WATSONVILLE COMMUNITY HOSPITAL

MEDICAL STAFF BYLAWS

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PREAMBLE

Watsonville Community Hospital is an acute care general hospital organized under the laws of the State of California. Its purpose is to provide quality patient care and education. In order to accomplish this purpose, the individual practitioners who provide care in this hospital accept the responsibility delegated to them by the Board of Trustees to organize themselves into a self-governing group to be known as the Medical Staff of Watsonville Community Hospital and, further, accept a shared dedication with the Board Trustees and the Administration to the goal of quality patient care. The Board of Trustees will give great weight to the actions of the Medical Staff, and will not act arbitrarily or capriciously in exercising its authority under these Bylaws.

Article 1 PURPOSES AND TERMS

Article 1.1 PURPOSES OF THE BYLAWS

These Bylaws are adopted in order to provide for the organization of the Medical Staff of Watsonville Community Hospital and to provide a framework for self-government in order to permit the Medical Staff to discharge its responsibilities including matters involving the quality of medical care, and to govern the orderly resolution of those purposes, subject to accountability to the Board of Trustees, while retaining all self-governance rights available to the medical staff under the law. These bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Board of Trustees, and relations with applicants to and members of the Medical Staff. The organized Medical Staff both enforces and complies with these Medical Staff Bylaws.

These bylaws recognize that the organized medical staff has the authority to establish and maintain patient care standards, including full participation in the development of hospital-wide policy involving the oversight of care, treatment, and services provided by members and others in the hospital. The Medical Staff is also responsible for and involved with all aspects of delivery of health care within the hospital including, but not limited to, the treatment and services delivered by practitioners credentialed and privileges through the mechanisms described in these bylaws and the functions of credentialing and peer review.

These bylaws acknowledge that the provision of quality medical care in the hospital depends on the mutual accountability, interdependence, and responsibility of the Medical Staff and the Hospital Board of Trustees for the proper performance of their respective obligations. In order to facilitate these mandates, the Medical Staff (as provided in its relevant Bylaws, Rules and Policies or as directed by its Medical Executive Committee), and the Hospital Board and Administration shall share quality evaluation data regarding Medical Staff Members' professional competence, conduct and performance, including with respect to individuals who perform quality-related functions under contracts with the Hospital.

Article 1.2 DEFINITIONS

Allied Health Practitioners or **AHP** means a credentialed individual, who is qualified to render direct or indirect clinical care either (a) under the supervision of a practitioner who has been afforded privileges to provide such care in the Hospital or (b) on an independent basis under state law. For such purposes of these Medical Staff Bylaws, “AHP” shall be deemed to refer only to advance practice professionals who are credentialed as AHPs pursuant to the Medical Staff credentialing process.

Authorized Representative or **Hospital’s Authorized Representative** means the individual designated by the Hospital to provide information to and request information from the National Practitioner Data Bank according to the terms of these Bylaws.

Board of Trustees means the local Governing Authority of the Hospital.

Chief Executive Officer means the person appointed by the Corporation to provide for the overall management of the Hospital or his/her designee.

Chief Of Staff means the chief officer of the Medical Staff elected by members of the Medical Staff.

Clinical Privileges or **Privileges** means the authorization granted to a practitioner to provide specific care, treatment or services in the Hospital within established limits, based on the following factors: license, education, training, experience, competence, health status judgment, and additional applicable factors under the Medical Staff Bylaws, Rules and policies.

Corporation means Watsonville Hospital Corporation.

Distant Site: see Article 3.8-1 under "Telemedicine Staff" for the definition of this term.

Distant Site Entity: see Article 3.8-1 under "Telemedicine Staff" for the definition of this term.

Doctors of Podiatric Medicine (Podiatrist): An individual who has received a doctor of podiatric medicine degree and is fully licensed to practice podiatry.

Hospital means Watsonville Community Hospital.

Investigation means a process specifically instigated by the Medical Executive Committee to determine the validity, if any, to a concern or complaint raised against a member of the Medical Staff, and does not include activity of the Medical Staff Well-Being Committee**.**

Ineligible Person means any individual or entity who:

a. Is currently excluded, debarred, suspended, or otherwise ineligible to participate in the federal health care programs or in Federal procurement or nonprocurement programs; or

b. Has been convicted of a criminal offense that falls within the scope of 42 U.S.C. § 1320a-7(a), but has not yet been excluded, debarred, suspended, or otherwise declared ineligible.

In Good Standing means a member is currently not under suspension or serving with any limitation of voting or other prerogatives imposed by operation of the bylaws, rules and regulations or policy of the medical staff and who is not currently the subject of any Investigation or formal corrective-action recommendation that would give rise to his/her right to a hearing under these Bylaws.

Medical Executive Committee (MEC) means the executive committee of the Medical Staff which shall constitute the governing body of the Medical Staff as it is described in these Bylaws.

Medical Staff or **Staff** means those physicians (MD or DO or their equivalent as defined in Section 2.2-2(a)), dentists, and doctors of podiatric medicine holding licenses in this state, who are granted medical staff membership and are privileged to provide patient care services in the hospital within the scope of their licensure and approved clinical privileges.

Medical Staff Year means the period from July 1 to June 30.

Member means, unless otherwise expressly limited, any physician (MD or DO or their equivalent as defined in Section 2.2-2(a)), dentist, or podiatrist holding a current license to practice within the scope of that license who is a member of the Medical Staff.

Originating Site: see Article 3.8-1 under "Telemedicine Staff" for the definition of this term.

Physician means an individual with an MD or DO degree, or the equivalent degree, as recognized by the Medical Board of California (MBC) or the Board of Osteopathic Examiners (BOE), who is licensed by either the MBC or the BOE.

Telemedicine Privileges: see Article 3.8-1 under "Telemedicine Staff" for the definition of this term.

Telemedicine Services: see Article 3.8-1 f under "Telemedicine Staff" or the definition of this term.

Telemedicine Staff: see Article 3.8-1 under "Telemedicine Staff" for the definition of this term.

Article 2 MEMBERSHIP

Article 2.1 NATURE OF MEMBERSHIP

Medical Staff membership is a privilege which shall be extended only to professionally competent practitioners who continuously meet and comply with the requirements as set forth in the Bylaws, Rules and Regulations and Medical Staff policies. No physician, dentist, or podiatrist including those in a medical administrative position by virtue of a contract with the Hospital, shall admit or provide medical or health-related services to patients in the Hospital unless the practitioner is a member of the Medical Staff and has been granted privileges to do so in accordance with the procedures set forth in these Bylaws. Medical Staff membership shall confer only such clinical privileges and prerogatives as have been granted in accordance with these Bylaws.

Article 2.2 QUALIFICATIONS FOR MEMBERSHIP

Membership and privileges shall be granted, revoked or otherwise restricted or modified based only on the professional training and experience criteria as set forth in these bylaws. Applicants and re-applicants for Telemedicine Staff shall meet the criteria of this Article 2.2 except as otherwise specified.

Article 2.2-1 General Qualifications

In order to demonstrate that they meet the basic qualifications for Medical Staff Membership, physicians, dentists, and podiatrists must:

a. document their: (1) current licensure, (2) adequate experience, education, and training, (3) current professional competence in the exercise of privileges that they seek, (4) good judgment, and (5) current adequate physical and mental health status, so as to demonstrate to the satisfaction of the Medical Staff that they are professionally and ethically competent and that patients treated by them can reasonably expect to receive quality medical care; applicants whose license to practice in the State of California is restricted or encumbered by the Medical Board, the Osteopathic Medical Board of California, or any other licensing agency, and those who have been debarred or sanctioned or otherwise ineligible under the Medicare and Medicaid program, or listed by a federal or state agency as debarred, excluded or otherwise ineligible for federal or state program participation, or have been convicted of any offense related to health care, shall not be considered for initial appointment to the Medical Staff. Documentation required under this subsection for Telemedicine Staff may be met by other means, to the degree otherwise specified in these Bylaws;

b. meet the criteria for membership in at least one Department of the Medical Staff and hold clinical privileges in at least one Department of the Medical Staff although exceptions to this requirement may be made by the Medical Executive Committee for good cause;

c. be Board certified in their specialty, or have completed an appropriate residency within the past five (5) years and are making adequate progress toward Board Certification, as determined by the MEC and the Board of Trustees. This requirement shall not apply to any practitioner already a member of the Medical

Staff as of January 1, 2015;

d. Show currently and agree on a continuous basis:

1) to adhere to the ethical principles of the American Medical Association and their respective specialty associations,

2) to be able to work cooperatively with others so as not to adversely affect patient care,

3) to keep as confidential, as required by law, all information or records received in the physician-patient relationship,

4) to be willing to participate in and properly discharge those responsibilities determined by the Medical Staff, including cooperating with any peer review activities as requested by the Medical Staff; and

5) to be willing to keep confidential and discuss only within established Medical Staff Committees the proceedings of such Medical Staff activities related to Quality and Peer Review activities.

e. maintain in force professional liability insurance in not less than the minimum amounts as determined by the Medical Executive Committee and approved by the Board. Professional liability insurance must be held with an insurance carrier approved by the State Insurance Commissioner to conduct business in the State of California, or the practitioner may demonstrate membership in a physician's cooperative with the same minimum amounts of coverage as determined by the Medical Executive Committee:

1) Each member of the Medical Staff or applicant thereto, shall certify in writing at the time of application, and provide ongoing documentation as required by the Medical Executive Committee, that he or she possesses professional liability insurance. Such certification shall include the name of the carrier, the period of coverage, assurance that the coverage can be reduced or canceled only after notification to the Medical Staff and, if requested by the Medical Executive Committee, a certified or copy of the face sheet of his or her policy evidencing such coverage, or the entire policy if requested;

2) Each member or applicant shall promptly report in writing to the Medical Executive Committee, any actual or proposed reductions, restrictions, cancellation or termination of the required professional liability coverage, or change in insurance carrier;

3) In the event of a failure to maintain such professional liability insurance as required above, a practitioner's clinical privileges shall be automatically suspended and shall remain suspended until the practitioner shall provide to the Medical Executive Committee evidence of coverage or insurance as required herein. Failure to provide such coverage within ninety (90) days after the date of suspension, shall be deemed to be a voluntary resignation from the Medical Staff.

f. not be currently excluded from any Federally funded program during any term of membership.

An exception to the above qualification requirements is made for Honorary Staff and Refer and Follow candidates or Members, such that such individuals need only meet those qualifications determined by the Medical Executive Committee on a case-by-case basis.

Article 2.2-2 PARTICULAR QUALIFICATIONS

a. Physicians: An applicant for physician membership in the Medical Staff, except for the honorary staff, must hold an MD or DO degree or their equivalent and a valid and unsuspended certificate to practice medicine issued by the Medical Board of California or the Board of Osteopathic Examiners of the State of California. For the purpose of this Section, "or their equivalent" shall mean any degree (i.e., foreign) recognized by the Medical Board of California or the Board of Osteopathic Examiners.

b. Special Conditions for Clinical Privileges: Requests for Clinical Privileges for Dentists and Podiatrists shall be processed in the manner specified in this Article for other Practitioners and shall be based on their training, experience, education, demonstrated current competence, and the need for their services in the Hospital.

1) **Dentists:** An applicant for dental membership in the Medical Staff, except for the honorary staff, must hold a DDS or equivalent degree and a valid and unsuspended certificate to practice dentistry issued by the Board of Dental Examiners of California. All Dentist Members may only admit patients if a Physician Member assumes responsibility for the care of the patient's medical problems, present at the time of admission or which may arise during hospitalization, which are outside of the limited license Practitioner's lawful scope of practice.

2) **Podiatrists:** An applicant for podiatric membership on the medical staff, except for the honorary staff, must hold a DPM degree and a valid and unsuspended certificate to practice podiatry issued by the Board of Podiatric Medicine.

Article 2.3 EFFECT OF OTHER AFFILIATIONS

No person shall be entitled to or denied membership in the Medical Staff solely because that person holds a certain degree, is licensed to practice in this or in any other state, is a member of any professional organization, is certified by any clinical board, or because such person had, or presently has, staff membership or privileges at another health care facility. Medical Staff membership or clinical privileges shall not be conditioned or determined on the basis of an individual's participation or non-participation in a particular medical group, surgery center or other outpatient service facility, IPA, PPO, PHO, Hospital-sponsored foundation, or other organization or in contracts with a third party which contracts with this Hospital.

Any allegations of a Medical Staff member's conflict of interest stemming from business interests and adverse impact on the delivery of quality of care resulting from that conflict may be considered, along with other factors, in assessing whether a member currently

complies with all requirements of the Bylaws and Medical Staff Policies.

Conflicts of interest, in particular, should be addressed in full compliance with all applicable Medical Staff Policies.

Article 2.4 NONDISCRIMINATION

No aspect of Medical Staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, color, religion, ancestry, national origin, disability, physical or mental impairment (except as such may impair the practitioner's ability to provide quality patient care or fulfill his/her duties under these bylaws), marital status, or sexual orientation or on the basis of any other criteria that does not relate to the quality of patient care.

Article 2.5 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

Except for the Honorary Staff and the Refer and Follow Staff, the ongoing responsibilities of each member of the Medical Staff include:

a. providing patients with the quality and continuity of care meeting the professional standards of the Medical Staff of this Hospital. In this regard, Staff members must ensure that their patients receive appropriate treatment and services during their entire length of stay at the Hospital;

b. continuously abiding by the Medical Staff Bylaws, Medical Staff Rules and Regulations, and Medical Staff Policies;

c. Acting in a responsible manner in accepting and fulfilling such reasonable responsibilities and assignments required of the member by virtue of medical staff membership, including committee assignments;

d. completing in a timely fashion medical records for all the patients to whom the member provides care in the Hospital. This includes, but is not limited to, completing—or, where applicable, updating—and documenting a medical history and physical examination no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, in accordance with State and Federal law, The Joint Commission Standards, these Bylaws, and the Staff Rules and Regulations. A history and physical performed within thirty (30) days prior to hospital admission may be used, as long as the medical record contains durable, legible practitioner documentation indicating the H&P was reviewed and the patient was examined, and noting any changes in the patient's condition. If there have been any changes in the patient's condition that are not consistent with or noted in the history and physical, those must be documented within twenty-four (24) hours of admission.

e. abiding by the lawful ethical principles of the California Medical Association or member's other professional association;

f. immediately notify the Chief of Staff of the revocation or suspension of the applicants professional license or the imposition of terms of probation or limitation of practice by any state licensing agency of the DEA or the commencement of any action with regard to such adverse licensure activity; of the voluntary or involuntary loss of staff membership or clinical privileges at any health care institution and the

filing of a Notice of Charges by any healthcare institution; of the cancelation or restriction of professional liability coverage; of any adverse determination by a peer review organization or a third party payor; of the commencement of a formal investigation or the filing of charges by the Centers for Medicare and Medicaid Services or any law enforcement agency or health regulatory agency of the United States or of any State; of the notice of intent to file of the filing of a claim alleging professional liability; arrest and/or the filing of any criminal charges; or any investigational or other action taken by any governmental agency related to the Medicare or Medicaid program.

g. complete accurately, adequately, and in a timely fashion, the medical and any other required records for all patients he admits or in any way provides care for in the Hospital;

h. aiding in any Medical Staff approved educational programs for medical students, interns, resident physicians, staff physicians and dentists, nurses and other personnel;

i. working cooperatively with Medical Staff Members, Nurses, Hospital Administration and others so as not to adversely affect patient care;

j. providing continuing coverage for his or her patients and making appropriate arrangements for coverage of that member's patients as determined by the Medical Staff;

k. refusing to engage in improper inducements for patient referral;

l. participating in continuing education programs as determined by the medical staff;

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

n. providing information to and/or testifying on behalf of the Medical Staff or an accused practitioner regarding any matter under an investigation pursuant to Section 6.1-3, and those which are the subject of a hearing pursuant to Article 7;

o. participating on a voluntary basis in emergency service coverage or consultation panels consistent with Section 2.6 of these Bylaws;

p. serving as a proctor or other peer reviewer, and otherwise participating in medical staff peer review as reasonably requested;

q. reporting to his/her clinical Department Chair any illness, disability, or absence which could prevent him/her from participating in the care of hospitalized patients and/or Medical Staff affairs; and

r. cooperating with any peer review activities or investigations of the member's practice as requested by the Medical Executive Committee or other Committee, or Department Chair or other Medical Staff leader.

Article 2.6 VOLUNTARY PARTICIPATION ON EMERGENCY DEPARTMENT BACKUP CALL PANELS

Participation on the Emergency Department backup call panel shall be voluntary. To the extent there is concern as to the extent of backup call panel coverage to be provided by the Medical Staff as a whole or by members of a particular Department, in light of the needs of patients, the Medical Staff shall discuss such matters with the Hospital in a good faith attempt to resolve them. With the exception of the hospitalist programs, monthly department or section call schedules for participating members shall be developed by each department or section and shared with the Medical Staff office no later than the 20th of each month for the month that follows, unless otherwise specified in Medical Staff Rules and Regulations. Should any department or section fail to submit its monthly ED backup schedule by the deadline, the Medical Staff office may assume the schedule making for that department or section for that month, so as to ensure necessary coverage is in place. If a member that is scheduled to take call wants to change his/her schedule, that member is responsible for finding a replacement to fill the schedule. The member will forward the change to the Medical Staff Office so the schedule can be revised and posted. All members of the medical staff who are eligible to take call for ED backup in a given specialty or service are entitled to an equal number of call days per month, unless the physician voluntarily relinquishes some or all of those days.

Article 2.7 BEHAVIOR

Members of the Medical Staff and others holding clinical privileges shall demonstrate a willingness and capability based on current behavior and evidence of performance:

a. To work with and relate to other staff members, members of other health disciplines, Hospital management and employees, patients, families, visitors and the community in general in a cooperative, professional, non-disruptive manner that is essential for maintaining a Hospital environment appropriate to quality patient care; and

b. To discharge the basic obligations of Medical Staff membership and to participate equitably in the discharge of staff obligations appropriate to staff membership category.

Failure of a member to demonstrate behavior as described in Section 2.7(a) and (b) may result in responsive action by the Medical Staff which may include, but is not limited to, disciplinary action as described in Article 6.

Article 2.8 HARASSMENT

Harassment by a Medical Staff member against any individual (e.g., against another Medical Staff member, house staff, Hospital employee or patient) for any reason, including but not limited to, on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex, gender, or sexual orientation, shall not be tolerated.

“Sexual harassment” is unwelcome verbal or physical conduct of a sexual nature which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and visual harassment (such as the display of derogatory cartoons, drawings, or posters).

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

All allegations of sexual harassment shall be immediately investigated by the appropriate representatives of the medical staff and, if confirmed, will result in appropriate corrective action, from reprimands up to and including termination of Medical Staff privileges or membership, if warranted by the facts.

Any other allegations of harassment of any kind shall be reported to the Medical Staff and may constitute grounds for corrective action as described in Article 6.

Article 2.9 PARTICIPATION IN ORGANIZED HEALTH CARE ARRANGEMENT

The Hospital and each member of the Medical Staff will be part of an Organized Health Care Arrangement ("OHCA"), which is defined as a clinically-integrated care setting in which individuals typically receive healthcare from more than one healthcare provider. The OHCA allows the Hospital and the Medical Staff members to share information for purposes of treatment, payment and healthcare operations. Under the OHCA, at the time of admission, a patient will receive that Hospital's Notice of Privacy Practices, which will include information about the Organized Health Care Arrangement between the Hospital and the Medical Staff.

Article 2.10 ALLIED HEALTH PRACTITIONERS

Article 2.10-1 General

This article shall pertain only to Advanced Practice Allied Health Professionals ("AHPs") that is, those who are credentialed pursuant to the Medical Staff process as outlined in the definition of "Allied Health Professional" herein. Clinical Assistants who are not Advanced Practice Allied Health Professionals and who are not credentialed pursuant to the Medical Staff process shall be governed by the applicable human resource policies of the Hospital. When Allied Health Professionals are employed by physicians on the staff, or are otherwise required by law or regulation to have a sponsoring physician, they must have a sponsoring physician who is approved pursuant to and in compliance with law and applicable Medical Staff and Hospital requirements.

Article 2.10-2 Credentialing and Prerogatives

AHPs shall be credentialed by the Medical Staff Credentials Committee under a process analogous to that applicable to Medical Staff applicants for initial appointment and reappointment, as tailored to AHP practices.

Article 2.10-3 Responsibilities

To the extent applicable, AHPs shall be held accountable for compliance with Medical Staff Bylaws, Rules and policies, as well as with hospital rules and polices, as pertinent to

their practices.

Article 2.10-4 Corrective Action

Whenever corrective action is deemed appropriate or necessary for the protection of patient safety or to ensure the delivery of quality care within the Hospital, the Medical Staff shall undertake such corrective action, consistent with the corrective action provisions of the AHP Rules and Regulations. At a minimum there shall be some process by which an AHP is notified of corrective action and is given an opportunity to comment as to all matters at issue.

Article 2.10-5 AHP Rules/Regulations

Details related to the eligibility, credentialing, granting of practice privileges, performance review, supervision, responsibilities, and corrective action regarding AHPs are addressed in the separate Allied Health Practitioners Rules/Regulations of Watsonville Community Hospital.

Article 2.10-6 Development, Approval, and Amendment of AHP Rules/Regulations

The AHP Rules/Regulations are developed by the Medical Executive Committee and approved by the Hospital Board of Trustees. Any and all amendments to the AHP Rules/Regulations shall be adopted by the Medical Executive Committee, in consultation with the Interdisciplinary Practice Committee. Once proposed amendments to the AHP Rules/Regulations have been adopted by the Medical Executive Committee, those amendments shall be forwarded to the Board of Trustees for consideration and approval, which shall not be unreasonably withheld.

Article 3 CATEGORIES OF MEMBERSHIP

Article 3.1 CATEGORIES

The categories of the Medical Staff shall include the following: active, courtesy, consulting, provisional, honorary, telemedicine, and refer and follow. At appointment and each time of reappointment, the member's staff category shall be determined.

Article 3.2 ACTIVE STAFF

Article 3.2-1 Qualifications

The active staff shall consist of members who:

a. meet the general qualifications for membership set forth in Section 2.2;

b. have offices and/or residences which, in the opinion of the Medical Executive Committee, are located closely enough to the Hospital to provide appropriate continuity of quality care, unless appropriate coverage arrangements have been made by the physician and approved by the Medical Executive Committee and Board of Trustees. In general, a 30-minute response time for presenting at the Hospital will be deemed acceptable;

c. actively care for patients in this hospital, or are otherwise regularly involved in the care of 12 or more patients per two-year period. For purposes of determining whether a practitioner is "actively involved" in the care of the requisite number of patients, a patient encounter or contact shall be deemed to include any of the following: admission; consultation with active participation in the patient's care; provision of direct patient care or intervention in the hospital setting; performance of any outpatient or inpatient surgical or interventional diagnostic or treatment procedure. When a patient has more than one procedure or diagnostic test performed or interpreted by the same practitioner during a single hospital stay, the multiple tests for that patient shall count as one patient contact; and

d. except for good cause shown as determined by the Medical Executive Committee, have satisfactorily completed their designated term in the provisional staff category.

Article 3.2-2 Prerogatives

Except as otherwise provided, the prerogatives of an active Medical Staff member shall be to:

a. admit patients and exercise such clinical privileges as are granted pursuant to Article 5;

b. attend and vote on matters presented at general and special meetings of the Medical Staff and of the Department and Committees to which the member is duly appointed; and

c. hold Staff, Division, or Department office and serve as a voting member of committees to which the member is duly appointed or elected by the medical staff or duly authorized representative thereof, so long as the activities required by the position fall within the member's scope of practice as authorized by law.

Article 3.2-3 Responsibilities

Each member of the Active Staff shall:

a. Meet the basic responsibilities set forth in Section 2.5;

b. Within his/her area of professional competence, the attending physician shall retain responsibility for the continuous care and supervision of each patient in the Hospital for whom he/she is providing services, or arrange a suitable alternative for such care and supervision; including an initial assessment of all patients within twelve (12) hours of admission except for normal newborns, who shall be assessed initially within twenty-four (24) hours of birth, and in the critical care unit, where an initial assessment shall occur no later than two (2) hours after admission or sooner if warranted by the patient's condition. The foregoing responsibilities are modified under special circumstances pursuant to Department or Section request and approval by the Medical Executive Committee and Board. Approval by the Board shall not be unreasonably withheld.

c. Actively participate:

1) in the performance improvement program and other patient care evaluation and monitoring activities required of the staff;

2) in promoting effective utilization of resources consistent with Medical Staff policies and the delivery of quality patient care; and

3) in discharging such other staff functions as may be required from time- to-time.

d. Serve on at least one (1) Medical Staff committee, if appointed by the Chief of Staff.

