Attachment A

ARROWHEAD REGIONAL MEDICAL CENTER
MEDICAL STAFF BYLAWS

Revised February 8, 2022

Attachment A

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DEFINITIONS

A. Advanced Practice Professional or APP means an individual other than a licensed physician, oral and maxillofacial surgeon, dentist, clinical psychologist, or podiatrist, who functions within the limits established by the Medical Staff, by the Governing Body, if applicable, and the applicable State Practice Act. APPs are not eligible for Medical Staff membership.

B. Date of Receipt means the date any notice, special notice, or other communication was delivered to a Practitioner. If a notice was sent by mail, it shall mean forty-eight (48) hours after it was deposited postage prepaid in the United States Postal Service. If a notice was sent return receipt requested, it shall mean the date the return receipt was signed by the receiving party. If a notice is sent by email or fax, it shall mean the date and time the email or fax was transmitted.

C. Department Chairman means the individual appointed to direct one (1) of the Departments of the Medical Center.

D. Ex-Officio means service by virtue of office or position held. An Ex officio membership is without vote, unless otherwise specified.

E. Governing Body means the San Bernardino County Board of Supervisors.

F. House Staff means the individual in an approved post-graduate medical education program at this institution or a contractually affiliated facility who treat patients under the supervision and direction of the teaching Members of the Medical Staff.

G. In Good Standing means a Member is currently not under suspension or serving with any limitation of prerogatives imposed by operation of the Bylaws, Rules and Regulations or policy of the Medical Staff.

H. Investigation means a formal process commenced only by the MEC, as described in Section 7.8 of the Medical Staff Bylaws to determine the validity, if any, to a concern or complaint raised against a Member of the Medical Staff or Advanced Practice Professional. An Investigation is ongoing until either formal action is taken or the Investigation is closed. An Investigation does not include the activity of the Physician Well-Being Committee. A routine or general review of cases or a routine review of a particular physician is not an Investigation.

I. Limited License Practitioners means dentists, oral surgeons, clinical psychologists, and podiatrists.

J. Medical Center Director means the individual appointed by the Governing Body to serve as the Medical Center Director.

K. Medical Director, Chief Medical Officer or CMO means the individual to direct the medico-administrative affairs of the Medical Center, including clinical services and medical education. The Medical Staff recognizes that the most effective Chief Medical Officer will be one who is fluent with current medical practice, and therefore supports the selection of a licensed physician who is a Member of the Active Medical Staff. The Chief Medical Officer position in of itself does not entitle its holder to vote on any matters of the Medical Staff or Committee of the Medical Staff.

L. Medical Executive Committee or MEC means the Executive Committee of the Medical Staff, which constitutes the ruling body of the Medical Staff as described in these Bylaws.

M. Medical Staff means those physicians (MD or DO, or their equivalent as defined in Section 3.2), dentists, oral and maxillofacial surgeons, clinical psychologists, and podiatrists who have been granted recognition as Members of the Medical Staff pursuant to these Bylaws.

N. Medical Staff Organization means both Medical Staff and Advanced Practice Professional Staff.

O. Medical Staff Year means the period from January 1st to December 31st.

P. Member means, unless otherwise expressly limited, any physician, dentist, clinical psychologist, or podiatrist, holding a current California license to practice who is a Member of the Medical Staff.

Q. Name of this Organization shall be the Medical Staff or Arrowhead Regional Medical Center.

R. New Privilege Focused Professional Practice Evaluation or **N-FPPE** means a Focused Professional Practice Evaluation associated with new privileges granted at the time of initial appointment or new privileges granted to existing Practitioners.

S. Notice means written communication emailed, faxed, hand delivered, or sent through the United States Postal Service addressed to a Practitioner at his/her current email address, fax number, or postal address as it appears in the office records of the Medical Staff or the Medical Center. It is the Practitioner's responsibility to ensure all address information on record at the Medical Center is accurate. Unless otherwise stated in these Bylaws or as determined by the Chairman of a Medical Staff Committee/Department, the primary means of communication with Practitioners and applicants will be by email.

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

U. Practitioner means those Medical Staff and Advanced Practice Professionals credentialed by the Medical Staff.

V. Privileges describe the specific patient services which each Member of the Medical Staff or Advanced Practice Professional Staff has been granted to provide, and includes unrestricted access to those Medical Center resources (including equipment, facilities, and Medical Center personnel) which are necessary to effectively exercise those privileges.

W. Rules and Regulations refers to the Medical Staff and/or Departmental Rules and Regulations adopted in accordance with these Bylaws unless specified otherwise.

X. Section Director means the individual appointed to direct one of the Sections of a Department.

Y. Telehealth is defined by California Business and Professions Code §2290.5 to mean the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care practitioner is at a distant site. Telehealth includes synchronous (a real-time interaction between a patient and a health care practitioner located at a distant site) and asynchronous (the transmission of a patient's medical information from an originating site to the health care practitioner at a distant site without the presence of the patient store and forward transfers)**.** For purposes of these Bylaws, "Telemedicine" is that subset of Telehealth services delivered to Medical Center patients by practitioners who have been granted privileges by this Medical Center to provide services via Telehealth modalities ("Telemedicine Practitioners").

ARTICLE I.
FOUNDATION STATEMENT AND DEFINITION

These Bylaws are adopted to provide a framework for self-government for the Medical Staff Organization of Arrowhead Regional Medical Center that permits the Medical Staff to discharge its responsibilities in matters involving the quality of medical care, to govern the orderly resolution of issues and the conduct of Medical Staff functions supportive of those purposes, and to account to the Governing Body for the effective performance of Medical Staff responsibilities. These Bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Governing Body, and relations with applicants to and Members of the Medical Staff. The 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. The Medical Staff is also responsible for and involved with many aspects of delivery of health care within the Medical Center including, but not limited to, the treatment and services delivered by Practitioners credentialed and privileged 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 Medical Center depends on the mutual accountability, interdependence, and responsibility of the Medical Staff and the Medical Center Governing Body for the proper performance of their respective obligations. The Governing Body recognized that the Medical Staff is required to be self-governing with respect to the professional work performed at the facility that it exercises self-governance rights and responsibilities derived from the statute, and that it is responsible to the Governing Body for the adequacy and quality of care rendered to patients. The Governing Body acknowledges that great weight should be given to the actions of the Medical Staff and its peer review activities.

The Medical Staff Organization at the Medical Center requires that each Member agree to abide by the Code of Ethics of his/her profession. It further requires that Doctors of Osteopathic Medicine subscribe to the distinctive osteopathic approach to the provision of care. It is expected that this approach is central to their practice. This includes, but is not limited to, the performance of a structural assessment as a part of the history and physical examination as appropriate. Osteopathic manipulation treatment is also expected to be a component of the treatment program where indicated.

ARTICLE II.
PURPOSE

2.1. Purposes of the Medical Staff Organization

A. To exercise the right of Medical Staff self-governance, as provided in California Business and Professions Code §2282.5, and to perform such acts as a Medical Staff organization is empowered to perform thereunder.

B. To ensure that all patients admitted to or treated in any of the facilities, Departments, or services of the Medical Center receive care which is at a level of quality and efficiency consistent with generally accepted standards and attainable within the Medical Center's means and circumstances.

C. To ensure the high level of professional performance consistent with generally accepted standards attainable within the Medical Center’s means and circumstances.

D. To provide an educational setting that shall lead to continued advancement in professional knowledge and skill.

E. To support medical education as follows:

1) Sponsorship of post-graduate programs based here or affiliated with accredited schools of medicine

2) Training medical students from such schools

3) Training of allied health personnel enrolled in university or college-based programs

4) Providing continuing medical education programs for Members of the Medical Staff

F. To initiate and maintain Rules and Regulations for the Medical Staff to carry out its responsibilities for the professional services performed through the Medical Center pursuant to the authority delegated by the Governing Body and by California Business and Professions Code §2282.5.

G. To provide the Medical Staff, the Chief Medical Officer, the Medical Center Director, and the Governing Body with a forum in which to discuss issues of mutual concern.

H. To provide for accountability of the Medical Staff to the Governing Body.

I. These Bylaws acknowledge that the provision of quality medical care in the Medical Center depends on the mutual accountability, interdependence, and responsibility of the Medical Staff and the Medical Center Governing Body for the proper performance of their respective obligations. To that end, the Medical Staff acknowledges that the Governing Body must act to protect the quality of medical care provided and the competency of the Medical Staff, and to ensure the responsible governance of the Medical Center. In adopting these Bylaws, the Medical Staff commits to exercise its responsibilities with diligence and good faith, and in approving these Bylaws, the Governing Body commits to supporting the Medical Staff's self-governance and independence in conducting the affairs of the Medical Staff.

J. To require that each Member agree to abide by the Code of Ethics of his/her profession.

K. The Medical Staff also requires that Doctors of Osteopathic Medicine subscribe to the distinctive osteopathic approach to the provision of care. It is expected that this approach is central to their practice. This includes, but is not limited to, the performance of a structural assessment as a part of the history and physical examination as appropriate. Osteopathic manipulation treatment is also expected to be a component of the treatment program where indicated.

ARTICLE III.
MEDICAL STAFF MEMBERSHIP

3.1. Nature of Medical Staff Membership

Membership on the Medical Staff of Arrowhead Regional Medical Center is a privilege which shall be extended only to professionally competent Practitioners who continuously meet the qualifications, standards, and requirements set forth in these Bylaws, and Rules and Regulations.

No physician, dentist, oral and maxillofacial surgeon, or podiatrist (including persons engaged by the Medical Center in only administrative responsible positions) shall admit or provide medical or health-related services to patients in the Medical Center unless the Practitioner is a Member of or applicantto the Medical Staff who has been granted privileges or has been granted temporary privileges in accordance with the procedures set forth in these Bylaws. Membership to the Medical Staff shall confer only such privileges and prerogatives as have been granted in accordance with these Bylaws.

A resident physician in training shall not be a of the Medical Staff unless he/she successfully completes an application as a Moonlighting Resident seeking privileges, under which circumstance the Moonlighting Resident still may not admit patients under his/her own name.

3.2. Qualifications for Membership

Membership on the Medical Staff shall be extended only to those Practitioners who meet and continue to meet the standards and requirements set forth in these Bylaws. The fact that a Practitioner meets the following qualifications does not by itself, entitle such Practitioner to membership on the Medical Staff. Membership eligibility shall be determined through the credentialing process in accordance with Article IV of these Bylaws.

A. General. Only physicians, dentists, clinical psychologists, podiatrists, and oral and maxillofacial surgeons shall be deemed to possess basic qualifications for membership in the Medical Staff. Such Practitioners must also:

1) Document current licensure, experience, education, and training sufficient to exercise the privileges requested, and exhibit current professional competence, good character, good judgment and current and adequate physical and mental health status (subject to any necessary reasonable accommodation), so as to demonstrate to the satisfaction of the Medical Staff that he/she is professionally and ethically competent and that patients treated by him/her can expect to receive quality medical care.

2) Adhere to the ethics of their respective professions, and be able to work cooperatively with others so as not to adversely affect patient care, keep as confidential, as required by law, all information or records received in the physician-patient relationship, and be willing to participate in and properly discharge those responsibilities determined by the Medical Staff.

3) Maintain in force professional liability insurance in not less than the minimum amounts, if any, as from time to time may be established by the Governing Body.

3.3. Particular Qualifications

A. Physicians who submit an application for initial Medical Staff appointment, except for the Honorary Staff, must hold an MD or DO degree or their equivalent and a valid and unsuspended license to practice medicine issued by the Medical Board of California or the Osteopathic Medical Board of California. For the purpose of this section, "or their equivalent" shall mean any degree (e.g., foreign) recognized by the Medical Board of California or the Osteopathic Medical Board of California.

B. Physicians who submit an application for initial Medical Staff membership and appointment after January 1, 2017:

1) Must be currently certified by a board recognized by the American Board of Medical Specialties, the American Osteopathic Association, or another board or association with equivalent requirements approved by the Medical Board of California and the MEC. Board certification must be in a specialty and/or a sub-specialty appropriate to the area of the Practitioner’s primary practice and privileges as determined by the MEC.

2) Must have successfully completed an approved residency/fellowship training program recognized by the American Board of Medical Specialties, the American Osteopathic

Association, or another board or association with equivalent requirements approved by the Medical Board of California and the MEC, in a specialty and/or sub-specialty appropriate to the area of his/her practice as determined by the MEC, must be an active candidate in the board certification process, and must meet the requirements of 3.2 and 3.3.

3) Who are not board certified at the time of application but who have completed their residency/fellowship or other applicable training within the last five (5) years will be eligible for Medical Staff membership and privileges. However, in order to remain eligible for Medical Staff membership and privileges, those individuals must achieve board certification in their primary area of practice within five (5) years from the date of completion of their residency, fellowship, or other required training. Failure to achieve board certification within five (5) years will result in automatic termination of Medical Staff membership and privileges.

4) Agree that individual Departmental privilege delineation forms may identify training, experience, and/or board certification requirements that exceed those described in this section.

5) Once achieving board certification must continuously maintain their board certification status in the specialty or sub-specialty in which they primarily practice and hold privileges. Failure to maintain board certification will result in automatic termination of Medical Staff membership and/or privileges.

6) Agree that exceptions to the provisions in this section related to board certification and maintenance of board certification may be made by the MEC, at its sole discretion, for cause.

7) Agree that provisions of Section 3.3.B do not apply to physicians holding membership and privileges, or physicians who have submitted a complete application for initial appointment, prior to January 1, 2017.

C. Limited License Practitioners. Dentists who submit an application for dental membership on the Medical Staff, except for the Honorary Staff, must hold a DDS or equivalent degree, and a valid and unsuspended license to practice dentistry issued by the Dental Board of California. Oral surgeons requesting initial Medical Staff membership and privileges after January 1, 2017 must be board certified by the American Board of Oral and Maxillofacial Surgery (ABOMS) or have successfully completed a residency program in an accredited oral and maxillofacial surgery program recognized by the American Dental Association. Board qualified oral surgeons must achieve board certification within the timeframe established by the ABOMS and within five (5) years of residency training completion. Board certification must be continuously maintained. Failure of a Practitioner to achieve board certification within five (5) years of residency completion or failure to continuously maintain board certification will result in the automatic termination of the Practitioner's Medical Staff membership and/or privileges. Exceptions to this board certification requirement may be made by the MEC for cause.

Podiatrists who submit an application for podiatric membership on the Medical Staff, except for the Honorary staff, must hold a DPM degree and a valid and unsuspended license to practice podiatry issued by the California Board of Podiatric Medicine. Podiatrists applying for initial Medical Staff membership and privileges after these Bylaws are effective, must be board certified by the America Board of Podiatric Medicine (ABPM), or American Board of Foot and Ankle Surgery

(ABFAS), formally known as the American Board of Podiatric Surgery (ABPS) and have successfully completed at least two (2) years of a hospital-based post-graduate podiatric surgical residency training in a program approved by the Council on Podiatric Medical Education. The hospital-based post-graduate training obtained must be relevant to the privileges requested. Board qualified podiatrists must achieve board certification within the timeframe established by the ABFAS or ABPM and within five (5) years of residency completion. Board certification must be continuously maintained. Failure of the Practitioner to achieve board certification within five (5) years or failure to maintain continuous board certification will result in the automatic termination of the Practitioner's Medical Staff membership and/or privileges. Exceptions to this board certification requirement may be made by the MEC for cause.

Clinical Psychologists who submit an application for clinical psychology membership on the Medical Staff, except for the Honorary staff, must hold a doctorate degree in clinical psychology, and a valid and unsuspended license to practice psychology issued by the California Board of Psychology. Clinical Psychologists must not have less than two (2) years of clinical patient care experience in a multi-disciplinary facility licensed or operated by this or another state or by the United States to provide health care or be listed in the latest edition of the National Register of Health Service Providers in Psychology. Psychologists may not hold admitting privileges, and may only provide clinical services upon request of a Medical Staff Member. Psychologists applying for initial Medical Staff membership and privileges after January 1, 2017 must be board certified by the American Board of Clinical Psychology (ABCP). Board qualified psychologists must achieve board certification within the timeframe established by the ABCP, and within five (5) years of training completion. Board certification must be continuously maintained. Failure of the Practitioner to achieve board certification within five (5) years or failure to maintain continuous board certification will result in the automatic termination of the Practitioner's Medical Staff membership and/or privileges. Exceptions to this board certification requirement may be made by the MEC for cause.

D. Provisions of Section 3.3.B do not apply to Limited Licensed Practitioners holding membership and privileges, or Limited Licensed Practitioners who have submitted a complete application for initial appointment prior January 1, 2017.

E. Requirements related to training and board certification are a condition of Medical Staff membership. Failure to maintain the requirements described in this section shall result in automatic termination of membership and/or privileges and such termination does not entitle a Practitioner to the procedural rights as provided by the Bylaws, Article VII, Hearing and Appellate Review.

3.4. Failure to Meet Medical Staff Qualifications

A Practitioner who does not meet all relevant qualifications for membership and/or privileges is ineligible to apply for Medical Staff membership and/or privileges and the application shall not be accepted for review. If it is determined during the processing that an applicant does not meet all relevant qualifications, the review of the application will be discontinued. An applicant who does not meet all relevant Medical Staff qualifications is not entitled to procedural rights describes in these Bylaws, but may submit comments and a request for reconsideration of the specific qualification which adversely affected the Practitioner’s ability to apply. Those comments and requests will be reviewed by the MEC and the MEC shall issue a final decision on the matter.

3.5. Effect of Other Affiliations

No Practitioner shall be entitled to Medical Staff membership merely because he/she holds a certain degree, is licensed to practice in this or in another state, is a member of any professional organization, is certified by any clinical board, or because he/she had, or presently has, staff membership or privileges at another health care facility. Neither Medical Staff membership nor privileges shall be conditioned or determined on the basis of an individual's participation, or non-participation, in a particular medical group, Independent Practice Association (IPA), Physician Practice Organization (PPO), Physician Hospital Organization (PHO), Medical Center-sponsored foundation, surgery or other outpatient service facility or other organization, or in contracts with a third party which contracts with this Medical Center. To the extent permitted by law, neither Medical Staff membership nor privileges shall be revoked, denied, or otherwise infringed based on the Member's professional or business interest.

3.6. Non-Discrimination

Neither Medical Staff membership nor particular privileges shall be denied on the basis of age, sex, religion, race, creed, color, national origin, gender identity, ancestry, disability, marital status, any physical or mental impairment, veteran status, or sexual orientation that does not pose a threat to the quality of patient care.

3.7. Basic Duties, Responsibilities, and Obligations of Medical Staff Member and APP Staff Membership

Except for Honorary Members, the ongoing basic duties and responsibilities of each Medical Staff and APP Staff Member include:

A. A medical history and physical (H&P) examination must be completed and documented by a physician or other qualified licensed Practitioner credentialed by the Medical Center to perform an H&P examination:

1) A medical (H&P) examination shall be completed and documented for each patient no more than thirty (30) days before, immediately prior to, or within twenty-four (24) hours after, admission or registration, but prior to surgery or a procedure requiring anesthesia services.

2) When the medical (H&P) examination was completed within thirty (30) days before admission or registration, an updated examination of the patient, which includes an authenticated record of any changes in the patient's condition, must be completed and documented in the medical record within twenty-four (24) hours after admission or registration and prior to surgery or a procedure requiring anesthesia services.

3) A typed or electronic copy of any (H&P) examination used as the basis of an update must be present in the patient's medical record at the time the update note is recorded.

B. Documenting and continuously providing evidence of current licensure, adequate experience, education and training, current professional competence in the exercise of requested privileges, good judgment, and current adequate physical and mental health status relative to the privileges requested, 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 expect to receive quality medical care.

C. Meeting the criteria for membership and privileges in at least one (1) Department of the Medical Staff.

D. Complying with Medical Staff meeting attendance requirements as may be established by the MEC related to a particular category of Medical Staff membership, such as the Active Staff category.

E. Providing patients with the quality of care meeting the professional standards of the Medical Staff of this Medical Center.

F. Participating in Medical Staff peer review and performance improvement programs, ongoing professional practice evaluation (OPPE), and proctoring/focused professional practice evaluation (FPPE).

G. Serving as a proctor when appointed by a Department Chairman or the MEC. Proctors must make reasonable accommodations when a request is made to proctor a particular case/procedure.

H. Providing requested information in connection with Medical Staff peer review activities (including applications for appointment and reappointment). A Practitioner has the burden of producing sufficient information regarding his/her clinical and professional performance to permit an adequate evaluation of the Practitioner's qualifications to hold membership and/or privileges. In addition to providing clinical information, the Practitioner may be required to submit a complete history and physical examination, a specialty medical assessment, psychometric testing, blood, hair or other chemical analysis, a fitness for duty evaluation, and/or a psychological examination as deemed appropriate by the MEC. Any such examination(s) and testing shall be at the Practitioner's expense and will be performed by a physician(s), laboratory, or testing facility approved by the MEC. Failure to provide such information when requested by MEC will result in an automatic suspension as described in Section 7.9 of these Bylaws.

I. Abiding by Medical Staff Bylaws, Rules and Regulations, credentialing and privilege criteria, and Medical Staff and Medical Center policies.

J. Discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the Practitioner by virtue of Medical Staff membership, including accepting committee, proctoring, and peer review assignments.

K. Participating in the organizational performance improvement program as requested by the MEC.

L. Agreeing to keep confidential and discuss only within established Medical Staff committees the proceedings of Medical Staff activities related to quality assessment and peer review.

M. Maintaining in force professional liability insurance covering the exercise of all requested privileges, in not less than $1,000,000 per occurrence and $3,000,000 in aggregate as described in the Medical Staff Rules and Regulations.

N. Remaining eligible to participate in Federal Health Care Programs. A Practitioner may not become federally ineligible and maintain Medical or APP staff membership or privileges.

