, are to:

a. Contribute to the organizational and administrative Medical Staff activities, including quality review, risk management and utilization management and serve in Medical Staff, Department and Section offices and on Hospital and Medical Staff committees. (Medical Staff Functions).

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

c. Attend Medical Staff and Department meetings ("Attend Meetings").

d. Pay Staff dues, application fees, fines and emergency assessments as determined by the MEC ("Pay Dues" and "Pay Application Fees").

3.3.3. Prerogatives and Obligations of Staff Categories:

The prerogatives and obligations of each Staff category are described in the table following:

	Active	**Associate**	**Affiliate**	**Emeritus/**
Admit Inpatients & Outpatients *with approved privileges	Yes	Yes	No	No
Surgical Assists Inpatients Outpatients	Does Not Apply	Does Not Apply	Yes	No
Eligible for Clinical Privileges	Yes	Yes	Yes	No
Vote	Yes	No	No	No
Hold Office	Yes	No	No	No
Serve on Committees	Yes	Yes	NO	Yes
Medical Staff Functions	Yes	Yes	No	No
Pay Dues	Yes	Yes	Yes	No
Pay Application Fee	N/A	Yes	Yes	No
Attend Meetings	Yes	Yes	No	No
Proctoring	Yes	Yes	No	No
Malpractice Insurance	Yes	Yes	Yes	No
File Application	Yes	Yes	Yes	No
Apply Reappointment	Yes	Yes	Yes	No

3.4 Qualifications For Staff Category

3.4.1. **Assignment and Transfer in Staff Category**

a. Medical Staff Members shall be automatically assigned to the proper staff category based upon their activity and compliance with the qualifications for the staff category. A Member who does not maintain sufficient activity or patient contacts to remain qualified for a staff category he or she has been assigned shall be automatically transferred to the next staff category for which the activity or patient contacts qualify, subject to subsection c. in this Section 3.4.1. Action shall be initiated to evaluate and possibly terminate the privileges and membership of any Staff Member who has failed to have any activity during the preceding appointment period.

b. A "Patient Contact" includes each admission as an Attending Physician, Inpatient and Outpatient Surgery, Surgery Assisting, Consultation, and Primary Physician Referral.

c. The Governing Body (on recommendation of the Executive Committee) may rescind an automatic transfer to a different staff category, but only if the Practitioner clearly demonstrates that unusual circumstances unlikely to occur again in his or her practice caused the failure to meet the minimum or maximum requirements, and the criteria available for credentialing was adequate to maintain the member's requested staff category.

3.4.2. **Active Staff**

The Active Staff shall consist of the *Members* who:

a. Have 50 or more Patient Contacts in the two-year period preceding reappointment.

b. If the contacts are not adequate to appropriately evaluate the quality of care, then the member must be able to provide other information as determined by the Medical Staff to evaluate the quality of care.

c. Completed at least twelve months on the Associate Staff.

d. Completed proctoring for the basic privileges.

3.4.3. **Associate Staff**

The Associate Staff shall consist of the Members who:

a. Have fewer than 50 Patient Contacts in the 2 years preceding reappointment, but more than 1 and therefore do not qualify for Active Status.

b. Members who have had no patient contacts during the preceding two years shall be deemed to have resigned Medical Staff Membership and shall have no hearing rights.

c. Have contacts with the hospital, which are adequate for appropriate evaluation of the quality of care provided in the exercise of privileges held. If the contacts are not adequate to appropriately evaluate the quality of care, then the member must be able to provide other information as determined by the Medical Staff to evaluate the quality of care.

3.4.4. **Affiliate Staff**

The Affiliate Staff shall consist of Practitioners who:

a. Have limited privileges only to perform history and physical examinations and assist at surgery.

b. May not admit or act as an attending or admitting physician.

c. May not write orders.

d. If assisting at surgery, may not act as a primary surgeon.

e. Members who have had no patient contacts during the preceding two years shall be deemed to have resigned Medical Staff membership and shall have no hearing rights.

3.4.5. **Emeritus Staff**

The Emeritus Staff shall consist of Practitioners who:

a. Are former Medical Staff members who have provided notable service to the Hospital or were members in good standing with twenty (20) years of service and have retired from active practice.

b. May be available when needed for advice concerning medical, administrative and clinical matters.

c. Are appointed at the recommendation of the Executive Committee.

d. Are individuals of outstanding reputation whom the Medical Staff wishes to honor.

3.4.6 **Telemedicine Staff**

a. The Telemedicine Staff shall consist of physicians who are not privileged to practice on the hospital premises; who practice at a Distant Site; who are granted privileges to provide only Telemedicine Services to patients physically located in the Hospital, a.k.a., the originating site; and who provide those services pursuant to a contract between the Hospital and a Distant Site as required by these Bylaws and the Rules. Telemedicine Staff are credentialed and privileged in accordance with Section 6.4 of these Bylaws and in accordance with the procedures and associated details outlined in relevant provisions of the Medical Staff Rules.

b. Telemedicine Staff are not authorized to:

1. Admit inpatients

2. Hold office or vote on any Medical Staff or committee matter

c. Telemedicine Staff:

1. Shall pay an application fee and Medical Staff dues at the levels set by the Medical Executive Committee

2. Shall maintain malpractice insurance as required by the Hospital

3. May attend, as a guest, any committee meeting when invited by the chair of the committee

4. Shall cooperate in any peer review matter relevant to the member's care when requested by the Chief of Staff or Chair of any Medical Staff committee responsible for reviewing that care.

ARTICLE 4

ADVANCED PRACTICE PROVIDERS

4.1 Qualifications For Advanced Practice Providers

Advanced Practice Providers (APP's) are not eligible for Medical Staff membership. They may be granted a practice prerogatives if they hold a license, certificate, or other credentials in a category of APP's that the Governing Body (after securing comments from the Interdisciplinary Practice Committee and Executive Committee) has identified as eligible to apply for practice Privileges, and only if the APP's are professionally competent and continuously meet the qualifications, standards, and requirements that apply to APPs as set forth in the Medical Staff Bylaws and Rules.

4.2 Categories

The Governing Body shall determine, based upon comments of the Executive Committee and Interdisciplinary Practice Committee, and such other information as it has before it, those categories of APP's that shall be eligible to exercise practice prerogatives in the Hospital. Such APPs shall be subject to the supervision requirements developed in each Department and approved by the Credentials Committee, the Executive Committee, and the Governing Body.

4.3 Privileges, Responsibilities, Prerogatives, and Procedural Rights

The privileges, responsibilities, and prerogatives of APP's shall be established and reviewed as provided in the Rules. APP Procedural Rights shall be those specified in the Rules and Regulations, Rule 15.

ARTICLE 5

PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

5.1 General

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

5.2 Applicant's Burden

An applicant for appointment, reappointment, advancement, transfer, and/or privileges shall have the burden of producing accurate and adequate information for a thorough evaluation of the applicant's qualifications and suitability for the requested status or privileges, resolving any reasonable doubts about these matters and satisfying requests for information. The provision of information containing significant misrepresentations or omissions and/or a failure to sustain the burden of producing information shall be grounds for denying an application or request. This burden may include submission to a medical or psychological examination as provided in the Bylaws or Rules.

5.3 Application For Initial Appointment and Reappointment

5.3.1. An applicant for appointment and reappointment shall complete an application form that requests information regarding the applicant and documents the applicant's agreement to abide by the Medical Staff Bylaws and Rules (including the standards and procedures for evaluating applicants contained therein) and to release all persons and entities from any liability that might arise from their evaluating and/or acting on the application. The information shall be verified and evaluated by the Medical Staff using the procedure and standards set forth in the Bylaws and Rules. Following its evaluation, the Medical Executive Committee shall recommend to the Governing Body whether to appoint, reappoint, and/or grant specific Privileges.

5.3.2. Guidelines for Time of Processing and Notifications to Practitioners

The details associated with the guidelines for time of processing applications for initial appointment and reappointment, and the timelines for notifying practitioners by Special Notice of any decision restricting or denying membership or privileges, shall reside in the Rules & Regulations. They shall be changed only in accordance with the procedures permitted for changes to the Rules & Regulations.

5.4 Basis for Appointment and Reappointment

Recommendations for appointment and reappointment to the Medical Staff and for granting and renewal of Privileges shall be based upon the applicant's or Member's professional performance and behavior at this Hospital and in other settings, whether the applicant or Member meets the qualifications and can carry out all of the responsibilities specified in these Bylaws and the Rules, and upon the Hospital's patient care needs and ability to provide adequate support services and facilities for the Practitioner.

5.5 Leave Of Absence

5.5.1. Members may request a leave of absence, which must be approved by the Executive Committee and cannot exceed 12 months. Members on leave of absence shall be required to file reappointment applications regardless of their leave status. A leave of absence that is scheduled to expire after the member's current appointment date does not give the member any right to remain on staff beyond his or her appointment expiration date. Failure to file a reappointment application as required under these bylaws while on leave will result in the expiration of the member's Medical Staff membership and privileges. Leaves of absence may be reviewed by legal counsel for the Medical Staff for any possible state law compliance issues at the discretion of the Department Chair, or the Chief of Staff.

5.5.2. The Member must provide information regarding his or her professional activities during the leave of absence and his or her health status. During the period of the leave, the Member shall not exercise Privileges at the Hospital, and membership rights and responsibilities shall be inactive. The obligation to pay dues, if any, shall continue unless waived by the Executive Committee.

5.5.3. There shall be no extension or renewal for a leave of Absence past 12 months. Members may not apply for another Leave of Absence for at least two years after having their membership to the Medical Staff reinstated. (Exceptions will be made for active military service.)

5.5.4. A failure to do any of the following shall result in an automatic expiration of staff membership and privileges with no hearing right:

5.5.4.1 request reinstatement at least 30 days prior to the expiration of the leave of absence,

5.5.4.2 to submit a completed reappointment application within 45 days of expiration, or

5.5.4.3 provide the requested information concerning the Member's professional activities during the leave of absence and his or her health status.

5.6 Confidentiality; Impartiality

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

5.7 Application Form

5.7.1. *Provision and Return of Application*

Each Practitioner who expresses formal interest in a recognized and appropriate category of membership and privileges shall be provided an application form for Medical Staff membership. Upon completion by the Practitioner, the form shall be returned to the Medical Staff Office together with the non-refundable application fee as required by the Rules and Regulations, Rule 4.2.

5.7.2. *Application Form*

The application form shall be approved by the Executive Committee and the Governing Body. The application shall request information pertinent to the applicant's qualifications and document the applicant's agreement to abide by the Medical Staff Bylaws, Medical Staff Rules and policies (including the standards and procedures for evaluating applicants contained therein) and to release all persons and entities from any liability that might arise from their evaluating and/or acting on the application.

5.8 Physical and Mental Capabilities

5.8.1. *Obtaining Information*

5.8.1.1 The application shall request information pertaining to the condition of the applicant's physical and mental health on a separate page of the form, which can be removed from the remaining application and processed separately. Upon receipt of the application, the page addressing physical and mental conditions shall be removed and referred to the Committee on Physician Health.

5.8.1.2 When the Medical Staff Office verifies information and obtains references, it shall ask for any information concerning physical or mental condition to be reported on a confidential form, which can be processed separately from the other information obtained regarding the applicant. This information will be referred to the Committee on Physician Health.

5.8.1.3 If directed by the Chief of Staff or MEC, the Committee on Physician Health shall be responsible for assisting as appropriate in investigating any Practitioner who has or may have a physical or mental condition that might affect the Practitioner's ability to exercise his or her requested privileges in a manner that meets the Hospital and Medical Staff's quality of care standards. This may include one or all of the following:

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

5.8.1.3.2 Interview: To ascertain the condition of the Practitioner and to assess if and how reasonable accommodations can be made.

5.8.1.3.3 Any Practitioner who feels limited or challenged in any way by a mental or physical condition in exercising his or her clinical privileges and in meeting quality of care standards should make such limitation immediately known to the Committee on Physician Health. Any such disclosure will be treated with the high degree of confidentiality that attaches to the Medical Staff's peer review activities.

5.8.2. *Review and Reasonable Accommodations*

5.8.2.1 Any Practitioner who discloses or manifests a physical or mental condition that may impact patient care will have his or her application processed in the usual manner without reference to the condition.

5.8.2.2 The Committee on Physician Health shall not disclose any information regarding any Practitioner's physical or mental condition until the Credentials Committee (or, in the case of temporary privileges, the Medical Staff representatives who review temporary privilege requests and the Chief Executive Officer) has determined that the Practitioner is otherwise qualified for membership and/or to exercise the privileges requested. Once the determination is made that the Practitioner is otherwise qualified, the Committee on Physician Health may disclose information they have regarding any physical or mental conditions and the effect of those on the Practitioner's application for membership and privileges to the Chief of Staff. The Committee on Physician Health shall not disclose information regarding a physical or mental condition to the Medical Executive Committee unless it has determined that the Practitioner cannot perform the essential functions even with a reasonable accommodation. The Committee on Physician Health and any other appropriate committees may meet with the Practitioner to discuss if and how reasonable accommodations can be made.

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

5.9 Effect of Application: By applying for or by accepting appointment or reappointment to the Medical Staff, the applicant:

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

5.9.2. Authorizes Medical Staff and Hospital representatives (as defined in Section 5.11) to consult with other hospitals, persons or entities who have been associated with him or her and/or who may have information bearing on his or her competence, and qualifications or that is otherwise relevant to the pending review and authorizes such persons to provide all information that is requested orally and in writing.

5.9.3. Consents to the inspection and copying, by Hospital representatives, of all records and documents that may be relevant or lead to the discovery of information that is relevant to the pending review, regardless of who possesses these records, and directs individuals who have custody of such records and documents to permit inspection and/or copying.

5.9.4. Certifies that he or she will report any subsequent changes in the information submitted on the application form to the Credentials Committee and the Chief Executive Officer within 10 business days of such change.

5.9.5. Releases from any and all liability the Medical Staff and the Hospital and their representatives for their acts performed in connection with evaluating the applicant to the fullest extent permitted by law.

5.9.6. Releases from any and all liability, to the fullest extent permitted by law, all individuals and organizations who provide information concerning the applicant, including otherwise privileged or confidential information, to Hospital and/or Medical Staff representatives.

5.9.7. Authorizes and consents to Hospital and/or Medical Staff representatives providing other hospitals or Medical Staffs, professional societies, licensing boards, and other organizations concerned with provider performance and the quality of patient care with relevant information the Hospital may have concerning him or her and releases the Hospital and Medical Staff and Hospital and Medical Staff representatives from liability for so doing to the fullest extent permitted by law.

5.9.8. Agrees that the Hospital and Medical Staff may share information with a representative or agent from any Affiliated Healthcare Entity, including information obtained from other sources, and releases each person and each entity who received the information and each person and each entity who disclosed the information from any and all liability to the fullest extent permitted by law, including any claims of violations of any federal or state law, including the laws forbidding restraints of trade, that might arise from the sharing of the information and likewise agrees that the Hospital and/or Medical Staff and any and all Affiliated Healthcare Entity may act upon such information.

5.9.9. Consents to undergo and to release the results of a medical, psychiatric, or psychological examination by a Practitioner acceptable to the Committee on Physician Health, at the applicant's expense, if deemed necessary by the Committee on Physician Health or Executive Committee.

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

5.9.11. Agrees to abide by the terms of the Notice of Privacy Practices prepared and distributed to patients as required by the federal patient privacy regulations.

5.10 *Definitions*

The term “Hospital Representative” includes the Governing Body, its individual Directors and committee members; the Chief Executive Officer, the Medical Staff, all Medical Staff, Service, Department, and Section officers and leaders and/or committee members having responsibility for collecting information regarding or evaluating the applicant's credentials; and any authorized representative or agent of any of the foregoing. The term “Affiliated Healthcare Entity” refers to any other health care entity or provider group with whom the Hospital has agreed to affiliate to provide cooperative credentialing, peer review, corrective action, and hearings and appeals.

5.11 *Verification of Information*

5.11.1. *Completion of Application and Verification*

5.11.1.1 The applicant shall fill out and deliver an application form to the Medical Staff Office, which shall seek to verify the information submitted. The application will be deemed complete when all necessary verifications have been obtained, including current and past licenses, licensing board disciplinary records, specialty board certification status, National Practitioner Data Bank information, DEA certificate, record of exclusion from federal programs, verification of all practice from professional school through the present, current and past malpractice liability insurance, and reference letters.

5.11.1.2 The Medical Staff Office verifies that the practitioner requesting approval is the same practitioner identified in the credentialing documents by viewing one of the following: a valid picture ID issued by a state or federal agency (e.g., driver’s license or passport) or current foreign passports.

5.11.1.3 The Medical Staff Office shall then transmit the application and all supporting materials to the Chair of each Department and Section in which the applicant seeks privileges and to the Credentials Committee.

5.11.2. *Incomplete Application*

5.11.2.1 If the Medical Staff Office is unable to verify the information, or if all necessary references have not been received, or if the application is otherwise significantly incomplete, the Medical Staff Office may delay further processing of the application upon notification and request to the applicant either to submit the missing information or cause it to be delivered as soon as possible. Alternatively, the Medical Staff Office may begin processing the application based only on the available information with a decision that further information may be considered upon receipt.

5.11.2.2 If the applicant fails to provide the information required to complete the application within 30 days after being notified, then the application shall be deemed incomplete and the file closed. Upon request, the Medical Staff, in its discretion, may grant the applicant additional time to complete the application; however, in no case shall that additional time extend beyond 180 days from when the applicant first was filed.

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

5.11.3. *Action on the Application*

5.11.3.1 Department and Section Action

Upon receipt, the Department Chair or Section Chair (if the Department has Sections) shall review the application, supporting documentation, and other relevant information available to him or her. The Department Chair and/or Section Chair may personally interview the applicant. The Section Chair shall forward his or her recommendations to the Department Chair. The Department Chair shall send his or her recommendations to the Credentials Committee. The recommendations shall address Staff appointment, Department and Section affiliations, and clinical privileges.

5.11.4. *Credentials Committee Action*

The Credentials Committee or a subcommittee thereof shall review the application, supporting documentation, Department Chair and Section Chair recommendations, and other relevant information available to it. The Credentials Committee or a subcommittee thereof may personally interview the applicant. The Credentials Committee shall send the Executive Committee a written report and recommendations as to Staff appointment, Department and Section affiliations, and clinical privileges.

5.11.5. *Executive Committee Action*

5.11.5.1 Preliminary Recommendation: At its next regular meeting after receiving the Credentials Committee and Department Chair reports and recommendations, the Executive Committee shall consider all relevant information available to it. The Executive Committee shall then formulate a preliminary recommendation. If the preliminary recommendation is favorable, the Executive Committee shall then, at the same meeting, assess the applicant's health status, the report from the Committee on Physician Health (if any) and determine whether the applicant is able to perform, with or without reasonable accommodation, the necessary functions of a Member of the Medical Staff.

5.11.5.2 Final Recommendation: Thereafter, a final recommendation shall be formulated, and the Executive Committee shall forward to the Governing Body a written report and recommendations, as follows:

5.11.5.2.1 Favorable Recommendation: Favorable recommendations shall be promptly forwarded to the Governing Body together with the application form and its accompanying information and Credentials Committee and Department Chair and Section Chair reports on Staff appointment, and Department and Section affiliations, clinical privileges to be granted, and any special conditions to be attached to the appointment.

5.11.5.2.2 Adverse Recommendation: When the recommendation is adverse in whole or in part, the Chief of Staff shall inform the Practitioner by Special Notice of the adverse recommendation and the reason(s) for the adverse action. If applicable, the applicant will be informed that he or she is entitled to the hearing and appeal rights provided in the Bylaws Article 14.

5.11.5.2.3 If the recommendation is adverse in whole or part, the Governing Body shall be generally informed of, but shall not receive detailed information and shall not take action on, the pending adverse

recommendation until the applicant has exhausted or waived his or her procedural rights, if any.

5.11.5.2.4 For the purposes of this Section, an “adverse recommendation” by the Executive Committee is as defined in the Medical Staff Bylaws Section 14.2.

5.11.5.3 Deferral: The Credentials Committee, Department Chair or Section Chair, and/or Executive Committee may defer its recommendation in order to obtain or clarify information, or in other special circumstances. A deferral must be followed up within 60 days with a recommendation for appointment and privileges, or for rejection for Staff membership.

