MEDICAL STAFF BYLAWS
SAN ANTONIO REGIONAL HOSPITAL

Approved by the Board of Trustees
April 27, 2020

The following articles included in this issue have been revised since the last edition dated October 1, 2019:

- Article II, 2.5 Practitioners Providing Contractual Professional Services
- Article II, 2.7 Basic Responsibilities of Medical Staff Members
- Article III, 3.6 Provisional Staff, 3.6.1 Qualifications
- Article VI, 6.4 Automatic Termination of Suspension, 6.4.8 Failure to Provide Updated Documentation
- Article VIII, 8.2 Qualifications, 8.2.1 General Officers
- Article VIII, 8.10 Duties of Department Officers
- Article VIII, 8.11 Division Chiefs, 8.11.1 Qualifications

Table of Contents

PREAMBLE ..... **xiii**
DEFINITIONS ..... **xiii-xv**

ARTICLE I NAME **1**
ARTICLE II MEMBERSHIP **1**

2.1. PURPOSES **1**
2.2. NATURE OF MEMBERSHIP **1**
2.3. QUALIFICATIONS FOR MEMBERSHIP **1**

2.3.1. GENERAL QUALIFICATIONS 1-2
2.3.2. PARTICULAR QUALIFICATIONS 2
2.3.3. MINIMUM QUALIFICATIONS 2-3
2.3.4. EFFECT OF OTHER AFFILIATIONS 3

2.4. NONDISCRIMINATION **3**
2.5. PRACTITIONERS PROVIDING CONTRACTUAL PROFESSIONAL SERVICES **3**

2.5.1. HOSPITAL-BASED PHYSICIANS 4
2.5.2. MEDICAL DIRECTORS 4
2.5.3. EFFECT OF MEMBERSHIP TERMINATION 4
2.5.4. EFFECT OF CONTRACT EXPIRATION OR TERMINATION 4
2.5.5 HOSPITAL BASED PHYSICIAN GROUPS WITH EXCLUSIVE PROVIDER AGREEMENT CONTRACTS 4-5

2.6. RESPONSIBILITIES OF THE MEDICAL STAFF **5-6**
2.7. BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERS **6-7**

ARTICLE III CATEGORIES **7**

3.1. CATEGORIES **7**
3.2. ACTIVE STAFF **7**

3.2.1. QUALIFICATIONS 7-8
3.2.2. PREROGATIVES 8
3.2.3. RESPONSIBILITIES 8

3.3 COURTESY STAFF **8**

3.3.1. QUALIFICATIONS 8-9
3.3.2 PEROGATIVES 9

3.4 AFFILIATE STAFF **9**

3.4.1. QUALIFICATIONS 9
3.4.2 PEROGATIVES 9

3.4.3 RESPONSIBILITIES 9
3.4.4 CATEGORY CHANGE 9

3.5. CONSULTING STAFF 9

3.5.1. QUALIFICATIONS 10
3.5.2. PREROGATIVES 10

3.6 PROVISIONAL STAFF 10

3.6.1. QUALIFICATIONS 10
3.6.2 PEROGATIVES 10
3.6.3 OBSERVATION OF PROVISIONAL STAFF MEMBER 10-11
3.6.4 TERM OF PROVISIONAL STAFF MEMBER 11
3.6.5 ACTION AT CONCLUSION OF PROVISIONAL STAFF STATUS 11

3.7. TELEMEDICINE STAFF 121

3.7.1. QUALIFICATIONS 11
3.7.2. PREROGATIVES 11

3.8. HONORARY STAFF 12

3.8.1. QUALIFICATIONS 12
3.8.2. LIMITATIONS 12

3.9. LIMITATION OF PREROGATIVES 12
3.10. MODIFICATION OF MEMBERSHIP CATEGORY 12

ARTICLE IV APPOINTMENT AND REAPPOINTMENT 12

4.1. GENERAL 12
4.2. BURDEN OF PRODUCING INFORMATION 13
4.3. APPOINTMENT AUTHORITY 13
4.4. DURATION OF APPOINTMENT 13
4.5. APPLICATION FOR INITIAL APPOINTMENT AND REAPPOINTMENT 13

4.5.1. APPLICATION FORM 13-14
4.5.2. EFFECT OF APPLICATION 14-15
4.5.3. VERIFICATION OF INFORMATION 15-16
4.5.4. CREDENTIALS COMMITTEE ACTION 16
4.5.5. CREDENTIALS COMMITTEE REPORT AND RECOMMENDATIONS 16-17
4.5.6. EFFECT OF EXECUTIVE COMMITTEE ACTION 17-18
4.5.7. ACTION ON THE APPLICATION 18-19
4.5.8. NOTICE OF FINAL DECISION 19
4.5.9. REAPPLICATION AFTER ADVERSE APPOINTMENT DECISION DENYING APPLICATION, ADVERSE CORRECTIVE ACTION

DECISION, OR RESIGNATION IN LIEU OF MEDICAL DISCIPLINARY ACTION 19-20

4.6. REAPPOINTMENTS AND REQUESTS FOR MODIFICATIONS OF STAFF STATUS OR PRIVILEGES 20

4.6.1. APPLICATION 20
4.6.2. EFFECT OF APPLICATION 20
4.6.3. STANDARDS AND PROCEDURE FOR REVIEW 20-21
4.6.4. FAILURE TO FILE REAPPOINTMENT APPLICATION 21

4.7. LEAVE OF ABSENCE 21

4.7.1. LEAVE STATUS 21
4.7.2. TERMINATION OF LEAVE 21-22
4.7.3. FAILURE TO REQUEST REINSTATEMENT 22

ARTICLE V CLINICAL PRIVILEGES 22

5.1. EXERCISE OF PRIVILEGES 22
5.2. DELINEATION OF PRIVILEGES IN GENERAL 23

5.2.1. REQUESTS 23
5.2.2. BASIS FOR PRIVILEGES DETERMINATION 23

5.3. PRECEPTORING 23

5.3.1. APPLICABILITY AND DURATION 23-24
5.3.2. STATUS AND PRIVILEGES DURING PRECEPTORING PERIOD 24
5.3.3. REQUIREMENTS FOR SUCCESSFUL COMPLETION 24-25

5.4. CONDITIONS FOR PRIVILEGES OF LIMITED LICENSE PRACTITIONERS 25
5.5. TEMPORARY CLINICAL PRIVILEGES 25

5.5.1. CIRCUMSTANCES 25-26
5.5.2. CONDITIONS 26
5.5.3. TERMINATION 26-27
5.5.4. EMERGENCY PRIVILEGES 27
5.5.5. EMERGENCY PRIVILEGES 27-28

5.6. MODIFICATION OF CLINICAL PRIVILEGES OR DEPARTMENT ASSIGNMENT 28
5.7. APPLICATION DEEMED WITHDRAWN 28
5.8. HISTORY AND PHYSICAL 28-29

ARTICLE VI CORRECTIVE ACTION 29

6.1. ROUTINE MONITORING AND EDUCATION 29
6.2. CORRECTIVE ACTION 29

6.2.1. CRITERIA FOR INITIATION 29
6.2.2. INITIATION 29-30
6.2.3. INVESTIGATION 30
6.2.4. EXECUTIVE COMMITTEE ACTION 30-31
6.2.5. SUBSEQUENT ACTIONS 31
6.2.6. PROCEDURAL RIGHTS 31-32

6.3. SUMMARY SUSPENSION 32

6.3.1. CRITERIA FOR IMMEDIATE SUSPENSION 32
6.3.2. EXECUTIVE COMMITTEE ACTION 32-33
6.3.3. PROCEDURAL RIGHTS 33

6.4. AUTOMATIC TERMINATION OR SUSPENSION 33

6.4.1. LICENSE 33
6.4.2. FELONY CONVICTION OR PLEA OF NO CONTEST TO A FELONY CHARGE 33-34
6.4.3. EXCLUSION FROM PARTICIPATION IN FEDERAL OR STATE PROGRAM 34
6.4.4. DRUG ENFORCEMENT ADMINISTRATION (DEA) CONTROLLED SUBSTANCE CERTIFICATE 34
6.4.5. FAILURE TO SATISFY SPECIAL APPEARANCE REQUIREMENTS 34
6.4.6. EXECUTIVE COMMITTEE DELIBERATION ON MATTERS INVOLVING LICENSE, DRUG ENFORCEMENT ADMINISTRATION, OR SPECIAL APPEARANCE ACTIONS OR EXCLUSION FROM PARTICIPATION IN FEDERAL OR STATE PROGRAMS 34-35
6.4.7. MEDICAL RECORDS 35-36
6.4.8. FAILURE TO PROVIDE UPDATED DOCUMENTATION 36
6.4.9. FAILURE TO PAY DUES 36
6.4.10. PROCEDURAL RIGHTS – FELONY CONVICTION, EXCLUSION FROM PARTICIPATION IN FEDERAL/STATE PROGRAM, MEDICAL RECORDS, MALPRACTICE INSURANCE, FAILURE TO PAY DUES 36
6.4.11. NOTICE OF AUTOMATIC SUSPENSION; TRANSFER OF PATIENTS 36-37

6.5. REAPPLICATION AFTER RESIGNATION 37
6.6. INTERVIEWS 37

ARTICLE VII HEARINGS AND APPELLATE REVIEWS 37

7.1. PREAMBLE AND DEFINITIONS 37

7.1.1. REVIEW PHILOSOPHY 37
7.1.2. INTRA-ORGANIZATIONAL REMEDIES 37-38
7.1.3. EXHAUSTION OF REMEDIES 38
7.1.4. DEFINITIONS 38

7.1.5. SUBSTANTIAL COMPLIANCE 38

7.2. GROUNDS FOR A HEARING 38-39
7.3. HEARING RULES AND PROCEDURE 39

7.3.1. NOTICE OF ACTION OR PROPOSED ACTION 39-40
7.3.2. REQUEST FOR HEARING 40
7.3.3. TIME AND PLACE FOR HEARING 40
7.3.4. NOTICE OF CHARGES AND WITNESSES 40-41
7.3.5. JUDICIAL HEARING COMMITTEE 41
7.3.6. THE HEARING OFFICER 41
7.3.7. THE PRESIDING OFFICER 41-42
7.3.8. PRE-HEARING PROCEDURE 42
7.3.9. DISCOVERY 42-43
7.3.10. PRE-HEARING DOCUMENT EXCHANGE 43
7.3.11. REPRESENTATION 43
7.3.12. FAILURE TO APPEAR 44
7.3.13. POSTPONEMENTS AND EXTENSIONS 44
7.3.14. RECORD OF THE HEARING 44
7.3.15. RIGHTS OF THE PARTIES 44
7.3.16. RULES OF EVIDENCE 44-45
7.3.17. BASIS OF DECISION 45
7.3.18. BURDEN OF GOING FORWARD AND BURDEN OF PROOF 45
7.3.19. ORGANIZATION AND CONDUCT OF HEARING PROCESS 45-46
7.3.20. ADJOURNMENT AND CONCLUSION 47
7.3.21. DECISION OF THE JUDICIAL HEARING COMMITTEE 47

7.4. APPEALS TO THE BOARD OF TRUSTEES 47

7.4.1. TIME FOR APPEAL 47
7.4.2. GROUNDS FOR APPEAL 47-48
7.4.3. TIME, PLACE AND NOTICE 48
7.4.4. APPEAL BOARD 48
7.4.5. HEARING PROCEDURE 48
7.4.6. POSTPONEMENTS AND EXTENSIONS 49
7.4.7. DECISION 49
7.4.8. FURTHER REVIEW 49
7.4.9. RIGHT TO ONE HEARING 49

7.5. EXCEPTIONS TO HEARING RIGHTS 49

7.5.1. CLOSED STAFF OR EXCLUSIVE USE DEPARTMENTS, HOSPITAL CONTRACT PHYSICIANS AND MEDICAL DIRECTORS 49-50
7.5.2. ALLIED HEALTH PROFESSIONALS 50
7.5.3. DENIAL OF APPLICATIONS FOR FAILURE TO MEET THE MINIMUM QUALIFICATIONS 50
7.5.4. AUTOMATIC SUSPENSIONS AND RESIGNATIONS 50

7.5.5. REMOVAL FROM EMERGENCY DEPARTMENT ROOM CALL PANEL 50

ARTICLE VIII OFFICERS/OTHER ELECTED REPRESENTATIVES 51

8.1. IDENTIFICATION 51

8.1.1. GENERAL OFFICERS 51
8.1.2. OTHER ELECTED REPRESENTATIVES 51
8.1.3. DEPARTMENT OFFICERS 51

8.2. QUALIFICATIONS 51

8.2.1. GENERAL OFFICERS 51
8.2.2. OTHER ELECTED REPRESENTATIVES 51
8.2.3. DEPARTMENT OFFICERS 51
8.2.4. TEM,PORARY REMOVAL 51

8.3. METHOD OF ELECTION 52

8.3.1. OFFICER/ELECTED REPRESENTATIVE PROCESS 52
8.3.2. DEPARTMENT CHAIR/NOMINATING COMMITTEE REPRESENTATIVE PROCESS 52-53

8.4. PRESIDENT AND IMMEDIATE PAST PRESIDENT PROVISIONS 53
8.5. CONFLICT OF INTEREST 54
8.6. TERM OF OFFICE 54
8.7. REMOVAL FROM OFFICE 54
8.8. VACANCIES 54-55
8.9. DUTIES OF GENERAL OFFICERS 55

8.9.1. PRESIDENT 55-56
8.9.2. PRESIDENT-ELECT 56
8.9.3. IMMEDIATE PAST PRESIDENT 56
8.9.4. SECRETARY-TREASURER 56

8.10. DUTIES OF DEPARTMENT OFFICERS 56-58
8.11. DIVISION CHIEFS 58

8.11.1.QUALIFICATIONS 58
8.11.2.SELECTION 58
8.11.3.TERM OF OFFICE 58
8.11.4.DUTIES 58-59

8.12. MEDICAL DIRECTORS 59

8.12.1.QUALIFICATIONS 59
8.12.2.SELECTION 59

8.12.3.TERM OF OFFICE....59
8.12.4.DUTIES 59-60

ARTICLE IX CLINICAL SERVICE COMMITTEES 60

9.1. ORGANIZATION OF SERVICES 60

9.1.1. COMPOSITION....60
9.1.2. ELIGIBILITY AND TENURE....60
9.1.3. MEETINGS....60
9.1.4. MINUTES 60
9.1.5. DUTIES....61
9.1.6. QUORUM 61
9.1.7. REPORT....62
9.1.8. ATTENDANCE 62

ARTICLE X STANDING COMMITTEES 62

10.1. DESIGNATION 62
10.2. GENERAL PROVISIONS 62

10.2.1.TERMS OF COMMITTEE MEMBERSHIP....62
10.2.2.REMOVAL....62
10.2.3.VACANCIES....62

10.3. GENERAL COMMITTEE REQUIREMENTS 62

10.3.1.REGULAR MEETINGS....63
10.3.2.SPECIAL MEETINGS 63
10.3.3.NOTICE OF MEETINGS....63
10.3.4.QUORUM....63
10.3.5.MANNER OF ACTION 63
10.3.6.MINUTES....63
10.3.7.ATTENDANCE REQUIREMENTS 63

10.4. BIOETHICS COMMITTEE....63

10.4.1.COMPOSITION 63-64
10.4.2.DUTIES 64
10.4.3.MEETINGS 64
10.4.4.REPORT 64

10.5. BYLAWS COMMITTEE....64

10.5.1.COMPOSITION 64
10.5.2.DUTIES 64
10.5.3.MEETINGS 64
10.5.4.REPORT 64

10.6. CANCER COMMITTEE....64

10.6.1.COMPOSITION 65
10.6.2.DUTIES 65
10.6.3.MEETINGS 65
10.6.4.REPORT 66

10.7. CONTINUING MEDICAL EDUCATION COMMITTEE 66

10.7.1.COMPOSITION 66
10.7.2.DUTIES 66
10.7.3.MEETINGS 66-67
10.7.4.REPORT 67

10.8. CREDENTIALS COMMITTEE 67

10.8.1.COMPOSITION 67
10.8.2.DUTIES 67
10.8.3.MEETINGS 67

10.9. PHYSICIANS WELL-BEING COMMITTEE 67

10.9.1.COMPOSITION 67-68
10.9.2.DUTIES 68
10.9.3.MEETINGS 68
10.9.4.MINUTES 69
10.9.5.REPORT 69

10.10.MEDICAL EXECUTIVE COMMITTEE 69

10.10.1.COMPOSITION 69
10.10.2.DUTIES 69-71
10.10.3.ASSISTANCE WITH FUNCTIONS 71-72
10.10.4.MEETINGS 72

10.11.INSTITUTIONAL REVIEW BOARD 72

10.11.1.COMPOSITION 72
10.11.2.DUTIES 72-73
10.11.3.MEETINGS 73
10.11.4.REPORT 73

10.12.INTERDISCIPLINARY PRACTICE COMMITTEE 73

10.12.1.COMPOSITION 73
10.12.2.DUTIES 73
10.12.3.MEETINGS 74
10.12.4.REPORT 74

10.13.NOMINATING COMMITTEE 74

10.13.1.COMPOSITION 74

10.13.2.DUTIES 74
10.13.3.MEETINGS 74
10.13.4.REPORT 74

10.14.PHARMACY AND THERAPEUTICS COMMITTEE 74

10.14.1.COMPOSITION 74-75
10.14.2.DUTIES 75
10.14.3.MEETINGS 75
10.14.4.REPORTING 75

10.15.QUALITY MANAGEMENT COMMITTEE 75

10.15.1.COMPOSITION 75-76
10.15.2.DUTIES 76-77
10.15.3.MEETINGS 77
10.15.4.REPORT 77

10.16.CANCER CONFERENCE 77

10.16.1.COMPOSITION 77-78
10.16.2.DEFINITION 78
10.16.3.DUTIES/RESPONSIBILITIES 78
10.16.4.MEETINGS 78
10.16.5.REPORT 78

10.17. JOINT CONFERENCE COMMITTEE 78-79
10.18. MULTISPECIALTY PHYSICIAN EXCELLENCE COMMITTEE 79

10.18.1.COMPOSITION 79
10.18.2.DUTIES 79
10.18.3.MEETINGS 79
10.18.4.REPORT 80

ARTICLE XI CLINICAL DEPARTMENTS AND DIVISIONS 80

11.1. ORGANIZATION OF DEPARTMENTS AND DIVISIONS 80
11.2. DESIGNATION 80
11.3. ASSIGNMENT TO DEPARTMENTS AND DIVISIONS 80
11.4. FUNCTIONS OF DEPARTMENTS 80
11.5. FUNCTIONS OF DIVISIONS 80-81
11.6. MODIFICATIONS IN CLINICAL ORGANIZATION UNIT 81
11.7. CREATION OF SUBDIVISION 81
11.8. ELIMINATIONS 81
11.9. COMBINATION 81

ARTICLE XII GENERAL MEETINGS 81

12.1. ANNUAL MEETING 81
12.2. REGULAR MEETINGS 81-82

12.3. SPECIAL MEETINGS 82
12.4. AGENDA 82
12.5. ATTENDANCE 82
12.6. QUORUM 82-83
12.7. COMMITTEE AND DEPARTMENT MEETINGS 83

12.7.1.REGULAR MEETINGS 83
12.7.2.SPECIAL MEETINGS 83
12.7.3.QUORUM 83
12.7.4.MANNER OF ACTION 83
12.7.5.MINUTES 83
12.7.6.SPECIAL APPEARANCE 83-84
12.7.7.CONDUCT OF MEETINGS 84

ARTICLE XIII CONFIDENTIALITY, IMMUNITY AND RELEASES 84

13.1. AUTHORIZATION AND CONDITIONS 84
13.2. CONFIDENTIALITY OF INFORMATION 84

13.2.1.GENERAL 84
13.2.2.AGREEMENT TO MAINTAIN CONFIDENTIALITY 84-85
13.2.3.BREACH OF CONFIDENTIALITY 85

13.3. IMMUNITY FROM LIABILITY 85

13.3.1.FOR ACTION TAKEN 85
13.3.2.FOR PROVIDING INFORMATION 85

13.4. ACTIVITIES AND INFORMATION COVERED 85

13.4.1.ACTIVITIES 85-86

13.5. RELEASES 86

ARTICLE XIV ALLIED HEALTH PROFESSIONALS 86

14.1. QUALIFICATIONS 86
14.2. DELINEATION OF CATEGORIES OF AHPs ELIGIBLE TO APPLY FOR SERVICE AUTHORIZATION 86
14.3. PROCEDURE FOR GRANTING SERVICE AUTHORIZATION 86-87
14.4. PREROGATIVES 87
14.5. RESPONSIBILITIES 87-88
14.6. PRIVILEGES 88
14.7. FAIR HEARING AND APPEAL PROCESS 88

14.7.1.GENERAL 88
14.7.2.PROCEDURES 88-89
14.7.3.FFECTIVE DATE OF ADVERSE ACTION 89

ARTICLE XV GENERAL PROVISIONS 89

15.1. STAFF RULES AND REGULATIONS..89

15.1.1 GENERAL RULES AND REGULATION 90
15.1.2 CLINICAL DEPARTMENT RULES & REGULATIONS………....................90
15.1.3 MEDICAL STAFF POLICIES.. 90
15.1.4INITIATION OF GENERAL RULES OR POLICIES BY ACTIVE STAFF MEMBERS 90
15.1.5URGENT AMENDMENT OF RULES..90
15.1.6EXCLUSIVITY……………………………………………………………... 90

15.2 ACTIVE STAFF PETITION TO EXECUTIVE COMMITTEE………………90-91
15.3 DUES OR ASSESSMENTS…………………………………………………………91

15.4. CONSTRUCTION OF TERMS AND HEADINGS 91
15.5. AUTHORITY TO ACT.. 91-92
15.6. DIVISION OF FEES 91-92
15.7. NOTICES.. 91-92

ARTICLE XVI ADOPTION AND AMENDMENT OF BYLAWS..92

16.1. PROCEDURE 92
16.2. ACTION BY THE ACTIVE STAFF.. 92-93
16.3 APPROVAL 92-93
16.4 COMPATIBILITY; NO UNILATERAL AMENDMENT 92-93

PREAMBLE

These Bylaws are adopted in order to provide for the organization of the Medical Staff of San Antonio Regional Hospital and to provide a framework for self-government in order to permit the Medical Staff to discharge its responsibilities in matters involving the quality of medical care, and to govern the orderly resolution of issues and the conduct of Medical Staff functions supportive of those purposes. The physicians, dentists, podiatrists, and psychologist are authorized to practice medicine, dentistry, podiatry, and psychology respectively at San Antonio Regional Hospital are responsible to the Board of Trustees for the promulgation of, and adherence to, an appropriate standard of medical care for hospital patients. This obligation can be most effectively performed through the concerted endeavor of all such Practitioners and the cooperative efforts of the Medical Staff, administration, and the Board of Trustees. These Bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Board of Trustees and administration, and relations with applicants to and Members of the Medical Staff. They are to be constructed in conformity with applicable hospital licensing laws, applicable accreditation guidelines and regulatory requirements. They do not constitute an express or implied contract between or among any individual, committee, or entity, unless otherwise expressly determined by state law.

DEFINITIONS

1. ALLIED HEALTH PROFESSIONAL or AHP means an individual, other than a licensed physician, dentist, podiatrist or psychologist, who exercises independent judgment within the areas of his or her professional competence and the limits established by the Medical Staff, the Board of Trustees, and the applicable state practice acts.
2. APPLICANT means an individual applying for appointment or reappointment to the Medical Staff.
3. BOARD OF TRUSTEES or BOARD means the governing body of San Antonio Regional Hospital.
4. CLINICAL PRIVILEGES or PRIVILEGES means the permission granted by the Executive Committee to a Member of the Medical Staff to render specific patient services, based on the Member's professional license and documented competence, experience, and judgment.
5. COMPLETED APPLICATION means an application, either for initial appointment or reappointment to the Medical Staff or for clinical privileges, as determined by the applicable Medical Staff Department(s), committees, Executive Committee, and Board to meet the requirements of these Bylaws and Rules and Regulations, and to contain sufficient information to act upon the application.
6. DATE OF RECEIPT of any notice or other communication shall be deemed to be the date it was received by personal delivery or, if sent by mail, five working days after it was deposited in the United States mail, postage prepaid.
7. DAYS means calendar days, unless otherwise specified as working days.
8. DENTIST means an individual who has received the Degree of Doctor of Dental Surgery or Dental Medicine and has a currently valid, unrestricted license to practice.
9. DEPARTMENT means a clinical service of the Medical Staff, grouping Members in accordance with their specialty or major practice interest as specified in Article 11 of these Bylaws. The Medical Staff Department is not the same as the Hospital operating department.
10. EX OFFICIO means to serve as a Member of a body by virtue of an office or position held and, unless otherwise expressly provided, without voting rights.