O. Maintaining all DEA certificates with an in-state California address. If privileges are requested which include the prescribing of medications, the Practitioner must maintain current DEA certification for DEA Schedules 2, 2N, 3, 3N, 4, and 5. Exceptions to this requirement for all DEA Schedules 2 through 5 may be made by the MEC for cause.

P. Preparing and completing in a timely fashion, medical records for all the patients to whom the Practitioner provides care in the Medical Center.

Q. Timely payment of all Medical Staff dues and fines.

R. Abiding by the lawful, ethical principles of the American Medical Association, the California Medical Association, and the Practitioner's professional association.

S. Working cooperatively with other Practitioners, Medical Center staff, Medical Center Administration, and others so as not to adversely affect patient care.

T. Providing continuing coverage for his/her patients and making appropriate arrangements for coverage when not available. This includes coverage for the Practitioner's patients who may come to the Medical Center for emergency services. Each Practitioner must have at least one (1) identified covering Practitioner who is qualified to provide coverage. Exceptions to this requirement may be made by the MEC for cause.

U. Refusing to engage in fee-splitting or in improper inducements for patient referral.

V. Participating in continuing education and other training programs as required by the MEC, including completing MEC required Meditech or HealthStream training modules.

W. Providing information to and/or testifying on behalf of the Medical Staff or an accused Practitioner regarding any matter under an Investigation pursuant to Article VI, or which is the subject of a hearing pursuant to Article VII.

X. Participating in any emergency services "on call" panel or Medical Center consultation panel as may be required by the MEC.

Y. Protecting and preserving the confidentiality of patient health, services, and payment information imposed by state and federal confidentiality laws and the confidentiality policies of the Medical Center, including without limitation the Health Insurance Portability and Accountability Act of 1996 as amended ("HIPAA").

Z. Cooperating with the Medical Center in matters involving its fiscal responsibilities and policies, including those relating to payment or reimbursement by governmental and third-party payers.

AA. Cooperating with all oversight activities related to utilization and medical appropriateness.

BB. Complying with MEC approved clinical practice protocols.

CC. Maintaining an active personal email account. Unless otherwise stated in these Bylaws or as determined by the Chairman of a Medical Staff Committee/Department, all communication with Practitioners and applicants will primarily be by email. It is each Practitioner's responsibility to ensure his/her email address listed with the Medical Staff Office (MSO) is valid and current. Notices are deemed to be received when sent to a Practitioner's email address as listed in the records of the MSO.

DD. Complying with evidence-based guidelines that are established by, and must be reported to, regulatory or accrediting agencies or patient safety organizations including those related to national patient safety initiatives and core measures, or clearly documenting in the medical record the clinical reasons for variance.

EE. Participating in necessary electronic health record (EHR) and computerized practitioner order entry (CPOE) training and utilizing the EHR, CPOE, practitioner documentation (pDoc), and other technology in use by the Medical Center when preparing a medical record for each patient.

FF. Discharging such other staff obligations as may be established from time to time by the Medical Staff or MEC.

3.8. Disruptive Behavior, Discrimination, and Harassment Prohibited

The County of San Bernardino has adopted policies prohibiting harassment including sexual harassment, in the workplace. The provisions set forth in this section are in addition to such policies.

A. Standards of Behavior and Acceptable Conduct. All Members of the Medical Staff are expected to conduct themselves at all times while on Medical Center premises in a courteous, professional, respectful, collegial, and cooperative manner as further described in the Medical Staff and Advanced Practice Professional Code of Conduct Policy. This applies to interactions and communications with or relating to Medical Staff colleagues, APP, nursing and technical personnel, other care providers, other Medical Center personnel, patients, patients' family members and friends, visitors, and others. Such conduct is necessary to promote high quality medical care, maintain a safe work environment, and avoid disruption of Medical Center operations. Disruptive, discriminatory, or harassing behavior, as defined below, shall not be tolerated.

Acceptable conduct is completely encompassed by these Bylaws and may include, but is not limited to:

1) Advocacy on medical matters.

2) Making recommendations intended to improve care.

3) Fulfilling duties of Medical Staff membership or leadership.

4) Engaging in legitimate business activities that may or may not compete with the Medical Center.

B. Abuse of Process. Retaliation or attempted retaliation against complainants or those who are carrying out Medical Staff duties regarding conduct will be considered inappropriate and disruptive conduct, and could give rise to evaluation and corrective action pursuant to the Medical Staff Bylaws.

C. Complaints Against Medical Center Employees. If a Medical Staff Member believes that a Medical Center employee is behaving or has behaved inappropriately, the Medical Staff Member may communicate constructive criticism politely and discreetly, and may report perceived misconduct to the employee's supervisor or senior administrator. If the Medical Staff Member believes that an employee's conduct warrants a reprimand or disciplinary action, then the Medical Staff Member should report the employee's conduct to the Director of Human Resources (DHR), and work with the DHR and other administrative and Medical Staff personnel, as appropriate, to resolve the problem. The types of conduct described in Section 3.8.D. below, are *not* acceptable responses to perceived employee deficiencies or misconduct, or disagreements with physician colleagues or other Medical Center personnel.

D. Definitions of Disruptive and Inappropriate Behavior.

1) **Disruptive Behavior** is aberrant behavior manifested through personal interaction with physicians, Medical Center personnel, other health care professionals, patients, family members, or others, which interferes with patient care or could reasonably be expected to interfere with the process of delivering quality care. Examples of disruptive behavior include, but are not limited to: refusing to cooperate with other caregivers; rude and inappropriate comments, particularly in the presence of patients, family, or peers; improper use of medical records to criticize other caregivers or the Medical Center; and insistence on idiosyncratic procedures that negatively impact services.

2) **Inappropriate Behavior**

a) "Discrimination" is conduct directed against any individual (*e.g.*, against another Medical Staff Member, APP, Medical Center employee, or patient) that deprives the individual of full and equal accommodations, advantages, facilities, privileges, or services, based on the individual's race, religion, color, national origin, ancestry, physical disability, behavioral disability, medical disability, marital status, sex, gender, veteran status, gender identity or sexual orientation.

b) "Harassment" is a course of conduct (including but not limited to violence or threat of violence) directed at a specific person or persons that seriously alarms, upsets, or annoys the person or persons, and that serves no legitimate purpose. A single incident may constitute harassment if sufficiently egregious. Concerns about the conduct or performance of other Medical Center personnel can and should be raised and addressed in accordance with these Bylaws and the applicable Medical Center policies and procedures, and such concerns do not constitute a "legitimate purpose" for engaging in harassing behavior.

c) "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:

- 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.

- This conduct substantially interferes with the individual's employment or creates an intimidating, hostile, or offensive work environment. Sexual harassment also includes conduct indicating that employment and/or employment benefits are conditioned upon acquiescence in sexual activities.

E. Investigation and Disciplinary Action Directed Toward Medical Staff Members. In the event that a Member of the Medical Staff is the subject of a complaint alleging any of the behavior described in Section 3.8.D, the Member shall be subject to the investigation and disciplinary action procedures and protections found in the Medical Staff and Advanced Practice Professional Code of Conduct Policy. Notwithstanding any other provision of these Bylaws or the Rules and

Regulations, documentation relating to such investigations, their conclusions, and any resulting corrective action shall be maintained by the Medical Staff Office as peer review documents.

ARTICLE IV.
MEDICAL STAFF CATEGORIES

4.1. Medical Staff Categories

Categories of the Medical Staff shall include the following:

- Active
- Associate
- Affiliate
- Honorary
- Provisional

At the initial appointment and each reappointment, the proposed staff category shall be disclosed by the applicant, to be finally recommended by the Department Chairman and approved by the MEC.

4.2. General

Each person whose application for Medical Staff membership is accepted shall be appointed to a specific Department. If the Member is awarded privileges, those privileges may be granted in more than one (1) Department, but the Member shall have the right to vote only in his/her primary Department, which is determined by the nature of his/her practice. Each Member must meet the general qualifications for Medical Staff membership and applicable privileges described in Articles III and VI. Every new applicant for Medical Staff membership, except for Affiliate and Fellows in Training (Section 4.6), shall enroll as a Provisional status Member.

4.3. Active Staff

A. Qualifications

1) Members of this category must be involved in at least twenty-four (24) direct patient contacts annually and have successfully completed Provisional Staff Category requirements as discussed in Section 4.9.

2) A direct patient contact is defined as an inpatient admission, outpatient care, consultation (including imaging and pathology), or an inpatient or outpatient surgical procedure performed at the Medical Center.

3) The MEC may recommend an exception to the requirement for twenty-four (24) direct patient contacts annually for Practitioners with at least five (5) years of service on Active Staff who demonstrate their efforts to support the Medical Center's patient care mission to the satisfaction of the MEC, and who wish to remain active in Medical Staff and Medical Center affairs.

B. Prerogatives. Members of this category may:

1) Attend and vote on all matters of any Medical Staff/Department/Section/Committee meetings of which he/she is a member.

2) Attend Medical Staff or Medical Center education programs.

3) Hold Medical Staff office and/or be Chairman of any Department, Section, or Committee in accordance with any qualifying criteria set forth elsewhere in the Medical Staff Bylaws, manuals, or policies.

C. Responsibilities. Members of this category shall:

1) Contribute to the organizational and administrative affairs of the Medical Staff.

2) Actively participate as requested or required in activities and functions of the Medical Staff, including quality/performance improvement, peer review, credentialing, risk management, utilization management, medical records completion, monitoring activities, and in the discharge of other functions as may be required by the Medical Staff.

3) Meet the meeting attendance requirements described in Section 12.4.

4) Fulfill or comply with any applicable Medical Staff or Medical Center policies or procedures.

D. Relinquishment of Active Staff Category. Active Staff Members who do not meet the requirements of Section 4.3 shall be deemed to have voluntarily relinquished Active Staff status and shall be automatically transferred to the appropriate staff category, if any, for which the Member is eligible. In the event the Member is not eligible for any other category, his/her Medical Staff Membership and privileges shall automatically terminate. No such transfer or automatic termination shall be reportable under California Business and Professions Code Section 800 through 809.9 and is not subject to the Hearing provisions of Article VIII.

4.4. Associate Staff

Associate Staff Members have affirmed an interest in caring for patients at the Medical Center but prefer a reduced role in the political and governance affairs of the Medical Staff. Physicians holding "Telemedicine Only" privileges will be placed in the Associate Staff Category after successful completing his/her term as a Provisional Member.

A. Qualifications

1) The Associate Staff Category is intended for a Member who does not meet the eligibility requirements for the Active Staff or chooses not to pursue Active Staff status.

2) Has satisfactorily completed his/her term as a Provisional Member.

B. Prerogatives. Members of this category may:

1) Serve on Medical Staff Committees, other than the MEC, and may vote on matters that come before such Committees.

2) Attend, without vote, Medical Staff/Department/Section meetings of which he/she is a member.

3) Attend any Medical Staff or Medical Center education program.

4) Not vote on matters before the entire Medical Staff, be an officer of the Medical Staff, vote in Departmental/Section Chairman elections, or serve as Chairman of a Department/Section or Committee.

C. Responsibilities

1) While not required to attend regular Department/Section/Committee meetings, Associate Staff Members are encouraged to do so in order to remain apprised of important general medical and specialty information that may affect their practices.

2) Actively participate, when requested by a Committee Chairman or required by a Department Chairman or the MEC, in activities and functions of the Medical Staff, including quality/performance improvement and peer review, credentialing, risk and utilization management, medical records completion, monitoring activities, and in the discharge of other staff functions. This includes mandatory attendance at specific meetings.

3) Must fulfill or comply with any applicable Medical Staff or Medical Center policies or procedures.

D. Relinquishment of Associate Staff Category. Associate Staff Members who do not meet the requirements of Section 4.5 shall be deemed to have voluntarily relinquished Associate Staff status and shall be automatically transferred to the appropriate staff category, if any, for which the Member is eligible. In the event the Member is not eligible for any other category, his/her Medical Staff Membership and privileges shall automatically terminate. No such transfer or automatic termination shall be reportable under California Business and Professions Code Section 800 through 809.9 and is not subject to the Hearing provisions of Article VIII.

4.5. Fellows in Training and the Associate Staff Category

Current Fellows in training who have completed their primary Residency, may apply for privileges as an attending, to practice in the specialty of their primary Residency. To obtain such privileges, the Fellow must undergo the complete Medical Staff credentialing process.

Fellows will not be assigned to Provisional category but must undergo N-FPPE for the privileges granted. The MEC may customize the Practitioner's N-FPPE plan based on the Fellows recent experience as a Resident at the Medical Center related to the privileges requested.

A. Qualifications. Fellows in Training must:

1) Be in good standing in their Fellowship training program.

2) Possess a current valid California physician's license and meet other Membership requirements described in Article III.

3) Have a favorable written recommendation for Medical Staff Membership from their Fellowship Program Director.

4) Maintain compliance with all ACGME training duty hours requirements in their Fellowship program and maintain documentation of same.

B. Prerogatives

1) May exercise such privileges as have been granted.

4.6. Affiliate Staff

A. Affiliate Staff Membership is Intended For

1) Community primary care practitioners who do not hold privileges at the Medical Center but do have an active outpatient primary care practice within the Medical Center's service area and are interested in having an affiliation with ARMC.

2) Faculty of a California medical school who do not hold privileges at the Medical Center but are interested in having an affiliation with ARMC.

B. Qualifications and Requirements

1) Affiliate Staff Members must meet the requirements for Medical Staff Membership set forth in Article III, other than Board Certification.

2) Practitioners placed in the Affiliate Staff category are not assigned to the Provisional Staff category and do not have N-FPPE requirements.

3) The Affiliate Staff category is not intended for retired practitioners.

C. Prerogatives

1) May participate in educational rounds with Medical Center staff and medical students but may not write orders or make medical record entries.

2) May attend open meetings of the Medical Staff and its Departments/Sections/ Committees, including educational programs, with no right to vote at such meetings, except with the specific approval of the MEC.

3) May participate in Quality and/or Utilization Management activities if requested by the Quality or Utilization Management Committee Chairman.

4) May refer his/her own patients to the Medical Center for admission, and may, with the patient’s written consent, follow the progress of his/her own patients within the Medical Center, including having access to medical record Protected Health Information of his/her own patients. Such prerogatives shall be known as “Refer and Follow.”

5) May order outpatient diagnostic testing and therapy.

D. Limitations

1) May not admit patients or exercise clinical privileges at the Medical Center.

2) May not enter inpatient orders or make entries into the medical record.

3) May not chair a Department/Section/Committee, or hold Medical Staff office.

4) May not work at a Medical Center-sponsored or Medical Center-licensed 1206(d) clinics, unless the Practitioner applies for Medical Staff privileges and his/her Medical Staff Category is changed.

E. Relinquishment of Affiliate Staff Status. Affiliate Staff Members who do not meet the requirements of Sections 4.7 shall be deemed to have voluntarily relinquished Affiliate Staff status and shall be automatically transferred to the appropriate staff category, if any, for which the Member is eligible. In the event the Member is not eligible for any other category, his/her Medical Staff Membership and prerogatives shall automatically terminate. No such transfer or automatic termination shall be reportable under California Business and Professions Code Section 800 through 809.9 and is not subject to the Hearing provisions of Article VIII.

4.7. Honorary Medical Staff

The Honorary Medical Staff category shall consist of Practitioners who no longer practice at the Medical Center but did actively practice at the Medical Center for at least fifteen (15) years and are deemed by the MEC to be deserving of Honorary Membership by virtue of their outstanding reputation, noteworthy contributions to health and medical sciences, and who continue to exemplify high standards of professional and ethical conduct.

A. Prerogatives. May attend open Medical Staff/Department/Section/Committee meetings (without vote) and may attend Medical Staff-sponsored educational programs.

B. Limitations. Honorary Medical Staff Members are not eligible to admit patients to the Medical Center, review patient medical records, access Protected Health Information, exercise privileges, vote on Medical Staff/Department/Section/Committee matters, or hold Medical Staff office.

4.8. Provisional Staff

A. Provisional Staff Category is for Members who meet the general Medical Staff Membership qualifications for Active or Associate category and have been recommended for the Provisional Staff by the MEC.

B. Prerogatives

1) Commensurate with awarded privileges, may admit patients and exercise other such privileges as are granted pursuant to these Bylaws.

2) May attend meetings of the Medical Staff, Department, Section, and Committees to which the Member is duly appointed.

C. Limitations

1) Provisional status precludes any voting rights except at the prerogative of the MEC.

2) May not hold Medical Staff office or chair any Department, Section, or Committee.

D. Observation of Provisional Staff Members

1) Provisional Staff Members with privileges are subject to N-FPPE observation, professionalism review, and competency evaluation as set forth in the Practitioner's N-FPPE Plan.

2) Every Practitioner granted new privileges will be assigned Core proctoring requirements and may also be assigned Advanced proctoring requirements based on Departmental guidelines.

3) Core proctoring requirements are defined in the Medical Staff N-FPPE Policy and Advanced proctoring requirements are defined on the Practitioner's Delineation of Privileges ("DOP") form(s).

4) The purpose of N-FPPE observation and competency evaluation is to evaluate the Practitioner's proficiency in the exercise of privileges initially granted and to evaluate the Practitioner's professionalism and overall eligibility for continued Medical Staff membership and advancement within Medical Staff categories.

5) Observation and competency evaluation of Provisional Staff applicants shall follow the frequency and format each Department and the MEC deem appropriate in order to adequately evaluate the Provisional Member including, but not limited to, concurrent or retrospective chart review, mandatory consultation, and/or direct observation.

6) Appropriate records of N-FPPE shall be maintained by the Medical Staff Office. The results of the N-FPPE and competency evaluation shall be communicated by the Department Chairman to the Credentials Committee.

E. Term of Provisional Staff

1) A Practitioner shall remain on Provisional Staff for a period of up to twelve (12) months, unless that status is extended by the MEC for an additional period of up to six (6) months upon a determination of good cause.

2) The reason for the “good cause” determination shall be recorded in Committee minutes.

3) A maximum of one (1) six (6) month extension period may be granted to any Practitioner.

4) The maximum term for Provisional Staff appointment is eighteen (18) months. There is no minimum term of Provisional Staff appointment provided all Core proctoring requirements have been successfully completed.

5) Failure of the MEC to recommend an extension of Provisional Staff status shall not be considered a disciplinary action and is not subject to hearing rights pursuant to Article VIII.

F. Action at Conclusion of Provisional Staff

1) If the Provisional Staff Member has satisfactorily completed all N-FPPE requirements (including Core and Advanced proctoring) demonstrated the ability to exercise the privileges initially granted, and otherwise appears qualified for Membership, the Practitioner is eligible for advancement to an appropriate staff category upon recommendation of the Department Chairman and action of the MEC.

2) If the Provisional Staff Member has satisfactorily completed Core proctoring and all other N-FPPE requirements, except for Advanced proctoring, has demonstrated the ability to exercise the privileges initially granted, and otherwise appears qualified for Membership, the Practitioner is eligible for advancement to an appropriate staff category upon recommendation of the Department Chairman and action of the MEC. Any privilege associated with an Advanced proctoring requirement that has not been met will automatically terminate at the end of the Practitioner's Provisional Staff status. Such automatic termination is not considered a disciplinary action and the procedural rights of

Article VIII do not apply. The Practitioner may reapply for the automatically terminated Advanced privilege(s) in the future.

3) If a Practitioner has not completed Core proctoring requirements by the end of his/her Provisional Staff status, the Practitioner's Membership and all privileges will automatically terminate. Such automatic termination is not considered a disciplinary action and the procedural rights of Article VIII do not apply. The Practitioner may reapply for Medical Staff Membership and any automatically terminated privilege in the future provided he/she meet all applicable current Membership and privilege requirements.

4) Termination of privileges due to a Practitioner's failure to successfully complete Core or Advanced proctoring requirements because of competency concerns, performance concerns, or medical disciplinary cause or reason, as determined by the MEC, is considered a disciplinary action and the procedural rights of Article VIII do apply.

4.9. General Exceptions to Prerogatives

Regardless of the category of membership in the Medical Staff, limited license Members 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 Chairman of the meeting, subject to final decision by the MEC.

4.10. Modification of Membership Applicable to All Medical Staff Categories

On its own, upon recommendation of the Credentials Committee, or pursuant to a request by a Member, or upon direction of the Board, the MEC may recommend a change in the Medical Staff category of a Member consistent with the requirements of the Bylaws.

ARTICLE V.
APPOINTMENT AND REAPPOINTMENT TO THE MEDICAL STAFF

5.1. General

A. Except as otherwise provided in these Bylaws, physicians, dentists, oral and maxillofacial surgeons, clinical psychologists, or podiatrists (including persons engaged by the Medical Center in administratively responsible positions) may not exercise privileges in this Medical Center unless and until the person applies for and receives an appointment to the Medical Staff, or, with respect to Advanced Practice Professional Practitioners, has been granted privileges under these Bylaws.

B. By applying to the Medical Staff for appointment and reappointment (or, in the case of Members of the Honorary Staff, by accepting a membership to that category), the applicant acknowledges responsibility to first review these Bylaws and the Medical Staff Rules and Regulations and policies, and agrees that throughout any period of appointment that he/she shall comply with the responsibilities of Medical Staff appointment and with the Medical Staff Bylaws, Rules and Regulations and policies as they exist and as they may be modified from time to time.

C. Appointment to the Medical Staff shall confer on the appointee only such privileges as have been granted in accordance with these Bylaws.

D. Duration of Appointment and Reappointment. Initial Appointment and Reappointment will be for a period of not more than twenty-four (24) months.

5.2. Appointment Authority

The Governing Body is the appointing authority for all Medical Staff, and shall review recommendations for appointment and reappointment, and privileges recommended by the Medical Staff. The Medical Staff shall consider each application for appointment and reappointment, and privileges as described in these Bylaws, and prepare a recommendation packet for consideration by the Governing Body, which shall include a summary of the applicant's qualifications.