Article 3.2-4 Transfer of Active Staff Member

After two consecutive years in which a member of the active staff fails to regularly care for patients in this Hospital or be actively involved in Medical Staff affairs as determined by the Medical Executive Committee and Board of Trustees based upon criteria set forth in these Bylaws, at the time of reappointment that member shall be transferred to the appropriate category, if any, for which the member is qualified. There will be every effort made to contact the member and discuss the change in advance of the final Board approval regarding the recommended change in staff category. In the event the member does not meet the qualifications for continued membership in another medical staff category, he or she will be deemed ineligible to apply for renewal of medical staff membership. A member who objects to any reassignment or deemed ineligibility under this section may request a meeting with the Medical Executive Committee to appeal that decision; however, the procedural rights of Article 7 shall not apply.

Article 3.3 THE COURTESY MEDICAL STAFF

Article 3.3-1 Qualifications

The courtesy Medical Staff shall consist of members who:

a. meet the general qualifications set forth in subsections (a)-(b) of Section 3.2-1;

b. do not regularly care for patients as determined by the Medical Staff. Courtesy staff shall:

   1) admit, or regularly care for not more than 11 patients per two year period in the Hospital; or

   2) provide patient care coverage for members of the active staff of this hospital.

c. are available to provide continuous care for their hospitalized patients or arrange to have continuous coverage of these patients by another member of the staff with privileges appropriate to the treatment provided;

d. are members in good standing of the active or consulting Medical Staff of another California licensed Hospital, although exceptions to this requirement may be made by the Medical Executive Committee for good cause; and

e. have satisfactorily completed their designated term in the provisional category.

Article 3.3-2 Prerogatives

Except as otherwise provided, the courtesy Medical Staff member shall be entitled to:

a. admit patients to the Hospital with the limitations of Section 3.3-1(b) and exercise such clinical privileges as are granted pursuant to Article 5; and

b. attend meetings of the Medical Staff and the Department of which the individual is a member, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment. Courtesy staff members shall not be eligible to hold office in the Medical Staff, but may serve on Committees.

Article 3.3-3 Responsibilities

Each member of the Courtesy Staff shall:

a. Discharge the basic responsibilities specified in Section 2.5;

b. Retain responsibility within his/her area of professional competence for the care and supervision of each patient in the Hospital for who he/she is providing service.

Article 3.3-4 Limitation

Courtesy staff members who admit patients or regularly care for patients at the Hospital and who do not meet the terms of Section 3.3-1 (b) shall be transferred at the time of

reappointment to the appropriate category, if any, for which the member is qualified. There will be every effort made to contact the member and discuss the change in advance of final Board approval regarding the recommended change in staff category. In the event the member does not meet the qualifications for continued membership in another medical staff category, he or she will be deemed ineligible to apply for renewal of medical staff membership. A member who objects to any reassignment or deemed ineligibility under this section may request a meeting with the Medical Executive Committee to appeal that decision; however, the procedural rights of Article 7 shall not apply.

Article 3.4 THE CONSULTING MEDICAL STAFF

Article 3.4-1 Qualifications

Any member of the Medical Staff in good standing may consult in that member's area of expertise; however, the consulting Medical Staff shall consist of such practitioners who:

a. are not otherwise members of the Medical Staff;

b. meet the general qualifications set forth in Section 2.2;

c. possess adequate clinical and professional expertise;

d. are willing and able to respond, when called to render non-emergency clinical services within their area of competence, and respond in a timely fashion when voluntarily participating in the provision of emergency on-call services;

e. are members of the active or courtesy Medical Staff of another Hospital licensed by California or another state, although exceptions to this requirement may be made by the Medical Executive Committee for good cause;

f. are involved in at least one patient care activity per two-year period. These patient care activities may consist of assisting at surgeries, consultations, and/or other patient care without managing the direct patient care, although exceptions to this requirement may be made for good cause by the Medical Executive Committee. Except where otherwise provided, Consulting Staff members shall not admit patients to the Hospital, transfer patients from the Hospital, or act as the physician of primary care or responsibility for any patient within the Hospital; and

g. have satisfactorily completed their designated term in the provisional category.

Article 3.4-2 Prerogatives

The consulting Medical Staff member shall be entitled to:

a. exercise such clinical privileges as are granted pursuant to Article 5; and

b. attend meetings of the Medical Staff and the Department of which that person is a member, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment. Consulting staff members shall not be eligible to hold office in the Medical Staff organization, but may serve on committees.

Article 3.4-3 Responsibilities

Each member of the Consulting Staff shall assume responsibility for consultation, treatment and appropriate documentation thereof with regard to his/her patients.

Article 3.4-4 Limitation

Consulting Staff members who do not meet the requirements of Section 3.4-1(a)-(f) shall be transferred at the time of reappointment to the appropriate category, if any, for which the member is qualified. There will be every effort made to contact the member and discuss the change in advance of final Board approval regarding the recommended change in staff category. In the event the member does not meet the qualifications for continued membership in another medical staff category, he or she will be deemed ineligible to apply for renewal of medical staff membership. A member who objects to any reassignment or deemed ineligibility under this section may request a meeting with the Medical Executive Committee to appeal that decision; however, the procedural rights of Article 7 shall not apply.

Article 3.5 PROVISIONAL STAFF

Article 3.5-1 Qualifications

The provisional staff shall consist of members who:

a. meet the general Medical Staff membership qualifications set forth in Sections 2.2, 3.2-1(a) and (b) or 3.4-1(a)-(f); and

b. immediately prior to their application and grant of membership were not members in good standing of this Medical Staff.

Article 3.5-2 Prerogatives

The provisional staff member shall be entitled to:

a. admit patients and exercise such clinical privileges as are granted pursuant to Article 5; and

b. except for Telemedicine Staff, attend meetings of the Medical Staff and the Department of which that person is a member, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment. Provisional staff members shall not be eligible to hold office in the Medical Staff organization, but may serve upon committees.

Article 3.5-3 Focused Professional Practice Evaluation (FPPE) of Provisional Staff Member

Each provisional staff member shall undergo a period of FPPE 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 provisionally granted, and (2) overall eligibility for continued staff membership and advancement within staff categories. Observation of provisional staff members shall follow the format established by the

Medical Executive Committee. Such observation should include concurrent or retrospective chart review, mandatory consultation with their proctor, and/or direct observation by the proctor. Appropriate observation and proctoring records shall be maintained. Each proctor shall complete a written proctoring report with his comments on the appointee's performance. Proctorship reports or FPPE will be timely completed and submitted for review on a concurrent basis (if requested) to identify any possible trend or pattern that might require early investigation and/or intervention. The results of the observation shall be communicated by the Department Chair to the Credentials Committee.

Article 3.5-4 Term of Provisional Staff Status

All new members of the Medical Staff requesting clinical privileges, except those requesting temporary privileges, will initially be appointed to the provisional staff and shall remain in the provisional staff for a period of 1 year, unless that status is extended by the Medical Executive Committee and approved by the Board for an additional period of up to 1 year upon a determination of good cause, which determination shall not be subject to review pursuant to Articles 6 or 7.

Article 3.5-5 Action at Conclusion of Provisional Staff Status

If the provisional staff member has substantially completed FPPE requirements and satisfactorily demonstrated the ability to exercise the clinical privileges provisionally granted and otherwise appears qualified for continued Medical Staff membership, the member shall be eligible for advancement to the active, courtesy or consulting staff as appropriate, upon recommendation of the Medical Executive Committee and approval by the Board of Trustees.

At the discretion of the Medical Executive Committee, failure to complete one or more procedure-specific proctoring requirements shall not of itself preclude advancement to another staff category provided that all basic proctoring requirements have been successfully completed pursuant to current Medical Staff proctoring policies.

In all other cases, the appropriate Department Chair shall advise the Credentials Committee which shall make its report to 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.

Article 3.6 HONORARY STAFF

Article 3.6-1 Qualifications

The Honorary Staff shall consist of physicians, dentists, and podiatrists 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.

Article 3.6-2 Prerogatives

Honorary Staff members are not eligible to admit patients to the Hospital or to exercise clinical privileges in the Hospital, or to vote or hold office in this Medical Staff organization, but they may serve upon committees with or without vote at the discretion of

the Medical Executive Committee. They may attend staff and Department meetings, including open committee meetings and educational programs.

Article. 3.7 TELEMEDICINE STAFF

Article 3.7-1 Telemedicine Definitions

Distant Site, for purposes of telemedicine services, means the location distant from the Hospital from which Telemedicine Staff provide telemedicine services to patients at the Hospital.

Distant Site Entity, for purposes of telemedicine services, means a health care entity other than Watsonville Community Hospital which is not owned or operated by Watsonville Community Hospital, such as another hospital, imaging center, urgent care center, medical practice, or other non-hospital care setting.

Originating Site[1], for purposes of telemedicine services, means the patient care site at Watsonville Community Hospital.

Telemedicine Privileges means the specific authority granted to a Telemedicine Staff member to provide Telemedicine Services, as required by the Medical Staff credentialing and privileging processes and other governing documents of the Medical Staff.

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

Telemedicine Staff [2] is the medical staff category reserved solely for physicians practicing at a Distant Site, and who are privileged by the medical staff to provide only Telemedicine Services to patients located at the Originating Site.

Article 3.7-2 Qualifications

a. The Telemedicine Staff shall consist of physicians who practice at a Distant Site; work as part of a Distant Site Entity that is contracted under a written agreement with the Hospital to provide telemedicine services for the Hospital [3]; and are privileged by the medical staff to provide only telemedicine services to patients physically located within the Hospital, a.k.a. to patients located at the Originating Site. Members of the

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[1] "Distant Site" and Originating Site" are common vernacular in the telemedicine arena.

[2] Written to narrowly define this category of provider as those who never come to WCH (the originating site) to practice medicine, but who treat WCH's patients from a distant site, and have no privileges at WCH other than Telemedicine Privileges.

[3] A written agreement is required between the Hospital and the Distant Site physician or entity before these telemedicine provisions can be implemented. (*See* Joint Commission Standard LD.04.03.09, Element of Performance No. 23.) The Hospital's agreement must affirmatively require, among other things, that [1] the Distant Site physician or entity is a contractor of services to the Hospital; [2] the Distant Site physician or entity operates such that the Originating Site remains in compliance with Medicare Conditions of Participation; and [2] the Distant Site's credentialing and privileging processes meet, at a minimum, Medicare CoPs.

Telemedicine Staff must satisfy a period of Focused Professional Practice Evaluation as set forth in these Bylaws. Telemedicine Staff do not qualify for any other category of medical staff.

b. Members of the Medical Staff who are privileged to come to the Hospital to provide care to patients may provide telemedicine services. Such members do not qualify for the Telemedicine Staff category of membership.

Article 3.7-3 Prerogatives

Telemedicine Staff members are not eligible to admit patients to the Hospital, or to vote or hold office in this Medical Staff organization. They may serve upon committees that oversee, review or evaluate telemedicine services, with or without vote at the discretion of the Medical Executive Committee. They may attend staff and Department meetings, including open committee meetings and educational programs.

Article 3.7-4 Credentialing Telemedicine Staff

a. Credentialing Appointments and Reappointments to the Telemedicine Staff. Applicants to the Telemedicine Staff must be credentialed pursuant to the complete appointment/reappointment and privileging process in these Bylaws. However, modified appointment, credentialing and privileging requirements may be implemented, but only when consistent with accreditation standards of The Joint Commission and consistent with Medicare Conditions of Participation. The Medical Staff General Rules & Regulations shall set forth the associated details and processes for such modified appointment, credentialing and privileging requirements.

b. Distant Site Credentialing and Privileging Decision. As an alternative to the credentialing and privileging process described in Article 5, the Executive Committee may make recommendations to the Governing Body regarding applicants seeking Telemedicine Staff membership who intend to provide Telemedicine services under a written agreement(s) between the Hospital and a Distant Site Entity by the processes set forth in the Medical Staff General Rules and Regulations.

Article 3.7-5 Temporary Privileges for Telemedicine.

Temporary privileges for Telemedicine Staff may be granted only in accordance with Article 5.5-1 of these Bylaws.

Article 3.7-6 Duty to Assure Quality of Care

At all times, the medical staff retains responsibility for overseeing the safety and quality of services offered to patients under these Telemedicine provisions, and shall take all appropriate action in carrying out that responsibility.[4]

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[4] Joint Commission Standard MS.13.01.01, "Rationale." Self-evident, perhaps, but worth being clear here, given the duty described earlier in the paragraph to send quality information to the Distant Site for its own use.

Article 3.8 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 or the Medical Executive Committee.

Article 3.8-1 General Exceptions to Prerogatives

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

a. shall only have the right to vote on matters within the scope of their licensure. In the event of a dispute over voting rights, that issue shall be determined by the Chair of the meeting, subject to final decision by the Medical Executive Committee; and

b. shall exercise clinical privileges only within the scope of their licensure and as set forth in Section 5.4.

Article 3.9 MODIFICATION OF MEMBERSHIP

On its own, upon recommendation of the Credentials Committee, or pursuant to a request by a member under Section 4.6-1(b), or upon direction of the Board of Trustees as set forth in Section 6.1-6, the Medical Executive Committee may recommend a change in the Medical Staff category of a member consistent with the requirements of the Bylaws.

Article 3.10 MEDICAL STUDENTS, INTERNS, AND RESIDENTS

The terms "medical students," "interns," and "residents," (herein referred to collectively as "House Staff") as used in these Bylaws refer to practitioners who are currently enrolled in a graduate medical education program approved by the Medical Executive Committee and Board of Trustees and who, as part of their educational program will provide health care services at the Hospital. House Staff shall not be considered Licensed Independent Practitioners, shall not be eligible for clinical privileges or Medical Staff membership, and shall not be entitled to any of the rights of hearing or appeal under these Bylaws. House Staff shall be credentialed by the sponsoring medical or osteopathic school or training program in accordance with provisions in a written affiliation agreement between the Hospital and school or program, or they shall be credentialed primarily by the Hospital for training programs which are sponsored by the Hospital. In compliance with federal laws, it shall not be necessary to submit a query to the National Practitioner Data Bank prior to permitting a House Staff practitioner to provide services at this Hospital. House Staff practitioners may render patient care services at the Hospital only pursuant to and limited by the following:

a. Application of provisions of the professional licensure requirements of the state;

b. A written affiliation agreement between the Hospital and the sponsoring medical school or training program. Such agreement shall identify the individual entity responsible for providing professional liability insurance coverage for House Staff practitioners in the amount of One Million Dollars ($ 1,000,000) for each claim and Three Million Dollars ($ 3,000,000) in aggregate. The House Staff practitioner shall provide clinical services pursuant to Hospital-sponsored training program policies and procedures. The affiliation agreement shall also address a mechanism for communication by and between the professional graduate medical education

committees, the medical staff and Board of Trustees about the safety and quality of patient care and the related educational and supervisory needs of the participant in the graduate medical educational program(s);

c. Policies, procedures and protocols established by the Medical Staff shall define the House Staff practitioner's authority, mechanism for the direction and supervision of the House Staff practitioner by a member of the Medical Staff or LIP, other conditions imposed on a House Staff practitioner by this Hospital and the Medical Staff; and mechanisms for evaluation of each participant's progressive involvement and independence in specific patient care activities. The policies shall also address participants who may write orders, the circumstances under which they may do so, and any countersignature requirements;

d. While functioning in the Hospital, the House Staff Practitioner shall abide by all provisions of the Medical Staff Bylaws, Rules and Regulations, and Medical Staff and Hospital policies and procedures and shall be subject to limitation or termination of their ability to function at the Hospital at any time at the discretion of the Medical Executive Committee;

e. The House Staff practitioner may perform only those services set forth in the practitioner's job description and/or training protocols;

f. A House Staff practitioner shall be responsible and accountable at all times to a member of the Medical Staff and shall be under the supervision and direction of a member of the Medical Staff.

Article 3.11 MEMBERSHIP WITHOUT DELINEATED CLINICAL PRIVILEGES

Article 3.11-1 Membership with "Refer and Follow" Privileges Only

Practitioners who do not wish to actively treat patients within the Hospital may seek "Refer and Follow" privileges only. These will permit the practitioner to refer patients to the Hospital for outpatient testing and refer patients to Medical Staff members for procedures or inpatient treatment. If the admitting/attending physician agrees, a practitioner with "Refer and Follow" privileges may visit his/her patients in the Hospital, review patient medical records and receive information concerning the patient's medical condition and treatment. However, under no circumstances shall a practitioner with "Refer and Follow" privileges participate in any treatment or procedure, make any entries in the medical record, or admit a patient to the Hospital.

"Refer and Follow" members may attend meetings of the Medical Staff and the Department of which the individual is a member, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment. "Refer and Follow" staff members shall not be eligible to hold office in the Medical Staff, but may serve on committees.

Article 4 APPOINTMENT AND REAPPOINTMENT

Article 4.1 GENERAL

Except as otherwise specified herein, no person, including persons engaged by the Hospital in administrative positions, shall exercise clinical privileges in the Hospital unless and until that person applies for and receives appointment to the Medical Staff, is granted privileges as set forth in these Bylaws, or, with respect to an Allied Health Practitioner, has been authorized to provide services under applicable Medical Staff policies, as set forth in the Allied Health Practitioner Rules and Regulations.

By applying to the Medical Staff for appointment or reappointment, or in the case of members of the Honorary Staff or Refer and Follow Staff, by accepting an appointment to that category, the applicant acknowledges responsibility to first review these Bylaws and Medical Staff Rules and Regulations and Medical Staff policies, and agrees that throughout any period of membership that person will comply with the responsibilities of Medical Staff membership and with the Bylaws, Rules and Regulations and policies of the Medical Staff as they exist and as they may be modified from time to time. Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted in accordance with these Bylaws. For the purpose of this Article, the term "member" shall include Medical Staff members and applicants, unless otherwise stated.

Article 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 in a timely fashion for an adequate evaluation of the applicant’s qualifications and suitability for the clinical privileges and staff category requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information. When the applicant fails to provide requested information, within the requested time frame, that application will be deemed incomplete and will be considered withdrawn.

To the extent consistent with law, and based upon a reasonable individualized suspicion of possible impairment, the individual applicant may be requested to submit to, and consent to the release of results from a health evaluation that could include blood, urine or chemical analysis or psychological/psychiatric examination, at the applicant's expense. The applicant may select the examining practitioner from among two who are chosen by the Medical Executive Committee. Under no circumstances shall this Section endorse a requirement for routine drug or alcohol or other health testing for all applicants to the Medical Staff.

This same burden of producing clinical, medical, and psychological information rests with any practitioner required to produce information as part of an authorized Medical Staff peer review activity.

Article 4.3 APPOINTMENT AUTHORITY

Appointments, denials and revocations of appointments of Medical Staff membership and/or privileges shall be made as set forth in these Bylaws, but only after there has been a recommendation from the Medical Executive Committee as set forth in Section 4.5.

Article 4.4 DURATION OF APPOINTMENT AND REAPPOINTMENT

Generally, except as otherwise provided in these Bylaws, initial appointments and reappointments shall be for a period not to exceed 2 years.

Article 4.5 APPLICATION FOR INITIAL APPOINTMENT AND REAPPOINTMENT

Article 4.5-1 Application Form and Requirements

Medical Staff application shall include forms to be completed by initial applicants for Medical Staff membership and/or privileges, and by those individuals seeking reappointment to the Medical Staff and/or renewal or revision of clinical privileges. The Medical Staff application forms are peer review evaluation documents, an official record of the Medical Executive Committee and are afforded all protections pursuant to California Evidence Code Section 1157. The forms shall require detailed information which shall include, but not be limited to, information concerning:

a. the applicant's qualifications, including, but not limited to, professional training and experience, current licensure, current DEA registration, special certifications; and continuing medical education information related to the clinical privileges to be exercised by the applicant;

b. peer references familiar with the applicant's professional competence and ethical character;

c. request for membership category, relevant Department membership, and clinical privileges sought;

d. past or pending professional disciplinary action, voluntary or involuntary denial, revocation, suspension, reduction, restriction or relinquishment of Medical Staff membership or privileges at any other Hospital, clinic or other health care facility;

e. the applicant's health status and specifically the ability to perform all procedures and other privileges requested with or without reasonable accommodations, according to accepted standards of professional performance without posing a threat to patient safety;

f. any allegations of civil or criminal fraud pending against any applicant and any past allegations including their resolution;

g. The existence and circumstances of any professional liability complaint, claim or other cause of action that has been brought against the practitioner, and the status or outcome of each such matter, including all final judgments and/or settlements involving the practitioner;

h. professional liability coverage for the clinical privileges to be exercised;

i. information as to any current or pending challenges or voluntary relinquishments affecting participation in any state or federal health care program or in federal procurement or nonprocurement programs or any action which might cause the practitioner to become an ineligible person, as well as any sanctions from a

professional review organization;

j. the existence and circumstances of any past or pending professional disciplinary action or investigation by a Hospital medical group or other institution involving the practitioner including the status or outcome of each such matter;

k. any prior or pending government agency or third party proceeding or litigation challenging or sanctioning the practitioner's admission, treatment, discharge, billing or collection practices, including but not limited to Medicare and Medicaid fraud and abuse proceedings, convictions, and or settlements and any investigations by any federal or state agency concerning participation in any health insurance program, including Medicare or Medicaid;

l. any prior or pending challenge to any licensure or DEA or other registration, or the voluntary or involuntary relinquishment of any such licensure or registration and the status or outcome of each such matter;

m. information as to whether the applicant has ever been subject to a felony conviction or whether any such action is pending;

n. A recent, wallet sized photograph of the applicant;

o. For all new applicants and practitioners requesting new or additional privileges, evidence of the practitioner's professional practice review, volumes and outcomes from organization(s) that currently privilege the applicant if available; and

p. Proof of United States citizenship or legal residency.

Each application for initial appointment to the Medical Staff shall be in writing submitted on the prescribed form with all provisions completed, or accompanied by an explanation of why answers are unavailable, and signed by the applicant. It is the applicant's obligation to assure that information contained on the application form is accurate and complete. During pendency of the application and on a continuing basis thereafter, the practitioner shall notify the Chief of Staff via the Medical Staff office within seven (7) days of notice of any of the matters listed in Section (d), (e), (f), or (k).

Only complete applications will receive consideration. At any time during the processing of an application, any committee or individual responsible for review of an application may request, in writing (via mail, fax, or email), further documentation or clarification from the applicant. If the applicant fails to respond to such request within thirty (30) days, the application shall be deemed incomplete and automatically withdrawn unless an exception is made for good cause within the discretion of the Chief of Staff or his/her designee. The failure to consider applications deemed incomplete shall not entitle the applicant to due process rights pursuant to Article 7.

For new applicants, any significant misrepresentation or omission of information on the application form or temporary privileges request shall be dealt with by rejection of the application as incomplete and without the right to a hearing pursuant to Article 7. For those reapplying for Medical Staff Membership , any significant misrepresentation or omission of information on the application form or temporary privilege request shall be grounds for immediate denial, termination, revocation and/or suspension of all Medical Staff membership and/or clinical privileges, and any applicable hearing rights under

Article 7 shall be limited to the issue of whether the information provided constitutes a misrepresentation, or whether information was in fact omitted.

A nonrefundable application fee as determined by the Medical Executive Committee must accompany all new applications. Each Medical Staff application shall be a confidential Peer Review document of the Medical Staff. Each completed Medical Staff application shall be delivered to the Medical Staff Office for action in accordance to these Bylaws. For good cause, the application fee may be waived within the discretion of the Chief of Staff.

When an applicant requests an application form, that person shall be given a copy of these Bylaws, the Medical Staff Rules and Regulations, and, if deemed appropriate by the Medical Executive Committee, copies or summaries of any other applicable Medical Staff policies relating to clinical practice in the Hospital.