5.11.6. *Governing Body Action*

5.11.6.1 On Favorable Executive Committee Recommendation: The Governing Body shall adopt, reject, or modify a favorable recommendation of the Executive Committee, or shall refer the recommendation back to the Executive Committee for further Consideration, stating the reasons for the referral and setting a time limit within which the Executive Committee shall respond. If the Governing Body's action is a ground for a hearing under Bylaws Article 14, the Chief Executive Officer shall promptly inform the applicant by Special Notice, and he or she shall be entitled to the hearing and appeal rights provided in Bylaws Article 14.

5.11.6.2 Without Benefit of Executive Committee Recommendation: If the Governing Body does not receive an Executive Committee recommendation within the time specified below, it may, after giving the Executive Committee written notice and a reasonable time to act, take action on its own initiative. If such recommendation is favorable, it shall become effective as the final decision of the Governing Body. If the recommendation is a ground for a hearing under Bylaws Article 14, the Chief Executive Officer shall give the applicant Special Notice of the tentative adverse recommendation and of the applicant's right to request a hearing. The applicant shall be entitled to the hearing and appeal rights provided in the Bylaws Article 14 before any final adverse action is taken.

5.11.6.3 After Procedural Rights: In the case of an adverse Executive Committee recommendation or an adverse Governing Body decision, the Governing Body shall take final action in the matter only after the applicant has exhausted or has waived his or her Bylaws, Article 14 procedural rights, if any. Action thus taken shall be the conclusive decision of the Governing Body, except that the Governing Body may defer final determination by referring the matter back for reconsideration. Any such referral shall state the reasons, therefore, shall set a reasonable time limit within which reply to the Governing Body shall be made, and may include a directive that additional hearings be conducted to clarify issues which are in doubt. After receiving the new recommendation and any new evidence, the Governing Body shall make a final decision.

5.11.6.4 Governing Body Deference to Executive Committee Action: The Governing Body shall affirm the recommendation of the Executive Committee if the Committee’s decision is supported by substantial evidence.

5.11.7. *Notice of Final Decision*

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

5.11.7.1.1 The Staff category to which the applicant is appointed;

5.11.7.1.2 The Department and Section, if any, to which the Practitioner is assigned;

5.11.7.1.3 The Privileges the Practitioner may exercise; and

5.11.7.1.4 Any special conditions attached to the appointment.

5.12 Expedited Action

If the Medical Staff Office determines an application or information that raises question regarding competence, character or any other aspect of an applicant's profile raises concerns in the file, the file may be referred to the Credentials Committee Chair or his or her designee, who will determine whether the application qualifies for expedited action according to criteria determined by the Medical Staff. An applicant is ineligible for expedited action if [1] the applicant submits an incomplete application, or [2] if the Executive Committee makes a final recommendation for privileges that is adverse or has limitations. Further, the expedited action processing will be terminated and routine processing resumed if anyone who reviews the file finds that expedited action is not warranted. An applicant is ineligible for expedited action if:

a. the applicant has a current challenge, or a previously successful challenge, to professional licensure or registration;

b. the applicant has had an involuntary termination of Medical Staff membership at another organization

c. the applicant has had an involuntary limitation, reduction, denial or loss of clinical privileges at another organization; or

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

If the Credentials Committee Chair or designee determines the file qualifies for expedited action, the file shall be forwarded to the Chair of each Department and to each Section Chair (if the Department has Sections) in which the applicant seeks membership. If they agree the applicant qualifies for expedited action, the file shall be referred to the Chief of Staff for approval. If approved by the Chief of Staff, the file shall be referred to a committee comprised of at least two members of the Governing Body with delegated authority to grant membership and privileges on an expedited basis.

If expedited approval is given, the file will nevertheless follow the standard credentialing process including submission to the Credentials Committee, Executive Committee and Governing Body at their regularly scheduled meetings for review. Any of those bodies except the Governing Body may act within 60 days to rescind an expedited approval for privileges while the application is undergoing the standard credentialing process. Nothing in these bylaws give an applicant the right to expedited action, and a decision not to take expedited action shall not give the applicant any hearing and appeal rights.

5.13 Duration of Appointment

5.13.1. All new Staff Members shall be appointed to the Associate Staff and subjected to a period of formal observation and review for a period of no longer than 24 months.

5.13.2. All appointments and reappointments shall be for a maximum period of 24 months, regardless of staff category.

5.14 Reappointment Process

5.14.1. Schedule for Reappointment

a. At least 180 days prior to the expiration date of each Staff Member's appointment (except temporary privileges), the Medical Staff Office shall provide the Member with a reappointment form. If the reappointment form is not completed and returned to the Medical Staff Office within 60 days after it was initially disseminated, a written notice shall be promptly sent to the applicant advising the Member that the application has not been received. Failure to return the reappointment form and all requested documentation within 30 days after the warning notice was mailed shall be handled as in Section 5.5.

b. Failure to return reappointment applications in a timely manner will result in late fee fines. The first fine is assessed if the application is not submitted within 60 days and is increased every 30 days until the maximum date of 120 days late results in individuals being required to pay a new application fee. The fine and fee schedules are listed in the Medical Staff Rules & Regulations.

c. Failure to file a complete application for reappointment within 120 days of the initial dissemination of the reappointment application shall result in the automatic lapse of a Practitioner's Membership and privileges at the expiration of the Member's current term. Members whose membership automatically lapses will be processed as new applicants should they wish to reapply. In the event membership lapses for the reasons set forth herein, the Member is not entitled to any hearing or review.

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

5.14.3. Appointments and reappointment shall expire on date and year shown in the Rules & Regulations, and the reappointment processing shall be started on date and year shown therein based upon the Department/Specialty to which a member is assigned. The month and year scheduled for expiration of appointments and reappointments constitute details associated with the guidelines for processing applications for initial appointment and reappointment. These details shall reside in the Rules & Regulations and shall be changed only in accordance with the procedures permitted for changes to the Rules.

5.14.4. Content of Reappointment Form

5.14.4.1 The reappointment form shall be approved by the Executive Committee and the Governing Body. The form shall seek information concerning the changes in the applicant's qualifications since his or her last review. Specifically, the form shall request an update of all of the information and certifications requested in the appointment application form, with the exception of that information which cannot change over time, such as information regarding the Member's premedical and medical education, date of birth, and so forth. The form shall also require information as to what privileges are requested, what, if any changes are requested in staff status and/or clinical privileges, including any reduction, deletion, or additional privileges. Requests for additional privileges must be supported by the type and nature of evidence that would be necessary for such privileges to be granted in an initial application.

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

5.14.4.3 Members applying for reappointment must complete the information requested on the reappointment form and pay any reappointment application fee, if applicable.

5.14.5. Verification and Collection of Information

5.14.5.1 The Medical Staff Office shall, in timely fashion, seek to verify the additional information made available on each reappointment application and to collect any other materials or information deemed pertinent by the Executive Committee, the Credentials Committee, or Chair of any Department or Section (if the Department has Sections) to which the Member belongs. The information shall address, without limitation:

5.14.5.2 Patterns of care and utilization as demonstrated in the findings of ongoing professional practice evaluations (OPPE), quality improvement, risk management and resource management activities.

5.14.5.3 Participation in relevant continuing education activities

5.14.5.4 Level/amount of clinical activity (patient care contacts) at the Hospital

5.14.5.5 Sanctions imposed or pending, exclusion from federal programs, and other problems.

5.14.5.6 Adverse actions pending or taken by any other hospital or health care entity

5.14.5.7 Health status including completion of a physical examination or psychiatric evaluation by a physician who is mutually accepted by the affected Practitioner and Staff, when requested by the Credentials Committee or Executive Committee and subject to the standards set forth in the Rules pertaining to Physical and Mental Capabilities.

5.14.5.8 Timely and accurate completion and preparation of medical records.

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

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

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

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

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

The Medical Staff Office shall transmit the completed reappointment application form and supporting materials to the Chair of each Department to which the Staff Member belongs, or to the Section Chair (if the Department has Sections) and to the Chair of any other Department or Section in which the member has or requests privileges and to the Credentials Committee.

5.14.6. Department and Section Action

The Department or Section Chair (if there is a relevant Section) shall review the application and all other relevant available information. He or she shall transmit to the Department

Chair his or her written recommendations, which are prepared in accordance with Bylaws Section 5.15.7. Upon receipt of an application from a Section Chair or the Medical Staff Office (if there is no Section), the Department Chair shall review the application and all other relevant available information. He or she shall transmit to the Credentials Committee his or her written recommendations, which are prepared in accordance with Bylaws Section 5.7.7.

5.14.7. Credentials Committee

The Credentials Committee shall review the application, the Department Chair and any Section Chair's recommendation, and all other relevant available information. The Credentials Committee shall transmit to the Executive Committee written recommendations, which are prepared in accordance with Bylaws Section 5.14.9, "Reappointment Recommendations."

5.14.8. Executive Committee Action

5.14.8.1 The Executive Committee shall review the Credentials Committee and Department Chair and any Section Chair's recommendations and all other relevant information available to it and shall forward to the Governing Body its favorable recommendations, which are prepared in accordance with Bylaws Section 5.14.9, "Reappointment Recommendations."

5.14.8.2 When the Executive Committee recommends adverse action, as defined in Bylaws Section 14.2, either with respect to reappointment or clinical privileges, the Chief of Staff shall give the applicant Special Notice of the adverse recommendation and, if applicable, of the applicant's right to request a hearing in the manner specified Bylaws Article 14. Thereafter the procedures specified for applicants in Bylaws Section 5.11.6 (Governing Body Action), and Bylaws Section 5.11.7 (Notice of Final Decision) shall be followed. The Governing Body shall be informed of, but not take action on, the pending recommendation of the Executive Committee until the applicant has exhausted or waived his or her procedural rights, if any.

5.14.9. Reappointment Recommendations

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

5.14.10. Basis for Reappointment

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

5.14.11. Appointment Expiring During Credentialing Process

If the reappointment application has not been fully processed before the Member's appointment expires, the Staff Member may qualify to be granted temporary privileges in accordance with Bylaws Article 6 to fulfill an important patient care, treatment or service need. Temporary privileges shall not be granted if the delay is due to the Member's failure to return the reappointment application form completed as required and Bylaws 5.5 applies. A temporary appointment shall not create any right for continued membership.

5.15 Failure To File Reappointment Application

Failure to file a complete application for reappointment within 45 days of the expiration of the current appointment shall result in the automatic lapse of a Practitioner's Membership and privileges at the expiration of the Member's current term. Members whose membership automatically lapses will be processed as new applicants should they wish to reapply. In the event membership lapses for the reasons set forth herein, the Member is not entitled to any hearing or review.

5.16 Relinquishment of Privileges

A Staff Member who wishes to relinquish or limit particular privileges shall send written notice to the Chief of Staff and the appropriate Department Chair or Section Chair (if the Department has Sections) identifying the particular privileges to be relinquished or limited and the effective date. The relinquishment shall be deemed effective once notice is received by the Chief of Staff, the Department Chair or Section Chair, or in the Medical Staff Office. A copy of this notice shall be forwarded to the Medical Staff Office for inclusion in the Member's credentials file.

5.17 36 Month Wait Period after Adverse Actions: A waiting period of 36 months shall apply to the following Practitioners:

5.17.1. An applicant who

5.17.1.1 has received a final adverse decision regarding appointment or

5.17.1.2 withdrew his or her application or request for membership or Privileges following an adverse recommendation by the Executive Committee or the Governing Body;

5.17.2. A former Member who has

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

5.17.2.2 resigned from the Medical Staff or relinquished privileges while an investigation was pending or following the Executive Committee or Governing Body issuing an adverse recommendation; or

5.17.3. A Member who has received a final adverse decision resulting in

5.17.3.1 termination or restriction of his or her Privileges or

5.17.3.2 denial of his or her request for additional Privileges.

5.17.4. Modification of the Waiting Period. Ordinarily the waiting period shall be 36 months. However, for Practitioners whose adverse action included a specified period or conditions of retraining or additional experience, the Executive Committee may exercise its discretion to allow earlier reapplication upon completion of the specified conditions. Similarly, the Executive Committee may exercise its discretion, with approval of the Governing Body, to waive the 36-month period in other circumstances where it reasonably appears, by objective measures that changed circumstances warrant earlier consideration of an application.

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

5.17.6. Date When the Action Becomes Final for Purposes of Calculating Wait Period. The action is considered final on the latest date on which the application or request was withdrawn, a Member's resignation became effective, or upon completion of (a) all Medical Staff and Hospital hearings and appellate reviews and (b) all judicial proceedings pertinent to the action served within 24 months after the completion of the Hospital proceedings.

5.17.7. Effect Of the Waiting Period Except as otherwise allowed (per Section 5.17.4), Practitioners subject to waiting periods cannot reapply for Medical Staff membership or the Privileges affected by the adverse action for at least 36 months after the action became final. After the waiting period, the Practitioner may reapply. The application will be processed like an initial application or request, plus the Practitioner shall document that the basis for the adverse action no longer exists, that he or she has corrected any problems that prompted the adverse action, and/or he or she has complied with any specific training or other conditions that were imposed.

ARTICLE 6

PRIVILEGES

6.1 Exercise Of Privileges

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

6.1.1. "Cross-Specialty" Privileges. Any request for clinical privileges that are either new to the Hospital or that overlap more than one department shall initially be reviewed by the appropriate departments, in order to establish the need for, and appropriateness of, the new procedure or services. The MEC shall facilitate the establishment of hospital-wide credentialing criteria for new or trans-specialty procedures, with the input of all appropriate departments, with a mechanism designed to ensure that quality patient care is provided for by all individuals with such clinical privileges. In establishing the criteria for such clinical privileges, the MEC may establish an ad-hoc committee with representation from all appropriate Departments.

6.2 History and Physical Privileges

6.2.1. A medical history and physical examination must be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.

6.2.2. An updated examination of the patient, including any changes in the patient's condition, must be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination are completed within 30 days before admission or registration.

6.2.3. The medical history and physical examination, and any update, must be completed and documented by a physician, an oral-maxillofacial surgeon, or other qualified licensed individual in accordance with State law and Medical Staff Rules & Regulations and Medical Staff Clinical Rules & Regulations. Except as provided in Section 6.2.4, H&P's and updates of H&P's may be performed only by licensed practitioners with privileges at St. Joseph Hospital to perform H&P's.

6.2.4. An H&P performed prior to the patient's hospital admission or registration complies with the requirements under this Section 6.2 when it is performed by a physician who is not a member of the Medical Staff, or who does not have admitting privileges, or by a practitioner who is a qualified licensed individual who does not practice at St. Joseph Hospital but is acting within his/her scope of practice under State law or regulations, as long as an update required under Section 6.2.2 is completed and documented by a license practitioner who has privileges at St. Joseph Hospital to perform an H&P.

6.3 Special Conditions

6.3.1. **Podiatric and Dental Privileges**

Surgical procedures performed by podiatrists and dentists shall be under the overall supervision of the Chairman of the Department of Orthopedics or the Chairman of the Department of Surgery or either's designee. All podiatric and dental patients shall be co-admitted by a physician Medical Staff member and receive the same basic medical appraisal as patients admitted to other surgical services. The co-admitting physician Medical Staff member shall be responsible for the care of any medical problems that may be present at the time of admission or that may arise during hospitalization and shall

determine the risk and effect of the proposed surgical procedure on the total health status of the patient.

6.3.2. **Clinical Psychologist Privileges**

Clinical psychologists may admit patients only to the psychiatry services and/or the Chemical Abuse program. All patients admitted by clinical psychologists shall be co-admitted by a physician Medical Staff member who has psychiatric privileges. The psychiatrist shall perform a psychiatric evaluation of the patient, be responsible for prescribing and managing any psychotropic medications that the patient needs and direct the patient's care (and document this in progress notes entered at least weekly).

All patients admitted by a clinical psychologist shall also receive the same basic medical appraisal as patients admitted to any other service. A physician Medical Staff member shall be responsible for performing the history and physical examination and caring for any medical problem that may be present at the time of admission or that may arise during hospitalization.

6.3.3. **Interns, Residents, and Fellows**

Interns, Residents and Fellows in formal approved training programs in the Hospital shall not hold appointments to the Medical Staff and shall not be granted specific clinical privileges in the training programs. Rather, they shall be permitted to perform only those clinical duties set out in training protocols developed by the Directors of Education, at the certifying training program, curriculum requirements, and/or affiliation agreements approved by the Hospital and Medical Executive Committee. Residents and fellows practicing independently of an approved training program must apply for and qualify for Medical Staff membership and privileges.

6.4 Telemedicine Privileges

6.4.1. Definitions: The following definitions apply to this Section 6.4:

6.4.1.1 “Distant Site” means [1] a Joint Commission-accredited hospital other than St. Joseph Hospital of Orange, or [2] a Joint Commission accredited ambulatory health care entity that provides Telemedicine Services and is not owned or operated by St. Joseph Hospital of Orange, such as an imaging center, urgent care center, medical practice, or [3] a hospital or ambulatory health care entity not owned or operated by St. Joseph Hospital of Orange and not accredited by The Joint Commission.

6.4.1.2 “Originating Site” or “Hospital” means St. Joseph Hospital of Orange.

6.4.1.3 “Telemedicine Privileges” means the specific authority granted to Telemedicine Staff to provide Telemedicine Services, as required by the Medical Staff credentialing and privileging processes in this Section 6.4, and the Medical Staff Rules. The specific types of Telemedicine Services that require credentialing and privileging shall be identified by each department and approved by the Medical Executive Committee and Governing Body.

6.4.1.4 “Telemedicine Staff” is the Medical Staff category reserved solely for physicians practicing at a Distant Site, and who are privileged by the Medical Staff to provide only Telemedicine Services to patients located at the Originating Site.

6.4.1.5 “Telemedicine Services” means the delivery of health care services by use of information and communication technologies to transmit and exchange reliable information for diagnosis, treatment and prevention of disease and injuries. Telemedicine services does not include delivery of health care services via telephone, texting, or electronic mail communications. Medical Staff members with

privileges to care for patients at the Hospital, other than Telemedicine Staff, are not required to be additionally credentialed or privileged to provide Telemedicine Services.

6.4.2. Qualifications: Each applicant for Telemedicine Staff must meet the basic qualifications set forth in Article 2 of these Bylaws. Applicants for Telemedicine Staff must pay all fees and dues established by the Executive Committee. Only Telemedicine Staff may be granted Telemedicine Privileges.

6.4.3. Credentialing Telemedicine Staff

6.4.3.1 **Full Credentialing:** Except as otherwise permitted in these bylaws, applicants to the Telemedicine Staff shall be credentialed pursuant to the complete appointment/reappointment and privileging process described in Article 5 and Section 6.6 of these Bylaws. Such applicants shall not be granted membership as Telemedicine Staff if privileges are sought other than those authorizing Telemedicine Services from a Distant Site to patients located at the Originating Site. Medical Staff members with privileges to care for patients at the Hospital, other than Telemedicine Staff, are not required to be additionally credentialed or privileged to practice telemedicine.

6.4.3.2 **Reliance on Distant Site Credentialing and Privileging Decision, or on Distant Site Credentialing Information:** As an alternative to the credentialing and privileging process described in Article 5 and Section 6.6, the Executive Committee may make recommendations to the Governing Body regarding applicants seeking Telemedicine Staff status by relying on the credentialing and privileging decision, or credentialing information, of the Distant Site in the manner set forth in the Medical Staff Rules.

6.4.4. **Temporary Privileges for Telemedicine:** If the Hospital has identified an important patient care need for Telemedicine Services that cannot be satisfied by Medical Staff members already granted Telemedicine Privileges, and an identified Distant Site Practitioner may be qualified and able to satisfy that patient care need, that Practitioner may be credentialed for temporary clinical privileges in accordance with section 6.5 of these Bylaws ("Temporary Clinical Privileges").

6.4.5. The Medical Staff is responsible for quality and safety of Telemedicine Services. At all times, the Medical Staff is responsible for overseeing and enforcing the safety and quality of care and services provided to patients by, and the professional conduct of, Telemedicine Staff members, and shall take all appropriate action in carrying out these responsibilities.

6.5 Temporary Clinical Privileges

6.5.1. Circumstances

6.5.1.1 Temporary privileges may be granted under two circumstances only: (1) to address an important patient care need or (2) to permit patient care to be provided while an application is pending. Temporary Privileges may be granted only after the Practitioner has satisfied the requirements set forth in these Bylaws.