5.3. Preparation of Recommendation

The MEC shall present a recommendation to the Governing Body within a reasonable period of time after the date upon which the Credentials Committee first considered the completed application. The Governing Body shall act upon the receipt of this recommendation. If the MEC is unable to make a recommendation it shall notify the Governing Body in writing giving the reasons for the lack of consensus. In this event, the Governing Body may act on its own initiative using the information obtained through the credentialing process. Any protected medical, legal or other credentialing information contained within the applicant's credentials file shall remain protected under California Evidence Code 1157, and shall be accessible to designees of the Governing Body only within the confines of a duly convened executive meeting of the Medical Staff.

5.4. Burden of Proof in Connection with all Applications for Membership, Reappointment, Advancement, or Transfer

The applicant shall have the burden of producing the information necessary for an adequate evaluation of competence, character, ethics, health and other qualifications and for resolving any doubts about such qualifications and suitability for privileges and Medical Staff category requested. The applicant's failure to shoulder and satisfy this burden of proof shall be grounds for denial of the application. To the extent consistent with law, this burden may include submission to a medical or psychological examination, if deemed appropriate by the MEC, which may select the examining physician. Such examination shall be at the applicant's expense.

5.5. Application

When an applicant requests an application form, that person shall be provided access to these Bylaws, the Medical Staff Rules and Regulations and, as deemed appropriate by the MEC, copies or summaries of any other applicable Medical Staff policies relating to clinical practice in the Medical Center. Application for initial membership will not be processed if adverse action is pending at other facilities.

Practitioners shall not qualify for reappointment unless arrangements have been made by the applicant and other facility to provide full details of any adverse actions pending or closed.

Each application for initial membership to the Medical Staff or APP Staff is to be in writing on the form approved by the MEC. It is to be a completed document, signed by the applicant and Department Chairman, and submitted with the necessary supporting documents. If applicable, a request for specific privileges signed by the applicant and Department Chairman is to accompany the application for membership.

A. Content of Application. Commensurate with Medical Staff category the application requests pertinent information including, but not limited to:

1) Qualifications including professional training, experience, current and prior license(s), and specialty board certification(s) or equivalent, or on-track status for board certification.

2) Current DEA registrations, if applicable. (Recognizing that certain specialties do not use DEA licenses, this requirement is not applicable to those specialties, e.g. Pathology).

3) Current certifications such as BCLS, ACLS, ATLS, NALS, or PALS, as required.

4) All current and previous professional and Medical Center affiliations.

5) Continuing medical education information related to the privileges to be exercised by the applicant.

6) All past or pending professional disciplinary actions, voluntary or involuntary denial, revocation, suspension, reduction or relinquishment of Medical Staff membership or privileges or any licensure or registration, and any related matters such as letters of admonishment, mandated proctoring or continuing medical education, and any similar practice limitation.

7) Health status, including completion of a physical examination or psychiatric evaluation by a physician who is mutually accepted by the affected Practitioner and staff when requested by the Department Chairman or MEC. This requirement is subject to the standards set forth in Section 5.6 pertaining to physical and mental capabilities.

8) Two (2) professional references from individuals who hold a comparable professional license, including, whenever possible, at least one (1) Member of the Active Staff at Arrowhead Regional Medical Center. These individuals must be able to provide an adequate reference based upon their current knowledge of the applicant's professional qualifications, clinical competence, and ethical character.

9) All final judgments or settlements of professional liability claims, including any amount of payment made as a consequence thereof.

10) All filed and served professional liability cases pending.

11) Evidence of professional liability coverage of $1,000,000.00 per occurrence, $3,000,000.00 aggregate for applicants who have a medical practice outside the Medical Center. Practitioners wishing to practice at the Medical Center who are not affiliated with a corporation contracted to provide services to the Medical Center must provide evidence of coverage for practice at the Medical Center.

12) Verification of tail coverage for prior practice, if applicable.

13) An agreement to abide by the Medical Staff and Medical Center Bylaws, Rules and Regulations, and applicable policies.

14) Reasonable evidence of current ability to perform privileges that may be requested, including but not limited to consideration of the applicant's professional performance, judgment, clinical or technical skills, and patterns of care and utilization as demonstrated in the findings of quality improvement, risk management, and utilization management activities.

15) Any past, pending, or current exclusion or sanctions from a federal health care program.

16) Criminal background check.

17) Any past or present felonies or misdemeanors, except for minor traffic violations. The applicant shall also report any legally mandated probation, past or present.

B. Application Fee. Each applicant for Staff membership shall be required to submit the application fee with the application form. No part of the application fee shall be refunded.

C. Medical Staff Dues. At the time of application, the applicant shall be required to submit a fee for biennial Medical Staff dues. These dues are nonrefundable unless the applicant is unsuccessful in gaining membership to the Medical Staff. Medical Staff Officers and Honorary Medical Staff are exempt during their term.

5.6. Physical and Mental Capabilities

A. Any Practitioner that has or may have a physical or mental disability that might affect the Practitioner's ability to exercise his/her requested privileges will be forwarded to the Physician's Well-Being Committee.

B. The Physician Well-Being Committee shall be responsible for investigating any Practitioner who has or may have a physical or mental disability that might affect the Practitioner's ability to exercise his/her requested privileges in a manner that meets the Medical Center's and Medical Staff's quality of care standards. Such investigation may include one (1) or both of the following:

1) **Medical Examination.** To ascertain whether the Practitioner has a physical or mental disability that might interfere with his/her ability to provide care.

2) **Interview.** To ascertain the condition of the Practitioner and to assess if and how reasonable accommodation can be made.

C. Any Practitioner who feels limited or challenged in any way by a qualified mental or physical disability in exercising his/her privileges and in meeting quality of care standards should make such limitation immediately known to the Physician Well-Being Committee. Any such disclosure shall be treated with the high degree of confidentiality that attaches to the Medical Staff's peer review activities.

D. Review and Reasonable Accommodations

1) Any Practitioner who discloses or manifests a physical or mental disability that qualifies for reasonable accommodation shall have his/her application processed in the usual manner without reference to the condition.

2) The Physician Well-Being Committee shall not disclose any information regarding any Practitioner's physical or mental disability until the MEC (or, in the case of temporary privileges, the Medical Staff representatives who review temporary privilege requests) have determined that the Practitioner is otherwise qualified for membership and to exercise the privileges requested. Once the determination is made that the Practitioner is otherwise qualified, the Physician Well-Being Committee may disclose information it has regarding any physical or mental disabilities and the potential effect of those on the Practitioner's application for membership and privileges. Any such disclosure shall be limited as necessary to protect the Practitioner's right to confidentiality of health information, while at the same time communicating sufficient information to permit the MEC to evaluate what, if any, accommodations may be necessary and feasible. The

Physician Well-Being Committee and any other appropriate Committees may meet with the Practitioner to discuss if and how reasonable accommodations can be made.

3) As required by law, the Medical Staff and Medical Center shall attempt to provide reasonable accommodation to a Practitioner with known physical or mental disabilities if the Practitioner is otherwise qualified and can perform the essential functions of the staff membership and privileges in a manner that meets the Medical Center and Medical Staff quality of care standards. If reasonable accommodation is not possible under the standards set forth herein, it may be necessary to withdraw or modify a Practitioner's proposed privileges and the Practitioner shall have the hearing and appellate rights described in Article VIII, Hearings and Appellate Review, of these the Bylaws. Alternately, the Practitioner may withdraw his/her application from consideration.

4) This discussion of reasonable accommodation applies equally to initial applications and reappointment applications.

5.7. Effect of Application

By applying for membership to the Medical Staff, each applicant:

A. Signifies a willingness to appear for interviews in regard to the application.

B. Authorizes Medical Center representatives to consult with other Medical Centers, persons or entities who have been associated with him or her and/or who may have information bearing on his/her competence and qualifications, and authorizes such persons or entities to provide all information that is requested orally and in writing.

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

D. Agrees that if membership is granted, and for the duration of Medical Staff membership, the Member has an ongoing and continuous duty to report to the Medical Staff Office within ten days any and all information that would otherwise correct, change, modify or add to any information provided in the application or most recent reapplication when such correction, change, modification or addition may reflect adversely on current qualifications for membership or privileges.

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. Releases from any and all liability the Medical Staff and the Medical Center and their representatives for acts performed in connection with the evaluation of the applicant.

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

H. Signifies his/her willingness to abide by all the conditions of membership, as stated on the appointment and reappointment application form, and in the Bylaws and Rules, access to which has been made available to the applicant.

I. Agrees to provide for continuous quality care for patients.

J. Acknowledges responsibility for timely payment of Medical Staff dues.

K. Pledges to maintain an ethical practice, including refraining from illegal inducements for patient referral, providing for the continuous care of the applicant's patients, seeking consultation whenever necessary, disclosing to patients when another surgeon will be performing the surgery, and refraining from delegating patient care responsibility to those who are not qualified to supervise Practitioners or Advance Practice Professionals.

L. Pledges to be bound by the Medical Staff Bylaws, Rules and Regulations, and policies.

5.8. Verification of Information

A. The applicant shall deliver a completely filled-in, signed, and dated application with supporting documents to the Medical Staff Office, and an advance payment of Medical Staff dues or fees. The Medical Staff Office shall expeditiously seek to collect or verify the references, licensure status, and other evidence submitted in support of the application. The Medical Staff's authorized representative shall query the National Practitioner Data Bank regarding the applicant and submit any resulting information to the Credentials Committee for inclusion in the applicant's credentials file. The applicant shall be notified of any problems in obtaining the information required, and it shall be the applicant's obligation to obtain any reasonably requested information. Failure to provide any requested information within thirty (30) days of a request shall be deemed a voluntary withdrawal of the application. When collection and verification of information is accomplished, the application shall be deemed complete and all such information shall be transmitted to the Chairman of each Department in which the applicant seeks privileges. No final action on an application may be taken until receipt of the National Practitioner Data Bank report.

B. **Incomplete Application.** If the Medical Staff Office is unable to verify the information, or if all necessary verifications have not been received, or if the application is otherwise significantly incomplete, the Medical Staff Office may delay further processing of the application, or may begin processing the application based only on the available information with a proviso that further information must be considered upon receipt.

If the processing of the application is delayed for more than sixty (60) days because of missing information, and if the missing information is reasonably deemed significant to a fair determination of the applicant's qualifications, the affected Practitioner shall be so notified in writing. He/she shall be given the opportunity to withdraw the application, or to request continued processing of the application. If the applicant does not respond within thirty (30) days of the date of the notice, he/she shall be deemed to have voluntarily withdrawn the application. If the applicant requests further processing, but then fails to provide or arrange for the provision (within forty-five (45) days or any other date mutually agreed to when the extension was granted, whichever is later) of the necessary information that the Practitioner could obtain using reasonable diligence, the Practitioner shall be deemed to have voluntarily withdrawn the application.

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

5.9. Action on the Application

A. Department Action. Upon receipt of a fully processed application, the Department Chairman(-men) shall review the application and supporting documentation, including information concerning the applicant's provision of services within the scope of privileges granted, his/her clinical and technical skills, and any relevant data available from Medical Center performance improvement activities, and the applicant's participation in relevant continuing education and shall transmit to the Credentials Committee or Committee on Interdisciplinary Practice (CIDP) a written recommendation concerning membership, and if membership is recommended, a written recommendation as to Department affiliation and privileges to be granted, and any special conditions to be attached. The Department Chairman(-men) has/have the option of personally interviewing the applicant. The Chairman(-men) may also request that the MEC defer action on the application.

The evaluation is to include a review of the applicant's physical and mental ability to appropriately exercise the privileges requested, with such reasonable accommodations as may be indicated, completed by an individual who has first-hand knowledge of the applicant's practice.

A fully processed application for initial appointment or reappointment shall be signed by the Chairman or Vice-Chairman of that Department, or by a Medical Staff Officer, prior to submission of the application to the Credentials Committee or CIDP.

B. Credentials Committee and Committee on Interdisciplinary Practice Action. The Credentials Committee or CIDP shall review the completed application, the supporting documentation, the Department Chairman's(-men's) recommendation and other relevant information within forty-five (45) days of the receipt of a completed application. If membership is recommended, it shall forward a written recommendation to the MEC concerning Department affiliation and privileges to be granted, and any special conditions to be attached to the membership. The Credentials Committee or CIDP may also recommend that the MEC defer action on the application.

At the time of final review, the Department(s), the Credentials Committee or CIDP, or the MEC may defer its recommendation in order to obtain additional information. In other special circumstances, action may be delayed for up to thirty (30) days, or a mutually agreed upon period of time by the applicant and the credentialing body, at which time a recommendation is to be made, and the application processed according to the established standards.

C. MEC Action. The MEC shall review the recommendation from the Department(s) and Credentials Committee or CIDP at its next scheduled meeting. The MEC may request additional information, return the matter to the Credentials Committee or CIDP for further investigation, and/or elect to interview the applicant.

The MEC shall forward to the Governing Body a written report and recommendation concerning Medical Staff membership and, if membership is recommended, a written recommendation concerning membership category, Department affiliation, privileges to be granted, and any special conditions to be attached to the membership. The MEC may also defer action on the application. The reasons for each special condition shall be stated.

1) **Effect of MEC Action**

- **Favorable Recommendation.** When the recommendation of the MEC is favorable to the applicant a written report with appropriate supporting documentation shall be forwarded to the Governing Body within thirty (30) days.
- **Adverse Recommendation.** When a final recommendation of the MEC is averse to the applicant, the Governing Body and the applicant shall be promptly informed by written notice. The Medical Staff applicant shall be entitled to the procedural rights described in Article VIII.

D. Governing Body Action. Upon receipt of the recommendation, the Governing Body shall act on the matter.

The Governing Body may adopt, reject, or modify a recommendation from the MEC, or may refer the recommendation back to the MEC for further consideration, stating the reasons for the referral and setting a time limit within which the MEC shall respond. If the Governing Body's action is grounds for a hearing under the Bylaws, Section 8.2, the President of the Medical Staff shall promptly inform the applicant by Certified Mail, Return Receipt Requested, and the applicant shall be entitled to the procedural rights as provided in the Bylaws, Article VIII.

E. Effective Date of an Unfavorable Recommendation. An unfavorable decision shall be held in abeyance until the applicant has exhausted or waived the procedural rights. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before.

F. Final Action on Procedural Rights. Within sixty (60) days after an applicant's rights under Article VIII have been exhausted or waived, the Governing Body shall act in the matter. The Governing Body's decision shall be conclusive.

G. Favorable Decisions. All favorable decisions by the Governing Body shall include a delineation of the privileges which may be exercised, the Department to which the person is assigned, and any special conditions attached to the membership.

H. Notice of Final Decision. When the Governing Body's decision is final, a notice of this decision shall be sent to the President of the Medical Staff, the Chairman of the Department concerned, to the applicant, and to the Medical Center Director or designee. In those cases where the Governing Body modified the recommendation from the MEC, or in the case of a decision unfavorable to the applicant, notice shall be sent to the Chief Medical Officer and the MEC for consideration. All notices to the applicant shall be sent by Certified Mail, Return Receipt Requested.

I. Reapplication after Adverse Membership Decision. Refer to Section 8.9.

J. Timely Processing of Application. Completed applications for staff memberships 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 time periods provide a guideline for routine processing of applications:

1) **Evaluation, review, and verification of application and all supporting documents by the Medical Staff Office.** Sixty (60) days from request for necessary documentation.

2) **Review and recommendation by Department(s).** Forty-five (45) days after receipt of all necessary documentation from the Medical Staff Office.

3) **Review and recommendation by Credentials Committee or CIDP.** Forty-five (45) days after receipt of all necessary documentation from the Department(s).

4) **Review and recommendation by the MEC.** Forty-five (45) days after receipt of all necessary documentation from the Credentials Committee or CIDP.

5) **Governing Body action.** Two hundred ten (210) days after a completed receipt of application is received by the Medical Staff Office.

5.10. Reappointment Process and Requests for Modification of Staff Status or Privileges

A. Schedule. At least one hundred eighty (180) days prior to the expiration of the current staff membership, the Medical Staff Office shall provide the Practitioner with an application for reappointment approved by the MEC.

The completed application for reappointment and supporting documents are to be returned to the Medical Staff Office at least one hundred fifty (150) days prior to the expiration date of current appointment. If the completed application for reappointment and supporting documentation is not returned within one hundred fifty (150) days prior to the expiration date of current appointment, a certified letter and phone call, and/or email notice shall be sent informing the Practitioner that the application for reappointment and supporting documentation must be returned within thirty (30) days. Failure to file a completed application for reappointment one hundred twenty (120) days prior to expiration of current membership shall be deemed as a voluntary resignation effective on the date that the current membership expires.

B. Reappointment Application Form. The reappointment application 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 Article V concerning initial application, as well as other relevant matters. Upon receipt of the application, the information shall be processed as set forth in Article V concerning initial application.

C. Reapplication Fee and Dues. Each applicant for Staff membership shall be required to submit the application fee with the application form. No part of the application fee shall be refunded. At the time of reappointment, the applicant shall also be required to submit a fee for biennial Medical Staff dues. This payment for dues is nonrefundable unless the applicant is unsuccessful in gaining reappointment to the Medical Staff or APP Staff.

D. Effect of Application. The effect of an application for reappointment, modification of staff status or privileges is the same as that set forth in Article V concerning initial application.

A Medical Staff Member who seeks a change in Medical Staff status or modification of privileges may submit such a request at any time upon a form developed by the MEC, except that such form may not be filed within one hundred eighty (180) days of the time a similar request has been denied.

Requests for new privileges must be supported by the type and nature of evidence that would be necessary for such privileges to be granted in an initial application.

E. Standards and Procedures for Review. When a Member submits the first application for reappointment, and every two (2) years thereafter, or when the Member submits an application

for modification of staff status or privileges, the Member shall be subject to an in-depth review generally following the procedures set forth in Article V concerning initial applications.

F. Verification and Collection of Information. The Medical Staff shall in timely fashion verify the information on each reappointment application and collect any other information deemed pertinent by the Credentials Committee. Commensurate with Staff category and current privileges, the information shall address:

1) Patterns of care and utilization as demonstrated in quality improvement, risk management, and utilization management activities.

2) Participation in relevant continuing education activities.

3) Attendance at Medical Staff, Department, and Committee meetings.

4) Participation as a Medical Staff Officer and/or Committee member/Chairman, as applicable.

5) Compliance with standards for timely and accurate completion of medical records.

6) Level of professionalism in relationships with Practitioners and other practitioners, Medical Center personnel, and patients.

7) New professional liability claims naming the applicant, and the outcome of any previously pending claims.

8) Level of compliance with applicable Medical Staff and Medical Center Bylaws, Rules and Regulations, and policies.

9) Any other pertinent information including the staff Member's activities at other Medical Centers or medical institutions.

G. Processing. (*Source of Information: Applicant for Reappointment).* Commensurate with Staff category and existing privileges, evaluation of the Practitioner's professional qualifications and competence to exercise the privileges requested shall be based upon his/her practice at the Medical Center. An exception may be made for low volume activities as defined in privilege documents for which supplemental information from other institutions where the Member practices may be used.

If there is insufficient information based upon the Practitioner's practice at the Medical Center, the Member may be transferred to an alternate Staff category or privilege tier upon the recommendation of the Department Chairman(-men) with the concurrence of the Credentials Committee, the MEC, and the Governing Body.

If the Practitioner's level of clinical activity at the Medical Center is not sufficient to permit the evaluation of his/her competence to exercise the privileges requested, the Practitioner shall have the burden of providing evidence of such competence from other institution(s) at which he/she practices in a format approved by the Medical Staff.

H. Failure to File an Application for Reappointment. Failure to file a completed application for reappointment one hundred twenty (120) days prior to expiration of current membership shall be deemed as voluntary resignation effective on the date that the current membership expires.

In the event membership terminates for the reasons set forth herein, the Practitioner shall not be entitled to any hearing or review.

The Medical Staff Office shall notify the Department Chairman(-men) if the Practitioner fails to submit a completed application for reappointment at one hundred fifty (150) and prior to one hundred twenty (120) days in advance of the expiration of his/her membership.

If the Practitioner was in good standing, but fails to submit a completed application for reappointment one hundred twenty (120) days prior to the expiration of the current membership, the Practitioner may submit a new application for Medical Staff membership within ninety (90) days of voluntarily resigning. The Practitioner shall be subject to the procedures set forth in Sections 5.5 to 5.10, except that the Practitioner will not be required to undergo initial proctoring requirements for privileges that were previously granted by the Medical Staff unless otherwise required by the MEC.

5.11. Leave of Absence Status

At the discretion of the MEC, a Practitioner may obtain a voluntary leave of absence from the staff upon submitting a written request to the Department Chairman(-men) for transmission to the MEC, stating the approximate period of leave desired, which may not exceed the reappointment cycle. During the leave, the Practitioner shall not exercise privileges at the Medical Center, and any membership rights and responsibilities shall be inactive, but the obligation to pay dues, if any, shall continue, unless waived by the MEC.

A. Termination of Leave. At least thirty (30) days prior to termination of the leave of absence, or at any earlier time, the Practitioner may request reinstatement of privileges by submitting a written notice to that effect to the MEC. The Practitioner shall submit a summary of relevant activities during the leave, if the MEC so requests. The MEC shall make a recommendation concerning the reinstatement of the Practitioner's privileges and prerogatives, and the procedure provided in Section 5.9 shall be followed.

B. Failure to Request Reinstatement. Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the Medical Staff and APP Staff and shall result in automatic termination of membership, privileges, and prerogatives. A Practitioner whose membership is automatically terminated shall be entitled to appear before or submit a written statement to the MEC for the sole purpose of determining whether the failure to request reinstatement was unintentional or otherwise excusable. A request for Medical Staff membership subsequently received from a Practitioner so terminated shall be submitted and processed in the manner specified for applications for initial membership.