Article 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:

a. signifies willingness to appear for interviews in regard to the application;

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

c. consents to inspection of records and documents that may be material to an evaluation of the applicant's qualifications, including but not limited to, training and education, experience, current competence and ability to perform privileges requested, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection, copying, and sharing such records for purposes of this appointment/reappointment process;

d. releases from any liability, to the fullest extent provided by law, all persons for their acts performed in connection with investigating and evaluating the applicant;

e. releases from any liability, to the fullest extent provided by law, all individuals and organizations who provide information regarding the applicant, including otherwise confidential information;

f. consents to the disclosure to other Hospitals, medical associations, licensing boards, and to other similar organizations as permitted or required by law, any information regarding the applicant's professional or ethical standing that the Medical Staff may have, and releases the Medical Staff and Hospital from liability for so doing to the fullest extent provided by law;

g. if a requirement then exists for Medical Staff dues, acknowledges responsibility for timely payment;

h. agrees to provide for continuous quality care for patients;

i. pledges to maintain an ethical practice including, but not limited to, refraining from

fee splitting or any other illegal inducements for patient referral, providing for the continuous care of the applicant's patients, seeking consultation whenever necessary, refraining from failing to disclose to patients when another surgeon will be performing the surgery, and refraining from delegating patient care responsibility to non-qualified or inadequately supervised practitioners or allied health practitioners;

j. pledges to be bound by the Medical Staff Bylaws, Rules and Regulations, and Medical Staff policies;

k. verifies that all information contained in or submitted with the application is true and agrees that any material omission or provision of false information will be grounds for summary rejection of the application without benefit of the hearing procedures outlined herein except as provided in Section 4.5-1 of these Bylaws; and

l. agrees that he/she will exhaust the administrative remedies afforded by these bylaws before resorting to formal legal action to the extent permitted by applicable law, should an adverse ruling be made with respect to his/her staff membership, and/or clinical privileges.

Article 4.5-3 Verification of Information, Department and Credentials Committee Action

a. Initial Review.

After receipt of the Medical Staff application and payment of applicable fees, the Medical Staff Office shall verify the information provided using primary source verification or a Credentials Verification Organization. Along with review and verification of the application and all supporting documentation by the Medical Staff Office, the Medical Staff Office shall query the Medical Board of California or other applicable licensing agency and the National Practitioner Data Bank regarding the applicant or member and submit any resulting information for inclusion in the applicant's or member's credentials file.

b. Incomplete Application or Otherwise Ineligible Candidate.

The application shall not be processed further if one (1) or more of the following applies:

1) Not Licensed: The practitioner is not licensed in this state to practice in a field of health care eligible for appointment to the Staff or has not applied for such licensure;

2) Privileges Denied or Terminated: Within two (2) years immediately preceding the request, the practitioner has had his/her application for Staff appointment at this Hospital denied, has resigned his/her Staff appointment at this Hospital during the pendency of an active investigation which could have led to revocation of his/her appointment, or has had his/her appointment revoked or terminated at this Hospital; or

3) Exclusive Contract: The practitioner practices a specialty which is the subject of a current written exclusive contract for coverage with the Hospital where such practitioner is not a member of the group holding the contract; or

4) Inadequate Insurance: The practitioner does not meet the liability insurance coverage requirements of these bylaws; or

5) Ineligible for Medicare Provider Status: The practitioner has been excluded, suspended or debarred from any government payer program; or

6) No DEA number: The practitioner's DEA number/controlled substance license has been revoked or voluntarily relinquished (this section shall not apply to voluntary relinquishment by practitioners whose practice does not require a DEA number); or

7) Application Incomplete: The practitioner has failed to provide any information required by these bylaws or requested on the application or requested by the Chief of Staff or his/her designee or has failed to fulfill any other application agreement (e.g., has failed to execute an acknowledgment, agreement or release required by these bylaws or included in the application.

The refusal to further process an application form for any of the above reasons shall not entitle the practitioner to any further procedural rights under these bylaws.

c. Processing of Completed Applications.

The completed application and all supporting materials then available shall be transmitted to the Chair of each Department in which the applicant seeks privileges and to the Credentials Committee. The appropriate Department Chair shall review the application and supporting documentation, and may conduct a personal interview with the applicant at his or her discretion. The Department Chair shall evaluate all matters deemed relevant to a recommendation, including information concerning the applicant's provision of services within the scope of privileges requested, the individual's clinical and/or technical skill as indicated by the results of quality assessment and performance improvement activities. The following six areas of general competencies are included in the comprehensive evaluation of the practitioner's professional practice: (1) patient care; (2) medical/clinical knowledge; (3) practice-based learning and improvement; (4) interpersonal and communication skills; (5) professionalism; and (6) systems-based practice, to the extent available. The Department Chair shall submit to the Credentials Committee Chair his or her recommendations as to appointment and, if appointment is recommended, as to membership category, Section and Department affiliation, clinical privileges to be granted, and any special conditions to be attached.

The Credentials Committee may also request additional information, shall conduct a personal interview with the applicant (unless there is good cause to waive this requirement), and/or return the matter to the Department Chair for further investigation. The Credentials Committee shall submit to the Medical Executive Committee a written recommendation as to appointment and, if appointment is recommended, as to membership category, Section and Department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment.

Article 4.5-4 Medical Executive Committee Action

At its next regular meeting after receipt of the Credentials Committee report and recommendation, or as soon thereafter as is practicable, the Medical Executive Committee shall consider the report and any other relevant information. The Medical Executive Committee may request additional information, return the matter to the Credentials Committee for further investigation, and/or elect to interview the applicant. The Medical Executive Committee shall immediately forward to the CEO, for prompt transmittal to the Chair of the Board (or for applications eligible for expedited review pursuant to Section 4.5-10, the Board of Trustees members appointed to a committee to handle expedited cases) a written report and recommendation as to Medical Staff appointment and, if appointment is recommended, as to membership category, Department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment, including but not limited to consultation, monitoring and/or proctoring requirements. The committee may also defer action on the application. The reasons for each recommendation shall be stated. Action by the MEC to defer the application for further consideration must be followed up within ninety (90) days with a recommendation for appointment with specified clinical privileges or for rejection of the application.

Article 4.5-5 Effect of Medical Executive Committee Action

a. When the recommendation of the Medical Executive Committee is for appointment and the granting of all requested privileges, it shall be immediately be forwarded, together with supporting documentation, to the Board of Trustees.

b. When a final recommendation of the Medical Executive Committee is denial of appointment, the Board of Trustees and the applicant shall be promptly informed by special notice. The applicant shall be entitled to the procedural rights as specified in Article 7.

c. When the Medical Executive Committee recommends appointment, but recommends denial of one or more requested privileges based on the applicant's professional competence or conduct, the Board of Trustees and the applicant shall be promptly informed by special notice and the applicant shall be entitled to the procedural rights specified in Article 7 with respect to the portion of the recommendation which is unfavorable. The remainder of the recommendation shall be transmitted to the Board of Trustees for action.

Article 4.5-6 Action on the Application

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

a. If the Medical Executive Committee issues a favorable recommendation, the Board of Trustees shall give great weight to this recommendation and shall affirm the recommendation of the Medical Executive Committee, unless the Medical Executive Committee’s decision is not supported by substantial evidence.

b. In the event the recommendation of the Medical Executive Committee is denial of appointment or denial of any requested privilege to the applicant, or if the Board determines that the Medical Executive Committee’s favorable recommendation is

not supported by substantial evidence, the procedural rights set forth in Article 7 shall apply.

1) If procedural rights are waived by the applicant, the Board of Trustees shall take final action on the matter.

2) If the applicant requests a hearing under Article 7, the Board of Trustees shall take final action only after the applicant has exhausted all procedural rights as established by Article 7. After exhaustion of the procedures set forth in Article 7, the Board shall make a final decision and shall affirm the decision of the Judicial Review Committee if the Judicial Review Committee's decision is supported by substantial evidence, following a fair procedure. The Board's decision shall be in writing and shall specify the reasons for the action taken.

Article 4.5-7 Notice of Final Decision

Notice of the final decision or Special Notice if the decision is adverse shall be given to: (1) the Chief of Staff, (2) the Medical Executive Committee, (3) the Credentials Committee, (4) the Chair of each Department concerned, (5) the applicant, (6) the CEO, and (7) the Chair of the Board of Trustees.

a. A decision and notice to appoint or reappoint shall include, if applicable:

1) the staff category to which the applicant is appointed;

2) the Department to which that person is assigned;

3) the clinical privileges granted; and

4) any special conditions attached to the appointment.

Article 4.5-8 Reapplication After Adverse Appointment Decision

An applicant who has received a final adverse decision regarding appointment shall not be eligible to reapply to the Medical Staff for a period of 2 years. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as set forth in Section 4.2, including such information as may be required to demonstrate that the basis for the earlier adverse action no longer exists.

Article 4.5-9 Timely Processing of Applications

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

a. evaluation, review, and verification of application and all supporting documents by the Medical Staff Office: 30 days from receipt of all necessary documentation;

b. review and recommendation by Department(s): 30 days after receipt of all necessary documentation from the Medical Staff office;

c. review and recommendation by Credentials Committee: 30 days after receipt of all necessary documentation from the Department(s);

d. review and recommendation by Medical Executive Committee: 30 days after receipt of all necessary documentation from the Credentials Committee; and

e. final action: 180 days after receipt of all necessary documentation by the Medical Staff Office, or 30 days after conclusion of hearings.

Article 4.5-10 Expedited Review

The Board of Trustees may use an expedited process for review and action on a favorable MEC recommendation for initial appointment and reappointment to the medical staff or for granting Privileges when criteria for that process are met. The Board of Trustees may delegate this authority to a committee comprised of at least two voting members of the Board of Trustees; however, any final decision of the committee must be subject to ratification by the full Board of Trustees at its next regularly scheduled meeting following notification of the committee's action. Expedited processing is usually not available if:

a. The applicant or Member submits an incomplete application;

b. The Medical Executive Committee's recommendation is adverse in any respect;

c. There is a current active investigation, restriction, or pending Accusation involving the practitioner brought or being conducted by the applicant's licensing authority or by the Medical Staff of another healthcare entity;

d. The applicant has received an involuntary termination of Medical Staff membership at another organization or an involuntary limitation, reduction, denial or loss of some or all Privileges;

e. There has been a final judgment adverse to the applicant in a professional liability action that is deemed excessive by the Department Chair and Credentials Committee.

There is no right to expedited review. Rather, use of the expedited review process is entirely within the discretion of the MEC and Board. After the Board committee established for expedited review has determined whether to approve or disapprove the recommendation of the MEC, further action shall be in accordance with Section 4.5-6 and/or 4.6 as applicable.

Article 4.6 REAPPOINTMENT AND REQUESTS FOR MODIFICATIONS OF STAFF STATUS OR PRIVILEGES

Article 4.6-1 Application

a. At least 150 days prior to the expiration date of the current staff appointment, a reapplication form developed by the Medical Executive Committee consistent with Section 4.5-1, shall be mailed or delivered to the member. If an application for reappointment is not received at least 120 days prior to the expiration date, written

notice shall be promptly sent to the applicant advising that the application has not been received. At least 90 days prior to the expiration date, each Medical Staff member shall submit to the Medical Staff Office the completed application form for renewal of appointment to the staff, and for renewal or modification of clinical privileges. Failure to submit a completed application at least 90 days prior to the expiration date of the current appointment shall be deemed a voluntary resignation from the Medical Staff effective the last day of the current appointment. A maximum 30-day exception to the 90-day deadline can be made for good cause, at the discretion of the Chief of Staff.

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 commencing at Section 4.5-3. Failure without good cause to timely supply the application for reappointment shall constitute a voluntary resignation from the Staff and shall result in expiration of membership at the expiration of the Member's current term. A Practitioner whose membership is so terminated shall not be entitled to the procedural rights provided in Article VII.

b. A Medical Staff member who seeks a change in Medical Staff status or modification of clinical privileges may submit such a request at any time upon a form developed by the Medical Executive Committee, except that such application may not be filed within 1 year of the time a similar request has been denied.

Article 4.6-2 Effect of Application

The effect of an application for reappointment or modification of staff status or privileges is the same as that set forth in Section 4.5-2.

Article 4.6-3 Standards and Procedure for Review

When a staff member submits the first application for reappointment, and every 2 years thereafter, or when the member submits an application for modification of staff status or clinical privileges, the member shall be subject to an in-depth review generally following the procedures set forth in Sections 4.5-3 through 4.5-9. When insufficient peer review information is available, peer recommendations as to relevant training and expertise, current competence and any effects of health status on privileges being requested shall be obtained from a practitioner in the same professional discipline with personal knowledge of the applicant’s abilities and shall be evaluated except for Honorary and Refer and Follow staff categories. In each such instance, the member's eligibility for Medical Staff membership as set forth in Article 2, and the member's eligibility for assignment to a category of the Medical Staff as set forth in Article 2, shall be re-determined. Any member who has failed to engage in at least one patient care activity at the Hospital for the preceding two (2) years shall be ineligible to apply for renewal of clinical privileges and the procedures set forth in Article 7 shall not apply. Exceptions to this activity requirement may be made by the Medical Executive Committee for good cause.

Article 4.6-4 Expedited Review for Extension of Appointment

In situations where it appears that the routine processing of applications under Section 4.5-9 will result in an application for reappointment not being fully processed by the expiration

of the member's appointment, the Board of Trustees may utilize the expedited review process, so long as the application qualifies for such review under Section 4.5-10.

Article 4.6-5 Failure to Timely File Reappointment Application

a. Except as otherwise provided below, failure to submit a completed application at least 90 days prior to the expiration date of the current appointment shall be deemed a voluntary resignation from the Medical Staff effective the last day of the current appointment.

b. If a Medical Staff member files a complete application with all supporting or requested documentation after the due date but prior to the expiration of the appointment period, the member will be assessed a late fee determined by the Medical Executive Committee. The application may continue to be processed; however, if the member's application is not fully processed and approved by the expiration of the member's current appointment period, that member's membership and clinical privileges will expire.

c. In the event membership or clinical privileges are deemed resigned or expired for the reasons set forth in (a) or (b), the procedures set forth in Article 7 shall not apply.

d. A member who requests reappointment to the Medical Staff and submits all supporting or requested documentation within sixty (60) days following a deemed resignation or expiration of privileges under this Section may, but only for good cause, as determined by the Chief of Staff, be deemed exempt from any requirement that he or she complete an application form for new applicants. Where such good cause has not been found and when requests are not received within sixty (60) days following deemed resignation under this Section, such requests shall be treated as applications for initial appointment.

Article 4.7 LEAVE OF ABSENCE

Article 4.7-1 Leave Status

At the discretion of the Medical Executive Committee, a Medical Staff member may obtain a voluntary leave of absence from the staff upon submitting a written request to the Medical Executive Committee stating reason for the requested leave of absence and the approximate period of leave desired, which may not exceed one year. During the period of the leave, the member shall not exercise clinical privileges at the Hospital, and membership rights and responsibilities shall be inactive. Members on leave of absence are not required to maintain continuous professional liability insurance, but must have appropriate "tail" coverage providing coverage for acts that occurred prior to the leave of absence. Periods of leave shall not be considered in calculating a member's satisfaction of requirements relating to patient care and Medical Staff activities.

Article 4.7-2 Termination of Leave

At least 30 days prior to the termination of the leave of absence, or at any earlier time, the Medical Staff member may request reinstatement of privileges by submitting a written notice to that effect to the Medical Executive Committee. The staff member shall submit a summary of relevant activities during the leave, if the Medical Executive Committee so requests. If deemed necessary, the Medical Executive Committee may require the member

to provide information to the Medical Executive Committee and/or Well Being Committee, which may include submission to a medical, psychiatric, or psychological examination, at the member's expense. The Medical Executive Committee shall make a recommendation concerning the reinstatement of the member's privileges and prerogatives, and the procedure provided in Sections 4.1 through 4.5-8 shall be followed if the time period since the member's appointment or last reappointment is eighteen (18) months or greater or the member's appointment or last reappointment has expired.

Article 4.7-3 Failure to Request Reinstatement

Failure, without good cause, to request reinstatement from a leave of absence within the time frame specified in Section 4.7-2 shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of membership, privileges, and prerogatives. A member whose membership is automatically terminated shall not be entitled to the procedural rights provided in Article 7 unless the circumstances require a report to the Medical Board of California and/or National Practitioners Data Bank. A request for Medical Staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

Article 4.7-4 Medical Leave Of Absence

The Medical Executive Committee shall determine the circumstances under which a particular Medical Staff member shall be granted a leave of absence for the purpose of obtaining treatment for a medical condition or disability. In the discretion of the Medical Executive Committee, unless accompanied by a reportable restriction of privileges, the leave shall be deemed a "medical leave" which is not granted for a medical disciplinary cause or reason.

Article 4.7-5 Military Leave of Absence

Requests for leave of absence to fulfill military service obligations shall be granted upon notice and review by the Medical Executive Committee. Reactivation of membership and clinical privileges previously held shall be granted, notwithstanding the provisions of Sections 4.7-2 and 4.7-3, but may be granted subject to monitoring and/or proctoring as determined by the Medical Executive Committee.

Article 4.7-6 Notification and Update to the Medical Staff

Each applicant or member agrees to notify the Medical Staff promptly and no later than fourteen (14) calendar days from the occurrence of any event representing a change or modification of information required as a condition of appointment and/or reappointment as described in Article 4. Such information includes but is not limited to:

a. Receipt of written notice of any adverse action by the Medical Board of California (or other applicable licensing agency) taken or pending including but not limited to an accusation filed, temporary restraining order, or imposition of any interim suspension, probation, or limitations affecting license to practice medicine or the practitioner's designated profession.

b. Any action taken by any health care organization which has resulted in the filing of a Section 805 report with the Medical Board of California (or other applicable licensing agency) or a report with the National Practitioner Data Bank.

c. The denial, revocation, suspension, reduction, limitation on renewal, or voluntary relinquishment by resignation of Medical Staff membership or clinical privileges at any health care organization.

d. Any material reduction in professional liability coverage including changes in the scope of coverage.

e. Receipt of notice of any legal action related to a filed or served malpractice suit or malpractice-related arbitration action.

f. Indictment for, charges brought against or Conviction of any felony.

g. Receipt of any proposed or actual exclusion or adverse action under Medicare or Medicaid programs or any other federally funded or state health care programs including but not limited to fraud and abuse proceedings or convictions or any other action that would cause the individual to become an ineligible person as defined by these Bylaws.

Article 5 CLINICAL PRIVILEGES

Article 5.1 EXERCISE OF PRIVILEGES

Except as otherwise provided in these Bylaws, a member providing clinical services at this Hospital shall be entitled to exercise only those clinical privileges specifically granted. Said privileges and services must be Hospital specific, within the scope of any license, certificate or other legal credential authorizing practice in this state and consistent with any restrictions thereon. The exercise of clinical privileges shall be subject to the Medical Staff Bylaws, Rules and Regulations, and Medical Staff Policies and the Rules and Regulations of the Clinical Department and subject to the authority of the Department Chair and the Medical Executive Committee. Medical Staff privileges may be granted, continued, modified or terminated by the Board of Trustees of this Hospital only upon recommendation of the Medical Executive Committee, (except as provided in Section 6.1-6) only for reasons directly related to quality of patient care and other provisions of the Medical Staff Bylaws, and only following the procedures outlined in these Bylaws.

Article 5.2 DELINEATION OF PRIVILEGES IN GENERAL

Article 5.2-1 Requests

Each application for appointment and reappointment to the Medical Staff must contain a request for the specific clinical privileges desired by the applicant. A request by a member for a modification of clinical privileges may be made at any time, but such requests must be supported by documentation of training and/or experience supportive of the request. Limited license practitioners who seek to exercise independent clinical privileges must specifically delineate the privileges desired.

Unavailable Clinical Privileges. Notwithstanding any other provisions of these Bylaws, to the extent that any requested Clinical Privileges are not available at the Hospital (whether because of exclusive contract, lack of facilities, policy design of the Governing Board, or otherwise), the request therefore shall be rejected without the necessity of processing pursuant to Article 4.5 above. Because such a rejection is unrelated to the applicant's qualifications, an applicant whose request is so rejected shall not be entitled to the procedural rights provided in Article VII.

Article 5.2-2 Bases for Privileges Determination

a. Not all clinical privileges are exercised at this Hospital. Requests for privileges not exercised at this Hospital may be denied solely on that ground. Any such denial shall not be subject to the provisions of Article 7.

b. Requests for clinical privileges shall be evaluated on the basis of the member's, licensure, education, training, experience, current demonstrated professional competence and judgment, clinical performance, current health status, and the documented results of patient care and other quality review and monitoring which the Medical Staff deems appropriate. Privilege determinations may also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a member exercises clinical privileges. Privileges shall be granted for a period not to exceed two (2) years and re-

evaluated/reviewed as part of the reappointment credentialing process as described in these Bylaws.

c. The burden of providing sufficient information to evaluate a request for privileges rests with the applicant. The provisions of Section 4.2 apply to requests for privileges.

Article 5.3 FPPE

Article 5.3-1 General Provisions

a. Any member of the Medical Staff in good standing who has completed his or her initial FPPE requirements may act as a proctor at the request of the Department Chair.

b. All initial appointees to the Medical Staff and all members granted new clinical privileges shall be subject to a period of FPPE. Each appointee or recipient of new clinical privileges shall be assigned to a Department where performance on an appropriate number of cases as established by the Medical Executive Committee, or the Department as designee of the Medical Executive Committee, and shall be observed by the Chair of the Department, or the Chair's designee, during the period of FPPE as specified in the Department's Rules and Regulations, to determine suitability to continue to exercise the clinical privileges granted in that Department. The exercise of clinical privileges in any other Department shall also be subject to direct observation by that Department's Chair or the Chair's designee.

c. Allied Health Practitioners shall be proctored and/or undergo other monitoring, as determined by the Medical Executive Committee.

d. Appropriate requirements for FPPE and/or monitoring, as determined by the Chief of Staff or Departmental Chair, or their designees, shall be imposed for all practitioners granted temporary privileges.

e. New clinical privileges granted to an existing Medical Staff member shall be evaluated as determined by the Medical Executive Committee.

f. The Medical Executive Committee may utilize FPPE reports from other Joint Commission accredited Hospitals pursuant to the current Medical Staff proctoring policy.

g. The Medical Executive Committee may utilize retrospective chart reviews in FPPE, however, significant concurrent review of a member should be a part of FPPE.

h. The Medical Executive Committee may impose additional consultation, monitoring or proctoring requirements as a condition of granting a new privilege, as a condition of renewal of privileges (e.g., for infrequently performed privileges where it is difficult to assess the member's current competence) or at any time the Medical Executive Committee determines that additional information is needed to assess a practitioner's performance.

Article 5.3-2 Completion of FPPE

A practitioner shall remain subject to such FPPE until the Credentials Committee and/or Medical Executive Committee has been furnished with:

a. a report signed by the Chair of the Department(s) to which the member is assigned describing the types and numbers of cases observed and the evaluation of the applicant's performance, a statement that the applicant appears to meet all of the qualifications for unsupervised practice in that Department, has discharged all of the responsibilities of staff membership, and has not exceeded or abused the prerogatives of the category to which the appointment was made; and

b. a report signed by the Chair of the other Department(s) in which the appointee may exercise clinical privileges, describing the types and number of cases observed and the evaluation of the applicant's performance and a statement that the member has satisfactorily demonstrated the ability to exercise the clinical privileges initially granted in those Departments.

c. a report that any relevant conditions which the Credentials and/or Medical Executive Committee has imposed have been satisfied.

Article 5.3-3 Other Applications of FPPE

Other Applications of FPPE. In addition to evaluating the professional practice of a newly appointed member of the Medical Staff, Focused Professional Practice Evaluation shall be utilized whenever:

a. New privileges are awarded, regardless of whether the Practitioner has already achieved full status as a member of the Medical Staff;

b. Clinical activity is insufficient to evaluate the ongoing clinical performance of a Practitioner; and

c. Questions about an individual Practitioner's judgment or competence arise.

The procedures for implementing FPPE in such instances shall be the same as in the case of appointment to provisional Medical Staff Status.

Article 5.3-4 Use of FPPE Information

Use of FPPE Information. FPPE information and results shall be forwarded to the Credentials Committee, Quality Review Committees, Physician Wellbeing Committee, and/or Medical Executive Committee, as appropriate. Determination will be made by the Chief of Staff if the information should be forwarded to the Physician Well Being Committee. Information may be utilized:

a. In the credentialing and recredentialing of a Professional;

b. In the decision to grant, deny or restrict Clinical Privileges;

c. In determining whether to initiate or seek disciplinary action; and

d. For educational purposes.

Article 5.3-5 Effect of Failure to Complete FPPE

a. Failure to Complete Necessary Volume: Any member who fails to complete the required number of proctored cases within the time frame imposed shall be deemed to have voluntarily withdrawn his or her request for membership (or the relevant privileges), and he or she shall not be afforded the procedural rights provided in Article 7. However, the Department has the discretion to extend the time for completion of proctoring in appropriate cases, subject to ratification by the Medical Executive Committee. The inability to obtain such an extension shall not give rise to procedural rights described in Article 7.

b. Failure to Satisfactorily Complete FPPE: If a practitioner completes the necessary volume of proctored cases within the time frame imposed but fails to perform satisfactorily during proctoring, the Medical Executive Committee may recommend restriction or revocation of the privileges, and the practitioner shall be afforded any applicable procedural rights under these Bylaws.