6.5.1.2 Temporary privileges may be granted after appropriate application:

a. Applicant Waiting for Review of Standard Application for Membership and Privileges. For 30-day periods, subject to renewal not to exceed 120 days, during the pendency of an application, while the credentials information is verified: or

b. Care, Treatment or Service Needs of Patients. To fulfill an important patient care, treatment or service need.

6.5.1.3 Care of Specific Patient. Temporary clinical privileges may be granted to serve an important patient care need by permitting the practitioner to provide care to a specific patient (but for not more than 30 days at a time subject to renewal to a total of 60 days during a calendar year), provided that the procedure described in Section 6.5 has been completed.

6.5.2. Granting Temporary Privileges.

6.5.2.1 Temporary Privileges may be granted by the Chief Executive Officer (or for the care of a specific patient, the Administrator on Call), but only on the recommendation of the Chief of Staff (or designee), in consultation with the Department Chair or Section Chair where the Privileges will be exercised, or either's designee.

6.5.2.2 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.

6.5.2.3 Members whose membership was automatically terminated for a failure to complete medical records shall not be eligible for temporary privileges.

6.5.3. Application for Temporary Privileges

6.5.3.1 Practitioners seeking temporary privileges must complete an application for staff membership (if temporary privileges are sought during the pendency of an application or to serve as locum tenens) or a temporary privilege application form (for temporary privileges to care for specific patients).

6.5.3.2 Pending Application for Medical Staff Membership

Temporary clinical privileges may be granted to an applicant while that person’s application for Medical Staff membership and privileges is completed and awaiting review and approval of the Medical Executive Committee or the Governing Body, provided that the procedure described in Section 6.5 has been completed, and that the applicant has no current or previously successful challenge to professional licensure or registration, no involuntary termination of Medical Staff membership at any other organization, and no involuntary limitation, reduction, denial or loss of clinical privileges. Such persons may only attend patients for a period not to exceed 90 days.

6.5.4. Application and Review

a. Upon receipt of a completed application and supporting documentation from a practitioner authorized to practice in California, the Chief Executive Officer on the recommendation of either the applicable clinical department chairperson or the Chief of Staff, may grant temporary privileges to a member who appears to have qualifications, ability and judgment consistent with Bylaws Section 2.2, but only:

i. With respect to applications by locum tenens, or to fulfill an important patient care need, after verification of current licensure and current competence; or

ii. With respect to a new applicant awaiting review and approval of the Medical Executive Committee and the Governing Body in compliance with the requirements in Section 6.5, after the following has been completed:

a. the National Practitioner Data Bank report regarding the applicant for temporary privileges has been received and evaluated and current California licensure has been verified.

iii. Verification of the following:

a. relevant training or experience;

b. current competence and ability to perform the privileges requested;

c. and any other criteria required by Medical Staff Bylaws

iv. the appropriate department chair has interviewed the applicant, and has documentation from the file from at least one person who:

a. has recently worked with the applicant;

b. has directly observed the applicant's professional performance over a reasonable time; and

c. provides reliable information regarding the applicant's current professional competence to perform the privileges requested, ethical character, and ability to work well with others so as not to adversely affect patient care, or other criteria required by Medical Staff bylaws.

v. the applicant's file, including the recommendation of the department chair of the applicable department, and the Chief of Staff (or designee) in all other cases, is forwarded to the credentials committee and the Medical Executive Committee.

vi. the Medical Executive Committee through the Chief of Staff, after reviewing the applicant's file and attached materials, recommends granting temporary privileges.

6.6 General Conditions.

a. If granted temporary privileges, the applicant shall act under the overall supervision of the department chair to which the applicant has been assigned, and shall ensure that the chair, or the chair's designee, is kept closely informed as to the applicant's activities within the hospital.

b. Temporary privileges shall automatically terminate at the end of the designated period, unless earlier terminated or suspended under Bylaws Articles 13 or 14 of these Bylaws or unless affirmatively renewed following the procedure as set forth in these Bylaws Section 6.5. A Medical Staff applicant's temporary privileges shall automatically terminate if the applicant's initial membership application is withdrawn. As necessary, the appropriate department chair or, in the chair's absence, the chair of the Medical Executive Committee, shall assign a member of the Medical Staff to assume responsibility for the care of such member's patient(s). The wishes of the patient shall be considered in the choice of a replacement Medical Staff member.

c. Requirements for proctoring and monitoring, including but not limited to those in Rule 8, shall be imposed on such terms as may be appropriate under the circumstances upon any member granted temporary privileges by the Chief of Staff after consultation with the departmental chair or the chair's designee.

d. All persons requesting or receiving temporary privileges shall be bound by the bylaws and rules and regulations of the Medical Staff.

e. Practitioners granted temporary Privileges shall be subject to quality improvement review.

f. There is no right to temporary Privileges. Accordingly, temporary Privileges should not be granted unless the available information supports, with reasonable certainty, a favorable determination regarding the requesting Practitioner's or APP's qualifications, ability, and judgment to exercise the Privileges requested, and only after the Practitioner or APP/AHP has demonstrated compliance with the Rules.

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

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

i. Temporary Privileges may be terminated with or without cause at any time by the Chief of Staff (or designees) in consultation with the Department Chair or Section Chair. Because hearing rights may be required when temporary privileges are terminated for medical disciplinary cause or reason, the Chief Executive Officer may also terminate such privileges, but only after conferring and obtaining agreement of the Chief of Staff or the responsible Department Chair or Section Chair. A person shall be entitled to the procedural rights afforded by the Bylaws and Rules only if a request for temporary Privileges is refused based upon, or if all or any portion of temporary Privileges are terminated or suspended for, a medical disciplinary cause or reason, and only if such refusal, termination, or suspension would give rise to hearing rights in Article 14 of these bylaws. In all other cases (including a deferral in acting on a request for temporary Privileges), the Practitioner shall not be entitled to any procedural rights based upon any adverse action involving temporary Privileges.

6.7 Emergency Privileges

a. In the case of an emergency involving a particular patient, any member of the Medical Staff with clinical privileges, 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 the patient or to save the patient from serious harm provided that the care provided is within the scope of the individual’s license. The member 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.

b. In the event of an emergency under subsection (a), any practitioner shall be permitted to do whatever is 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 qualified members of the Medical Staff when it becomes reasonably available.

6.8 Emergency Disaster Credentialing

6.8.1. General

6.8.1.1 There shall be a plan for the care of mass casualties at the time of a major disaster, based upon the Hospital's capabilities in conjunction with other emergency facilities in the community. The plan shall be developed by a disaster planning committee.

6.8.1.2 All Practitioners shall be assigned to posts, either in the Hospital, an auxiliary hospital, or a mobile casualty station in the event of a mass disaster. The Practitioner shall be responsible for reporting to his or her assigned station and performing the assigned duties unless the Disaster Assignment Chair changes the assignment.

6.8.1.3 If patients are evacuated from one Section of the Hospital to another, or from the Hospital premises, the Administrator on Call, after conferring with the Medical Staff Chair, Department Chairs, and/or Section Chairs, will arrange for the transfers.

6.8.1.4 An individual who presents as a volunteer LIP should be directed to the appropriate area as designated by the emergency management Command Center.

6.8.2. Disaster privileges may only be granted to a licensed independent practitioner (LIP) when the following two criteria have been met:

6.8.2.1 The organization's emergency management plan has been formally activated, and;

6.8.2.2 The organization is unable to meet immediate patient needs.

6.8.3. The verification process of the credentials and privileges of individuals who receive disaster privileges under this subsection shall be developed in advance of a disaster situation. This process shall begin as soon as practical after the immediate disaster situation is under control, and shall meet the following requirements in order to fulfill important patient care needs:

6.8.3.1 The Medical Staff identifies in writing the individual(s) responsible for granting disaster privileges.

6.8.3.2 The Medical Staff describes in writing the responsibilities of the individual(s) responsible for granting disaster privileges.

6.8.3.3 The Medical Staff describes in writing a mechanism to manage the activities of individuals who receive disaster privileges. There is a mechanism to allow staff to readily identify these individuals.

6.8.3.4 The Medical Staff addresses the verification process as a high priority. The Medical Staff has a mechanism to ensure that the verification process of the credentials and privileges of individuals who receive disaster privileges begins as soon as the immediate situation is under control. This privileging process is identical to the process established under the Medical Staff bylaws for granting temporary privileges to fulfill an important patient care need.

6.8.4. Granting of disaster privileges must be authorized by the Chief Executive Officer (or designee), the Chief of Staff (or designee) or the appointed Disaster Medical Director (or authorized designee). Disaster privileges will be granted on a case-by-case basis.

6.8.5. A volunteer LIP must present a valid government issued photo identification issued by a state or federal or regulatory agency (e.g., driver's license or passport). In addition, the volunteer LIP must provide at least one of the following:

(1) A current hospital picture identification card that clearly identifies the individual's professional designation

(2) A current license to practice.

(3) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organization or group(s).

(4) Identification indicating that the individual has been granted authority to render patient care, treatment, or services in disaster circumstances (such as authority having been granted by a federal, state, or municipal entity).

(5) Identification by a current member of the organization or Medical Staff who possesses personal knowledge regarding the individual's ability to act as a LIP during a disaster.

6.8.6. Current professional licensure of those providing care under disaster privileges is verified from the primary source as soon as the immediate emergency situation is under control and completed or within 72 hours from the time the volunteer licensed independent practitioner presents him- or herself to the hospital, whichever comes first. If primary source verification cannot be completed within 72 hours of the practitioner's arrival due to extraordinary circumstances, the hospital documents all of the following:

(1) The reason[s] verification could not be performed within 72 hours of the practitioner's arrival,

(2) Evidence of the licensed independent practitioner's demonstrated ability to continue to provide adequate care, treatment and services.

(3) Evidence of an attempt to perform primary source verification as soon as possible.

6.8.7. Primary source is the entity or agency that has the legal authority to issue the credential in question. If the entity or agency has designated another entity or agency to communicate information about the status of a staff member's credential, then the other entity or agency may be considered the primary source.

6.8.8. If the volunteer LIP is not providing care, treatment, or service that required the granting of disaster privileges, then primary source verification is not required.

6.8.9. The Medical Staff Office, or other designee, shall be responsible for securing primary source verification on all volunteer practitioners.

6.8.10. An initial grant of disaster privileges is reviewed by a person authorized to grant disaster privileges within 72 hours to determine whether the disaster privileges should be continued.

6.8.11. Volunteer LIP's will be identified by a name badge or tag provided by the organization. The badge / tag will list the name and professional designation of the volunteer (e.g., John Smith MD) as well as the notation that the individual is a volunteer. The volunteer LIP will be required to wear the badge / tag on his or her person while performing in that role / capacity.

6.8.12. Volunteer LIP's will be assigned to a member of the Medical Staff who is a peer in the volunteer's area of practice and experience. The Medical Staff member will serve as a

mentor and resource for the volunteer practitioner. The Medical Staff member will be responsible for overseeing the professional performance of the volunteer LIP. This shall be accomplished by;

(1) Direct observation, and, to the degree possible or

(2) Clinical review of care documented in the patient's medical record.

6.8.13. Volunteer LIP's will cease providing care, treatment, or service if any one of the following criteria is met:

(1) Implementation of the emergency management plan ceases and the capability of the organization's staff becomes adequate to meet patient care needs or

(2) A decision is made that the professional practice of the volunteer LIP does not meet professional standards.

6.8.14. Termination of privileges under this provision shall not entitle the practitioner to a hearing under Article 14 of the Bylaws.

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

ARTICLE 7

GENERAL OFFICERS OF THE MEDICAL STAFF AND CHIEF MEDICAL OFFICER

7.1 General Officers of The Medical Staff

7.1.1. Identification of the General Officers

The general officers of the Medical Staff shall be a Chief of Staff, a Vice Chief of Staff, Immediate Past Chief of Staff, a Secretary-Treasurer, and two Members-at-large (who shall be nominated and elected for a two-year term. They shall comprise the Staff Officer Committee as described in the Rules Section 1.15.

7.1.2. Qualifications

All General Officers of the Medical Staff shall meet the following conditions in order to qualify and serve as an Officer.

At the time of becoming a candidate for an Office under this Section, the member must provide a written statement that the following conditions are met and provide an immediate update at any time, as a candidate or while in office, that any of the following conditions are not being met:

a. Utilize St. Joseph Hospital as the primary hospital for the candidate's practice of medicine.

b. Not hold a leadership position as an elected Staff Officer or hold membership on the MEC at a competing hospital, once elected.

c. Have had no clinical or behavior issues which resulted in action by the MEC for the last five (5) years.

d. understand the purposes and functions of the Medical Staff and agree to assure that patient welfare always takes precedence over other concerns;

e. understand and be willing to work towards supporting the Hospital's mission and vision;

f. have competent administrative ability as applicable to the respective office;

g. Demonstrate leadership and/or enter into a training and/or formal leadership program in order to enhance the skill needed to serve in the Office.

h. work with and motivate others to achieve the objectives of the Medical Staff and the Hospital;

i. demonstrate clinical competence in his or her field of practice;

j. be an Active Medical Staff member (and remain in good standing as an Active Medical Staff member while in office). Failure to maintain such status shall create a vacancy in the office involved;

k. be licensed as physician and surgeon, given the nature of the duties of the office;

l. Have prior experience as a Section or department chair, member-at-large, or the chair of a major Medical Staff committee at St. Joseph Hospital or experience at a like hospital, if running for, or serving in, the Office of Chief of Staff, Vice Chief of Staff or Secretary Treasurer.

7.1.3. **Disclosure Of Conflict of Interest**

7.1.3.1 **In Meetings or Other Forums.** In addition to exercising their responsibilities pursuant to these bylaws, all General Officers shall verbally disclose all actual or potential conflicts of interest in the course of each Medical Staff meeting, committee meeting or other event where such a disclosure may be relevant to any discussion or agenda item under consideration. Any potential conflicts so disclosed shall be resolved as set forth in this Article.

7.1.3.2 **As Candidates.** All nominees for election to Medical Staff office (including those nominated by petition of the Medical Staff pursuant to the Bylaws and Rules) shall disclose in writing to the Medical Staff Office, within five business days after accepting nomination by the nominations Committee or after being notified that their petition for nomination is successful, disclose in writing to the Medical Staff Office those personal, professional, and financial interests, affiliations and relationships, of which they are reasonably aware, including contractual, employment, fiduciary, or other relationships with the hospital, hospital system or other entity that could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff. The Medical Staff office shall notify the membership of the candidates for elective office and shall include with that notification the disclosure forms provided by each of the candidates. Additionally, such disclosure statements shall accompany the ballot. Such disclosures shall not relieve any committee member or elected officer from the duty to verbally disclose under Article 9 of these Bylaws ("Committees").

7.2 Method of Election for Medical Staff Office

7.2.1. **Nominations**

a. **Nominating Committee Composition:** Medical Staff elections shall be every two years. A Nominating Committee shall be appointed by the Executive Committee no later than 120 days prior to the mailing of ballots to the voting members of the Medical Staff. The nominating committee shall consist of:

i. the immediate past Chief of Staff in the active staff category (chair without vote except to break a tie)

ii. Two other former chiefs of staff in active staff, in chronological order.

iii. Two active Medical Staff members chosen by the Credentials Committee from a pool of candidates comprised of one member from each Department selected by the Department.

iv. and two MEC members as selected by vote of the MEC

b. **Nominating Committee Charge:** The nominating committee shall formally request names of potential candidates for the positions of Secretary-Treasurer and Members-at-Large from members of the Medical Staff no later than [100] days prior to the day ballots are to be disseminated to the voting members of the Medical Staff. Such a request may be made electronically to each Medical Staff member through the Medical Staff's Internet-based bulletin board and electronically to those Medical Staff members that have provided their e-mail address [and/or facsimile numbers], or through any other method that satisfactorily communicates this request to all voting members of the Medical Staff. Such request shall also be posted in Medical Staff common areas, such as Medical Staff offices, dining room, and lounges. The Nominating Committee shall accept responses to its request for 30 days, and thereafter shall nominate at least two nominees for Secretary/Treasurer and Member-at-Large based on the names it received from

the general Medical Staff and its own assessment of the candidates. For Chief of Staff and Vice Chief of Staff, the Nominating Committee shall accept responses to its request for 30 days, and thereafter shall review the names based on the names it received from the general Medical Staff and its own assessment of the candidates, based on qualifications of Article 7.1.2. The Nominating Committee slate of nominees" shall be presented to the Executive Committee no later than sixty days prior to the dissemination of ballots to the membership and shall be delivered or mailed to the voting members of the Medical Staff within five days of that presentation. The hospital administration and Governing Body shall have no right to approve the slate of candidates or otherwise influence or participate in the activities of the nominating committee.

c. Additional Nominations: Further nominations may be made for any office by submitting the name of the candidate to the Chairman of the Nominating Committee together with a written petition which is signed by at least ten percent (10%) of the Active Staff members. These nominations shall be delivered to the Chairman of the Nominating Committee in care of the Medical Staff Office at least twenty (20) days prior to the day of election for authentication. If nominations are made in this manner, the voting members of the Medical Staff shall be advised of the additional candidate(s) by notice delivered or disseminated no later than ten [10] days prior to the day the ballots are disseminated to the voting members of the Medical Staff.

7.2.2. **Election Process**

Officers shall be elected in November of the appropriate Medical Staff year. Only Active Staff members shall be eligible to vote. Voting shall be by the prescribed manner as established by the MEC (mail ballot, electronic, etc.), as defined in Bylaws Section 15.7. Ballots shall be disseminated to the voting members of the Medical Staff by **the first Tuesday in November and must be received in the Medical Staff Office not later than 4:00 p.m. on the third Tuesday of November. A nominee shall be elected upon receiving a majority of the valid votes cast. For candidates for elected office, if no candidate 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. Ballots for a runoff election should be disseminated within five days of tallying the plurality vote and returned to the Medical Staff office within fifteen days of dissemination. In case of a tie, the majority vote of the Executive Committee at its next meeting or at a special meeting called for the purpose shall decide the election. This vote shall be by secret ballot.

7.3 Immediate Past Chief of Staff Provisions

The Chief of Staff shall, upon completion of his term of office, immediately succeed to the office of Immediate Past Chief of Staff.

7.4 Term of Elected Officers of the Medical Staff

Each officer shall serve an elected two-year consecutive full term, commencing on the first day of the Medical Staff year following his election. Each shall serve until the end of his term, unless he shall sooner resign or be removed from office or position. No staff officer may be elected to the same office for more than one term. Terms of Committee members shall be as set forth in the Rules.

7.5 Removal of General Medical Staff Officers

A Medical Staff Officer may be removed from their position for any valid cause, including, but not limited to, failure to meet the qualifications for office or to carry out the duties of his or her office. Removal may be initiated by majority vote of the Executive Committee, or upon the written request of 20 percent of the members eligible to vote. Such removal will be effected by a two-thirds majority of the valid votes cast. Voting on removal of an elected officer shall be by secret ballot. The written

mail or electronic ballots shall be sent to each voting member at least 14 business days before the scheduled election date and the ballots shall be counted by the Secretary/Treasurer of the Medical Staff (except when he is the subject of the balloting, in which case the Chief of Staff shall count the ballots) and the Director of Medical Staff Services. The Executive Committee must consider whether to initiate removal of an officer whenever a member has missed three consecutive meetings of the Executive Committee.

7.6 Vacancy in Office

Vacancies in office, other than that of Chief of Staff, shall be filled by the Executive Committee. If there is a vacancy in the office of Chief of Staff, the Vice Chief of Staff shall serve out the remaining term. A vacancy in the office of the Immediate Past Chief of Staff need not be filled.

7.7 Duties Of Officers

7.7.1. **Chief of Staff**

The Chief of Staff shall serve as the Chief Executive Officer of the Medical Staff. He shall:

a. Represent the views, bylaws, rules & regulations, needs, and grievances of the Medical Staff to the Governing Body and to the CEO.

b. Serve as Chairman of the Executive Committee.

c. Be responsible for the enforcement of the Medical Staff Bylaws and Rules, for the implementation of sanctions where indicated, and for the Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner.

d. Act in coordination and cooperation with the CEO in all matters of mutual concern within the Hospital.

e. Call, preside at, and be responsible for the agenda of all general staff meetings of the Medical Staff.

f. Serve as an ex-officio member of all other staff committees without vote, unless his membership in a particular Committee is required by these Bylaws.

g. Appoint, with Executive Committee approval, committee members to all standing and special Medical Staff committees, except where otherwise provided by these Bylaws or by Medical Staff Rules.

h. Serve as a member of the Governing Body in such capacity as may be permitted or required by the Hospital's Corporate Bylaws.

i. Interpret the policies of the Governing Body to the Medical Staff.

j. Be a spokesman for the Medical Staff in external professional public relations.

k. Perform such other functions as may be assigned to him by these Bylaws, by the membership, by the Executive Committee.