C. Medical Leave of Absence. The MEC shall determine the circumstances under which a particular Practitioner shall be granted a leave of absence for the purpose of obtaining treatment for a medical condition or disability. In the discretion of the MEC, unless accompanied by a reportable restriction of privileges, the leave shall be deemed a "medical leave" not involving a medical disciplinary cause or reason.

D. Military Leave of Absence. Requests for leave of absence to fulfill military service obligations shall be granted upon notice and review by the MEC. Reactivation of membership or provisional status and privileges previously held shall be granted, notwithstanding the provisions of Section 5.9 shall be followed.

5.12. Requesting New Privileges

Requests for new privileges must be supported by the type and nature of evidence that would be necessary for such privileges to be granted in an initial application.

5.13. Medical Staff Role in Exclusive Staffing

The Governing Body of the Medical Center may determine, as a matter of policy and in accordance with State and Federal law, that certain hospital clinical facilities may be used only on an exclusive basis in accordance with written contracts between the hospital and qualified professionals, or in a limited fashion pursuant to a closed/limited staff policy. The Medical Staff may review and make recommendations to the Governing Body regarding quality of care issues related to such exclusive arrangements in the following situations:

(a) the decision to execute an exclusive contract or closed/limited staff policy in a previously open Department or Service;

(b) the decision to renew or modify an exclusive contract or closed/limited staff policy in a particular Department or Service;

(c) the decision to terminate an exclusive contract or closed/limited staff policy in a particular Department or Service.

Following Governing Body review of any Medical Staff quality of care recommendations, the decision of the Governing Body regarding execution, modification, or termination of an exclusive contract or closed/limited staffing in a particular Department or Service will be final.

5.14. Lapse in Application

If a Practitioner requesting a modification of privileges or Department assignments fails to timely furnish the information reasonably necessary to evaluate the request, the application shall automatically lapse, and the applicant shall not be entitled to a hearing as set forth in Article VIII.

ARTICLE VI.
PRIVILEGES

6.1. Exercise of Privileges

Except as otherwise provided in these Bylaws, a Practitioner providing clinical services at this Medical Center shall be entitled to exercise only those privileges specifically granted. Such privileges and services are Medical Center specific, within the scope of any license, certificate, or other legal credential authorizing practice in California and consistent with any restrictions thereon, and shall be subject to the rules and regulations of the clinical Department and the authority of the Department Chairman and Medical Staff.

Medical Staff privileges may be granted, continued, modified, or terminated by the Governing Body after considering the recommendation of the Medical Staff, and only after following the procedures outlined in these Bylaws

6.2. Declination of Privileges in General

A. Requests. Each application for membership and reappointment must contain a request for the specific privileges desired by the applicant. A request for modification of privileges may be submitted at any time, except as discussed in the Bylaws, and is to be accompanied by documentation of training and/or experience related to the request. A report shall be obtained from the National Practitioner Data Bank each time that a Practitioner requests new privileges.

B. Basis for Privileges Determination. Evaluation of the request for privileges shall be based on the applicant's education, training, experience, current demonstrated professional competence and judgment, current health status, and the documented results of patient care and other quality review monitors as applicable.

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 Practitioner exercises privileges.

No specific privilege may be granted to a Member if the task, procedure, or activity constituting the privilege is not available within the Medical Center despite the Member's qualifications or ability to perform the requested privilege.

C. New or Trans-Specialty Procedures. Any request for privileges that are either new to the Medical Center or that overlap more than one (1) Department shall initially be reviewed by the appropriate Departments in order to establish the need for, and appropriateness of, the new procedure or services. The MEC shall facilitate the establishment of Medical Center-wide credentialing criteria for new or trans-specialty procedures, with the input of all appropriate Departments, with a mechanism designed to ensure that quality patient care is provided for by all individuals with such privileges. In establishing the criteria for such privileges, the MEC may establish an ad-hoc Committee with representation from all appropriate Departments, or may charge the Credentials Committee with this task.

D. Telemedicine Privileges

1) **Definition of Telemedicine.** Telemedicine involves the use of electronic communication or other communication technologies to provide or support clinical care by a Practitioner at a distant site to patients located at an originating site. Practitioners who render diagnostic services or otherwise provide clinical treatment to a patient at this Medical Center by telemedicine are subject without exception to the Medical Staff credentialing and privileging process in these Bylaws.

2) **Telemedicine Services.** Telemedicine Services provided shall be identified by each involved specialty Department.

3) **Qualifications for Privileges.** In order to qualify for telemedicine privileges, the Practitioner must meet all the requirements set forth in the Bylaws and Rules and Regulations; or information provided by the distant-site Medical Center or telemedicine entity, subject to compliance with 42 CFR §482.12, as further described in the Rules.

4) Reappointment of a Telemedicine Staff Member's privileges may be based upon performance at this Medical Center, and/or (and subject to compliance with 42 CFR §482.12) upon information from the distant-site Medical Center(s) where the Practitioner routinely practices.

6.3. Temporary Privileges

A. An applicant for temporary privileges must submit a completed application and supporting documents to demonstrate that he/she possesses a current California license, a current and unrestricted DEA registration reflecting a current California address (if the Practitioner will be prescribing or administering controlled substances), evidence of ability to perform the temporary privileges requested, current competence related to the temporary privileges requested, and documentation of professional liability insurance coverage, if applicable. A Practitioner's compliance with these qualification elements shall be verified and recorded in a temporary privilege credential file. In addition, the following elements shall be met:

1) Qualifications and current competency for temporary privileges shall be verified from a primary source or designated agent of the primary source and documented.

2) The National Practitioner Data Bank shall be queried prior to the granting of temporary privileges.

3) The Medical Center shall verify whether the applicant has been deemed an Ineligible Person. For this purpose, the applicant shall provide his/her Medicare NPI, and the Medical Center shall check the OIG Sanction Report, and the State Exclusion List. If the applicant is excluded from such participation, temporary privileges shall not be granted and any exclusion subsequent to having been granted temporary privileges shall result in immediate termination of such privileges without any right to the hearing and appeal procedures in Article VIII of these Bylaws.

4) Each applicant shall agree in writing to be bound by the Medical Staff Bylaws, Rules and Regulations, Medical Staff policies, and applicable Medical Center policies.

5) Practitioners who are granted temporary privileges shall be subject to the Medical Staff's policy regarding Focused Professional Practice Evaluation (FPPE). Special requirements of supervision and reporting may be imposed on any individual granted temporary privileges.

B. **Conditions and Authority for Granting Temporary Clinical Privileges.** Temporary privileges may be granted by the Medical Center Director, or designee, upon receiving a favorable recommendation from the President of the Medical Staff, or designee, under the conditions described in Section 6.3. Individuals practicing based on temporary privileges shall be acting under the supervision of the Chairman of the Department to which he/she is assigned:

1) All temporary privileges shall be time-limited, as specified for the type of temporary privileges listed below.

2) During the time temporary privileges are in effect, the exclusion lists shall be rechecked according to the frequencies defined by Medical Center policy.

3) Temporary privileges shall automatically terminate at the end of the specific period for which they were granted without the Hearing and Appeal rights set forth in these Bylaws.

4) Temporary privileges shall be specifically delineated and may include the privilege to admit patients.

C. **Pendency of Application for New Privileges.** Applicant for new privileges includes: an individual applying for privileges at the Medical Center for the first time; an individual currently holding

clinical privileges who is requesting one (1) or more additional privileges; and an individual who is in the reappointment/re-privileging process and is requesting one (1) or more additional privileges. After receipt of a completed application for membership, as defined in these Bylaws, and Privileges Eligibility Criteria which includes a written request for temporary privileges, an applicant qualified as described in Section 6.3.1 may be granted temporary privileges while his/her complete application has been approved by the MEC, and awaiting action by the Board. Temporary privileges granted under this condition shall not exceed one hundred twenty (120) consecutive days. An applicant waiting processing of a completed application for membership shall be eligible for temporary privileges in pendency of the application only under the following conditions:

1) There are no pending or previous successful challenges to licensure or registration.

2) The applicant has never been subject to an involuntary limitation, reduction, denial, or loss of privileges at a hospital or other healthcare organization and no such actions are pending.

3) There are no pending or previous adverse membership actions at a hospital or other healthcare organization.

4) There are no pending or previous adverse actions against the applicant's privileges at a hospital or other healthcare organization.

D. Care of Specific Patients or Assistance with Proctoring. Temporary privileges may be granted on a case-by-case basis when an important patient care or Medical Staff proctoring need justifies the authorization to practice for a limited period of time. After receipt of a written request for temporary privileges, a Practitioner qualified as described in Section 6.3.1 may be granted temporary privileges if the Practitioner has a specific skill not possessed by a currently available Practitioner and the skill is needed by either a specific patient(s) or to assist in proctoring of a specific Medical Staff privilege(s):

1) Temporary privileges granted under the conditions described above shall not exceed either the proctoring need(s) or length of stay of the specific patient(s) or one hundred twenty (120) consecutive days, whichever is less.

2) Except for Practitioners serving as Medical Staff appointed proctors, a Practitioner may be granted temporary privileges no more than three (3) instances in a twelve-month period. After a Practitioner has been granted temporary privileges the third time for care of specific patients within twelve (12) months, he/she shall be required to apply for membership and privileges before providing additional patient care, treatment, or services at the Medical Center.

6.4. Emergency Privileges

In the case of an emergency, any Practitioner on staff to the degree permitted by license and regardless of Department or staff status or privileges shall be permitted to do everything reasonably possible to save the life of a patient, or save a patient from serious harm using every facility in the Medical Center necessary or desirable.

The Practitioner shall make every reasonable effort to communicate promptly with the Department Chairman concerning the need for emergency care and assistance from Members of the Medical Staff with appropriate privileges. Once the emergency has passed or assistance has been made available, the

Practitioner shall defer to the Department Chairman with respect to further care of the patient at the Medical Center.

6.5. Disaster Privileges

A. In the case of a disaster in which the disaster plan has been activated and the Medical Center is unable to handle the immediate patient needs, the President of the Medical Staff or designee, or the Medical Center Director or designee may grant disaster privileges. In the absence of the President of the Medical Staff or Medical Center Director or their designees, a Department Chairman or designee may grant disaster privileges consistent with this subsection. The granting of privileges under this subsection shall be on a case-by-case basis at the sole discretion of the individual authorized to grant such privileges. An initial grant of disaster privileges is reviewed by a person authorized to grant disaster privileges within seventy-two (72) hours to determine whether the disaster privileges should be continued.

B. The verification process of the credentials and privileges of individuals who receive disaster privileges under this subsection is documented below. Verification shall begin as soon as the immediate disaster situation is under control, guided by the following principles, codified in the Medical Center's Disaster Policy:

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

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

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

4) The Medical Staff addresses the verification process as a high priority. The Medical Staff has a mechanism to ensure that the verification process of the credentials and privileges of individuals who receive disaster privileges begins as soon as the immediate situation is under control.

C. Those authorized hereinabove Subsection 6.7.A may grant disaster privileges upon presentation by the Practitioner of a valid picture ID issued by a state, federal, or regulatory agency, and at least two (2) of the following:

1) A current picture Medical Center ID card clearly identifying professional designation.

2) A current license to practice medicine in the State of California.

3) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT) or MRC, ESAR-VHP, or other recognized state or federal organizations or groups.

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

5) Identification by current Medical Center or Medical Staff Member(s) with personal knowledge regarding the volunteer's ability to act as a licensed independent Practitioner during a disaster.

D. Current professional licensure of those providing care under disaster privileges is verified from the primary source as soon as the immediate situation is under control and completed within seventy-two (72) hours, unless extraordinary circumstances prohibit verification, in which case the following is documented:

1) The reasons verification could not be performed within seventy-two (72) hours of the Practitioner's arrival.

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

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

E. Members of the Medical Staff shall oversee those granted disaster privileges by direct observation, mentoring, and/or medical record review.

6.6. Privileges Eligibility Criteria

Core privileges are those based on successful completion of an ACGME, AOA, or equivalent residency training program, or board certification. Non-core or advanced privileges and procedures are those that require completion of fellowship training beyond the basic residency program or demonstrated competency. Generally, non-core, or advanced privileges or procedures are low volume and/or higher-risk procedures.

The Practitioner applying for renewal of privileges is expected to document that he/she has exercised these privileges within the past two (2) years at the Medical Center and/or at another institution where he/she holds privileges. Relevant Category I – Continuing Medical Education may be substituted in lieu of exercise of these privileges. Performance of substantially similar procedures, or procedures that involve substantially similar degrees of skill, may be substituted for evaluation at the time of privilege renewal, at the discretion of the Credentials Committee, CIDP, and the relevant Department Chairman.

The Department Chairman may recommend that the Practitioner's specific privileges be renewed in the absence of use and/or education for good cause. This includes, but is not limited to, privileges, which are used only in emergency situations. Specific documentation of the reason for the recommendation shall be required.

6.7. Performance Evaluation and Monitoring

A. General Overview of Performance Evaluation and Monitoring Activities. The credentialing and privileging processes described in Bylaws, Article 5, Appointment and Reappointment require that the Medical Staff develop ongoing performance evaluation, and monitoring activities to ensure that decisions regarding membership on the Medical Staff, and Advanced Practice Professional Staff, and granting or renewing of privileges are, among other things, detailed, current, accurate, objective, and evidence-based. Additionally, performance evaluation, and monitoring activities help ensure timely identification of problems that may arise in the ongoing provision of services in the Medical Center. Problems identified through performance evaluation and monitoring activities are addressed via the appropriate performance improvement, and/or remedial actions as described in the Bylaws.

B. General Performance Monitoring. The Medical Staff shall regularly monitor all Members' privileges in accordance with the provisions set forth in these Bylaws, and such performance

monitoring policies as may be developed by the Medical Staff, and approved by the MEC, and the Governing Body.

Performance monitoring is not viewed as a disciplinary measure, but rather is an information-gathering activity. Performance monitoring does not trigger the procedural rights described in Bylaws, Article VIII, Hearing and Appellate Review (unless the form of monitoring is Level III proctoring and its imposition becomes a restriction of privileges because procedures cannot be done unless a proctor is present, but a proctor is not available after reasonable attempts to secure one).

The Medical Staff shall clearly define how information is gathered during performance monitoring, and how it will be shared in order to effectuate change and additional action, if determined necessary.

Performance monitoring activities and reports shall be integrated into other quality improvement activities. The results of any Practitioner-specific performance monitoring shall be considered when granting, renewing, revising, or revoking privileges of that Practitioner.

C. Ongoing Professional Performance Evaluations (OPPE). Each Medical Staff Department shall recommend, for MEC and Governing Body approval, the criteria to be used in the conduct of Ongoing Professional Performance Evaluations for its Practitioners. Ongoing performance reviews shall be factored into the decision to maintain, revise, or revoke a Practitioner's existing privilege(s).

D. Focused Professional Practice Evaluation (FPPE). The Medical Staff is responsible for developing a Focused Professional Practice Evaluation process that shall be used in appropriate situations to evaluate, for a time-limited period, a Practitioner's competency in performing specific privilege(s). The Medical Staff may supplement these Bylaws with policies, for approval by the MEC and the Governing Body, that will clearly define the circumstances when a focused evaluation shall occur, what criteria, and methods should be used for conducting the focused evaluation, the duration of the evaluation period, requirements for extending the evaluation period, and how the information is gathered during the evaluation process that will be analyzed and communicated.

E. Information for a focused evaluation process may be gathered through a variety of measures including, but not limited to:

1) Retrospective or concurrent chart review
2) Monitoring clinical practice patterns
3) Simulation
4) External peer review
5) Discussion with other individuals involved in the care of each patient
6) Proctoring, as fully described below
7) Formal testing of knowledge base

F. A Focused Professional Practice Evaluation shall be used in at least the following situations:

1) All initial appointees to the Medical Staff, APP Staff, and all Practitioner's granted new privileges shall be subject to a period of Focused Professional Practice Evaluation in

accordance with these Bylaws (and the Rules of the Department in which the applicant or Member will be exercising those privileges). Such focused evaluation will generally include a period of Level I proctoring in accordance with Bylaws, Section 6.7.7(a)(1) below, unless additional circumstances appear to warrant a higher level of proctoring, as described below.

2) In special instances, focused evaluation will be imposed as a condition of renewal of privileges (for example, when a Practitioner requests renewal of a privilege that has been performed so infrequently that it is difficult to assess the Member's current competency in that area). Such evaluation will generally consist of Level I proctoring in accordance with Bylaws, Section 6.7.7(a)(1) below, unless additional circumstances appear to warrant a higher proctoring level, as described below.

3) When questions arise regarding a Practitioner's competency in performing specific privilege(s) at the Medical Center as a result of specific concerns or circumstances, a focused evaluation may be imposed. Such evaluations may include either Level II or III proctoring, in accordance with these Bylaws.

4) Nothing in these Bylaws precludes the use of other Focused Professional Practice Evaluation tools, in addition to, or in lieu of proctoring, as deemed warranted by the circumstances.

G. Proctoring

1) **Overview of Proctoring Levels**

a) Level I proctoring shall be considered routine and is generally implemented as a means to review initially requested privileges in accordance with Bylaws, above, and for review of infrequently used privileges in accordance with the Bylaws.

b) Level II proctoring is appropriate in situations where a Practitioner's competency or performance is called into question, in accordance with Bylaws above, but where the circumstances do not involve a "medical disciplinary" cause or reason or where the proctoring does not constitute a restriction on the Practitioner's privilege(s) (i.e., the Practitioner is required to participate in proctoring, and to notify either the proctor or other designated individual(s) prior to providing services, but is permitted to proceed without the proctor if one is not available).

c) Level III proctoring is appropriate in situations where a Practitioner's competency or performance is called into question due to a "medical disciplinary" cause or reason in accordance with Bylaws, above, and where the form of proctoring is a restriction on the Practitioner's privilege(s) (because the Practitioner may not perform a procedure or provide care in the absence of the proctor). Upon imposition of Level III proctoring, that Practitioner is afforded such procedural rights as provided at Bylaws, Article 8, Hearing and Appellate Review.

2) **Overview of Proctoring Procedures**

a) Whenever proctoring is imposed, the number and types of procedures to be proctored and the duration, shall be delineated and defined as described in Section 6.8 to 6.11.

b) During the proctoring, the Practitioner must demonstrate that they are qualified to exercise the privileges that were granted.

c) In the event that the new applicant has privileges at a neighboring Medical Center where Members of this Medical Center's Medical Staff are familiar with the Practitioner to be proctored, and familiar with that neighboring Medical Center's peer review standards, privileging and proctoring information from the neighboring Medical Center may, at the discretion of the appropriate Department Chairman, be acceptable to satisfy a portion of the focused professional practice evaluation required.

d) If proctoring for a privilege is not available inside the Medical Center, the Department Chairman may, at his/her discretion, arrange for an outside proctor who is qualified to be a Member of this Medical Staff.

6.8. Responsibility of Provisional Member

The proctoree is responsible for requesting a proctor to serve on each case and for informing the proctor of necessary patient information (i.e., patient's date of admission, diagnosis, proposed date of surgery or procedure, and planned course of treatment). To the extent possible, surgical cases should be scheduled at the convenience of the proctor. The availability of the surgical proctor should be confirmed prior to scheduling elective cases. Elective surgical or other invasive procedures may not begin if the proctor is not present. Proctors for nonsurgical admissions, consultations, and other procedures should be notified in a timely fashion, but within twenty-four (24) hours. In emergency and urgent cases, the safety of the patient is paramount, but every effort should be made to secure a proctor in a timely fashion.

The proctoree must request proctoring on all cases until the requisite number for the Department procedure has been satisfied, and proctoring is to be concurrent, beginning with the proctoree's clinical debut at the Medical Center.

6.9. Responsibility of Proctor

The proctor must have the appropriate privileges at the Medical Center for the case being proctored.

The proctor should review the care provided through direct observation of surgery or other invasive procedures, and concurrent review of the patient's chart including physician's orders, progress record, history and physical, and consultation notes.

A proctor should not receive a fee for proctoring unless he/she also functions as a consultant or surgical assistant.

Proctors are permitted to take such action, as is reasonably necessary to protect the patient when, in his/her professional judgment, it is necessary to intervene to prevent injury to the patient. In certain rare instances this may even involve dismissal of the proctoree from a patient's care and assumption of responsibility by the proctor.

If the Provisional Staff Member appears to be performing in less than a satisfactory manner, the proctor should bring this to the attention of the Department Chairman.

6.10. Completion of Proctoring

Proctoring shall be performed throughout the period of the Provisional year unless the proctoring requirements are satisfied prior to the end of the Provisional staff year.

The Department Chairman has the authority to waive the need for further proctoring of a particular privilege or type of case as soon as the proctoring requirements for that particular privilege, procedure, or type of case have been satisfactorily met. The Chairman also has the authority to extend proctoring requirements if there is documented evidence to demonstrate the need for further proctoring. Random chart review may be performed on Provisional Staff Members after initial proctoring requirements have been fulfilled.

If the requisite number of proctored cases does not include a sufficient variety, the Department Chairman and/or the Credentials Committee may require additional proctoring of specific procedures.

Upon the completion of proctoring, the Department Chairman shall provide a written report to the Credentials Committee. This shall include a description of the number and type of cases proctored. An evaluation of the proctoree's clinical competence to exercise the privileges requested and a specific recommendation as to the action to be taken shall be provided. The report is to be submitted prior to the end of the provisional period or the period required to complete the proctoring of an individual granted new privileges. This report shall be acted upon by the Credentials Committee at its next scheduled meeting and thereafter by the MEC and the Governing Body.