11. EXECUTIVE COMMITTEE means the Executive Committee of the Medical Staff which shall constitute the governing body of the Medical Staff described in these Bylaws.
12. HE, HIS or HIM means "he or she," "his or hers," or "him or her" and are intended to refer to an individual without respect to gender.
13. HOSPITAL means San Antonio Regional Hospital located in Upland, California.
14. INVESTIGATION means a process specifically instigated by the Medical Executive Committee to determine the validity, if any, to a concern or complaint raised against a medical staff member or individual holding clinical privileges, and does not include activity of the Medical Staff Well-Being Committee.
15. MEDICAL DIRECTOR means a Practitioner employed by, or otherwise engaged by, the Hospital on a full, or part-time basis, whose duties include certain responsibilities which are both administrative and clinical in nature. Clinical responsibilities may relate to direct medical care of patients and/or supervision of the professional activities of individuals under such Practitioner's direction.
16. MEDICAL DISCIPLINARY CAUSE OR REASON ("MDCR") shall mean a basis for corrective action involving an aspect of a Practitioner's competence or professional conduct which is reasonably likely to be detrimental to patient safety or the delivery of quality care.
17. MEDICAL STAFF or STAFF means those physicians (M.D. or D.O.), dentists, podiatrists, and psychologist who have been appointed Members of the Medical Staff and are privileged to provide patient care services in the Hospital within the scope of their licensure and approved clinical privileges, pursuant to the terms of these Bylaws.
18. MEDICAL STAFF YEAR means the period from January 1 to December 31.
19. MEMBER means, unless otherwise expressly limited, any physician (M.D. or D.O.), dentist, podiatrist or psychologist holding a current license to practice within the scope of his or her license and who is appointed to the Medical Staff.
20. MEMBER in "GOOD STANDING" means that a member has unrestricted clinical privileges; is not subject to any actual or recommended corrective action under Article VI; and is not subject to any current probation, limitation or accusation by the Medical Board of California.
21. PHYSICIAN means an individual, possessing either an M.D. or D.O. degree, with a currently valid and unrestricted license to practice medicine in all its phases in the State of California.
22. PODIATRIST means an individual who has received the degree of Doctor of Podiatric Medicine Degree and has a currently valid, unrestricted license to practice podiatry in the State of California.
23. PRACTITIONER means, unless otherwise expressly limited, any physician, podiatrist, dentist, or psychologist as defined in these Bylaws applying for or exercising clinical privileges in this Hospital, or exercising the ability to render services in this Hospital.
24. PREROGATIVE means a participatory right granted, by virtue of staff category or otherwise, to a Member or AHP and exercisable subject to the conditions imposed in these Bylaws and Medical Staff policies.
25. PRESIDENT OF THE HOSPITAL means the person appointed by the Board of Trustees to act on its behalf in the overall management of the Hospital.
26. PRESIDENT OF THE MEDICAL STAFF means a Member of the active Medical Staff who is elected in accordance with these Bylaws to serve as Chief Officer of the Medical Staff of this Hospital.

27. PSYCOLOGIST means an individual who has received the degree of Doctor of Psychology or Clinical Psychology and has a currently valid, unrestricted license to practice psychology in the State of California.
28. SERVICE AUTHORIZATION means the permission granted to an allied health professional to participate in the provision of certain patient care services.
29. SPECIAL NOTICE means written notification sent by certified or registered mail, return receipt required, unless otherwise expressly provided.

ARTICLE I
NAME

The name of this organization shall be the Medical Staff of San Antonio Regional Hospital.

ARTICLE II
MEMBERSHIP

2.1 PURPOSES

The purposes of the Medical Staff are:

To be the formal organizational structure through which:

The benefits of membership on the staff may be obtained by individual Practitioners; and

The obligations of membership may be fulfilled;

To serve as the primary means for accountability to the Board for the appropriateness of the professional performance and ethical conduct of its Members, and to strive toward the continual upgrading of the quality and efficiency of patient care delivered in the Hospital consistent with the state of the healing arts and the resources locally available;

To provide a means through which the Medical Staff may participate in the Hospital's policy-making, governance, and planning processes.

2.2 NATURE OF MEMBERSHIP

Membership on the Medical Staff is a privilege that shall be extended only to professionally competent Practitioners who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and Rules and Regulations. Initial and continued membership are dependent upon professional competence and ethical practice in keeping with the qualifications, standards and requirements set forth in these Bylaws and Rules and Regulations.

No Practitioner, including Medical Directors, shall admit or provide medical or health-related services to patients in the Hospital unless the Practitioner is a Member of the Medical Staff or has been granted temporary privileges in accordance with the procedures set forth in these Bylaws. Appointment to the Medical Staff shall confer only such clinical privileges and prerogatives as have been granted in accordance with these Bylaws.

2.3 QUALIFICATIONS FOR MEMBERSHIP

2.3.1 GENERAL QUALIFICATIONS

Only Practitioners who:

Document their current licensure, adequate experience, education, and training, current professional competence, good judgment, and adequate physical and mental health status, so as to demonstrate to the satisfaction of the Medical Staff and the Board of Trustees that they are professionally and ethically competent to carry out any and all of the clinical privileges requested;

Are determined, on the basis of current documented references, to adhere to the Medical Staff of San Antonio Regional Hospital Code of Conduct and the Ethics of their respective professions, to be able to work cooperatively with others (including Members, AHPs, Hospital employees, Hospital management, patients and patients' families) in the care of patients, to refrain from disruptive behavior which could interfere with patient care, and to be willing to participate in and properly discharge those responsibilities determined by the Medical Staff and the Board of Trustees; and

Agree that they will strictly abide by these Bylaws and Rules and Regulations of the Medical Staff, and the Medical Staff of San Antonio Regional Hospital Code of Conduct, Principles of Medical Ethics of the American Medical Association, or by the Code of Ethics of the individual professional associations, whichever is applicable, as well as the Hospital's ethical standards contained in its Compliance Plan, and the same are made a part of these Bylaws;
Shall be deemed to possess basic qualifications to be a Member of the Medical Staff, except for the honorary staff, in which case these criteria shall only apply as deemed individually by the medical staff.

2.3.2 PARTICULAR QUALIFICATIONS

Physicians. An applicant for physician membership on the Medical Staff must hold a M.D. or D.O. degree and must hold a valid and unsuspended certificate to practice medicine issued by the Medical Board of California or the Osteopathic Medical Board of California.

Dentists. An applicant for dental membership on the Medical Staff must hold a D.D.S. or equivalent degree, and must also hold a valid and unsuspended certificate to practice dentistry issued by the Board of Dental Examiners of California.

Podiatrists. An applicant for podiatric membership on the Medical Staff must hold a D.P.M. degree, or equivalent, and must hold a valid and unsuspended certificate to practice podiatry issued by the Medical Board of California.

Psychologist. An applicant for psychology membership on the Medical Staff must hold a PsyD. or PhD., and must hold a valid and unsuspended certificate to practice psychology issued by the California Board of Psychology.

2.3.3 MINIMUM QUALIFICATIONS

Only Practitioners who:

Are licensed to practice in the State of California;

Are graduates of approved medical, dental, or podiatric schools; or doctorate program in Psychology;

Pay the current, non-refundable application fee upon application to the Medical Staff;
Are located close enough to the Hospital to physically respond as appropriate to the patient's condition or arrange for another physician on staff to provide coverage;

Provide the name of the Physician, Podiatrist, Dentist, Psychologist providing backup coverage, and provide a letter of confirmation from that Physician, Podiatrist, Dentist, or Psychologist regarding such coverage;

Provide proof of professional liability (malpractice) insurance in the amount of $1,000,000.00 per case and $3,000,000.00 aggregate per year. The required coverage limits may not be shared by multiple practitioners and may not apply to coverage other than for professional malpractice liability; and

Are able to communicate in English, both orally and in writing shall be qualified for consideration for membership on the Medical Staff.

The geographical proximity and communication skills criteria shall be reviewed in accordance with the rules and regulations pertaining thereto. Affiliate, Consulting and Honorary Members are exempt from the geographic requirements. Home and office proximity will be taken into consideration at the time of appointment and reappointment.

In addition, an applicant shall not be qualified for consideration for membership if it is determined that the applicant's standard of patient care has, or is likely to fall below, the generally recognized professional level of quality and efficiency established by the Medical Staff. Applicants may also be ineligible for consideration for membership due to physical health impairment, a mental health impairment, an inability to work cooperatively with others in the Hospital setting, failure to adhere to the lawful ethics of the profession and any other factors which may adversely affect patient care or Hospital functioning.

2.3.4 EFFECT OF OTHER AFFILIATIONS

No physician, dentist, podiatrist, or psychologist shall be entitled to membership on the Medical Staff or to the exercise of particular clinical privileges in the Hospital merely by virtue of the fact that the applicant is duly licensed to practice medicine, dentistry, or podiatry in this, or in any other state, or is a Member of any professional organization, or had in the past, or presently has, membership or privileges at another health care facility or in another practice setting.

In the event that the Hospital contracts with an insurer, a nonprofit Hospital service plan, or a health care service plan, Staff memberships or privileges shall not be determined by or conditioned upon the Practitioner’s participation or non-participation in a contract with such insurer, Hospital service plan, or health care service plan.

2.4 NONDISCRIMINATION

No aspect of Staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, national origin, or any physical or mental impairment if, after any necessary reasonable accommodation, the applicant complies with these Bylaws and Rules and Regulations of the Medical Staff.

2.5 PRACTITIONERS PROVIDING CONTRACTUAL PROFESSIONAL SERVICES

2.5.1 HOSPITAL-BASED PHYSICIANS

A Practitioner, who is or who will be providing specified professional services pursuant to a contract with the Hospital, must meet the same membership qualifications; must be processed for appointment, reappointment, and clinical privileges in the same manner; and must fulfill all of the obligations for his or her membership category as any other applicant for membership.

2.5.2 MEDICAL DIRECTORS

A Medical Director must be a Member of the Medical Staff in good standing as this individual has clinical as well as administrative responsibilities. In addition to any applicable terms of the contract, such Practitioners shall achieve membership and clinical privilege delineation through the same procedures as is required by other Medical Members. The right to the hearing and appeal procedures under these Bylaws shall only apply if an action is taken or recommended which must be reported pursuant to California Business and Professions Code Section 805.

2.5.3 EFFECT OF MEMBERSHIP TERMINATION

Practice at the Hospital is always contingent upon continued membership and is also dependent on the clinical privileges granted. A Practitioner’s right to use the Hospital facilities is automatically terminated when membership expires or is terminated. Similarly, a Practitioner’s right to render services under contract is automatically limited to the extent that his or her clinical privileges are reduced, restricted, or terminated.

2.5.4 EFFECT OF CONTRACT EXPIRATION OR TERMINATION

The effect of expiration or other termination of a contract upon a Practitioner’s membership status and clinical privileges will be governed solely by the terms of the Practitioner’s contract with the Hospital. The right to the hearing and appeal procedures shall only apply when the action if taken or recommended must be reported pursuant to California Business and Professions Code Section 805.

If the contract is silent on the matter, or if there is no written contract, then contract expiration or other termination alone will not affect the Practitioner’s membership status or clinical privileges, except that the Practitioner may not thereafter exercise any clinical privileges for which the Hospital has made exclusive contractual arrangements with other Practitioners. Notwithstanding the above, in the event the only clinical privileges in which the Practitioner was authorized to exercise were clinical privileges which were terminated pursuant to an exclusive contract, then the Staff membership of the Practitioner automatically terminates simultaneously with the termination of the Practitioner’s clinical privileges.

2.5.5 HOSPITAL BASED PHYSICIAN GROUPS WITH EXCLUSIVE PROVIDER AGREEMENT CONTRACTS

Hospital Based Physician Groups with exclusive provider agreement contracts (Pathology, Emergency Medicine, Radiology and Anesthesiology) have unique relationships with the

Hospital, and by nature are not afforded many of the protections provided by the Medical Staff Bylaws.

In the event the Administration of San Antonio Regional Hospital deems it necessary to remove or replace an existing Group, the impact on the Hospital and Medical Staff may have profound intended or unintended consequences relating to quality of care and efficiencies.

The Administration shall notify the Medical Executive Committee when contemplating the removal of an existing Hospital Based Physician Group. The Hospital Based Physician Group and the MEC shall be informed in writing the reasons for possible termination. In addition, a formal meeting shall be set within seven days between the Hospital Administration, Hospital Based Group and the MEC to discuss the situation in its entirety. This process is to make sure all parties are fully informed and fully understand the potential effects on patient care.

2.6 RESPONSIBILITIES OF THE MEDICAL STAFF

The responsibilities of the Medical Staff are to:

Promote quality and efficiency of patient care provided by all Practitioners authorized to practice in the Hospital through the following measures;

Review and evaluation of the quality of patient care through a valid and reliable patient care evaluation procedure;

An organizational structure and mechanisms that allow ongoing monitoring of patient care practices;

A credentials program, including mechanisms for the appointment and reappointment and the matching of clinical privileges to be exercised or of specified services to be performed with the verified credentials and current demonstrated performance of the applicant, Member or AHP;

A continuing education program, fashioned at least in part on the needs demonstrated through the quality review, evaluation, and monitoring programs; and

A utilization review program to provide for the allocation of inpatient medical and health services to patients in need of them;

Recommend action to the Board with respect to appointments, reappointments, staff category, clinical Department assignment, clinical privileges, and service authorizations;

Recommend programs to the Board for the establishment, maintenance, continuing improvement, and enforcement of professional standards in the delivery of health care within the Hospital;

Account to the Board for the quality and efficiency of patient care through regular reports and recommendations concerning the implementation, operation, and results of quality review, evaluation and monitoring activities;

Initiate and pursue corrective action with respect to Practitioners when warranted.
Develop, administer, recommend amendments to, and seek compliance with these Bylaws, the Rules and Regulations of the staff, and other Hospital policies.

Assist in identifying community health needs and in setting institutional goals; implementing programs to meet those needs.

Develop and set priorities for Medical Staff goals and objectives.

Exercise the authority granted by these Bylaws as necessary to adequately fulfill the foregoing responsibilities.

Enforce these Bylaws and Rules and Regulations uniformly and consistently.

2.7 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERS

The ongoing responsibilities of each Member of the Medical Staff include:

Abiding by these Bylaws and Medical Staff Rules and Regulations, and by all other lawful standards and policies of the Hospital;

Abiding by all applicable laws and regulations of governmental agencies and complying with applicable standards of the Joint Commission;

Discharging in a responsible and cooperative manner such responsibilities and assignments imposed upon the Member by virtue of Staff membership;

Preparing and completing in timely fashion medical records for all the patients to whom the Member provides care in the Hospital;

Performing, if granted the requisite privileges, or arranging for the performance of, a history and physical on every patient he/she admits or performs surgery on within twenty-four hours of admission or within 24 hours prior to surgery. If a history and physical has been performed up to 30 days prior to admission/surgery, such history and physical may be accepted, subject to the conditions set forth in the medical staff rules and regulations, and an update is documented in the medical record on the day of surgery prior to the start of surgery;

Abiding by the lawful ethical principles of their profession;

Working cooperatively with Members, hospital employees including nurses, Hospital administration, and others, so as not to adversely affect patient care;

Making appropriate arrangements for coverage of that Member's patients as determined by the Medical Staff;

Refusing to engage in improper inducements for patient referral;

Participating in continuing education programs as determined by the Medical Staff;
Participating in such emergency service coverage or consultation as may be determined by the Medical Staff;

Discharging such other staff obligations as may be lawfully established from time to time by either the Medical Staff or Executive Committee;

Members must immediately disclose, in writing to the President of the Medical Staff or Credentials Chair any changes in:

i. Licensure or registration;
ii. Medical Malpractice coverage, including final judgments and settlements;
iii. DEA Certificate;
iv. Medical Board actions;
v. Adverse Actions with respect to privileges, membership or employment at other hospital affiliations;
vi. Changes in participation in federal or state health care programs and/or;
vii. Any felony charges or convictions.
viii. Actions requiring reporting under the California Patient's Right to Know Act of 2018. Members may obtain a copy of the Patient's Right to Know Act from the Medical Staff Office.

ARTICLE III
CATEGORIES

3.1 CATEGORIES

Each Medical Staff Member shall be assigned to a Medical Staff category based upon qualifications defined in the Bylaws of the Medical Staff. The Members of each category shall have the prerogatives and carry out the duties defined in these Bylaws and Rules and Regulations. 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 in these Bylaws and Rules and Regulations. A change in the Medical Staff category of a Practitioner shall not entitle the Practitioner to hearing rights set forth in these Bylaws.

The categories of the Medical Staff shall include the following: active, courtesy, provisional affiliate, telemedicine and honorary. All initial appointments to the Medical Staff in the provisional staff category shall be subject to a provisional period of preceptorship as set forth in Section 5.3.

3.2 ACTIVE STAFF

3.2.1 QUALIFICATIONS

The active staff shall consist of Members who:

Meet the qualifications for membership set forth in Section 2.3; and

Regularly exercise clinical privileges as granted, or are otherwise regularly involved in the care of a minimum of ten (10) patients a year in the hospital [admit, consult, perform procedures, assist at surgery] ; and

Have satisfactorily completed their designated term in the Provisional category.

3.2.2 PREROGATIVES

Except as otherwise provided, prerogatives of an active Medical Staff Member who is in good standing shall be to:

Admit patients and exercise such clinical privileges as are granted pursuant to Article V;

Attend meetings;

Vote on any matter of the medical staff;

Hold staff, division, committee, or Department office and serve as a voting Member of committees to which the Member is duly appointed or elected by the Medical Staff or to serve as a duly authorized representative thereof.

3.2.3 RESPONSIBILITIES

Each active Member shall meet the basic responsibilities set forth in Section 2.7 and actively participate and regularly assist the Hospital and Medical Staff in fulfilling the obligations related to patient care within the areas of the Member's professional competence, including, but not limited to: emergency service and backup function; quality assurance monitoring; peer review; utilization review; quality evaluation; and related monitoring activities required of the Medical Staff in supervising and preceptoring medical staff Members and Allied Health Professionals. When requested, all Members of the Active Medical Staff shall act as preceptors, complete the appropriate paperwork and forward it to the Medical Staff Office.

3.3 COURTESY STAFF

3.3.1 QUALIFICATIONS

The courtesy staff shall consist of Members who:

Meet the qualifications for membership set forth in Section 2.3;

Do not regularly care for patients at San Antonio Regional Hospital or are not regularly involved in medical staff functions as determined by the medical staff;

Are members in good standing of the Active staff of another California licensed hospital, although exceptions to this requirement may be made by the medical executive committee; and

Have satisfactorily completed their designated term in the Provisional category.

3.3.2 PREROGATIVES

Except as otherwise provided, the courtesy medical staff member shall be entitled to:

Admit patients to the hospital;

Exercise such clinical privileges as are granted pursuant to Article V;

Attend general and special meetings of the Medical Staff and of the Department and committees to which the Member is duly appointed;

Vote if serving on a committee to which they have been appointed, but are not eligible to hold office or vote in medical staff elections or ballots.

3.4 AFFILIATE STAFF

(Community-Based) – The Affiliate Staff is usually reserved for members who maintain a clinical practice in the hospital service area and wish to follow their patients and have access to patient information when they are admitted to the hospital.

3.4.1 QUALIFICATIONS

The Affiliate Staff shall consist of members who meet the general qualifications for membership set forth in Section 2.3 and are not otherwise members of the Medical Staff.

3.4.2 PREROGATIVES

The Affiliate Medical Staff members are eligible to:

1. Refer their patients to the hospital for care.
2. Have access to their patient information including electronic medical records.
3. Attend General Medical Staff meetings and educational programs.

The affiliate Medical Staff members are not eligible:

1. To manage or admit patients to the hospital.
2. For clinical privileges.
3. Vote or hold office in the Medical Staff organization.

3.4.3 RESPONSIBILITIES

Each affiliate Member shall be required to pay membership dues or a reappointment assessment fee as set by the Medical Executive Committee.

3.4.4 CATEGORY CHANGES

The Affiliate Staff member who changes staff status must meet all the Category requirements set forth in these Bylaws.

3.5 CONSULTING STAFF

3.5.1 Composition

The Consulting Staff shall consist of practitioners who are specialists whose practices are primarily outside of the hospital but who may, on occasion, be asked to consult on patients. Any member of the Medical Staff may consult in their area of expertise, but the Consulting Staff consists of practitioners who:

- Meet the qualifications for membership set forth in Section 2.3;
- Are willing and able to come to the hospital when called to render clinical services within their area of competence;
- Have satisfactorily completed their designated term in the Provisional category as determined by the Department Chair and Medical Executive Committee.

3.5.2 PREROGATIVES

Except as otherwise provided, prerogatives of a Consulting Medical Staff member who is in good standing shall be entitled to:

- Exercise such clinical privileges as are granted pursuant to Article V.
- Vote if serving on a committee to which they have been appointed, but are not eligible to hold office or vote in medical staff elections or ballots.

3.6 PROVISIONAL STAFF

3.6.1 Qualifications

The provisional medical staff shall consist of members who:

Meet the qualifications for membership set forth in Section 2.3;

Are initial appointees to the medical staff and plan to qualify for, and seek transfer to the Active, Courtesy or Consulting Staff.

3.6.2 Prerogatives

The provisional medical staff member shall be entitled to:

Admit patients and exercise such clinical privileges as are granted pursuant to Article V;

Attend meetings of the medical staff and the department of which that person is a member, including open meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment to the committee;

Provisional staff members shall not be eligible to hold office in the medical staff organization, but may serve on committees.

3.6.3 Observation of Provisional Staff Member

Each provisional staff member shall undergo a period of observation by designated monitors as described in Section 5.3. The purpose of observation shall be to evaluate the member's (1) proficiency in the exercise of clinical privileges initially granted and (2) overall eligibility for continued staff membership and advancement within staff categories. Observation of provisional staff members shall follow whatever frequency and format each department deems appropriate in order to adequately evaluate the provisional staff member including, but not limited to, concurrent or retrospective chart review, mandatory consultation, and/or direct observation. Appropriate records shall be maintained.

3.6.4 Term of Provisional Staff Status

A member shall remain in the provisional staff for a minimum period of one year. The Provisional status of that member can be extended by the medical executive committee for an additional period of up to one year upon a determination of good cause, which determination shall not be subject to review pursuant to Articles VI or VII. A member may remain Provisional for a period not to exceed two (2) years.

3.6.5 Action at Conclusion of Provisional Staff Status

If the provisional staff member has satisfactorily demonstrated the ability to exercise the clinical privileges initially granted and otherwise appears qualified for continued medical staff membership, the member shall be eligible for placement in the appropriate staff category as appropriate, upon recommendation of the medical executive committee;

The appropriate department shall advise the medical executive committee, which in turn shall make its recommendation to the board of trustees regarding a modification or termination of clinical privileges or termination of medical staff membership.

If the member fails to meet the requirements of Provisional status, the appropriate department will advise the Medical Executive Committee accordingly.

3.7 TELEMEDICINE STAFF

3.7.1 Telemedicine involves the use of electronic communication or other communication technologies (in addition to or other than telephone or email communications) to provide or support clinical care at a distance. Diagnosis and treatment of a patient may be performed via Telemedicine link.

Telemedicine practitioners must meet the qualifications for members and privileges as outlined in Section 2.3; Telemedicine staff members are not entitled to vote or hold office in the medical staff organization

3.7.2 Prerogatives

Telemedicine practitioners are:

not entitled to admit patients;

required to pay application and reappointment fee

3.8 HONORARY STAFF

3.8.1 QUALIFICATIONS

The Honorary Staff shall consist of Medical Staff members who do not actively practice at the hospital but are deemed deserving of membership by virtue of their outstanding reputation, noteworthy contributions to the health and medical sciences, or their previous long-standing service to the hospital, and who continue to exemplify high standards of professional and ethical conduct. This shall be determined by the Medical Executive Committee.

3.8.2 LIMITATIONS

Members may attend Medical Staff or clinical service committee meetings, as well as CME activities. Members may be appointed to committees, but they shall not hold clinical privileges, hold office, or be eligible to vote.

3.9 LIMITATION OF PREROGATIVES

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

3.10 MODIFICATION OF MEMBERSHIP CATEGORY

On its own, upon recommendation of the applicable service committee, or pursuant to a request by a Member, the Executive Committee may recommend a change in the Medical Staff category of a Member consistent with the requirements of these Bylaws. A change in the Medical Staff category of a Practitioner shall not entitle the Practitioner to hearing rights set forth in these Bylaws.

ARTICLE IV
APPOINTMENT AND REAPPOINTMENT

4.1 GENERAL

Except as otherwise specified herein, no person, including persons engaged by the Hospital in administratively responsible positions, shall exercise clinical privileges in the Hospital unless the individual applies for and receives appointment to the Medical Staff or is granted temporary privileges as set forth in these Bylaws. By applying to the Medical Staff for appointment or reappointment (or, in the case of Members of the honorary staff, by accepting an appointment to that category), the applicant acknowledges responsibility to review these Bylaws and agrees that, throughout any period of membership, the individual will comply with the responsibilities of Staff membership and with these Bylaws and Rules and Regulations and as they may be modified from time to time. Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted in accordance with these Bylaws.

4.2 BURDEN OF PRODUCING INFORMATION

In connection with all applications for appointment, reappointment, advancement or transfer, the applicant shall have the burden of producing information for an adequate evaluation of the applicant's qualifications and suitability for the clinical privileges and staff category requested, of resolving any reasonable doubts about these matters, and of satisfying additional requests for information. The applicant's failure to sustain this burden shall be grounds for denial of the application. This burden may include submission to a medical or psychological examination by a Practitioner selected by the Executive Committee, at the applicant's expense.

4.3 APPOINTMENT AUTHORITY

Appointments, and denials of appointments to the Medical Staff, shall be made as set forth in these Bylaws, but only after there has been a recommendation from the Medical Staff to the Board of Trustees.

Any favorable recommendation shall become effective upon the final decision of the Board of Trustees. If the recommendation is adverse, the President of the Hospital shall give the applicant written notice of the adverse decision, and the applicant shall be entitled to the procedural rights set forth in Article VII before any final adverse action is taken.

4.4 DURATION OF APPOINTMENT

Except as otherwise provided in these Bylaws, initial appointments to the Medical Staff shall be made by the Executive Committee until the next reappointment process. Reappointments shall be for a period not to exceed two (2) Medical Staff years.

4.5 APPLICATION FOR INITIAL APPOINTMENT AND REAPPOINTMENT

4.5.1 APPLICATION FORM

Each application for appointment to the Medical Staff shall be in writing, submitted on a form developed by the Executive Committee, and supplied by the Medical Staff or its designee. The form shall require detailed information which shall include, but not be limited to, information concerning:

The applicant's qualifications, including, but not limited to, professional training and experience, current licensure, current DEA registration (with the exception of Affiliate, Telemedicine and Pathologists), and continuing medical education information related to the clinical privileges to be exercised by the applicant;

Personal and professional references including, whenever possible, at least two Members of the active Medical Staff who can provide adequate references pertaining to the applicant's professional competence and ethical character;

Requests for membership categories, Departments, and clinical privileges;

Past or pending professional disciplinary action, voluntary or involuntary relinquishment of Staff membership or privileges or any licensure or registration; licensure limitations, and related matters;

Physical and mental health status;

Professional liability insurance and any professional liability claims, or causes of action that have been lodged against the applicant and the status or outcome of such matters.