7.7.2. **Vice Chief of Staff**

7.7.2.1 The Vice Chief of Staff, in the absence of the Chief of Staff, shall assume all duties and authority of the Chief of Staff; perform such other supervisory duties as the Chief of Staff may assign to him; and carry out such other functions as may be delegated to him by these bylaws, by the membership, by the Executive

Committee, or by the Governing Body. He shall automatically succeed the Chief of Staff upon the Chief's resignation or departure from the office for any reason.

7.7.2.2 If the Chief of Staff leaves office before completing his term of office, the Vice Chief of Staff shall succeed the outgoing Chief and shall serve out the remainder of the outgoing Chief's term. At the end of service, the election for General Officers shall include election of a Chief of Staff. The Chief of Staff who served out the remainder of the prior Chief's term under this provision shall be eligible to run for position of the Chief of Staff.

7.7.2.3 The Vice Chief of Staff serves as a member of the Board of Trustees.

7.7.2.4 The Vice Chief of Staff serves as the Credentials Committee chair.

7.7.3. **Immediate Past Chief of Staff**

The Immediate Past Chief of Staff shall be a member of the Executive Committee; and the Staff Officers Committee and shall perform such supervisory duties as the Chief of Staff may assign him; and carry out such other functions as may be delegated to him by these Bylaws, by the membership, by the Executive Committee.

7.7.4. **Secretary-Treasurer**

The Secretary/Treasurer shall be a member of the Executive Committee and is the Chairman of the Quality & Safety Committee of the Medical Staff. He/she will assure the following duties are fulfilled:

7.7.4.1 maintaining a roster of members; keeping accurate and complete minutes of all Executive Committee and Medical Staff meetings;

7.7.4.2 calling meetings on the order of the Chief of Staff;

7.7.4.3 attending to all correspondence;

7.7.4.4 receiving, safeguarding, and being accountable for all funds of the Medical Staff;

7.7.4.5 preparing an annual proposed budget in cooperation with, and for approval by, the Executive Committee of anticipated income (including a recommendation for the setting of Medical Staff dues) and expenditures, and preparing on a quarterly basis a financial statement in accordance with generally accepted accounting principles (GAAP), and recommending, where needed, the creation of a finance subcommittee to assist in these duties;

7.7.4.6 excusing absences from meetings on behalf of the Executive Committee;

7.7.4.7 assuming duties of the Chief of Staff when the Chief of Staff and Vice Chief of Staff are absent;

7.7.4.8 and performing such other duties as ordinarily pertain to his office or as may be assigned to him.

7.7.5. **Members at Large:**

Members at large are representatives of the Medical Staff on the Medical Executive Committee and are available at the request of the Chief of Staff. The MEC shall select one member-at-large to serve as the Medical Staff's representative and delegate to the CMA Organized Medical Staff Section and the second to serve as the alternate.

7.8 Duties of the Chief Medical Officer

The Chief Medical Officer shall:

a. Help the Medical Staff to develop, implement, and evaluate quality improvement, peer review, and education programs.

b. Assist the Medical Staff, whenever requested, in reviewing and investigating applicants or members.

c. Serve as an *Ex Officio* member, without vote, of all Medical Staff committees.

d. In cooperation and close consultation with the Chief of Staff and the Executive Committee, assist with quality improvement, utilization management, and corrective action investigations and actions.

e. In supervising the day-to-day performance of the Medical Staff Office, assure that confidential information in the possession of the Chief Medical Officer and Medical Staff Office employees involving protected peer review information and other confidential or sensitive Medical Staff activities remains confidential as to all other hospital personnel, except as required by these bylaws to carry out the Medical Staff's duties.

7.9 Medical Directors

a. Appointments of Medical Directors for special units (such as the intensive care unit), Departments or other directorship programs may be appointed by the Chief Executive Officer after consulting with the Executive Committee.

b. Responsibilities

i. The duties of Medical Directors shall be delineated by the Chief Executive Officer in keeping with the general provisions set forth in paragraph "ii" below. Job descriptions for all Medical Director positions must be reviewed and approved by the Executive Committee prior to the position being filled, to prevent encroachment upon Medical Staff self-governance and other conflicts with Medical Staff bylaws, rules and regulations and policy, and to maximize effectiveness of the position and cooperation between Medical Directors and the Medical Staff.

ii. In keeping with the foregoing, the Medical Directors may serve as administrative liaison among Hospital administration, the Governing Body, outside agencies, and the Medical Staff and shall assist and support the Medical Staff in performing its assigned functions and coordinating such functions with the responsibilities and programs of the Hospital

c. Selection

i. The CEO shall coordinate candidate interviews with representatives of Medical Staff leadership, who shall participate in the interview and review of candidates for position of medical director in the hospital.

ARTICLE 8

CLINICAL DEPARTMENTS AND SECTIONS

8.1 Organization of Departments and Sections

Each Department and Section shall be organized as an integral unit of the Medical Staff and have leaders who are selected and have the authority, duties, and responsibilities specified in the Rules. Additionally, each Department Chair shall appoint a Department committee and each Section Chair may appoint a Section Committee and each Department Chair and each Section Chair may appoint such other standing or ad hoc committees as he or she deems appropriate to perform the required functions. The composition and responsibilities of each standing Department or Section committee shall be specified in the Rules.

8.2 Designation

8.2.1. The current Departments are:

8.2.1.1 Anesthesia

8.2.1.2 Behavioral Sciences

8.2.1.3 Emergency Medicine

8.2.1.4 Family Practice

8.2.1.5 Medicine

8.2.1.6 Obstetrics/Gynecology

8.2.1.7 Ophthalmology and Otorhinolaryngology

8.2.1.8 Orthopedic

8.2.1.9 Pathology

8.2.1.10 Pediatric

8.2.1.11 Radiology

8.2.1.12 Surgery

Sections and subsections are as listed or specified in the Rules of each Department.

8.3 Assignment To Departments and Sections

Each Member shall be assigned membership in at least one Department and one Section within the Department (if the Department has Sections) but may be granted membership and/or privileges in other Departments (and Sections).

8.4 Functions Of Departments

8.4.1. The Departments and Sections shall fulfill the clinical, administrative, quality improvement risk management, utilization management, and collegial and education functions described below. Each Department and Section, through its officers and any established committees, is responsible for the quality of care within the Department and Section and for the effective performance of the following as relates to the Members of the Department and Section and APPs/AHPs practicing within the Department and Section:

a. Patient care evaluation, observation, and monitoring (including periodic demonstrations of ability), consistent with guidelines developed by the committees responsible for quality improvement, utilization management, education, and medical records, and by the Executive Committee.

b. Credentials review, consistent with guidelines developed by the Credentials Committee and the Executive Committee.

c. Corrective action, when indicated, in accordance with the Bylaws and Rules.

d. Continuing education, consistent with guidelines developed by the Continuing Medical Education Committee and the Executive Committee.

e. Planning and budget review, consistent with guidelines developed by the Executive Committee.

8.4.2. When the Department or Section or any Department or Section committee meets to carry out the duties described below, the meeting body shall constitute a peer review committee, which is subject to the standards and entitled to the protections and immunities afforded by federal and state law for peer review committees. Each Department, Section, Department Committee, and Section Committee shall meet when and if necessary to carry out its duties, at the request of the Chair.

8.5 Department and Section Officers

8.5.1. **Qualifications**

Each Department and Section Officer shall:

8.5.1.1 Be willing and able to faithfully discharge the functions of his or her office.

8.5.1.2 Demonstrate prior or present board certification in his or her appropriate specialty.

8.5.1.3 Have demonstrated clinical competence in his or her field of practice sufficient to maintain the respect of the Members of his or her Department or Section.

8.5.1.4 Have an understanding of the purposes and functions of the Staff organization and a demonstrated willingness to promote patient safety over all other concerns.

8.5.1.5 Support the Hospital’s mission and vision..

8.5.1.6 Have an ability to work with and motivate others to achieve the objectives of the Medical Staff organization in the context of the Hospital’s lawful and reasonable objectives.

8.5.1.7 Be (and remain during tenure in office) a member of the Active Medical Staff in good standing.

8.5.1.8 Not have any significant conflict of interest that would prevent him or her from fulfilling the duties of his or her office.

8.5.1.9 Not concurrently serve as an officer of the Medical Staff.

8.5.2. **Selection**

The Department and Section Chair and Vice Chair shall be elected by ballot by the Active Staff members of the Department and Section. Each Department Chair shall appoint a Nominating Committee consisting of at least three (3) Active staff members who are members of the Department including at least one member who has not previously been a Department Chair but who is presently a member of the Department Committee and at least two members who have served as the Department Committee Chair. If it is not possible to comply with these Nominating Committee requirements, the Department Chair or the Chief of Staff may appoint the Nominating Committee for the Department. Each Section Chair shall appoint a Nominating Committee comprised of at least three members of the Section. The Nominating Committees shall be appointed not later than September 1st of each election year.

The Nominating Committee's recommendations for one or more nominees for Chair and Vice Chair shall be circulated to the voting members of each Department and Section by October 1. The voting members of the Department and Section may submit additional nominations by submitting the name of the candidate together with a petition signed by twenty (20) percent of the Active Department or Section members by October 21.

Voting shall be by ballot, as defined in Bylaws Section 15.7. All Ballots shall be disseminated on the first Tuesday in November and must be received in the Medical Staff Office by 4:00 p.m. on the third Tuesday in November. A nominee shall be elected upon receiving a majority of the valid votes cast. In the event there are more than two nominees for an office, and if no nominee receives a majority of the votes cast, a runoff election shall be held between the two highest vote-getters, and the nominee with a majority of votes case shall be elected. In case of a tie, the majority vote of the Department or Section at its next meeting or at a special meeting called for the purpose shall decide the election. This vote shall be by secret ballot.

8.5.3. **Term of Office**

Each Department Chair and Vice Chairman and each Section Chair and Vice Chair shall serve a two-year term commencing on his election with the beginning of the next Medical Staff year. He shall serve until the end of the Medical Staff year and until his successor is chosen, unless he shall sooner resign or be removed from office. Department and Section leaders are eligible to succeed themselves.

8.5.4. **Removal**

A Department or Section Chair or Vice Chair may be removed from office for any valid cause, including, but not limited to, failure to meet the qualifications for office or to carry out the duties of his or her office. Removal of a Department or Section Chair or Vice Chair from office may be initiated by a majority vote of the Executive Committee or by written request from twenty percent (20%) of the members of the Chair or Vice Chair Department or Section who are eligible to vote. Such removal may be effected by a majority vote of the Executive Committee members or by a majority vote of the Active Department or Section members. All voting shall be conducted by written secret ballot, as defined in Bylaws Section 15.7, which shall be sent to those eligible to vote within 45 days after the initiation of removal pursuant to this Section. The ballots must be received no later than 14 days after they are mailed and shall be counted by the Chief of Staff, Secretary/Treasurer, and Medical Staff Coordinator.

8.5.5. **Filling Vacancies**

A vacancy in a Department or Section leader position shall be filled by a special election to be held using mail ballots. The Chair of the Department shall secure nominations from the voting members of the Department or Section at a regular meeting or by mail ballot and thereafter shall send a mail ballot with all nominations to each voting member of the

Department or Section where there was the vacancy. The Member who is elected to fill the vacancy shall serve until the end of the term of the leader he or she was replacing.

8.6 Responsibilities of Department and Section Leaders

8.6.1. Each Department Chair shall be responsible for:

8.6.1.1 All clinically related activities of the Department.

8.6.1.2 All administrative activities of the Department (unless otherwise provided for by the Hospital), including regular attendance at the Medical Executive Committee.

8.6.1.3 Working with the Hospital Administration on matters that affect the Department.

8.6.1.4 Integrating the Department into the primary functions of the organization.

8.6.1.5 Coordinating and integrating interdepartmental and intradepartmental services.

8.6.1.6 Developing and implementing policies and procedures that guide and support the provision of care, treatment and services in the Department.

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

8.6.1.8 Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Department.

8.6.1.9 Recommending rules that set forth the criteria for clinical privileges in the Department.

8.6.1.10 Recommending clinical privileges for each Member of the Department and each Staff Member desiring to exercise privileges in the Department.

8.6.1.11 Evaluating the qualifications and competence of AHPs who provide patient care services within the purview of the Department.

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

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

8.6.1.14 Maintaining quality control programs, as appropriate and in coordination with the Quality & Safety Committee of the Medical Staff.

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

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

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

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

8.6.1.19 Serving as an Ex Officio member of all committees of his or her Department and attending such committee meetings as deemed necessary.

8.6.1.20 Assuring that records of performance are maintained and updated for all Members of his or her department.

8.6.1.21 Reporting on activities of the Department to the Executive Committee when called upon to do so by the Chief of Staff.

8.6.1.22 Performing such additional responsibilities as may be delegated to him or her by the Executive Committee, the Chief of Staff.

8.6.2. Each Section Chair shall be responsible for:

a. All Section clinical activities.

b. All administrative activities of the Section (unless otherwise provided for by the Hospital).

c. Working with the Hospital Administration on matters that affect the Section.

d. Integrating the Section into the primary functions of the organization.

e. Coordinating and integrating interdepartmental and intradepartmental services.

f. Developing and implementing policies and procedures that guide and support the provision of services in the Section.

g. Recommending a sufficient number of qualified and competent persons to provide care, treatment and services in the Section.

h. Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Section.

i. Recommending to the Medical Staff rules that set forth the criteria for clinical privileges in the Section.

j. Recommending clinical privileges for each Member of the Section and each Staff Member desiring to exercise privileges in the Section.

k. Each Section chair will be a member of the Department Committee, ex-officio with a vote.

l. Evaluating the qualifications and competence of APPs/AHPs who provide patient care services within the purview of the Section.

m. Continuously assessing and improving the quality of care, treatment and services provided in the Section.

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

o. Maintaining quality control programs, as appropriate and in coordination with the Quality & Safety Committee of the Medical Staff.

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

q. Making recommendations regarding space and other resources needed by the Section.

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

s. Deciding when to convene Section meetings and chairing those meetings.

t. Serving as an Ex Officio member of all committees of his or her Section and attending such committee meetings as deemed necessary.

u. Assuring that records of performance are maintained and updated for all Members of his or her Section.

v. Reporting on activities of the Section to the Department chair.

w. Performing such additional responsibilities as may be delegated to him or her by the Executive Committee, the Chief of Staff, or the Department Chair.

ARTICLE 9

COMMITTEES

9.1 General

9.1.1. **Designation**

The Executive Committee and the other committees described in these Bylaws, and the Rules, shall be the standing committees of the Medical Staff. Special or ad hoc committees may be created by the Executive Committee, by any standing committee, or by a Department Chair 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.

9.1.2. Appointment of Members and Conduct of Business:

The chair and members of all committees shall be appointed as provided in the Rules. The business of committees shall be conducted as provided in the Rules.

9.1.3. In addition to exercising their responsibilities pursuant to Section 15.10, all committee members shall verbally disclose all actual or potential conflicts of interest in the course of each Medical Staff meeting, committee meeting or other event where such a disclosure may be relevant to any discussion or agenda item under consideration. Any potential conflicts so disclosed shall be resolved as set forth in Section 15.10.

9.2 Executive Committee

9.2.1. **Composition**

The Executive Committee shall be composed of the general Medical Staff officers; two members-at-large elected in accordance with Article 7; the Department Chairs; the Vice Chairs of the Surgery and Medicine Departments. Additionally, the Executive Committee shall include as ex officio members without vote: the Chief Executive Officer, the Chief Medical Officer and one member from the governing board chosen by the governing board and approved by the Medical Executive Committee. The Board member shall not be employed by the hospital or hospital system. The Chief of Staff shall chair the Executive Committee. The Vice Chief of Staff shall chair the committee if the Chief of Staff is absent. The Chair of the Governing Body may attend the meeting without vote. A majority of the Committee shall be physicians.

a. Officers

The Chief of Staff, Vice Chief of Staff, and Secretary/Treasurer shall serve as Chairman, Vice Chairman, and Secretary-Treasurer of the Executive Committee, respectively.

9.2.2. **Duties**

With the assistance from the Chief of Staff, the Executive Committee shall perform the following duties, which are delegated to it by the Medical Staff:

a. Be accountable to the organized Medical Staff.

b. Seek out the Medical Staff's views on all appropriate issues.

c. Convey accurately to the Governing Body the views of the Medical Staff on all issues, including those relating to quality and safety.

d. Affirmatively implement, enforce and safeguard the self-governance rights of the Medical Staff to the fullest extent permitted by law, such rights of the Medical Staff including but not limited to the following:

i. initiating, developing and adopting Medical Staff bylaws, rules and regulations, and amendments thereto, subject to the approval of the hospital governing board, which approval shall not be unreasonably withheld;

ii. selecting and removing Medical Staff officers;

iii. assessing Medical Staff dues and utilizing the Medical Staff dues as appropriate for the purposes of the Medical Staff;

iv. the ability to retain and be represented by independent legal counsel at the expense of the Medical Staff;

v. establishing in Medical Staff bylaws, rules or regulations, clinical criteria and standards to oversee and manage quality assurance, utilization review and other Medical Staff activities including, but not limited to, periodic meetings of the Medical Staff and its committees and departments and review and analysis of patient medical records;

vi. establishing, in Medical Staff bylaws, rules or regulations, criteria and standards for Medical Staff membership and privileges, and for enforcing those criteria and standards;

vii. taking such action as appropriate to enforce Section 15.11 of these bylaws regarding the prohibition against retaliation directed towards a member;

e. Take such other steps as appropriate to meet and confer in good faith to resolve disputes with the Governing Body, or any other person or entity, regarding any self-governance rights of the Medical Staff, as provided for in Bylaws Sections 9.4, 9.5 and 15.9 as applicable.

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

g. Report to the Medical Staff at each Medical Staff meeting;

h. Supervise the performance of all Medical Staff functions, which shall include:

i. Requiring regular reports and recommendations from the Medical Staff officers, Hospital Officers, Department and Section leaders, and committees concerning discharge of assigned functions;

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

iii. Following up to assure implementation of all directives.

i. reviewing the qualifications, credentials, performance and professional competence, and character of applicants and staff members, and making recommendations to the Governing Body regarding staff membership and renewals of membership, assignments to departments, clinical privileges, and corrective action;

j. participating in the interview and review of candidates for position of Chief Medical Officer in the hospital, and in approving or vetoing the selection of any such candidate, with any veto being binding upon the hospital;

k. Review the job description (e.g., qualifications, responsibilities, and reporting relationships) of medical directorships, participate in interviews and selection of candidates for these positions, and carry out reviews of these personnel as set forth in Article VII of these Bylaws;

l. Coordinate the activities of the committees and Department and Section leaders.

m. Based upon input from the Department and Section leaders and Credentials Committee, make recommendations regarding all applications for Medical Staff or APP/AHP appointment, reappointment, and privileges.

n. Receive and act upon reports and recommendations from Medical Staff departments, Sections, and committees.

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

p. With the assistance of the Chief of Staff, supervise the Medical Staff's compliance with:

   i. Medical Staff Bylaws, Rules;

   ii. Hospital's Bylaws, Rules, and hospital policies (to the extent that the Hospital's standards, policies and bylaws do not conflict with or infringe on the Medical Staff's self- governance and independent rights);

   iii. State and federal laws and regulations; and

   iv. Joint Commission accreditation requirements.

q. Oversee the development of Medical Staff rules & regulations, approve (or amend) all such rules, and oversee the implementation of all such rules.

r. Participate in the development of all hospital policy, practice, and planning, as required by Title 22.

s. Recommend actions to the Governing Body on matters of a medical-administrative nature.

t. Assist in obtaining the maintenance of accreditation.

u. Develop and maintain methods and policies for the protection and care of patients and others in the event of internal or external disaster.