Article 5.4 LIMITATIONS ON PRIVILEGES OR PRACTICE PREROGATIVES OF DENTISTS, PODIATRISTS, AND ALLIED HEALTH PRACTITIONERS

Article 5.4-1 Dentists and Podiatrists

The following general provisions shall apply to dentists and podiatrists:

a. Admitting and other clinical privileges of dentists and podiatrists may not exceed the scope of their licensure;

b. Patients admitted by dentists and podiatrists must receive all necessary and appropriate medical evaluations and care;

c. For any patient admitted by a dentist or podiatrist, a physician member of the Medical Staff must conduct or directly supervise the admitting history and physical examination and assume responsibility for the care of the patient's medical problems present at the time of admission or which may arise during Hospitalization which are outside of the dentist/podiatrist scope of licensure or privilege, and

d. Notwithstanding Section c. above, dentists and podiatrists who demonstrate the requisite education, training and experience may be privileged to conduct the admitting history and physical, without physician supervision.

e. Any dispute between a dentist or podiatrist and a physician member regarding proposed treatment must be promptly resolved by the Department Chair.

f. A Podiatrist or Dentist shall not serve in or be nominated, elected or appointed to a position that requires him to supervise directly or indirectly medical practice beyond the scope of practice authorized by his license.

Article 5.5 TEMPORARY CLINICAL PRIVILEGES

Article 5.5-1 Requirement of Need and Definition of Circumstances

Temporary privileges may only be granted in two circumstances: 1) to fulfill an important patient care, treatment, and/or service need, and 2) when an applicant for new privileges with a complete application that raises no concerns is awaiting review and approval of the Medical Executive Committee and the Board of Trustees. Temporary privileges may be granted on a case-by-case basis and within the discretion of the Medical Staff and Board of Trustees, for a period of time not to exceed 120 days. Each circumstance has different criteria for granting temporary privileges:

1) **To Fulfill an Important Care Need.** The following criteria must be met in order to grant temporary privileges to meet an important care need:

   - The individual must have a current license to practice in the State in which privileges are sought.

   - The individual must have current competence to perform the privileges requested. Evidence of current competence can be demonstrated by meeting the following:

     - Graduate of an approved residency program in the area in which privileges are being requested, and evidence of recent relevant (past 2 years) education, training, and experience in the area of privileges being requested.

     - Additional criteria (if any) for the specific privileges requested.

2) **New Applicant Awaiting Review:** The following criteria must be met in order to grant temporary privileges to an applicant for new privileges and approval of the Medical Staff Executive Committee and the Board of Trustees:

   - Current license to practice in the State in which application to medical staff membership is sought.
   - Evidence of recent relevant (past two years) training or experience.
   - Evidence of current competence.
   - Ability to perform the privileges requested.
   - A query and evaluation of National Practitioner Data Bank (NPDB) information, as well as clearance from OIG sanctions.
   - A complete application
   - No current or previously successful challenge to licensure or registration.
   - No subjection to involuntary termination of medical staff membership at another organization.
   - No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges.

   Temporary privileges are granted by the Chief Executive Officer, or authorized designee, based upon the recommendation of the Chief of Staff or authorized designee. Individuals granted temporary privileges may be subject to proctoring requirements as noted in the bylaws and/or rules and regulations. Temporary

privileges shall be granted for a time period not to exceed 120 days. Temporary privileges may be revoked at any time in accordance with attendant processes outlined in the bylaws. Revocation of temporary privileges does not afford the affected individual the hearing and appeals rights noted in the bylaws.

NOTE: "Applicant for new privileges" includes an individual applying for clinical privileges at the hospital for the first time; an individual currently holding clinical privileges who is requesting one or more additional privileges; and/or an individual who is in the reappointment/re-privileging process and is requesting one or more additional privileges.

Article 5.5-2 Review of Application

a. Upon receipt of a completed application and a request for temporary privileges, related to an applicant for new clinical privileges (i.e., Section 5.5-1 (b)), and upon receipt of all required fees and supporting documentation, including responses to all requests for information, from a physician, dentist, or podiatrist authorized to practice in California, the Chief Executive Officer or his or her designee (acting for the Board), on the recommendation of the Chief of Staff after positive recommendations by the Department Chairs and Chair of the Credentials Committee**,** may grant temporary privileges to an individual who appears to have qualifications, ability and judgment consistent with Section 2.2-1, but only after:

   1) The applicant has turned in a complete application and all elements of the application, as described in Section 2.2-1, have been verified with all required reports such as the National Practitioner Data Bank query and OIG sanction report have been run;

   2) Review to ensure that there are no current, recommended or previous restrictions, denials, or terminations of licensure or registration, and no involuntary terminations of medical staff membership or involuntary restrictions, reductions, denials or terminations of clinical privileges at another institution;

   3) Review to determine that there is neither an unusual pattern nor an excessive number of professional liability actions resulting in final judgments against the applicant;

   4) After evaluation and assessment of the complete file has been conducted, and written or verbal positive recommendation has been obtained from the Chair or designee of each Department in which the applicant is requesting privileges, and review and approval is obtained from the Credentials Committee Chair; and

   5) The applicant's file, including the recommendation of the Department Chairs or designee is reviewed on behalf of the Medical Executive Committee by the Chief of Staff or designee with a positive recommendation.

b. Upon a request for temporary privileges to meet an important patient care need (e.g., Section 5.5-1(a)) and upon receipt of all required fees and responses to all requests for information, from a physician, dentist, or podiatrist authorized to practice in

California, the Chief Executive Officer or his or her designee (acting for the Board), on the recommendation of the Chief of Staff, may grant temporary privileges to a member who appears to have qualifications, ability and judgment consistent with Section 2.2-1. Temporary privileges may only be granted after verifying the applicant's current licensure and competence (relevant to the privileges requested).

c. All practitioners requesting temporary privileges to meet an important patient care need (e.g., Section 5.5-1(a)) must demonstrate Active Staff membership and good standing at a Joint Commission approved Hospital, although exceptions may be made by the Chief of Staff or designee for good cause.

d. In the event of a disagreement between the Chief Executive Officer and the Chief of Staff regarding the granting of temporary clinical privileges, the matter shall be referred to the Joint Conference Committee for resolution.

e. The omission of any information, response or recommendation specified in this section may preclude the granting of temporary privileges. A determination to grant temporary privileges shall not be binding or conclusive with respect to an applicant's pending request for appointment to the Medical Staff.

Article 5.5-3 General Conditions

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

b. There is no right to temporary privileges. If the available information is inconsistent or casts any reasonable concerns on the practitioner's qualifications, action on the request for temporary privileges shall be deferred until the concerns have been satisfactorily resolved. Temporary privileges shall terminate immediately should the applicant's application be deemed incomplete or should the MEC make a final adverse determination on the application.

c. Temporary privileges shall automatically terminate at the end of the designated period, unless earlier terminated or suspended upon recommendation by the MEC or unless affirmatively renewed. As necessary, the appropriate Department Chair or, in the Chair's absence, the Chief of Staff, shall assign a member of the Medical Staff to assume responsibility for the care of such member's patient(s). The wishes of the patient shall be considered in the choice of a replacement Medical Staff member.

d. Appropriate requirements for FPPE as determined by the Chief of Staff or Departmental Chair, or their designees, shall be imposed on any individuals granted temporary privileges.

e. All persons requesting or receiving temporary privileges must submit a signed acknowledgment that he or she shall be bound by the Medical Staff Bylaws, Rules and Regulations and Medical Staff Policies.

Article 5.6 DISASTER-EMERGENCY PRIVILEGES

a. In the case of a disaster or other emergency, when the Disaster Plan has been

activated, any member of the Medical Staff, regardless of Department, staff status, or clinical privileges, shall be permitted to do everything reasonably possible to save the life of a patient or to save a patient from serious harm provided that the care provided is within the scope of the individual's license. The member shall make every reasonable effort to communicate promptly with the Department Chair concerning the need for emergency care and assistance by members of the Medical Staff with appropriate clinical privileges, and once the emergency has passed or assistance has been made available, shall defer to the Department Chair with respect to further care of the patient at the Hospital.

b. In the event of a disaster, when the Disaster Plan has been activated, any licensed practitioner may be granted privileges to provide patient care in accordance with the policy entitled "Credentialing Licensed Independent Practitioners in the Event of Emergency or Disaster".

c. The policy entitled "Credentialing Licensed Independent Practitioners in the Event of Emergency or Disaster" has been developed by the Medical Executive Committee and approved by the Hospital's Board of Trustees. Any amendments to this document must also be adopted by the Medical Executive Committee and approved by the Board of Trustees.

Article 5.7 MODIFICATION OF CLINICAL PRIVILEGES OR DEPARTMENT ASSIGNMENT

On its own, upon recommendation of the Credentials Committee, or pursuant to a request under Section 4.6-1(b), the Medical Executive Committee may recommend a change in the clinical privileges or Department assignment(s) of a member. The Medical Executive Committee may also recommend that the granting of additional privileges to a current Medical Staff member be made subject to monitoring in accordance with procedures similar to those outlined in Section 5.3-1.

Article 5.8 LAPSE OF APPLICATION

If an initial applicant for Medical Staff membership and clinical privileges fails to furnish the information reasonably necessary to evaluate the request within thirty (30) days of being requested to do so by the Medical Staff, the application shall be deemed incomplete and automatically withdrawn, unless an exception is made for good cause within the discretion of the Chief of Staff or his/her designee, and the applicant shall not be entitled to a hearing as set forth in these Bylaws. The applicant may file a new application with the supporting information.

Article 6 CORRECTIVE ACTION

Article 6.1 CORRECTIVE ACTION

Article 6.1-1 Routine Monitoring and Evaluation

The Medical Staff Departments and committees are responsible for carrying out delegated routine review and quality assessment functions. They may counsel, educate, issue letters of warning or censure, or institute retrospective or concurrent monitoring (so long as the Practitioner is only required to provide reasonable notice of admissions and procedures) in the course of carrying out their duties without initiating formal corrective action. Comments, suggestions and warnings may be issued orally or in writing. The Practitioner shall be given an opportunity to meet with the Department or committee. Any informal actions, monitoring, or counseling shall be documented in the Practitioner's file. Medical Executive Committee approval is not required for such actions, although the actions shall be reported to the Medical Executive Committee. Such activity shall not constitute an official investigation (Sec. 6.1-2) nor shall they constitute a restriction of Privileges or grounds for any formal hearing or appeal rights under Article 7. When deemed appropriate, within his or her discretion, the Chief of Staff or other Medical Staff officer may assist with Departmental or committee reviews under Section 6.1-1.

Article 6.1-2 Initiation of Official Medical Executive Committee Investigation

Any person may provide information to the Medical Executive Committee about the conduct, performance, or competence of Medical Staff members. When reliable information indicates a member may have exhibited acts, demeanor, or conduct reasonably likely to be (1) detrimental to patient safety or to the delivery of quality patient care; (2) unethical; (3) contrary to the Medical Staff Bylaws, Medical Staff policies or Rules and Regulations; (4) below applicable professional standards, or (5) the Medical Staff becomes aware that a member has sustained a summary suspension or limitation of privileges at another hospital, a request for an investigation or action against such member may be initiated.

If the Medical Executive Committee initiates an investigation, it shall make an appropriate record of the reasons.

Within his/her discretion, the Chief of Staff may initiate an official MEC investigation acting alone, so long as the matter is subsequently submitted to the full MEC for its consideration and any appropriate action.

Article 6.1-3 Investigation

a. If the Medical Executive Committee concludes an investigation is warranted, it shall direct an investigation to be undertaken. The Medical Executive Committee may conduct the investigation itself, or may assign the task to an appropriate Medical Staff Officer, Medical Staff Department, or standing or ad hoc committee of the Medical Staff. The Medical Executive Committee in its discretion may appoint practitioners who are not members of the Medical Staff as temporary members of the Medical Staff for the sole purpose of serving on a standing or ad hoc committee, and not for the purpose of granting these practitioners temporary clinical privileges under Section

5.5, should circumstances warrant.

b. If the investigation is delegated to an officer or committee other than the Medical Executive Committee, such officer or committee shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the Medical Executive Committee as soon as practicable. The report may include recommendations for appropriate corrective action.

c. At a time deemed appropriate, within the discretion of the person(s) conducting the investigation, the member shall be given notice that an investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The individual or body investigating the matter may, but is not obligated to, conduct interviews with persons involved; however, such investigation shall not constitute a "hearing" as that term is used in Article 7, nor shall the procedural rules with respect to hearings or appeals apply. Despite the status of any investigation, at all times the Medical Executive Committee shall retain authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension, termination of the investigative process, or other action.

Article 6.1-4 Executive Committee Action

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

a. determining no corrective action be taken and, if the Medical Executive Committee determines there was no credible evidence for the complaint in the first instance, entering a statement to that effect in the member's file;

b. deferring action for a reasonable time where circumstances warrant;

c. issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude the Medical Executive Committee or Department heads from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letters are issued by the MEC, the affected member may make a written response which, along with the MEC's letter shall be placed in the member's file;

d. recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admission, mandatory consultation, or monitoring;

e. recommending reduction, modification, suspension or revocation of clinical privileges;

f. recommending changes to membership status or limitation of any prerogatives directly related to the member's delivery of patient care;

g. recommending suspension, revocation or probation of Medical Staff membership;

h. refer the member to the Well-Being Committee for guidance, evaluation, and

follow-up, as appropriate; and/or

i. taking other actions deemed appropriate under the circumstances.

Article 6.1-5 Subsequent Action

a. If corrective action as set forth in Section 7.2(a)-(k) is taken or recommended by the Medical Executive Committee, notice of that action or recommendation shall be transmitted to the Board of Trustees. Any required notice or special notice of the action shall also be provided to the individual who is the subject of the action.

b. Unless the recommendation is not supported by the weight of the evidence, the action or recommendation of the Medical Executive Committee shall be adopted by the Board as final action, unless the member is entitled to and requests a formal hearing under the Bylaws, in which case the final decision shall be determined as set forth in Article 7.

c. If the Medical Executive Committee's recommended action is to recommend no corrective action, such recommendation, together with such supporting documentation as may be requested by the Board shall be transmitted thereto as an informational item.

Article 6.1-6 Initiation by Board of Trustees

In compliance with Business and Professions Code Section 809.05, if the Medical Executive Committee fails to investigate or take corrective action, contrary to the weight of the evidence, the Board of Trustees may take action as follows:

a. After consultation (by the Chief Executive Officer or other representative of the Board) with the Chief of Staff or MEC, if the Board determines that the Medical Staff is not appropriately addressing a peer review matter, contrary to the weight of the evidence suggesting that it should be addressed, the Board shall contact the Medical Staff leadership (Chief of Staff or MEC) and request that it initiate investigation or corrective action.

b. If the Medical Staff fails to take action as requested by the Board in this regard, then the Board may investigate and if deemed necessary may act directly against the physician or other practitioner. However, any such action may be taken only after the Board has given written notice to the Medical Executive Committee of its intent to take action. In no event may the Board act unreasonably.

c. In taking such action, the Board takes the place of the MEC to perform all functions relating to this matter that are otherwise delegated to and would be performed by MEC representatives and, to the extent applicable, the Board must act in compliance with these Bylaws (Articles 6 and 7) and with the peer review action requirements under Section 809 et seq. of the Business & Professions Code.

d. If the Medical Executive Committee fails to take action in response to that Board of Trustees direction, the Board of Trustees may initiate corrective action after written notice to the Medical Executive Committee, but this corrective action must comply with these Medical Staff Bylaws.

Article 6.1-7 Physician Health Concerns

a. When reliable information indicates that a practitioner may be suffering from a disabling mental or physical condition that might pose a threat to patient care, the Chief of Staff or other officer or a Department Chair may request involvement by the Well-Being Committee on an informal basis in order to provide support to the practitioner and to make appropriate inquiries as to underlying facts. The Well- Being Committee should keep the referring person reasonably up-to-date as to its activities and progress in the matter. In addition, any time that the Well-Being Committee finds that the practitioner is not cooperative and/or it determines that corrective action may be necessary in order to protect patients, the Committee Chair must promptly contact the Chief of Staff with such information.

b. When the information regarding a practitioner's health is of sufficient magnitude that it is reasonably determined that the practitioner may pose an immediate threat, summary suspension may be imposed if the circumstances warrant such action under Section 6.2. For matters that do not warrant summary suspension, but are nevertheless of significant concern, the MEC may decide to order an official Investigation under Section 6.1-2. The MEC may delegate such Investigation to an existing committee or to a special Ad Hoc Committee. The individual who is the subject of the investigation shall be provided with notice that an Investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The investigating body will keep the Medical Executive Committee or Chief of Staff informed of the progress of its investigation and of any timelines.

c. The investigative body shall also inform the Chief of Staff promptly when circumstances indicate a possible need for formal corrective action so that the Chief of Staff may take summary action, if necessary, and/or refer the matter to the Medical Executive Committee for additional consideration and action.

Article 6.2 SUMMARY RESTRICTION OR SUSPENSION

Article 6.2-1 Criteria for Initiation

Notwithstanding any other provision of these Bylaws, the Medical Staff may immediately suspend or restrict clinical privileges of a Medical Staff member or Allied Health Staff member whenever failure to take such action may result in an imminent danger to the health of any individual. Summary suspension of clinical privileges may be imposed by the Medical Executive Committee (acting as a whole) the Chief of Staff (or Vice Chief in the Chief's absence) or the Chair (or Vice Chair in the Chair's absence) of the Department in which the member holds privileges. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition and the person or body responsible shall promptly give written notice to the Board of Trustees, the Medical Executive Committee and the CEO.

In addition, the affected Medical Staff member shall be provided with a special notice of the action which notice fully complies with the requirements of Section 6.2-2 below. The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary restriction or suspension, the member's patients shall be promptly

assigned to another member by the Department Chair or by the Chief of Staff, considering where feasible, the wishes of the patient in the choice of a substitute member.

Article 6.2-2 Special Notice of Summary Suspension

Within one working day of imposition of a summary suspension, the affected Medical Staff member shall be provided with special notice of such suspension. This initial notice shall include a statement of facts demonstrating that the suspension was necessary because failure to suspend or restrict the practitioner's privileges summarily could reasonably result in an imminent danger to the health of an individual. The statement of facts provided in this initial special notice shall also include a summary of one or more particular incidents giving rise to the assessment of imminent danger. This initial notice shall not substitute for, but is in addition to, the notice required under Section 7.3-1 (which applies in all cases where the Medical Executive Committee does not immediately terminate the summary suspension). The notice under Section 7.3-1 may supplement the initial notice provided under this Section, by including any additional relevant facts supporting the need for summary suspension or other corrective action.

Article 6.2-3 Medical Executive Committee Action

Within one week after such summary restriction or suspension has been imposed, a special meeting of the Medical Executive Committee shall be convened to review and consider the action. Upon his or her request, the member who is the subject of the summary suspension may attend and make a statement concerning the issues under investigation, on such terms and conditions as the Medical Executive Committee may impose, although in no event shall any meeting of the Medical Executive Committee, with or without the member, constitute a "hearing" within the meaning of Article 7, nor shall any procedural rules apply. The Medical Executive Committee may modify, continue, or terminate the summary restriction or suspension, but in any event it shall furnish the member with special notice of its decision within 2 working days of the meeting.

Article 6.2-4 Procedural Rights

Unless the Medical Executive Committee promptly terminates the summary restriction or suspension, the member shall be entitled to the procedural rights afforded by Article 7

Any affected practitioner shall have the right to challenge imposition of the summary suspension, among other grounds on the issue of whether or not the facts stated in the notice present a reasonable possibility of "imminent danger" to an individual. Initially, the practitioner may present this challenge to the Medical Executive Committee at the meeting held within one week of imposition of the suspension. If the Medical Executive Committee's decision is to continue the summary suspension, then any practitioner who has properly requested a hearing under the Medical Staff Bylaws may challenge the propriety of summary suspension and the substantive reasons for the summary suspension

Unless, within its sole discretion, the MEC earlier lifts the suspension, the summary restriction or suspension shall remain in effect during the pendency and completion of the corrective action process and of the hearing and appellate review process. When a summary action is continued, the affected Practitioner shall be entitled to the procedural rights afforded by Article 7, but the hearing may be consolidated with the hearing on any other corrective action that is recommended so long as the hearing commences within sixty (60) days after the hearing on the summary action was requested.

Article 6.2-5 Summary Suspension by Board of Trustees

Notwithstanding anything to the contrary in the provisions of this Section 6.2, above, if the Chief of Staff, members of the Medical Executive Committee or the Chief of the Department in which the member holds privileges (or their designees) are not available to summarily restrict or suspend the member's membership or clinical privileges, the Board of Trustees (or designee) may immediately suspend a member's privileges if a failure to suspend those privileges may result in an imminent danger to the health of any person, provided that the Board of Trustees (or designee) made reasonable attempts to contact the Chief of Staff, members of the Medical Executive Committee and the head of the Department (or designee) before the suspension.

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

Article 6.3 AUTOMATIC SUSPENSION OR LIMITATION

In the following instances, the member's privileges or membership may be suspended or limited as described below.

Article 6.3-1 Licensure

a. Revocation and Suspension: Whenever a member's license or other legal credential authorizing practice in this state is revoked, relinquished, placed in inactive status or suspended, Medical Staff membership and clinical privileges shall be automatically revoked as of the date such action becomes effective.

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

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

Article 6.3-2 Controlled Substances

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

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

Article 6.3-3 Medical Records

Members of the Medical Staff are required to complete medical records within such reasonable time as may be prescribed by the Medical Executive Committee.

A limited suspension in the form of withdrawal of admitting and other related privileges until medical records are completed, shall be imposed by the Chief of Staff, or the Chief of Staff's designee, after notice of delinquency for failure to complete medical records within such period.

For the purpose of this Section, "related privileges" means voluntary on-call service for the emergency room, scheduling or performing surgery, assisting in surgery, consulting on Hospital cases, and providing professional services within the Hospital for future patients.

Bona fide vacation or illness may constitute an excuse subject to approval by the Medical Executive Committee.

Members whose privileges have been suspended for delinquent records may admit or perform procedures upon patients only in life-threatening situations.

The suspension shall continue until lifted by the Chief of Staff or his or her designee.

Article 6.3-4 Failure to Pay Dues/Assessments

Failure without good cause as determined by the Medical Executive Committee, to pay dues or assessments, as required under Section 13.2, shall be ground for automatic suspension of a member's clinical privileges, and if within three months after a written warning of the delinquency the member does not pay the required dues or assessments, the member's membership shall be automatically terminated.

Article 6.3-5 Professional Liability Insurance

Failure to maintain required professional liability insurance shall be grounds for immediate automatic suspension of a member's clinical privileges, and if within [90 days] after written warnings of the delinquency the member does not provide evidence of required professional liability insurance, the member's membership shall be automatically terminated.

Article 6.3-6 Exclusion from Federal Health Care Program

Whenever a practitioner or AHP is excluded, debarred or suspended from any state or federal health care program or procurement program or otherwise becomes an ineligible person, the event shall result in immediate automatic suspension of practicing in the Hospital and automatic termination of Medical Staff membership.

Article 6.3-7 Medical Executive Committee Deliberation

As soon as practicable after action is taken or warranted as described in Section 6.3-1(b) or (c), 6.3-2, 6.3-4, 6.3-5, or 6.3-6 the Medical Executive Committee shall convene to review and consider the facts, and may recommend any further corrective action as it may deem appropriate in accordance with these Bylaws.

A practitioner whose membership and/or privilege has been terminated or suspended pursuant to an automatic suspension or limitation shall not be entitled to procedural rights afforded under Article 7.Within 30 days of receiving notice of the automatic termination or suspension, the practitioner may request a review the form of which shall be a meeting or similar opportunity to provide information, within the discretion of the MEC, which will consist of presenting information to the Medical Executive Committee solely on the issue of whether the act or event which generated the automatic suspension or limitation occurred. Following this opportunity afforded to the affected individual, the Medical Executive Committee shall provide the affected member with notice of any final recommendations and shall forward those recommendations to the Board of Trustees.

Article 6.3-8 Automatic Suspension or Limitation of AHP Clinical Privileges

An Allied Health Practitioner's clinical privileges shall automatically terminate, be suspended, or otherwise restricted in analogous circumstances as those described above for Medical Staff members. In addition, with respect to an Allied Health Practitioner who must practice under physician supervision, the privileges of the AHP will automatically terminate if the supervising physician is terminated, the supervising physician no longer agrees to act in such capacity, or the relationship between the AHP and the supervising physician is otherwise terminated regardless of the reason, and the AHP has no other supervising physician. Details regarding the automatic termination, suspension, or restriction of an AHP's clinical privileges reside in the Allied Health Practitioner Rules/ Regulations.