Each application for initial appointment to the Medical Staff shall be submitted on the prescribed form with all provisions completed (or accompanied by an explanation of why answers are unavailable), and signed by the applicant. Upon request, applicants will be given an application for membership and a letter outlining minimum standards to qualify for membership. When an applicant requests an application form, the applicant shall be given access to an electronic copy of the Medical Staff Bylaws, and the Medical Staff Rules and Regulations. A paper copy of the Bylaws and Rules & Regulations will be provided upon request.

Completed applications are acted on within a reasonable period of time, as specified in these Bylaws. The Board of Trustees makes the final decision on each completed application for appointment within a reasonable period of time, as specified in these Bylaws. Willful and substantial omissions or misrepresentations of the information provided by the applicant may result in denial, modification, or revocation of Medical Staff membership and clinical privileges. Neither the Board of Trustees nor any Medical Staff Committee shall have any obligation to review any application until the applicant completes it in all respects and submits all required information, supporting material, and information deemed necessary by the appropriate body or committee.

4.5.2 EFFECT OF APPLICATION

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

Signifies willingness to appear upon request for interviews in regard to the application;

Authorizes consultation with others who have been associated with the applicant and who may have information bearing on the applicant's competence, qualifications and performance, and authorizes such individuals and organizations to candidly provide all such information;

Consents to inspection of records and documents that may be material to an evaluation of the applicant's qualifications and ability to carry out clinical privileges as requested including, but not limited to, the applicant’s current and prior physical and mental health status to the extent and in a manner as permitted by law, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying;

Releases from any liability, to the fullest extent permitted by law, all Hospital representatives for their acts performed in good faith and without malice in connection with investigating and evaluating the applicant;

Releases from any liability, to the fullest extent permitted by law, all individuals and organizations who provide information in good faith and without malice regarding the applicant, including otherwise privileged or confidential information;

Consents to the disclosure to other hospitals, medical associations, licensing boards and other similar organizations any information regarding the applicant's professional or ethical standing that the Hospital or Medical Staff may have, and releases the Medical Staff and Hospital from liability for so doing, provided they act in good faith and without malice, to the fullest extent permitted by law;

Acknowledges responsibility for timely payment of Medical Staff reappointment fees, if any;

Pledges to maintain an ethical practice, including refraining from illegal inducements for patient referral, providing for the continuous care of the applicant's patients, seeking consultation whenever necessary, and refraining from delegating patient care responsibility to non-qualified or inadequately supervised Practitioners;

Certifies and agrees that the applicant will report any changes in the information submitted on the application that may subsequently occur to the Credentials Committee or its Chair.

For the purpose of this section, the term “Hospital representatives” includes the following: Hospital employees, the Board, its Members and committees; the Medical Staff organization and all members, clinical departments, and committees which have responsibility for collecting and evaluating the applicant’s credentials or acting upon his or her application, and any authorized representative of any of the foregoing.

4.5.3 VERIFICATION OF INFORMATION

The applicant shall deliver a completely filled-in, signed, and dated application and supporting documents to the Credentials Committee representative and an advance payment of Medical Staff dues or fees, if any is required. The Credentials Committee Chair shall expeditiously seek to collect or verify the references, licensure, and other evidence submitted in support of the application. The Hospital's authorized representative shall query the National Practitioner Data Bank (“NPDB”) regarding the applicant or Member and submit any resulting information to Credentials Committee or its Chair for inclusion in the applicant's or Member's credential file. The applicant shall be notified of any problems in obtaining the information required, and it shall be the applicant's obligation to obtain the required information. Failure of an applicant to adequately respond within thirty (30) days of notification of problems and obtain the required information needed to complete the file will constitute the applicant’s withdrawal of his application for membership.

When collection and verification of information other than the NPDB is accomplished, the application shall be considered complete and all such information shall be transmitted to the

Credentials Committee or its Chair. No final action on an application may be taken until receipt of the query result from NPDB.

4.5.4 CREDENTIALS COMMITTEE ACTION

The Credentials Committee or its Chair shall review the application, evaluate and verify the supporting documentation, recommendations, and other relevant information. The Credentials Committee or its Chair may elect to interview the applicant and seek additional information. If, following the interview, it is determined that additional information or further review is required to complete the application, the applicant will be so notified and given thirty (30) days to submit the needed information for review and approval prior to transmittal to the Clinical Service Committee. Failure to respond with such information within the 30-day period will constitute the applicant's withdrawal of his application for membership.

The Credentials Committee or its Chair will determine whether the applicant meets the minimum requirements for membership. Applicants who fail to meet the minimum qualifications for membership set forth in Article II, will be recommended for denial of membership to the Executive Committee. The Credentials Committee or its Chair will forward the supporting documentation. The report shall be processed in accordance with the provisions set forth in this section.

4.5.5 CREDENTIALS COMMITTEE REPORT AND RECOMMENDATIONS

Specific cause for adverse recommendation:

The Credentials Committee or its Chair, as a result of its review of the applicant's credentials or the committee's interview with the applicant, may determine that specific cause exists for an adverse recommendation. The application shall be processed in the same manner as an applicant who did not meet the minimum qualifications, provided that a report including a statement of such cause and the basis upon which the Credentials Committee or its Chair arrived at such determination is prepared and transmitted together with the report.

Transmittal of application to Clinical Service Committee or its Chair:

The application of any applicant who meets the minimum requirements to qualify for membership and who has not been subject to an adverse recommendation based on specific cause, shall be sent for evaluation to the Clinical Service Committee (or its Chair) of the Department in which the applicant would practice.

Clinical Service Committee evaluation of applicant:

Upon receipt of the application, the Clinical Service Committee (or its Chair) of the Department to which the application is submitted shall review the application and supporting documentation, and may conduct a personal interview with the applicant at its discretion. The Clinical Service Committee or its Chair shall evaluate all matters deemed relevant to a recommendation, including information concerning the applicant's privileges granted, and shall transmit to the Executive Committee a

written recommendation as to appointment and, if appointment is recommended, as to membership category, Department affiliation, clinical privileges to be granted, and any special conditions to be attached. The Clinical Service Committee or its Chair may also request that the Executive Committee or its representative defer action on the application.

Executive Committee evaluation of applicant:

At its next regular meeting after receipt of the report and recommendations from the Clinical Service Committee, or its Chair, or as soon thereafter as is practicable, the Executive Committee, or its representative, shall consider the report and any other relevant information. The Executive Committee or its representative may request additional information, return the matter to the Clinical Service Committee or its Chair, or the Credentials Committee or its Chair, for further investigation and/or to elect to interview the applicant. The Executive Committee or its representative shall forward a written report and recommendation to the President of the Hospital for prompt transmittal to the Board of Trustees, as to Medical Staff appointment and privileges, and if appointment is recommended, as to membership category, and any special conditions to be attached to the appointment. The Executive Committee or its representative may also defer action on the application. The reasons for each recommendation shall be stated.

4.5.6 EFFECT OF EXECUTIVE COMMITTEE ACTION

Interviews, Further Documentation, Deferral:

The Executive Committee or its representative may elect to defer action on an application in cases where it determines that an interview with the applicant, further documentation, or deferral of the application for further consideration is appropriate. Any such deferral of final action must be followed up within a reasonable time with a subsequent recommendation for appointment or denial of the application.

Favorable recommendation:

When the recommendation of the Executive Committee is favorable to the applicant, it shall be promptly forwarded, together with supporting documentation, to the Board of Trustees.

Adverse recommendation:

When a final recommendation of the Executive Committee is adverse to the applicant, the Board of Trustees and the applicant shall be promptly informed by written notice. The applicant shall then be entitled to the procedural rights as provided in the following section.

Request for Executive Committee Interview:

When the recommendation of the Executive Committee is adverse to the applicant, and such recommendation is in accord with the initial adverse recommendation by

the Credentials Committee, the applicant shall have fifteen (15) days following the date of the receipt of notice of such action to request an interview by the Executive Committee or its representative. In the event the applicant does not request an interview within the time and in the manner set forth, the applicant shall be deemed to have accepted the recommendation, decision, or action involved, and it shall thereupon become effective upon approval by the Board of Trustees.

If the recommendation of the Clinical Service Committee is adverse, the applicant may request an interview with the Clinical Service Committee in the same manner as that outlined for an Executive Committee interview.

Applicants who received a favorable recommendation from the Credentials Committee or its Chair, or Clinical Service Committee or its Chair, but were the subject of an adverse recommendation by the Executive Committee, shall be entitled to an interview with the Executive Committee, followed by the procedural rights provided in Article VII if the unfavorable recommendation stands.

Interview, Time of Interview, Statement of Basis for Decision:

The committee or its representative shall meet with the applicant within a reasonable time after the request for an interview is received by the Executive Committee Chair. Prior to the interview, the applicant shall be given a copy of a statement of the reasons for denying the application in the event it was determined the applicant did not meet the minimum qualifications set forth in Article II or was the subject of an adverse recommendation based on specific cause. If the Executive Committee has made any additional comments with respect to the applicant or the application, such comments shall also be made available to the applicant and the Executive Committee at this time.

At the interview, the applicant may present any documentation or information which pertains to any specific cause identified by the Credentials Committee or comments made by the Executive Committee with respect to the application. The applicant may not challenge the validity of the criteria which were used to evaluate the application. Upon completion of the interview, the Executive Committee shall determine whether the previous recommendation pertaining to the applicant shall remain the same or be modified. In the event a modification is recommended, the procedure set forth in this section shall be followed. In the event the Executive Committee recommends no change in the adverse decision, the applicant shall be notified by written notice by the Chair of the Executive Committee and shall be entitled to the procedural rights provided by Article VII.

4.5.7 ACTION ON THE APPLICATION

The Board of Trustees or its representative may accept the recommendation of the Executive Committee, or may refer the matter back to the Executive Committee for further consideration, stating the purpose for such referral. The following procedures shall apply with respect to action on application:

If the Executive Committee issues a favorable recommendation; and

The Board of Trustees or its representative concurs in that recommendation, the decision of the Board shall be deemed final action;

The tentative recommendation of the Board of Trustees or its representative is unfavorable, the applicant shall be entitled to the hearing and appellate review rights set forth in Article VII;

In the event the recommendation of the Executive Committee is unfavorable to the applicant, the procedural rights set forth in Article VII shall apply; and

If no Judicial Review Committee hearing is requested by the applicant, the recommendation of the Executive Committee shall become final action;

If a hearing is requested, the decision of the Judicial Review Committee shall be final, unless appellate review is requested and the Board of Trustees issues a final appellate review decision.

4.5.8 NOTICE OF FINAL DECISION

Notice of the final decision shall be given to the President of the Medical Staff, the Executive Committee, the Credentials Committee, the Chair of each service committee concerned, the applicant, and the President of the Hospital.

A decision and notice to appoint or reappoint shall include the staff category to which the applicant is appointed, the Department to which the applicant is assigned, the clinical privileges granted, and any special conditions attached to the appointment.

4.5.9 REAPPLICATION AFTER ADVERSE APPOINTMENT DECISION DENYING APPLICATION, ADVERSE CORRECTIVE ACTION DECISION, OR RESIGNATION IN LIEU OF MEDICAL DISCIPLINARY ACTION

A waiting period of thirty-six (36) months shall apply to the following situations:

an applicant has received a final adverse decision regarding appointment;

an applicant who withdrew the application following an adverse recommendation by the Executive Committee;

a former Medical Staff Member whose Staff membership and clinical privileges were terminated;

a former Medical Staff Member who resigned from the Medical Staff following an Executive Committee recommendation to terminate the Member's membership or privileges;

a Medical Staff Member who has received a final adverse decision resulting in termination of clinical privileges.

The waiting period will begin when the decision becomes final, which shall occur upon the date of the completion of all hearing, appellate review, and other proceedings conducted by the Hospital and all judicial proceedings bearing on the decision.

For the purposes of this section, a decision shall be considered to be adverse only if it is based upon the types of occurrence which might give rise to corrective action and not if it is based upon reasons that do not pertain to medical and ethical conduct. Actions which are not considered adverse for the purpose of this section include such actions as those based upon a failure to live in the area, which can be cured by a move; to reappointment fee, which can be cured by paying reappointment fee; or to maintain liability insurance, which can be cured by securing the insurance.

After the waiting period, the applicant or Member may reapply; however, any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as may be required to demonstrate that the basis for the earlier adverse action no longer exists and/or that the Practitioner has complied with any specific requirements that the adverse decision may have included.

4.6 REAPPOINTMENTS AND REQUESTS FOR MODIFICATIONS OF STAFF STATUS OR PRIVILEGES

4.6.1 APPLICATION

At least three months prior to the expiration date of the current staff appointment (except for temporary appointments), a reapplication form developed by the Executive Committee shall be mailed or delivered to the Member. If an application for reappointment is not returned at least sixty (60) days prior to the expiration date, written notice shall be promptly sent to the applicant advising that the application has not been received.

The reapplication form shall include all information necessary to update and evaluate the qualifications of the applicant including, but not limited to, the matters set forth in Section 4.5.1 as well as other relevant matters. Upon receipt of the application, the information shall be processed as set forth in Section 4.5.3.

A Medical Staff Member who seeks a change in Medical Staff status or modification of clinical privileges may submit such a request at any time to the appropriate Clinical Service Committee, except that such application may not be filed within six (6) months of the time a similar request has been denied.

4.6.2 EFFECT OF APPLICATION

The effect of an application for reappointment or modification of staff status or privileges is the same as set forth in Section 4.5.2.

4.6.3 STANDARDS AND PROCEDURE FOR REVIEW

The application for reappointment shall be submitted to the Clinical Service Committee or the Chair of the Department of which the applicant is a Member.

The Clinical Service Committee or its Chair shall review the reappointment application and all pertinent documentation and shall transmit to the Executive Committee, or its Chair, a written report and recommendation regarding reappointment and privilege renewal.

Following receipt of the report from the Clinical Service Committee or its Chair, the Executive Committee, or its Chair, shall review all the reports and recommendations and shall forward to the Board of Trustees its recommendations. Thereafter, the procedure set forth in Sections 4.5.7, 4.5.8, and 4.5.9 shall be followed. If the recommendation of the Executive Committee is adverse, the Member shall be given notice of the adverse recommendation and of the Member's right to a hearing and appellate review, as provided in Article VII. The matter shall not be referred to the Board of Trustees until the Member has either waived the right to request a hearing or the matter is subject to appellate review under Article VII.

Each report and recommendation regarding reappointment shall specify whether the Member's requests shall be approved or denied. The report shall state the reason for the recommendation if either reappointment is not recommended, or if denial of requested privileges is recommended. Each recommendation concerning reappointment shall be based upon whether the Member has met the qualifications set forth in Section 2.3, and met the other standards set forth in these Bylaws and Rules and Regulations, and Hospital policies.

4.6.4 FAILURE TO FILE REAPPOINTMENT APPLICATION

Failure without good cause to file a completed application for reappointment in a timely manner shall result in the automatic suspension of the Member's clinical privileges and prerogatives at the end of the current staff appointment. If the Member fails to submit a completed application for reappointment within ten (10) days past the date it was due, the Member shall be deemed to have resigned membership in the Medical Staff. In the event membership terminates for the reasons set forth herein, the procedures set forth in Article VII shall NOT apply.

4.7 LEAVE OF ABSENCE

4.7.1 LEAVE STATUS

A Member may request a voluntary leave of absence (LOA) from the Staff for any reason. A written request must be submitted to the Executive Committee stating the reason for the request, and the approximate period of leave desired, which must be for a minimum of thirty (30) days and may not exceed a period of one (1) year. A member may request an additional consecutive leave of absence for up to one (1) year. The member will still be responsible for applying for reappointment when due in accordance with these Bylaws. The reappointment process remains the same regardless of leave of absence. During the period of leave, the staff member will have no clinical privileges and prerogatives. The Executive Committee has the authority to place a Member on a medical Leave of Absence after it has fully investigated the circumstances surrounding the Member’s medical condition and determines that a Practitioner cannot provide continuous care to his or her patients.

4.7.2 TERMINATION OF LEAVE

At least thirty (30) days prior to the termination of the leave of absence, or at any earlier time, the Member may request reinstatement of privileges and prerogatives by submitting a written notice to that effect to the Credentials Committee or its Chair. The Member shall submit a written summary of activities during the leave. Requests for reinstatement for LOA's granted for health reasons must be accompanied by an appropriate physician's recommendation that privileges can be resumed. After verifying the necessary documentation, the Credentials Committee or its Chair shall forward a recommendation to the appropriate Clinical Service Committee or its Chair, who in turn shall forward a recommendation to the Executive Committee.

The Executive Committee shall make a recommendation to the Board of Trustees concerning the reinstatement of the Member's privileges and prerogatives and the procedure provided in Section 4.5 shall apply.

4.7.3 FAILURE TO REQUEST REINSTATEMENT

Failure without good cause to request reinstatement prior to the expiration of the leave, or to provide a summary of professional and other activities as above required, shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of membership, privileges, and prerogatives. The Executive Committee shall, at its sole discretion, and after giving such practitioner the opportunity to address the committee, determine whether or not a good cause existed. A Practitioner whose membership is automatically terminated shall not be entitled to the procedural rights provided in Article VII for the sole purpose of determining whether the failure to request reinstatement was unintentional or excusable, or otherwise. A request for Staff membership subsequently received from a Member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

At the discretion of the appropriate Department and/or Executive Committee, reinstatement may be made subject to an observation requirement, which may include preceptorship for a period of time, during which the Practitioner's clinical performance is observed by one or more designated Members to determine the Practitioner's continued satisfaction of qualifications and current competence.

ARTICLE V
CLINICAL PRIVILEGES

5.1 EXERCISE OF PRIVILEGES

Except as otherwise provided in these Bylaws, a Member providing clinical services at this Hospital shall be entitled to exercise only those clinical privileges specifically granted to the Member by the Board of Trustees. Said privileges and services must be Hospital specific, within the scope of any license, certificate, or other legal credential authorizing practice in this State and consistent with any restrictions thereon, and shall be subject to the rules and regulations of the Clinical Department and the authority of the Department Chair and the Medical Staff.

5.2 DELINEATION OF PRIVILEGES IN GENERAL

5.2.1 REQUESTS

Each application for staff appointment and reappointment must contain a request for the specific clinical privileges the applicant desires. A Member may request modification of privileges at any time. This request will be subject to evaluation which includes: changes to any licensure or registration; voluntary and involuntary relinquishment of any license or registration; voluntary and involuntary termination of medical staff membership; voluntary and involuntary limitation, reduction, or loss of clinical privileges; involvement in a professional liability action, as defined in the medical staff bylaws, including final judgments and settlements involving a practitioner; documentation as to applicant's health status; relevant practitioner-specific outcome data compared to aggregate data if available. Requests from an applicant for privileges or from Members for modification of privileges must be supported by documentation of the requisite training, experience, qualifications, and competency to exercise such privileges.

5.2.2 BASIS FOR PRIVILEGES DETERMINATION

Requests for clinical privileges or modification of privileges shall be evaluated on the basis of the Practitioner's education, training, experience, demonstrated current competence and judgment, health status as it may affect the Practitioner's ability to exercise the privileges sought, and the documented results of the patient care and other quality review, evaluation, and monitoring activities required by these Bylaws. Privileges determinations shall also take into account pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a Member exercises clinical privileges. Information collected in connection with an application for privileges will be maintained in a Medical Staff file established for the Member or applicant.

5.3 PRECEPTORING

5.3.1 APPLICABILITY AND DURATION

All Practitioners newly appointed to the staff, or newly granted clinical privileges (including temporary privileges or increased privileges for a Member), are subject to a period of preceptoring as determined by the appropriate Clinical Department's rules and regulations not to exceed twenty-four (24) months, although Members may be subjected to a continuation of preceptoring as a condition of renewal of Membership and/or Privileges. In addition, Members may be subjected to a continuation of preceptoring as a condition of renewal of Privileges. Preceptoring shall include, at a minimum, retrospective chart review.

Within these guidelines, each Department may, subject to the approval of the Executive Committee and the Board of Trustees, establish a greater minimum length of time, increase the case review requirements, and/or describe different review methods (e.g., retrospective review, concurrent review, mandatory consultation, or direct observation). During this period, a Practitioner's performance will be reviewed and evaluated by the Chair of the Department in which the Practitioner exercises initial or increased privileges (or such person's designee).

The Board of Trustees may waive the preceptoring requirement after receiving the recommendation, if any, of the Credentials Committee or its representative, the Clinical Service Committee or its representative, and the Executive Committee or its representative. Preceptoring shall not constitute a restriction of privileges or grounds for any formal hearing or appeal rights under Article VII of these Bylaws.

5.3.2 STATUS AND PRIVILEGES DURING PRECEPTORING PERIOD

During the preceptoring period, a Practitioner must demonstrate that the qualifications for membership and clinical privileges are being met, and all of the obligations of the Practitioner's Staff category are being fulfilled.

A Practitioner's exercise of prerogatives and clinical privileges during the preceptoring period is subject to any conditions or limits imposed as part of the Practitioner's staff appointment or grant of privileges, or which may be imposed during the preceptoring period as a result of corrective action taken pursuant to these Bylaws.

During this period, the following shall apply to Practitioners:

Practitioners may admit patients and exercise such clinical privileges as are granted pursuant to Article V;

Practitioners may attend meetings of the Medical Staff and the Department of which the individual is a Member, including educational programs, but shall have no right to vote at such meetings;

Practitioners shall not be eligible to hold office in the Medical Staff organization, nor serve on committees;

Practitioners shall be required to take Emergency Department room back-up call and will be placed on the schedule, with preceptorship, unless clinical service Department rules and regulations allow criteria for exemption.

5.3.3 REQUIREMENTS FOR SUCCESSFUL COMPLETION

Preceptoring shall be deemed successfully completed when the Practitioner completes the required number of proctored cases within the time frame established in these Bylaws and the Rules and Regulations, and the Practitioner’s professional performance in the cases met the standard of care of the Hospital.

Review and Observation Required/Practitioner's Obligation: The Practitioner must work with the Medical Staff to arrange for any required monitoring and observation by the Practitioner's preceptors and, except for good cause, do so within the time established in the Rules and Regulations. The appropriate Department Chair or the Chair's designee, shall prepare a summary for the Member's file of the evaluations of the proctored Practitioner's performance.
Failure to Complete Necessary Volume: Any Member who fails to complete the required number of preceptored cases within the time frame established in these Bylaws and Rules and Regulations shall be deemed to have voluntarily withdrawn his or her request for membership (or the relevant Privileges), and he shall not be afforded the procedural rights provided in

Article VII. However, the Department has the discretion to extend the time for completion of preceptoring in appropriate cases subject to ratification by the Medical Executive Committee. The inability to obtain such an extension shall not give rise to procedural rights described in Article VIII.

Failure to Satisfactorily Complete Preceptoring: If a Practitioner completes the necessary volume of preceptored cases but fails to perform satisfactorily during preceptoring, he may be terminated (or the relevant Privileges may be revoked), by the Medical Executive Committee, upon recommendation of the Department Chair, and he/she shall be afforded the procedural rights as provided in Article VII.

Satisfactory Completion of Preceptoring: If a practitioner completes all required preceptored cases to the satisfaction of the Department Chair(s) or Clinical Service Committee Chair(s), they will remove the practitioner from preceptoring and inform the relevant Departments and the Medical Executive Committee.

5.4 CONDITIONS FOR PRIVILEGES OF LIMITED LICENSE PRACTITIONERS

Surgical procedures performed by dentists and podiatrists shall be under the overall supervision of the Chair of the Department of Surgery or the Chair's designee and subject to the provisions of the Rules and Regulations.

5.5 TEMPORARY CLINICAL PRIVILEGES

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 physician, dentist, podiatrist, or psychologist's qualification, ability, and judgment to exercise the Privileges requested, and only after the physician, dentist, podiatrist or psychologist has demonstrated compliance with these Bylaws and Rules and Regulations, including the requirements for professional liability insurance. Practitioners holding temporary privileges are not members of the Medical Staff.

5.5.1 CIRCUMSTANCES

Upon the written concurrence of 1) Chair of the Credentials Committee, 2) President of the Hospital, and 3) either the Chair of the Department where the privileges will be exercised or the President of the Medical Staff, temporary privileges may be granted to a Practitioner, subject to the conditions set forth in Section 5.5.2 below, in the following circumstances:
Pendency of Application: After receipt of a completed Medical Staff Application, proof of malpractice coverage verification of malpractice history, query to the National Practitioner Data Bank, and current copies of the applicant's medical license Drug Enforcement Administration Certificate, and request for specific temporary privileges, an applicant may be granted temporary privileges for an initial period of sixty (60) days, with subsequent renewal not to exceed one hundred and twenty (120) days.

Deferred Applications: If the information available to the persons or committees charged with deciding whether to grant temporary privileges is inconsistent or casts any reasonable doubt on the applicant's qualifications, action on the request for temporary privileges may be deferred until such doubts are satisfactorily resolved. A deferral of a decision on an

application for temporary privileges shall not constitute a restriction of privileges or grounds for any formal hearing or appeal rights under Article VII of these Bylaws.

Care of Specific Patients: Upon receipt of a written request form for specific temporary privileges, a physician, dentist, podiatrist or psychologist who is not an applicant for membership may be granted temporary privileges to care for one or more specific patients. These privileges shall be granted to treat a maximum of four patients in any one year and are limited to the duration of the patient's stay in the Hospital. Physicians, dentists, podiatrists, or psychologist requesting permission to attend additional patients shall be required to apply for Staff membership before being granted the requested privileges.

Locum Tenens: A locum tenens serves in place of a physician who is physically absent from the physician's practice during the period of locum tenens. The period of locum tenens may be for as little as one day. Locum tenens temporary privileges may be granted for an initial period of no more than ninety (90) days within a twelve-month period. Such privileges may be renewed by the Credentials Committee or its Chair if the Practitioner being covered is injured or ill. The privileges shall not exceed the Practitioner's services as locum tenens. The locum tenens must be qualified to practice the same specialty as the Practitioner being served. The physician, dentist, podiatrist or psychologist requesting locum tenens must submit to the Chair of the Credentials Committee a completed staff application, proof of malpractice coverage, and current copies of the applicant's medical license and Drug Enforcement Administration Certificate. The locum tenens may not serve on the Emergency Department backup roster.