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

w. Evaluate the medical care rendered to patients in the hospital.

x. Regularly report to the Governing Body through the Chief of Staff on at least the following:

y. The outcomes of quality improvement programs with sufficient background and detail to assure the Governing Body that quality of care is consistent with professional standards, and

z. The general status of any Medical Staff or APP/AHP disciplinary or corrective actions in progress.

aa. Make recommendations to the Governing Body regarding the structure of the Medical Staff, the mechanism used to review credentials and to delineate individual Privileges including establishing appropriate criteria for cross-specialty privileges, the organization of the quality assessment and improvement activities of the Medical Staff as well as the mechanism used to conduct, evaluate, and revise such activities, the mechanism by which membership on the Medical Staff may be terminated, and the mechanism for hearing procedures. (This responsibility may be satisfied by way of Medical Staff Bylaws and Rules addressing these issues.)

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

cc. Take reasonable steps to promote ethical conduct and competent clinical performance on the part of all members including the initiation of and participation in Medical Staff corrective or review measures when warranted;

dd. Establish a mechanism for dispute resolution between Medical Staff members (including limited license practitioners) involving the care of a patient.

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

ff. Establish the date, place, time, and program of the regular meetings of the Medical Staff Committees.

gg. In cooperation with the Secretary/Treasurer, develop a budget and act upon matters of expenditure or investment of Medical Staff funds.

hh. Review and make recommendations concerning budget requests for capital expenditures in all areas where the purchase of new equipment will have an effect on the overall care of patients treated by this Medical Staff.

ii. Fulfill the Medical Staff's responsibility of accountability to the Governing Body for the medical care rendered to patients in the Hospital.

jj. Act on behalf of the Medical Staff in the intervals between meetings within the scope of its defined responsibilities.

kk. Impose fines on individual members of the Medical Staff, as appropriate for the good administration of Medical Staff affairs, for specified violations of these Bylaws, Rules and Regulations, or the Clinical Rules & Regulations or provisions of other documents approved by the MEC in order for the MEC to exercise this delegation of authority. The specific violations for which fines may be imposed are specified in the Medical Staff Bylaws, Rules & Regulations or Clinical Rules. The amounts shall be in the range of $100 to $1,000.

9.2.3. **Meetings**

a. Frequency. The Executive Committee shall meet at least quarterly.

b. Duties of Members. The duties attendant upon serving as a member of the Executive Committee are personal. No member of the Executive Committee may delegate to any other person, other than their elected vice-chair

9.3 Medical Staff Members to the Board

9.3.1. The Medical Staff shall recommend to the BOT up to five members from the active staff, of which two shall be chosen to serve as voting members of the Governing Body of the hospital, and, where applicable, system in which the hospital is affiliated.

9.3.2. The process involves each Department nominating an individual to be a candidate to serve on the BOT. The MEC will formally interview each candidate and then select five candidates to be interviewed by the Nominating Committee of the BOT, whose composition includes the Chief of Staff as a voting member.

9.3.3. The Nominating Committee will give great weight to these candidates in their decision to choose two from these five to be Medical Staff members of the BOT.

9.3.4. If the two Medical Staff positions on the BOT are staggered then the MEC shall recommend up to three candidates for each position to be interviewed by the Nominating Committee of the BOT.

9.3.5. If the BOT does not choose from the candidate pool submitted, the MEC will resubmit an additional five candidates for their reconsideration

9.4 Joint Conference Committee

9.4.1. **Composition.**

The Joint Conference Committee shall be composed of an equal number of members of the Governing Body and of the Medical Executive Committee, [five from each as selected by the respective body]. 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 Governing Body members shall at least include the Governing Body chair, vice-chair, and Chief Executive Officer. A quorum shall consist of an equal number of directors and MEC members. The chair of the committee shall alternate every other meeting between the Governing Body and the Medical Staff. In no event shall the chair representing the Medical Staff have a personal compensation agreement with the hospital or hospital system for clinical services that constitutes in excess of fifty percent (50%) of such member's annual compensation.

9.4.2. **Duties.**

The Joint Conference Committee shall constitute a forum for the discussion of matters of hospital and Medical Staff policy, practice, and the exclusive 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, except as set forth in Section 9.5. The Joint Conference Committee may serve as the body to handle Medical Staff and Governing Body disputes (which includes disputes involving the CEO or administration), except as provided under Section 9.5, “Disputes with the Governing Body.” The Joint Conference Committee shall exercise any other responsibilities set forth in these bylaws.

9.4.3. **Meetings.**

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

9.5 Disputes with the Governing Body

In the event of a dispute between the Medical Staff and the Governing Body relating to the independent rights of the Medical Staff, as further described in California Business and Professions Code Section 2282.5, the following procedures shall apply.

a. **Invoking the Dispute Resolution Process**

The Executive Committee may invoke the good faith dispute resolution processes under this Section, upon its own initiative, or upon written request of 25% of the members of the active staff.

b. **Dispute Resolution Forum**

i. Ordinarily, the initial forum for dispute resolution shall be the Joint Conference Committee, which shall meet and confer as further described in Bylaws Section 9.4.

ii. However, upon request of at least 2/3 of the members of the Executive Committee, the meet and confer will be conducted by a meeting of the full Executive Committee and the full Governing Body. A neutral mediator acceptable to both the Governing Body and the Executive Committee may be engaged, but is not required, to further assist in dispute resolution if both the Governing Body and the Executive Committee agree.

9.6 BYLAWS COMMITTEE

9.6.1. **Composition**

The Bylaws Committee shall include at least 5 Active Members, including the Vice Chief of Staff who serves as an Ex-Officio member with vote and the Chief Medical Officer (CMO) who serves Ex Officio without votes

9.6.2. **Duties**

9.6.2.1 Conduct an annual review of the Medical Staff Bylaws, as well as the Rules promulgated by the Medical Staff and its Departments.

9.6.2.2 Receive and evaluate suggestions for modifications of the Medical Staff Bylaws, as well as the Rules promulgated by the Medical Staff and its departments

9.6.2.3 Submit recommendations to the Medical Executive Committee for changes in these documents as necessary to reflect current Medical Staff practices and;

9.6.2.4 Assure that the Medical Staff Bylaws and Rules adequately and accurately describe the Medical Staff structure, including but not limited to:

9.6.2.4.1 mechanism used to review credentials and to delineate individual clinical privileges, establishment and enforcement criteria and standards for Medical Staff membership

9.6.2.4.2 provisions for assessing Medical Staff dues and use of Medical Staff dues as appropriate for the purposes of the Medical Staff, and in a manner that is consistent with the Hospital's nonprofit tax-exempt status

9.6.2.4.3 the organization of the quality improvement and assessment, utilization review and other Medical Staff activities including the procedures for conducting, evaluating, and revising such activities,

9.6.2.4.4 the mechanism for terminating Medical Staff membership,

9.6.2.4.5 the fair hearing and appeal procedures.

9.6.2.4.6 Provisions respecting the Medical Staff's ability to retain and be represented by independent legal counsel at the expense of the Medical Staff; and

9.6.2.4.7 The Bylaws Committee should review and update the Bylaws and Rules as necessary

9.6.3. **Meetings**

The Committee will meet as requested by the Bylaws Committee Chair or the Chief of Staff.

9.7 EXECUTIVE SESSION

Executive session is a meeting of any Medical Staff committee, department, or Section, or of the Medical Staff as a whole which only voting members may attend, unless others are expressly requested by the member presiding at the meeting to attend. Executive session may be called by the presiding member at the request of any Medical Staff committee member and shall be called by the presiding member on his or her own or 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, candor and free discussion.

ARTICLE 10

MEETINGS

10.1 Medical Staff Meetings

Meetings of the Medical Staff may be called at any time by the Chief of Staff and shall be called at the request of the Executive Committee or Governing Body, or upon the written request of (20) percent of the Active Staff voting members.

10.1.1. Notice of Meetings.

Any general Medical Staff meeting must be held within (30) days after receipt of such request. No business shall be transacted at any Medical Staff meeting except that stated in the Notice calling the meeting. Notice of any meeting and its agenda items shall be provided electronically to each Medical Staff member through the Medical Staff Internet-based bulletin board, and via e-mail to those Medical Staff members that have provided their e-mail addresses, and via facsimile to those who have not. Such notices shall also be posted in Medical Staff common areas such as Medical Staff offices, dining rooms, and lounges. Where the members are being asked to consider or review a document, bylaw(s) or other Medical Staff or hospital policy document, whether draft or in final form, a copy of the document shall be appended to the electronically posted or emailed agenda, except for those items that constitute peer-review protected documents containing confidential medical or other peer review information, which shall instead be made available at the meeting itself. Further, any proposal considered at the meeting shall be accompanied by a clear explanation as to the source of the proposal and why that proposal is needed.

10.1.2. Annual Business Meeting

There shall be an annual business meeting of the Medical Staff. The Chief of Staff, or such other officers, department or Section chairs, 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 and its agenda items, to include Medical Staff financial reports, and the annual Medical Staff budget being considered for adoption by the Executive Committee, shall be given to the members at least 30 days prior to the meeting. The meeting agenda may distributed electronically. The membership shall be invited to provide input on the proposed budget for Executive Committee consideration.

10.1.3. Communication Outside of Meetings

The Executive Committee shall keep the Medical Staff informed about significant issues by means of regularly published newsletters, memoranda, electronically if available, and at all department meetings. Medical Staff members shall be encouraged to participate and comment on matters of interest to the Medical Staff at department meetings and general Medical Staff meetings, as well as through elected representatives.

10.1.4. Combined or Joint Medical Staff Meetings

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

10.2 Department, Section and Committee Meetings

10.2.1. Regular Meetings

Departments, Sections and committees, by resolution, may provide the time for holding regular meetings and no notice other than publication to the Medical Staff of such resolution shall then be required. Each Department and Section shall meet at the request of the Chair as necessary, to review and discuss patient care activities and to fulfill other Departmental and Section responsibilities.

10.2.2. Special Meetings

A special meeting of any Department, Section or Committee may be called by, or at the request of, the Chairman thereof, the Executive Committee, the Chief of Staff or by 33-1/3 percent of the group's current members, but not less than three members. No business shall be transacted at any special meeting except that stated in the Notice calling the meeting.

10.2.3. Combined or Joint Department, Section or Committee Meetings

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

10.3 Notice Of Meetings

10.3.1. Notice for Meetings

Notice stating the place, day, and hour of any regular or special Medical Staff meeting or of any regular or special Department, Section or Committee meeting not held pursuant to resolution shall be delivered either personally, by mail, by facsimile, or by e-mail to each person entitled to be present not less than 2 working days before the date of such meeting. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

10.3.2. Agendas and Documents for Meetings

Where the meeting requires members to consider or review a document, bylaw(s) or other Medical Staff or hospital policy document, whether draft or in final form, a copy of the document shall be appended to the agenda at the in-person meeting. Drafts of any documents to be considered at any meeting shall be available to any Medical Staff member upon request, except for those items that constitute peer-review protected documents containing patient medical or other confidential peer review information, and such members shall have the right to comment on such documents in writing to the respective committee. Further, any proposal considered at the meeting shall be accompanied by a clear explanation as to the source of the proposal and why that proposal is needed.

10.4 Quorum

10.4.1. **General Medical Staff Meetings**

There shall be no quorum requirements for general Medical Staff meetings.

10.4.2. Quorum: The presence of 50 percent of the voting members shall be required for:

a. Executive Committee

b. Credentials Committee and

c. Quality & Safety Committee of the Medical Staff meetings.

For committees other than the Medical Staff sitting as a committee of the whole, a quorum shall consist of the greater of 30 percent of the voting committee members or 3 voting committee members.

Department and Section Committee Meetings

For Department or Section meetings, a quorum shall consist of the greater of 30 percent of the voting members or 3 voting members.

10.5 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 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 if it is acknowledged in writing setting forth the action so taken which is signed by at least 66-2/3 percent of the members entitled to vote. Proxy votes will not be accepted and a member who is present may not delegate his vote to another member.

10.6 Minutes

Minutes of all meetings shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall include the names of those who disclosed potential conflicts of interest and those who abstained and/or recused themselves. The minutes shall be reviewed and approved at the next meeting and forwarded to the Executive Committee "and, except the minutes relating to peer review and matters discussed in executive session, to other appropriate designated committees, departments or Sections, and to the Governing Body.

Minutes of all Medical Staff meetings (except the minutes relating to peer review and matters discussed in executive session), shall be available for review by any staff member not part of the committee/meeting upon request. The staff member must submit a written request to the Chief of Staff stating the reason for the review. If appropriate, the Chief of Staff will schedule a mutually convenient time for the review. Minutes will only be reviewed in the presence of the Chief of Staff or his/her Staff Officer designee. Each Committee and Department shall maintain a permanent file of the minutes of each meeting. When meetings are held with outside entities, access to minutes shall be limited as necessary to preserve the protections from discovery as provided under California law.

10.7 Attendance Requirements

Medical Staff members are encouraged but are not required to attend Medical Staff meetings. Members who are required to attend meetings must attend the number of meetings as specified in the Rules. Committee members who fail to attend may be removed from the Committee.

10.7.1. **Special Appearance**

A committee, department, or Section, at its discretion, may require a Practitioner to respond to specific questions concerning the care of a patient or professional behavior, either in

writing or by appearing at a meeting. If appearance at a meeting is requested but not mandated, the chair of the meeting should try to give the Practitioner at least 10 days' advance Notice of the time and place of the meeting. In addition, whenever a response or an appearance is requested because of an apparent or suspected deviation from standard clinical practice, Special Notice shall be given and shall include a statement of the issue involved and that the Practitioner's response or appearance is mandatory. Failure of a Practitioner to respond in writing by the deadline date or to appear at any meeting with respect to which he or she was given Special Notice shall be cause for the Executive Committee to impose an automatic suspension of the Practitioner's Privileges until an appearance is made or other action is taken by the Executive Committee. The Practitioner shall be entitled to the procedural rights described in these Bylaws and the Rules.

10.8 Conduct Of Meetings

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

ARTICLE 11

CONFIDENTIALITY, IMMUNITY, AND RELEASES

11.1 General

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

11.2 Breach Of Confidentiality

Effective quality improvement, peer review, credentialing and evaluation of the qualifications of Medical Staff members and applicants for membership and privileges require free and candid discussions among those responsible for carrying out these functions. These functions are critical to quality of care and patient safety. Therefore, this Medical Staff organization and each of its members recognize that discussions, deliberations and all other Medical Staff activities supporting these vital functions will be kept confidential by all those participating in them, and by those who otherwise have a valid "need to know" regarding them, except as otherwise provided in the Medical Staff Bylaws related to provision of confidential information. This requirement includes, but is not limited to, preserving and maintaining the confidentiality of discussions and deliberations of Medical Staff departments, Sections and committees. It is expected, therefore that every Medical Staff member who participates in these Medical Staff functions, or who has knowledge of the matters reviewed and evaluated by those who participate in these functions, will preserve and maintain confidentiality of these matters inviolate. Any breach of this duty of confidentiality is outside of appropriate standards of conduct for this Medical Staff and will be deemed conduct that threatens the culture of safety that this Medical Staff engenders and supports. If it is determined that such a breach has occurred, the Executive Committee may undertake such corrective action as it deems appropriate, up to and including termination of Medical Staff membership and clinical privileges.

11.3 Immunity And Releases

11.3.1. Immunity from Liability for Providing Information or Taking Action

a. For Communications

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

b. For Actions:

The Hospital, the Medical Staff, each representative of the Medical Staff and Hospital and all third parties shall be immune from liability, to the fullest extent permitted by law, to a health practitioner for damages or other relief for any action taken pursuant these Bylaws and the Rules.

11.4 Activities and Information Covered

11.4.1. Activities

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

a. Applications for appointment, privileges or specified services

b. Periodic reappraisals for reappointment, privileges or specified services

c. Corrective action

d. Hearings and appellate reviews

e. Quality improvement review, including patient care audit

f. Peer review

g. Utilization reviews

h. Morbidity and mortality conferences; and

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

11.4.2. Information

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

11.5 Releases

Each health practitioner shall, upon request of the Medical Staff execute general and specific releases in accordance with the tenor and import of this Article, however, execution of such releases shall not, be deemed a prerequisite to the effectiveness of this Article.

11.6 Cumulative Effect

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

11.7 Insurance Coverage

The hospital shall maintain insurance coverage, including the provision of appropriate legal defense, which covers Medical Staff members acting on behalf of the Hospital and within the course and scope of their responsibilities as defined in these Medical Staff Bylaws and Rules.

ARTICLE 12

ROUTINE MONITORING, EDUCATION AND FOCUSED REVIEW

12.1 Routine Monitoring and Education

12.1.1. The Departments, Sections, and committees are responsible for carrying out delegated review and quality improvement functions. They may be assisted by the Medical Directors, Medical Staff Office and Department and Section Leaders.

12.1.2. 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.

12.1.3. The Practitioner shall be given an opportunity to respond in writing and may be given an opportunity to meet with the Department or committee.

12.1.4. Any informal actions, monitoring, or counseling shall be documented in the Member's file.

12.1.5. Neither Credentials Committee nor Executive Committee approval is not required for such actions, although the actions shall be reported to the Credentials Executive Committee.

12.1.6. The actions shall not constitute a restriction of Privileges or grounds for any formal hearing or appeal rights under the Bylaws or Rules.

12.2 Focused Review

12.2.1. A focused review should generally be initiated in the following instances:

a. Unexpected deaths, deaths within 24 hours of hospital admission, deaths during an operation and within 12 hours post-operatively, and all unexpected deaths of full-term babies.

b. Unexpected complications in patient condition and/or care or treatment, including those that result in major permanent loss of function, not related to the natural course of the patient’s illness or underlying condition.

c. Postoperative complications identified for special study by all Departments with surgical and invasive procedure privileges.

d. Severe drug reactions.

e. Severe transfusion reactions (hemolytic, febrile, allergic).

f. Sentinel Events.

g. Potentially compensable events identified by the Risk Manager and all cases in which a letter of intent has been filed.

h. Patient complaints concerning a Medical Staff member or allied health professional, including complaints about the care the member or Allied Health Practitioners provided and/or about the member or Allied Health Practitioner’s conduct.

i. Staff reports of concerns about a Medical Staff member or allied health professional, including reports of concerns about the care the member or allied

health practitioner provided and/or about the member or allied health practitioner's conduct.

j. Utilization issues (*e.g.*, excessive delay in discharge, prolonged length of stay, unsafe transfer or discharge of patient related to clinical stability).

k. Iatrogenic complications.

l. Cases for a specific Medical Staff member or allied health practitioners, when indicators suggest there have been a pattern of problems or a particular need for the review that is documented by the Department or Committee that will review the cases. For example, a specific study may be warranted if a member has had problems elsewhere or if a few problems suggest there may be more that are not being picked up by the screening criteria.

m. Service specific defined performance indicators, which have been established and approved by the Departments and/or the appropriate Medical Staff Committee.

n. Criteria set by the appropriate Medical Staff Committee for selecting cases for focused review to assess:

i. Appropriate use of blood and blood components.

ii. Appropriate use of medications.

iii. Appropriate use of nutritional products.

iv. Appropriate medical record documentation, including assessment of whether the documentation is timely, complete, and legible.

12.2.2. Reviewers

a. Generally, cases involving medical management and clinical care issues will be referred initially to the appropriate Medical Staff Committee for review. The Chief of Staff and/or the Chief Medical Officer (or his/her designee) shall be responsible for determining where to refer a case for review and where and he or she may confer with Department and Committee chairs when it is not clear where a case should be referred.

b. A person who participated in caring for a patient should not serve as a Peer Reviewer regarding the case, although opinions and information may be obtained from such a person.

c. Ad Hoc Peer Review Panels may also be set up when additional expertise may be necessary to adequately review a specific case. Panelists may be selected for their expertise in a given subject of medicine or in a specific medical specialty.

d. External peer review should be considered in the following circumstances

i. When no other Medical Staff Members provide the services that are under review.

ii. A peer review committee cannot make a determination and requests external review or would like a second opinion from an external reviewer;

iii. The individual whose case is under review requests external peer review, although in such cases the individual who requests the outside review must be solely responsible for paying the cost of the external review.