6.11. Failure to Complete Proctoring

A. Failure to Complete Necessary Volume. Any Practitioner who fails to complete the required number of proctored cases within the time frame established in the Bylaws and Rules shall be deemed to have voluntarily withdrawn the request for membership or for the relevant privileges and shall not be afforded the procedural rights provided in Article VIII. However, the Department has the discretion to extend the time for completion of proctoring for up to eighteen months from the initial date of membership. The inability to obtain such an extension shall not give rise to procedural rights described. Practitioners who are already Members of the Medical Staff, and APP Staff, and who have been granted new privileges must complete proctoring within twelve (12) months of initial approval. Failure to complete proctoring shall result in voluntary relinquishment of the specific privilege in question. Such voluntary relinquishment of the specific privilege in question shall not give rise to the procedural rights provided in Article VIII.

B. Failure to Perform Satisfactorily. If a Practitioner completes the necessary volume of proctored cases but fails to perform satisfactorily, he/she may be terminated (or the relevant privileges may be revoked), and he/she shall be afforded the procedural rights as provided in Article VIII.

The failure to complete proctoring for any specific privilege shall not, by itself, preclude advancement from Provisional status. If advancement is approved prior to completion of proctoring, the proctoring shall continue for the specified privileges. The specific privileges subject to proctoring may be voluntarily relinquished or terminated if proctoring is not completed thereafter within the period of the initial membership. Such voluntary relinquishment or termination shall not give rise to the procedural rights provided in Article VIII

6.12. Verification of Scope of Practice

It is the responsibility of the Practitioner to provide or supervise the provision of only those services for which privileges have been granted. Verification of the specific privileges granted may be obtained from the Medical Staff Office or other designated locations. The Department Chairman, or in his/her absence, the Medical Director-on-call shall make the final determination in the event of questions.

6.13. Privilege Limitations for Dentists, Oral and Maxillofacial Surgeons, and Clinical Psychologists

A. Privileges. The privileges granted to dentists, oral and maxillofacial surgeons, clinical psychologists, and podiatrists should be based on their training, experience, demonstrated competence, and judgment. The scope and extent of procedures that each Practitioner may perform shall be specifically delineated and granted in the same manner as other privileges. Procedures performed by dentists and oral and maxillofacial surgeons shall be under the supervision of the Chairman of the Department of Surgery. Dentists granted privileges to admit patients to the inpatient service are expected to have training or experience in Medical Center procedures. Podiatrists shall be under the supervision of the Chairman of the Department of Orthopedics. Clinical Psychologists will be under the supervision of the Chairman of the Department of Behavioral Health.

B. The following general provisions shall apply to dentists and podiatrists:

1) Admitting and other privileges of dentists and podiatrists may not exceed the scope of their licensure.

2) Patients admitted by dentists and podiatrists must receive all necessary and appropriate medical evaluations and care.

3) If a patient is admitted for inpatient or outpatient care by a dentist or podiatrist, and the episode of care requires some type of history and physical examination, the dentist or podiatrist must complete the relevant dental or podiatric portions of the history and physical examination. Except as noted below in Section 5.4-2 (f), an appropriately credentialed physician must conduct or supervise the remaining required elements of the history and physical examination.

4) An appropriately credentialed physician must assume responsibility for the care of the patient's medical problems present at the time of admission or which may arise during the episode of care which is outside of the dentist’s/podiatrist’s scope of licensure or privilege.

5) Any dispute between a dentist and/or podiatrist and a physician Member regarding proposed treatment must be promptly resolved by the appropriate Department Chairman.

6) Oral and maxillofacial surgeons and podiatrists, who demonstrate training and current competence, may be credentialed to perform history and physical examinations

6.14. Advanced Practice Professional Staff (APP)

A. Qualifications. The APP must:

1) Document current licensure, experience, education, and training sufficient to exercise the privileges requested, current professional competence, good character, good judgment and current and adequate physical and mental health status (subject to any necessary reasonable accommodation), so as to demonstrate to the satisfaction of the Medical Staff that he/she is professionally and ethically competent and that patients treated by him/her can reasonably expect to receive quality medical care.

2) Be determined, on the basis of documented references: to adhere strictly to the lawful ethics of the APP's profession, to work cooperatively with others in the Medical Center setting so as not to adversely affect patient care, and to be willing to commit to and regularly assist the Medical Staff in fulfilling its obligations related to patient care, within the areas of the practitioner's professional competence and credentials.

3) Agree to comply with all Medical Staff Bylaws and policies, and Rules and Regulations, and protocols to the extent applicable to the APP.

4) Maintain, if applicable, professional liability insurance with a suitable insurer, with minimum limits as determined by the MEC and Governing Body.

5) A Nurse Practitioner or a Physician Assistant can only provide services for which he/she has obtained Medical Staff authorization, and only in accordance with a standardized procedure, delegation of services agreement, or protocol, as applicable, approved by the supervising physician and the MEC.

B. Categories of APP Eligible for Advanced Practice Professional Staff. The categories include: Nurse Practitioners, Physician Assistants, Audiologists, Genetic Counselors, Certified Registered Nurse Anesthetists, recent Nurse Anesthetist Graduates, Certified Nurse Midwives, and Clinical Perfusionists, which shall be eligible to apply for Advanced Practice Professional Staff membership and for privileges in the Medical Center, and the corresponding clinical privilege prerogatives, terms, and conditions for each such APP category shall be approved by the Governing Body based upon the recommendation of the MEC. The Governing Body shall review the designation of categories of APPs eligible to apply for privileges at least every two (2) years, and at other times, within its discretion or upon the recommendation of the MEC.

C. Procedure for Reviewing Applications for Advanced Practice Professional Staff

1) All such applications shall be processed in a parallel manner to that provided in Article V for Medical Staff Members.

2) APP applications for initial granting and reappointment by Nurse Practitioners, Physician's Assistants, Audiologist and Genetic Counselors who are eligible for Advanced Practice Professional Staff membership, shall be submitted to the Committee on Interdisciplinary Practice (CIDP).

3) APP applications for initial granting and reappointment by Nurse Midwives, Nurse Anesthetist who are eligible for Advanced Practice Professional Staff membership, shall be submitted to the Credentials Committee.

4) Except as is provided in Section 8.9.3 Duration and Commencement Date of the Waiting Period, an APP who has received a final adverse decision regarding his/her application for a service authorization, having withdrawn his/her application for privileges following an adverse recommendation by the MEC, or after having been granted privileges has received a final adverse decision resulting in termination of membership and privileges, has relinquished his/her APP membership and privileges following the issuance of a Medical Staff or Governing Body recommendation adverse to his/her membership and privileges ,that a APP shall not be eligible to reapply for membership and privileges affected by such decision or recommendation for a period of at least twenty-four (24)

months from the date that the adverse decision became final, the application was withdrawn, or the APP relinquished his/her membership and privileges.

D. Request to Consider APP Category. An APP who does not have licensure or certification in an APP category identified as eligible for APP Staff membership and privileges pursuant to Section 6.14.2 may not apply for APP Staff membership and privileges, but may submit a written request to the President of the Medical Staff and MEC asking the Governing Body to consider designating the appropriate category of APPs as eligible to apply for APP Staff membership and privileges. The Governing Body shall consider such request and the MEC's recommendation either before or at the time of its review of the categories of APPs, in accordance with Section 6.14.2.

E. Department Assignment. Each APP who is granted privileges shall be assigned to a Medical Staff Department appropriate to their occupational or professional training and, unless otherwise specified in the Medical Staff Rules and Regulations, shall be subject to terms and conditions that parallel those specified in Article III.

F. Prerogatives. The prerogatives may include:

1) Provision of specified patient care services subject to a Medical Staff Member's responsibility, to the extent indicated, for the patient's general medical condition and under the general oversight of the Medical Staff, and, where the APP does not practice independently, also under the supervision and direction of a Member of the Active Medical Staff and within the scope of the APP's licensure or certification.

2) Service on Medical Staff and Medical Center committees except as otherwise expressly precluded in the Medical Staff Bylaws, Rules and Regulations, and Committee Manual. An APP may not serve as chairman of Medical Staff committees.

3) Attendance at meetings of the Department to which the APP is assigned, as permitted by the Medical Staff Departments, and attendance at Medical Staff educational programs in the APP's field of practice. An APP may not vote at Medical Staff Department meetings

G. Responsibilities. Each APP shall:

1) Meet those responsibilities required by the Medical Staff Rules and Regulations and if not so specified, meet those responsibilities specified in the Medical Staff Bylaws as are generally applicable to the more limited practice of the APP.

2) Retain appropriate responsibility within the APP's area of professional competence for the care of each patient at the Medical Center for whom the APP is providing services.

3) Participate, when requested, in patient care audit and other quality review, evaluation, and monitoring activities required of APPs, in evaluating APP applicants, in supervising initial APP appointees of the APP's same occupation or profession or of an occupation or profession which is governed by a more limited scope of practice statute, and in discharging such other functions as may be required by the Medical Staff from time to time.

H. Termination, Suspension, or Restriction of Privileges

1) **General Procedures**

a) At any time, the President of the Medical Staff or Department Chairman to which

the APP has been assigned may recommend to the MEC that an APP's Staff membership and privileges be terminated, suspended or restricted. After investigation (including, if appropriate, consultation with CIDP or the Credentials Committee) the MEC agrees that corrective action is appropriate, the MEC shall recommend specific corrective action to the Governing Body. A Notification Letter regarding the recommendation shall be sent by certified mail to the subject APP. The Notification Letter shall inform the APP of the recommendation and the circumstances giving rise to the recommendation.

b) Nothing contained in the Medical Staff Bylaws shall be interpreted to entitle an APP Staff Member, to the hearing rights set forth in Articles VII and VIII. However, an APP shall have the right to challenge any recommendation which would constitute grounds for a hearing under Section 8.2 of the Bylaws (to the extent that such grounds are applicable by analogy to the APP Staff) by filing a written request for an APP Staff hearing with the MEC within thirty (30) days of receipt of the Notification Letter. Upon receipt of a request, the MEC or its designee, shall afford the APP an opportunity for an APP Staff hearing concerning the grievance. The hearing need not be conducted according to the procedural rules applicable to a Medical Staff Member hearing; however the purpose of the APP Staff hearing is to allow both the APP and the party recommending the action the opportunity to discuss the situation and to produce evidence in support of their respective positions. A record of the APP Staff hearing shall be made.

c) Within thirty (30) days following the APP Staff hearing, the MEC, based on the APP Staff hearing and all other aspects of the investigation, shall make a final recommendation to the Governing Body, which shall be communicated in writing, sent by certified mail, to the subject APP. The final recommendation shall discuss the circumstances giving rise to the recommendation, and any pertinent information from the interview. Prior to acting on the matter, the Governing Body may, in its discretion, offer the affected APP the right to appeal to the Board or a subcommittee thereof. The Governing Body shall adopt the MEC's recommendation, so long as it is reasonable, appropriate under the circumstances and supported by substantial evidence. The final decision by the Governing Body shall become effective upon the date of its adoption. The APP shall be promptly provided with notice of the final action, sent by certified mail.

I. Summary Restriction and Suspension. Whenever an APPs conduct is such that a failure to take action may result in imminent danger to the health of any individual, the President of the Medical Staff or the Chairman of the Department in which the Member holds privileges, or the Governing Body (or its designee) may summarily restrict or suspend the APP Staff membership and/or privileges of such Member as described in the Medical Staff Bylaws Section 7.8.10.

J. Automatic Suspension and Limitation. APPs privileges or membership may be automatically suspended or limited as described in the Medical Staff Bylaws Section 7.9.

K. Reapplication. Every two (2) years, each APP must reapply for reappointment in accordance with Article VI.

ARTICLE VII.
EVALUATION AND CORRECTIVE ACTION

7.1. Evaluation

The Medical Staff is responsible for oversight of its quality of medical care, treatment and services delivered in the Medical Center. An important component of that responsibility is the oversight of care rendered by Members and Advanced Practice Professionals practicing in the Medical Center. The following provisions are designed to achieve quality improvements through collegial ongoing peer review and educative measures whenever possible, but with recognition that, when circumstances warrant, the Medical Staff is responsible for corrective action as necessary to achieve and assure quality of care, treatment, and services. Toward these ends:

The initial goals of the peer review process are to prevent, detect, and resolve problems and potential problems through routine collegial monitoring, education, and counseling. Evaluation results are used in privileging, system improvement, and when necessary, remedial measures, including formal investigation and discipline, and may need to be implemented and monitored for effectiveness.

Peers in Departments and Committees are responsible for carrying out delegated review and quality improvement functions in a manner that is consistent, timely, defensible, balanced, useful, and ongoing. The term “peers” generally requires that a majority of the peer reviewers be Members holding the same license as the Practitioner being reviewed, including, when necessary, at least one (1) Member practicing the same specialty as the Member being reviewed. Notwithstanding the foregoing, D.O.s and M.D.s shall be deemed to hold the “same licensure” for purposes of participating in peer review activities. Peer Review activities are carried out per the Medical Staff Peer Review Guidelines of the Medical Center.

7.2. Peer Review

Peer Review is fairly conducted, and is essential to preserving the high standards of medical practice.

A. Peer Review of Applicants. All applicants are evaluated for membership and privileges using only those Medical Staff peer review criteria adopted consistent with these Bylaws, and applied exclusively through the processes established in these Bylaws.

B. Ongoing Peer Review. All Members are subject to evaluation based on Medical Staff peer review criteria, adopted consistent with these Bylaws. Evaluation results are used in privileging, system improvement, and when warranted, corrective action.

7.3. Peer Review Criteria

Departments shall develop and routinely update, at least annually, peer review criteria based on current practices and standards of care, which shall be the sole criteria used in evaluating those applying for membership and privileges, and the performance of Members and privilege holders. These criteria are subject to the approval by the MEC.

Included in the peer review criteria are the types of data to be collected for evaluation. These include:

- Operative and other clinical procedure(s) performed and their outcomes
- Patterns of blood and pharmaceutical usage
- Requests for tests or procedures

- Patterns of length of stay
- Morbidity and mortality

7.4. Focused Peer Review of Initial Members

All initial grants of privileges shall be subject to proof of current clinical competence under these Bylaws, and otherwise reviewed for compliance with the relevant Departmental peer review criteria. All initial appointees to the Medical Staff and APP Staff, and all Members granted new privileges shall be subject to a period of Focused Professional Practice Evaluation in accordance with these Bylaws (and the Rules of the Department in which the applicant or Member will be exercising those privileges). Such focused evaluation will generally include a period of Level I proctoring in accordance with Bylaws, Section 6.7.7 (a)(1) above, unless additional circumstances appear to warrant a higher level of proctoring, as described below.

A. In special instances, focused evaluation will be imposed as a condition of renewal of privileges (for example, when a Member requests renewal of a privilege that has been performed so infrequently that it is difficult to assess the Member's current competency in that area). Such evaluation will generally consist of Level I proctoring in accordance with Bylaws below, unless additional circumstances appear to warrant a higher proctoring level, as described below.

B. When questions arise regarding a Practitioner's competency in performing specific privilege(s) at the Medical Center as a result of specific concerns or circumstances, a focused evaluation may be imposed. Such evaluations may include either Level II or III proctoring, in accordance with these Bylaws.

7.5. Focused Peer Review of Members

All Practitioners and privilege holders not otherwise subject to initial review are reviewed for compliance with relevant Department peer review criteria on an on-going basis. In addition to information gathered under routine screening, determined by the Department, such as periodic chart review, proctoring on a rotational basis, monitoring of diagnostic and treatment techniques, and discussions with other professionals, complaints and concerns are analyzed in light of the Department peer review criteria. Peer review analysis shall be conducted and reported by the Peer Review Committee at least quarterly to the Department and MEC. Members are kept apprised of reviews of their performance. Performance monitoring, corrective action, or other measures are implemented or recommended as needed.

7.6. Results of Reviews

Information resulting from ongoing peer review of Members according to the relevant Department criteria and analyzed by the process established in these Bylaws must be acted upon. Resulting action can be, but is not limited to:

A. Documenting in the Member's credentials file that the Member is performing well or within desired expectations.

B. Identifying issues that require a focused evaluation.

C. Determining that the privilege should be continued because the Medical Center's mission is to be able to provide the privilege to its patients.

D. Recommending to the MEC needed changes in Medical Center systems to improve patient safety or the quality of patient care.

E. Recommending limiting a privilege or privileges or other corrective action under these Bylaws.

The report shall be included in the Member's credentials file and dealt with according to these Bylaws.

7.7. External Peer Review

External peer review may be used to supplement the Medical Staff peer review process as delineated under these Bylaws.

The Credentials Committee, CIDP or the MEC, upon request from the Department or upon its own motion, may obtain external peer review in the following circumstances:

A. Committee or Department review(s) that could affect an individual's membership or clinical.

B. Privileges do not provide a sufficiently clear basis for action.

C. No current Medical Staff Member can provide the necessary expertise in the clinical.

D. Procedure or area under review.

E. To prevent allegations of bias or conflict of interest, even if unfounded.

F. Upon the reasonable request of the Practitioner as determined by the MEC.

7.8. Corrective Action

A. Informal Remedial Activities. The Medical Staff Officers, Departments, and Committees may counsel, educate, or issue letters of warning and conduct Focused Professional Practice Evaluation (so long as the Practitioner is only required to provide reasonable notice of admissions and procedures) in the course of carrying out their duties without initiating formal corrective action. Comments, suggestions, and warnings may be issued orally or in writing. The Practitioner shall be given an opportunity to respond in writing and shall be given an opportunity to meet with the Officer, Department, or Committee prior to institution of any informal remedial action under this section. Any informal actions, monitoring, or counseling shall be documented in the Member's Credentials file. MEC approval is not required for such actions, although the actions shall be reported to the MEC. Such informal remedial action shall not constitute a restriction of privileges or grounds for any formal hearing or appeal rights under Article VIII, Hearings and Appellate Review.

B. Criteria for Investigation. Any person may provide information to the President of the Medical Staff or designee about the conduct, performance, or competence of any of the 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 within the Medical Center.

2) Unethical.

3) Contrary to the Medical Staff Bylaws or Rules and Regulations.

4) Below applicable professional standards.

5) Disruptive to Medical Staff or Medical Center operations.

6) An improper use of Medical Center resources, a request for an investigation and/or corrective action against such Member may be initiated by the Department Chair, Chief Medical Officer, President of the Medical Staff, or the MEC.

C. Initiation of Investigation. Any person who believes that formal corrective action may be warranted may provide information to the President of the Medical Staff, any other Medical Staff Officer, the Department Chairman of the involved Department, any Medical Staff Committee, Chairmen of the Medical Staff Committee, the Governing Body, or the Medical Center Director.

If any of the above, after such notification, then determines that formal corrective action may be warranted, that person, entity or Committee may request the initiation of a formal corrective action investigation.

Request for an investigation must be conveyed to the MEC in writing supported by reference to the specific activity or conduct~~,~~ which constitutes the grounds for the request. If the MEC initiates the request, it shall make an appropriate recording of the reasons.

The President of the Medical Staff shall promptly notify the Chief Medical Officer of all requests for corrective action received by the MEC and shall continue to keep the Chief Medical Officer informed of all action taken in connection therewith.

D. Expedited Initial Review. Whenever information suggests that corrective action may be warranted, the President of the Medical Staff or designee may, on behalf of the MEC, immediately investigate and conduct whatever interviews may be indicated. The information developed during this initial review shall be presented to the MEC by the President of the Medical Staff or designee, and the MEC shall decide whether to initiate a formal corrective action investigation.

In cases of complaints of harassment or discrimination involving a patient, an expedited initial review shall be conducted on behalf of the MEC by the President of the Medical Staff or designee, together with a representative from Medical Center Administration, or by an attorney for the Medical Center. The information developed during this initial review shall be presented to the MEC by the President of the Medical Staff or designee, and the MEC shall decide whether to initiate a formal corrective action investigation.

In cases of complaints of harassment or discrimination where the alleged harasser is a Medical Staff or APP Member, and the complainant is not a patient, an expedited initial review shall be conducted by the President of the Medical Staff or designee, the Medical Center's human resources director or designee, or the Medical Center's attorney, who shall use best efforts to complete the expedited initial review within the time frame outlined in the Bylaws. The information gathered from an expedited initial review shall be presented to the MEC by the President of the Medical Staff if it is determined that corrective action may be indicated against the Member.

E. Initial Review. Whenever information suggests that corrective action may be warranted, the President of the Medical Staff or his/her designee and/or the Chief Medical Officer may, on behalf of the MEC, immediately investigate and conduct initial interviews to obtain information. The information developed during this initial review shall be presented to the MEC, which shall decide whether to initiate a formal investigation. The Medical Staff Office shall maintain a written summary of the interview(s) and action taken

F. Formal Investigation. If the MEC concludes that an investigation is warranted, it shall direct that an investigation be undertaken. The MEC may conduct the investigation itself or may assign the task to an appropriate officer or to a standing or ad hoc Committee.

Such an ad hoc Committee shall include at least three (3) Medical Staff Members who have not been directly involved with the event(s) being investigated. If indicated, the President of the Medical Staff or his/her designee, in consultation with the MEC, may authorize the membership of a Member to the ad hoc Committee who are not Members of the Medical Staff but who have particular expertise in relation to the issue under investigation.

G. Conduct of the Formal Investigation. The MEC shall advise the Chairman of the Department in which the Member has privileges that an investigation is to be conducted. The investigator(s) shall notify the Member in writing of the general nature of the charges and that an investigation is to be conducted.

The investigator(s) shall conduct such investigation as needed to prepare their report. The Member shall be afforded an opportunity to meet with the investigator(s) to discuss, explain, or refute the charges. This interview shall not constitute a hearing, shall be preliminary in nature, and the procedural rules provided in these Bylaws with respect to a hearing shall not apply. A record of such interview shall be made by the investigating Committee and included with its report to the MEC.

Upon completion of the investigation, the investigator(s) shall report to the MEC. The report may include a recommendation for corrective action, as appropriate.