5.5.2 CONDITIONS

If granted temporary privileges, the physician, dentist, podiatrist or psychologist shall act under the supervision of the appropriate Department Chair and shall ensure that the Chair, or the Chair's designee, is kept closely informed as to the physician, dentist, podiatrist or psychologist's activities within the Hospital. The Department Chair may impose special consultation and reporting conditions. The physician, dentist, podiatrist or psychologist requesting temporary privileges agrees to abide by these Bylaws in all matters relating to the physician, dentist, podiatrist, or psychologist's activities in the Hospital. A physician, dentist, podiatrist or psychologist granted temporary privileges during the pendency of an application or as locum tenens shall be preceptored as if the physician, dentist, podiatrist or psychologist was a new Member.

5.5.3 TERMINATION

At any time, acting with or without cause, the President of the Hospital or the President of the Medical Staff may, after consulting with the Department Chair responsible for supervision, or the Chair's designee, terminate any or all of such physician, dentist, podiatrist, or psychologist's temporary privileges. If a patient's life or well-being is determined to be endangered by continued treatment by the physician, dentist, podiatrist or psychologist, the termination may be effected by any person entitled to impose summary suspensions under Article VI. In the event of any such termination, the physician, dentist, podiatrist, or psychologist's patients then in the Hospital shall be assigned to another physician, dentist, podiatrist or psychologist by the Department Chair responsible for supervision. The wishes

of the patient shall be considered, where feasible, in choosing a substitute physician, dentist, podiatrist or psychologist.

5.5.4 EMERGENCY PRIVILEGES

For the purpose of this Section, an "emergency" is defined as a condition in which a patient is in imminent danger of serious or permanent harm or death and any delay in administering treatment would add to that danger. In the case of an emergency, any physician, dentist, podiatrist or psychologist, to the degree permitted by the physician, dentist, podiatrist or psychologist's license and regardless of Department, Medical Staff status, or clinical privileges, shall be permitted to do, and shall be assisted by Hospital personnel in doing, everything possible to save a patient from such danger. When an emergency no longer exists, such physician, dentist, podiatrist or psychologist must request the privileges necessary to continue to treat the patient. In the event such privileges are either not requested or denied, the patient shall be assigned to an appropriate Member of the Staff by the President of the Medical Staff.

5.5.5 EMERGENCY DISASTER PRIVILEGES

(a) In the case of a disaster in which the disaster plan has been activated and the hospital is unable to handle the immediate patient needs, an Officer of the Medical Staff or Department Chairmen, may grant disaster privileges. In the absence of the above, the Chief Executive Officer or the CEO's designee may grant the disaster privileges consistent with this subsection. The grant of privileges under this subsection shall be on a case-by-case basis at the sole discretion of the individual authorized to grant such privileges. 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.

(b) Those authorized under subsection (a) may grant disaster privileges upon presentation of a valid picture ID issued by a state, federal or regulatory agency and at least one of the following:

(i) A current picture hospital ID card clearly identifying professional designation.
(ii) A current license to practice and a valid picture ID issued by a state, federal, or regulatory agency.
(iii) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT) or MRC, ESAR-VHP, or other recognized state or federal organizations or groups.
(iv) Identification indicating that the individual has been granted authority by a federal, state, or municipal entity to render patient care in disaster circumstances.
(v) Identification by current hospital or medical staff member(s) with personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during a disaster.

(c) Current professional licensure of those providing care under disaster privileges is verified from the primary sources as soon as the immediate emergency situation is

under control or within 72 hours from the time the volunteer licensed independent practitioner presents 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:

(i) The reason(s) verification could not be performed within 72 hours of the practitioner's arrival
(ii) Evidence of the licensed independent practitioner's demonstrated ability to continue to provide adequate care, treatment and services
(iii) Evidence of an attempt to perform primary source verification as soon as possible

(d) Members of the medical staff shall oversee those granted disaster privileges

5.6 MODIFICATION OF CLINICAL PRIVILEGES OR DEPARTMENT ASSIGNMENT

On its own, upon recommendation of the Clinical Service Committee, or pursuant to a request under Section 4.6.1, the Executive Committee may recommend a change in the clinical privileges or Department assignment of a Member. The Executive Committee may also recommend that the granting of additional privileges to a current Member be made subject to preceptoring.

5.7 APPLICATION DEEMED WITHDRAWN

If a Member requesting a modification of clinical privileges or Department assignments fails within 30 days of the request to furnish the information necessary to evaluate the request in a timely manner, the application shall automatically be deemed withdrawn, and the applicant shall not be entitled to a hearing as set forth in Article VII.

5.8 HISTORY AND PHYSICALS

A medical history and physical examination shall be completed within 24 hours of admission or before the performance of any procedure, with our without anesthesia, whichever is earlier. The content of the history and physical examination is described in greater detail in the Medical Staff Rules and Regulations, policies, or the applicable departmental rules, regulations, as the case may be. A medical history and physical examination completed within 30 days of admission or registration (the "Pre-Admission H&P") will meet the foregoing requirement under the following circumstances:

(a) The content of the Pre-Admission H&P meets the applicable Medical Staff Standard, and

(b) A member of the Medical Staff with appropriate privileges must complete and document an interval history and physical examination of the patient within 24 hours of admission or before the performance of any procedure, with or without anesthesia, whichever is earlier, by completing the following:

1. Reviewing the report of the Pre-Admission H&P,
2. Performing an examination to confirm the information and findings in from the Pre-Admission H&P,

3. Updating the information and findings in the Pre-Admission H&P, as necessary and appropriate, regarding physical/psychological status, and
4. Signing and dating the report of the interval history and physical examination as an attestation to it being current.

ARTICLE VI
CORRECTIVE ACTION

6.1 ROUTINE MONITORING AND EDUCATION

The Clinical Service Committees and divisions are responsible for carrying out delegated review and quality assurance review functions. They may counsel, educate, issue letters of warning or censure, or institute retrospective or concurrent monitoring (so long as the Practitioner is only required to provide reasonable notice of admissions and procedures) in the course of carrying out their duties without initiating formal corrective action proceedings. 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 Clinical Service Committee or division. 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. This section shall not be construed to confer any rights upon a Practitioner to any routine monitoring and education prior to corrective action. These actions shall not constitute a restriction of privileges or grounds for any hearing under Article VII.

6.2 CORRECTIVE ACTION

6.2.1 CRITERIA FOR INITIATION

When reliable information indicates a Member may have exhibited acts, demeanor, or conduct, either within or outside the hospital, reasonably likely to be (a) detrimental to patient safety or to the delivery of quality patient care within the Hospital; (b) unethical; (c) contrary to these Bylaws and Rules and Regulations or Medical Staff approved policies; (d) below applicable professional standards; (e) reasonably likely to be disruptive to Hospital operations involved in patient care; (f) in violation of state or federal laws or regulations; or (g) detrimental to the Hospital's licensure or accreditation or efforts to comply with utilization review requirements, a request for an investigation or action against such Member may be initiated by the President of the Medical Staff, or his designee, the Chairman of the Department for which the practitioner is a member, the President of the Hospital, or his designee. Any person may supply the information relied on to initiate the request through the appropriate channels.

6.2.2 INITIATION

A request for an investigation must be signed, in writing, and submitted to the Executive Committee and supported by reference to specific activities or conduct alleged which constitutes the ground for the referral. The President of the Medical Staff shall promptly notify the President of the Hospital in writing of all requests for corrective action received by

the Executive Committee and shall continue to keep him or her fully informed of all action taken in conjunction therewith. If the Executive Committee initiates the request, it shall record the reasons.

6.2.3 INVESTIGATION

Investigation means a process specifically instigated by the Medical Executive Committee to determine the validity, if any, to a concern or complaint raised against a medical staff member or individual holding clinical privileges, and does not include activity of the medical staff wellness committee.

If the Executive Committee concludes that an investigation 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 staff officer, Clinical Service Committee, or standing or ad hoc committee of the Medical Staff. If the investigation is delegated to an officer or committee other than the Executive Committee, such officer or committee shall promptly investigate the matter and forward a written report on the findings from the investigation to the Executive Committee as soon as practicable. The report may include recommendations for appropriate corrective action. An investigation is deemed to have begun when the Medical Executive Committee approves and initiates a formal investigation.
If corrective action is being contemplated, the Member shall be notified by the Executive Committee or its designee 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 individual or body deems appropriate. The individual or body investigating the matter may, but is not obligated to, interview the persons involved; however, such interview shall not constitute a "hearing" as that term is used in Article VII, nor shall any of the procedural rules for hearings or appeals apply. Despite the status of any investigation, at all times the Executive Committee retains its authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension, termination of the investigative process, or other action.

The Executive Committee may at any time within its discretion, and shall at the request of the Board of Trustees, terminate the investigative process and proceed with action as provided in Section 6.2.4 below.

In cases of complaints of harassment or discrimination involving a patient, an expedited initial review shall be conducted on behalf of the Medical Executive Committee by the President of the Medical Staff, or the President's designee, together with representatives of administration, or by an attorney for the Hospital. In cases of complaints of harassment where the alleged harasser is a Member and the complainant is not a patient, an expedited initial review shall be conducted by the Human Resources Director or his designee, or by an attorney for the Hospital. The President of the Medical Staff shall be kept appraised of the initial review. The information gathered from an expedited initial review shall be referred to the Medical Executive Committee if it is determined that corrective action may be warranted against a Member.

6.2.4 EXECUTIVE COMMITTEE ACTION

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

Deferring action for a reasonable time not to exceed ninety (90) days where circumstances warrant;

Issuing a letter of warning, admonition, reprimand, or censure, although nothing herein shall be deemed to preclude the Medical Staff President, Clinical Service Committee, division or standing committee Chairs from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letters are issued, the affected Member may make a written response which shall be placed in the Member's file;

Recommending the imposition of terms of probation or special limitation upon continued Staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or proctoring;

Recommending reduction, modification, suspension, or revocation of clinical privileges;
Recommending reductions of membership status or limitation of any prerogatives directly related to the Member's delivery of patient care;

Recommending suspension, revocation, or probation of Staff membership;
Taking other actions deemed appropriate under the circumstances.

6.2.5 SUBSEQUENT ACTIONS

In the event the Executive Committee determines that no corrective action is required, or a letter of warning, admonition, reprimand, or censure should be issued, that decision shall become final subject to review by the Board of Trustees. The Executive Committee shall transmit a report on its findings and conclusions to the Board of Trustees. The Board of Trustees may affirm, modify, further investigate, or reject the recommendation referred for review. The Board of Trustees shall give great weight to the Executive Committee's recommendation. The Board of Trustees shall initiate further action only if the failure to act is contrary to the weight of the evidence that is before it, and then only after it has consulted with the Executive Committee and the Executive Committee has not acted. In no event shall a Practitioner be entitled to a hearing when the only action of the Executive Committee is to issue a letter of reprimand or admonition.

If the Executive Committee recommends action which constitutes grounds for a hearing under Article VII, the Board of Trustees shall not act on the matter until the Practitioner has waived the hearing rights or invoked the hearing rights and the matter is set for appellate review.

6.2.6 PROCEDURAL RIGHTS

Any recommendation by the Executive Committee which constitutes grounds for a hearing as set forth in Section 7.2 shall entitle the Practitioner to the procedural rights as provided in

Article VII. In such cases, the President of the Medical Staff shall give the Practitioner special notice of the adverse recommendation and of the Practitioner's right to request a hearing in the manner specified in Article VII.

6.3 SUMMARY SUSPENSION

6.3.1 CRITERIA FOR IMMEDIATE SUSPENSION

Whenever a Practitioner's conduct requires immediate action to either reduce a substantial likelihood of imminent danger to the health or safety of any person, or to prevent the continued violation of safeguards imposed pursuant to Section 6.4.6. the President of the Medical Staff, Chair of the Department of which the Practitioner is assigned, the President of the Hospital (acting with a Medical Staff officer or Department Chair), the Executive Committee or the Chair of the Board of Trustees (acting with a Medical Staff officer or Department Chair) shall have the authority to summarily suspend or restrict the Staff membership or all or any portion of the clinical privileges of such Practitioner.
If no Medical Staff officers are available after reasonable attempts to contact them, the President of the Hospital or Chair of the Board of Trustees may summarily suspend or restrict a Member's clinical privileges when necessary in order to prevent imminent harm to any person.

Such summary suspension or restriction shall become effective immediately upon imposition, and the person or body responsible for the suspension, shall promptly (within no more than five days) give the Practitioner written notice of the suspension. Such notice must comply with the requirements set forth in Section 7.3.1. In addition, the notice should inform the Practitioner of the right to Executive Committee review under Section 6.3.2. The notice of the suspension or restriction given to the Executive Committee shall constitute a request for corrective action and the procedures set forth in Section 6.2 shall be followed. The corrective action investigation should be completed promptly so any hearing on the summary suspension or restriction and corrective action can be commenced within the sixty (60) day limit after a hearing on a summary suspension or restriction is requested.

If the President of the Hospital or Chair of the Board of Trustees acts without a Medical Staff officer's concurrence, the summary suspension or restriction shall last only two (2) days excluding holidays or weekends. Thereafter, it shall automatically terminate unless ratified by the Executive Committee.

In the event of any suspension or restriction, the Practitioner's patients whose treatment is affected by the summary suspension or restriction shall be assigned to another Practitioner by the President of the Medical Staff or Department Chair. The wishes of the patient and the physician shall be considered, where feasible, in choosing a substitute Practitioner.

6.3.2 EXECUTIVE COMMITTEE ACTION

A Practitioner who has been summarily suspended or restricted may request an interview with the Executive Committee.

Such interview shall be informal and shall not constitute a hearing as provided in Article VII. The interview shall be convened as soon as reasonably possible under the circumstances, not

to exceed thirty (30) days. The Executive Committee may thereafter modify, continue, or terminate the terms of the summary suspension or restriction order and it shall give the Practitioner written notice of its decision.
If the summary suspension or restriction was imposed by the President of the Hospital or Chair of the Board of Trustees acting without the concurrence of a Medical Staff officer, the Executive Committee shall be convened within two (2) working days, excluding weekends and holidays, to consider the action. This review shall be informal and shall not constitute a hearing as provided in Article VII.

The Executive Committee may modify, continue or terminate the terms of the summary suspension or restriction order, and shall give the Practitioner written notice of its decision.

6.3.3 PROCEDURAL RIGHTS

Unless the Executive Committee terminates the suspension or restriction, it shall remain in effect during the pendency of and the completion of the corrective action process and of the hearing and appellate review process, unless the summary suspension or restriction is terminated by the decision of the Judicial Hearing Committee. The Practitioner shall be entitled to the procedural rights afforded by Article VII but the hearing may be delayed until the Executive Committee or Board of Trustees has taken corrective action pursuant to Section 6.2.4 except that the hearing may not be delayed beyond the time limit of sixty (60) days.

6.4 AUTOMATIC TERMINATION OR SUSPENSION

6.4.1 LICENSE

Revocation, Suspension, or Expiration: Whenever a Practitioner's license authorizing practice in this State is revoked, suspended, or has expired, the Practitioner's Staff membership, prerogatives, and clinical privileges shall be immediately and automatically terminated.

Restriction: Whenever a Practitioner's license authorizing practice in this state is limited or restricted by the applicable licensing authority, those clinical privileges that the Practitioner has been granted rights to perform within the scope of said limitation or restriction shall be immediately and automatically terminated.

Probation: Whenever a Practitioner is placed on probation by the applicable licensing authority, the Practitioner's applicable membership status, prerogatives, privileges and responsibilities, if any, shall automatically become subject to the terms of the probation effective upon and for at least the term of the probation.

Nothing shall prohibit the Medical Staff from taking additional action against a Practitioner whose license is restricted in any way.

6.4.2 FELONY CONVICTION OR PLEA OF NO CONTEST TO A FELONY CHARGE

Any Practitioner who is convicted of a felony, or pleads “no contest” to a felony charge, in any jurisdiction, shall immediately and automatically have Medical Staff membership and all privileges suspended. Such immediate and automatic suspension shall be imposed

notwithstanding the pendency of an appeal of such criminal conviction. In the event a final judgment reversing the felony conviction is issued, Medical Staff privileges may be reinstated only upon application by the Practitioner, and privileges shall be reviewed by the appropriate departments and granted if appropriate pending Medical Executive Committee review as specified in 6.4.6.

6.4.3 EXCLUSION FROM PARTICIPATION IN FEDERAL OR STATE PROGRAM

Any Practitioner who is excluded from participation in any federal or state program for the provision of healthcare services including, but not limited to, Medicare or Medicaid, shall immediately and automatically have Medical Staff membership and all privileges suspended pending the Executive Committee review specified in Section 6.4.6.

6.4.4 DRUG ENFORCEMENT ADMINISTRATION (DEA) CONTROLLED SUBSTANCE CERTIFICATE

Revocation: Whenever a Practitioner's DEA certificate is revoked, the Practitioner shall immediately and automatically be divested of the right to prescribe medications covered by the certificate.

Suspension: Whenever a Practitioner's DEA certificate is suspended, the Practitioner's shall be divested, at a minimum, of the right to prescribe medications covered by the certificate effective upon and for at least the term of the suspension.

Probation: Whenever a Practitioner's DEA certificate is subject to an order of probation, the Practitioner's right to prescribe medications covered by the certificate shall automatically become subject to the terms of the probation effective upon and for at least the term of the probation.

6.4.5 FAILURE TO SATISFY SPECIAL APPEARANCE REQUIREMENTS

A Member who fails without good cause to appear and satisfy the requirements of Section 12.7.6 may automatically be suspended from exercising all or such portion of privileges as may be specified in accordance with the provisions of that section.

6.4.6 EXECUTIVE COMMITTEE DELIBERATION ON MATTERS INVOLVING LICENSE, DRUG ENFORCEMENT ADMINISTRATION, OR SPECIAL APPEARANCE ACTIONS OR EXCLUSION FROM PARTICIPATION IN FEDERAL OR STATE PROGRAMS

As soon as practicable after action is taken as described in Section 6.4.1, Section 6.4.2, Section 6.4.3, or Section 6.4.4, the Executive Committee shall convene to review and consider the facts upon which the action is predicated. In the case of an action taken as described in Section 6.4.1., Section 6.4.2. or Section 6.4.4., the Executive Committee may recommend such further corrective action as may be appropriate based upon information disclosed or otherwise made available to it and/or it may direct that an investigation be undertaken pursuant to Section 6.2.3. The Executive Committee shall, at its discretion, also determine whether to afford the Practitioner an informal meeting. The meeting itself shall not constitute a hearing and none of the procedural rights provided in Article VII shall apply. The Practitioner shall not have the right to representation by legal counsel. The Executive

Committee review, and any subsequent hearing and appeal, shall not address the propriety of the licensure or DEA Certificate action, or special appearance requirement, but shall address instead what action the Hospital should take.

In the case of an automatic suspension as described in Section 6.4.3, the suspension shall continue until the Practitioner's exclusion ends or the Practitioner agrees to the imposition of safeguards to ensure that Practitioner does not treat, directly or indirectly, a beneficiary of the state or federal program from which the Practitioner is excluded. Such safeguards shall include: (1) Practitioner's written, signed agreement not to treat such beneficiaries at the Hospital; (2) the Practitioner arranging, at his or her own expense, for a non-excluded physician member of the Medical Staff to provide the excluded Practitioner's on-call coverage at the Hospital pending the suspended Practitioner's reversal of the exclusion from the federal program; and (3) the Practitioner's agreement to waive any procedural bar to the immediate reinstatement of the suspension in the event Practitioner breaches either safeguard (1) or (2). If the Practitioner breaches safeguards (1) and/or (2), the suspension will be automatically reinstated pending the Practitioner's reversal of the exclusion from the state or federally funded program. A Practitioner whose clinical privileges are automatically suspended pursuant to Section 6.4.3 shall not be entitled to the procedural rights set forth in Article VII as to that suspension, the imposition of the safeguards, or the reinstatement of suspension in the event of breach of the safeguard.

Finally, neither the automatic suspension under Section 6.4.3, the lifting of the suspension pursuant to the imposition of the safeguards under this Section 6.4.6, nor the possible reinstatement of the suspension in the event of breach, shall prevent or bar the Hospital or Medical Staff from independently, concurrently or consecutively pursuing additional corrective action against any excluded Practitioner's privileges pursuant to Article VI, entitled Corrective Action, subject to the procedural rights set forth in Article VII. That corrective action may extend up to and including termination of Medical Staff membership and privileges.

6.4.7 MEDICAL RECORDS

Members of the Medical Staff are required to complete medical records within fourteen (14) days after discharge. A limited suspension, in the form of withdrawal of admitting and other related privileges until medical records are completed, shall be imposed by the President of the Medical Staff, or his designee, after notice of delinquency for failure to complete medical records within such period. For the purpose of this section, "related privileges" means scheduling elective surgery or outpatient cases, assisting in elective surgery cases, and consulting on Hospital cases. Members whose privileges have been suspended for delinquent records may admit patients only in life-threatening situations. The suspension shall continue until the records are completed and the suspension is lifted by the President of the Medical Staff or his designee.

Failure to complete the medical records within sixty (60) days after the date a suspension became effective pursuant to this section or after sixty (60) cumulative suspension days within a rolling twelve (12) month period shall be deemed to be a voluntary resignation of the Practitioner's Staff membership.

For the purposes of this section, a failure to complete records will not be cause for suspension if:

The Member is ill or otherwise unavailable for an extended period of time due to circumstances beyond his control;

The Practitioner is waiting for the results of a late report and the record is otherwise complete except for the discharge summary and the final diagnosis;

The Practitioner has dictated the reports and is waiting for Hospital personnel to transcribe them; and

Any other substantial reason acceptable to the Executive Committee.

6.4.8 FAILURE TO PROVIDE UPDATED DOCUMENTATION

A practitioner (Medical Staff and AHP Staff) may be suspended for failure to provide updated documentation of current information required to maintain a current credential file. A failure to provide such evidence within three (3) months after the date the automatic suspension became effective shall be deemed a voluntary resignation of the practitioner's membership and/or privileges.

6.4.9 FAILURE TO PAY REAPPOINTMENT FEE

Failure to submit the reappointment fee in conjunction with a reappointment application shall deem the reappointment application incomplete. Failure to submit the reappointment fee prior to the end of the appointment date shall be deemed a voluntary resignation of membership and privileges.

6.4.10 PROCEDURAL RIGHTS – FELONY CONVICTION, EXCLUSION FROM PARTICIPATION IN FEDERAL/STATE PROGRAM, MEDICAL RECORDS, MALPRACTICE INSURANCE, FAILURE TO PAY REAPPOINTMENT FEE

Practitioners whose clinical privileges are automatically terminated pursuant to the provisions of 6.4.2 (felony conviction) or automatically suspended pursuant to 6.4.3 (exclusion from participation in federal/state program) shall not be entitled to the procedural rights set forth in Article VII. Practitioners whose clinical privileges are automatically suspended and/or who have resigned their Staff membership pursuant to the provisions of 6.4.7 (failure to complete medical records) shall not be entitled to the procedural rights set forth in Article VII unless the delinquencies constitute an MDCR and the suspension is reportable under Business and Professions Code 805. Practitioners whose privileges are automatically suspended and/or who have resigned their Staff membership pursuant to the provisions of 6.4.8 (failure to maintain malpractice insurance), or 6.4.7 (failure to pay reappointment fee) shall not be entitled to the procedural rights set forth in Article VII.

6.4.11 NOTICE OF AUTOMATIC SUSPENSION; TRANSFER OF PATIENTS

Whenever a Practitioner's privileges are automatically suspended in whole or in part, notice of such suspension shall be given to the Practitioner, the Executive Committee, the President of the Hospital, and the Board of Trustees. Giving of such notice shall not, however, be

required in order for the automatic suspension to become effective. In the event of any such suspension, the Practitioner's patients whose treatment is affected by the automatic suspension shall be assigned to another Practitioner by the President of the Medical Staff or Department Chair. The wishes of the patient and the Practitioner shall be considered, where feasible, in choosing a substitute Practitioner.

6.5 REAPPLICATION AFTER RESIGNATION

Previous Members of the Medical Staff whose membership and privileges have been terminated due to resignation may reapply. Those previous Members whose membership and privileges were terminated in accordance with Section 6.4 of these Bylaws may only reapply when the condition causing the termination no longer exists.

Any such reapplication shall be processed as an initial application. Applicants shall submit such additional information as may be required to demonstrate current minimum qualifications for membership as identified in Section 2.3.4.

6.6 INTERVIEWS

Interviews shall neither constitute nor be deemed a "hearing," as that term is used in Article VII. Interviews 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 the Practitioner an interview only when so specified in this Article VI. In all other cases and when the Executive Committee or the Board of Trustees has before it an adverse recommendation, as defined in Section 7.2, it may, but shall not be required to, furnish the Practitioner an interview. In the event an interview is granted, the Practitioner shall be informed of the general nature of the circumstance leading to such recommendation and may present information relevant thereto. A record of the matters discussed, and findings resulting from such interview, shall be made.

ARTICLE VII
HEARINGS AND APPELLATE REVIEWS

7.1 PREAMBLE AND DEFINITIONS

7.1.1 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.
The Medical Staff, the Board of Trustees, and their officers, committees, and agents hereby constitute themselves as peer review bodies under the federal Health Care Quality Improvement Act of 1986 and State Peer Review Act and claim all privileges and immunities afforded by the federal and state laws.

7.1.2 INTRA-ORGANIZATIONAL REMEDIES

The hearing and appeal rights established in these Bylaws are strictly "judicial" rather than "legislative" in structure and function. The hearing committees have no authority to adopt or modify rules and standards, or to decide questions about the merits or substantive validity of Bylaws, rules, regulations or policies. The Board of Trustees may, however, entertain challenges to the merits or substantive validity of Bylaws, rules, regulations 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 may appeal directly to the Board of Trustees or its designee. The Practitioner must submit challenges first to the Hospital Board of Trustees and only thereafter may the Practitioner seek judicial intervention.