12.2.3. Participation In the Peer Review Process by The Practitioner Whose Performance Is Under Review.

a. If, after initial review, there remain questions or concerns regarding a case or cases, the practitioner should be advised of these questions or concerns in writing by the Department. The practitioner should be advised of the name, medical record number and date(s) of services of the case(s) to be discussed.

b. Every effort will be made to provide the practitioner with an opportunity to present information or opinions concerning the issues under consideration. The Department may request a response from the practitioner or may request that the practitioner appear in person before the Department Committee or delegated Subcommittee.

i. If a reply is requested, notice should include the date by which a response is required.

ii. If the practitioner is requested to appear in person, the notice should include the date, time, and place of the meeting.

iii. However, if a Medical Staff Member or Allied Health practitioner fails to respond in a timely fashion to a request, or fails to appear before the Committee as requested, the committee may proceed and may act on the available information.

12.2.4. Time Frame for Review

a. Cases forwarded to Medical Staff committees for peer review should be reviewed within one quarter of referral.

b. Cases requiring immediate action in the opinion of the Chief of Staff and/or Chief Medical Officer or designee will be referred to the appropriate committee chair, for immediate attention. When necessary, the review will be completed without waiting for the medical record to be completed. Such review should be completed and a preliminary assessment prepared within 30 days after the receipt of the referral.

c. The time frames for any review may be extended for good cause upon determination of the Medical Staff committee engaging in the review, and upon notification to and discussion with the Chief of Staff. The Chief of Staff may take such other action as he or she deems appropriate under the Bylaws and Rules as warranted by the discussion, including declining to permit the review to be extended if quality of care or patient safety warrant.

d. The results of the Focused Review and recommendations warranted by the review shall be forwarded to the Chair of the member's Department and the Chief of Staff for evaluation and further action.

12.3 Routine Monitoring and Education

The Departments, Sections, and Committees are responsible for carrying out delegated review and quality improvement functions. They may be assisted by the Medical Directors, Medical Staff Officers and Department and Section Leaders. 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 respond in writing and may be given an opportunity to meet with the Department, or Committee. Any informal actions, monitoring, or counseling shall be documented in the Member's file. Executive Committee approval

is not required for such actions, although the actions shall be reported to the Executive Committee. The actions shall not constitute a restriction of Privileges or grounds for any formal hearing or appeal rights under the Bylaws or Rules.

12.4 Corrective Action – Harassment/Assault

Notwithstanding any other provision of these bylaws, investigation and corrective action pertaining to any allegation of harassment or assault by a member of the Medical or Affiliate Staff shall be conducted pursuant to Bylaws Article 13.

ARTICLE 13

CORRECTIVE ACTION

13.1 Criteria For Initiation

A corrective action investigation may be initiated whenever reliable information indicates a Member may have exhibited acts, demeanor, or conduct, either within or outside of the Hospital that is reasonably likely to be:

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

unethical;

contrary to the Medical Staff Bylaws or Rules;

below applicable professional standards;

disruptive of Medical Staff or Hospital operations and safe patient care, or intimidating behavior to the extent it has a potential adverse nexus to patient care in violation of the Medical Staff's professional conduct rules; or

an improper use of Hospital resources to the degree that medical disciplinary cause or reason for discipline is indicated.

13.2 Initiation

13.2.1. Any person who believes that corrective action may be warranted may provide information to the Chief of Staff, CMO or any Medical Staff officer, any Department Chair, any Section Chair, any Medical Staff Committee, the Chair of any Medical Staff Committee, the Governing Body, or the Chief Executive Officer.

13.2.2. If the Chief of Staff, CMO or any Medical Staff officer, any Department Chair, any Section Chair, any Medical Staff Committee, the Chair of any Medical Staff Committee, the Governing Body, or the Chief Executive Officer determines that corrective action may be warranted under Bylaws Section 13.1, that person, entity, or Committee may request the Executive Committee to initiate a formal investigation and/or may recommend particular corrective action. Such requests may be conveyed to the Executive Committee orally or in writing.

13.2.3. The Chief of Staff or his/her designee or CMO shall notify the Chief Executive Officer of the commencement of an investigation and when it has concluded. In addition, the Chief of Staff shall immediately forward all necessary information to the Committee or person that will conduct any investigation provided, however, that the Chief of Staff or the Executive Committee may dispense with further investigation of matters deemed to have been adequately investigated by a Committee pursuant to Section 13.1 through 13.4 or otherwise.

13.3 Expedited Initial Review

13.3.1. The Chief of Staff, or his or her designee, may, on behalf of the Executive Committee, immediately take steps to determine if the information alleged regarding the acts or violations listed in Bylaws Section 13.1 appears reasonably reliable. If the Chief of Staff or designee so determines, then that information shall be presented to the Executive Committee, which may decide whether or not to initiate a corrective action investigation or recommend corrective action. If the Chief of Staff determines that the information obtained

may pose a threat of imminent danger to the health of any individual, then the procedures of Bylaws Section 13.8 (“Summary Restriction or Suspension”) shall apply.

13.3.2. If the complaint is of harassment or discrimination by a Medical Staff member that involves a patient or patient visitor, the Chief of Staff or his or her designee, together with representatives of administration, and/or an attorney for the Hospital shall conduct an initial expedited review on behalf of the Executive Committee. In cases of complaints of harassment or discrimination where the alleged harasser is a Medical Staff member and the complainant is not a patient or patient visitor, an expedited initial review shall be conducted by the Chief of Staff and the Hospital's Human Resources Director or their designee, or by an attorney for the Hospital. The practitioner shall be interviewed by the Chief of Staff or his designees and the physician shall be informed of the nature of the allegations. If the Chief of Staff does not conduct the review, he or she shall be kept apprised of the status of the initial review. The information gathered from an expedited initial review may be referred to the Executive Committee for its review and determination whether correction should be initiated.

13.4 Formal Investigation

13.4.1. If the Executive Committee concludes a corrective action is warranted, it shall direct an investigation to be undertaken. The Executive Committee may conduct the investigation itself or may assign the task to an appropriate Medical Staff Officer or standing or ad hoc Committee. If the investigation is delegated to any appropriate member or members of the MEC, or standing or ad hoc committee, it/they shall proceed with the investigation in a prompt manner and shall forward a report of the investigation to the Executive Committee as soon as practicable.

13.4.2. The report may include recommendations for appropriate corrective action. If the Executive Committee concludes action is indicated but no further investigation is necessary, it may proceed to recommend action.

13.4.3. 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.

13.4.4. 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 suspension, termination of the investigative process, or other action.

13.5 Executive Committee Action

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

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

b. Deferring action for a reasonable time;

c. Issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude Department or Committee Chairs from issuing informal 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 Privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring;

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

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

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

h. Taking other actions deemed appropriate under the circumstances, including the levy of fines.

13.6 Procedural Rights

13.6.1. If the Executive Committee determines that no corrective action is required or only a letter of warning, admonition, reprimand, or censure should be issued, the decision shall be forwarded to the Governing Body. The decision shall become final if the Governing Body affirms it or takes no action on it within 70 days after receiving the Notice of decision.

13.6.2. If the Executive Committee recommends an action that is a ground for a hearing under the Bylaws or Rules, 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 Member has either waived his or her right to a hearing or completed the hearing.

13.7 Initiation by Governing Body

If the Executive Committee fails to investigate or take disciplinary action, the Governing Body may direct the Executive Committee to initiate an investigation or disciplinary action, after consulting with the Executive Committee. If the Executive Committee fails to act in response to that Governing Body direction, the Governing Body may initiate corrective action, but must comply with applicable hearing and appeal provisions of these Bylaws and the Rules. The Governing Body shall inform the Executive Committee in writing of what it has done.

13.8 Summary Restriction or Suspension

13.8.1. Criteria for Initiation

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

b. If the Chief of Staff or Executive Committee is not available after reasonable efforts are made to contact him or her or it, the Chief Executive Officer, or his or her designee, may summarily suspend a Practitioner. In such cases, if the summary suspension is not ratified by the Chief of Staff or Executive Committee within two working days, excluding weekends and holidays, after the suspension was imposed, the summary suspension shall terminate automatically.

c. Unless otherwise stated, such summary restriction or suspension (“summary action”) shall become effective immediately upon imposition and the person or body responsible shall

promptly give Special Notice to the Member and Notice to the Governing Body, the Executive Committee, and the Chief Executive Officer. The Notice shall generally describe the reasons for the action.

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

e. The Notice of the summary action given to the Executive Committee shall constitute a request to initiate corrective action and the procedures set forth in Section 13.2 shall be followed.

13.8.2. Executive Committee Action

A Practitioner who has been summarily suspended may request an interview with the Executive Committee. The interview shall be convened as soon as reasonably possible under all circumstances not to exceed ten days and shall be informal and not constitute a hearing, as that term is used in the Bylaws. The Executive Committee may thereafter continue, modify, or terminate the terms of the summary action. It shall give the Practitioner Special Notice of its decision, which shall include the information specified in Section 13.6 if the action is adverse.

13.8.3. Procedural Rights

Unless the Executive Committee terminates the summary action, it shall remain in effect during the pendency and completion of the corrective action process and of the hearing and Appellate Review process.

When a summary action is continued, the affected Practitioner shall be entitled to the procedural rights afforded by the Bylaws and Rules, but the hearing on the summary action may be consolidated with the hearing on any corrective action that is recommended so long as the hearing commences within 60 days after the hearing on the summary action was requested.

13.9 Automatic Suspension or Limitation

In the following instances, the Member's Privileges or membership may be suspended or limited as described. Members must immediately inform the Medical Staff Department of any event that would result in an automatic suspension or limitation, and in no event less than seven days after the event occurs.

13.9.1. **Licensure**

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

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

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

13.9.2. **DEA Certificate**

a. Revocation, Suspension, and Expiration: Whenever a Member's DEA certificate is revoked, limited, suspended, or expired; the Member shall automatically be suspended of Medical Staff privileges, Failure to provide the documentation of an updated certificate will result in voluntary resignation.

b. All Medical Staff members are required to maintain DEA Schedules 2-5 with the exception of Pathologists. Physicians who wish to practice without Schedules 2-5 prescribing certification must provide documentation of the reason which will be reviewed by the Credentials Committee for consideration of a waiver.

13.9.3. **Failure to Pay Dues**

Members will be billed for dues annually. They must pay their dues within 45 calendar days from the date of dissemination. Failure to pay dues within 45 calendar days shall result in the automatic suspension of the Medical Staff member's privileges. Failure to pay dues within 90 days from suspension shall result in voluntary resignation.

13.9.4. **Failure to Satisfy Special Appearance Requirement**

A Member who fails without good cause to appear and satisfy the requirements of Bylaws Section 10.7.1 shall automatically be suspended from exercising all or such portion of Privileges as the Executive Committee specifies.

13.9.5. **Medical Records**

a. Medical Staff Members are required to complete medical records no later than 14 days after the patient is discharged.

b. If a record remains incomplete 10 days after the patient was discharged, the practitioner(s) who needs to complete the record will be given notice that he or she must complete the record by the 14th day after discharge or face an automatic suspension of their privileges. If the record is not completed by the 14th day after discharge, the Practitioner shall be given notice that the record remains incomplete and that his or her privileges are automatically suspended commencing and will remain automatically suspended until the records are completed.

c. The suspension shall continue until all incomplete medical records are completed.

d. While suspended, the physician may not admit new patients, perform or assist in surgery, schedule operative procedures, perform consultations, or write orders or attend patients_admitted by an associate. In the interest of patient care, the physician may continue treating any of his own patients in the Hospital when the suspension was imposed. If physician has a patient requiring emergency admission during the period of suspension, the physician must call in another physician to admit and care for the patient until the physician is off suspension. In emergent situations, the Chief of Staff may authorize an override of the suspension on a case-by-case basis.

e. Physicians who remain on suspension 5 or more days after suspension was imposed for medical record deficiency will be required to pay a fee as required in Bylaws Section 9.2.2.

f. Physicians who remain on suspension for medical record delinquency for 90 or more consecutive days will be considered to have voluntarily resigned from the Medical Staff. The physician may reapply for Medical Staff membership after three months following the voluntary resignation that result from medical record delinquency.

13.9.6. **Cancellation of Professional Liability Insurance**

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

13.9.7. **Exclusion or Suspension from Federal Programs; Failure to Comply with Government and Other Third-Party Payor Requirements**

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

The Executive Committee shall be empowered to determine that compliance with any other specific third-party payor, government agency, and professional review organization rules or policies is essential to Hospital and/or Medical Staff operations and that compliance with such requirements can be objectively determined. Any Practitioner who fails to comply with a policy that has been deemed essential shall be automatically suspended. The suspension shall be effective until the Practitioner complies with such requirements

13.9.8. **Medical Staff Health Services Requirements**

Medical Staff Members are required to comply with hospital policies approved by the Medical Executive Committee with regard to of immunizations and annual testing. Individuals who fail to meet these requirements will be suspended until such time as compliance has been maintained. If after 90 days the individual has failed to provide the necessary document (e.g., TB results, screening questionnaire, etc.) the individuals Medical Staff membership shall be voluntarily resigned.

13.9.9. **Automatic Termination**

If a Practitioner remains suspended under an automatic suspension provision for more than 90 days, his or her membership (or the affected Privileges, if the suspension is a partial suspension) shall be automatically terminated.

13.9.10. **Executive Committee Deliberation and Procedural Rights**

a. As soon as practicable after action is taken or warranted as described in Bylaws Section 13.9.1 (licensure revocation, suspension, expiration, restriction, or probation), Bylaws Section 13.9.2 (DEA certificate revocation, suspension, limitation, or expiration), or 13.9.4 (failure to satisfy a special appearance), the Executive Committee shall review and consider the facts and may recommend such further corrective action as it may deem appropriate following the procedure generally set forth in these Bylaws Article 13. There is no need for the Executive Committee to act on automatic suspensions for failures to pay dues (Bylaws Section 13.9.3) complete medical records (Bylaws Section 13.9.5), maintain professional liability insurance (Bylaws Section 13.9.6), or comply with government and other third-party payor rules and policies (Bylaws Section 13.9.7). The

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

b. The Medical Executive Committee shall immediately terminate any action that was based on a material mistake of fact as to the basis for such action; however, an automatic suspension or limitation based on a material mistake of fact that the Medical Executive Committee later terminates shall not be grounds for a civil action for damages against the hospital, board of members, Medical Staff, or Medical Staff members.

c. Practitioners whose Privileges are automatically suspended and/or who have been deemed to have automatically resigned their Medical Staff membership shall be entitled to a hearing only if the suspension is reportable under California Business and Professions Code Section 805 or to the federal National Practitioner Data Bank.

13.9.11. **Notice of Automatic Suspension or Action**

Notice of an automatic suspension or action shall be given to the affected individual, and Chief of Staff and the CMO, but such Notice shall not be required for the suspension to become effective. Patients affected by an automatic suspension shall be assigned to another Member by the Department Chair or Chief of Staff. The wishes of the patient and affected Practitioner shall be considered, where feasible, in choosing a substitute Member.

13.10 Interview

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

13.11 Confidentiality

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

13.12 Coordinated Corrective Action

13.12.1. **Notice Of Pending Investigations/Joint Investigations**

a. The Chief of Staff and the Chief Executive Officer each shall have the discretion to notify their counterpart officers at St. Joseph Hoag Health System whenever a request for corrective action has been received regarding a practitioner that has privileges at both facilities.

b. In addition, the Executive Committee may authorize a coordinated investigation and may appoint other St. Joseph Hoag Health System Medical Staff Members to assist in the coordinated investigation. St. Joseph Hoag Health System Medical Staff Members who are appointed by the Executive Committee to assist in the investigation shall sign any required confidentiality statements prior to their participation.

c. The Chief of Staff and the Chief Executive Officer are authorized to disclose to St. Joseph Hoag Health System's individual ministry(s) peer review body (or an authorized representative of that body) information from Hospital and Medical Staff records to assist in independent or joint investigation of any Practitioner.

d. The results of any joint investigation shall be reported to the appropriate St. Joseph Hoag Health ministry(s) peer review body for its independent determination of what, if any, corrective action should be taken.

13.12.2. **Notice of Actions**

a. In addition to the discretionary reporting and joint investigation provisions set forth at Bylaws Section 13.12.1, the Chief of Staff or designee is authorized to inform their counterpart officer at St. Joseph Hoag Health ministry(s), if the Practitioner is known to hold privileges there, whenever any of the following actions has been taken:

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

ii. Other corrective actions or recommendations may be reported at any time the Chief of Staff or designee determines such a report to be appropriate and should be reported promptly upon final action by the Governing Body.

b. The effect of such action on the involved Practitioner's Privileges at a St. Joseph Hoag Health ministry shall be determined by the Medical Staff bylaws or other applicable policies of St. Joseph Hoag Health ministry(s).

c. The Chief of Staff or designee is authorized to disclose to a St. Joseph Hoag Health ministry peer review body (or an authorized representative of that body) information from the Hospital and Medical Staff records regarding such a Practitioner, APP or AHP.

13.12.3. **Effect of Actions Taken by Other Entities**

Except as provided in Bylaws Section 13.12.1, whenever the Chief of Staff or Executive Committee receives information about an action taken at a St. Joseph Hoag Health ministry and involving a Practitioner or AHP holding Privileges at the Hospital, the Chief of Staff or Executive Committee shall, if time permits, independently assess the facts and circumstances to ascertain whether to take comparable action.

ARTICLE 14

HEARINGS AND APPELLATE REVIEWS

14.1 General Provisions

14.1.1. **Review Philosophy**

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

Accordingly, discretion is granted to the Medical Staff and Governing Body to create a hearing process which provides for the least burdensome level of formality in the process and yet still provides a fair review and to interpret the Bylaws and these Rules in that light. The Medical Staff, including its officers, Committees, and agents hereby constitutes itself as a professional review organization under the federal Health Care Quality Improvement Act of 1986 and a peer review body under the California peer review hearing laws and claim all privileges and immunities afforded by the federal and state laws.

14.1.2. Exhaustion of Remedies

If an adverse action as described in Bylaws Section 14.2 is taken or recommended, the Practitioner must exhaust the remedies afforded by these Bylaws before resorting to legal action.

14.1.3. Intra-Organizational Remedies

The hearing and appeal rights established in the 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 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 challenges first to the Governing Body and only thereafter may he or she seek judicial intervention.

14.1.4. Joint Hearings and Appeals

The Medical Staff and Governing Body are authorized to participate in joint hearings and appeals in accordance with Bylaws Section 14.11 of these Bylaws.

14.1.5. 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 Executive Committee in all cases where the Executive Committee or authorized Medical Staff officers, Members, or Committees took the action or rendered the decision that resulted in a hearing being requested. It refers to the Governing Body in all cases where the Governing Body or its authorized officers, directors, or Committees took the action or rendered the decision that resulted in a hearing being requested.

b. “Practitioner,” as used in this Article, refers to the Practitioner who has requested a hearing pursuant to Section 14.4 below.

14.1.6. Substantial Compliance

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

14.2 Grounds for Hearing

Except as otherwise specified in these Bylaws, (including those Exceptions to Hearing Rights specified in Bylaws Section 14.10) any one or more of the following actions or recommended actions shall be deemed actual or potential adverse action and constitute grounds for a hearing if the final imposition of such action would require a report to be filed under Section 805 of the California Business and Professions Code or to the National Practitioner Data Bank:

14.2.1. Denial of Medical Staff membership, reappointment, and/or Privileges.

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

14.2.3. Involuntary imposition of significant consultation or proctoring requirements that is in place for more than 14 days (excluding proctoring incidental to provisional staff status, or the granting of new Privileges, or imposed because of insufficient activity, or proctoring or consultation that does not restrict the Practitioner's Privileges).

14.2.4. Summary suspension of Medical Staff membership and/or Privileges that is in place for more than 14 days.

14.2.5. Any other disciplinary action or recommendation that must be reported to the Medical Board of California pursuant to Business and Professions Code Section 805.

14.3 Requests for Hearing

14.3.1. Notice of Action or Proposed Action

In all cases in which action has been taken or a recommendation made as set forth in Bylaws Section 14.2, the Practitioner shall be given Special Notice of the recommendation or action and of the right to request a hearing. The Notice must state:

a. What action has been proposed against the Practitioner;

b. A brief statement of the reasons for the action or proposed action;

c. That the Practitioner may request a hearing;

d. That a hearing must be requested within 30 calendar days; and

e. That the Practitioner has the hearing rights described in the Medical Staff Bylaws, including those specified in this Article.

f. A summary of the rights granted in the hearing pursuant to the Medical Staff bylaws.