Despite the status of any investigation, at all times the MEC 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.

H. MEC Action. As soon as practicable following the receipt of the above report the MEC shall act. Actions may include:

1) Determining no corrective action should be taken.

2) Determining that no credible evidence of the complaint existed and the adverse information shall be removed from the Member's file.

3) Deferring action for a reasonable time, which shall be specified.

4) Issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude Department or Committee Chairmen from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letters are issued, the affected Member may make a written response which shall be placed in the Member's file.

5) Recommending the imposition of terms of probation or special limitations upon continued Medical Staff membership or exercise of privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring.

6) Recommending reduction, modification, suspension, or revocation of privileges. If suspension is recommended, the term and duration of the suspension and the conditions that must be met before the suspension is ended shall be stated.

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

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

9) Determining whether the action is taken for any of the reasons required to be reported pursuant to California Business and Professions Code §805.01.

10) Referring the Member to the Physicians Well-Being Committee for evaluation and follow--up as appropriate.

11) Taking other actions deemed appropriate under the circumstances.

I. Subsequent Action. If corrective action or termination of the investigative process is recommended by the MEC, that recommendation shall be transmitted to the Governing Body. The Governing Body may affirm, reject, or modify the action. The Governing Body shall give great weight to the MEC's recommendation and initiate further action only if the failure to act is contrary to the weight of the evidence that is before it, and then only after it has consulted with the MEC and the MEC still has not acted. The decision shall become final if the Governing Body affirms it. Failure of the Governing Body to take any action within sixty (60) days may require address through the Dispute Mediation Committee process.

If the MEC recommends an action that is grounds for a hearing under Article VIII, the President of the Medical Staff shall advise the Chief Medical Officer. The procedure to be followed shall be as provided in this Article VII, or in Article VIII, if applicable, of these Bylaws.

J. Summary Restriction or Suspension

1) **Criteria for Initiation.** Whenever a Practitioner's conduct is such that a failure to take action may result in imminent danger to the health of any individual, the President of the Medical Staff or the Chairman of the Department in which the Practitioner holds privileges, or the Governing Body, (or its designee), subject to the conditions set forth in subsection7.8.J, may summarily restrict or suspend the Medical Staff and APP Staff membership and/or privileges of such Member. Unless otherwise stated, such summary restriction or suspension ("summary action") shall become effective immediately upon imposition, and the person or body responsible shall promptly give written notice to the Governing Body, the President of the Medical Staff, the MEC, the Chief Medical Officer, and the Medical Center Director. The summary restriction may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein.

   Unless otherwise indicated by the terms of the summary action, the Member's patients shall be promptly assigned to another Member by the Department Chairman or by the President of the Medical Staff considering, where feasible, the wishes of the patient and the affected Member in the choice of a substitute Member.

2) **Written Notice.** The affected Member shall be promptly provided with written notice of such suspension. The initial written notice shall generally describe the reasons for the action. This initial written notice shall not substitute for, but is in addition to, the notice required under Article VIII, Paragraph 8.3.1 (which applies in all cases unless the MEC

immediately terminates the summary suspension). The notice under Article VIII, Paragraph 8.3.1 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.

3) **MEC Action.** As soon as reasonably possible under all circumstances after such summary restriction or suspension has been imposed, a meeting of the MEC, or a subcommittee appointed by the President of the Medical Staff shall be convened to review and consider the action. Upon request, the Member may attend and make a statement concerning the issues under investigation, on such terms and conditions as the MEC may impose, although in no event shall any meeting of the MEC, with or without the Member, constitute a "hearing" within the meaning of Article VIII, nor shall any procedural rules apply. The MEC may modify, continue, or terminate the summary restriction or suspension, but in any event, it shall furnish the Member with notice of its decision within two (2) working days of the meeting.

4) **Procedural Rights.** Unless the MEC promptly terminates the summary restriction or suspension, it shall remain in effect during the pendency of the corrective action, hearing, and appeal process, and the Member shall be entitled to the procedural rights afforded by Article VIII.

5) **Initiation by Governing Body.** If the President of the Medical Staff, members of the MEC, and the Chairman of the Department (or designee) in which the Member holds privileges are not available to summarily restrict or suspend the Member's membership and/or privileges, the Governing Body (or designee) may immediately suspend a Member's privileges if a failure to suspend those privileges is likely to result in an imminent danger to the health of any person, provided that the Governing Body (or designee) made reasonable attempts to contact the President of the Medical Staff, members of the MEC, and the Chairman of the Department (or designee) before the suspension. Such a suspension is subject to ratification by the MEC. If the MEC does not ratify such a summary suspension within two (2) working days, excluding weekends and holidays, the summary suspension shall terminate automatically. If the MEC does ratify the summary suspension, all other provisions under Section 7.6 of these Bylaws shall apply. In this event, the date of imposition of the summary suspension shall be considered the date of ratification by the MEC for purposes of compliance with notice and hearing requirements.

7.9. Automatic Suspension and Limitation

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

A. License

1) **Revocation and Suspension.** Whenever a Practitioner's license or other legal credential authorizing practice in this state is revoked or suspended, Medical Staff or APP Staff membership and privileges shall be likewise revoked or suspended on the date such action becomes effective.

2) **Restriction.** Whenever a Practitioner's license or other legal credential authorizing practice in this state is limited or restricted by the applicable licensing or certifying

authority, any privileges which the Member has been granted at the Medical Center 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.

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

4) **Expiration.** When a Practitioner's license or other legal credential authorizing practice in California expires; the Practitioner's privileges shall be suspended at 12:01 a.m. on the day following the expiration. The suspension shall be lifted when verification of a current valid California license or other legal credential is obtained.

B. Controlled Substances. Whenever a Practitioner's Drug Enforcement Administration Certificate is revoked, limited, or suspended, or when it expires 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.

Whenever a Practitioner's DEA certificate is subject to probation, the Practitioner'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.

C. Medical Records. Practitioners are required to complete medical records within the time described in the Rules and Regulations. A suspension in the form of withdrawal of admitting and other related privileges, until all delinquent medical records are completed, shall be imposed by the President, or designee, after notice of delinquency for failure to complete medical records within fourteen (14) days of discharge. For the purpose of this section, "related privileges," means scheduling elective surgery, assisting in surgery, consulting on Medical Center cases, and providing professional services within the Medical Center for future patients. Bona fide vacation or illness may constitute an excuse subject to approval by the MEC. Members whose privileges have been suspended for delinquent records may admit patients only in life-threatening situations. The suspension shall continue until the medical records have been completed.

D. Professional Liability Insurance. Failure to maintain professional liability insurance, if any is required, shall be grounds for automatic suspension of a Practitioner's privileges, and if within ninety (90) days after written warning of the delinquency the Practitioner does not provide evidence of required professional liability insurance, and evidence of coverage in the interim, the Practitioner's membership shall be automatically terminated.

E. Failure to Pay Dues. For failure to pay dues, a Practitioner's Staff membership and privileges after written warning of delinquency, shall be automatically suspended and shall remain so suspended until the Practitioner pays the delinquent dues. A failure to pay such dues within sixty (60) days after the date the automatic suspension became effective shall be deemed to be a voluntary resignation of the Practitioner's Staff membership and privileges.

F. Failure to Provide Information or Satisfy Special Attendance Requirement. Failure of a Practitioner without good cause to provide information or appear when requested by a Medical Staff Committee as described in these Bylaws shall result in referral to the MEC for action, which may include automatic suspension of all privileges. The automatic suspension shall remain in

effect until the Practitioner has provided requested information and/or satisfied the special attendance requirement which has been made by the Medical Staff Committee.

G. Felony Conviction or Plea. A Practitioner who has been convicted of, or who has pleaded guilty or no contest to, a felony related directly to his/her professional practice, or patient relationships, or involving moral turpitude, within the past seven (7) years, shall not be entitled to apply for initial appointment to the Medical Staff. If a Member of the Medical Staff is convicted of, or pleads guilty or no contest to a felony directly related to his/her professional practice or patient relationships, or involving moral turpitude, the member's Medical Staff membership and privileges shall be automatically suspended pending review by the MEC. If the MEC confirms that the felony was directly related to the member's professional practice or patient relationships or involving moral turpitude, the member's staff membership and privileges shall terminate without right to a hearing. If the MEC determines the felony was not directly related to the member's professional practice or patient relationships, the Member shall be permitted to request reinstatement.

H. Exclusion from Governmental Program. Practitioner who is excluded as a provider from any governmental health care program (including but not limited to Medicare and Medi-Cal) may not apply for initial appointment to the Medical Staff. If a Member of the Medical Staff is excluded as a provider from such governmental program, the member's Medical Staff membership and privileges shall be automatically terminated without right to a hearing.

I. MEC Deliberation. Within one (1) week after action is taken as described above, the MEC 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.

ARTICLE VIII.
HEARING AND APPELLATE REVIEW PROCEDURE

8.1. Applications of this Article

A. Members to Whom the Article Applies. For purposes of this Article, the term "Member" refers to a Medical Staff Member and shall include a Medical Staff applicant, unless otherwise stated.

B. Process to Challenge Quasi-Legislative Measures. Any Member whose privileges, staff membership or practice opportunities are adversely affected by a quasi-legislative Bylaw, rule, regulation, policy or procedure adopted by the Medical Staff in accordance with these Bylaws may challenge the measure by providing written notice to the MEC setting forth all information, reasons and arguments supporting the challenge. Upon receipt of such a notice, the MEC shall conduct such review of the matter as it deems proper. Such review shall include an opportunity for the affected Member to in person address the MEC or, at the discretion of the MEC, an ad-hoc sub-committee.

C. Process to Challenge Adverse Actions Responsible Under Business and Professions Code Section 805. The notice, hearing, and appeal provisions available to a Member to contest an action or final recommended action which must be reported to the appropriate California Licensing Board under California Business and Professions Code Section 805 shall be governed by the provisions of this Article commencing with Section 8.2 below.

D. Process to Challenge Quasi-Judicial Actions NOT Responsible Under California Business and Professions Code Section 805. A Member who is adversely and significantly affected by a quasi-

judicial action or recommended action for which a review process is not otherwise provided in these Bylaws or in Medical Staff rules, regulations, or policies, and which is not reportable under California Business and Professions Code Section 805, may contest such actions or recommended actions by delivering a written request for review to the MEC. If the action or recommended action was made by the Governing Body, the Member may contest the matter by providing written request for review to the Governing Body. Any such request for review must be delivered within thirty (30) days from the Member's receipt of notice of the action or recommendation.

Upon receipt of such a request for review, the applicable body shall afford the Member such review rights as it may deem appropriate. Such review rights shall include notice of the reasons for the action or recommendation, a reasonable opportunity to respond, and resolution of the matter by an unbiased panel.

Examples of matters reviewable under this section include, without limitation, restriction of privileges for less than thirty (30) days in a twelve (12) month period, suspension of privileges for fourteen (14) days or less, and termination, denial, or restriction of privileges or membership rights for reasons other than medical disciplinary cause as defined in California Business and Professions Code Section 805.

E. Duty to Exhaust Internal Remedies. All Members and applicants are obligated to exhaust all remedies provided in this Article or elsewhere in Medical Staff Bylaws, Rules and Regulations or policies before initiating legal action. Any Member who fails to exhaust the remedies (including all hearing and appeal remedies) provided in these Bylaws before initiating legal action, shall be liable to pay the full costs, including legal fees, required to respond to such legal action.

8.2. Grounds for Hearing

Except as otherwise specified in these Bylaws, any one (1) or more of the following actions taken for a medical disciplinary cause or reason shall be deemed actual or potential adverse action and constitute grounds for hearing:

A. Denial of Medical Staff membership.

B. Denial of Medical Staff Reappointment.

C. Summary suspension of Medical Staff membership or privileges for greater than fourteen (14) days.

D. Involuntary termination of Medical Staff membership.

E. Denial of requested privileges.

F. Involuntary reduction or restriction of current privileges for thirty (30) days or more in any twelve (12) month period.

G. Termination of privileges.

H. Involuntary imposition of significant consultation or monitoring requirements (excluding monitoring incidental to provisional status).

I. Any other disciplinary action or recommendation that must be reported to the licensing board pursuant to California Business and Professions Code 805.01.

8.3. Request for Hearing

A. Notice. In all cases in which action has been taken or a recommendation made as set forth in Section 8.2, the President of the Medical Staff or designee on behalf of the MEC, shall give the Member prompt written notice of:

1) The recommendation or final proposed action and that such action, if adopted, shall be taken and reported to the appropriate California licensing Board or other relevant state agency and/or to the National Practitioner Data Bank if required.

2) The reasons for the proposed action including the acts or omissions with which the Member is charged.

3) The right to request a hearing pursuant to Section 8.3.2, and that such hearing must be requested within thirty (30) days.

4) A summary of the rights granted in the hearing pursuant to the Medical Staff Bylaws, including the right to request approval of representation by legal counsel.

If the hearing is based upon an adverse decision or recommendation of the Governing Body, the Governing Body or its designee shall fulfill the duties assigned to the MEC or the President of the Medical Staff when the MEC is the body whose decision prompted the hearing. This shall include, but not be limited to, preparing the notice of adverse action or recommended action and right to a hearing, scheduling the hearing, providing the notice of hearing and statement of charges, and designating the Judicial Review Committee, presenter and witnesses.

B. Request. The Member shall have thirty (30) days following receipt of notice of such action to request a hearing before a Judicial Review Committee. The request shall be in writing, addressed to the President of the Medical Staff. In the event the Member does not request a hearing within the time and in the manner described, the Member shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved. Such action shall become effective immediately subject to consideration by the Governing Body.

C. Time and Place for Hearing. Upon receipt of a request for hearing, the President of the Medical Staff shall deliver the request to the MEC, which shall schedule a hearing, and within thirty (30) days give notice to the Member of the time, place and date of the hearing. The MEC shall give notice by Certified Mail, Return Receipt Requested to the applicant or Member of the time and date of the hearing. The date of the commencement of the hearing shall be not less than thirty (30) days or more than sixty (60) days from the date of receipt of the request by the MEC for a hearing. However, when the request is received from a Member who is under summary suspension, the hearing shall be held as soon as the arrangements may reasonably be made, so long as the Member has at least thirty (30) days from the date of the notice to prepare for the hearing or waive this right.

D. Notice of Changes. As a part of, or together with, the notice of hearing, the MEC shall state in writing, the reasons for the adverse action taken or recommended, including the acts or omissions with which the Member is charged, a list of the charts in question, if applicable, and a list of witnesses (if any) expected to testify at the hearing on behalf of the MEC. Such list is subject to update.

E. The Hearing Officer. The MEC shall recommend a Hearing Officer to the Governing Body to preside at the hearing. The Governing Body (or its designee) shall provide written notice within

five (5) days to the MEC stating the reasons for any objections. The Hearing Officer shall be an attorney at law qualified to preside over a quasi-judicial hearing, but attorneys from a firm regularly utilized by the Medical Center, the Medical Staff, or the involved Medical Staff Member or applicant for membership, for legal advice regarding their affairs and activities shall not be eligible to serve as Hearing Officer. The Hearing Officer shall gain no direct financial benefit from the outcome and must not act as a prosecuting officer or as an advocate. The hearing officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The Hearing Officer shall be entitled to determine the order of or procedure for, presenting evidence and argument during the hearing, and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure, or the admissibility of evidence. If the Hearing Officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the Hearing Officer may take such discretionary action as seems warranted by the circumstances, including but not limited to, reducing the scope of examination and cross-examination and setting fair and reasonable time limits on either side's presentation of its case, in accordance with California law. Under extraordinary circumstances, the Hearing Officer may recommend termination of the hearing; however, the Hearing Officer may not unilaterally terminate the hearing and may only issue an order that would have the effect of terminating the hearing (a "termination order") at the direction of the Judicial Review Committee. The terminating order shall be in writing and shall include documentation of the reasons therefore. If a terminating order is against the MEC, the charges against the Member will be deemed to have been dismissed with prejudice.

Upon adjournment of the evidentiary portion of the hearing, the Hearing Officer shall meet with the members of the Judicial Review Committee to assist them with their review of the evidence and preparation of the report of their decision. Upon request from the Judicial Review Committee members, the Hearing Officer may remain during the Hearing Committee's full deliberations. During the deliberative process, the Hearing Officer may act as legal advisor to the Hearing Committee, but shall not be entitled to vote.

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

The Hearing Officer's authority shall include, but not be limited to, making rulings with respect to requests and objections pertaining to the production of documents, requests for continuances, designation and exchange of proposed evidence, evidentiary disputes, witness issues, including disputes regarding expert witnesses, and setting reasonable schedules for timing and/or completion of all matters related to the hearing.

F. Judicial Review Committee. When a hearing is requested, the MEC shall appoint a Judicial Review Committee which shall be composed of not less than three (3) Members of the Active Medical Staff who shall have not actively participated in the consideration of the matter involved at any previous level. Individuals involved shall not have an economic interest in and/or a conflict of interest with the subject of the peer review activity. Impartial peer review would also exclude

individuals with blood relationships, employer/employee relationships, or other potential conflicts that might prevent the individual from giving an impartial assessment, or give the appearance for the potential of bias for or against the subject of peer review. The Judicial Review Committee members shall gain no direct financial benefit from the outcome, and shall not have acted as accusers, investigators, fact finders, initial decision makers or otherwise have not actively participated in the consideration of the matter leading up to the recommendation or action. One (1) Member shall have the same licensure as the individual under investigation and, where feasible, a Member practicing in the same specialty as the individual shall be included. The President of the Medical Staff shall appoint a Chairman of the Judicial Review Committee. Knowledge of the matter shall not preclude a Member of the Active Medical Staff from serving as a Member of the Judicial Review Committee. In the event that it is not possible to appoint a fully qualified Judicial Review Committee from the Active Medical Staff, the Executive Committee may appoint qualified Members from any staff categories, or from qualified Practitioners who are not Members of the Medical Staff.

G. Failure to Appear. Failure without good cause of the Member to personally attend and proceed at such hearing shall be deemed to constitute voluntary acceptance of the recommendations or actions involved, which shall become final and effective immediately, subject to ratification by the Governing Body.

H. Postponements and Extensions. Postponements and extensions beyond the times set forth in these Bylaws may be permitted by the Judicial Review Committee or its Chairman acting upon its behalf on a showing of good cause or upon agreement of the parties. The MEC shall exercise ongoing oversight over the hearing to ensure the timely resolution of issues.

8.4. Prehearing Procedure

A. A Right of Inspection and Copying. The Member 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 Member has in his or her possession or under his or her control. The requests for discovery shall be fulfilled as soon as practicable. Failures to comply with reasonable discovery requests at least thirty (30) days prior to the hearing shall be good cause for a continuance of the hearing.

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

C. Ruling on Discovery Disputes

1) The Hearing Officer shall consider and rule upon any request for access to information and may impose any safeguards that the protection of the peer review process and justice requires. In so doing, the Hearing Officer shall consider:

    - Whether the information sought may be introduced to support or defend the charges

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

2) **Objections to Introduction of Evidence Previously not Produced for the Medical Staff.** The body whose decision prompted the hearing may object to the introduction of the evidence that was not previously provided during initial membership, application for 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 Member can prove he or she previously acted diligently and could not have submitted the information.

D. 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 (10) days prior to the hearing. A failure to comply with this rule is good cause for the Hearing Officer to grant a continuance. Repeated failures to comply shall be good cause for the Hearing Officer to preclude the introduction of any documents not provided to the other side in a timely manner.

E. Witness Lists. Not less than fifteen (15) days prior to the hearing, each party shall furnish to the other a written list of the names and addresses 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 (10) days prior to the hearing date at which the witness is to appear shall constitute good cause for a continuance.

F. Procedural Disputes. 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 timely. Objections to any pre-hearing decisions may be succinctly made at the hearing.

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 five (5) working days 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.

G. The Member shall be entitled to a reasonable opportunity to challenge the impartiality of any Judicial Review Committee members or the Hearing Officer. Challenges to the impartiality of any

Judicial Review Committee Member or the Hearing Officer shall be ruled on by the Hearing Officer.

8.5. Representation

The hearings provided for in these Bylaws are for the purpose of interprofessional resolution of matters bearing on professional conduct, professional competency, or character. The Member and the MEC shall not be represented by an attorney at the hearing unless the President of the Medical Staff, in consultation with the chairman of the Governing Body (or its designee), permits both sides to be represented by legal counsel. The Member shall be informed of his/her right to request representation by an attorney at the time of the notice of a right to request a hearing. In the absence of legal counsel, both the Member and the MEC shall be entitled to be represented by a California licensed practitioner who is not also an attorney at law.

Notwithstanding the foregoing and regardless of whether the Member elects to have attorney representation at the hearing, the parties shall have the right to consult with legal counsel to prepare for a hearing or an appellate review.

Any time attorneys will be allowed to represent the parties at a hearing, the Hearing Officer shall have the discretion to limit the attorneys' role to advising their clients rather than presenting the case.

8.6. Conduct of Hearing

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

B. Rights of Both Sides. At a hearing, both sides shall have the following rights:

1) To call and examine witnesses for relevant testimony.

2) To introduce relevant exhibits or other documents.

3) To cross-examine any witness on any matter relevant to the issues.

4) To impeach any witness and to rebut any evidence.

The Member not testifying on his/her own behalf, may be called and examined as if under cross-examination.

C. Admissibility of Evidence. The hearing shall not be conducted according to the strict rules of law relating to the examination of witnesses or presentation of evidence. Any relevant evidence shall be admitted by the presiding officer if it is the kind of evidence in which responsible persons are accustomed to relying upon the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Each party shall have the right to submit a memorandum of points and authorities, and the Judicial Review Committee may request such a memorandum to be filed following the close of the hearing. The Judicial Review Committee may interrogate the witnesses or call additional witnesses as deemed appropriate. Thus, every witness called by the Judicial Review Committee need not appear on previously shared witness lists, under these circumstances.