7.1.3 EXHAUSTION OF REMEDIES

If an adverse ruling is made with respect to a Practitioner's membership, Staff status, or clinical privileges at any time, regardless of whether the Practitioner is an applicant or a Member, the Practitioner must exhaust the intra-organizational remedies afforded by these Bylaws before resorting to formal legal action challenging the decision, the procedures used to arrive at it, or asserting any claim against the Hospital or any participants in the decision process.

7.1.4 DEFINITIONS

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

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

"Practitioner" refers to the Practitioner who has requested a hearing pursuant to Section 7.3 of this Article.

7.1.5 SUBSTANTIAL COMPLIANCE

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

7.2 GROUNDS FOR A HEARING

Any one or more of the following actions or recommended actions, except as otherwise specifically provided in these Bylaws, shall constitute grounds for a hearing as provided in Section 7.3:

Denial of initial Staff appointment;

Denial of Staff reappointment;

Suspension of membership or clinical privileges until completion of specific conditions or requirements for a cumulative period of more than thirty (30) days in any twelve (12) months;

Summary suspension of membership or clinical privileges during the pendency of corrective action and hearing and appeals procedures;

Revocation or termination of, or expulsion from, Staff membership;

Denial or termination of clinical privileges, including temporary privileges;

Reduction or revocation of privileges;

Summary suspension of clinical privileges for more than fourteen (14) consecutive days;

Requirement of consultation, co-admitting, or proctoring, when that requirement is beyond what may be required for quality assessment purposes or as required by these Bylaws or Rules and Regulations;

Any other action which requires a report to be made to the Medical Board` of California under the provisions of Section 805 of the California Business and Professions Code.

7.3. HEARING RULES AND PROCEDURE

7.3.1 NOTICE OF ACTION OR PROPOSED ACTION

A body that has the authority to take any of the actions constituting grounds for a hearing set forth in Section 7.2.1 shall give written notice of its recommendation or action to the affected Practitioner and of the Practitioner's right to request a hearing. The notice must state:

What corrective action has been proposed against the Practitioner, and whether the action is temporary or permanent:

That, if the recommended or final proposed action is adopted and it is based on competence or professional conduct such that it adversely affects the clinical privileges of the Practitioner for a period of time which is reportable under Federal law and/or California Business and Professions Code Section 805, it will be so reported to the National Practitioner Data Bank and/or the Medical Board of California accordingly;

A brief indication of the reasons for the proposed action;

That the Practitioner may request a hearing and has the hearing rights enumerated in these Bylaws; and

That a hearing must be requested within thirty (30) days; and

The consequences of not requesting a hearing.

7.3.2 REQUEST FOR HEARING

The Practitioner shall have thirty (30) days following the date of receipt of a notice of an adverse action to request a hearing by a Judicial Hearing Committee. Said request must be submitted in writing to the President of the Medical Staff with a copy to the President of the Hospital. If the Practitioner does not request a hearing within the time and in the manner set forth above, the Practitioner shall be deemed to have accepted the recommendation, decision, or action involved and waived any right to a hearing. It shall become the Medical Staff's final action. Such final recommendation shall be considered by the Board of Trustees within seventy (70) days, and shall be given great weight by the Board of Trustees, although it is not binding on the Board of Trustees.

7.3.3 TIME AND PLACE FOR HEARING

Upon receiving a request for hearing, the President of the Medical Staff, within thirty-five (35) days after receipt of the request, shall schedule and arrange for a hearing. The President of the Medical Staff shall give the Practitioner notice of the time, place, and date of the hearing. The date of the commencement of the hearing shall be not less than thirty (30) days from the date of the notice of hearing, nor more than sixty (60) days from the date the President of the Medical Staff received the request for a hearing; provided, however, that when the request is received from a Practitioner who has been summarily suspended, the hearing shall be held as soon as the arrangements may reasonably be made consistent with the goal of simultaneously completing any corrective action proceedings. However, the date of the hearing may be delayed upon a written decision issued by the Presiding Officer finding that the Practitioner failed to comply with Sections 7.3.9 and 7.3.10 below, or consented to the delay.

7.3.4 NOTICE OF CHARGES AND WITNESSES

As a part of, or together with the notice of hearing required by Section 7.3.3 above, the President of the Medical Staff, on behalf of the body whose decision prompted the hearing, shall state in writing the reasons for the adverse action and specifically the acts or omissions with which the Practitioner is charged. The President of the Medical Staff shall include a list of any charts being questioned or the grounds upon which the application was denied, where applicable. Amendments to the statement of charges may be made from time to time, but not later that the close of the case by the Medical Staff representative at the hearing. Such amendments may delete, modify, clarify, or add to the acts, omissions, charts, or reasons specified in the original Notice. Notice of amendment shall be given to the affected Practitioner, the hearing officer, and each party. The hearing officer may grant the affected Practitioner a reasonable postponement if the affected Practitioner promptly requests, in writing, the hearing officer to postpone the hearing to prepare a response or defense to any such amendment that adds acts, omissions, charts, or reasons to the original Notice. The Presiding Officer, as defined below, shall give prompt notice to the parties of the postponement.

Upon the request of either party, at least ten (10) working days prior to the hearing, each party shall furnish to the other a written list of the names and addresses of the individuals whom the parties anticipate will give testimony or evidence in support of that party at the hearing. The witness list shall be amended when additional witnesses are identified or when the party no longer wishes to call previously anticipated witnesses. A failure to comply with this requirement is good cause to postpone the hearing.

7.3.5 JUDICIAL HEARING COMMITTEE

The President (if the Medical Staff initiated the action) or the President of the Hospital (if the Board of Trustees initiated the action and the President of the Medical Staff has declined to act for the Board) shall appoint a Judicial Hearing Committee consisting of at least three (3) Medical Staff Members, and alternates as appropriate, who have the requisite expertise to ensure an efficacious and fair hearing. The hearing panel Members shall be unbiased, shall not have actively participated in the formal consideration of the matter at any previous level (i.e., they shall not have acted as an accuser, investigator, fact finder or initial decision-maker in the same matter), shall not be in direct economic competition with the affected Practitioner, and shall stand to gain no direct financial benefit from the outcome. Whenever possible, at least one Member should practice the same specialty as the affected Practitioner. In the event that it is not feasible to appoint a Judicial Hearing Committee from the Medical Staff, the President of the Medical Staff or President of the Hospital may appoint Practitioners who are not Members of the Medical Staff. Any such physician, and/or dentist, podiatrist or psychologist, if appropriate, must be licensed to practice their specialty in the State of California. The President of the Medical Staff or President of the Hospital shall designate a Chair who shall preside in the manner described in Section 7.3.7 below, and handle all pre-hearing matters and preside until a hearing officer, as described in Section 7.3.6 below, is appointed.

The President of the Medical Staff, at the direction of the Executive Committee, and with the approval of the Hospital President or his designee, has authority to enter into an agreement with the person who requested the hearing to hold the hearing before an arbitrator(s) who is/are mutually acceptable to the physician and the Hospital.. The arbitrator need not be a health professional. The arbitrator shall carry out all the duties assigned to the Presiding Officer and Hearing Committee. Failure or refusal to offer arbitration shall not constitute a breach of the Executive Committee's responsibility to provide a fair hearing.

7.3.6 THE HEARING OFFICER

At the request of the Practitioner, the Executive Committee, the Judicial Hearing Committee, or the Board, the President of the Medical Staff may 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 and preferably have experience in Medical Staff matters. The hearing officer shall address pre-hearing rulings on the admissibility of evidence and hearing procedure. The hearing officer shall not be biased for or against the Practitioner, will gain no direct financial benefit from the outcome and must not act as a prosecuting officer or as an advocate for any party. The hearing officer may participate in the deliberations and act as a legal advisor, but he/she shall not be entitled to vote.

7.3.7 THE PRESIDING OFFICER

The Presiding Officer at the hearing shall be a hearing officer as described in Section 7.3.6 or, if no such hearing officer has been appointed, the Chair of the Judicial Hearing Committee. The Presiding Officer shall act to assure that all participants in the hearing have a reasonable opportunity to be heard and to present all relevant oral and documentary evidence, and that proper decorum is maintained. The Presiding Officer shall be entitled to determine the order of, or procedure for, presenting evidence and argument during the hearing. The Presiding Officer shall have the authority and discretion, in accordance with these Bylaws, to grant continuances, impose sanctions for delay or inappropriate conduct, determine whether or when attorneys may be permitted in accordance with Section 7.3.11, to rule on disputed discovery requests, to decide when evidence may not be introduced, to rule on challenges to hearing committee members, to rule on challenges to the individual serving as a hearing officer, and to rule on questions which are raised prior to or during the hearing pertaining to matters of law, procedure, or the admissibility of evidence.

7.3.8 PRE-HEARING PROCEDURE

It shall be the duty of the Practitioner and the body whose decision prompted the hearing to exercise reasonable diligence in notifying the Presiding Officer of any pending or anticipated procedural irregularity, as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may expeditiously be made. Objection to any such pre-hearing decisions shall be raised at the judicial hearing and when so raised shall be preserved for consideration at any appellate review hearing which thereafter might be requested.

7.3.9 DISCOVERY

Rights of Inspection and Copying:

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

Limits of Discovery:

Upon the request of either side, the Presiding Officer may deny a discovery request on any of these grounds:

The information refers solely to individually identifiable Practitioners other than the affected Practitioner;

Denial is justified to protect peer review;

Denial is justified to protect justice.

In ruling on discovery disputes, the factors that may be considered include:

Whether the information sought may be introduced to support or defend the charges; Whether the information is reasonably "exculpatory" in that it would tend to dispute or cast doubt upon the charges, or reasonably "inculpatory" in that it would tend to prove or help support the charges and/or recommendation;

The burden on the party of producing the requested information;

Any previous discovery requests made by the party;

Whether the information sought would intrude on privacy rights or otherwise threaten the frank and open exchange of ideas in the process by which peer review decisions or policies are formulated.

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

The body whose decision prompted the hearing may object to the introduction of 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 Presiding Officer unless the Practitioner can prove the Practitioner previously acted diligently and could not have submitted the information.

7.3.10 PRE-HEARING DOCUMENT EXCHANGE

At the request of either party, the parties must exchange all documents that will be introduced at the hearing and identify all witnesses who will testify for each party at least ten (10) days prior to the hearing. A failure to comply with this rule is good cause for the Presiding Officer to grant a continuance. Repeated failures to comply shall be good cause for the Presiding Officer to limit introduction of any documents not timely provided to the other party or testimony from witnesses not identified pursuant to this provision. Notwithstanding the above, testimony from additional witnesses whose participation was not reasonably anticipated shall not be automatically precluded, but may be permitted in the discretion of the Presiding Officer, provided the parties notify each other in writing as soon as they become aware of the possible participation of such additional witnesses.

7.3.11 REPRESENTATION

The hearings provided for in these Bylaws are for the purpose of interprofessional resolution of matters bearing on conduct or professional competency. Accordingly, neither the Practitioner, the Executive Committee, nor the Board of Trustees shall be represented by an attorney-at-law at the judicial hearing unless, at the discretion of the Presiding Officer, both sides are permitted to be represented by legal counsel. In no event shall the Executive Committee be represented by legal counsel if the Practitioner is not represented. 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. When attorneys are not allowed, the Practitioner and the body whose decision prompted the hearing may be represented at a

hearing by a licensed Practitioner who is a Member of the Hospital's Medical Staff and is not an attorney-at-law.

7.3.12 FAILURE TO APPEAR

Failure without good cause of the Practitioner to appear and proceed at such a hearing, if the Practitioner ceases participation in the proceedings after they have commenced, shall be deemed to constitute voluntary acceptance of the recommendations or actions involved and the recommendations or actions shall thereupon become the final recommendation of the Medical Staff. Such final recommendation shall be considered by the Board of Trustees within seventy (70) days. The recommendation shall be given great weight but shall not be binding on the Board of Trustees.

7.3.13 POSTPONEMENTS AND EXTENSIONS

Postponements and extensions of time beyond the times expressly permitted in these Bylaws may be requested by any affected person, and shall be permitted upon agreement of the parties or by the Presiding Officer on a showing of good cause.

7.3.14 RECORD OF THE HEARING

The Judicial Hearing Committee shall maintain a record of the hearing by using a certified shorthand reporter to record the hearing or by audio or video tape recording the proceedings. The Practitioner shall be entitled to receive a copy of the transcript or recording upon paying the reasonable cost for preparing the record. Though not required, the Presiding Officer may order that oral evidence shall be taken only on oath administered by any person designated by such body and entitled to notarize documents in this State or by affirmation under penalty of perjury to the Presiding Officer.

7.3.15 RIGHTS OF THE PARTIES

At a hearing, both sides shall have the following rights: to ask Judicial Hearing Committee members and/or the Hearing Officer questions which are directly related to determining whether they meet the qualifications set forth in these Bylaws, and to challenge such Members or the Hearing Officer, to call and examine witnesses, to introduce relevant documents and other evidence, to receive all information made available to the Judicial Hearing Committee, to cross-examine or otherwise attempt to impeach any witness who testified orally on any matter relevant to the issues, and otherwise to rebut any evidence. The Practitioner may be called by the body whose decision prompted the hearing and examined as if under cross-examination regardless of whether the Practitioner testified on his or her behalf. The Judicial Hearing Committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate. Each party has the right to submit a written statement in support of that party's position at the close of the hearing. The Judicial Hearing Committee may request such a statement to be filed following the conclusion of the presentation of oral testimony.

7.3.16 RULES OF EVIDENCE

The rules of law relating to the examination of witnesses and presentation of evidence shall not apply in any hearing conducted hereunder. Any relevant evidence, including hearsay, shall be admitted by the Presiding Officer if it is the sort of evidence which responsible persons are accustomed to rely on in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.

7.3.17 BASIS OF DECISION

If the Judicial Hearing Committee should find the charge(s) or any of them to be true, it shall recommend such form of discipline as it finds warranted. If the recommended discipline is more stringent than that recommended by the body whose decision prompted the hearing, the Practitioner shall be notified by the hearing committee and be given a further opportunity to submit evidence to that hearing panel in support of the Practitioner's position if the Practitioner can demonstrate the Practitioner previously was unaware of the possible severity of the consequences, and fairness requires a further chance to respond.

The decision of the Judicial Hearing Committee shall be based on the evidence produced at the hearing and any written statements submitted to the Judicial Hearing Committee.

7.3.18 BURDEN OF GOING FORWARD AND BURDEN OF PROOF

The body whose decision prompted the hearing shall have burden of initially presenting evidence to support the charge or recommended action.

A Practitioner who requested the hearing to challenge a recommendation to deny an application for appointment to the Medical Staff or application for any initial or additional clinical privileges ("Initial Applicant") shall bear the burden of persuading the Judicial Hearing Committee by a preponderance of the evidence of the applicant's qualifications by producing information which allows for an adequate evaluation and resolution of any reasonable doubts concerning the Applicant's current qualifications. Initial Applicants shall not be permitted to introduce information not produced upon request of the Medical Staff during the application process, unless the Initial Applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

Except as provided above for Initial Applicants, the body whose decision prompted the hearing shall bear the burden of persuading the Judicial Hearing Committee, by a preponderance of the evidence, that its action or recommendation was reasonable and warranted. The term "reasonable and warranted" means within the range of the alternatives available to the body whose decision prompted the hearing under the circumstances. "Reasonable and warranted" does not necessarily mean that the action or recommendation is the only measure or the best measure that could have been taken or formulated in the opinion of the Judicial Hearing Committee.

7.3.19 ORGANIZATION AND CONDUCT OF HEARING PROCESS

The hearing shall be conducted as follows:
The parties shall have a reasonable opportunity to question of the Judicial Hearing Committee members and the Hearing Officer, in order to evaluate their qualifications to serve and the right to challenge the appointment of any Judicial Hearing Committee member or the Hearing

Officer. The Presiding Officer shall establish the procedure by which this right may be exercised, which may include requirements that such questions be proposed in writing in advance of the hearing and that the questions be presented by the Presiding Officer. The Presiding Officer shall rule on any challenges in accordance with applicable legal principles defining standards or impartiality for hearing panels and hearing officer in proceedings of this type:

The Medical Staff representative shall present an opening statement;

The Medical Staff representative shall then present the facts upon which he is relying, by calling the witnesses and presenting the evidence to support the case. He may call any person or opposing party who is present in support of the case. The affected Practitioner may be called by the Medical Staff representative and examined as if under cross-examination. The Judicial Hearing Committee may also question any witness;

At the close of the Medical Staff representative's case, the affected Practitioner or his or her representative shall make an opening statement and shall make a case presentation of evidence and testimony. He may call any person specified on his or her witness list in support of the case, including opposing parties. The Judicial Hearing Committee may also question any witness;

Upon the close of the initial presentations of the parties, each party shall be entitled to present evidence to rebut the presentation of the other, subject to reasonable limitations by the Presiding Officer as to order, time, relevance, and repetition;

Upon close of all presentation and evidentiary rebuttal, the parties shall be entitled, subject to reasonable limitation by the Presiding Officer, to give closing statements and argument;
Upon the close of all presentation, rebuttals, statements, and argument, the Presiding Officer shall declare the hearing finally adjourned, and all persons other than the Judicial Hearing Committee and Presiding Officer shall thereupon leave the hearing. The Judicial Hearing Committee shall thereafter, at the convenience of its members but subject to the provisions of Section (h) below, deliberate in order to reach its decision;

The hearing process shall be completed within a reasonable time. The absence of any Judicial Hearing Committee member or alternate at any hearing(s) shall not be reason to cancel or delay the proceedings; rather, so long as three (3) panel members are present, the proceedings shall continue, and the absent member or alternate will have the opportunity to read the transcripts from any hearing(s) they did not attend. The decision of the Presiding Officer after consultation with the Judicial Hearing Committee regarding such matters shall be final;

No persons shall disrupt any hearing. Any person in attendance (whether a party or any other person) who disrupts a hearing after being warned by the Presiding Officer to cease such disruption on penalty of indefinite exclusion, shall, at the direction of the Presiding Officer, leave the hearing. Unless directed otherwise for good cause by the Presiding Officer, the hearing shall proceed in the absence of such excluded person; and

Except at otherwise provided in these Bylaws, and subject to reasonable restriction by the Presiding Officer, the following shall be permitted to attend the entire hearing in addition to

the Judicial Hearing Committee: Presiding Officer, court reporter, parties, the President of the Hospital, one or more persons designated by the President of the Hospital, and the Medical Staff coordinator or assistant.

7.3.20 ADJOURNMENT AND CONCLUSION

The Presiding Officer may adjourn the hearing and reconvene the same at the convenience of the participants without notice. The hearing shall be concluded within a reasonable time and the Presiding Officer may set guidelines for introduction of evidence to achieve a timely conclusion.

7.3.21 DECISION OF THE JUDICIAL HEARING COMMITTEE

Within fifteen (15) days after final adjournment of the hearing (or within ten [10] working days if the Practitioner is currently under suspension) the Judicial Hearing Committee shall render a decision. Final adjournment is defined as the conclusion of deliberations by the Judicial Hearing Committee. The Judicial Hearing Committee may recommend that the Board of Trustees affirm, modify, or terminate the action or recommendation that prompted the hearing. The decision shall be based on evidence produced at the hearing, including any recognized matters and reasonable inferences that may be drawn. The decision shall be accompanied by a written report that contains findings of fact and conclusions that articulate the connection between the evidence produced at the hearing and the decision. The report shall include sufficient detail to enable the parties, any appellate review board, and the Board of Trustees to determine the basis for the Judicial Hearing Committee's decision. The report shall be delivered to the Executive Committee, the President of the Hospital, the Board of Trustees and the affected Practitioner. The Practitioner's copy of the report shall be delivered by registered or certified mail, return receipt requested. The decision of the Judicial Hearing Committee shall be considered final, subject only to the right of review by an appeal to the Board of Trustees as provided in Section 7.4.

7.4 APPEALS TO THE BOARD OF TRUSTEES

7.4.1 TIME FOR APPEAL

Within forty (40) days after the date of receipt of the Judicial Hearing Committee decision, either the Practitioner, or the body whose decision prompted the hearing or review, may request an appellate review by the Board of Trustees. Said request shall be delivered to the President of the Hospital in writing either in person, or by certified or registered mail, return receipt requested, and it shall briefly state the reasons for the appeal. If appellate review is not requested within this period, both sides shall be deemed to have accepted the action involved and it shall thereupon become the final action of the Medical Staff. Such final recommendation shall be considered by the Board of Trustees within seventy (70) days. The recommendation shall be given great weight, but shall not be binding on the Board of Trustees.

7.4.2 GROUNDS FOR APPEAL

The grounds for appeal from the final decision of the Judicial Hearing Committee shall be:

Substantial non-compliance with the procedures required by these Bylaws which caused demonstrated prejudice; and/or

The decision was not supported by substantial evidence based upon the hearing record.

7.4.3 TIME, PLACE AND NOTICE

When appellate review is requested, The Board of Trustees shall, within forty-five (45) days after the date of receipt of such an appeal notice, schedule and arrange for an appellate review. The Board of Trustees shall give the Practitioner notice of the time, place, and date of the appellate review. The date of appellate review shall be not less than fifteen (15) nor more than ninety (90) days from the date of receipt of the request for appellate review. If, however, a Practitioner is under suspension, the appellate review shall be held as soon as the arrangements may reasonably be made, but not more than forty-five (45) days from the date of receipt of the request for appellate review. The time for appellate review may be extended for good cause by the Board of Trustees, or appeal board (if any).

7.4.4 APPEAL BOARD

When an appellate review is requested, the Board of Trustees may sit as the appeal board or it may appoint an appeal board which shall be composed of Board of Trustees and shall have at least three (3) members. 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 participate in the matter at any previous level, (i.e., as an accuser, investigator, fact finder, or initial decision-maker in the same matter).

7.4.5 HEARING PROCEDURE

The proceedings by the appeal board shall be in the nature of an appellate hearing based upon the record of the hearing before the Judicial Hearing Committee. The appeal board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the Judicial Hearing Committee in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the Judicial Hearing Committee hearing; or the appeal board may remand the matter to the Judicial Hearing Committee for the taking of further evidence and for decision. Each party has the right to be represented by an attorney or any other representative the party chooses. The appeal board may select an unbiased attorney to assist it by fulfilling the duties of a presiding and hearing officer, as described in Sections 7.3.6 and 7.3.7. Each party has the right to present a written statement in support of that party's position on appeal (provided that any statement shall be provided to the other party not less that seven (7) days prior to the date of the review) and the right to personally appear and present oral argument. The appeal board shall, in its sole discretion, establish a page limit for the parties briefs. At the conclusion of oral argument, the appeal board may thereupon conduct, at a convenient time, deliberations outside the presence of the parties and their representatives.

If an appeal board is appointed, the appeal board shall present to the Board of Trustees its written recommendations as to whether the Board of Trustees should affirm, modify, or

reverse the Judicial Hearing Committee decision, or remand the matter to the Judicial Hearing Committee for further review and decision. If no appeal board is appointed, the procedures outlined in this subsection shall apply to a hearing before the Board of Trustees.

7.4.6 POSTPONEMENTS AND EXTENSIONS

Postponements and extensions beyond the times expressly permitted in these Bylaws may be requested by any party and shall be granted on agreement of the parties by the Presiding Officer on a showing of good cause.

7.4.7 DECISION

Within fifteen (15) days after adjournment of the appellate review proceedings, the Board of Trustees shall render a final decision in writing. Final adjournment shall not occur until the Board of Trustees has completed its deliberations. The Board of Trustees may affirm, modify, or reverse the Judicial Hearing Committee decision, or, at its discretion, remand the matter for further review and recommendation by the Judicial Hearing Committee or any other body or person. The final decision shall be in writing and shall include a statement of the basis for the decision and provide finding of fact and conclusions articulating the connections between the evidence produced at the hearing and the appeal (if any new evidence was presented) and the decision reached. The Board of Trustees shall give great weight to the recommendation of the Medical Staff and shall not act arbitrarily or capriciously. The Board of Trustees is allowed, however, to exercise its independent judgment in determining whether a Practitioner was afforded a fair hearing, whether the decision is reasonable and warranted, and whether any Bylaws provision, rule, or regulation relied upon by the hearing committee in reaching its decision is reasonable and warranted. Copies of the decision shall be delivered to the Practitioner and to the Executive Committee, by personal delivery or by mail.

7.4.8 FURTHER REVIEW

Except when the matter is remanded for further review and recommendation, the final decision of the Board of Trustees following the appeal procedures set forth in this Article shall be effective immediately and shall not be subject to further review. If the matter is remanded to the Judicial Hearing Committee or any other body or person, said committee, body, or person shall promptly conduct its review and make its recommendations to the Board of Trustees in accordance with the instructions given by the Board of Trustees. The time for a further review and report shall not exceed ninety (90) days except as the parties may otherwise stipulate.

7.4.9 RIGHT TO ONE HEARING

Notwithstanding any other provision of these Bylaws, no Practitioner shall be entitled as a right to more than one judicial, evidentiary hearing and one appellate review on any matter which shall have been the subject of action by either the Executive Committee or the Board of Trustees or by both.

7.5 EXCEPTIONS TO HEARING RIGHTS

7.5.1 CLOSED STAFF OR EXCLUSIVE USE DEPARTMENTS, HOSPITAL CONTRACT PHYSICIANS AND MEDICAL DIRECTORS

Closed Staff or Exclusive Use Departments. The fair hearing rights of Articles VI and VII do not apply to a Practitioner whose application for Staff membership and privileges was denied or whose privileges were terminated on the basis the privileges the Practitioner seeks are granted only pursuant to a closed staff or exclusive use policy. Such Practitioners shall have the right, however, to request that the Board of Trustees review the denial and the Board of Trustees shall have the discretion to determine whether to review such a request and, if it decides to review the request, to determine whether the Practitioner may personally appear before and/or submit a statement in support of the Practitioner's position to the Board of Trustees.

Hospital Contract Physicians and Medical Directors. The fair hearing rights of Articles VI and VII do not apply to Practitioners serving the Hospital as Hospital contract physicians or in the capacity of Medical Director. Removal of these Practitioners from office shall instead be governed by the terms of their individual contract and agreements with the Hospital. The hearing rights of this Article VII and of Article VI shall apply if an action is taken which must be reported under Business and Professions Code Section 805 and/or the Practitioner's Staff membership status or clinical privileges which are independent of the Practitioner's contract are also removed or suspended.