14.3.2. Request for Hearing

a. The Practitioner shall have 30 days following the documented date of the Special Notice of such action to request a hearing. The request shall be in writing addressed to the Chief of Staff with a copy to the Chief Executive Officer. If 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. Such final recommendation

of the Medical Staff shall be considered by the Governing Body within 70 days and shall be sustained if the recommendation is supported by substantial evidence.

b. The Practitioner shall state, in writing, his or her intentions with respect to attorney representation in accordance with Section 14.5.6, 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.

14.4 Hearing Procedure

14.4.1. Hearings Prompted by Governing Body Action

If the hearing is based upon an adverse action by the Governing Body, the Chair of the Governing Body shall fulfill the functions assigned in this Rule to the Chief of Staff.

14.4.2. Time and Place for Hearing

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

14.4.3. Notice of Charges

At least 30 days prior to the hearing, the Chief of Staff shall state clearly and concisely in writing the reasons for the adverse proposed action taken or recommended, including the acts or omissions with which the Practitioner is charged and a list of the charts in question, where applicable. A supplemental Notice may be issued at any time, provided the Practitioner is given sufficient opportunity to prepare to respond.

14.4.4. Hearing Committee

a. When a hearing is requested, the Chief of Staff shall appoint a Hearing Committee which shall be composed of not less than 3 Members who shall gain no direct financial benefit from the outcome and who have not acted as accuser, investigator, fact finder, initial decision-maker, or otherwise have not actively participated in the consideration of the matter leading up to the recommendation or action. Alternates should be appointed when feasible. Members of the judicial review committee shall disclose in writing to the parties to the hearing those personal, professional, or financial affiliations or relationships of which they are reasonably aware, including contractual, employment or other relationships with the hospital or the practitioner, which could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Judicial Review Committee. Knowledge of the matter involved shall not preclude a Member of the Medical Staff from serving as a member of the Hearing Committee. In the event that it is not feasible to appoint a Hearing Committee from the active Medical Staff, the Chief of Staff may appoint Members from other Medical Staff categories or Practitioners who are not Medical Staff Members. Such appointment shall include designation of the Chair. Of the 3 members of the Medical Staff that serve on the judicial review committee at least one shall, where feasible, be a member who shall have the same healing arts licensure as the accused, and where feasible, the committee shall also include an individual practicing the same specialty as the member. All other members shall have MD or DO degrees. The Chief of Staff may appoint alternates who meet the standards described above and who can serve if a Hearing Committee member becomes unavailable.

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

c. The Hearing Committee, or the arbitrator, if one is used, shall have such powers as are necessary to discharge its or his or her responsibilities.

14.4.5. The Hearing Officer

The Chief of Staff 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 not be biased for or against any party, shall gain no direct financial benefit from the outcome, and must not act as a prosecuting officer or as an advocate. The hearing officer shall preside over the voir dire process and may question panel members directly and shall make all rulings regarding service by the proposed hearing panel members or the hearing officer. The Hearing Officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The Hearing Officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure, or the admissibility of evidence that are raised prior to, during, or after the hearing, including deciding when evidence may not be introduced; granting continuances; ruling on disputed discovery requests, evidentiary disputes, and witness issues, including disputes regarding expert witnesses, and ruling on challenges to Hearing Committee members or himself or herself serving as the Hearing Officer.

In all matters, the hearing officer shall act reasonably under the circumstances and in compliance with applicable legal principles. In making rulings, the hearing officer shall endeavor to promote a less formal, rather than more formal, hearing process and also to promote the swiftest possible resolution of the matter, consistent with the standards of fairness set forth in these Bylaws. When no attorney is accompanying any party to the proceedings, the hearing officer shall have authority to interpose any objections and to initiate rulings necessary to ensure a fair and efficient process.

If the Hearing Officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the Hearing Officer may take such discretionary action as seems warranted by the circumstances, including, but not limited to, limiting the scope of examination and cross-examination and setting fair and reasonable time limits on either sides' presentation of its case. The Hearing Officer should participate in the deliberations of the Hearing Committee and be a legal advisor to it, but the Hearing Officer shall not be entitled to vote.

14.4.6. Representation

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

a. If the practitioner wishes to be accompanied at the hearing by an attorney, he/she shall state the notice of such intent in the written Request for Hearing, as provided for above. The Medical Executive Committee representative shall not be accompanied by an attorney if the practitioner is not accompanied by an attorney. The foregoing shall not

be deemed to deprive any party of its right to the assistance of legal counsel for the purpose of preparing for the hearing.

Attorneys for either party may accompany their clients in the hearing sessions in order to advise their clients, although any such attorney shall not examine witnesses, shall not address the Hearing Committee, and shall not make any oral statement whatsoever in the hearing.

Whether or not attorneys are present in the hearing pursuant to this Article, the practitioner and the Medical Executive Committee may be represented at the hearing by a practitioner licensed to practice medicine in the State of California who is not also an attorney at law.

The Presiding Officer shall not allow the presence of attorneys at the hearing to be disruptive or cause a delay in the hearing process.

The practitioner and the Medical Executive Committee may stipulate together to allow greater participation by attorneys in the hearing than this Article provides. Otherwise, the above provisions of this Section will control and may not be overridden by the Hearing Officer.

14.4.7. Failure to Appear or Proceed

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

14.4.8. Postponements and Extensions

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

14.4.9. Discovery

a. Rights of Inspection and Copying

The Practitioner may inspect and copy (at his or her expense) any documentary information relevant to the charges that the Medical Staff has in its possession or under its control, including all evidence which was considered by the Medical Executive Committee in determining whether to proceed with the adverse action, and any exculpatory evidence in the possession of the Medical Staff. The body whose decision prompted the hearing may inspect and copy (at its expense) any documentary information relevant to the charges that the Practitioner has in his or her possession or under his or her control. The requests for discovery shall be fulfilled as soon as practicable. Failures to comply with reasonable discovery requests at least 30 days prior to the hearing shall be good cause for a continuance of the hearing.

b. Limits on Discovery

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

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

i. Whether the information sought may be introduced to support or defend the charges;

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

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

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

14.4.10. Pre-Hearing Document Exchange

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

14.4.11. Witness Lists

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

14.4.12. Procedural Disputes

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

b. The parties shall be entitled to file motions as deemed necessary to give full effect to rights established by the Bylaws and to resolve such procedural matters as the Hearing Officer determines may properly be resolved outside the presence of the full Hearing Committee. Such motions shall be in writing and shall specifically state the motion, all relevant factual information, and any supporting authority for the motion. The moving party shall deliver a copy of the motion to the opposing party, who shall have at least 5 working days to submit a response to the Hearing Officer, with a copy to the moving party. The Hearing Officer may extend deadlines as he or she deems appropriate. The Hearing Officer shall determine whether to allow oral argument on any such motions. The Hearing Officer's ruling shall be in writing and shall be provided to the parties promptly upon its rendering. All motions, responses, and rulings thereon shall be entered into the hearing record by the Hearing Officer.

c. Upon motion of either party or the Hearing Officer, the Hearing Committee may terminate the hearing if it finds that either party has (1) exhibited flagrant or

repeated noncompliance with this Article in a manner that prejudices the other party or results in repeated delays to the hearing process, or (2) has egregiously interfered with the orderly conduct of the hearing. A finding that the termination results from the practitioner's noncompliance or egregious conduct shall result in a finding that the practitioner has waived his or her right to a hearing. The hearing officer shall be permitted to advise the Judicial Review Committee regarding his or her recommendation with regard to the disposition of the motion. Evidence of, or a finding that, a party intended to prejudice the other party, delay the hearing process, or interfere with the orderly conduct of the hearing is not necessary to support or grant the motion to terminate the hearing.

14.4.13. Record of the Hearing

A court 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 court reporter shall be borne by the Hospital, but the cost of the transcript, if any, shall be borne by the party requesting it. The Practitioner is entitled to receive a copy of the transcript upon paying the reasonable cost for preparing the record. Oral evidence shall be taken only on oath administered by any person lawfully authorized to administer such oath.

14.4.14. Rights of the Parties

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

14.4.15. Rules of Evidence

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

Evidence of mediation, compromise or offers of settlement, as well as any conduct or statements made in negotiation thereof, is inadmissible to prove either parties' opinion regarding the strength or weakness of the actions that provide the grounds for the hearing.

The body whose decision prompted the hearing may object to the introduction of the 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 the information.

14.4.16. Burdens of Presenting Evidence and Proof

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

b. An applicant for Membership and/or Clinical privileges shall bear the burden of persuading the Hearing Committee, by a preponderance of the evidence, that he or she is qualified for membership and/or the denied Privileges. The Practitioner must produce information, which allows for adequate evaluation and resolution of reasonable doubts concerning his or her current qualifications for membership and Privileges.

c. Except as provided above for initial applicants, the body whose decision prompted the hearing shall bear the burden of persuading the Hearing Committee by a preponderance of the evidence that the recommended action is reasonable and warranted.

14.4.17. Adjournment and Conclusion

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

14.4.18. Basis for Decision

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

14.4.19. Presence of Hearing Committee Members and Vote

Hearing Committee members must be present for all evidence and testimony presented. Failure of a hearing committee member to be able to be present may warrant placement of an alternate hearing committee member as a member of the committee. The final decision of the Hearing Committee must be sustained by a majority vote of the number of members appointed.

14.4.20. Decision of the Hearing Committee

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

14.5 Appeal

14.5.1. Time for Appeal

Within 40 days after receiving the decision of the Hearing Committee, either the Practitioner or the Executive Committee may request an Appellate Review. A request for such review shall be delivered to the Chief of Staff, the Chief Executive Officer, and the other side in the hearing. If Appellate Review is not requested within such period, that action or recommendation shall thereupon become the final action of the Medical Staff. The Governing Body shall consider the decision within 70 days and shall affirm the decision if it is supported by substantial evidence.

14.5.2. Time, Place, and Notice

If an Appellate Review is to be conducted, the Appeal Board shall, within 30 days after receiving a Notice of appeal, schedule a review date and cause each side to be given Notice (with Special Notice to the Practitioner) of the time, place, and date of the Appellate Review.

The Appellate Review shall commence within 60 days from the date of such Notice provided, however, when a request for Appellate Review concerns a Member who is under suspension, which is then in effect, the Appellate Review should commence within 45 days from the date the request for Appellate Review was received. The time for Appellate Review may be extended by the Appeal Board for good cause.

14.5.3. 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 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 who will act as an appellate Hearing Officer and have all of the authority of and carry out all of the duties assigned to a Hearing Officer as described in this Article 14. The Hearing Officer shall not be entitled to vote with respect to the appeal. The Appeal Board shall have such powers as are necessary to discharge its responsibilities.

14.5.4. Appeal Procedure

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

14.5.5. Decision

a. Within 30 days after the adjournment of the Appellate Review proceeding, the Appeal Board shall render a final decision in writing. Final adjournment shall not occur until the Appeal Board has completed its deliberations.

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

c. The decision shall specify the reasons for the action taken and provide findings of fact and conclusions articulating the connection between the evidence produced at the hearing and the appeal (if any), and the decision reached, if such findings and conclusions differ from those of the Hearing Committee.

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

e. Should the Appeal Board determine that the hearing committee decision is not supported by substantial evidence; the Appeal Board may modify or reverse the decision of the hearing committee. Alternatively, the Appeal Board may remand the matter to the Hearing Committee or any other body the Appeal Board designates for reconsideration or may refer the matter to the full Governing Body for review. If the matter is remanded for further review and recommendation, the further review shall be completed within 60 days unless the parties agree otherwise or for good cause as determined by the Appeal Board. The Governing Body shall affirm the hearing committee decision as the final action if it is supported by substantial evidence, following a fair procedure.

14.5.6. Right to One Hearing

No Practitioner shall be entitled to more than 1 evidentiary hearing and 1 Appellate Review on any matter that shall have been the subject of adverse action or recommendation.

14.6 Confidentiality

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

14.7 Release

By requesting a hearing or Appellate Review under these Bylaws, a Practitioner agrees to be bound by the provisions in the Medical Staff Bylaws relating to immunity from liability for the participants in the hearing process.

14.8 Governing Body Committees

In the event the Governing Body should delegate some or all of its responsibilities described in this Article 14 to its Committees, the Governing Body shall nonetheless retain ultimate authority to accept, reject, modify, or return for further action or hearing the recommendations of its Committee.

14.9 Exceptions to Hearing Rights

14.9.1. Exclusive Use Departments, Hospital Contract Practitioners

a. Exclusive Use Departments

The hearing rights of Article 14 do not apply to a Practitioner whose application for Medical Staff membership and Privileges was denied or whose Privileges were terminated on the basis the Privileges he or she seeks are granted only pursuant to a contract or an exclusive use policy.

Such Practitioners shall have the right, however, to request that the Governing Body review the denial and the Governing Body shall have the discretion to determine whether to review such a request and, if it decides to review the request, to determine whether the Practitioner may personally appear before and/or submit a statement in support of his or her position to the Governing Body.

b. Hospital Contract Practitioners

The hearing rights of Article 14 do not apply to Practitioners who have contracted with the Hospital to provide clinical services. Removal of these Practitioners from office and of any exclusive Privileges shall instead be governed by the terms of their individual contracts and agreements with the Hospital. The hearing rights of this Article 14 shall apply if an action is taken which must be reported under the federal or California law, and/or the Practitioner's Medical Staff membership status or Privileges which are independent of the Practitioner's contract are removed or suspended for medical disciplinary cause or reason.

14.9.2. Allied Health Practitioners

Allied Health Practitioners (AHPs) are not entitled to the hearing rights as set forth in this Article. (See the Medical Staff Rules & Regulations, Rule 15 for a description of AHP procedural rights.)

14.9.3. Denial of Applications for Failure to Meet the Minimum Qualifications

Practitioners shall not be entitled to any hearing or Appellate Review if their membership, Privileges, applications, or requests are denied because of their failure to have a current California license to practice medicine, dentistry, clinical psychology, or podiatry; to maintain an unrestricted Drug Enforcement Administration certificate (Schedules 2-5) (when it is required); to maintain the required professional liability insurance; to meet any of the other basic standards specified in Article 2, or to file a complete application.

14.9.4. Automatic Suspension or Limitation of Privileges

Practitioners are not entitled under Bylaws Section 14.5 to any hearing or Appellate Rights if their privileges are automatically suspended for any of the following reasons:

a. Failure to pay Medical Staff dues

b. Failure to pay fines imposed by the Medical Executive Committee

c. Failure to satisfy a special appearance without good cause

d. Failure to complete medical records

e. Failure to maintain professional liability insurance including prior acts

f. Exclusion or suspension from federal programs (Medicare, MediCal or other Federal government programs)

g. Any other reason identified in the bylaws as grounds for automatic suspension.

14.10 Joint Hearings and Appeals

14.10.1. Joint Hearings

a. Whenever a Practitioner is entitled to a hearing because a coordinated, cooperative, or joint credentialing or corrective action has been taken or recommended pursuant to Bylaws Section 13.12, a single joint hearing may be conducted in accordance with hearing procedures that have been jointly adopted by the involved entities, provided such procedures are substantially comparable to those set forth in Bylaws Section 14.5 and further provided at least 1 member of the Hearing Committee is a Member of this Hospital's Medical Staff.

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

14.10.2. Joint Appeals

The procedures may also call for joint appeal rights, provided such procedures are substantially comparable to those set forth in Bylaws Section 14.6 and, further, provided that at least 1 member of the Appeal Board is a representative of this Hospital's Governing Body.

14.10.3. Effect of Joint Hearings/Appeals

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

14.10.4. Provision for Separate Hearing

Notwithstanding the foregoing, if a Practitioner can demonstrate to the Executive Committee (in the case of a hearing based on a recommendation of the Executive Committee) or the Governing Body (in the case of a hearing based on a recommendation of the Governing Body or in the case of an appeal) prior to the initiation of a joint hearing and/or appeal that the benefits of quasi-judicial economy and efficiency are outweighed by particular burdens or unfairness unique to the individual Practitioner's circumstances, the Executive Committee or Governing Body may, in its sole discretion, order that a separate hearing and/or appeal be conducted solely with respect to Privileges at this Hospital, in accordance with this Hospital's Hearing and Appellate Review Provisions. (Examples of such unique burdens or unfairness would include unavailability of witnesses or documents to the joint proceeding; but the mere fact that the outcome would affect Privileges at more than 1 facility would not ordinarily be deemed sufficient to preclude a joint hearing.)

ARTICLE 15

GENERAL PROVISIONS

15.1 General Medical Staff Rules

The Medical Staff shall initiate and adopt such Rules as it may deem necessary and shall periodically review and revise its Rules to comply with current Medical Staff practice.

Recommended changes to the Rules shall be submitted to the Executive Committee for review and approval by a two-thirds (2/3) majority of the Executive Committee voting members. Before such Executive Committee action may be taken, however, the Executive Committee must provide written or electronic notice to the General Medical Staff of the proposed change or amendment. The notice of the meeting shall include the exact wording of the existing language of the Rule(s), if any, any other relevant wording that may clarify the nature of the changes being proposed, the proposed change(s) themselves, and that there is provided a 14-day period after the notice has been disseminated to a secure website for members to provide input on the proposed Rule change with the last date acceptance of such input is permitted, and the location, address, or email address to submit input.

Following approval by the Executive Committee, a Rule shall become effective following approval of the Governing Body, which approval shall not be withheld unreasonably, if there is a conflict between the Bylaws and the Rules, the Bylaws shall prevail.

15.2 Department Rules

Each clinical department of the Medical Staff shall initiate and adopt such rules as it may deem necessary and shall periodically review and revise these rules to comply with current practice in that Department. Recommended changes to the Department Rules shall be submitted to the Department Committee for review and approved by a two-thirds majority of Department Committee voting members present. Following approval by the Department Committee and Executive Committee, a Department Rule shall become effective following approval of the Governing Body, which approval shall not be withheld unreasonably. If there is a conflict between the Department Rules and the Medical Staff Bylaws or Rules, the Medical Staff Bylaws or Rules shall prevail.

15.3 Section Rules

Subject to the approval of the committee of the Department that oversees the Section, the Executive Committee, and the Governing Body, each Section may formulate its own Rules for conducting its affairs and discharging its responsibilities. Such Rules shall not be inconsistent with the Medical Staff or Hospital Bylaws, Rules, or policies. If there is a conflict between the Department and Section rules, the Department Rules shall prevail.

15.4 Dues And Application Fees

15.4.1 The Medical Executive Committee shall have the power to recommend the amount of annual dues or assessments, if any, for each category of Medical Staff membership, subject to the approval of the Medical Staff by an affirmative vote of the majority of members who have voted, as long as at least 50% of the membership votes on the question. Application fees shall be set by the Executive Committee in the Rules. The Executive Committee shall determine the manner of expenditure of the funds that are received provided, however, that such expenditures shall not jeopardize the nonprofit status of the Medical Staff and Hospital. Medical Staff dues & fees shall remain under the control of the Medical Staff. Expenditures may be reviewed by the Hospital to assure that any expenditure would not be contrary to State or Federal law.

15.4.2 Funds shall be deposited into the Medical Staff account from the hospital to assure the Medical Staff the financial ability to solely administer those functions required under the bylaws.

15.5 Forms

Application forms and any other prescribed forms required by these Bylaws for use in connection with Medical Staff appointments, re-appointments, delineation of Privileges, corrective action, notices, recommendations, reports, and other matters shall be approved by the Executive Committee and the Governing Body. They may be amended by approval of the Executive Committee and the Governing Body.

15.6 Notices

Except where specific notice provisions are otherwise provided in these Bylaws, any and all notices, demands, requests, and other communications required or permitted to be served on or given to a party or parties by another, pursuant to these Bylaws, shall be in writing and shall be delivered personally or by United States Postal Service, first-class postage prepaid, certified or registered, return receipt requested. In the case of notice to Hospital, Governing Body, Medical Staff or officers or committee thereof, the notice shall be addressed as follows:

St. Joseph Hospital
1100 W. Stewart Drive
Orange, California 92868 (92863-5600)

In case of a notice to a practitioner, AHP, or other party, the notice shall be addressed to the address as it appears in the records of the Hospital. If personally delivered, such notice shall be effective upon delivery. If mailed, the notice of the meeting shall be deemed delivered when deposited, postage prepaid, in the United States mail addressed to each practitioner at his address as it appears on the records of the Hospital. Any party may change its address as indicated above, by giving notice of such change to the other party in the manner as above indicated.