Article 7 HEARINGS AND APPELLATE REVIEWS

Article 7.1 GENERAL PROVISIONS

Article 7.1-1 Exhaustion of Remedies

If adverse action described in Section 7.2 is taken or recommended, the applicant or member must exhaust the remedies afforded by these Bylaws before resorting to litigation.

Article 7.1-2 Application of Article

For purposes of this Article, the term "member" may include an applicant or holder of temporary privileges, as may be applicable under the circumstances, unless otherwise stated. In addition to Medical Staff members and applicants, clinical psychologists, family therapists and clinical social workers (or any other "licentiate" as defined by Business and Professions Code Section 805(a)(2), who are providing or applying to provide professional services in the Hospital, but are not members of the Medical Staff, are entitled to the hearing rights specified in this article.

Article 7.1-3 Definitions

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

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

b. "Practitioner," as used in this Article, refers to the practitioner who is entitled to request a hearing pursuant to Section 7.1-2 of this Article.

Article 7.1-4 Final Action

Recommended adverse actions described in Section 7.2 shall become final only after the hearing and appellate rights set forth in these Bylaws have either been exhausted or waived, and only upon being adopted as final actions by the Board of Trustees.

Article 7.1-5 Substantial Compliance

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

Article 7.2 GROUNDS FOR HEARING

Except as otherwise specified in these Bylaws, any one or more of the following Medical Executive Committee or Board actions or recommended actions for a medical disciplinary cause or reason and if reportable to the Medical Board of California (or other applicable licensing agency), under Business and Professions Code Section 805 or its successor statute, shall be deemed actual or potential adverse action and constitute grounds for a hearing:

a. denial of Medical Staff membership;

b. denial of requested advancement in staff membership status, or category;

c. denial of Medical Staff reappointment;

d. suspension of Medical Staff Membership;

e. revocation of Medical Staff membership;

f. denial of requested clinical privileges;

g. involuntary reduction of current clinical privileges;

h. suspension of clinical privileges;

i. termination of all clinical privileges; or

j. involuntary imposition of significant consultation or other requirements that restrict a member's ability to exercise clinical privileges.

Article 7.3 REQUESTS FOR HEARING

Article 7.3-1 Notice of Action or Proposed Action

In all cases in which action has been taken or a recommendation made as set forth in Section 7.2, the practitioner shall be given special notice of the recommendation or action and of the right to request a hearing pursuant to Section 7.3-2, Request for Hearing. The notice shall state:

a. What action has been proposed against the practitioner;

b. Whether the action, if adopted, must be reported under Business and Professions Code Section 805;

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

d. That the practitioner may request a hearing;

e. That a hearing must be requested within 30 days and that failure to request a hearing within the specified time period shall constitute a waiver of rights to a hearing and to an Appellate Review of the matter;

f. That after receipt of this hearing request, the practitioner will be notified of the date, time and place of the hearing, the grounds upon which the adverse action is based, and a list of

the witnesses expected to testify in support of the adverse action; and

g. That the practitioner has the hearing rights described in the Medical Staff Bylaws, including those specified in Section 7.4, Hearing Procedure.

Article 7.3-2 Request for Hearing

The practitioner shall have 30 days following receipt of notice of such action to request a hearing. The request shall be in writing addressed to the Chief of Staff with a copy to the Chief Executive Officer. If the practitioner does not request a hearing within the time and in the manner described, the practitioner shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved. In this event, the matter shall be reported promptly to the Board of Trustees.

Article 7.4 HEARING PROCEDURE

Article 7.4-1 Hearings Prompted By Board of Trustees Action

If the hearing is based upon an adverse action by the governing body, the Chair of the Board of Trustees shall fulfill the functions assigned in this section to the Chief of Staff.

Article 7.4-2 Time and Place for Hearing

Upon receipt of a request for hearing, the Chief of Staff shall schedule a hearing and, within 30 days from the date he or she received the request for a hearing, give special notice to the practitioner of the time, place and date of the hearing. The date set for the commencement of the hearing shall be not less than 30 days no more than 60 days from the date the Chief of Staff received the request for a hearing. The start date of the hearing or any session thereof may be delayed only upon agreement of the parties or upon written decision issued by the Hearing Officer pursuant to Section 7.4-8. At the discretion of the Medical Executive Committee the hearing may be held using video conferencing.

Article 7.4-3 Notice of Charges

Together with the notice stating the place, time and date of the hearing, the practitioner shall be provided with a written statement of the reasons for the adverse proposed action taken or recommended, including the acts or omissions with which the practitioner is charged and a list of the charts in question, where applicable. A supplemental notice may be issued at any time, provided that the practitioner is given sufficient time to prepare to respond.

Article 7.4-4 Judicial Review Committee

a. When a hearing is requested, the Chief of Staff shall appoint a Judicial Review Committee which shall be composed of 3 members of the Medical Staff who shall gain no direct financial benefit from the outcome and who have not acted as accuser, investigator, fact finder, initial decision maker or otherwise have not actively participated in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude a member of the Medical Staff from serving as a member of the Judicial Review Committee. Members of the Medical Staff demonstrating actual bias or a high probability of bias in favor of or

against either party, as determined by the Hearing Officer, shall not be eligible to be members of the Judicial Review Committee. The Judicial Review Committee shall include at least one member who has the same healing arts licensure as the practitioner and, where feasible, include an individual who practices the same general specialty as the practitioner. Such appointment may, but need not, include designation of a Chairperson. In the event that it is not feasible to appoint a Judicial Review Committee from the active Medical Staff, the Chief of Staff may appoint members from other Medical Staff categories or practitioners who are not Medical Staff members. The Chief of Staff shall also appoint a minimum of one alternate who meets the standards described above and who can serve if a Judicial Review Committee member becomes unavailable. Such alternates shall be subject to voir dire, attend sessions of the hearing and otherwise participate as though they were official members of the JRC, but they may not vote on the JRC's ultimate findings and conclusions and shall not sign the JRC's Report.

b. Alternatively, within the discretion of the MEC, in circumstances when it is not reasonably practical to assemble a panel of physicians to serve as a Judicial Review Committee, an arbitrator may be used who is mutually acceptable to the MEC and to the practitioner. The arbitrator shall carry out all of the duties assigned to the Hearing Officer and to the Judicial Review Committee.

Article 7.4-5 The Hearing Officer

a. The Chief of Staff shall appoint a Hearing Officer to preside at the hearing. The Hearing Officer shall be an attorney at law qualified to preside over a quasi- judicial hearing, but an attorney regularly utilized by the Hospital or Medical Staff for legal advice regarding its affairs and activities and/or any attorney who has at any time represented the subject practitioner shall not be eligible to serve as Hearing Officer. The Hearing Officer shall not be biased for or against any party, shall gain no direct financial benefit from the outcome, and must not act as a prosecuting officer or as an advocate.

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

c. If the Hearing Officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the Hearing Officer may take such discretionary action as seems warranted by the circumstances. The Hearing Officer may participate in the deliberations of the Judicial Review Committee and be a legal advisor to it, but the Hearing Officer shall not be entitled to vote. The Hearing Officer shall assist in preparation of the Judicial Review Committee's report and recommendation.

Article 7.4-6 Representation

The hearings provided for in these Bylaws are for the purpose of intraprofessional resolution of matters bearing on professional conduct or professional competency. Accordingly, neither the Affected Practitioner nor the body whose decision prompted the hearing shall be represented in any phase of the hearing by an attorney at law, unless the MEC, in its discretion, permits each to be represented by legal counsel. Any request for legal representation shall be made at the time the hearing request is made. In no event shall the body whose decision prompted the hearing be represented by legal counsel if the Affected Practitioner is not so represented. When attorneys are not permitted, the Affected Practitioner shall be entitled to be accompanied by and represented at the hearing by a Practitioner licensed to practice in the State of California who is not also an attorney at law and who, preferably, is a Member in good standing of the Medical Staff. The body whose decision prompted the hearing shall appoint a representative from the Medical Staff to present the evidence in support of its recommendation or actions. Any party may obtain legal counsel at its own expense for the purpose of preparing for the hearing. Only one representative for each party shall be designated as the spokesman for the party. A representative may also be a witness.

Article 7.4-7 Failure to Appear or Proceed

a. Failure without good cause of the practitioner to personally attend and proceed at a requested hearing in an efficient and orderly manner or to produce relevant documents (including any failure to cooperate with or abide by any ruling of the Hearing Officer) shall be good cause for a consideration of whether the practitioner has 1) waived his or her right to further proceedings and 2) should be deemed to have voluntarily accepted the recommendation(s) of the body whose decision prompted the hearing.

b. Whether there has been waiver of future proceedings and deemed acceptance of the recommendation(s) shall be determined by the Judicial Review Committee upon motion by a party or recommendation by the Hearing Officer. In either event, the Hearing Officer shall meet with and advise the Judicial Review Committee as to the facts and the relevant law, and may attend the Judicial Review Committee's deliberations on the matter, but may not vote. The Judicial Review Committee shall decide on questions by majority vote.

c. Nothing in this section shall be interpreted to limit the Judicial Review Committee to a one-time consideration of such matters. Rather, the Judicial Review Committee shall consider any and all such motions at the time that they are made. In determining any such motion, the Judicial Review Committee may consider past relevant behaviors

Notwithstanding the above, the practitioner's (or counsel's) failure (or failure by the MEC or its counsel) to attend a particular hearing session or conference with the Hearing Officer, without good cause, may constitute grounds to proceed with the particular session or conference without the presence of the practitioner. Any such ruling shall be made by the Hearing Officer in consideration of relevant law and facts. Similarly, the Hearing Officer shall consider having the hearing go forward despite the absence of a member of the JRC, so long as such member reviews transcripts of the missed session.

Article 7.4-8 Postponements and Extensions

Once a request for hearing is initiated, postponements and extensions of time beyond the

times permitted in these Bylaws may be agreed upon by the parties or permitted by the Hearing Officer, for good cause, within his or her discretion.

Article 7.4-9 Discovery

a. Rights of Inspection and Copying: Formal court rules regarding discovery do not apply to hearings under this Article. However, the practitioner may inspect and copy (at his or her expense) any documentary information relevant to the charges that the Medical Staff has in its possession or under its control. The body whose decision prompted the hearing may inspect and copy (at its expense) any documentary information relevant to the charges that the practitioner has in his or her possession or under his or her control. Alternatively, the parties may provide copies of all relevant documents to each other. The requests for discovery shall be fulfilled as soon as practicable. Failures to comply with reasonable discovery requests at least 30 days prior to the hearing shall be good cause for a continuance of the hearing.

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

c. Ruling on Discovery Disputes: In ruling on discovery disputes, the factors that may be considered include:

    1) Whether the information sought may be introduced to support or defend the charges;

    2) Whether the information is exculpatory in that it would dispute or cast doubt upon the charges or inculpatory in that it would prove or help support the charges and/or recommendation;

    3) The burden on the party of producing the requested information; and

    4) What other discovery requests the party has previously made.

d. Objections to Introduction of Evidence Not Previously Produced: The body whose decision prompted the hearing may object to the introduction of evidence that was not provided during an appointment, reappointment or privilege application review or during corrective action despite the requests of the peer review body for such information. The information will be barred from the hearing by the Hearing Officer unless the practitioner can prove he or she previously acted diligently and could not have submitted the information.

Article 7.4-10 Pre-Hearing Document Exchange

At the request of either party, the parties must exchange all documents that will be introduced at the hearing. The documents must be exchanged at least ten days prior to the hearing. A failure to comply with this rule is good cause for the Hearing Officer to grant a continuance. Repeated failures to comply shall be good cause, within the Hearing

Officer's discretion, to limit the introduction of any documents not provided to the other side in a timely manner.

Article 7.4-11 Witness Lists

Not less than 15 days prior to the hearing, each party shall furnish to the other a written list of the names of the individuals, so far as is then reasonably known or anticipated, who are expected to give testimony or evidence in support of that party at the hearing. Nothing in the foregoing shall preclude the testimony of additional witnesses whose possible participation was not reasonably anticipated. The parties shall notify each other as soon as they become aware of the possible participation of such additional witnesses. The failure to have provided the name of any witness at least ten days prior to the hearing date at which the witness is to appear shall constitute good cause for a continuance.

Article 7.4-12 Procedural Disputes

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

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

Article 7.4-13 Record of the Hearing

A court reporter shall be present to make a record of the hearing proceedings and the pre-hearing proceedings if deemed appropriate by the Hearing Officer. The cost of attendance of the court reporter shall be borne by the Hospital, but the cost of the transcript, if any, shall be borne by the party requesting it, or jointly if both parties desire copies. The Hearing Officer may, but shall not be required to, order that oral evidence shall be taken only on oath administered by any person lawfully authorized to administer such oath.

Article 7.4-14 Additional Rights of the Parties

Within reasonable limitations, both sides at the hearing may:

a. ask the Judicial Review Committee members and Hearing Officer questions which are directly related to evaluating their qualifications to serve and for challenging such members or the Hearing Officer,

b. call and examine witnesses for relevant testimony,

c. introduce relevant exhibits or other documents,

d. cross-examine or impeach witnesses who shall have testified orally on any matter relevant to the issues, and otherwise rebut evidence, and

e. submit a written statement at the close of the hearing, as long as these rights are exercised in an efficient and expeditious manner.

The practitioner who is the subject of the hearing may be called by the body whose action and/or recommendation prompted the hearing or the Judicial Review Committee and examined as if under cross-examination. The Judicial Review Committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate.

Article 7.4-15 Rules of Evidence

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

Article 7.4-16 Burdens of Presenting Evidence and Proof

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

b. An applicant for membership and/or privileges shall bear the burden of persuading the Judicial Review Committee, by a preponderance of the evidence, that he or she is qualified for membership and/or the denied privileges. The practitioner must produce information which allows for adequate evaluation and resolution of reasonable doubts concerning his or her current qualifications for membership and privileges. An applicant shall not be allowed to introduce information not produced upon request of the Medical Executive Committee during the application process, unless the applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

c. Except as provided above for applicants for membership and/or privileges, throughout the hearing, the body whose decision prompted the hearing shall bear the burden of persuading the Judicial Review Committee by a preponderance of the evidence, that its action or recommendation was reasonable and warranted.

d. When an applicant has been granted temporary privileges that are later suspended, restricted, or revoked for a medical disciplinary cause or reason, the burden established in Sub-section (c) shall apply.

Article 7.4-17 Adjournment and Conclusion

The Hearing Officer may adjourn the hearing and reconvene the same without special notice at such times and intervals as may be reasonable and warranted with due

consideration for reaching an expeditious conclusion to the hearing.

Article 7.4-18 Basis for Decision

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

Article 7.4-19 Presence of Judicial Review Committee Members and Vote

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

Article 7.4-20 Decision of the Judicial Review Committee

Within 30 days after final adjournment of the hearing and conclusion of deliberations, the Judicial Review Committee shall render a written decision. If the practitioner is currently under suspension, however, the time for the decision and report shall be 20 days after final adjournment and conclusion of deliberations. Final adjournment shall be when the Judicial Review Committee has concluded its deliberations. A copy of the decision shall be forwarded to the Medical Executive Committee, the Chief Executive Officer, the Board of Trustees, and to the practitioner. The report shall contain the Judicial Review Committee's findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached. Both the practitioner and the body whose decision prompted the hearing shall be provided a written explanation of the procedure for appealing the decision. The decision of the Judicial Review Committee shall be considered final, subject only to such rights of appeal or Board of Trustees review as described in these Bylaws.

Article 7.5 APPEAL

Article 7.5-1 Time for Appeal

Within 30 days after receiving the decision of the Judicial Review Committee, either the practitioner or the Medical Executive Committee may request an appellate review. A written request for such review shall be delivered to the Chief of Staff, the Chief Executive Officer and the other side in the hearing. If appellate review is not requested within such period, that action or recommendation shall thereupon become the final action of the Medical Staff. The Board of Trustees shall consider the decision within 60 days, and shall give it great weight.

Article 7.5-2 Time, Place and Notice

If an appellate review is to be conducted, the Appeal Board shall, within 30 days after receiving a notice of appeal, schedule a review date and cause each side to be given notice (with special notice to the practitioner) of the time, place, and date of the appellate review.

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

Article 7.5-3 Appeal Board

The Board of Trustees may sit as the Appeal Board, or it may appoint an Appeal Board which shall be composed of not less than three members of the Board of Trustees. Knowledge of the matter involved shall not preclude any person from serving as a member of the Appeal Board, so long as that person did not take part in a prior hearing on the same matter. The Appeal Board may select an attorney to assist it in the proceeding. That attorney shall not be entitled to vote with respect to the appeal. The Appeal Board shall have such powers as are necessary to discharge its responsibilities.

Article 7.5-4 Grounds for Appeal

Any request for appeal shall include a statement of the grounds for appeal and a concise statement of facts that support the appeal. The grounds for appeal from a decision of the Judicial Review Committee shall be:

a. substantial non-compliance with the hearing procedures required by these Bylaws or applicable law which has resulted in demonstrable prejudice to the appealing party; or

b. the decision is not supported by substantial evidence in the hearing record as a whole.

Article 7.5-5 Appeal Procedure

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

Article 7.5-6 Decision

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

b. The Appeal Board may affirm, modify, reverse the decision or remand the matter for further review by the Judicial Review Committee.

c. The Appeal Board shall give great weight to the Judicial Review Committee recommendation, and shall affirm the findings of the JRC if they are supported by substantial evidence. The Appeal Board may, however, exercise its independent judgment in determining whether either side was afforded a fair hearing. The decision shall specify the reasons for the action taken and, if additional evidence was produced on appeal, provide findings of fact and conclusions articulating the connection between the evidence produced at the appeal, and the decision reached.

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

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

Article 7.5-7 Final Action

In the event that the entire Board of Trustees sits as the Appeal Board, the action of the Appeal Board shall be final as of the date it renders its decision. When the Appeal Board is comprised of a subset of the Board of Trustees, its action shall be final as of the date that its decision is adopted by the full Board of Trustees.

Article 7.6 RIGHT TO ONE HEARING

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

Article 7.7 CONFIDENTIALITY

To maintain confidentiality in the performance of peer review, disciplinary and credentialing functions, participants in any stage of the hearing or appellate review process shall limit their discussion of the matters involved to discussions held in the course of fulfilling their duties under these Bylaws. Members of the Judicial Review Committee shall not discuss the proceedings with anyone outside of the Judicial Review Committee's deliberations except for any discussions with the Hearing Officer, nor shall they reveal any deliberations or decisions of the Committee to anyone prior to or other than through the formal written Judicial Review Committee Decision.

Article 7.8 RELEASE

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

Article 7.9 BOARD OF TRUSTEES COMMITTEES

In the event the Board of Trustees should delegate some or all of its responsibilities described in this Article 7 to its committees, the Board of Trustees shall nonetheless retain ultimate authority to accept, reject, modify or return for further action or hearing the

recommendations of its committee.

Article 7.10 EXCEPTIONS TO HEARING RIGHTS

Article 7.10-1 Automatic Termination, Suspension, Revocation or Limitation of Practice Privileges and/or Membership

A practitioner whose membership and/or privilege has been automatically terminated, suspended, revoked or otherwise limited under this Section 7.10 of these Bylaws shall not be entitled to formal hearing rights afforded under Article 7. However, within 30 days of receiving notice of the automatic termination or suspension, the practitioner may request a review, the form of which shall be a meeting or similar opportunity to provide information, within the discretion of the MEC, which will consist of presenting information to the Medical Executive Committee solely on the issues of whether the act or event which generated the automatic termination, suspension, revocation occurred or, in the cases of other limitations, whether the member may continue to practice with those limitations imposed. Practitioners may not present information regarding whether a determination by an outside licensing, credentialing, or certifying authority was unwarranted. Following any review afforded to the practitioner, the Medical Executive Committee shall provide the practitioner with special notice of any final recommendations and shall forward those recommendations to the Board of Trustees.

Article 7.10-2 Exclusive Contracts

Expiration/Termination of Contract. The effect of expiration or other termination of a contract upon a Practitioner's Staff membership and Clinical Privileges will be governed solely by the terms of the Practitioner's contract. If the contract is silent on the matter, then contract expiration or termination will not affect the Practitioner's Staff membership or Clinical Privileges. Expiration or termination of a Practitioner's contract due to other than quality of care or disciplinary reasons will not result in a negative or adverse response to requests for references.

When an applicant for membership or privileges is denied, due to the existence of a current exclusive arrangement, the applicant shall be provided with notice of the reasons for the action and shall not be entitled to the procedural rights afforded by Article 7 of these Bylaws, except to the extent provided under Section 13.9.

Article 7.10-3 Allied Health Practitioners

a. Allied health practitioners (AHPs) are not entitled to the hearing rights set forth in this Article unless the action involves a clinical psychologist, podiatrist, marriage and family therapist, or clinical social worker (or other “licentiate” as defined by Business and Professions Code Section 805(a)(2)), and must be reported under Business and Professions Code Section 805. However, an AHP shall have the right to challenge any recommendation which would constitute grounds for a hearing under the hearing and appellate review section of the Bylaws, to the extent such grounds are applicable by analogy to the AHP status, by filing a written grievance. The basic steps of this process shall include notice of the adverse recommendation or action and the right to be present at a meeting called for the purpose of hearing the AHP’s position on the matters at issue. Associated details regarding the hearing rights of Allied Health Practitioners in connection with the denial, termination, suspension, or restriction of

clinical privileges are governed by the provisions of the Allied Health Practitioner Rules/ Regulations.

b. With respect to automatic termination, suspension, or restriction of an Allied Health Practitioner's clinical privileges, Section 7.10-1 and the provisions in the AHP Rules/Regulations shall apply.

Article 7.11 MEDICAL BOARD AND NATIONAL PRACTITIONER DATA BANK REPORTING

When required by law, the Medical Staff representative shall report an adverse action to the Medical Board of California (or other applicable licensing agency) and to the National Practitioner Data Bank. The authorized representative shall report any and all revisions of an adverse action, including, but not limited to, any expiration of the final action consistent with the terms of that final action.

Article 7.12 DISPUTING REPORT LANGUAGE

Whether or not a hearing was requested, a member who is the subject of a proposed adverse action report to the Medical Board of California (or other applicable licensing agency) or the National Practitioner Data Bank may request an informal meeting to discuss the text of any reports to be filed. The meeting shall not constitute a hearing.

Article 7.13 INFORMAL DISPUTE RESOLUTION

Notwithstanding any applicable hearing rights, at any time, applicants, Medical Staff members, and/or the Medical Executive Committee may seek agreement to resolve peer review matters through less formal methods, including mediation or settlement.

Article 7.14 INFORMAL CONFERENCE

Except as to those matters specified in Section 7.10, when the Medical Executive Committee proposes imposition of a corrective action that does not give rise to the right of a Formal Hearing under Section 7.2 of the Bylaws or California Business and Professions Code Section 809, the Medical Executive Committee may, nonetheless, offer the affected practitioner an informal hearing opportunity in the form of a conference with the MEC or honor the request of the affected practitioner for such conference, in accordance with the provisions of this Section. Such circumstances shall be determined by the MEC on a case-by-case basis.

Article 8 OFFICERS

Article 8.1 OFFICERS OF THE MEDICAL STAFF

Article 8.1-1 Identification

The officers of the Medical Staff shall be the Chief of Staff, Vice Chief of Staff, and immediate past Chief of Staff.

Article 8.1-2 Qualifications

Officers must be members of the active Medical Staff in good standing at the time of their nominations and election, and must remain members in good standing during their term of office. Failure to maintain such status shall create a vacancy in the office involved. All officers must be licensed as physicians and surgeons, given the nature of their duties in office.

Article 8.1-3 Nominations

The Medical Staff election shall be scheduled for some time within the last quarter of the Medical Staff year. The Nominating Committee shall be the Medical Executive Committee, which shall announce the nominees at the general or special medical staff meeting held before the election occurs. Further nominations may be made from the floor at this meeting, and such nominations will be recognized if the nominee is present, is in good standing, and consents.

The nominations shall be delivered or mailed to the voting members of the Medical Staff prior to the election. Any nominee who is determined not to be in good standing shall be removed from the ballot prior to delivery to the voting members.