7.5.2 ALLIED HEALTH PROFESSIONALS

Allied Health Professionals (AHPs) are not entitled to the hearing rights set forth in this Article unless the action involves a clinical psychologist in which case they shall be entitled to the hearing rights of this Article on the same basis as Members (See Section 14.6 for a description of AHP hearing rights).

7.5.3 DENIAL OF APPLICATIONS FOR FAILURE TO MEET THE MINIMUM QUALIFICATIONS

Practitioners shall not be entitled to any hearing, or appellate review rights if their membership or privileges, applications or requests are denied because of their failure to have a current and unrestricted California license to practice medicine, dentistry, podiatry or psychology; to maintain an unrestricted Drug Enforcement Administration certificate (for physicians); to maintain professional liability insurance as required by the Bylaws; and/or to file a complete application.

7.5.4 AUTOMATIC SUSPENSIONS AND RESIGNATIONS

Practitioners whose clinical privileges are automatically suspended and/or who have resigned their Staff membership for failing to complete medical records (Section 6.4.5), failing to maintain malpractice insurance (Section 6.4.6), or failing to pay reappointment fee (Section 6.4.7) are not entitled under Section 6.4.8 to any hearing or appellate review rights except when a suspension for failure to complete medical records must be reported to the Medical Board of California pursuant to Section 805 of the Business and Professions Code.

7.5.5 REMOVAL FROM EMERGENCY DEPARTMENT ROOM CALL PANEL

Removal from Emergency Department Call Panel is subject to Medical Staff Rules and Regulations.

ARTICLE VIII
OFFICERS/OTHER ELECTED REPRESENTATIVES

8.1 IDENTIFICATION

8.1.1 GENERAL OFFICERS

The officers of the Medical Staff shall be a President, President-Elect, Secretary-Treasurer, and immediate Past-President.

8.1.2 OTHER ELECTED REPRESENTATIVES

Other elected representatives of the Medical Staff shall include three at-large Executive Committee representatives, and five (5) Members of the Nominating Committee.

8.1.3 DEPARTMENT OFFICERS

The Department elected representative shall be a Department Chair.

8.2 QUALIFICATIONS

8.2.1 GENERAL OFFICERS

Officers must have been Members of the active Medical Staff for three (3) years and must have had Clinical Service Committee experience at the time of nomination and election, must maintain Board Certification and remain Members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

8.2.2 OTHER ELECTED REPRESENTATIVES

Other elected representatives must have been Members of the active Medical Staff for three (3) years and must remain Members in good standing during their term of service.

8.2.3 DEPARTMENT OFFICERS

Each Department Chair shall be a Member of the active Medical Staff, be board certified, and have two (2) years' experience at this hospital in at least one of the clinical areas covered by the Department, be in good standing in that clinical area, and be willing and able to faithfully discharge the functions of the office. The Chairman of Pediatrics must be a participating provider for California Children's Services.

8.2.4 TEMPORARY REMOVAL

Any of the above officers and/or elected representatives who have been placed under an FPPE ordered by the Medical Executive Committee shall be temporarily removed from their position until such FPPE has been lifted.

8.3 METHOD OF ELECTION

8.3.1 OFFICER/ELECTED REPRESENTATIVE NOMINATION PROCESS

The Nominating Committee shall nominate one or more nominees for the offices of President-Elect and Secretary-Treasurer, and for the at-large representative position on the Executive Committee which will be vacant. In addition, one nominee shall be nominated for the Credentials Committee for a three-year position. Members of the Nominating Committee are not eligible for office;

The Nominating Committee recommendations shall be presented to the Medical Staff at the September general staff meeting.

Further nominations may be made for any position identified in 8.3.2(a) by submitting, to the Chair of the Nominating Committee, the name of the candidate together with a written petition which is signed by at least ten percent (10%) of the active staff. These nominations by petition shall be delivered to the Medical Staff Office at least twenty (20) days prior to the election for authentication.

A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate for the office receives a majority vote on the first ballot, a runoff election shall be held promptly between the two candidates receiving the highest number of votes. In the case of a tie on the second ballot, the majority vote of the Executive Committee at its next meeting or a special meeting called for that purpose shall decide the election. This vote shall be by secret written ballot.

Ballots for Medical Staff Officer shall be mailed to the Active Medical Staff at least forty-five (45) days prior to the annual meeting. Active staff members will cast their vote on the ballot and must seal their ballot in the unmarked envelope provided with the ballot. The unmarked envelope must be sealed in the return envelope provided with the ballot. The return envelope will have the Active Staff member’s name marked on the outside in order to determine who has returned a ballot. In those instances where a voter indicates that he did not receive a ballot and requests a second ballot, the Medical Staff Services Department will verify that the voter’s original ballot was not received. If the ballot had not been received, the voter will be issued a second ballot. Ballots must be returned and received by a date not later than fourteen (14) calendar days from the postmarked date that the ballot was mailed. No ballots, whether hand-delivered or mailed, will be accepted after 4:30 pm on the fourteenth day. As soon as possible following the 4:30 pm deadline, ballots will be counted. All candidates or their designee will be invited to witness the opening of the ballots; however, their presence is not required. Either the President of the Medical Staff or the Nominating Committee Chair or their designee must be present during the opening and counting of the ballots. The Director of Medical Staff Services or designee must be present during the opening and counting of the ballots. Winner of the Election will be announced at the Annual General Medical Staff Meeting in December.

8.3.2 DEPARTMENT CHAIR/NOMINATING COMMITTEE REPRESENTATIVE PROCESS

Candidates interested in the positions of Department Chair or nominating committee representative may submit a signed, written statement indicating their candidacy to the Medical Staff Office no later than the second Friday in September.

The names of the candidates received to date shall be announced at the September general Staff meeting to be held on the third Tuesday in September.

If there are no candidates for Department Chair received by the due date, the President-Elect may appoint individuals for those vacant positions after the fourth Tuesday in September.
If only one candidate statement for Department Chair is received, that person will be announced at the next Clinical Service Committee meeting.

If only five (5) candidate statements for nominating committee representative are received, ballots need not be mailed. The five candidates will automatically become nominating committee Members.

If less than five (5) candidate statements for nominating committee representative are submitted, the Executive Committee shall fill the vacant position(s).

If there is more than one candidate for Department Chair, or more than five candidates for nominating committee, ballots will be mailed to all active Department Members for their respective Department Chair elections, and to all active staff for nominating committee representative elections, on the first Tuesday in October, with ballots to be returned no later than the third Tuesday in October. The return envelopes for the ballots will be marked with the physicians identifying number. One week prior to counting the ballots, a reminder letter will be sent to all physicians eligible to vote, reminding them when the ballots are due and instructing them to contact the Medical Staff Office if they have not received a ballot. The ballots will be opened and tallied by an officer(s) of the Medical Staff and the results will be posted in the Medical Staff Office. The winner of the Department Chair election will be announced at the next Clinical Service Committee meeting. The five nominees receiving the most votes for nominating committee representative will serve on the nominating committee.
In the event of a tie for Department Chair, a second mail ballot will be sent to all active Department Members on the fourth Tuesday in October, with ballots to be returned by the second Tuesday in November. The ballots will be opened and tallied on the following day, with results immediately posted in the Medical Staff Office. In the event of a second tie for Department Chair, the President-Elect of the Medical Staff will break the tie between the two candidates. In the event of a tie for the fifth nominating committee position, a secret written ballot election will be conducted at the annual staff meeting. The winning nominating committee representative will be announced at the annual staff meeting.

Members elected as Department Chair will serve as non-voting Members of their respective Clinical Service Committee for the remainder of the year, if they are not already voting Members of the committee.

8.4 PRESIDENT AND IMMEDIATE PAST PRESIDENT PROVISIONS

Section 8.3 shall not apply to the offices of President and immediate Past President. The President-Elect shall, upon completion of his term of office in that position, immediately succeed to the office of President and then to the office of immediate Past President.

8.5 CONFLICT OF INTEREST

Members accepting nominations for any position, whether by the Nominating Committee, petition, or appointment must provide to the Medical Staff Office all possible conflicts of interest, both financial and otherwise, which might influence their decisions while holding the office for which they are nominated.

8.6 TERM OF OFFICE

Each officer, nominating committee representative, and Department Chair shall serve a one (1) year term, commencing on the first day of the Medical Staff year following the election. The Executive committee representative shall serve a three (3) year term, commencing on the first day of the Medical Staff year following the election.

Each officer, elected representative, and Department Chair shall serve until the end of the term and until a successor is elected, unless the individual resigns or is removed from office. Officers, representatives, and Chairs are eligible to succeed themselves, but none may hold the same office for more than two (2) consecutive terms.

8.7 REMOVAL FROM OFFICE

Except as otherwise provided in these Bylaws, removal of an officer may be initiated by the Executive Committee or upon the written request of twenty percent (20%) of the Members eligible to vote for officers submitted to the Executive Committee. Removal may occur for any valid cause including, but not limited to, failure to carry out the duties of the office. Such removal may be effected by a two-thirds (2/3) vote of the Members eligible to vote for officers. Voting on removal of an elected officer shall be by secret written mail ballot. The written mail ballots shall be sent to each voting Member at least 21 days before the voting 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 President shall count the ballots.
Removal of a Department Chair from office may be initiated by the Executive Committee or by written request submitted to the Executive Committee from twenty percent (20%) of the Members of the Chair's Department who are eligible to vote. Removal may occur for any valid cause including, but not limited to, failure to carry out the duties of the office. Such removal may be effected by a two-thirds vote of the Executive Committee Members or by a two-thirds vote of the Department Members eligible to vote on Departmental matters. All voting shall be conducted by written secret mail ballot, as defined in these Bylaws, 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 returned no later than 21 days after they are mailed and shall be counted by the President and Secretary-Treasurer. No removal shall be effective unless and until it is ratified by the Executive Committee.

8.8 VACANCIES

All vacancies in office, other than that of President, shall be filled by the Executive Committee, except as defined in 8.3.3.c of these Bylaws. If there is a vacancy in the office of President, the President-Elect shall serve out the remaining term and shall then serve as President for the following term. If there is a vacancy in the office of President-Elect, a special election shall be held to fill that office within 60 days of the vacancy occurring on or before the end of the Medical Staff Year. Preceding the special election, the Nominating Committee shall be called into special session for the purpose of presenting to the Medical Staff a slate of candidate(s) for the vacant office.

A vacancy in the office of immediate Past President need not be filled, except that the Executive Committee may appoint qualified successors to serve as the Chair of, or as a Member of, any committee that the immediate Past President is automatically appointed to pursuant to these Bylaws.

8.9 DUTIES OF GENERAL OFFICERS

8.9.1 PRESIDENT

The President shall serve as the Chief Executive Officer of the Medical Staff. The duties of the President shall include, but not be limited to:

Act in coordination and cooperation with the President of the Hospital on all matters of mutual concern within the Hospital;

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

Serve as Chair of the Medical Executive Committee;

Serve as an Ex-Officio Member of all other staff committees, with vote, with the exception of the Nominating Committee;

Be responsible for the enforcement of these Bylaws and Rules and Regulations, 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;
Appoint committee Chairs to all standing and special Medical Staff committees, except where otherwise provided by these Bylaws or by the Medical Staff Rules and Regulations;

Serve as a Member of the Board of Trustees and be responsible for the Medical Staff agenda at the meetings of the Board. This agenda may represent the views, policies, needs, and grievances of the Medical Staff to the Board of Trustees and to the President of the Hospital;
Interpret the policies of the Board of Trustees to the Medical Staff;

Be a spokesperson for the Medical Staff in external professional and public relations;

Be accountable to and advise the Board, in conjunction with the Executive Committee, for the quality and efficiency of clinical care and performance within the Hospital, and for the effectiveness of the patient care evaluation and other quality review, evaluation. and

monitoring functions delegated to the Staff by means of regular reports and recommendations based on the results of these activities;

Develop and implement, in cooperation with Department Chairs, methods for patient care evaluations, on-going monitoring of practice, improvement of care, credentials review, delineation of privileges and specific services, continuing education, and utilization review;
Perform such other functions as may be assigned to him by these Bylaws, by the membership, by the Executive Committee, by the Board of Trustees, or as required by JOINT COMMISSION or the Medicare Conditions of Participation.

8.9.2 PRESIDENT-ELECT

The President-Elect shall be a Member of the Medical Staff and shall serve as Chairman of the Quality Management Committee and as a member of Executive Committee with voting privileges.

The President-Elect shall accept the responsibilities of membership on the Board of Trustees for three (3) years. The President-Elect shall serve as Ex-Officio Member of all other committees without vote except the Nominating Committee, on which the President-Elect shall not serve. The President-Elect shall be elevated to the office of President following the term as President-Elect. The President-Elect shall serve in the absence of the President, and shall automatically assume all duties and authority of the President when the latter fails to serve for any reason.

8.9.3 IMMEDIATE PAST PRESIDENT

The immediate Past President shall be a Member of the Executive Committee, perform such other supervisory duties as may be assigned by the President, and carry out such other functions as may be delegated by these Bylaws, by the membership, by the Executive Committee, or by the Board of Trustees.

8.9.4 SECRETARY-TREASURER

The Secretary-Treasurer shall be a Member of the Executive Committee, and shall ensure the following: a roster of Members is maintained; complete minutes of all Executive Committee and Medical Staff meetings are kept; meetings on the order of the President are called; all correspondence is attended to, received, and safeguarded; accountability for all funds to the Medical Staff, and presentation of a report on same at the quarterly Staff meeting; prepare an annual budget with assistance of the Medical Staff President for review and approval by the Executive Committee; absences are excused from meetings on behalf of the Executive Committee; and other such duties as ordinarily pertain to this office or as may be assigned.

8.10 DUTIES OF DEPARTMENT OFFICERS

Each Department Chair shall have the following authority, duties, and responsibilities, and the Vice-Chair, in the absence of the Chair, shall assume all of them and shall otherwise perform such duties as may be assigned:

Be accountable to the Executive Committee and to the President of the Medical Staff for all professional and administrative activities within the Department, and particularly for the continuous assessment and improvement of quality of patient care, treatment and services rendered by Members of the Department, and for the effective conduct of quality assurance assessments, Ongoing Professional Practice Evaluation, (OPPE) and other quality review, evaluation, and monitoring functions delegated to the Department by the Medical Executive Committee in coordination and integration with organization-wide quality assessment and improvement activities;

Develop, implement and maintain Departmental programs in cooperation with the President of the Medical Staff, for retrospective patient care review, monitoring of patient care, credential review, privileges delineation, continuing medical education (CME), orientation, utilization review and quality assessment and improvement;

Be a Member of the Executive Committee, give guidance on the overall medical policies of the Hospital, and make specific recommendations and suggestions regarding the Department;
Maintain continuing review of the professional performance of all Practitioners with clinical privileges in the Department and report thereon to the Executive Committee;

Transmit to the appropriate authorities the Department's recommendations concerning appointment and classification, completion of preceptoring requirements, reappointment, criteria for clinical privileges, delineation of clinical privileges, and corrective action with respect to practitioners, both dependent and independent in the Department;

Enforce the Hospital and Medical Staff Bylaws, Rules and Regulations, and policies within the Department, including initiation of corrective action, investigation of clinical performance, and ordering of consultations to be provided or sought when necessary;

Implement within the Department actions taken by the Executive Committee and the Board of Trustees;

Participate in every phase of administration of the Department through cooperation with the nursing service and the Hospital administration in matters affecting patient care, including personnel, supplies, special regulations, standing orders, techniques, and the approval and monitoring of contracted patient care services;

Assist in the preparation of such annual reports, including budgetary planning, pertaining to the Department as may be required by the Executive Committee or the Board of Trustees;

Review the evaluation of medical records, or a representative sample, to determine whether they: (1) properly describe the condition, diagnosis and progress of the patient during hospitalization and at the time of discharge; the treatment and tests provided and the results thereof; and adequate identification of individuals responsible for orders given and treatment rendered; and (2) are sufficiently complete at all times to facilitate continuity of care and communications between individuals providing patient care services in the Hospital;

Recommending space and other resources needed by the department or service;

Assess and recommend to the Board of Trustees off-site resources for needed patient care, treatment, and services not provided by the department or the hospital;

Integrate the department or service into the primary functions of the hospital, and coordinate and integrate interdepartmental and intradepartmental services;

Develop and implement departmental policies and procedures that guide and support the provision of care, treatment, and services in the department.

Perform such other duties commensurate with the office as may from time to time be reasonably requested by the President of the Medical Staff or the Executive Committee or as required by (THE) JOINT COMMISSION Standard MS 01.01.01., Elements of Performance or the Conditions of Participation for Medicare.

8.11 DIVISION CHIEFS

8.11.1 QUALIFICATIONS

Each Division Chief shall be a Member of the active Medical Staff, a Member of the Clinical Service Committee of the Department, and a Member of the division; shall be qualified by training, experience, interest, maintain Board Certification in their specific specialty and demonstrated current ability in the clinical area covered by the division; and shall be willing and able to discharge the administrative responsibilities of the office.

8.11.2 SELECTION

Candidates interested in serving as Division Chief shall submit a signed, written statement to the Medical Staff Office no later than the second Friday in September.

If there are no candidates for Division Chair received by the due date, the President-Elect may appoint individuals for those vacant positions after the fourth Tuesday in September.
If only one candidate statement for Division Chair is received, that person will be announced at the next Division meeting.

If there is more than one candidate for Division Chair, ballots will be mailed to all active Division Members for their respective elections, on the first Tuesday in October, with ballots to be returned no later than the third Tuesday in October.

8.11.3 TERM OF OFFICE

Each Division Chief shall serve a one (1) year term, commencing on the first day of the Medical Staff year following the election. The Division Chief shall serve unless the Division Chief resigns or is removed from office. A Division Chief may be removed by the President of the Medical Staff in consultation with the Department Chair for failure to fulfill the responsibilities of the position.

8.11.4 DUTIES

Each division chief shall:
Account to the Department Chair for the effective operation of the division;

Develop and implement, in cooperation with the Department Chair, programs to carry out the quality review, evaluation, and monitoring functions assigned to the division;

Exercise general supervision over all clinical work performed within the division;

Conduct investigations and submit reports and recommendations to the Department Chair regarding the clinical privileges to be exercised within the division by Members of, or applicants to, the Medical Staff;

Act as Presiding Officer at all division meetings;

Perform such other duties commensurate with the office as may, from time to time, be reasonably requested by the Department Chair, the President of the Medical Staff, or the Executive Committee, or as required by Joint Commission or the Conditions of Participation for Medicare.

8.12 MEDICAL DIRECTORS

8.12.1 QUALIFICATIONS

Each Medical Director contracted by the Hospital shall be an applicant or Member of the Medical Staff, qualified by training, experience, interest, and demonstrated current ability in the designated area, and shall be willing and able to discharge the administrative responsibilities of the office.

8.12.2 SELECTION

Each Medical Director shall be contracted by the Hospital subject to input from relevant medical committees. Prior to the contracting of a Medical Director, administration shall provide a job description to the Executive Committee.

8.12.3 TERM OF OFFICE

Each Medical Director shall serve a term as stipulated in the contract with the Hospital. The Executive Committee shall provide administration with a yearly evaluation of the Medical Director's performance.

8.12.4 DUTIES

Each Medical Director shall:

Meet the basic responsibilities of Staff membership as outlined in Article II, Section 2.5;

Fulfill those responsibilities outlined in the job description;

Be accountable to the Medical Executive Committee for effective performance of the Medical Director's responsibilities.

Each Medical Director shall not:

Supersede the duties of the Department or Division Chair described in Article VIII, Section 8.10 and 8.11.4.

ARTICLE IX
CLINICAL SERVICE COMMITTEES

9.1 ORGANIZATION OF SERVICES

The Clinical Service Committees of the Medical Staff shall be the Medicine, Surgery, Obstetrics and Gynecology, Pediatrics, Emergency Medicine, Family Medicine, and Anesthesia and Radiology. Other services may be added at the discretion of the Executive Committee, as may be deemed necessary. For the purpose of granting and review of clinical privileges, Pathology, Dentistry, and Podiatry shall be regarded as part of the Surgery service; and Psychiatry, Psychology, and Neurology shall be regarded as part of the Medicine service.

9.1.1 COMPOSITION

Each Department established pursuant to Article XI shall be governed by a Clinical Service Committee consisting of no less than eight (8) Members of the active Medical Staff. The Chair of the Clinical Service Committee shall be the Department Chair elected pursuant to Article VIII. Clinical Service Committee Members shall be appointed by the service committee Chair with the President of the Medical Staff. No one may serve as either Chair or vice Chair of more than one Clinical Service Committee simultaneously. To ensure continuity, the Chair of the Clinical Service Committee shall serve on that committee for the year following serving as Chair.

9.1.2 ELIGIBILITY AND TENURE

The Clinical Service Committee Members shall be active Members. Clinical Service Committee Chairs and Vice Chairs shall have demonstrated interest in Medical Staff affairs and shall have had previous Clinical Service Committee experience. Members of the Clinical Service Committees shall continue to serve until their successors have been duly selected.

9.1.3 MEETINGS

The Clinical Service Committees shall meet no less than quarterly. Any Member of the Medical Staff may attend meetings of a Clinical Service Committee as a guest at the discretion of the Chair. Emergency sessions of the Clinical Service Committees may be called by the Chairs or shall be called by the Chair on petition of three (3) committee Members. Notice of emergency sessions shall be distributed no less than 72 hours prior to the session. Such notification shall be by personal telephone call or by mail.

9.1.4 MINUTES

The Clinical Service Committees shall maintain permanent minutes of all meetings signed by the Chair at the earliest opportunity and approved at the next meeting.

9.1.5 DUTIES

It shall be the duty of the Chairs of the Departments to serve as Chairs of their respective Clinical Service Committees and to be responsible for consulting with other Members and with Hospital administration concerning matters of policy and practice on their respective services. The duties of the committees shall be:

To have primary jurisdiction over, and be responsible for, all qualitative and quantitative aspects of patient care rendered on their services;

To conduct quality assurance monitoring for the purpose of analyzing and evaluating the quality of care and appropriateness of treatment provided to patients within the Department in accordance with such procedures as may be adopted by the Quality Management Committee;
To recommend rules and regulations not inconsistent herewith for administration of their services;

To identify actions that should be taken in order to resolve identified problems in patient care and clinical performance, and evaluate the effectiveness of action which has been taken in resolving such problems;

To submit written reports to the Executive Committee concerning (1) findings of the committee's review, evaluation, and monitoring activities; and (2) recommendations for maintaining and improving the quality of care provided;

To communicate to Department Members the findings, conclusions, recommendations, and actions taken regarding review, evaluation, and monitoring activities;

To make recommendations for the commencement of disciplinary actions for deficient professional care on their services;

To make recommendations to the Executive Committee with respect to the granting of clinical privileges or limitations thereof for Members practicing on the services;

To review clinical privileges on the service at least every two years. In the event of recommendation for denial or limitation of privileges, the Member involved shall have an opportunity for interview with the appropriate Clinical Service Committee. This interview shall be conducted in the manner outlined in Section 4.5.6 before the recommendation is forwarded to the Executive Committee;

To review nursing policies and procedures that affect their respective service; and

To perform such other duties as may be assigned by the Executive Committee, or as required by JOINT COMMISSION or Medicare Conditions of Participation.

9.1.6 QUORUM

Fifty percent (50%) of the membership shall constitute a quorum.

9.1.7 REPORT

The Clinical Service Committees shall report to the Executive Committee.

9.1.8 ATTENDANCE

All committee Members shall be required to attend no less than fifty percent (50%) of the regular meetings of their respective Clinical Service Committee. If any Member is absent for more than 50% of the regular meetings or if any Member has more than two consecutive unexcused absences from a regularly scheduled committee meeting, the committee Chair shall select a replacement for such Member.

ARTICLE X
STANDING COMMITTEES

10.1 DESIGNATION

The committees described in this Article shall be the standing committees of the Medical Staff. Special or ad hoc committees may be created by the Executive Committee to perform specified tasks. Unless otherwise specified, the Chair shall be appointed by, and may be removed by, the President of the Medical Staff. All committee and subcommittee Chairs must be Members of the active staff. Medical Staff committees shall be responsible to the Executive Committee, unless otherwise specified.

10.2 GENERAL PROVISIONS

10.2.1 TERMS OF COMMITTEE MEMBERSHIP

Unless otherwise specified, committee Members shall be appointed for a term of one year and shall serve until the end of this period or until the Member's successor is appointed, unless the Member shall sooner resign or be removed from the committee.

10.2.2 REMOVAL

If a Member of a committee ceases to be a Member in good standing of the Medical Staff, or loses employment or a contract relationship with the Hospital, suffers a loss or significant limitation of clinical privileges, or if any other good cause exists, that Member may be removed by the President of the Medical Staff.

10.2.3 VACANCIES

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

10.3 GENERAL COMMITTEE REQUIREMENTS

10.3.1 REGULAR MEETINGS

Committees, by resolution, may provide the time for holding regular meetings and no notice other than such resolution shall then be required.

10.3.2 SPECIAL MEETINGS

A special meeting of any committee may be called by, or at the request of, the Chair thereof, the Executive Committee, or the President of the Medical Staff.

10.3.3 NOTICE OF MEETINGS

Written notice stating the place, day, and hour of any regular or special committee meeting not held pursuant to resolution shall be delivered by mail or telephone to each person entitled to be present thereat not less than seventy two (72) hours nor more than twenty (20)days before the date of such meeting.

10.3.4 QUORUM

A quorum for the Credentials Committee, Executive Committee, and Nominating Committee shall consist of fifty percent (50%) of the voting Members. A quorum for other standing committees shall be the voting Members in attendance, with a minimum of three (3).

10.3.5 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 so 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. Action may be taken without a meeting by a writing setting forth the action so taken signed by each Member entitled to vote.