D. Burden of Proof. At the hearing, the MEC shall have the initial duty to present evidence for each case or issue in support of its action or recommendation. Thereafter the burden shall be on the Member to come forward with evidence on his/her behalf.

An applicant shall bear the burden of persuading the Judicial Review Committee by a preponderance of the evidence of the applicant's qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning the applicant's current qualifications for membership and privileges. An applicant shall not be permitted to introduce information requested by the Medical Staff but not previously produced unless the applicant establishes that the information could not have been produced earlier by the exercise of reasonable diligence.

Except as provided above for applicants, throughout the hearing the MEC shall bear the burden of persuading the Judicial Review Committee, by a preponderance of the evidence, that its action or recommendation is reasonable and warranted.

E. Adjournment and Conclusion. To the extent permitted by law, the Hearing Officer may adjourn the hearing and reconvene the same at the convenience of the participants without special notice. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. Thereafter, both the MEC and the Member may submit a written closing statement. To the extent permitted by law, the Judicial Review Committee shall thereupon, within the time specified in this Article VIII and outside of the presence of any other person, conduct its deliberations and render a decision and report.

F. 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.

G. 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/she shall not be permitted to participate in the deliberations or the decision unless and until he/she has read the entire transcript of the portion of the hearing from which he/she was absent. The final decision of the Judicial Review Committee must be sustained by a majority vote of the number of members appointed.

H. Decision of the Judicial Review Committee. Within thirty (30) days after final adjournment of the hearing (except that, in the event the Member is currently under suspension, this time shall be fifteen (15) days), the Judicial Review Committee shall render a written decision. A copy of the decision shall be forwarded to the Medical Center Director, the MEC, the Governing Body, and to the Member. 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. If the final proposed action adversely affects the privileges of a physician, dentist or oral and maxillofacial surgeon, clinical psychologist, or podiatrist for a period longer than thirty (30) days and is based on a question of competence or professional conduct, the decision shall state that the action, if adopted, shall be reported to the National Practitioner Data Bank and the Medical Board of California (or other appropriate Licensing Board). Both the Member 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 Governing Body review as described in these Bylaws.

8.7. The Appeal Process

The decision of the Judicial Review Committee shall be considered final, subject only to the right of appeal as provided for herein.

A. Time for Appeal. Within ten (10) days after receipt of the decision of the Judicial Review Committee, either the person who requested the hearing or the body whose decision prompted the hearing may request an appellate review by the Governing Body. Said request shall be in writing and delivered to the Chief Medical Officer and the President of the Medical Staff, and to the other party in the hearing, either in person or by Certified or Registered Mail. The written request for appeal shall include a description of the grounds for appeal and a clear and concise statement of the facts in support of the appeal. If appellate review is not requested within such period, both sides shall be deemed to have accepted the action involved, and the recommendation by the Judicial Review Committee shall thereupon become the final action of the Medical Staff. Such final recommendation shall be considered by the Governing Body, but shall not be binding on the Governing Body.

B. Grounds for Appeal. The grounds for appeal from the hearing shall be:

1) Substantial non-compliance with the procedures required by these Bylaws or applicable law which has created demonstrable prejudice.

2) The Judicial Review Committee decision was not supported by substantial evidence, based upon the hearing record.

3) The decision of the Judicial Review Committee was not supported by the findings.

C. Response to Appeal. In the event of any appeal to the Governing Body as set forth in the preceding section, the Governing Body shall, within sixty (60) days after receipt of such notice of appeal, schedule, and arrange for an appellate review. The Governing Body shall cause written notice of the time, place, and date of the appellate review to be given to each side. The date of appellate review shall not be less than thirty (30) days, or more than sixty (60) days, from the date of receipt by the Governing Body of the request for appellate review. When a request for appellate review is from a Member who is under summary suspension, the appellate review shall be held as soon as the arrangements may reasonably be made, not to exceed thirty (30) days from the date of receipt by the Governing Body of the request for appellate review. The time for appellate review may be extended by the Chairman of the Governing Body for good cause.

D. Nature of Appellate Review. The Governing Body may hear the appeal directly or it may, in its sole discretion, refer the matter to an individual designated "Hearing Officer" for such proceedings as the Governing Body may direct. The Hearing Officer may not be legal counsel to the Medical Center and must not act as a prosecuting officer, an advocate for the Medical Center, Governing Body, or any other body whose action prompted the proceeding. The Hearing Officer shall be an attorney at law admitted to practice in this State for at least ten (10) years, and shall possess any additional qualifications determined necessary by the Governing Body. The Hearing Officer may not be the attorney who represented either party at the initial hearing or the attorney who served as the Hearing Officer at the initial hearing.

E. Appellate Hearing Procedure. The appellate proceedings by either the Hearing Officer or the Governing Body shall be in the nature of an appellate review based upon the record of the original hearing before the Judicial Review Committee. Additional oral or written evidence may be accepted, subject to a foundational showing that such evidence could not have been made available to the Judicial Review Committee in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the Judicial Review Committee hearing. In the alternative, the Governing Body or Hearing Officer 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 present a written statement in support of their position on appeal. The Hearing Officer or Governing Body, at his/her/its sole discretion, may allow each party or representative to personally appear and make oral argument. 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. The hearing shall be conducted by designees of the Governing Body within the confines of a duly convened executive meeting of the Medical Staff in order to maintain full protection under Evidence Code 1157.

F. Action by a Hearing Officer. If the Governing Body has appointed a Hearing Officer, he/she shall prepare findings of fact and a proposed decision in such form that it may be adopted as the decision of the Governing Body. The findings of fact and the proposed decision shall be filed by the Hearing Officer with the Governing Body within fifteen (15) days after conclusion of the hearing.

G. Decision

1) Within thirty (30) days after the conclusion of any review proceedings hereinbefore provided for, the Governing Body shall render a final decision in writing. The Governing Body may affirm, modify, or reverse the decision or remand the matter for further review by the Judicial Review Committee. The Governing Body shall give great weight to the Judicial Review Committee recommendation, and shall not act arbitrarily or capriciously. The Governing Body may, however, exercise its independent judgment in determining whether a Member was afforded a fair hearing, whether the decision was reasonable and warranted, and whether any Bylaw, rule or policy relied upon by the Judicial Review Committee is unreasonable and unwarranted. If the Governing Body determines that the Member was not afforded a fair hearing in compliance with these Bylaws, the Governing Body shall remand the matter for further review.

2) The decision made or adopted by the Governing Body shall be in writing, specify the reasons for the action taken, and provide findings of fact and conclusions articulating the connection between the evidence produced at the hearing and the decision reached. The Governing Body shall direct the delivery of copies thereof to the Member and to the MEC in person or by Certified or Registered Mail, Return Receipt Requested. The final decision of the Governing Body following the appeal procedure set forth herein shall be effective immediately and shall not be subject to further review.

3) The decision shall include notice to the Member that any request for judicial review under California Code of Civil Procedure Section 1094.5 must be filed within ninety (90) days following the date upon which the decision becomes final.

4) If the matter is remanded to the Judicial Review Committee for further review and recommendation, the Committee shall promptly conduct its review and make its

recommendation to the Governing Body. This further review and the time required to report back shall not exceed thirty (30) days in duration except as the parties may otherwise agree or for good cause as jointly determined by the Governing Body and the Hearing Committee.

H. Right to One Hearing. Except in circumstances where a new hearing is ordered by the Governing Body or a court because of procedural irregularities or otherwise for reasons not the fault of the Member, no Member shall be entitled to more than one (1) evidentiary hearing and one (1) appellate review before the Governing Body on any matter which has already been the subject of action by either the MEC of the Medical Staff or the Governing Body or by both.

8.8. Waiting Period after Adverse Action

A. Effect of the Waiting Period. Except as otherwise allowed per the Bylaws, Members subject to waiting periods cannot reapply for Medical Staff membership or the privileges affected by the adverse action for at least twenty-four (24) months after the action became final. After the waiting period, the Member may reapply. The application will be processed like an initial application or request, plus the Member shall document that the basis for the adverse action no longer exists, that he/she has corrected any problems that prompted the adverse action, and/or he/she has complied with any specific training or other conditions that were imposed.

B. Who Is Affected? A waiting period shall apply to the following Members:

1) An applicant who has received a final adverse decision regarding membership; or withdrew his/her application or request for membership or privileges following an adverse recommendation by the MEC or the Governing Body.

2) A former Member who has received a final adverse decision resulting in termination of Medical Staff membership and/or privileges; or resigned from the Medical Staff or relinquished privileges while an investigation was pending or following the MEC or Governing Body issuing an adverse recommendation.

3) A Member who has received a final adverse decision resulting in termination or restriction of his/her privileges; or denial of his/her request for new privileges.

An action is considered adverse only if it is based on the type of occurrences which are grounds for a hearing as specified in Section 8.2. An action is not considered adverse if it is based upon reasons that are not based on medical disciplinary cause or reason, such as actions based on a failure to maintain a practice in the area (which can be cured by a move), to pay dues (which can be cured by paying dues), or to maintain professional liability insurance (which can be cured by obtaining the insurance).

C. Duration and Commencement Date of the Waiting Period

1) Ordinarily the duration of the waiting period shall be the longer of:

- Twenty-four (24) months.

- Completion of all judicial proceedings pertinent to the action served within two (2) years after completion of the Medical Center proceedings described in Bylaws. However, for Practitioners whose adverse action included a specified period or conditions of retraining or additional experience, the MEC may exercise its

discretion to allow earlier reapplication upon completion of the specified conditions. Similarly, the MEC may exercise its discretion, with approval of the Governing Body, to waive the twenty-four (24) month period in other circumstances where it reasonably appears, by objective measures that changed circumstances warrant earlier consideration of an application.

2) The waiting period commences on the latest date on which the application or request was withdrawn, a Member's resignation became effective, or upon final Governing Body action following completion or waiver of all Medical Staff and Medical Center hearings and appellate reviews.

8.9. Automatic Suspension or Limitation of Privileges

No hearing is required when a Practitioner's license or legal credential to practice has been revoked or suspended or has expired as set forth in the Bylaws. In other cases described in the Bylaws, the issues which may be considered at a hearing, if requested, shall not include evidence designed to show that the determination by the licensing or credentialing authority or the DEA was unwarranted, but only whether the Practitioner may continue to practice in the Medical Center with those limitations imposed.

8.10. National Practitioner Data Bank Reporting

The Medical Staff's authorized representative shall report an adverse action to the National Practitioner Data Bank only upon its adoption as final and only using the description set forth in the final action as adopted by the Governing Body. 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.

8.11. Report of Final Action

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

8.12. Closed Staff or Exclusive Use Departments and Medico-Administrative Officers

A. Closed Staff or Exclusive Use Clinical Services. The fair hearing rights of Article VIII do not apply to a Practitioner whose application for Medical Staff membership, Advanced Practice Professional Staff and privileges was denied on the basis the privileges are only granted pursuant to a closed staff or exclusive use policy.

B. Medico-Administrative Officer. The fair hearing rights of Article VIII do not apply to those persons serving the Medical Center in a medico-administrative capacity. Removal from office of such persons shall be governed by the terms of their individual contracts and agreements with the Medical Center. However, the hearing rights of the preceding sections of Article VIII shall apply to the extent that Medical Staff membership status or privileges, which are independent of the Member's contract, are also removed or suspended, unless the contract includes specific provision establishing alternative procedural rights applicable to such decisions.

ARTICLE IX.
OFFICERS

9.1. Officers of the Medical Staff

The Officers of the Medical Staff shall be:

A. President

B. President-Elect

C. Immediate Past President

D. Secretary-Treasurer

9.2. Qualifications of Officers

Officers must be members of the Active Medical Staff who have completed the Provisional Staff period at the time of nomination and election, and must remain Members of the Active Medical Staff in good standing during their term of office. Failure to maintain such status shall create a vacancy in the office involved.

9.3. Election of Officers

A. The President-Elect and Secretary-Treasurer shall be elected by the Medical Staff in the odd-numbered years. The President-Elect shall succeed to the position of President upon the President's completion of his/her two (2) year term. Only Members of the Active Medical Staff shall be eligible to vote for Officers. Should there be three (3) or more candidates and no candidate receives the majority of the votes, there shall be successive balloting such that the name of the candidate receiving the fewest votes is omitted from each successive slate until the majority vote is obtained by one (1) candidate.

B. Electoral votes, including all ballots previously submitted (electronic or paper), shall be tallied by the President of the Medical Staff, the President-Elect, the Medical Center Compliance Officer, and the Director of the Medical Staff Office, or their designees.

C. Nomination of Officers shall be as described under Nominating Committee, Section 10 of the Medical Staff Committee Manual.

9.4. The Term of Office

All Officers shall serve a two-year term from their election date and shall take office on the first day of the Medical Staff year following their election. Each Officer shall serve in each office until the end of that Officer’s term or until a successor is elected, unless the Officer shall sooner resign or be removed from office. At the end of the President’s term, the President-Elect shall automatically assume the office of President. No officer shall serve consecutive terms in the same position.

9.5. Vacancies of Office

Vacancies in office during the Medical Staff year, except for the Presidency, shall be filled by appointment by the MEC, such appointment being valid until the next regular election. If there is a vacancy in the office of the President, the President-Elect shall serve out the remaining term. If the President-Elect is unable to assume the Office of the President, a special election shall be held to elect a new President. The Nominating Committee shall be convened as soon as possible, and the election process shall take place

as set forth in Section 9.3, except for the requirement that the election take place in an odd numbered year, if applicable.

9.6. Removal of Elected Officer

A. If a Medical Staff Officer ceases to be a Member in good standing of the Medical Staff or loses his/her employment or contractual relationship with the Medical Center or with the entity contracting with the Medical Center, or suffers a long or significant limitation of privileges, that Member may be removed as noted in 9.6.2 below. In addition, any Officer may be removed from office for valid cause, including but not limited to gross neglect or misfeasance in office, or serious acts of moral turpitude.

B. Except as otherwise provided in these Bylaws, removal of a Medical Staff Officer may be initiated by the MEC or by a petition signed by at least 25% of the Members of the Medical Staff eligible to vote for officers. Removal shall be considered at a special meeting called for that purpose and shall require a 66% vote of the Medical Staff Members eligible to vote for Medical Staff Officers who actually cast votes. If the recall is conducted by mail ballot, the voting shall be by secret written mail ballot. The ballots shall be sent to each voting Memberat least fourteen (14) days before the voting date and shall be counted by the Secretary-Treasurer of the Medical Staff (except when that office is the subject of the balloting, in which case the President of the Medical Staff shall count the ballots). Two (2) other MEC members shall be present when the ballots are counted.

9.7. Duties of Officers

A. President. The President shall serve as Chief Administrative Officer of the Medical Staff to:

1) Act in coordination and cooperation with the Chief Medical Officer in all matters of mutual concern within the Medical Center.

2) Call, preside over, and be responsible for the agenda of all general meetings of the Medical Staff.

3) Serve as Chairman of the MEC and call, preside at, and be responsible for the agenda of all meetings thereof.

4) Enforce the Medical Staff Bylaws and Rules and Regulations, implement sanctions where indicated, and promote compliance with procedural safeguards where corrective action has been requested or initiated.

5) Appoint Committee chairmen and members to all standing and special Committees except the MEC and the Nominating Committee. Appoint Medical Staff representatives to Interdisciplinary and Liaison Committees, as required.

6) Represent the views, policies, needs, and grievances of the Medical Staff to the Governing Body.

7) Receive and interpret the policies of the Governing Body.

8) Speak for the Medical Staff in its external professional and public relations.

9) Serve as Chairman of the Nominating Committee.

10) Serve on the Joint Conference Committee.

11) Perform such other functions as may be assigned to the President by these Bylaws, or the MEC.

12) Consult with the Governing Body periodically on matters related to the quality of medical care provided to patients of the Medical Center, and represent the views and policies of the Medical Staff to the Governing Body.

B. President-Elect. In the absence of the President, the President-Elect shall assume all of the duties and authority of the President. The President-Elect shall be a member of the Executive Committee of the Medical Staff and the Joint Conference Committee and shall automatically succeed the President when the latter is unable to serve for any reason. The President-Elect serves as the Chairman of the Quality Management Committee and the Chairman of the Bylaws Committee, and shall perform such other duties as may be assigned.

C. Immediate Past President. The Immediate Past President shall be a member of the MEC and perform such duties as may be assigned by the President of the Medical Staff or delegated by these Bylaws, or by the MEC.

D. Secretary-Treasurer. The Secretary-Treasurer shall be a member of the MEC, and shall keep accurate and complete minutes of all Medical Staff meetings, attend to all appropriate correspondence on behalf of the Medical Staff, and perform such duties as ordinarily pertain to the office, or as may be assigned from time to time. The Secretary-Treasurer shall be responsible for monitoring all monies of the Medical Staff and shall keep accurate records of all income and expenses and report to the Executive Committee of the Medical Staff as needed.

9.8. Disclosure of Conflict of Interest

All nominees for election or membership to Medical Staff Offices (including those nominated by petition of the Medical Staff pursuant to Bylaws, Section 9.3.3 and Section 10 of the Medical Staff Committee manual) shall, at least twenty (20) days prior to the date of election or membership, disclose in writing to the MEC those personal, professional, or financial affiliations or relationships of which they are reasonably aware that could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff. Generally, a conflict of interest arises when there is a divergence between an individual's private interests and his/her professional obligations, such that an independent observer might reasonably question whether the individual's professional actions or decisions are determined by those private interests. A conflict of interest depends on the situation and not on the character of the individual. The fact that an individual practice in the same specialty as a Member who is being reviewed does not by itself create a conflict of interest. The evaluation of whether a conflict of interest exists shall be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. The MEC shall evaluate the significance of such disclosures and discuss any significant conflicts with the nominee. If a nominee with a significant conflict remains on the ballot, the nature of his or her conflict shall be disclosed in writing and circulated with the ballot.

A person nominated from the floor shall be asked to verbally disclose conflicts to those in attendance at the meeting, and the MEC or its representative shall have an opportunity to comment thereon, prior to the vote.

ARTICLE X.
CLINICAL DEPARTMENTS

10.1. Organization of Departments and Sections

The Medical Staff shall be divided into Clinical Departments, each of which is organized as a separate component of the Medical Staff. Each shall consist of at least 3 Members of the Active Staff and have a Chairman who has the authority, duties, and responsibilities described in the Bylaws. As appropriate, a Department may be further divided into Sections directly responsible to the Chairman of the Department in which they function.

The following are the Departments and Sections in this Medical Center. Additional Departments and Sections may be created on recommendation of the Chief Medical Officer with the approval of the MEC.

A. Department of Anesthesiology, Pain Rehabilitation, and Critical Care

1) Section of Clinical Anesthesiology
2) Section of Pain Management and Rehabilitation

B. Department of Behavioral Health

C. Department of Emergency Medicine

D. Department of Family Medicine

1) Section of General Family Medicine
2) Section of Geriatric Medicine

E. Department of Internal Medicine

1) Section of Cardiology
2) Section of Dermatology
3) Section of Endocrinology
4) Section of Gastroenterology
5) Section of General Internal Medicine
6) Section of Hematology/Oncology
7) Section of Infectious Disease
8) Section of Nephrology
9) Section of Neurology
10) Section of Pulmonary Disease/Critical Care Medicine
11) Section of Rheumatology

F. Department of Laboratory Medicine

G. Department of Women's Health Services

1) General Obstetrics and Gynecology
2) Section of Maternal-Fetal Medicine

H. Department of Orthopedic Surgery

1) Section of General Orthopedic Surgery
2) Section of Upper Extremity Surgery
3) Section of Musculoskeletal Trauma
4) Section of Podiatry
5) Section of Rehabilitation Medicine

I. Department of Pediatrics

1) Section of General Pediatrics
2) Section of Neonatology

J. Department of Medical Imaging

1) Section of Diagnostic Radiology
2) Section of Nuclear Medicine
3) Section of Radiation Therapy
4) Section of Teleradiology

K. Department of Surgery

1) Section of Burn Surgery
2) Section of Cardiothoracic Surgery
3) Section of General Surgery
4) Section of Neurological Surgery
5) Section of Ophthalmology
6) Section of Oral and Maxillofacial Surgery/General Dentistry
7) Section of Otolaryngology
8) Section of Plastic Surgery
9) Section of Urology

10.2. Assignment to Departments and Sections

Each Practitioner shall be assigned membership in at least one (1) Department, and to a Section, if commensurate with Staff category and current privileges, within such Department, but may also be granted privileges in other Departments or Sections consistent with privileges granted.

10.3. Qualifications, Selection, and Tenure of Department Chairman and Section Directors

A. Qualifications – Chairman and Vice Chairman. Each Department shall have a Chairman and a Vice-Chairman who shall be an applicant to or Member of the Active Staff and shall be qualified by licensure, training, experience, and demonstrated ability in at least one (1) of the clinical areas covered by the Department. Department Chairmen must be certified by an appropriate specialty board or must demonstrate comparable qualification. The Vice Chairman of each Department shall be appointed by the respective Department Chairman.

B. Selection. Each Chairman shall be appointed by the Medical Center Director and the Chief Medical Officer, and approved by the MEC and the Governing Body.

C. Removal. Each Chairman serves at the discretion of the Medical Center Director and the Chief Medical Officer. Removal of a Chairman may occur:

1) Upon recommendation of the Medical Center Director, with the advisement of the Chief Medical Officer, and with the concurrence of the MEC.

2) Upon recommendation of and a 2/3 affirmative vote by all Members of the appropriate Department who are entitled to vote, and with the concurrence of the MEC, the Medical Center Director, and the Chief Medical Officer.

3) Upon recommendation of the MEC, with the concurrence of the Medical Center Director and the Chief Medical Officer.