Article 8.1-4 Elections

Only Active Staff members shall be eligible to vote. Voting shall be by written ballot, email, and/or other electronic means, so long as adequate precautions are taken to ensure reliability and security. Ballots may be submitted at the meeting held for this purpose or may be submitted to the Medical Staff Office in advance of that meeting. Only one vote per member shall be allowed. Written ballots shall include handwritten signatures on the envelope for comparison with signatures on file, when necessary. A nominee shall be elected upon receiving a majority of the valid votes cast so long as the total number of votes cast constitutes a quorum for the conduction of medical staff business. If no candidate for the office receives a majority vote on the first ballot, a run-off election shall be held promptly between the 2 candidates receiving the highest number of votes. In the case of a tie on the second ballot, the majority vote of the Medical Executive Committee shall decide the election by ballot at its next meeting or a special meeting called for that purpose.

Article 8.1-5 Term of Elected Office

Each officer shall serve a 2-year term, commencing on the first day of the Medical Staff year following the election. Each officer shall serve in each office until the end of that officer's term, or until a successor is elected, unless that officer shall sooner resign or be

removed from office. At the end of that officer's term, the Chief of Staff shall automatically assume the office of immediate past Chief of Staff and the vice chief of staff shall automatically assume the office of Chief of Staff.

Article 8.1-6 Recall of Officers

Any Medical Staff officer may be removed from office for valid cause, including, but not limited to, failure to remain in good standing, neglect of duties or misfeasance in office. Recall of a Medical Staff officer may be initiated by the Medical Executive Committee or may be initiated by a petition signed by at least one-third of the members of the Medical Staff eligible to vote for officers. Recall shall be considered at a special meeting called for that purpose. Recall shall require a two-thirds vote of the Medical Staff members eligible to vote for Medical Staff officers who actually cast votes at the special meeting in person or by written ballot. Ballots may be submitted by mail, email, and/or other electronic means, so long as adequate precautions are taken to ensure reliability and security.

Article 8.1-7 Vacancies in Elected Office

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

Article 8.2 DUTIES OF OFFICERS

Article 8.2-1 Chief of Staff

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

a. enforcing the Medical Staff Bylaws and Rules and Regulations, implementing sanctions where indicated, and promoting compliance with procedural safeguards where corrective action has been requested or initiated;

b. serving as Chair of the Medical Executive Committee and calling, presiding at, and being responsible for the agenda of all meetings thereof;

c. serving as an ex officio member of all other staff committees without vote, unless Chief of Staff membership in a particular committee is required by these Bylaws;

d. interacting with the CEO and Board of Trustees in all matters of mutual concern within the Hospital;

e. appointing, in consultation with the Medical Executive Committee, committee

members for all standing committees other than the Medical Executive Committee and all special Medical Staff, liaison, or multi-disciplinary committees, except where otherwise provided by these Bylaws and, except where otherwise indicated, designating the Chairs of these committees;

f. representing the views and policies of the Medical Staff to the Board of Trustees and to the CEO;

g. being a spokesperson for the Medical Staff in external professional and public relations;

h. performing such other functions as may be assigned to the Chief of Staff by these Bylaws, the Medical Staff, or by the Medical Executive Committee;

i. serving on liaison committees with the Board of Trustees and Administration, as well as outside licensing or accreditation agencies;

j. serve as a voting member of the Watsonville Community Hospital Board of Trustees.

Article 8.2-2 Vice Chief Of Staff

The Vice Chief of Staff shall assume all duties and authority of the Chief of Staff in the absence of the Chief of Staff or where the Chief of Staff may be precluded from acting (e.g. due to a conflict or other cause). The Vice Chief of Staff shall be a member of the Medical Executive Committee and of the Joint Conference Committee, and shall perform such other duties as the Chief of Staff may assign or as may be delegated by these Bylaws, or by the Medical Executive Committee.

Article 8.2-3 Immediate Past Chief Of Staff

The immediate past Chief of Staff shall be a member of the Medical Executive Committee and shall perform such other duties as may be assigned by the Chief of Staff or delegated by these Bylaws, or by the Medical Executive Committee.

Article 9 CLINICAL DEPARTMENTS AND SECTIONS

Article 9.1 ORGANIZATION OF CLINICAL DEPARTMENTS AND SECTIONS

The Medical Staff shall be organized into clinical Departments. Each Department shall be organized as a separate component of the Medical Staff and shall have a Chair selected and entrusted with the authority, duties, and responsibilities specified in Section 9.6. A Department may be further divided, as appropriate, into Sections which shall be directly responsible to the Department within which it functions, and which shall have a Section Chair selected and entrusted with the authority, duties and responsibilities specified in Section 9.7. When appropriate, the Medical Executive Committee may recommend to the Medical Staff the creation, elimination, modification, or combination of Departments or Sections.

Article 9.2 CURRENT DEPARTMENTS AND SECTIONS

The current Departments are:

a. Medicine: including Sections in Cardiology, Internal Medicine, Family Practice, Critical Care Medicine, and Radiology;

b. Surgery: including Sections in Anesthesiology, Pathology, Orthopedics and Otolaryngology;

c. Emergency Medicine;

d. OB/GYN; and

e. Pediatrics.

Article 9.3 ASSIGNMENT TO DEPARTMENTS AND SECTIONS

Each member shall be assigned membership in at least one Department, and to the appropriate Section, if any, within such Department, but may also be granted membership and/or clinical privileges in other Departments or Sections consistent with practice privileges granted.

Article 9.4 FUNCTIONS OF DEPARTMENTS

The general functions of each Department shall include:

a. Serving as a forum for the exchange of clinical information regarding services provided by Department members.

b. Receiving data and reports related to relevant Medical Staff and/or organizational quality assessment and performance improvement activities.

c. Providing information and/or recommendations when requested by the Department Chair and/or Medical Executive Committee related to:

1) Medical Staff policies and procedures.

2) Issues of standard of practice and/or clinical competence.

3) Criteria for clinical privileges.

d. Conducting, participating and making recommendations regarding continuing education programs pertinent to Departmental clinical practice.

Medical Staff Departments will meet as often as necessary but at least quarterly. Departmental meetings may be combined with other Departments.

Each Medical Staff Department shall participate in the activities of either the Medicine or Surgery Quality Review Committee (QRC). The medicine or surgery QRC will assume all duties and responsibilities of the Departments assigned to them as it relates to quality assessment, performance improvement and peer review as defined in these Bylaws, Medical Staff Rules and Regulations, and Medical Staff policies. The QRC will report to appropriate Medical Staff members the substantive results of their activities and will submit a quarterly report on their activities to the relevant Department and/or Section and to the Medical Executive Committee.

Article 9.5 FUNCTIONS OF SECTIONS

Sections shall be comprised of all members of a Department who are granted practice privileges in the Section subspecialty area.

Sections shall meet as often as necessary at the call of the Section Chair.

The Section meetings shall serve as a forum to discuss clinical aspects of care related to the Section.

A Section meeting may be requested by the Department and/or Section Chief(s) to meet to discuss specific issues related to quality assessment, performance improvement, peer review, and/or credentialing. In such cases, the Section shall report their findings directly to the Department Chair and/or to the relevant Quality Review Committee.

Article 9.6 DEPARTMENT CHAIRS

Article 9.6-1 Qualifications

Each Department shall have a Chair and Vice-Chair who shall be physician members of the active staff, who are and remain in good standing and who are qualified by licensure, training, experience and demonstrated ability. Department Chairs must be certified by an appropriate specialty board or shall affirmatively establish through the privilege delineation process that he or she possesses comparable competence.

Article 9.6-2 Selection

Department Chairs and Vice-Chairs shall be elected every two years by those members of

the Department who are eligible to vote for general officers of the Medical Staff. Candidates for Department Chair and Department Vice-Chair who meet the qualifications of Section 9.6-1 shall be nominated and elected by a majority of the voting Active Staff members of that Department. Voting shall be by ballot. Voting for the Chair shall be first. The person receiving the largest number of votes shall be the Department Chair. After the Chair has been elected, Department members shall then nominate eligible individuals for Vice-Chair and voting shall be by separate ballot. The person receiving the largest number of votes shall be the Department Vice-Chair. The Medical Executive Committee shall accept a person elected Chair and Vice-Chair by valid process unless the individual is not in good standing or does not meet the qualifications specified in 9.6-1. Voting for Chair and Vice Chair may be accomplished by written ballot submitted by mail, email, and/or other electronic means, so long as adequate precautions are taken to ensure reliability and security.

Article 9.6-3 Term of Office

Each Department Chair and Vice-Chair shall serve a 2-year term which coincides with the Medical Staff year or until their successors are chosen, unless they shall sooner resign, be removed from office, or lose their Medical Staff membership or clinical privileges in that Department. Department officers shall be eligible to succeed themselves.

Article 9.6-4 Removal

The removal of a Department Chair or Vice-Chair may be initiated for failure to remain in good standing, for failure to carry out the duties and responsibilities as set forth in Section 9.6-5, or for other good cause. Removal of Department Chairs and Vice-Chairs from office may occur for cause by the MEC or by ballot vote of the majority of the Department members eligible to vote. Voting may be accomplished by written ballot, email, and/or other electronic means, so long as adequate precautions are taken to ensure reliability and security.

Article 9.6-5 Duties

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

a. act as presiding officer at Departmental meetings;

b. direct and supervise all administrative and clinical activities within the Department and report to the Medical Executive Committee and to the Chief of Staff regarding all clinical and administrative activities within the Department. Such activities shall include the development of and transmittal to the Medical Staff office, on a monthly basis for distribution, a roster of Department members who participate on call to the Emergency Department, noting who will serve on what day;

c. generally monitor on a continuous basis the quality of patient care and professional performance rendered by members with clinical privileges in the Department through a planned and systematic process; oversee the effective conduct of the patient care, evaluation, and monitoring functions delegated to the Department and its associated Quality Review Committee (QRC) by the Medical Executive Committee in coordination and integration with organization-wide quality assessment and improvement activities;

d. recommend to the Quality Review Committee specific programs for the continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Department. Programs developed are to include objective measurement, data collection, assessment of data collected, and peer review when appropriate;

e. develop and implement Departmental policies and procedures, including programs for retrospective patient care review, ongoing monitoring of practice, credentials review and privilege delineation, medical education, utilization review, and quality assessment and improvement;

f. be a member of the Medical Executive Committee, and give guidance on the overall policies of the Medical Staff and Hospital and make specific recommendations and suggestions regarding the Department;

g. provide information and recommendations to the Credentials and/or Medical Executive Committees regarding the qualifications of applicants seeking appointment or reappointment or clinical privileges in the Department;

h. review and evaluate adherence of Medical Staff members to the Medical Staff Bylaws, Rules and Regulations and Medical Staff policies, and make recommendations regarding such adherence to the appropriate Quality Review Committee, appropriate Medical Staff committee and/or Medical Executive Committee;

i. recommend to the Credentials Committee and Medical Executive Committee proctoring programs to be utilized at the time of appointment or when practitioners are requesting new privileges in the Department;

j. make recommendations to the Medical Executive Committee concerning criteria for clinical privileges related to the Department, sufficient numbers of qualified persons to provide care, treatment and services, and the qualifications and competence of dependent practitioners who provide services within the Department;

k. transmit to the Medical Executive Committee any recommendations regarding a request for investigation or recommendations for corrective action regarding any person holding clinical privileges in the Department;

l. serve as member of the relevant Quality Review Committees;

m. participate in programs to assure the continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Department;

n. endeavor to enforce the Medical Staff Bylaws, Rules and Regulations and Medical Staff policies within the Department;

o. implement within the Department appropriate actions taken by the Medical Executive Committee;

p. participate in every phase of Administration of the Department, including coordination and integration of interdepartmental and intradepartmental services, cooperation with

the nursing service and the Hospital Administration in matters such as personnel, including assisting in determining the qualifications and competence of Department/service personnel who are not licensed independent practitioners and who provide patient care services, supplies, special regulations, standing orders and techniques;

q. assist in the preparation of such annual reports, including budgetary planning, pertaining to the Department as may be required by the Medical Executive Committee;

r. recommend delineated clinical privileges for each member of the Department at the time of appointment and reappointment;

s. identify and recommend to the Medical Executive Committee the specific types of Telemedicine Services and Telemedicine Privileges appropriate for the care overseen by the department;

t. assessing and recommending to Hospital Administration off-site sources for needed patient care, treatment and services not provided by the Department or organization;

u. orient new department members;

v. make recommendations concerning CME for all persons in the Department;

w. make recommendations to the MEC and Hospital Administration regarding space and other resources needed; and

x. perform such other duties commensurate with the office as may from time to time be reasonably requested by the Chief of Staff or the Medical Executive Committee.

The Department Vice Chair shall assume all duties and authority of the Department Chair in the absence of the Department Chair and shall perform other duties as assigned by the Department Chair, delegated by the Medical Staff Bylaws, Rules and Regulations, and Medical Staff Policies or as directed by the Medical Executive Committee.

Article 9.6-6 Vacancies

If the position of Department Chair becomes vacant, the vacancy shall be filled by the Department Vice Chair. If the Vice Chair declines to fill the vacancy, the vacancy will be filled by election per the procedure outlined in 9.6-2. If the position of Department Vice Chair becomes vacant, the vacancy shall be filled for the remainder of the current term by election per the procedures in 9.6-2.

Article 9.7 SECTION CHAIRS

Article 9.7-1 Qualifications

Each Section shall have a Chair who shall be a member of the active Medical Staff and a member of the Section, and shall be qualified by training, experience, and demonstrated current ability in the clinical area covered by the Section. Section Chair candidates and elected Chair must at all times, be and remain in good standing.

Article 9.7-2 Selection

Each Section Chair shall be selected or elected with such mechanism as the relevant Medical Staff Department may adopt. Vacancies due to any reason shall be filled for the unexpired term by the Department Chair.

Article 9.7-3 Term of Office

Each Section Chair shall serve a 2-year term which coincides with the Medical Staff year or until a successor is chosen, unless the Section Chair shall sooner resign or be removed from office or lose Medical Staff membership or clinical privileges in that Section. Section Chairs shall be eligible to succeed themselves.

Article 9.7-4 Removal

After appointment and ratification, a Section Chair may be removed by the Department Chair with the approval of the Medical Executive Committee, or by the MEC acting alone in the event of disagreement, for failure to remain in good standing or other good cause.

Article 9.7-5 Duties

Each Section Chair shall:

a. act as presiding officer at Section meetings;

b. assist in the development and implementation, in cooperation with the Department Chair, of programs to carry out the quality review, and evaluation and monitoring functions assigned to the division and its associated Quality Review Committee;

c. evaluate the clinical work performed in the division and serve as a member of the associated Quality Review Committee;

d. conduct investigations and submit reports and recommendations to the Department Chair regarding the appointment, reappointment and clinical privileges to be exercised within the Section by members of or applicants to the Medical Staff; and

e. perform such other duties commensurate with the office as may from time to time be reasonably requested by the Department Chair, the Chief of Staff, or the Medical Executive Committee.

Article 10 COMMITTEES

Article 10.1 DESIGNATION

Medical Staff committees shall include but not be limited to, the Medical Staff meeting as a committee of the whole, meetings of Departments and Sections, meetings of committees established under this Article, and meetings of special or ad hoc committees created by the Medical Executive Committee or by Departments. The committees described in this Article shall be the standing committees of the Medical Staff. Special or ad hoc committees may be created by the Medical Executive Committee to perform specified tasks.

Unless otherwise specified, the Chair and members of all committees shall be appointed by and may be removed by the Chief of Staff, subject to consultation with and approval by the Medical Executive Committee.

Medical Staff committees shall be responsible to the Medical Executive Committee.

The purpose of Medical Staff committees shall be to monitor and improve the quality of patient care and perform other functions relative to the needs of the facility, the regulations of the state and federal government and the standards of the Joint Commission on Accreditation of Health Care Organizations.

Unless otherwise specified in these Bylaws, all non-Medical Staff members appointed to the Medical Staff committees shall be nonvoting. When non-physician members have been granted a vote on a Medical Staff committee, such voting rights shall only be exercised relative to the practitioner's area of clinical expertise and restricted by the practitioner's scope of licensure. The Chief of Staff shall be a nonvoting, ex-officio member on all committees to which he/she is not otherwise specifically assigned.

Article 10.2 GENERAL PROVISIONS

Article 10.2-1 Terms of Committee Members

Unless otherwise specified, committee members shall be appointed for a 2-year term, corresponding with the terms of the Medical Staff officers 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.

Article 10.2-2 Removal

If a member of a committee ceases to be a member in good standing of the Medical Staff, suffers a loss or significant limitation of practice privileges, or if any other good cause exists, that member may be removed from the committee by a majority vote of the Medical Executive Committee.

Article 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 Medical Executive Committee.

Article 10.2-4 Addition, Deletion, or Modification of Standing Committees of the Medical Staff

The Medical Executive Committee may recommend to the Board of Trustees the addition, deletion or modification of any standing committee of the Medical Staff as may be described in these Bylaws, or as has otherwise been appointed with the exception of the Medical Executive Committee. Modification of the Medical Executive Committee requires vote of the General Medical Staff pursuant to Bylaws modification requirements.

Article 10.3 QUORUM, VOTING AND REPORTS

Quorum requirements and voting by committees shall be governed by the provisions of Article 11 of these Bylaws. All committees of the Medical Staff shall report to their Department and/or to the Medical Executive Committee. Written reports shall be submitted to the Medical Executive Committee at periodic intervals as established by the Medical Executive Committee.

Article 10.4 MEDICAL EXECUTIVE COMMITTEE

Article 10.4-1 Composition

The Medical Executive Committee (MEC) shall consist of the following persons:

a. the Officers of the Medical Staff;

b. the Department Chairs;

c. the Chief of Radiology;

d. the Chief of Pathology;

e. the Chief of Anesthesiology;

f. the Chief of Family Practice;

g. the Chief of Internal Medicine;

h. the Chair of the Credentials Committee;

i. the Chief of Critical Care Medicine; and

j. the CEO, who shall serve in an ex officio capacity, without vote.

No member of the Active Medical Staff is ineligible for membership on the Medical Executive Committee solely because of his or her professional discipline or specialty, and may include physicians and other practitioners and individuals as determined by the MEC.

Members of Hospital Administration (in addition to the CEO) and other individuals may attend an MEC meeting at the invitation of the Chief of Staff or MEC as a whole.

In the event of inability to attend, MEC Members who serve due to their status as Department Chairs may send their Vice-Chairs to MEC meetings. Under such circumstances, the Vice-Chair is authorized to vote on behalf of the Department Chair

Article 10.4-2 Duties

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

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

b. coordinating and implementing the professional and organizational activities and policies of the Medical Staff;

c. receiving and acting upon reports and recommendations from Medical Staff Departments, Sections, committees, and assigned activity groups;

d. recommending actions to the CEO and Board of Trustees on matters of a medical-administrative nature;

e. making recommendations as to the Medical Staff structure and on appropriate Hospital management matters to the Board of Trustees;

f. providing liaison between the Medical Staff, the CEO and the Board of Trustees;

g. fulfilling the Medical Staff organization's accountability to the Board of Trustees for the medical care rendered to patients of the Hospital, including the organization of the quality assessment and performance improvement activities of the Medical Staff and the mechanisms to conduct, evaluate and revise such activities;

h. participating in the development of all Medical Staff Bylaws, Rules and Regulations, and Medical Staff policies;

i. reviewing the qualifications, credentials, performance, professional competence, and character of applicants and staff members, and making recommendations to the Board of Trustees at least quarterly regarding staff appointments and reappointments, assignments to Departments, clinical privileges, and corrective action;

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

k. taking reasonable steps to develop continuing education activities and programs for the Medical Staff;

l. ensuring that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of the Hospital;

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

n. reporting to the Medical Staff at each regular staff meeting;

o. assisting in the obtaining and maintenance of accreditation;

p. developing and maintenance of methods for the protection and care of patients and others in the event of internal or external disaster;

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

r. recommending to the relevant Hospital authority off-site sources needed for clinical patient care services which are not provided by the Hospital;

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

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

u. reviewing and recommending amendments to the Medical Staff Bylaws to the active Medical Staff;

v. conducting such other functions as are necessary for the effective operation of the Medical Staff;

w. exercising all rights of self-governance as described in Business and Professions Code; and

x. recommends to the Board of Trustees which telemedicine clinical services should be delivered by members of the medical staff. [5]

The authority delegated to the Medical Executive Committee under these Bylaws may be removed only via an amendment to these Bylaws under the process set forth in Article 14.

Article 10.4-3 Meetings

The Medical Executive Committee shall meet as often as necessary, but at least ten (10) times per year, and shall maintain a record of its proceedings and actions.

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[5] Joint Commission Standard MS.13.01.03, Element of Performance No. 1.

Article 10.4-4 Removal of MEC Members

The removal process (including the reasons for removal) for members of the MEC who are Department or Section Chairs shall be as specified under Section 9.6-4. All other members of the MEC may be removed pursuant to the process described in Section 8.1-6 with respect to removal of Medical Staff officers.

Article 10.5 BIOETHICS COMMITTEE

Article 10.5-1 Composition

The Bioethics Committee shall consist of physicians and such other non-physician members as the Medical Executive Committee may deem appropriate. When an ad hoc meeting is called, it may include nurses, lay representatives, social workers, clergy, ethicists, attorneys, administrators and representatives from the Board of Trustees, whoever is deemed necessary for the patient. The Vice Chief of Staff shall serve as the Chair of this Committee.

Article 10.5-2 Duties

The Bioethics Committee may participate in development of guidelines for consideration of cases having bioethical or medical practice ethics 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 and medical practice ethics policies; consultation with concerned parties to facilitate communication and aid conflict resolution; and education of the Hospital staff on bioethical and medical practice ethics matters.

Article 10.5-3 Meetings

The committee shall be an ad hoc committee, meeting as often as necessary at the call of its Chair. Physicians will enter notes of actions taken into the patient's medical record. It shall maintain a record of its activities and report to the Medical Executive Committee, as requested.

Article 10.6 CREDENTIALS COMMITTEE

Article 10.6-1 Composition

The Credentials Committee shall consist of at least one representative from each Department, insofar as possible.

Article 10.6-2 Duties

The Credentials Committee shall:

a. review and evaluate the qualifications of each practitioner applying for initial appointment, reappointment, or modification of clinical privileges, and, in connection therewith, obtain and consider the recommendations of the appropriate Departments;

b. submit required reports and information to the Medical Executive Committee on the

qualifications of each practitioner applying for membership or particular clinical privileges including recommendations with respect to appointment, membership category, Department affiliation, clinical privileges, and special conditions;

c. investigate, review and report on matters referred by the Chief of Staff or the Medical Executive Committee regarding the qualifications, conduct, professional character or competence of any applicant or Medical Staff member; and

d. submit periodic reports to the Medical Executive Committee on its activities and the status of pending applications.

Article 10.6-3 Meetings

The Credentials Committee shall meet as often as necessary at the call of its Chair and at least quarterly at the call of the chair. The committee shall maintain a record of its proceedings and actions and shall report to the Medical Executive Committee.

Article 10.7 INTERDISCIPLINARY PRACTICE COMMITTEE

Article 10.7-1 Composition

The Committee on Interdisciplinary Practice (IDPC) shall consist of, at a minimum, the Chief Nursing Officer, the CEO or designee, and an equal number of physicians appointed by the Medical Executive Committee and registered nurses appointed by the director of nursing. Licensed or certified health professionals other than registered nurses who perform functions requiring standardized procedures may be included in the committee. The Chair of the committee shall be a physician member of the active Medical Staff appointed by the Medical Executive Committee. All members on the Committee shall vote within the scope of their licensure and practice. A quorum for conducting business shall be two (2) physicians, two (2) R.N.s and one (1) person from Administration.

Article 10.7-2 Duties

The duties of this committee shall be:

a. to develop policies relevant to the formation and approval of standardized procedures;

b. to review and approve all standardized procedures and clinical protocols utilized by nurses practicing in expanded roles and/or practitioners providing clinical services under the supervision of a Medical Staff member;

c. evaluating and making recommendations regarding the need for and appropriateness of the performance of in-Hospital services by allied health professionals (AHPs);

d. to assure that an appraisal is performed on each allied health practitioner at the time of reappointment to the Allied Health Practitioner Staff. The actual appraisal may be performed by the Interdisciplinary Practice Committee or another committee of the Medical Staff;

e. evaluating and making recommendations regarding:

1) the mechanism for evaluating the qualifications and credentials of AHPs who

are eligible to apply for and provide in-Hospital services;

2) the minimum standards of training, education, character, competence, and overall fitness of AHPs eligible to apply for the opportunity to perform in-Hospital services;

3) identification of in-Hospital services which may be performed by an AHP, or category of AHPs, as well as any applicable terms and conditions thereon; and

4) the professional responsibilities of AHPs who have been determined eligible to perform in-Hospital services.

f. making recommendations regarding appropriate monitoring, supervision, and evaluation of AHPs who may be eligible to perform in-Hospital services;

g. evaluating and reporting whether in-Hospital services proposed to be performed or actually performed by AHPs are consistent with the rendering of quality medical care and with the responsibilities of members of the Medical Staff;

h. evaluating and reporting on the effectiveness of supervision requirements imposed upon AHPs who are rendering in-Hospital services;

i. periodically evaluating and reporting on the effectiveness of in-Hospital services performed by AHPs; and

j. as appropriate, making recommendations for a change in services that may be performed by or corrective action with respect to an AHP.