10.3.6 MINUTES

Minutes of all meetings shall be prepared and shall include a record of attendance of Members and the vote taken on each matter. The minutes shall be signed by the Chair or his designee, approved by all Members at the following meeting, and forwarded to the Executive Committee. Each committee shall maintain a permanent file of the minutes of each meeting.

10.3.7 ATTENDANCE REQUIREMENTS

Unless excused for good cause, failure to attend may be grounds for removal from such committee, upon request by the committee Chair.

10.4 BIOETHICS COMMITTEE

10.4.1 COMPOSITION

The Bioethics Committee shall consist of physicians and such other Members as the medical executive committee may deem appropriate. It may include nurses, lay representatives, social workers, clergy, ethicists, attorneys, administrators, and representatives from the Board of Trustees, although a majority shall be physician Members of the Medical Staff. All members of the Bioethics Committee, regardless of profession, shall be entitled to vote.

10.4.2 DUTIES

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

10.4.3 MEETINGS

The Bioethics Committee shall meet as often as necessary at the call of its Chair.

10.4.4 REPORT

The Bioethics Committee shall report to the Executive Committee.

10.5 BYLAWS COMMITTEE

10.5.1 COMPOSITION

The Bylaws Committee shall consist of at least three (3) Member.

10.5.2 DUTIES

The duties of the Bylaws Committee shall be to:

Prepare such revisions or amendments of these Bylaws and Rules and Regulations as may be directed by the Medical Staff; and

Conduct an annual review of these Bylaws and Rules and Regulations, as well as procedures and the forms promulgated in connection therewith.

10.5.3 MEETINGS

The Bylaws Committee shall meet as necessary.

10.5.4 REPORT

The Bylaws Committee shall report to the Executive Committee as necessary.

10.6 CANCER COMMITTEE

10.6.1 COMPOSITION

The Cancer Committee shall include one physician representing each of the diagnostic and treatment services; diagnostic radiologist, pathologist, surgeon, medical oncologist, radiation oncologist, Cancer Liaison Physician (CLP may also fulfill a leadership position within the Cancer Committee). Each required member shall be required to attend at least seventy-five percent (75%) of the Cancer Committee meetings or as set-forth by the Cancer Program Standards. Each required member may designate an alternate member at the beginning of each year.

Additional members of the Medical Staff, including other medical oncologists, radiation oncologists, and other specialists shall be appointed as members of the Cancer Committee by the chairman annually.

The Cancer Liaison Physician shall be appointed by the committee and shall serve a three-year term. The CLP is eligible for an unlimited number of terms based on performance and evaluation through the Survey Application Record.

All physicians are voting members.

Required non-physician members are as follows: cancer program administrator, oncology nurse, social worker or case manager, certified tumor registrar, performance improvement or quality management representative, and a genetic counselor if services are available on-site. The non-physician members shall serve as non-voting members. The Cancer Committee may appoint consultants/alternative members to the Committee as may be necessary or helpful to its proper functioning.

The Chairman of the Cancer Committee shall be appointed by the incoming President of the Medical Staff annually.

10.6.2 DUTIES

The Cancer Committee shall:

Appoint a vice-chairman annually to serve in the absence of the chairman;

Designate one coordinator for each of the specified areas of cancer program activities; cancer conference, quality of cancer registry data, quality improvement, and community outreach;

Establish and monitor cancer program goals;

Oversee cancer conference activities;

Monitor compliance with the Commission on Cancer's Cancer Program Standards.

10.6.3 MEETINGS

The Cancer Committee shall meet no less than quarterly.

10.6.4 REPORT

The Cancer Committee shall report to the Executive Committee at least annually.

10.7 CONTINUING MEDICAL EDUCATION COMMITTEE

10.7.1 COMPOSITION

The Continuing Medical Education Committee shall consist of no less than five (5) Members, including the Chair appointed by the President of the Medical Staff. The Chair shall serve for two (2) consecutive years. The CME Chairman shall also serve as a member of the Quality Management Committee. One Member shall be selected from each Service Committee by the Chair of that committee with the approval of both the President of the Medical Staff and the Chair of the Continuing Medical Education Committee. Additional Members may be appointed at the discretion of the Chair of the Continuing Medical Education Committee with approval of the President of the Medical Staff. The Committee Members shall serve staggered terms, in order to assure continuity. Representatives of administration and appropriate Hospital Department representatives shall serve as Ex-Officio Members without voting privileges.

10.7.2 DUTIES

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

Establish medical education goals and objectives in accordance with the Mission Statement of the CME Program for the Medical Staff;

Develop medical education programs based on the results and recommendations of Clinical Service Committee quality assurance activities as to the quality of medical care rendered on the respective service, working with each Department to develop such programs;

Coordinate, plan, and evaluate the medical educational materials available in the Hospital;

Plan, evaluate, and coordinate Medical Staff educational activities and programs within the Hospital or jointly with other hospitals;

Enlist and promote the involvement of the Medical Staff in all educational activities within the Hospital;

Document Medical Staff educational activities through the Medical Staff office for accrediting agency review; and

Prepare and submit an annual budget for Medical Staff educational activities and materials in the Hospital.

10.7.3 MEETINGS

The Continuing Medical Education Committee shall meet no less than quarterly.

10.7.4 REPORT

The Continuing Medical Education Committee shall present reports of each meeting to the Medical Staff through the Executive Committee.

10.8 CREDENTIALS COMMITTEE

10.8.1 COMPOSITION

The Credentials Committee shall consist of not less than five (5) members of the Active_Medical Staff. Members are to include the President-Elect, Immediate Past President and three (3) others who will be appointed by the President of the Medical Staff. The Immediate Past President shall serve as the Chairman of the Credentials Committee. Members of the Credentials Committee shall serve for a term of one (1) year; members may serve additional terms if so appointed.

10.8.2 DUTIES

The Credentials Committee, or its Chair acting on its behalf, shall:

Review and evaluate the qualifications of each Practitioner applying for initial appointment and reappointment; and, in connection therewith, make recommendations to the appropriate service Chair;

Investigate, review and report on matters regarding the qualifications, conduct, professional character or competence;

Review all information available regarding competence of Members and make recommendations to the Clinical Service Committees; and

10.8.3 MEETINGS

The Credentials Committee shall meet as often as necessary, but at least bi-annually.

10.9. PHYSICIANS WELL-BEING COMMITTEE

10.9.1 COMPOSITION

The Medical Staff Well-Being Committee shall consist of five (5) Members of the Medical Staff. The Medical Staff President shall appoint one Member each year to a term of three (3) years and as many additional members as needed to one (1) year terms. The members appointed for a three-year term shall serve as chairman during their third year. If no member

is in his or her third year, the medical Staff President shall appoint a member to serve as chairman. To the extent possible, Members of this committee shall not serve concurrently on another committee which has review authority over members of the Medical Staff. In no event shall such committee member participate in the review of a Member who has been referred by another committee.

10.9.2 DUTIES

The duties of the Medical Staff Well-Being Committee shall be to:

Review issues referred to them by the President of the Medical Staff or Executive Committee of the Medical Staff against any Medical Staff Member which deals with disruptive physician and/or licensed independent practitioner behavior, sexual harassment, hostile work environment, ethical care, or any practice or activity that relates to a Member of the Medical Staff, but does not directly involve the quality of medical care rendered. The Committee may deal directly with the physician and/or licensed independent practitioner involved. If it is felt disciplinary action is needed, the Committee will furnish its recommendation to the Executive Committee;

Receive reports related to the health, well-being, or impairment of Medical Staff Members and, as it deems appropriate, investigate such reports. The Committee shall not actively search out instances of impairment. Its investigations shall be confidential, and it will respond and make recommendations only to the referral source as indicated in paragraph (a) above and to the physician and/or licensed independent practitioner in question. All contacts with the Committee will be confidential to the degree protected by law;

Provide advice and recommendations, including education for the physician in question. The Committee shall not provide treatment for a physician but shall refer to appropriate sources for treatment. The Committee shall be concerned primarily with the needs of the physician in questions. However, in the event the information received by the committee demonstrates that the health or known impairment of a Member poses a risk of harm to Hospitalized patients, hospital staff and/or other physicians and/or licensed independent practitioners that information shall be referred for corrective action. The President of the Medical Staff shall be advised of any significant discussions. The Committee shall have no authority to take disciplinary action; and

Educate its members and Members of the Medical Staff with regards to physician and/or licensed independent practitioner health, well-being, interaction with the hospital staff and recognition of impairment, and appropriate responses to different levels and kinds of distress and impairment, and about appropriate resources for prevention, treatment, and rehabilitation of the impaired physician and/or licensed independent practitioner. They shall develop an appropriate relationship with the Medical Board of California (MBOC) Diversion and Enforcement Programs. They shall be able to facilitate assistance and referral for Physicians and/or licensed independent practitioner identified in need of stress reduction techniques, coping skills, and resources available to physicians and/or licensed independent practitioners such as the crisis intervention and professional counseling program provided by outside services.

10.9.3 MEETINGS

The Committee shall meet as often as needed, with quarterly reports submitted to the MEC.

10.9.4 MINUTES

As with any Medical Staff committee, all records should be kept confidential. General activities of the Committee (e.g., educational functions) may become part of the general Medical Staff records. However, any record regarding an individual physician and/or licensed independent practitioner to whom assistance is provided should be kept separately, not circulated with other Medical Staff records, and maintained absolutely confidential.

10.9.5 REPORT

The Committee shall report on its activities as often as necessary, but at least quarterly, to the Executive Committee and Board of Trustees.

10.10 MEDICAL EXECUTIVE COMMITTEE

10.10.1 COMPOSITION

The Executive Committee shall consist of the following persons:

The officers of the Medical Staff;

The Department Chairs;

The Credentials Committee Chair;

Three at-large physician Members of the active Medical Staff who shall have been elected according to Article VIII of these Bylaws. One Member shall be elected each year to a three (3) year term; and

The CEO or, in his absence, his Representative as non-voting members.
The Medical Director of Quality shall be an ex-officio member without voting privileges.

At the discretion of the Chair, any Member of the Medical Staff may attend Medical Executive Committee meetings as a guest.

10.10.2 DUTIES

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

Representing and acting on behalf of the Medical Staff in the intervals between Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws;

Coordinating and implementing the professional and organizational activities and policies of the Medical Staff;

Receiving and acting upon reports and recommendations from Medical Staff Departments, divisions, committees, and assigned activity groups;

Recommending action to the Board of Trustees on matters of a medical-administrative nature;

Establishing the structure of the Medical Staff, the mechanism to review credentials and delineate individual clinical privileges, the organization of quality assurance activities and mechanisms of the Medical Staff, termination of Staff membership and fair hearing procedures, as well as other matters relevant to the operation of an organized Medical Staff;

Evaluating the medical care rendered to patients in the Hospital;

Participating in the development of all Medical Staff policy, practice, and planning, participating in developing Hospital policies that affect patient care or the discharge of Medical Staff responsibilities; working with the Board of Trustees to resolve any disputes that may arise regarding the propriety of any policy that affects patient care or the discharge of Medical Staff responsibilities that the Board of Trustees is considering or has approved;

Reviewing the qualifications, credentials, performance, and professional competence and character of applicants and Members, and making recommendations to the Board of Trustees regarding staff appointments and reappointments, assignments to Departments, clinical privileges, and corrective action;

Taking 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;

Taking steps to develop continuing education activities and programs for the Medical Staff;

Designating such committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the Medical Staff and approving or rejecting appointments to those committees by the President of the Medical Staff;

Reporting to the Medical Staff at each regular staff meeting the outcome of the Medical Staff quality improvement programs with sufficient background and detail to ensure that quality of care is consistent with professional standards;

Assisting in the obtaining and maintaining of Hospital accreditation;

Appointing such special or ad hoc committees as may seem necessary or appropriate to assist the Executive Committee in carrying out its functions and those of the Medical Staff;

Reviewing the quality and appropriateness of services provided by contract physicians;

Reviewing and approving the designation of the Hospital's authorized representative for National Practitioner Data Bank purposes;

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

Implementing, enforcing and safeguarding the self-governance rights of the medical staff pursuant to Business and Professions Code Section 2282.5;

Taking such steps as appropriate to meet and confer in good faith to resolve disputes with the Board of Trustees, or any other person, or entity, regarding any self-governance rights of the Medical Staff.

Performing or delegating to an appropriate committee, the following patient safety functions:

Review and approve the hospital's patient safety plan, and review and revise the plan at least once a year, or more often as necessary to incorporate advancements in patient safety practices;

Receive and review reports of patient safety events, including but not limited to all adverse events or potential adverse events that are determined to be preventable (as defined by state law), and health care associated infections (as defined)by the Centers for Disease Control and Prevention's National Healthcare Safety Network);

Monitor implementation of corrective action for patient safety events;

Make recommendations to eliminate future patient safety events;

Conducting an annual review of all in-house Medical Director positions with input from the appropriate service committee whose Chair shall be invited to participate when the review is conducted;

Reviewing nursing polices.

Assisting the Hospital and the President of the Medical Staff to ensure Medical Staff compliance with:

The Medical Staff Bylaws and Rules and Regulations;

The Hospital's Bylaws, Rules and Regulations and policies;

State and Federal laws and regulations; and

Joint Commission accreditation requirements.

10.10.3. ASSISTANCE WITH FUNCTIONS

Whenever these Bylaws require that a function be performed by, or that a report or recommendation be submitted to:

A Medical Staff committee, but no such committee exists, the Executive Committee shall perform such function or receive such report or recommendation, or shall assign the functions of such committee to a new or existing committee of the Staff or to the Staff as a whole;

The Executive Committee, but a standing or special committee has been formed to perform the function, the committee so formed shall act in accordance with the authority delegated to it and report to the Executive Committee.

10.10.4 MEETINGS

The Executive Committee shall meet as often as necessary, but not less than quarterly, and shall maintain a record of its proceedings and actions.

10.11 INSTITUTIONAL REVIEW BOARD

10.11.1 COMPOSITION

The Institutional Review Board (IRB) shall be composed of at least five (5) Members with varying backgrounds, to promote complete and adequate review of research activities commonly conducted by the Hospital. Membership shall be sufficiently qualified through experience, expertise, and diversity of backgrounds (including consideration of the racial and cultural backgrounds), and sensitivity to such issues as community attitudes, in order to promote respect of its advice and counsel in safeguarding the rights and welfare of human subjects. The Chair and Members shall be appointed by the President of the Medical Staff. All members of the IRB, regardless of profession, shall be entitled to vote.
Membership shall:

Include at least one Member whose primary concern is in non-scientific areas (e.g., lawyer, ethicist, clergy); and

Include at least one Member who is not otherwise affiliated with the Hospital or part of the immediate family of a person affiliated with the Hospital.

The curriculum vitae of each Member shall be maintained to describe the Member's anticipated contribution to deliberations and any employment relationship with the Hospital.

The IRB may invite individuals with competence in special areas to assist in the review of complex issues which require expertise beyond or in addition to that available on the IRB.

10.11.2 DUTIES

The IRB shall review all biomedical and behavioral research (i.e., experimental or investigational drugs) involving human subjects conducted at or sponsored by the Hospital in order to protect the rights of the human subjects of such research. Reviews are conducted objectively and in a manner to ensure the exercise of independent judgment of the Members. Members are excluded from review of protocols or research activities in which they have an active role, or when a conflict of interest exists.

The IRB shall maintain appropriate records of review of applications and active protocols, or documentation of informed consent, and of other documentation that may pertain to the selection, participation, and protection of subjects, as well as, reviews of circumstances that adversely affect the rights or welfare of individual subjects.

The IRB has the authority to approve, require modifications in (to secure approval), or disapprove research protocols.

The IRB shall develop policies and/or procedures for the duties as noted.

10.11.3 MEETINGS

The IRB shall meet as often as necessary at the call of its Chair.

10.11.4 REPORT

The IRB shall report to the Executive Committee.

10.12 INTERDISCIPLINARY PRACTICE COMMITTEE

10.12.1 COMPOSITION

The Interdisciplinary Practice Committee shall consist of, at a minimum, the vice president of nursing, the President of the Hospital or designee, registered nurses appointed by the vice president of nursing, and an equal number of physicians appointed by the President of the Medical Staff. Licensed or certified health professionals, other than registered nurses, who perform functions requiring standardized procedures shall be included in the committee as shall a representative of each approved category of independent Allied Health Professional (Optometrists). The Chair shall be a physician Member of the active Staff appointed by the President of the Medical Staff. Only physician Members may vote except that, in accordance with Title 22, registered nurse members may vote on standardized procedures only.

10.12.2 DUTIES

The Interdisciplinary Practice Committee identifies initiates, approves, implements, and administers standardized procedures pursuant to Section 2725 of the Business and Professions Code for the employed registered nurse and the non-employed registered nurse at San Antonio Regional Hospital. The Committee reviews the credentials of all who function under standardized procedures and all Members of the Allied Health Professional staff in the categories approved by the Board of Trustees and listed in the Rules and Regulations of the Allied Health Professional staff.

The Interdisciplinary Practice Committee is responsible for the development of specific privileges, and rules and regulations to govern the approved categories, in conjunction with the appropriate service committee having jurisdiction over the category.

10.12.3 MEETINGS

The Interdisciplinary Practice Committee shall meet on an as needed basis but not less than annually.

10.12.4 REPORT

The Interdisciplinary Practice Committee shall forward applications of Allied Health Professionals recommended for membership to the appropriate service committee for approval. They shall report to the Executive Committee as necessary.

10.13 NOMINATING COMMITTEE

10.13.1. COMPOSITION

The Nominating Committee shall consist of five elected Staff Members and the two Past Presidents, with the most recent Past President serving as Chair of this committee.

10.13.2 DUTIES

The duties of the Nominating Committee shall be to:

Select one or more candidates for the offices of President-Elect, Secretary-Treasurer, and one Member of the Executive Committee who shall serve three (3) years. In addition, one nominee shall be nominated from the Credentials Committee for a three-year position. Members of the Nominating Committee are not eligible for office;

Present to the Medical Staff the slate of suggested candidates at the September Medical Staff meeting; and

Select a slate of candidates for any special elections as required by these Bylaws.

10.13.3 MEETINGS

The Nominating Committee shall meet as necessary to perform its duties.

10.13.4 REPORT

The Nominating Committee shall report directly to the Medical Staff.

10.14 PHARMACY AND THERAPEUTICS COMMITTEE

10.14.1 COMPOSITION

The President-Elect shall serve as the Chairman of the Pharmacy and Therapeutics Committee. The committee shall consist of a representative of at least the following clinical Departments as appointed by the Chairman of the Clinical Department: Anesthesiology, Emergency Medicine, Medicine, Pediatrics, and Surgery. Additional members shall include the Director of Pharmacy, Vice President of Nursing (or designee), Hospital administrator (or designee), representative from quality management, and other appropriate clinical Hospital departments. All members as noted shall have voting authority.

10.14.2. DUTIES

The Pharmacy and Therapeutics Committee is responsible for:

Development, ongoing review, and annual approval of policies regarding the selection and procurement, storage, ordering, and transcribing, preparation and dispensing, safety procedures, administration, monitoring and all other matters relating to drugs and diagnostic testing materials in the Hospital;

Advising the professional Staff on matters pertaining to the choice of available drugs;
Defining and evaluate all significant untoward drug reactions and medication errors;
Making recommendations and annual approval of the drugs to be stocked throughout the Hospital;

Evaluation and approval of all standardized drug procedures and pre-printed (standardized) drug orders;

Developing, maintaining, and annual approval of a current drug formulary for use in the Hospital. Determine the medications on the formulary considered to be high-risk. Review and approve the high-risk list annually;

Annual approval of Therapeutic Interchanges;

Coordinating and conducting medication usage evaluation (MUE) activities and ongoing review of data related to medication use evaluation studies;

Reviewing instances where drug product defects have been identified or where medications have been recalled by their manufacturer;

Review of the Institute for Safe Medication Practices (ISMP) Alerts and Quarterly Action Agenda to determine potential applicability to the hospital.

10.14.3 MEETINGS

The Pharmacy and Therapeutics Committee shall meet at least quarterly.

10.14.4 REPORTING

The Pharmacy and Therapeutics Committee shall report directly to the Medical Executive Committee. Medication safety related issues shall be reported to Quality Management Committee.

10.15 QUALITY MANAGEMENT COMMITTEE

10.15.1 COMPOSITION

The President-Elect shall serve as the Chairman of Quality Management Committee. The Quality Management Committee shall consist of a representative of each clinical Department, and the Chair of Continuing Medical Education Committee. The Physician Advisor of Case Management, the Medical Director of Quality and representatives from administration, quality management, and appropriate Hospital Departments shall serve as non-voting Members.

10.15.2 DUTIES

The duties of the Quality Management Committee shall be to (in addition to other established duties):

Recommend for approval of the Medical Executive Committee plans for maintaining quality patient care within the Hospital, reduce medical errors and hazardous conditions, establish systems to identify problems in patient care, select key processes for quality monitoring, set priorities for action on problem correction, refer priority problems for assessment and corrective action to appropriate Clinical Service Committees, and coordinate quality assurance activities throughout the hospital and monitor and evaluate the quality of patient care.

Coordinate medical records monitoring functions, including:

Quarterly review and evaluation of a representative sample of medical records for completeness, accuracy, clinical pertinence, and timely completion of information. Such reports shall be referred to the appropriate Clinical Service Committee(s) for assessment and action as necessary; and

Review and make recommendations for Medical Staff and Hospital policies and Rules and Regulations relating to medical records, including completion, forms, filing, indexing, storage, destruction, availability, and methods of enforcement.

Coordinate the tissue and transfusion monitoring functions, including:

Quarterly review and evaluation of processes related to the use of surgical and other invasive procedures, including selecting appropriate procedures, preparing the patient for the procedure, performing the procedure and monitoring the patient, and providing post-procedure care. Such reports shall be referred to the appropriate Clinical Service Committee(s) for assessment and action as necessary; and

Quarterly review and evaluation of processes related to the use of blood and blood components, including ordering, distributing, handling, dispensing, administration, and monitoring the blood and blood components' effect on patients. Such reports shall be referred to the appropriate Clinical Service Committee(s) for assessment and action as necessary.

Coordinate the risk management functions, including:

Periodic review of all claims activity or actual or threatened suits pertaining to patient care; refer identified problems concerning appropriateness, quality, and safety of patient care to appropriate committees for further action; identify potential risks; develop criteria for identifying cases with potential risk and evaluation of these cases; assure follow-up so that identified problems are resolved in a reasonable length of time; design programs to reduce clinical risk.

Coordinate the Utilization Management functions including:

Identify and analyze factors contributing to over-utilization and under utilization; make recommendations regarding identified utilization problems; review activities of non-physician reviewers and the Medical Director of Care Management; assure coordination of continuous and ongoing monitoring of medical care.

Coordinate the Surveillance, Prevention, and Control of Infection functions including:

Quarterly review and evaluation of processes related to the Surveillance, Prevention, and Control of Infection. Such reports shall be referred to the appropriate Clinical Service Committee(s) for assessment and action as necessary.

Appoint a medical staff representative to sit on the Surveillance, Prevention, & Control of Infection Functional Team.

Coordination of the Patient Safety Program as described in the Patient Safety Plan including:

i. The establishment of mechanisms that support effective responses to actual patient safety occurrence and hazardous conditions.
ii. The promotion of ongoing proactive reductions in medical/health care related errors.
iii. The integration of patient-safety priorities in the design and redesign of all relevant organizational processes functions and services.
iv. The establishment of a medical staff Code of Conduct that addresses and appropriately deals with disruptive behavior.
v. The use of feedback from patients and families regarding patient safety concerns.

10.15.3. MEETINGS

The Quality Management Committee shall meet at least quarterly.

10.15.4. REPORT

The Quality Management Committee shall report directly to the Executive Committee following each meeting.

10.16 CANCER CONFERENCE

10.16.1. COMPOSITION

The Cancer Conference shall be composed of the Members of the Cancer Committee. Other interested Members of the Medical Staff may also attend. The Cancer Conference Chair shall be appointed by the Cancer Committee on an annual basis.

10.16.2 DEFINITION

The Cancer Conference is defined as the hands-on facet of the Cancer Program at the Hospital, combining multidisciplinary specialties in cancer care.

10.16.3. DUTIES/RESPONSIBILITIES

The duties of the Cancer Conference shall be to:

Provide advice and support for the physician in cancer patient care;

Provide ongoing follow-up of the patient;

Provide education for the physicians caring for cancer patients; and

Provide benefit, at no charge, to patients who are seen or whose case is presented for discussion.

10.16.4. MEETINGS

Cancer Conference meetings shall be held at least monthly.

10.16.5 REPORT

The Cancer Conference shall report to the Cancer Committee.

10.17 JOINT CONFERENCE COMMITTEE

The Joint Conference Committee shall be composed of eight (8) members: the President of the Medical Staff and three (3) other members of the Medical Staff appointed by the Medical Executive Committee, the CEO and three (3) other members of the Board of Trustees. All members are voting members. The person serving as the Joint Conference Committee Chair shall alternate annually between the President of the Medical Staff and CEO.

a. This committee shall serve as a focal point for furthering an understanding of the roles, relationships, and responsibilities of the Governing Body, Board of Trustees, administration, and the Medical Staff. It may also serve as a forum for discussing any hospital matters regarding the provision of patient care including credentialing and privileging matters. Any member of the committee shall have the authority to place matters on the agenda for consideration by the committee.
b. The Joint Conference Committee shall meet as necessary.
c. The committee shall also serve as the initial forum for the attempted resolution of disputes between the Medical Staff and Administration or the Board relating to the Medical Staff's rights of self-governance provided in Business and Professions

Code, Section 2282.5. A neutral mediator may be engaged to assist in dispute resolution, if desired by a majority of the Joint Conference Committee.

d. The Joint Conference Committee is directly accountable to and reports to the Medical Executive Committee and to the Governing Board of Trustees.

10.18 MULTI-SPECIALTY PHYSICIAN EXCELLENCE COMMITTEE

10.18.1. COMPOSITION

The Multi-Specialty Physician Excellence Committee (MPEC) shall consist of ten (10) members with a minimum of one representative from each of the eight (8) Clinical Services Departments with two (2) additional member selected at large to provide additional expertise and shall serve a three (3) year term. All Active Members of the Medical Staff who are in good standing and have been on staff for a minimum of three years are eligible to be members of the MPEC.