15.7 Ballot

Whenever these bylaws require voting by ballot, the following procedures shall be observed:

15.7.1. Mail ballots for election of general staff officers and department chairs shall be returned in a specially marked ballot envelope on which the Staff member has printed and signed his or her name. The Staff member's name shall be verified against the Medical Staff records.

15.7.2. Mail ballots for approval of Bylaws changes shall be returned in a single envelope with the name of the voting member printed on the outside of the return envelope.

15.7.3. Written ballots that may be required by the Executive Committee at a committee or general meeting shall be folded, collected and counted at said meeting, under the direction of the Secretary/Treasurer or a designated representative.

15.7.4. Electronic ballots may be used when a secure process is in place. The use of electronic voting is authorized for all voting requirements just as mail ballots may be used.

15.8 Non-Contractual Nature of Bylaws

15.8.1. These Bylaws shall not be deemed to be a contract of any kind between the Governing Body, the Hospital, the Medical Staff and/or any individual (including any Medical Staff member, applicant, or allied health professional [“AHP”]). Application for, the conditions of, and the duration of appointment to the Medical Staff, or the granting of privileges to a practitioner or to an AHP shall not be deemed contractual in nature.

15.8.2. The consideration of applications and the granting and continuance of any privileges at this Hospital are based solely upon a practitioner's or AHP's continued ability to justify the

exercise of privileges. The granting of privileges does not obligate the practitioner or AHP to practice at the Hospital.

15.8.3. The Governing Body and Medical Staff are obligated to use essential fairness in dealing with Medical Staff members, allied health professionals and applicants for those positions and may fulfill that obligation by following the procedures specified in these Bylaws or, if the Bylaws do not mandate a procedure, any procedure which is fair under the circumstances.

15.9 Conflict and Dispute Management

15.9.1. Issues raised by a Medical Staff Member – any Medical Staff member(s) may forward a communication to the Medical Executive Committee or any Medical Executive Committee member, about any issue affecting the member or the membership which, in the opinion of the member, requires Medical Executive Committee involvement for its resolution. The Chief of Staff may take any action as he/she feels appropriate, including but not limited to, determining that no action is necessary, discussing the matter with the member(s) in an attempt to resolve the issue, and/or including such communication on the agenda of a meeting of the Medical Executive Committee for review and discussion and possible action.

15.9.2. Issues Raised by 20% of the Active Members of the Medical Staff. Upon presentation of a petition signed by twenty (20%) of active Medical Staff members, two active staff members designated by the petition may attend an executive session of the Medical Executive Committee to discuss an issue of perceived or actual dispute or conflict between the petitioners and the Medical Executive Committee. The petition must set forth with clarity the nature of the issue, dispute or conflict, the interest(s) of petitioners in the dispute or conflict, and one or more suggested resolutions or mitigations of the matter. The executive session shall be held at the next Medical Executive Committee meeting that is more than fifteen calendar days after formal presentation of the petition. The Chief of Staff shall be responsible for notifying the petitioners' representatives of the time and date of the appearance at Executive Session, and of the amount of time that the Medical Executive Committee will reasonably dedicate in discussion with the representatives. The Chief or his/her designee on the Medical Executive Committee shall preside over the Medical Executive Committee discussion with the representatives. The Medical Executive Committee may discuss the matter further in executive session after the joint discussion concludes and the petitioners' representatives depart or take such further action as it may choose. The Chief shall promptly notify the petitioners' representatives of the Medical Executive Committee's decisions or conclusions arising from the joint discussion, or if no decision or conclusion is forthcoming, the next steps in deliberations, if any, that the Medical Executive Committee may plan to make on the issues presented in the joint discussion.

15.9.3. No Violation of Law, Governing Rules, or Accreditation Standards. These conflict and dispute management provisions shall not serve to permit or validate any violation of state or federal law, of the Medical Staff Bylaws or Rules, or of any accreditation requirement applicable to the activities of the Medical Staff or St. Joseph's Hospital.

15.10 Disclosure Of Interest, And Resolution of Conflicts of Interest

The requirements of this Section 15.10 apply to all Medical Staff members, including officers, department chiefs, Section chairs, Medical Staff representatives, Medical Staff members serving on committees, and all nominees or candidates for those positions, or any member addressing a committee or other body within the Medical Staff. A person's disclosure of an interest, as set forth in these bylaws, does not automatically mean that an actual conflict of interest exists. Whether a disclosed interest constitutes a conflict is determined as set forth below.

15.10.1. Application

a. In order to encourage unbiased, responsible management and decision-making, a member shall comply with the disclosure of interest and conflict of interest requirements as relevant to the position held (or being sought) and the circumstances, consistent with these bylaws. However, neither the existence of a conflict of interest, nor the disclosure thereof, shall affect membership or privileges of any Practitioner.

b. These bylaws shall be the unique and exclusive mechanism for discerning and acting upon conflicts of interest applicable to Medical Staff members. Only those Medical Staff members who also serve on the Governing Body may be required to adhere to a disclosure and conflict of interest policy, if any, of the Governing Body in addition to that of the Medical Staff. As to Medical Staff members who serve as members of the Governing Body, they shall not be required to adhere to a disclosure and conflict of interest policy that imposes requirements that are unique to those holding a license to practice medicine or are in any way different from those imposed on board members without such a license, unless required by law or accreditation requirements.

15.10.2. General Requirements

a. No member may exercise any leadership or committee role unless or until the member completes the Disclosure of Interest form approved by the Executive Committee as consistent with these bylaws. This form shall be updated by such members within thirty (30) days of the occurrence of any changes relating to Statements on that form. This form shall be available for viewing by any member of the Medical Staff but may only be used for bona fide Medical Staff purposes and not for individual personal use. Nor may the information be shared with non-Medical Staff members.

b. Members holding any leadership or committee role must disclose their potential conflict of interest relevant to the subject under discussion when they address a Medical Staff body or during a discussion on a matter prior to voting upon the subject where a potential conflict of interest may exist.

15.10.3. Information That Must Be Disclosed

Disclosure must be made of all personal and financial interests that may lead to a potential conflict of interest include, but not limited to current or impending:

a. Competitive or personal relationships, activities, or interests that may influence, or may be reasonably viewed by others to possibly influence, a member's decisions or actions;

b. Grants or other financial, academic or professional relationships involving research relating to decisions under review;

c. Ownership or investment interests in excess of $5,000 or 5% of the whole, whichever is less, in any hospital, hospital system, and/or ambulatory health facility;

d. Ownership or investment interests in excess of $5,000 or 5% of the whole, whichever is less, in any company that furnishes goods or services to the hospital or is seeking to provide goods or services to the hospital;

e. Employment, consulting or other personal compensation agreement with any hospital or ambulatory health facility;

f. Ownership or investment interests in excess of $5,000 or 5% of the whole, whichever is less, or a director, trustee, officer or key employee in, a managed care company that contracts with or could contract with the hospital;

g. Receipt of gifts including goods, services, or honoraria from the hospital or any company or person who contracts with or otherwise sells to the hospital, in excess of $100;

h. Employment, consulting or other personal compensation agreement with any quality assurance, credentialing, and/or utilization review entity, including but not limited to any third-party payor, quality improvement organization, or the Medical Board of California.

i. Any other personal or financial interest or conflicting fiduciary obligation that may raise a conflict of interest.

15.10.4. Management of Conflicts of Interest

a. Not all disclosures of a potential conflict of interest require the member's abstention or recusal, however, a member may choose to abstain from voting on any particular issue. A member shall recuse himself/herself if the member reasonably believes that his/her ability to render a fair and independent decision is or may be affected by a conflict of interest. A recused member shall not be counted in determining the quorum for that vote but may answer questions or otherwise provide information about the matter after disclosing the conflict. A recused member must not be present for the remainder of the deliberations or the vote.

b. If a member has not voluntarily recused him/herself and a majority of voting members of the committee or in the staff meeting vote that the member should be excused from discussion or voting due to a stated conflict of interest, that member shall be excused from the discussion or vote.

c. If a member discloses a potential conflict of interest and another member requests a vote regarding excusing that member, the member shall leave the room while that issue is being discussed and voted upon.

d. The minutes of the meeting shall include the names of those who disclosed potential conflicts and those who abstained and/or recused themselves, or were excused by vote of the committee, and the nature of the conflict of interest(s) that served as basis for the recusal or excusal.

15.10.5. Corrective Action

Medical Staff members who fail to comply with all provisions of these bylaws concerning actual or potential conflicts of interest shall be subject to corrective action under these bylaws, including but not limited to removal from the Medical Staff position.

15.11 Retaliation Prohibited

a. Neither the Medical Staff, its members, committees or department heads, the Governing Body, its chief administrative officer, or any other employee or agent of the hospital or Medical Staff, may engage in any punitive or retaliatory action against any member of the Medical Staff because that member claims a right or privilege afforded by, or seeks implementation of any provision of, these Medical Staff bylaws.

b. The Medical Staff recognizes and embraces that it is the public policy of the State of California that a physician and surgeon be encouraged to advocate for medically appropriate health care for his or her patients. To advocate for medically appropriate

health care includes, but is not limited to, the ability of a physician to protest a decision, policy, or practice that the physician, consistent with that degree of learning and skill ordinarily possessed by reputable physicians practicing according to the applicable legal standard of care, reasonably believes impairs the physician's ability to provide medically appropriate health care to his or her patients. No person, including but not limited to the Medical Staff, the hospital, its employees, agents, directors or owners, shall retaliate against or penalize any member for such advocacy or prohibit, restrict or in any way discourage such advocacy, nor shall any person prohibit, restrict, or in any way discourage a member from communicating to a patient information in furtherance of medically appropriate health care.

c. A member who advocates for medically appropriate care must do so in a way that is not disruptive to Medical Staff operations or safe patient care. A member may be subject to corrective and/or disciplinary action if his or manner of advocating for medically appropriate care is inappropriate. Examples include, but are not limited to, yelling, shouting, or demeaning other health care providers; making threats of violence; unilaterally refusing to follow Medical Staff bylaws, rules and regulations, or policies and procedures without obtaining waivers, if necessary; and any other behavior prohibited by the Medical Staff's code of conduct.

d. This Section does not preclude corrective and/or disciplinary action as authorized by these Medical Staff bylaws.

15.12 Medical Staff Representation by Legal Counsel

Upon the authorization of the Executive Committee, the Medical Staff may retain, be represented by, and pay for independent legal counsel of its choosing. At its discretion, the Medical Staff may enter into a written engagement letter with the individual selected to be independent legal counsel affirming that the Medical Staff, not the hospital, is the counsel's client, that the counsel represents solely the interests of the Medical Staff, and that the attorney-client privilege of confidentiality applicable to all communications between the counsel and the Medical Staff is held solely by the Medical Staff, regardless of whether the Medical Staff or a third party pays the counsel's fees. In the event the counsel is paid for by a third party, the counsel shall also provide a written assurance to the Medical Staff that he/she will permit no interference by the third party with his/her independence of professional judgment or with the attorney-client relationship, as required by State Bar of California Rules of Professional Conduct, Rule 1.8.6 and successor Rules.

15.13 Successor in Interest/Affiliations

15.13.1. 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 this hospital, except where hospital Medical Staffs are being combined. In the event that the staffs are being combined, the Medical Staffs 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 institution will remain in effect.

15.13.2. Affiliations

Affiliations between the hospital and other hospitals, health care systems or other entities shall not, in and of themselves, affect these bylaws unless otherwise provided in these bylaws.

15.13.3. No Violation of Law, Governing Rules, or Accreditation Standards. These conflict and dispute management provisions shall not serve to permit or validate any violation of

state or federal law, of the Medical Staff Bylaws or Rules, or of any accreditation requirement applicable to the activities of the Medical Staff or St. Joseph's Hospital.

ARTICLE 16

ADOPTION AND AMENDMENT OF BYLAWS AND RULES

16.1 Medical Staff Responsibility and Authority

The Medical Staff shall have the initial responsibility and delegated authority to formulate, adopt, and recommend Medical Staff Bylaws and Rules and amendments thereto which shall be effective when approved by the Governing Body. Such responsibility and authority shall be exercised in good faith and in a reasonable, timely, and responsible manner, reflecting the interests of providing patient care of the generally recognized level of quality and efficiency, and maintaining a harmony of purpose and effort with the Governing Body.

16.1.1. Changes to Medical Staff Bylaws

a. Amendments to these Bylaws initiated by the Executive Committee shall be submitted to the Medical Staff for vote upon the approval of the Executive Committee. Before such Executive Committee action may be taken, however, the Executive Committee will provide notice to the General Medical Staff of the proposed change or amendment providing ample time to provide input for MEC consideration. The notice shall include the exact wording of the existing language of the bylaw(s), if any, any other relevant wording that may clarify the nature of the changes being proposed, the proposed change(s) themselves, and that there is provided at least a 30-day period for members to provide input on the proposed Bylaw change with the last date acceptance of such input is permitted This paragraph shall not apply to Technical Amendments or State or Regulatory compliance amendments permitted under Section 16.3.

b. Initiated by Petition of the Medical Staff. The process for amendment to these Bylaws may be initiated or upon receipt of a petition signed by at least 20 percent of the Active Medical Staff members

16.1.2. Changes to Medical Staff Rules

a. Initiated by the Executive Committee. Recommended changes to the Rules shall be submitted to the Executive Committee for review and approval by a two-thirds (2/3) vote of the Executive Committee voting members as set forth in Section 15.1.

b. Initiated by Petition of the Medical Staff. The process for amendment of the Medical Staff Rules may be initiated by petition of the Medical Staff upon receipt of a petition signed by at least 20% of the Active Medical Staff members. Adoption of changes is in accordance with Section 16.2 of these bylaws.

c. A rule shall become effective following approval of the Governing Body, which approval shall not be withheld unreasonably.

d. If there is a conflict between the Bylaws and the Rules, the Bylaws shall prevail.

The Executive Committee shall make available a copy of all amendment(s) approved for a vote of the Medical Staff immediately upon its approval of the amendment(s) for such vote. The Executive Committee shall educate the Medical Staff, and permit forums for Medical Staff members to learn and engage in debate and discourse, about the background and history of the amendment(s), the reasons why the Executive Committee believes the Medical Staff should adopt the amendment(s), and the various implications of the proposed amendment(s) including the pros and cons about the amendment(s).

16.1.3. Procedures for Amendment of Bylaws or Rules initiated by Petition of the Medical Staff

a. The draft of the proposed amendment(s) to either Bylaws or Rules initiated by the Medical Staff must be forwarded to the Medical Staff Office which shall transmit a copy promptly to each member of the Executive Committee. The proposed amendment(s) shall be placed on the agenda for the next regularly scheduled Executive Committee meeting that is on calendar to meet no less than ten days after the receipt of the proposed amendment(s).

b. The Executive Committee shall review the proposed amendment(s) and determine by a majority vote of the members whether:

i. the MEC supports the proposed amendment(s) or any of them if there are more than one;

ii. the MEC opposes the proposed amendment(s), or any of them if there are more than one; and/or

iii. the MEC neither supports nor opposes the proposed amendment(s), or any of them if there are more than one.

c. If, after review, the Executive Committee determines that it does not oppose the amendment, or any of them if more than one, the Chief of Staff must implement the procedures of Section 15.1 if the amendment involves the Rules. The following information must be included with the ballot sent on the proposed Bylaws amendment:

i. that the proposed amendment(s) is initiated by a petition of at least 20% of the voting members of the Medical Staff;

ii. the proposed amendment or amendments;

iii. the exact wording of the current provision(s) of the bylaws proposed to be amended, if applicable;

iv. any other relevant wording or provisions in the current bylaws that may provide context and/or may clarify the nature of the change(s) being proposed;

v. which amendment or amendments the Executive Committee supports, and which amendment or amendments it neither supports nor opposes, and a clear explanation for same if so desired;

vi. the quorum requirement, and the number of votes required, to adopt the amendment(s);

d. If, after review, the Executive Committee determines that it opposes one or more specified amendment(s), the Chief must promptly provide written notice for a meeting of the general Medical Staff regarding the amendment(s). The meeting so noticed shall be held no less than seven, nor more than thirty, days from the date the Executive Committee determines its opposition. The notice of the meeting shall state:

16.1.4. Actions Taken at Medical Staff Meetings

a. The Medical Staff meeting required under this Section shall serve to educate the Medical Staff, and permit forums for Medical Staff members to learn and engage in debate and discourse, about the background and history of the amendment(s),. The meetings should assist the Medical Staff in understanding the reasons why

the proponent(s) of the amendment(s) believes the Medical Staff should adopt the amendment(s), the position taken by the Executive Committee on the amendments, if any, and the various implications of the proposed amendment(s) including the pros and cons about the amendment(s).

b. At this meeting, the members in attendance may discuss any matters germane to the proposed amendment(s); modify or reject the proposed amendment(s); certify the proposed amendment(s) (if unchanged) for vote as a proposed amendment(s) to either the Bylaws or Rules if the Executive Committee has already reviewed the amendment(s) and notified the Medical Staff of its position; or postpone consideration of all, or any part of, proposed amendment(s).

c. If the proposed amendment(s) are further modified at the general staff meeting, they must be returned to the Executive Committee for review. Under such circumstances, the Executive Committee need not call another meeting of the Medical Staff, but shall, at its next regular meeting which is not less than ten days after the general meeting where the modifications were made, assess its position regarding the modified amendments.

d. After completion of the foregoing steps, the MEC shall implement the procedures of Section 16.1. The information listed in 16.1.3.c must be included with the ballot sent to on the proposed amendment(s).

16.2 Methodology

Medical Staff Bylaws and Rules changes initiated by the Medical Staff may be adopted, amended, or repealed by the following combined actions:

16.2.1. The affirmative vote of a two-thirds (2/3) majority of the Active Medical Staff Members voting on the matter by electronic or mailed ballot, provided at least fourteen (14) days' advance Notice, accompanied by the proposed Bylaws and/or alterations, has been given; and

16.2.2. The approval of the Governing Body, which shall not be unreasonably withheld, or automatic approval if no action is taken by the Governing Body within 90 days after the Governing Body is notified of results of the vote. 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 Executive Committee, and the Bylaws Committee. A copy of the writing shall be made available to the Medical Staff through any method that satisfactorily communicates to all voting members of the Medical Staff, and which shall include posting the writing in Medical Staff common areas, such as Medical Staff offices, dining room, and lounges.

16.3 Technical and Editorial Amendments

The Executive Committee shall have the power to adopt such amendments to the Bylaws as are, in its judgment, technical modifications or clarifications, reorganization or renumbering of the Bylaws, or amendments made necessary because of punctuation, spelling or other errors of grammar or expression, or inaccurate cross-references. Such amendments shall be effective immediately and shall be permanent if not disapproved by the Medical Staff or the Governing Body within (90) days after adoption by the Executive Committee. The action to amend may be taken by motion and acted upon in the same manner as any other motion before the Executive Committee. After approval, such amendments shall be communicated in writing to the Medical Staff and to the Governing Body.

16.4 Effect of The Bylaws

a. These bylaws may not be unilaterally amended or repealed by the Medical Staff or Governing Body.

b. No Medical Staff governing document and no hospital corporate bylaws or other hospital governing document shall include any provision purporting to allow unilateral amendment of the Medical Staff bylaws or other Medical Staff governing document.

c. The Medical Staff Bylaws, Rules & Regulations and the Governing Body bylaws and hospital policies shall be compatible with each other and compliant with law and regulation. If either the MEC or hospital board believes that a conflict has arisen between Governing Body bylaws, policy, rules, contracts, or other hospital requirements and the Medical Staff Bylaws, Medical Staff Rules, and/or Medical Staff's right to self-governance, the Chief of Staff or Board Chair, as appropriate, will promptly notify the other in writing regarding the possible conflict.

d. The Governing Body upholds, and does not act inconsistent with, the Medical Staff Bylaws and Rules so long as those Bylaws and Rules do not conflict with applicable laws.

16.5 Exclusivity

The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff bylaws and rules & regulations.

Approved by: Medical Executive Committee: 11/29/2018; 1/17/2019 (Technical Amendments Only), 5/16/2019 (Technical Amendments Only)
11/21/2019 (Technical Amendments Only)
7/21/2022 (by vote of Active Staff)

Board of Trustees: 12/6/2018; 1/31/2019 (Technical Amendments Only), 5/23/2019 (Technical Amendments Only)
12/5/2019 (Technical Amendments Only)
8/1/2022 (as approved by MEC)