Article 10.7-3 Meetings

The IDP Committee shall meet at the call of the Chair at such intervals as the Chair or the Medical Executive Committee may deem appropriate.

Article 10.8 JOINT CONFERENCE COMMITTEE

Article 10.8-1 Composition

The Joint Conference Committee (JCC) shall consist of equal numbers of non-medical members of the Board of Trustees and members of the active Medical Staff, the latter appointed by the Medical Executive Committee. The Chair shall be the Chief of the Medical Staff.

Article 10.8-2 Duties

The Committee shall be responsible for deliberating on issues affecting the discharge of medical staff responsibilities and shall provide liaison between the governing body, the Medical Staff, and Administration on particular matters of mutual concern.

Article 10.8-3 Meetings

The JCC shall meet as deemed necessary and may be called by either the MEC or the Board of Trustees.

Article 10.9 MEDICAL STAFF WELL-BEING COMMITTEE

Article 10.9-1 Composition

The Medical Staff Well-Being Committee shall be comprised of no less than [3] active members of the Medical Staff, a majority of which, including the Chair, shall be physicians. Insofar as possible, members of this committee shall not serve as active participants on other peer review or quality assessment and improvement committees while serving on this committee.

Article 10.9-2 Duties

With respect to this Section, the phrase "Medical Staff Members" or "Members" shall also include licensed independent practitioners who are not members of the Medical Staff. The Medical Staff Well-Being Committee shall receive reports from any source related to the health, well-being, or impairment of Medical Staff members and, shall investigate such reports. With respect to matters involving individual Medical Staff members, the committee shall provide such advice, counseling, or referrals as it deems appropriate to facilitate diagnosis, treatment, and rehabilitation of physicians who suffer from potentially impairing conditions. In addition, the committee may aid the physician in regaining or retaining optimal professional functioning consistent with protection of patients.

Such activities shall generally be confidential; however, in the event information received by the committee clearly demonstrates that the health or known impairment of a Medical Staff member may pose a risk of harm to hospitalized patients, that information shall be referred to the Chief of Staff or Medical Executive Committee for possible corrective action. The committee shall also consider general matters related to the health and well-being of the Medical Staff and, with the approval of the MEC, develop educational programs about physician health, illness and impairment recognition among physicians, and addressing prevention of physical, psychiatric, or emotional illness or related activities.

In addition the committee shall: allow for self-referral by physicians and referral by other organizational staff; refer affected physicians to appropriate professional internal or external resources for diagnosis and treatment of physical, emotional, or drug dependency related conditions; maintain the confidentiality of the physician seeking referral or referred for assistance except as stated above or otherwise limited by law, ethical obligation, or when the safety of a patient is threatened; evaluate the credibility of any complaint, allegation, or concern regarding the physical or emotional health of a physician; monitor impaired physicians during programs of treatment and rehabilitation; and monitor compliance with any mandatory drug treatment programs. Nothing herein shall preclude the implementation of summary suspension pursuant to these Bylaws should the practitioner's behavior or condition pose a risk of imminent harm to any patient, employee, staff member or other person.

Article 10.9-3 Meetings

The committee shall meet as often as necessary. It shall maintain adequate records of its proceedings and shall report on its activities to the Chief of Staff. The Chief of Staff will report issues to the Medical Executive Committee as deemed necessary, such as concern that a licensed independent practitioner is providing unsafe treatment.

Article 10.10 BLOOD-TISSUE QUALITY REVIEW COMMITTEE

Article 10.10-1 Composition

The Blood-Tissue Quality Review Committee shall consist of members of the Active Medical Staff representing each of the clinical departments insofar as possible.

Article 10.10-2 Duties

The duties of the Blood-Tissue Quality Review Committee shall be to:

a. Study and evaluate the preoperative diagnoses, postoperative diagnoses, and reports by the pathologists on all tissues removed by surgery or needle biopsy. Review shall include cases in which no tissue was removed.

b. Review, monitor, and make recommendations regarding all blood usage in the Hospital and the processes regarding blood usage, including, but not limited to:

1) Distributing, handling, and dispensing blood products

2) Monitoring of the patient

3) Ordering and administering of blood products

The attending physician shall be present during discussion of the case when requested by the Committee. In all cases in which there is a significant discrepancy between preoperative diagnosis, postoperative diagnosis, and pathologist's report of findings, and in all cases of questionable usage of blood, the case shall be scored and referred to the Medical Executive Committee for further evaluation.

Article 10.10-3 Meetings

The committee shall meet as often as necessary, but at least quarterly.

Article 10.11 PHARMACY, THERAPEUTICS AND INFECTION CONTROL COMMITTEE

Article 10.11-1 Composition

The Pharmacy, Therapeutics and Infection Control Committee shall consist of at least 3 representatives from the Medical Staff, a voting representative from the pharmacy service, and an individual employed in a surveillance or epidemiological capacity. It shall also include, as a voting member, the Infection Control Nurse. It may also include non- voting consultants in microbiology, non-voting representatives from relevant Hospital services, non-voting representatives from Hospital Administration and non-voting additional representatives from the nursing service.

Article 10.11-2 Duties

The duties of the Pharmacy and Therapeutics-Infection Control Committee shall include:

a. evaluating and improving the quality of patient care provided to patients related to

medication usage, nutritional care, and infection surveillance and control;

b. developing, implementing and assessing appropriate quality control and performance improvement measures for medication usage, nutrition care and infection control;

c. assisting in the formulation of professional practices and policies regarding the continuing evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs, nutritional care, and infection control in the Hospital, including antibiotic usage;

d. advising the Medical Staff and the pharmacy service on matters pertaining to the choice of available drugs and nutritional supplements on the Hospital formulary;

e. making recommendations concerning drugs to be stocked on the nursing unit floors and by other services;

f. periodically developing and reviewing the formulary used in the Hospital;

g. evaluating clinical data concerning new drugs or preparations requested for use in the Hospital;

h. establishing standards concerning the use and control of investigational drugs and of research in the use of recognized drugs. The P&T / IC Committee shall also function as the Institutional Review Board (IRB) approval entity with oversight responsibility for any research drug brought into the hospital associated with a patient;

i. maintaining a record of all activities relating to pharmacy and therapeutics functions and submitting periodic reports and recommendations to the Medical Executive Committee concerning those activities;

j. reviewing adverse drug reactions;

k. reviewing aggregate data relevant to medication errors;

l. overseeing clinical care related to the nutritional needs of patients;

m. developing a Hospital-wide infection control program and maintaining surveillance over the program;

n. developing a system for reporting, identifying and analyzing the incidence and cause of nosocomial infections, including assignment of responsibility for the ongoing collection and analytic review of such data, and follow-up activities;

o. developing and implementing a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing and evaluating aseptic, isolation and sanitation techniques;

p. developing written policies defining special indications for isolation requirements;

q. coordinating action on findings from the Medical Staff's review of the clinical use of antibiotics;

r. acting upon recommendations related to infection control received from the Chief of Staff, the Medical Executive Committee, Departments and other committees; and

s. reviewing sensitivities of organisms specific to the facility.

Article 10.11-3 Meetings

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

Article 10.12 QUALITY AND PATIENT SAFETY COUNCIL

Article 10.12-1 Composition

The Quality and Patient Safety Council (QPSC) shall consist of voting members including the Vice Chief of Staff, Vice-Chairs of each Department, Chief Nursing Officer, and Director of Quality/Risk. Additional non-voting members may be designated by the Medical Executive Committee covering areas such as safety, risk, pharmacy, infection prevention, nursing and administration. The Vice Chief of Staff will be the chair.

Article 10.12-2 Duties

The Quality and Patient Safety Council has a central role in the initiation, performance and maintenance of the organization's performance improvement program. The QPSC provides a forum to address the collaborative integration and prioritization of all organization performance improvement activities. The fundamental responsibilities of the QPSC shall include:

a. prioritizing for organizational performance improvement and patient safety activities that are designed to improve patient care processes and outcomes;

b. developing performance improvement training programs for the organization's staff;

c. fostering communication and collaboration among departments and services;

d. receiving aggregate reports related to performance improvement activities from Hospital departments. Medical Staff committees and organizational performance improvement teams;

e. prioritizing and approving performance improvement teams;

f. developing and facilitating proactive risk reduction strategies;

g. providing oversight in the evaluation and improvement of patient experience;

h. providing oversight of compliance and/or participation in national patient safety programs and initiatives.

Article 10.12-3 Meetings

The Committee shall meet as often as necessary at the call of its Chair, but at least

quarterly. It shall maintain a record of its proceedings and report its activities and recommendations to the Medical Executive Committee and Board of Trustees on a regular basis, except that routine reports to the board shall not include peer evaluations related to individual members.

Article 10.12-4 Quorum

The presence of at least 4 (four) voting members, 2 of which must be physicians, shall constitute a quorum. When a quorum is present, action of the majority of the voting members shall be the action and recommendation of the committee.

Article 10.13 QUALITY REVIEW COMMITTEES (QRCs)

Article 10.13-1 Composition and General Description

The QRCs shall be standing committees of the Medical Staff with members appointed to monitor the care, treatment and services provided by those holding clinical privileges, in order to optimize quality and promote uniform quality of patient care. When requested, the QRC shall also make recommendations to the Credentials and/or Medical Executive Committees related to specific credentialing issues. The Department Chair, however, shall have the ultimate duty and responsibility to make recommendations regarding credentialing issues to the Credentials and/or Medical Executive Committees. The following QRCs shall represent standing committees of the Medical Staff:

a. Medical QRC (MQRC):

1) Shall provide oversight of all Physicians and Allied Health Practitioners holding privileges related to Medicine, including the Sections of Cardiology, Internal Medicine, Family Practice, Critical Care Medicine, Radiology, Emergency Medicine, Pediatrics, Telemedicine, and any other Medical specialties.

2) The Chair of the Department of Medicine shall be the Chair of the Medical QRC, insofar as possible. The Medical Executive Committee may appoint a member from one of the other subspecialties, if deemed necessary.

3) Members of the Medical QRC shall include the Chairs of the relevant Departments and Sections (or designee), as well as a representative from Radiology. The Director of Quality Management shall be an ex officio member without vote. The Committee may also include other additional members as may be appointed by the Medical Executive Committee.

b. Surgical QRC (SQRC):

1) Shall provide oversight of all Physicians and Allied Health Practitioners holding clinical privileges related to Surgery, including the Department of Obstetrics/Gynecology and the Sections of Anesthesia and Pathology, Dentistry, Podiatry, Orthopedics, and any other surgical specialties.

2) The Chair of the Department of Surgery shall be the Chair of the Surgical QRC, insofar as possible. The Medical Executive Committee may appoint a member from one of the other subspecialties, if deemed necessary.

3) Members of the Surgical QRC shall include the Chairs of all relevant Departments and Sections (or designee), and a representative from Radiology and Emergency Services. The Director of Quality Management shall be an ex officio member without vote. The Committee may also include other additional members as may be appointed by the Medical Executive Committee.

Article 10.13-2 Duties

The duties and responsibilities of the QRCs shall be:

a. to evaluate and promote uniformity and improvement in the quality of care provided to Hospital patients;

b. to conduct patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided by practitioners within the Departments and Sections represented by the QRC;

c. to perform peer review and/or other physician specific intensified assessments when indicated;

d. to identify system problems requiring process improvement activity and make such recommendations to the Quality Coordinating Council;

e. to submit written reports to the Medical Executive Committee concerning the QRCs' quality assessment and peer review activities, the actions taken thereon, results of such actions and specific recommendations for maintaining and improving the quality of patient care provided by the Departments and Sections;

f. to take appropriate actions when important problems in patient care or opportunities to improve patient care are identified;

g. to recommend to the Department and Section Chairs those Medical Staff policies and procedures as may be relevant to the conduct of the QRCs;

h. to communicate the significant results of peer review and performance improvement activities to relevant practitioners and seek comment from such practitioners as deemed appropriate;

i. to implement any adopted programs regarding clinical pathways and assess compliance with practice guidelines and other recognized standards of care;

j. to assume all duties and responsibilities of the Departments and Sections related to quality assessment, peer review and performance improvement, which have not been otherwise assigned to the Department or Section Chair, and as may be described in the Bylaws and/or Rules and Regulations.

Article 10.13-3 Meetings

The Quality Review Committees shall meet as often as necessary but at least every two months.

Article 10.14 UTILIZATION-RESOURCE MANAGEMENT COMMITTEE

Article 10.14-1 Composition

The Utilization/Resource Management Committee shall consist of a multi-disciplinary group composed of at least 2 physician members of the Medical Staff appointed by the Chief of Staff and others as specified. Physician members shall include the Physician Advisor, if any. Non-physician members may include the Case Management Director, Case Manager, Administrative Directors from Primary Care/Perinatal/ED/CCU/ Surgery, the CFO, CNO, CEO, HIM Director, Business Office Director and other personnel as needed. The Committee may establish subcommittees as deemed necessary to perform its duties. Only physician members shall serve with vote. The chair will be a physician.

Article 10.14-2 Duties

The Committee shall conduct or oversee the utilization and record review functions for Watsonville Community Hospital. In performing its duties, the Committee shall:

a. Evaluate length of stay, cost, charges by DRG, physician, service, and/or payment source.

b. Evaluate cases of over- and under- utilization.

c. As appropriate, initiate and evaluate the results of focused reviews. Recommend appropriate actions to the Medical Executive Committee.

d. Determine the appropriateness of services provided.

e. Review reports of delays in service and/or treatment.

f. When necessary, develop and approve medical necessity criteria.

g. Provide education to physician, support service departments, and/or the Board of Trustees relating to resource utilization.

h. Participate in product/equipment evaluation relating to resource utilization.

i. As appropriate, assist physicians and the hospital in appealing denials of payment.

j. Review medical records delinquency rates, medical record content and clinical pertinence.

k. Develop the Utilization and Record Review Plans which meet regulatory requirements.

l. Monitor the effectiveness of the Utilization and Record Review Plans.

m. Recommend standards and guidelines pertaining to the clinical pertinence, completeness and timeliness of patient records.

n. Provide a report, as needed, identifying any significant utilization or resource

management issues requiring QPSC support or assistance.

Article 10.14-3 Meetings

The committee shall be called together by the Case Management Department and meet as often as necessary, but at least quarterly.

Article 11 MEETINGS

Article 11.1 GENERAL STAFF MEETINGS

Article 11.1-1 Regular Meetings

Regular meetings of the Medical Staff shall be held annually. The annual general Medical Staff meeting shall be the spring meeting, which will meet before the end of the designated Medical Staff Term. The agenda of such meetings will be determined by the Chief of Staff. Except under the provisions of new business, no additional agenda items will be permitted unless they have been requested in writing, with justification, at least five (5) days prior to the meeting and approved by the Chief of Staff. Elections for Staff office will be held or announced at the annual meeting in each even year. The Chief of Staff shall preside at all general meetings of the Medical Staff.

Article 11.1-2 Special Meetings

The Chief of Staff may call a special meeting of the Medical Staff at any time. The Chief of Staff shall call a special meeting within 30 days after request from the MEC or receipt of a written request for same from not less than 20% of the Active Staff stating the proposed purpose for such meeting. The Chief of Staff shall designate the time and place for any special Medical Staff meeting.

Article 11.2 DEPARTMENT AND COMMITTEE MEETINGS

Article 11.2-1 Regular Meetings

Departments and committees, by resolution, may provide the time for holding regular meetings and no notice other than such resolution shall then be required. Each Department shall meet regularly, at least quarterly, to review and discuss patient care activities and to fulfill other Departmental responsibilities.

Article 11.2-2 Special Meetings

A special meeting of any Department or committee may be called by, or at the request of, the Department Chair, the Medical Executive Committee, Chief of Staff, or by 33% of the group's current members, but not fewer than 3 members. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

Article 11.3 NOTICE OF MEETINGS

a. Regular Meetings: Written notice stating the place, day and hour of any regular Medical Staff meeting or any regular or special Department or Committee meeting not held pursuant to resolution shall be delivered personally or via Hospital mailbox, mail, email, and/or other electronic means, to each person entitled to be present not fewer than five (5) working days nor more than 45 days before the date of such meeting. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

b. Special Meetings: Except as provided in Article 14 with respect to action on proposed Medical Staff Bylaws, written or printed notice stating the place, day and hour and nature of business to be conducted for any special Medical Staff meeting shall be delivered to each member of the Active Staff not less than 10 days before the date of such meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited, postage prepaid, in the United States mail addressed to each staff member at his address as it appears on the records of the Medical Staff. For other methods of delivery, the notice of the meeting shall be deemed effected upon delivery. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

Article 11.4 QUORUM

Article 11.4-1 Medical Staff Meetings

For purposes of conducting an item of business which has been noticed to members and as to which provision for returned ballots has been made, the presence of 15% of the active Medical Staff members, whether in person or via returned ballot, at any regular or special meeting shall constitute a quorum. For all other business, 15% of the active staff members must be physically present or attending through tele-conferencing means, in order to constitute a quorum. Discussions may be held at any Medical Staff meeting that lacks a quorum, but no voting or official action may be taken, except as provided under Section 11.5-2. This section will not apply to Medical Staff meetings for purposes of consideration of Bylaws amendments.

Article 11.4-2 Committee Meetings

The presence of 50% of the voting members (either by person or through tele-conferencing means) shall be required for the conduct of business by the Medical Executive Committee. For other committees, a quorum shall be the majority of voting members present or attending through tele-conferencing means, but in no event less than 2 voting members.

Article 11.4-3 Department and Section Meetings

For Department or Section meetings, a quorum shall be the majority of voting members present or attending through tele-conferencing means but in no event less than 2 voting members. Where a quorum is not present, the committee may not transact business but may make recommendations to the Medical Executive Committee in this regard.

Article 11.5 VOTING AND MANNER OF ACTION

Article 11.5-1 Voting

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

Article 11.5-2 Manner of Action

The Medical Executive Committee shall determine if any action to be taken at a regular or

special Medical Staff meeting shall be subject to ballots submitted by mail, email, and/ or other electronic means. Mail-in ballots will always be permitted relevant to the election of officers and amendment of Bylaws. If the Medical Executive Committee determines that ballots submitted by mail, email, and/or other electronic means are appropriate for other actions to be taken at a Medical Staff meeting, the Medical Executive Committee shall prepare a summary of the issue(s) to be voted upon and the written summary of the issue(s), along with a ballot, shall be delivered to each member of the active Medical Staff at least 10 days before the date of such meeting.

Except as otherwise specified in these Bylaws, the action of a majority of the members voting in person, or ballots received by mail, email, and/or other electronic means, 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 not withstanding 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 or videoconference which shall be deemed to constitute a meeting for the matters discussed in that telephone or videoconference. Valid action may be taken without a meeting by a committee if it is ratified, by a written statement of the action so taken, which is signed by at least two-thirds of the members entitled to vote.

Article 11.6 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, the vote taken on significant matters, a description of issues and documents considered and the underlying rationale for non-routine significant matters (e.g. adverse peer review recommendations). A copy of the minutes shall be taken to the next regularly scheduled meeting for review and approval. Approved minutes will stand as the official record of that meeting.

Article 11.7 ATTENDANCE REQUIREMENTS

Article 11.7-1 Regular Attendance

Members of the Medical Staff are encouraged to attend meetings of the Medical Staff. Meeting attendance will not be used by the Medical Executive Committee in evaluating Medical Staff members at the time of reappointment, except as may be appropriate with respect to any issue arising with respect to the mandatory meeting attendance requirements as described in Section 11.7-2.

Article 11.7-2 Attendance Requirements

a. Members of the Medical Executive Committee are encouraged to attend at least 50% of all regular Medical Executive Committee meetings. Failure of a Medical Executive Committee member to attend 50% of regularly scheduled Medical Executive Committee meetings in any 12-month period may constitute a voluntary resignation of Medical Executive Committee membership and voluntary resignation from any Medical Staff position which afforded the member a seat on the Medical Executive Committee, as determined by the Chief of Staff and approved by the MEC. Any non-

Departmental vacancies created by such a voluntary resignation will be filled by the Medical Executive Committee for the remainder of the current term except for the position of Chief of Staff which would be filled by the Vice Chief of Staff. All Departmental vacancies will be filled under the process in Sec. 9.6-6. Exceptions to this requirement may be made by the Medical Executive Committee for cause.

b. The Chair of any Medical Staff committee may give notice to a practitioner that his/her attendance at a meeting to discuss his/her clinical competence, behavior or conduct, or any other quality assessment or performance improvement issue is mandatory. Such notice shall be in writing and shall be mailed or hand delivered (or sent via another delivery mechanism if it is reliable and expeditious, and if evidence of its use is obtained) at least seven days prior to the scheduled date of the meeting.

1) A practitioner's failure to attend any meeting with respect to which he/she was given notice that attendance was mandatory, unless excused by the Medical Executive Committee upon a showing of good cause, may result in corrective action at the discretion of the Medical Executive Committee, including, but not limited to suspension of all of the practitioner's clinical privileges until the practitioner's mandatory attendance requirement has been met.

2) If the practitioner makes a timely request for postponement of mandatory meeting attendance supported by an adequate showing that his/her absence will be unavoidable, his/her attendance may be postponed to the next regular or special meeting of the committee by the Chair or by the Medical Executive Committee.

3) If the committee Chair is the practitioner involved, such a postponement may only be granted by the Medical Executive Committee.

4) This requirement shall not preclude any committee from reviewing the competence or conduct of any practitioner in his/her absence.

Article 11.8 CONDUCT OF MEETINGS

Unless otherwise specified, meetings shall be conducted at the discretion of the Chair of the Committee, Department or Section, in a manner designed to address all items on the Agenda in a manner that allows for presentation of relevant information and adequate discussion of the issues.

Motions that are made and seconded should generally be voted upon after adequate discussion. However, the Chair of the Committee, Department or Section may also allow amendments to a motion, with consent from the originally moving party.

Upon request and with the consent of a majority of the voting members, matters may be tabled for vote at a later meeting.

Article 11.9 AGENDA

The order of business at a meeting of the Medical Staff or Committee shall be determined by the presiding Chair of the Committee.

Article 11.10 EXECUTIVE SESSION

Executive session is a portion of any Medical Staff Committee meeting that only voting members of the given Committee may attend, unless another attendee is specifically invited to attend by the Chair of the Medical Staff Committee. The Hospital's CEO and any other ex officio member of the Medical Executive Committee may attend every Medical Executive Committee meeting. However, attendance at any executive session portion of the Medical Executive Committee or any other Medical Staff Committee will be by invitation only. Unless such invitation is extended to a non-voting member or other individual for good cause, all non-voting members of any given committee will be excused for the executive session. Minutes of the Executive Session shall contain the topics discussed and any actions taken. If Peer Review or Case Review is the subject of the Executive Session, the physician number and/or the case number will appear in the minutes. The minutes will be submitted to the appropriate Medical Staff Department and/or the Medical Executive Committee.

Article 12 CONFIDENTIALITY, IMMUNITY AND RELEASES

Article 12.1 AUTHORIZATION AND CONDITIONS

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

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

b. authorizes persons and organizations to provide information concerning such practitioner to the Medical Staff;

c. agrees to be bound by the provisions of this Article and to waive all legal claims against any representative of the Medical Staff or the Hospital who would be immune from liability under Section 12.3 of this Article; and

d. 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 at this Hospital.

Article 12.2 CONFIDENTIALITY OF INFORMATION

Article 12.2-1 General

Records and proceedings of all Medical Staff committees having responsibility for evaluation and improvement of quality of care rendered in this Hospital, including, but not limited to, meetings of the Medical Staff meeting as a committee of the whole, meetings of Departments and Sections, meetings of committees established under Article 6, 7, and 10, and meetings of special or ad hoc committees created by the Medical Executive Committee or by Departments and including information regarding any member or applicant to this Medical Staff shall, to the fullest extent permitted by law, be confidential and protected from discovery pursuant to California Evidence Code Section 1157. Dissemination of such information and records shall only be made where expressly required by law, or pursuant to officially adopted policies of the Medical Staff or, where no officially adopted policy exists, only with the express approval of the Chief of Staff or Medical Executive Committee in conjunction with credentialing and peer review activities.