All voting members of the MPEC are eligible to serve as Chairman. The Chairman will be elected by majority vote of all current MPEC members. The elected MPEC Chairman will serve no more than two (2) consecutive year terms. The MPEC members shall also annually elect a Vice Chair.

The following individuals shall serve on the MPEC in an advisory capacity, in a non-voting capacity:

- Medical Director of Quality Management
- Clinical Performance Coordinator
- Representatives from Administration, nursing, ancillary departments as needed to discuss system, process or other improvement opportunities.

10.18.2.DUTIES

The MPEC is responsible the following duties using multiple sources of information including:

- Review of individual peer review cases
- Review of compliance with “Rule Indicators”
- Ensure that the process for peer review is clearly defined, fair, defensible, useful, and followed up in a timely manner.
- Review cases that are identified for screening and make determination(s) regarding appropriateness of care
- Identify circumstances requiring external peer review in accordance with the Peer Review Policy. (Especially those involving conflict of interest.)
- Identify and refer educational topics to Continuing Medical Education (CME) Committee.
- Identify and refer potential system/process issues including those involving nursing or other ancillary staff to appropriate administrative staff.

10.18.3.MEETINGS

The MPEC shall meet, at a minimum, quarterly.

10.18.4. REPORT

The MPEC Committee shall report to the Medical Executive Committee.

ARTICLE XI
CLINICAL DEPARTMENTS AND DIVISIONS

11.1 ORGANIZATION OF DEPARTMENTS AND DIVISIONS

Each Department shall be organized as a separate part of the Medical Staff and shall have a Chair and a vice Chair who have the authority, duties, and responsibilities specified in these Bylaws. Each division, if any of a Department shall be organized as a specialty subdivision within a Department, shall be directly responsible to the Department within which it functions, and shall have a division chief elected in accordance with Bylaws, Section 8.11.2 and has the authority, duties, and responsibilities specified in these Bylaws.

11.2 DESIGNATION

The current Departments are Medicine, Surgery, Obstetrics and Gynecology, Pediatrics, Family Medicine, Emergency Medicine, and Anesthesia and Radiology. The Medicine Department shall include Dermatology, Cardiology, Gastroenterology and Neurology. The Surgery Department shall include all surgical specialties, and shall include Oral Surgery, Podiatry and Pathology.

11.3 ASSIGNMENT TO DEPARTMENTS AND DIVISIONS

Each Practitioner shall be assigned membership in one Department. A Practitioner may be assigned to a division, if appropriate, based on the Practitioner’s training, experience and current competence. Such assignment shall not restrict the exercise of the Practitioner’s clinical privileges, except as provided in section 2.5.3.

11.4 FUNCTIONS OF DEPARTMENTS

The general functions of each Department shall include the annual election of Department Chairs pursuant to Section 8.6, who shall also serve as Chairs of the Department's Clinical Service Committee.

Each Department shall have a Clinical Service Committee responsible for carrying out the duties and specific functions of the Department.

Department Members shall receive information regarding the monitoring activities, including findings, conclusions, recommendations, and actions taken.

11.5 FUNCTIONS OF DIVISIONS

Each division, upon the approval of the Executive Committee, shall perform the functions assigned to it by the Department Chair. Such functions may include, without limitation, retrospective quality assurance assessment, the continuous monitoring of patient care practices, credentials review and privileges delineation, and continuing education programs. The division shall transmit regular reports to the Department Chair on the conduct of its assigned functions. Its recommendations shall be subject to approval by the appropriate Clinical Service Committee.

11.6 MODIFICATIONS IN CLINICAL ORGANIZATION UNIT

When deemed appropriate, the Executive Committee, after consulting with the Board of Trustees, may create, eliminate, subdivide, further subdivide, or combine Departments and/or divisions.

In creating, eliminating, subdividing, or combining Departments, divisions, or any other clinical organization units that may exist or be contemplated, the following guidelines shall be followed:

11.7 CREATION OF SUBDIVISION

In order to create a subdivision, a sufficient number of Practitioners shall be available for appointment to the new organizational component to enable accomplishment of the functions generally assigned to such components in these Bylaws and relevant Rules and Regulations adopted pursuant hereto; and the patient or service activity to be associated with the new component must be substantial enough to warrant imposition on the Members thereof the responsibility to accomplish such functions.

11.8 ELIMINATIONS

In order to dissolve a subdivision, the number of Members available shall no longer be adequate and shall not be so in the foreseeable future to accomplish assigned functions, or the patient or service activity associated with the component to be dissolved is no longer substantial enough to warrant imposition of the responsibility to accomplish those assigned functions on the Members of such subdivision.

11.9 COMBINATION

In order to combine subdivisions, the union of the two or more organizational components must result in more effective and efficient accomplishment of assigned functions, and the patient or service activity to be associated with the combination must be substantial enough, without being unwieldy, to warrant imposition of the responsibility to accomplish those assigned functions on the Members of such combined components.

ARTICLE XII
GENERAL MEETINGS

12.1 ANNUAL MEETING

The annual meeting shall be the last meeting held in each Medical Staff Year.

12.2 REGULAR MEETINGS

Regular meetings of the Members shall be held on the Third Tuesday of each quarter, except that the annual meeting shall constitute the regular meeting during the quarter in which it occurs. The meetings shall be held after 6:00 p.m. Medical Staff meetings in which voting on Bylaws or election of Medical Staff officers is held will only be at regularly scheduled Medical Staff meetings. Voting on these Bylaws or election of officers will occur during the first hour of the Medical Staff meeting.

Medical Staff meetings in which voting for Bylaws changes or Medical Staff officers occurs will not be held during national holidays.

12.3 SPECIAL MEETINGS

Special meetings of the Medical Staff may be called at any time by the President of the Medical Staff, and shall be called when requested by the Board of Trustees, the Executive Committee, or any 10 Members of the active Medical Staff. No business shall be transacted at any special meeting except that stated in the notice calling the meeting. Sufficient notice of any meeting shall be a notice posted on the bulletin boards at least seventy-two (72) hours before the time set for the meeting.

12.4 AGENDA

The order of business at a meeting of the Medical Staff shall be determined by the President of the Medical Staff, and shall include, insofar as feasible:

Reading and acceptance of the minutes of the last regular and all special meetings held since the last regular meeting;

Administrative reports from the President of the Medical Staff and the President of the Hospital;

Election of officers when required by these Bylaws;

Reports by responsible officers, committees, and Departments as necessary;

Recommendations for improving patient care within the Hospital;

Old business; and New business.

12.5 ATTENDANCE

Members of the Medical Staff shall be encouraged to attend the regular Medical Staff meetings. The business portion of any Medical Staff meeting may be limited to Medical Staff Members only at the discretion of the President of the Medical Staff.

12.6 QUORUM

A quorum shall consist of the voting Members in attendance at any regularly scheduled or special meeting of the Medical Staff. A majority vote of fifty percent (50%) of the voting Members in attendance shall be required for all actions considered unless otherwise specified in these Bylaws.

12.7 COMMITTEE AND DEPARTMENT MEETINGS

12.7.1 REGULAR MEETINGS

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

12.7.2 SPECIAL MEETINGS

A special meeting of any committee, Department, or division may be called by the Chair thereof, the Executive Committee, the President of the Medical Staff, or by written request of one-third (1/3) of the current Members, but not less than two (2) Members.

12.7.3 QUORUM

A quorum for Clinical Service Committees, the Credentials Committee, Executive Committee and Nominating Committee shall consist of fifty percent (50%) of the voting Members. A quorum for other standing committees of the Medical Staff shall be the voting Members in attendance, with a minimum of three (3).

12.7.4 MANNER OF ACTION

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

12.7.5 MINUTES

Except as otherwise specified herein, minutes of meetings shall be prepared and retained. They shall include, at a minimum, a record of the attendance of Members and the vote taken on significant matters.

12.7.6 SPECIAL APPEARANCE

At the discretion of the Chair or Presiding Officer, when a Member's practice or conduct is scheduled for discussion at a division or committee meeting, the Member may be requested to attend. Failure of a Member to appear at any meeting, with respect to which he was given such notice, shall be a basis for corrective action, unless excused by the Executive Committee upon a showing of good cause.

12.7.7 CONDUCT OF MEETINGS

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

ARTICLE XII
CONFIDENTIALITY, IMMUNITY AND RELEASES

13.1 AUTHORIZATION AND CONDITIONS

By applying for or exercising clinical privileges within this Hospital, an applicant:

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

Authorizes persons and organizations to provide information concerning such Practitioner to the Hospital and its Medical Staff;

Agrees to be bound by the provisions of this article and to waive all legal claims against any representative of the Medical Staff or the Hospital who acts in accordance with the provisions of this article; and

Acknowledges that the provisions of this article are express conditions to an application for Medical Staff membership, the continuation of such membership, and to the exercise of clinical privileges of this Hospital.

13.2 CONFIDENTIALITY OF INFORMATION

13.2.1 GENERAL

Records and proceedings of all Medical Staff committees having the responsibility of the evaluation and improvement of quality care and performance in this hospital; and including, but not limited to, information regarding any member or applicant to the Medical Staff or for clinical privileges or service authorizations, shall be confidential, subject to release only in accordance with policies of the Medical Staff, and privileged to the fullest extent permitted by law.

13.2.2 AGREEMENT TO MAINTAIN CONFIDENTIALITY

All individuals participating or attending such committees, or entitled to access such information, shall execute a signed agreement to keep all of the proceedings, minutes, discussions, and documents related to any peer review, clinical performance, or quality management matter confidential and subject to disclosure only in accordance with policies of the Medical Staff or as required by law.

13.2.3 BREACH OF CONFIDENTIALITY

Inasmuch as effective peer review and consideration of the qualifications of Members and applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of Medical Staff divisions or committees is prohibited and will be deemed disruptive to the operations of the organized Medical Staff. If it is determined that such a breach has occurred, the Executive Committee may undertake such corrective action as it deems appropriate. Notwithstanding the foregoing, disclosure of confidential information is permitted pursuant to court order, and under limited circumstances to aid in the investigation of peer review bodies of other hospitals, professional societies, licensing authorities, and governmental agencies.

13.3 IMMUNITY FROM LIABILITY

13.3.1 FOR ACTION TAKEN

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

13.3.2 FOR PROVIDING INFORMATION

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

13.4 ACTIVITIES AND INFORMATION COVERED

13.4.1 ACTIVITIES

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

Applications for appointment, reappointment, or clinical privileges;

Corrective action;

Hearings and appellate reviews;

Utilization reviews;

Other Department, division, committee, or Medical Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and

Peer review organization, MBC and similar reports.

13.5 RELEASES

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

ARTICLE XIV
ALLIED HEALTH PROFESSIONALS

14.1 QUALIFICATIONS

Allied Health Professionals (AHPs) holding a license, certificate, or such other legal credential, if any as required by California law authorizing the AHP to provide certain professional services, are not eligible for Medical Staff membership. Such AHPs are eligible for service authorization in this Hospital only if they:

Hold a license, certificate, or other legal credential in a category of AHPs which the Board of Trustees has identified as eligible to apply for practice privileges;

Document their experience, background, training, demonstrated ability, judgment, and physical and mental health status with sufficient adequacy to demonstrate that any patient treated by them will receive care of the generally recognized professional level of quality and efficiency established by the Hospital, and that they are qualified to exercise service authorization within the Hospital; and

Are determined, on the basis of documented references, to adhere strictly to the lawful ethics of their respective professions; to work cooperatively with others in the Hospital setting; and to be willing to commit to and regularly assist the Hospital in fulfilling its obligations related to patient care, within the areas of their professional competence and credentials.

14.2 DELINEATION OF CATEGORIES OF AHPs ELIGIBLE TO APPLY FOR SERVICE AUTHORIZATION

The Board of Trustees shall determine the categories of AHPs eligible to apply for service authorization to perform specified services within the scope of their licensure, certification, or other authorization by the State of California, and the corresponding service authorization, prerogatives, terms and conditions for each such AHP category.

14.3 PROCEDURE FOR GRANTING SERVICE AUTHORIZATION

An AHP must apply and qualify for service authorization. Applications for initial granting of service authorization and biennial renewal thereof shall be submitted and processed in a parallel manner to that provided for Practitioners, unless otherwise specified in the Medical Staff rules and regulations.

An AHP who does not have licensure or certification in an AHP category identified as eligible for service authorization in the manner required by Section 14.2 may not apply for service authorization, but may submit a written request to the President of the Hospital, asking that the Board of Trustees consider identifying the appropriate category of AHPs as eligible to apply for service authorization.

The Board of Trustees may refer the request to the Executive Committee for recommendation and the Board of Trustees shall consider such request either before or at the time of its annual review of the categories of AHPs.

Each AHP shall be assigned to the clinical Department appropriate to the AHP's occupational or professional training, and, unless otherwise specified in the rules and regulations, shall be subject to terms and conditions paralleling those specified in Article II (membership) as they may logically be applied to AHPs and appropriately tailored to the particular AHP's profession.

14.4 PREROGATIVES

The prerogatives which may be extended to an AHP shall be defined in the Medical Staff Rules and Regulations or Hospital policies. Such prerogatives may include:

> Provision of specified patient care services under the supervision or direction of a physician Member of the Medical Staff consistent with the service authorization granted to the AHP and within the scope of the AHP's licensure or certification;
>
> Service on Medical Staff, Department, and Hospital committees; and
>
> Attendance at education programs in the AHP's field of practice.

14.5 RESPONSIBILITIES

Each AHP shall:

> Strictly abide by the applicable provisions of the Medical Staff and Hospital Bylaws, all standards, policies and Rules and Regulations of the Medical Staff and Hospital, all applicable laws and regulations of government agencies, applicable ethical code(s) and the Hospital’s ethical standards contained in its Compliance plan;
>
> Retain appropriate responsibility within the AHP's area of professional competence for the care and supervision of each patient in the Hospital for whom the AHP is providing services; and

Participate as appropriate in quality assurance assessments and other quality review, evaluation, and monitoring activities required of AHPs, in supervising initial appointees of the same occupation or profession, or of a lesser, included occupation or profession, and in discharging such other functions as may be required from time to time.

14.6 PRIVILEGES

In addition, at any time, the Chair of the Department to which the AHP is assigned, the President of the Medical Staff, or the President of the Hospital, may terminate, suspend, reduce or restrict an AHP's privileges based on (a) failure of the AHP to meet the qualifications for membership in Section 14.1; (b) any violation by the AHP of any Hospital or Department policy or procedure; or (c) for any business, operations or other reason in the sole discretion of the Chair of the Department, the President of the Medical Staff, or the President of the Hospital. Such termination, suspension,

reduction or restriction of privileges may be immediate or otherwise in accordance with Hospital personnel and other policies.

14.7 FAIR HEARING AND APPEAL PROCESS

14.7.1 GENERAL

Clinical psychologists who are the subject of an action which must be reported in accordance with Section 805 of the Business and Professions Code are entitled to the hearing and appeal rights set forth in Article VII of these Bylaws. Except as provided herein with respect to clinical psychologists, AHP's shall not be entitled to the hearing and appeal rights set forth in Article VII of these Bylaws. Instead, an AHP with clinical privileges at the Hospital whose privileges are terminated, suspected, reduced or restricted pursuant to Section 14.6, shall be entitled to the fair hearing and appeal process set forth in this Section 14.7.

14.7.2 PROCEDURES

An AHP whose privileges are adversely affected in accordance with action taken pursuant to Section 14.6 of these Bylaws shall be provided with written notice by the [Medical Staff Office] of such action. Such notice shall include the effective date of the adverse action, a concise description of the acts or omissions or other reasons which form the basis for the adverse action, and a notice and description of the AHP's right to request a hearing and appellate review. A failure of the AHP to request a hearing to which such AHP is entitled by these Bylaws within the time frame and in the manner herein provided shall be deemed to be a waiver of the AHP's right to such hearing and to any appellate review and an acceptance of the adverse decision.

An AHP's request for a hearing must be received in writing by the [President of the Hospital] within ten (10) days of the AHP's receipt of the notice of the adverse action. The request must include the AHP's written response to the basis of the adverse action, if any, including any documentation in support thereof that the AHP would like to be considered in the hearing. Where the President of the Hospital is the individual who took the adverse action against the AHP, such AHP's request for a hearing shall be submitted instead to the President

of the Medical Staff, who shall conduct the hearing as described herein, and under such circumstances all such references to the Chief Executive Officer in subsection (c) below shall be read as the President of the Medical Staff.

Within fifteen (15) days of the Chief Executive Officer's receipt of the AHP's request, the Chief Executive Officer shall send the AHP a notice of hearing which shall include the time, place and date of the meeting (which shall be no more than thirty (30) days from the Chief Executive Officer's receipt of the AHP's request for a hearing) and the nature of the discussions to take place at such a hearing. The hearing shall take place at the Hospital and shall be compromised of the Chief Executive Office and AHP and a Hospital representative who shall take notes of the meeting. The nature of the discussion shall be basis for the adverse action as stated in the notice of suspension or termination, and the AHP's response as set forth in his or her request for a hearing.

The Chief Executive Officer shall consider the oral and written information provided by the AHP, and shall render a written decision to uphold, amend, or reject the adverse action, and shall provide such decision to the AHP in writing within five (5) days of the hearing.

Within ten (10) days after the AHP's receipt of an adverse decision of the Chief Executive Officer, the AHP may, by notice to the Board of Trustees, request an appellate review be held on the record on which the adverse decision was based. If such a request is not made within (10) days, the AHP shall be deemed to have waived his or her right to an appellate review and to have accepted the adverse decision.

The Board at its next regularly scheduled meeting shall conduct the appellate review. The Board will exercise its independent judgment whether evidence exists to support the decision. New or additional matters not raised during the original hearing shall be not be introduced at the appellate review except under unusual circumstances, and the Board shall, in its sole discretion, determine whether such new matters shall be accepted.

Within ten (10) days of the conclusion of the appellate review, the Board shall make its final decision in the matter and shall send notice thereof to the AHP, by special notice. The Board's decision shall be final and shall not be subject to further hearing or appellate review.

14.7.3 EFFECTIVE DATE OF ADVERSE ACTION

Nothing in this Section 14.7 shall require the Hospital to extend the effective date of any termination, suspension, reduction or suspension of an AHP's privileges until the completion of the fair hearing and appeal process set forth herein.

ARTICLE XV
GENERAL PROVISIONS

15.1 MEDICAL STAFF RULES & REGULATIONS AND POLICIES

The Executive Committee is hereby authorized to establish Rules and Regulations, and policies as provided in this Article. These Rules and Regulations and policies shall be reviewed every 2 years.

15.1.1 GENERAL RULES AND REGULATIONS

The Executive Committee may propose the adoption, amendment or repeal of Rules & Regulations for approval by the Board of Trustees, following notice to the members of the Active staff. Rules and Regulations shall become effective when approved by the Board of Trustees whose approval shall not be unreasonably withheld.

15.1.2 CLINICAL DEPARTMENT RULES AND REGULATIONS

A clinical department may propose Rules and Regulations applicable to that department to the Executive Committee. Clinical department Rules and Regulations shall become effective upon approval by the Executive Committee and the Board of Trustees following notice to members of the Clinical Department. The Board of Trustees shall not unreasonably withhold its approval.

15.1.3 MEDICAL STAFF POLICIES

The Executive Committee may establish or revise policies and procedures consistent with the Bylaws and Rules & Regulations following written notice to the Medical Staff. Policies shall include policies and procedures relating to Medical Staff self-governance as well as operation and clinical practice policies approved by the Executive committee which are binding on the Medical Staff members.

15.1.4 INITIATION OF GENERAL RULES OR POLICIES BY ACTIVE STAFF MEMBERS

Voting members of the active staff may propose adoption, amendment or repeal of Rules & Regulations or of Medical Staff policies by following the process provided in Article XVI, Section 16.1(b), below.

15.1.5 URGENT AMENDMENT OF RULES

The Executive Committee, with the approval of the Board of Trustees, may adopt amendments to Rules & Regulations or Department Rules & Regulations provisionally without notice to the general Medical Staff upon a documented need for an urgent amendment to comply with applicable law or regulation. Following notice of such action, members of the Active staff, by petition signed by at least one-third of such members, may ask the Executive Committee to reconsider such changes.

15.1.6 EXCLUSIVITY

Neither the Medical Staff nor the Board of Trustees shall unilaterally amend the Rules and Regulations or policies. Applicants and members of the Medical Staff shall be governed by such Rules and Regulations and policies as are properly initiated and adopted. If there is a conflict between the Bylaws and the Rules and Regulations or policies, the Bylaws shall prevail. The mechanisms described herein shall be the sole methods for the initiation, adoption, amendment, or repeal of the Medical Staff Rules & Regulations and policies.

15.2 DISPUTES BETWEEN THE MEDICAL STAFF AND THE MEDICAL EXECUTIVE COMMITTEE

Disputes between the Medical Executive Committee and voting members of the Active Staff, shall be resolved as follows:

If a majority of the members of the Active Staff sign a petition proposing a change to these Bylaws or the General Medical Staff Rules and Regulations or policies, or objecting to an action of the Medical Executive Committee relating to these Bylaws, General Medical Staff Rules and Regulations, policies or other official Medical Executive Committee actions, such petition shall be transmitted to the Medical Executive Committee via the President or the Medical Staff Office.

a) The Medical Executive Committee shall, within sixty (60) days after it receives such petition via the President of the Medical Staff or Medical Staff Office, meet with representatives of those who have signed the petition to discuss and attempt to resolve the matter by mutual agreement.

b) If the Medical Executive Committee and such representatives cannot agree on the subject matter of such petition, a consultant or a mediator may be engaged, by mutual agreement of the Medical Executive Committee and such representatives, to assist in resolving the dispute. If such a consultant or a mediator is engaged, the parties shall share equally in the costs of such consultant or mediator, provided however, that in no event shall the consultant or mediator be the Board of Trustees or a representative thereof.

c) If a matter relating to these Bylaws or the General Medical Staff Rules and Regulations or policies is not resolved within ninety (90) days after such matter was transmitted to the Medical Executive Committee via the President of the Medical Staff or Medical Staff Office, the Medical Executive Committee and such representatives shall prepare separate written statements of their respective positions and submit them to the Board of Trustees for information only.

d) This process shall not apply to decisions or recommendations of the Medical Executive Committee relating to corrective or disciplinary action involving a practitioner.

15.3 REAPPOINTMENT FEES OR ASSESSMENTS

The Executive Committee shall have the power to recommend the amount of assessments or fee associated with a reappointment, if any, for each category of Medical Staff membership, subject to the approval of the Medical Staff, and to determine the manner of expenditure of such funds received.

15.4 CONSTRUCTION OF TERMS AND HEADINGS

The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope of, or affect any of the substantive provisions of, these Bylaws.

15.5 AUTHORITY TO ACT

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

15.6 DIVISION OF FEES

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

15.7 NOTICES

Except where specific notice provisions are otherwise provided in these Bylaws, any and all notices, demands, or requests required or permitted to be mailed shall be in writing, properly sealed, and shall be sent through the United States Postal Service, first class, postage prepaid. An alternative delivery mechanism may be used if it is reliable, as expeditious, and if evidence of its use is obtained.
Mailed notices to a Member, Applicant, or other party, shall be to the addressee at the address as it last appears in the official records of the Medical Staff or the Hospital.

ARTICLE XVI
ADOPTION AND AMENDMENT OF BYLAWS

16.1 PROCEDURE

Proposals to adopt, amend or repeal the Bylaws may be initiated by either of the following methods:

a) The Executive Committee, with the recommendation of the Bylaws committee, or on its own motion, may recommend adoption, amendment or repeal of the Bylaws to the voting members of the Medical Staff as provided in this Article.
b) The members of the active staff, by a written petition signed by at least one fourth of the Active staff members, may petition the Executive Committee to initiate a proposal to adopt, amend or repeal the Bylaws. Such petition shall identify exact language to be added, changed or deleted. If the Executive Committee agrees with the proposed change, it may recommend the change as provided in subsection (a), above. If the Executive Committee does not agree with the proposed change, the Executive Committee shall meet with proponents of the proposed change to discuss and attempt to resolve the disagreement. If the disagreement has not been resolved within 180 days from the date the proposal was delivered to the Executive Committee, the president of the Medical Staff shall give notice of a regular or a special meeting of the Active staff, as provided below, to consider the proposal.

16.2 ACTION BY THE ACTIVE STAFF

If a proposal is initiated as provided in 16.1.a as above, the members of the Active staff shall be notified by President of the Medical Staff of changes to the Medical Staff Bylaws and/or Rules and Regulations as provided in 16.1 at least 14 days and not more than 90 days prior to the next vote by mail ballot.

Final revisions of the proposed amendments will be mailed to all members of the Active staff with a ballot to indicate a vote for acceptance or rejection of each proposed amendment. Amendments receiving the majority affirmative votes for adoption shall become effective when approved by the Board of Trustees.

The outcome of the vote for the proposed changes will be announced at the regular or special meeting wherein the proposed change was considered. Any challenges to the outcome of the vote not raised at the meeting will be deemed waived.

16.3 APPROVAL

Upon approval by the active staff as provided above, the proposed Bylaws change shall be submitted to the Board of Trustees for approval. The Board of Trustees shall give great weight to the active staff's proposed change. If no action on the proposed change is taken by the Board of Trustees within 90 days, the proposed change shall be deemed to have been approved by the Board of Trustees. The Board of Trustees may not unreasonably withhold its approval from the active staff's recommended change. If the Board of Trustees votes to disapprove any part of the recommended change, the Board of Trustees chair shall give the President of the Medical Staff written notice of the reasons for non-approval within ten business days from the Board of Trustees action.

16.4. COMPATIBILITY – NO UNILATERAL AMENDMENT

The Medical Staff and the Hospital Bylaws shall be compatible. The Medical Staff may not amend the Medical Staff Bylaws unilaterally. Likewise, the Board of Trustees may not unilaterally amend the Medical Staff Bylaws by amendment of Board Bylaws or otherwise. The mechanisms described herein shall be the sole methods for the initiation, adoption, amendment, or repeal of these Bylaws.