Article 12.2-2 Breach of Confidentiality

As effective peer review and consideration of the qualifications of Medical Staff members and other individuals exercising clinical privileges must be based on free and candid discussions, any breach of confidentiality of the discussions, documents, or deliberations of Medical Staff Departments, Sections, committees, or Judicial Review Committee proceedings, except as noted under Section 12.2-1, is outside appropriate standards of conduct for this Medical Staff, violates the Medical Staff Bylaws, and will be deemed disruptive to the operations of the Medical Staff.

Members participating in any and all peer review activities must refrain from discussion of those activities with other Medical Staff members, except in the context of legitimate committee discussion or as requested in the course assisting the Medical Staff with official peer review activities. If it is determined that such a breach has occurred, the Medical Executive Committee may undertake such corrective action as it deems appropriate.

Individuals who are permitted to attend Medical Staff committee meetings, but who are neither Members of the Medical Staff nor ex-officio Members, may be required to sign the sign-in sheets, which shall include pledges of confidentiality consistent with the requirements of these Bylaws. Objective evidence of failure to respect such pledge shall, within the discretion of the MEC, constitute grounds for termination of the individual's right to continue to participate on such committee(s), and may also result in referral by the MEC to administration to consider disciplinary action related to such employee.

Article 12.2-3 Medical Staff Records

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

a. As provided in Sections 12.2-1, the records of the Medical Staff and its Departments and Committees responsible for the evaluation and improvement of the quality of patient care rendered in the Hospital shall be maintained as confidential.

b. Access to such records shall be limited to duly appointed officers and committees of the Medical Staff for the sole purpose of discharging Medical Staff responsibilities and subject to the requirement that confidentiality be maintained.

c. Information which is disclosed to the Board of Trustees of the Hospital or its appointed representatives, in order that the Board of Trustees may discharge its lawful obligations and responsibilities, shall be maintained by that body as confidential and any relevant documentation shall be returned or referred to the Medical Staff for safekeeping.

d. Information contained in the credentials file of any member may be disclosed with the member's consent, to any Medical Staff or professional licensing board, or as otherwise required or permitted by law. However, any disclosure outside of the Medical Staff shall require the authorization of the Chief of Staff and notice to the member.

e. Within the discretion of the MEC, a Medical Staff member may be granted access to the information from his or own credentials file, subject to the following provisions:

    1) a request for access must be submitted in writing by the member to the Chief of Staff or the Chief of Staff's designee;

    2) the member may receive a copy of only those documents provided by or addressed personally to the member. A summary of all other information, including peer review committee findings, letters of reference, proctoring reports, complaints, etc., shall be provided to the member, in writing, by the designated officer of the Medical Staff. Such summary shall disclose the substance, but not the source, of the information summarized.

f. In the event a notice of action or proposed action is filed against a member, access to the information in that member's credentials file shall be governed by Section 7.4-9.

Article 12.3 IMMUNITY FROM LIABILITY

Article 12.3-1 For Action Taken

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

Article 12.3-2 For Providing Information

Each representative of the Medical Staff and Hospital and all third parties shall be immune, to the fullest extent provided by law, from liability to an applicant or member or other individual exercising clinical privileges for damages or other relief by reason of providing information to a representative of the Medical Staff, Hospital Board or other entity with which the member, applicant or other individual exercising clinical privileges may be affiliated concerning such person who is, or has been, an applicant to or member of the staff or who did, or does, exercise clinical privileges or provide services at this Hospital in connection with any evaluation of his or her competence or conduct.

Article 12.4 ACTIVITIES AND INFORMATION COVERED

The confidentiality, Evidence Code 1157 protections, and immunity provided by this Article shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health care facility's or organization's activities concerning, but not limited to:

a. application for appointment, reappointment, or clinical privileges;

b. corrective action;

c. hearings and appellate reviews;

d. utilization reviews;

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

f. queries and reports concerning the National Practitioner Data Bank, peer review organization, the Medical Board of California (or other applicable licensing agency), and similar queries and reports.

Article 12.5 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 12.6 INDEMNIFICATION

The Hospital shall, to the extent permitted by law, indemnify, defend and hold harmless any Medical Staff Officer, Department chair or committee member and any individual member acting in the course of official duties related to the organized medical staff, from and against losses and expenses (including attorneys' fees, judgments, settlements, and all other costs, direct or indirect) incurred or suffered by reason of or based upon any threatened, pending or completed action, suit, proceeding, investigation, or other dispute relating or pertaining to any alleged act or failure to act that is not grossly negligent, reckless, intentional or in willful and knowing violation of applicable law or regulations, and was within the scope of good faith peer review or quality assessment activities including, but not limited to:

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

b. as a member or witness for the Hospital Board or any Hospital task force, group, or committee; and

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

Payment of any losses or expenses by the Medical Staff or member is not a condition precedent to the Hospital's indemnification obligations hereunder.

Article 13 GENERAL PROVISIONS

Article 13.1 CONFLICT RESOLUTION

Article 13.1-1 Peer Review Recommendation Disputes

In compliance with Business and Professions Code Section 805.01, with respect to the management of conflicts between the Medical Staff and the Board of Trustees relating to the initiation of an investigation of or adverse action against a Medical Staff member (e.g., with respect to appointment or reappointment and the granting or clinical privileges), the parties shall follow the provisions set forth in Article 6, Section 6.1-6 of these Bylaws.

Article 13.1-2 Conflict Related to Medical Staff Self-Governance

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

Article 13.1-3 Other Conflicts Between Leadership Groups

Leadership groups are comprised of the members of the Board of Trustees, elected or appointed leaders of the Medical Staff, and the Hospital Management Team. With respect to any dispute between the Hospital's leadership groups that could adversely affect patient safety or quality of care, that do not relate to peer review recommendations or the Medical Staff's right of self-governance, the leadership groups shall meet and confer in good faith as early as possible in order to resolve the dispute in a forum mutually agreed upon by the parties to the conflict.

Article 13.1-4 Conflicts Between the Medical Staff and Medical Executive Committee

The Medical Executive Committee or the Medical Staff may initiate the process described in Section 11.1-2 in order to resolve policy-oriented or organizational conflicts between the Medical Executive Committee and Medical Staff on issues including, but not limited to, proposals to adopt a Rule or Policy, or an amendment thereto. The Medical Executive Committee and Medical Staff shall make a good faith effort to resolve the conflict.

Article 13.2 DUES OR ASSESSMENTS

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

Article 13.3 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. These Bylaws apply with equal force to both sexes wherever either term is used.

Article 13.4 AUTHORITY TO ACT

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

Article 13.5 DIVISION OF FEES

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

Article 13.6 DISCLOSURE OF POTENTIAL CONFLICT OF INTEREST

In compliance with applicable Medical Staff Policies, all nominees for election or appointment to the Medical Staff offices, Department or Section Chair, or to the MEC shall, at least 20 days prior to the date of election or appointment, disclose in writing to the appointing or electing Medical Staff members those personal, professional, or affiliation relationships of which they are aware, which could foreseeably result in conflict of interest with any of their activities or responsibilities on behalf of the Medical Staff. Medical Staff leaders shall work with other Hospital leaders to develop a written Policy that defines how conflicts of interest involving Medical Staff leaders and those involving all licensed independent practitioners and/or staff will be defined, disclosed, and further addressed.

Article 13.7 NOMINATION OF MEDICAL STAFF REPRESENTATIVES

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

Article 13.8 MEDICAL STAFF CREDENTIALS FILES

Article 13.8-1 Insertion of Letter of Reprimand

The Medical Executive Committee may issue of a letter of admonition, censure, reprimand or warning to any member of the medical or allied health practitioner staff. Nothing herein shall be deemed to preclude a Department or Section Chair, committee Chair, or the Medical Executive Committee from issuing informal written or oral warning outside of the mechanism for issuance of a letter of reprimand as described in these Bylaws. The following provisions apply to issuance of a letter of reprimand:

a. Only the Medical Executive Committee shall have the authority to issue a letter of reprimand and place the letter of reprimand into the practitioner's credential file.

b. If the Medical Executive Committee authorizes the issuance of a letter of reprimand and insertion of a letter of reprimand into the practitioner's credential file, the practitioner shall be provided with special notice of this action and may respond in accordance with Section 13.8-2.

c. Special notice to the practitioner shall include a copy of the letter of reprimand which will be inserted into the practitioner's credential file.

Article 13.8-2 Opportunity to Request Correction of Information Contained in a Letter of Reprimand and/or Make an Addition of Information to the Credential File

a. When an individual has received notice of insertion of a letter of reprimand into his/her credential file, the practitioner may address to the Medical Executive Committee a written request for correction of information contained in the Letter of Reprimand. Such request shall include a statement of the basis for the action requested.

b. The Medical Executive Committee shall review such a request within a reasonable time and determine after such review whether or not to make the correction or deletion requested by the practitioner.

c. The member shall be notified in writing of the decision of the Medical Executive Committee in this matter.

d. In any case, the practitioner shall have the right to add to his/her own credentials file, upon written request to the Medical Executive Committee, a statement responding to the information contained in the letter of reprimand.

Article 13.9 MEDICAL STAFF ROLE IN EXCLUSIVE CONTRACTING

a. The Medical Executive Committee shall, in a timely manner, review and make recommendations to the Board of Trustees regarding quality of care and operational issues related to exclusive arrangements for physician and/or professional services, prior to any decision being made, in the following situations:

    1) the decision to execute an exclusive contract in a previously open Department or service;

    2) the decision to modify an existing exclusive contract in a Department or service in a manner that will materially affect the provision or availability of particular medical services;

    3) the decision to terminate an exclusive contract in a particular Department or service.

b. Under the circumstances referenced in subsection (a.), above, the Medical Executive Committee shall, within thirty (30) days of the Board’s request for input, solicit written

input from the Medical Staff, relating to the quality of care and operational issues that may arise related to the proposed arrangements. The Medical Executive Committee may arrange for meetings of standing or ad hoc committees, or the medical staff as a whole (with additional invitees as determined by the Medical Executive Committee), as it deems appropriate in furtherance of its assessment of the issues, and in support of its goal to timely make recommendations to the Board under this section 13.9.

The Medical Executive Committee shall seek input on, and evaluate, such factors as:

- Whether the proposed arrangement would provide full coverage of a needed service.
- Whether conflict or dysfunction within an existing department/service are adversely affecting quality of care.
- Whether demonstrable efficiencies would result from instituting the exclusive arrangement, producing significant improvement in the ability of the Medical Staff to oversee and deliver quality care.
- Whether the scope of the contracted services should be broadened, reduced or otherwise modified in furtherance of the medical staff's goals of quality oversight, quality improvement and patient safety.
- The desired expectations that should be imposed on the contractor for the performance of the contracted services, including, where possible, recommended methods for monitoring the contractor's performance in fulfillment of those expectations.
- Any other recommendations pertinent to enhanced medical staff oversight of quality of care, quality of care and services delivered to patients, and patient safety.

c. The results of the Medical Executive Committee assessment shall be reported to the Chief Executive Officer and to the Board of Trustees, within sixty (60) days of the Board's request for input on such issues.

d. The Board of Trustees shall give great weight to the recommendations of the Medical Executive Committee related to quality of care and operational issues, and shall uphold the Medical Staff's recommendations, unless the Board makes specific written findings as to why the Board disagrees.

e. The Medical Staff shall recommend the need to close a department/service pursuant to an exclusive contract to be appropriate where:

- a failure to provide full coverage of a needed service cannot be remedied by less extreme measures, such as compensated call schedules, or instituting new medical staff rules, policies or bylaws changes; or
- Historically intractable conflict or dysfunction within an existing department/service adversely affects quality of care, and cannot be resolved by less extreme measures; or
- demonstrable efficiencies would result, producing significant improvement in the ability of the Medical Staff to oversee and deliver quality care, which have not been accomplished through less extreme measures.

f. A Medical Staff recommendation to close a department/service pursuant to an exclusive contract must be based upon the preponderance of the evidence, viewing the record as a whole, presented by any and all interested parties selected by the MEC, to include at a minimum the hospital Board, the medical staff membership, and any others invited by the MEC to provide information, following notice and opportunity for comment.

g. The Medical Staff shall recommend the transfer of an existing exclusive contract to be appropriate only when quality oversight by the medical staff, and overall quality of care, are maintained or improved by the transfer.

h. A Medical Staff Member providing professional services under a contract with the hospital shall not have medical staff privileges terminated for reasons pertaining to the quality of care provided by the Medical Staff Member without the same rights of hearing and appeal as are available to all members of the medical staff.

Article 14 ADOPTION AND AMENDMENT OF BYLAWS, RULES AND REGULATIONS, AND POLICIES AND PROCEDURES

Article 14.1 GENERAL PROVISIONS

Article 14.1-1 Governing Documents

The primary governing documents of the Medical Staff are its Bylaws, Rules and Regulations ("Rules"), and policies and procedures ("policies"). These Bylaws describe the fundamental principles of Medical Staff self-governance and accountability to the Board of Trustees, providing key standards and processes for Medical Staff membership, appointment, reappointment, and privileging. Provisions regarding implementation of the Medical Staff standards, including but not limited to the associated details of Bylaws' processes, may reside in the Medical Staff Bylaws, Rules, or policies, as required by law or The Joint Commission Standards and as further described below.

For any topic that is required by law or accreditation standards to be addressed in the Bylaws, the basic provision shall reside in the Bylaws. However, associated details meant to address implementation of the basic provisions may reside in the Rules and/or policies. Such associated details may be adopted or amended by the Medical Executive Committee, consistent with the delegation of such authority, as described in this Article.

Article 14.1-2 Exclusivity

The mechanisms described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff Bylaws, Rules, and policies. Neither the Medical Staff nor the Board of Trustees may unilaterally amend the Medical Staff Bylaws.

Article 14.1-3 Medical Staff Members Entitled to Vote

References within this Article to voting by "members" or the signing and/or submission of a petition by "members" are references to the Active members of the Medical Staff in good standing.

Article 14.1-4 Voting

When a vote is required by Medical Staff members under this Article (as opposed to any vote to be taken by the Medical Executive Committee), voting may be accomplished by written ballot, email, and/or other electronic means, so long as adequate precautions are taken to ensure reliability and security. Notice of the proposed change(s) by mail, email, or other electronic means shall be sent to all members entitled to vote at least thirty (30) days prior to the date set for submission of the votes. Approval shall require the affirmative vote of the majority of those eligible to vote.

Article 14.1-5 Approval by Board of Trustees

Bylaws changes adopted by the Medical Staff and Rules and/or policies adopted by the Medical Executive Committee on behalf of the Medical Staff or by the voting Medical Staff members directly, pursuant to the procedures of this Article, shall become effective following approval by the Board of Trustees which approval shall not be withheld unreasonably. Adopted changes shall be submitted to the Board of Trustees for consideration at its next regularly scheduled meeting. The Board of Trustees shall take action on such proposed Bylaws, Rules or policy changes within sixty (60) days of receipt of request for such change. If no action is taken within sixty (60) days, the Bylaws, Rules, or policy change shall be deemed automatically approved except in extraordinary circumstances in which the Board was unable to review the matter and the Chair provides written reasons therefore, in which case an additional thirty days shall be allowed. For purposes of this section, Board of Trustees action may include approval, rejection, or deferral of action pending receipt of additional information or clarification concerning the proposed changes. In any event, the Board of Trustees may not defer approval or rejection beyond one hundred twenty (120) days of receipt of the request for change absent a showing that relevant information reasonably requested by the Board has been unreasonably withheld. If approval is withheld, the reasons for doing so shall be specified by the Board of Trustees in writing, and shall be forwarded to the Chief of Staff, the Medical Executive Committee and, if a proposed change to the Bylaws, the Bylaws Committee.

Article 14.1-6 Conflicts between Bylaws, Rules, and Policies

If there is a conflict between the Bylaws and Medical Staff Rules and Regulations, the Bylaws shall prevail. If there is a conflict between Medical Staff Rules and Regulations and Medical Staff policies and procedures, the document which has most recently been reviewed and approved by the Medical Executive Committee or Medical Staff shall prevail. The Medical Executive Committee or the Medical Staff may initiate the process described in Section 11.1-2 in order to resolve policy-oriented or organizational conflicts between the Medical Executive Committee and Medical Staff on issues including, but not limited to, proposals to adopt a Rule or Policy, or an amendment thereto. The Medical Executive Committee and Medical Staff shall make a good faith effort to resolve the conflict.

The Medical Staff Bylaws, the Board of Trustee Bylaws, and the Hospital policies shall be compatible with each other and compliant with law and regulation. If there is a conflict between the Medical Staff Bylaws and the Board of Trustee Bylaws, either party may request a meeting to discuss the matter and attempt to resolve it under Section 13.1-2 of the Bylaws. If there is a conflict between the Medical Staff's Bylaws, Rules, or policies, these Bylaws shall prevail.

Article 14.2 ADOPTION AND AMENDMENT OF BYLAWS

Article 14.2-1 Procedure

Upon the request of (1) the Medical Executive Committee, or the Chief of Staff or the Bylaws Committee, and after approval by the Medical Executive Committee, or (2) upon timely written petition signed by at least ten percent (10%) of the members, consideration shall be given to the adoption, amendment, or repeal of these Bylaws by the Medical Staff members entitled to vote in the manner described in Section 14.1-4. Upon adoption by the Medical Staff, the procedure in Section 14.1-5 shall be followed to obtain approval by the Board of Trustees.

Article 14.2-2 Technical Amendments

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

Article 14.2-3 Successor in Interest

These Bylaws, and prerogatives of individual members of the Medical Staff accorded under these Bylaws, will be binding upon the Medical Staff, and the Board of Trustees of any successor in interest in the Hospital.

Article 14.2-4 Affiliations

Affiliations between the Hospital and other Hospitals, health care systems or other entities shall not, in and of themselves, affect these Bylaws.

Article 14.2-5 Effect of the Bylaws

Upon adoption and approval of theses Bylaws, in consideration of the mutual promises and agreements contained within them, the Hospital and the Medical Staff, are legally bound by their provisions. Thus, an aggrieved individual, the Medical Staff as a whole, or the Hospital may seek court intervention to specifically enforce performance of the obligations as set forth in these Bylaws or otherwise as provided by California Business and Professions Code Sec. 2282.5.

Article 14.3 ADOPTION AND AMENDMENT OF RULES

Article 14.3-1 Medical Executive Committee Delegation and Adoption

a. The Medical Staff delegates authority to the Medical Executive Committee to initiate and adopt such Rules as it may deem necessary for the proper conduct of Medical Staff business. Recommended changes to the Rules may be submitted to the Medical Executive Committee by any Member of the Medical Executive Committee or by other Medical Staff committees. If the Medical Executive Committee proposes to adopt a change(s) to the Rules, it must communicate the proposal to the Medical Staff in writing at least 15 days before it is adopted.

b. Following adoption by the Medical Executive Committee, such Rules shall become effective upon approval of the Board of Trustees as set forth in Section 14.1-5.

c. Rules shall be reviewed every two (2) years, or more frequently, as needed, and revised to comply with current Medical Staff practice. Applicants and members of the Medical Staff shall be governed by such Rules as are properly initiated and adopted.

Article 14.3-2 Amendments for Legal/Regulatory Compliance

a. The Medical Staff has delegated authority to the Medical Executive Committee to provisionally adopt, without prior notification to the Medical Staff, an amendment to the

Rules when there is a documented need to promptly comply with specific rules required by law or governmental and/or accrediting agencies.

b. The action to amend may be taken by motion and acted upon in the same manner as any other motion before the Medical Executive Committee.

c. Upon adoption by the Medical Executive Committee, notice will promptly be provided to the Board of Trustees who will approve or reject the amendment promptly.

d. Upon approval by the Board of Trustees, the Medical Executive Committee will notify the Medical Staff promptly and provide the Medical Staff with an opportunity to retrospectively review and comment on the amendment. If 30 days after notification, the organized medical staff has not indicated – in writing – that it is in disagreement with the provisional adoption or amendment, the adoption or amendment shall be considered final.

e. If there is a conflict regarding the amendment between the Medical Staff and the Medical Executive Committee, the process for resolving conflicts described in Sections 13.1-4 (Conflicts between the Medical Staff and Medical Executive Committee) and Section 11.1-2 (Special Meetings) will be implemented.

Article 14.3-3 Technical Amendments

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

Article 14.4 ADOPTION AND AMENDMENT OF POLICIES

Article 14.4-1 Medical Staff Policies – Medical Executive Committee

a. For purposes of this Section, the term "Medical Staff Policies" shall mean those policies that are adopted by the Medical Executive Committee and pertain to the Medical Staff as a whole. It does not include policies developed by Departments or Sections for their members or Hospital policies, even if such policies are approved by the Medical Executive Committee.

b. Medical Staff policies shall be developed as necessary to implement more specifically the general principles found within these Bylaws and the Rules. The Medical Staff delegates authority to the Medical Executive Committee to initiate and/or adopt such Medical Staff policies as it may deem necessary for the proper conduct of the Medical Staff's business. The Medical Executive Committee may develop such Medical Staff policies itself or may direct a Department or designate a committee to draft a Medical Staff policy for its review.

c. Following adoption or amendment of a Medical Staff policy by the Medical Executive Committee, such Medical Staff policy shall become effective upon approval of the Board of Trustees as set forth in Section 14.1-5.

d. Adoption or amendment of a Medical Staff policy shall be communicated to the organized Medical Staff by the Medical Executive Committee.

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

Article 14.4-2 Clinical Department Policies

Departmental policies may be formulated by each clinical Department for the conduct of its affairs and the discharge of its responsibilities. The Departmental policies shall be consistent with the Medical Staff Bylaws, Rules, and Policies. Departmental policies shall be approved or revised by the affected Department and approved by the Medical Executive Committee and the Board of Trustees. It is the responsibility of the Department to communicate approved policies to its Members, as appropriate.

Article 14.5 DIRECT MEDICAL STAFF PROPOSAL TO BOARD OF TRUSTEES – ADOPTION AND AMENDMENTS TO RULES OR POLICIES

Notwithstanding any other provision of these Bylaws, the Medical Staff Members entitled to vote may propose adoption or amendment of a Rule or policy that pertains to the Medical Staff as a whole directly to the Board of Trustees. To propose a Rule, policy, or amendment directly to the Board of Trustees, an Active Member of the Medical Staff in good standing must take the following steps:

a. Obtain an initial written petition in support of the proposed Rule, policy, or amendment language signed by at least twenty-five percent (25%) of the members of the Medical Staff who are entitled to vote.

b. Communicate in writing both the proposed Rule, policy, or amendment and the reason for the proposed Rule, policy, or amendment to the Medical Executive Committee for its consideration and vote.

c. Proposed Rule. If the MEC agrees with a proposed Rule, or amendment, the MEC shall communicate the proposal to the Medical Staff in writing at least 15 days before it is adopted by the Medical Executive Committee.

d. Proposed Policy. If the Medical Executive Committee adopts the proposed policy or amendment, it shall follow the process outlined in Section 14.4-1(c)(d).

e. In the event of conflict regarding the proposal, either the Medical Executive Committee or the Medical Staff petitioners may initiate the process described in Sections 13.1-4(Conflicts between the Medical Staff and Medical Executive Committee) and 11.1-2 (Special Meetings) in an attempt to resolve the conflict.

f. If, following a failed attempt to resolve any conflict over the proposed Rule, policy, or amendment, the Medical Executive Committee ultimately rejects the proposed Rule, policy, or amendment, the Members of the Medical Staff entitled to vote shall be given notice of the proposed Rule, policy, or amendment and a vote shall be taken in the manner described in Section 14.1-4.

If the proposed Rule, policy, or amendment is adopted by the Medical Staff, it shall become effective upon approval of the Board of Trustees, which approval shall not be withheld unreasonably, or automatically after sixty (60) days if no action is taken by the Board of Trustees. In the latter event, the Board of Trustees shall be deemed to have approved the Rule, policy, or amendment. Board of Trustees action may include, approval, rejection, or deferral of action pending receipt of additional information or clarification concerning the proposed changes. If approval is withheld, the reasons for doing so shall be specified by the Board of Trustees in writing, and shall be forwarded to the Chief of Staff, the Medical Executive Committee and, if a proposed change to the Bylaws, the Bylaws Committee.

ADOPTED by the Medical Staff on

April 20, 2021
Date

By: Chief of Staff, Roy Martinez, MD

APPROVED by the Board of Trustees on

April 28, 2021
Date

By: Chair, Board of Trustees