The simple removal of a Chairman from office, absent any other cause, shall not affect the Member's Medical Staff category or privileges unless the Department is one (1) that practices Exclusive Staffing (see Section 8.14). In the latter case the removed Chairman may retain his/her Medical Staff membership and privileges if the new Chairman elects to keep him/her in the Department. Any removal for cause that endangers Medical Staff membership or privileges shall trigger due process protections as outlined in these Bylaws.

D. Duties. Each Chairman shall have the following authority, duties, and responsibilities, and the Vice Chairman, in the absence of the Chairman, shall assume all of them and shall otherwise perform such duties as may be assigned:

1) Act as residing officer at Department meetings.

2) Report to the MEC, the President of the Medical Staff, the Chief Medical Officer, and the Governing Body regarding all professional and administrative activities within the Department.

3) Maintenance of quality control programs; generally monitor the quality of patient care and professional performance rendered by Practitioners with privileges in the Department through a planned and systematic process; oversee the effective conduct of the patient care, evaluation, and monitoring functions delegated to the Department by the MEC in coordination and integration with organization-wide quality assessment and improvement activities.

4) Develop and implement Departmental programs and policies for retrospective patient care review, ongoing monitoring of quality of care, treatment and services, procedures that guide the provision of care, treatment, and services, credentials review and privilege

delineation, medical education, utilization review, and quality assessment and improvement.

5) Be a member of the MEC, and give guidance on the overall medical policies of the Medical Staff and Medical Center, and make specific recommendations and suggestions regarding the Department.

6) Transmit to the MEC the Department's recommendations concerning Practitioner membership and classification, reappointment, criteria for privileges, monitoring of specified services, and corrective action with respect to persons with privileges in the Department.

7) Endeavor to enforce the Medical Staff Bylaws, Rules and Regulations, and policies within the Department.

8) Implement within the Department appropriate actions taken by the MEC.

9) Participate in every phase of administration of the Department, including cooperation with the nursing service and the Medical Center 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, order sets, and techniques.

10) Assist in the preparation of such reports, including input into budgetary planning, pertaining to the Department as may be required by the MEC.

11) Recommend delineation of privileges for each Member of the Department.

12) Be accountable for all clinical and administrative activities including research in the Department.

13) Oversee the orientation and continuing education of all persons in the Department.

14) Integrate the Department or service into primary functions of the Medical Center, and coordinate inter-Departmental and intra-Departmental activities.

15) Perform such other duties commensurate with the office as may from time to time be reasonably requested by the President of the Medical Staff or the MEC.

16) Assess and recommend to the Governing Body off-site sources for needed patient care, treatment, and services not provided by the Department or the Medical Center.

17) Recommend space and other resources needed by Department.

E. Qualifications – Section Director. Each Section Director shall be a Member of or an Applicant to the Active Medical Staff and shall be qualified by licensure, training, experience, and demonstrated ability in at least one (1) of the clinical areas covered by the Department. Each Section Director shall be board certified or shall demonstrate that he/she has attained comparable competence through education and experience.

F. Selection. Each Section Director shall be appointed by the relevant Department Chairman and approved by the MEC.

G. Removal. The Section Director serves at the discretion of the relevant Department Chairman and the MEC. Removal of a Section Director may occur:

1) Upon recommendation of the Department Chairman with concurrence of the MEC.

2) Upon recommendation of and a 2/3 affirmative vote by the voting Members of the involved Section who are entitled to vote, with the concurrence of the MEC and the Department Chairman.

3) Upon recommendation of the MEC, with concurrence of the Medical Center Director and the Department Chairman.

The simple removal from office of a Section Director, absent any other cause, shall not affect the member's Medical Staff category or his/her privileges, unless the Section Director is party to a separate contract, outside of the Department proper, that states otherwise. Except in this latter case, the removed Section Director may retain his/her Medical Staff membership and privileges if the Chairman agrees to keep him/her in the relevant Department and/or Section. Any removal for cause that endangers Medical Staff membership or privileges shall trigger due process protections as outlined in these Bylaws.

H. Function of Section Directors. Each Section Director shall:

1) Act as presiding officer at Section meetings.

2) Assist in the development and implementation, in cooperation with the Department Chairman, of programs to carry out the quality review, evaluation, and monitoring functions assigned to the Section.

3) Evaluate the clinical work performed in the Section.

4) Conduct investigations and submit reports and recommendations to the Department Chairman regarding the privileges to be exercised within the Section by Members of, or applicants to, the Medical Staff.

5) Perform such other duties commensurate with the office as may from time to time be reasonably requested by the Department Chairman, the President of the Medical Staff, or the MEC.

10.4. Functions of the Department

The General Functions of each department shall include:

A. Conducting patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the Department. The Department shall routinely collect information about important aspects of patient care provided in the Department, periodically assess this information, and develop objective criteria for use in evaluating patient care. Patient care reviews shall include all clinical work performed under the jurisdiction of the Department, regardless of whether the Practitioner whose work is subject to such review is a Member of that Department.

B. Recommending to the MEC criteria for the granting of privileges and the performance of specified services within the Department.

C. Evaluating and making appropriate recommendations regarding the qualifications of applicants

seeking membership or reappointment and privileges within that Department.

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

E. Reviewing and evaluating Departmental adherence to:

1) Medical Staff policies and procedures.

2) Sound principles of clinical practice.

F. Coordinating patient care provided by the Department's Practitioners with nursing and ancillary patient care services.

G. Submitting written reports to the MEC concerning:

1) The Department's review and evaluation activities, actions taken thereon, and the results of such action.

2) Recommendations for maintaining and improving the quality of care provided in the Department and the Medical Center.

H. Consider patient care review findings and the results of the Department's other review and evaluation activities, as well as reports on other Department and staff functions.

I. Establishing such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring protocols.

J. Taking appropriate action when important problems in patient care and clinical performance or opportunities to improve care are identified.

K. Appointing such committees as may be necessary or appropriate to conduct Departmental functions.

L. Formulating recommendations for Departmental Rules and Regulations reasonably necessary for the proper discharge of its responsibilities, subject to the approval by the MEC and the Medical Staff.

10.5. Functions of Sections

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

10.6. Future Departments

The MEC and/or Chief Medical Officer shall periodically restudy the designation of the Departments and recommend to the Governing Body what action is desirable in creating, eliminating, or combining Departments for better organizational efficiency and improved patient care. Action shall be effective upon approval by the MEC, Medical Center Director, and Governing Body.

ARTICLE XI.
COMMITTEES

11.1. 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 MEC (pursuant to this Article) 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 MEC to perform specified tasks. Except for the Chairmen of the following Committees, the Chairman, Vice-Chairman, and members of all Committees shall be appointed by and may be removed by the President of the Medical Staff, with the approval of the MEC: Trauma; GMECA; OMEC, Bylaws; QMC; and Nominating. Medical Staff Committees shall be accountable to the MEC.

A. Terms of Committee Members. Unless otherwise specified, the term of a Committee member shall be two (2) years subject to unlimited renewal. The Member shall serve this period unless the Member resigns or is removed from the Committee.

B. Continuity. To the extent feasible, and except on peer review Committees, Committee memberships shall be staggered so that no more than 75% of the members are newly appointed.

C. Removal of Committee Members. If a member of a Committee ceases to be a Member in good standing of the Medical Staff, loses employment or contractual relationship with the Medical Center or with the entity contracting with the Medical Center, or 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 the President of the Medical Staff with the concurrence of the MEC.

D. Vacancies. Unless otherwise specified, vacancies on any Committee shall be filled in the same manner in which the original membership to the Committee was made. For vacancies of the Chairmen of Committees normally chaired by Medical Staff Members by virtue of office, the vacancy shall be filled by membership by the President of the Medical Staff, with the approval of the MEC.

E. Confidentiality. As a condition of serving on a Committee or attending a Departmental meeting and to the extent provided by law, each Memberagrees not to divulge any of the peer review proceedings, documents, or protected health information from the meeting outside of the legally protected Medical Staff review process. Failure to abide by the confidential nature of the Committee or meeting shall subject the Memberto immediate corrective action including the possibility of expulsion from the Medical Staff.

F. Committees. The Committees of the Medical Staff are:

1) Medical Executive Committee

    a) Credentials Committee

    b) Committee on Interdisciplinary Practice

    c) Continuing Medical Education Committee

    d) Physician Well-Being Committee

e) Graduate Medical Education Committee for ACGME (GMECA)

f) Osteopathic Medical Education Committee (OMEC)

g) Nominating Committee

h) Bylaws Committee

i) Utilization of Osteopathic Methods and Concepts Committee

j) Medical Ethics Committee

k) Quality Management Committee (QMC)

   i. Blood Use Committee

   ii. Infection Control Committee

   iii. Health Information/Utilization Management Committee

   iv. Oncology Committee

   v. Operative and Other Invasive Procedure Review Committee

   vi. Pharmacy and Therapeutics Committee

   vii. Trauma Committee

   viii. Specialty Care Committee

   ix. Stroke Committee

l) Dispute Mediation Committee

m) Peer Review Committee

n) Conflict Management Committee

o) Physician Assistant Post-Graduate Training Committee

11.2. The Medical Executive Committee

A. Composition. The MEC shall be a standing Committee consisting of Officers of the Medical Staff; Department Chairmen, the Director of Medical Education for AOA residency programs or his/her designee; the Designated Institutional Official or his/her designee; Chairmen of the Credentials Committee and Peer Review Committee; and two (2) "at-large" members. The President of the Medical Staff shall be Chairman of the MEC.

"At-large" members of the MEC shall be elected every two (2) years at the same time as the odd-numbered year Medical Staff Officer elections. Should there be three (3) or more candidates for the "At-large" spots, the two (2) candidates receiving the most votes in the first polling shall win the "At-large" positions. In the event of a tie involving three (3) or more candidates, those tied candidates shall enter a run-off election.

The Medical Center Director and the Chief Medical Officer shall be ex-officio members of the Committee without vote.

A Department Chairman who also serves as an Officer of the Medical Staff shall designate a Medical Staff Member from the Department to represent the Department on the MEC.

The Department Chairman of each clinical Department shall designate an alternate to attend the MEC meetings and to vote in his/her absence.

The President of the House Staff or his/her designee, who shall be a voting member, shall represent the House Staff on the MEC.

B. Duties. The duties of the MEC, as delegated by the Medical Staff, shall include, but not be limited to:

1) Accountable to the organized Medical Staff and acts on its behalf in the interval between Medical Staff meetings.

2) Subject to such limitations as may be imposed by these Bylaws.

3) Coordinate and implement the professional and organizational activities and policies of the Medical Staff including those related to the performance improvement program.

4) Make recommendations to the Governing Body regarding the MEC's authority to receive, review, and act upon reports and recommendations from the clinical Departments and Committees and other groups as applicable.

5) Implement policies of the Medical Staff not otherwise the responsibility of the Departments.

6) Serve as a liaison between the Medical Staff, the Chief Medical Officer and the Governing Body.

7) Recommend action to the Chief Medical Officer on matters of medical-administrative nature.

8) Participate in the development of Medical Staff and Medical Center policy, practices and planning such as emergency preparedness.

9) Ensure the Medical Staff's full participation in the institutional Performance Improvement program, including an evaluation of the medical care provided by Members and non-member contractors.

10) Ensure that the Medical Staff complies with the Medical Center's licensure and accreditation requirements, and remains informed of the accreditation status of the Medical Center.

11) Subject to Governing Body approval, adopt policies regarding: the structure of the Medical Staff; the mechanisms to review applications for Medical Staff membership; the delineation of individual privileges and the mechanisms to terminate Medical Staff membership; establishment of appropriate criteria for cross-specialty privileges; the conduct of fair hearings and the mechanisms to change the Bylaws; and other matters relevant to the operation of an organized Medical Staff.

12) Ensure the provision of the same level of patient care by all Practitioners with delineated privileges within and across Medical Staff Departments.

13) Promote ethical conduct and competent clinical performance on the part of all Medical Staff Members and APPs, including the initiation of and participation in Medical Staff corrective action or review measures when warranted.

14) Disburse revenue from fees or other fund-raising activities.

15) Report to the Medical Staff at regular meetings.

16) Review the process, qualifications, credentials, privileges, performance, professional competence, and character of applicants and staff members, review of and actions on reports of Medical Staff Committees, Departments, and other assigned activity groups, and make recommendations to the Governing Body regarding staff memberships, terminations, and reappointments, assignments to Departments, privileges, and corrective action.

17) Develop continuing education activities and programs for the Medical Staff.

18) Designate such Committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the Medical Staff Organization, and approve or reject memberships to those Committees by the President of the Medical Staff.

19) Develop and maintain methods for the protection and care of patients and others in the event of internal or external disasters.

20) Establish a mechanism for dispute resolution between Medical Staff Members (including limited license Practitioners) involving patient care.

21) Shall have the power to recommend the amount of annual dues or assessments, if any, for each category of Medical Staff membership, subject to the approval of the Medical Staff, and to determine the manner of expenditure of such funds received. Medical Staff funds, regardless of source (e.g., Medical Staff dues, etc.) shall be under the sole control of the Medical Staff.

22) Review and make recommendations to the Medical Center Director regarding quality of care issues related to exclusive contract arrangements for professional medical services. In addition, the MEC shall cooperate in providing relevant input to notice-and-comment proceedings or other mechanisms that may be implemented by Medical Center Administration in making exclusive contracting decisions.

23) Establish, as necessary, such ad-hoc Committees that shall fulfill particular functions for a limited time and shall report directly to the MEC.

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

    a) Initiating, developing, and adopting Medical Staff Bylaws, Rules and Regulations, Policies, and amendments thereto, subject to the approval of the Governing Body, which approval shall not be unreasonably withheld.

    b) Selecting and removing Medical Staff Officers.

c) Retention and representation by independent legal counsel at the expense of the Medical Staff.

d) Taking such action as appropriate to enforce these Bylaws regarding the prohibition against retaliation directed towards a member.

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

f) After having met and conferred in good faith to remedy any dispute under subsection(s) of this section, exercising its discretion as appropriate to resolve the dispute.

25) When there is a question about the ability of the Practitioner to perform privileges granted through the Medical Staff process, the MEC shall then request an evaluation of that Practitioner in accordance with these Bylaws.

26) The MEC shall evaluate the result of the Medical Staff performance improvement activities, and if these activities identify a problem, or that a Practitioner is functioning below the acceptable level of care, the MEC shall take action in accordance with these Bylaws. This action shall be documented in the minutes of the MEC meeting.

27) Assisting in obtaining and maintaining accreditation, including providing recommendations to the Medical Center on the selection of the accreditation organization and structure of the survey process. The Governing Body shall give great weight to the recommendation of the MEC.

28) Providing upon request of a Medical Staff Member a listing of all Medical Directorship positions in the Medical Center.

29) Participating in the interview and review of candidates for the position of Chief Medical Officer or Medical Center Director, and recommendation of approval or veto of any such candidate.

30) Via a majority vote of the MEC, requesting the termination of an individual in a Chief Medical Officer or Medical Director position. The Governing Body shall give great weight to the recommendation of the MEC. Prior to removing an individual from the administrative staff, the Medical Center Director shall meet and discuss the proposed action with the MEC.

31) Fulfilling such other duties as the Medical Staff has delegated to the MEC in these Bylaws.

32) By action of greater than 50% of the Active Medical Staff Members present who are entitled to vote, the Medical Staff may, at a regular or special meeting at which a quorum is achieved, remove and reassign a duty or duties delegated to the MEC for a stated period of time, for a reason identified and supported at that meeting.

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

34) Receiving and acting upon reports and recommendations from the Medical Staff, Departments, Sections, Committees and assigned activity groups.

35) Reviewing and approving the designation of the Medical Center's authorized representative for National Practitioner Data Bank purposes.

11.3. Meetings

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

11.4. Reports to the Medical Executive Committee

Each of the standing and special Committees shall provide scheduled reports to the MEC. The Chairman of each Committee is expected to attend the MEC meeting at which the Committee report is to be presented. If a Committee Chairman is unavailable, a designee shall present the report.

11.5. Removal of a Member

An MEC member can be removed from the Committee only if the Medical Staff acts to remove that member from the position held as an Officer or At Large member, in the same manner provided in Section 9.6 for the recall of Officers, or in the case of Department Chair, if the Department acts to remove the Memberfrom the Department Chairmanship as provided in Section 10.3.3.

11.6. Dispute Mediation Committee

All disputes between Medical Center Administration or the Governing Body and the Medical Staff ("Party" or "Parties" as applicable) relating to the Medical Staff's rights of self-governance as set forth in California Business and Professions Code Section 2282.5 ("Dispute") that have not been resolved by prior informal meetings and discussions may be addressed and mediated in accordance with the process described in this section. In the event either Party determines that a Dispute exists, such Party shall give written notice to the other Party, stating the nature of the Dispute. Within ten (10) business days following receipt of such notice, both Parties shall appoint representatives to the Committee as provided below or the noticed party shall notify the other party of its intent to decline mediation. Neither Party shall initiate any legal action related to the Dispute until the Committee has completed its efforts to mediate the Dispute or mediation has been declined. A failure to appoint representatives to the mediation Committee or to decline mediation within ten (10) days of notice may be deemed a declination of mediation.

A. Composition. The Dispute Mediation Committee, which shall be a subcommittee of the MEC, shall be comprised of three (3) Members appointed by the Governing Body, and three (3) Members appointed by the MEC. The six (6) Members shall appoint an outside professional mediator as the seventh member, and the mediator shall serve as Chairman of the Committee, but shall have no vote. The Parties shall cooperate to select the mediator from a list of candidates provided by a service such as JAMS (Judicial Arbitration and Mediation Service) or the American Arbitration Association. The cost of the mediator shall be divided equally between the Parties.

B. Duties. The Committee shall receive and promptly review the written request(s) for initiation of the Dispute mediation process. The Committee may request such assistance as it deems necessary to gather relevant information and consider the opposing viewpoints. The Committee then shall meet and confer in good faith to formulate a recommendation for mediation of the Dispute. The Committee's efforts shall continue for up to sixty (60) days. After that period, the mediator shall prepare a written report of the Committee's findings and recommendations and transmit it to the Parties if the Committee has reached consensus, or the Committee may ask the Parties for additional time to consider the Dispute. Both Parties must agree to any such extension of time. If

the Committee has not reached consensus, but chooses not to request additional time, the mediator shall submit a written report outlining any areas of agreement and the remaining issues, but shall not make any recommendations. Following receipt of the mediator's report, the Parties may adopt the Committee's recommendations, agree to some alternative resolution of the Dispute, or refer the Dispute back to the Committee with instructions for further mediation efforts. Unless requested by the Parties to continue its deliberations, the Committee shall dissolve thirty (30) days after the mediator has made his/her report to the Parties.

11.7. Joint Conference Committee

By Resolution 94-57, the Governing Body established a subcommittee known as the Joint Conference Committee whose purpose is to provide a systematic and effective means for communication between the Governing Body and the Medical Center's Administration and Medical Staff.

The Committee is responsible for providing periodic reports to the Governing Body regarding the quality of medical care provided at Arrowhead Regional Medical Center.

The Committee meets quarterly. The Committee is subject to the Ralph M. Brown Act (Government Code Sections 54950 et. seq.).

11.8. Conflict Management Process

Upon the receipt of a written petition signed by at least 25% of the Members of the Medical Staff in good standing who are entitled to vote, specifying issues in which there is disagreement between the petitioners and the Medical Staff leadership, the MEC shall provide written notice of the petition to all Medical Staff Members within ten (10) days. The notice shall include the exact wording of the petition.

A. Conflict Management Committee. A Conflict Management Committee shall be formed within fifteen (15) days of written notification of the petition to all Medical Staff Members. The Committee shall be composed of at least six (6) people, comprising of equal numbers of Members of the MEC and petitioners. A quorum shall consist of at least 50% of the Committee members from each side. The Chairman of the Committee shall alternate every other meeting between the MEC and the petitioners.

B. Duties. The Conflict Management Committee shall discuss and resolve conflicts between the Medical Staff and the MEC related to Medical Staff policy, practice, and planning. The Committee shall gather information concerning the dispute and shall meet and confer in good faith, as early as possible, to resolve such disputes. The Committee shall implement a process for dispute resolution as follows:

1) Identify the conflict.

2) Identify the stakeholders.

3) Receive statements, ask questions and gather information to better understand the conflict facts from the perspective of all stakeholders.

4) Prioritize issues.

5) Produce a written summary of what was accomplished during the conflict management session. The summary could include facts, definition or clarification of issues, agreement on options for resolution, agreement to meet again, and delineation of the barriers to reaching resolution. The summary shall be made available to all stakeholders, and

stakeholders shall have reasonable opportunity to respond to the summary in a timely fashion.

6) File a report of the outcome with the Medical Staff Office for review by Members of the Medical Staff. The report shall document:

   a) The use of the conflict management process.

   b) The recommendation of the Committee as to how the conflict should be managed.

7) Any decision by the Conflict Management Committee requires approval by 50% or more of both the petitioners and the representatives of the MEC.

8) The Conflict Management Committee shall submit recommendations to the MEC for ratification, which shall not be unreasonably withheld.

C. Medical Staff Meeting. If the Committee is not able to resolve the conflict within forty-five (45) days of written notice to Members of the Medical Staff, or if the MEC does not approve the recommendations from the Conflict Management Committee, action as defined below shall be taken at a regular or special meeting of the Medical Staff. Medical Staff Members shall receive:

1) A written summary of what was accomplished during the conflict management session.

2) Notice of the next regular or special meeting at which the issue is to be discussed and action is to be taken. The purpose of the meeting shall be to either override the MEC's rejection or to formulate and approve an alternative proposal. The change shall require an affirmative vote of greater than 50% of the Members voting.

11.9. Medical Staff Committee Manual

The Medical Staff shall adopt a Committee Manual, which describes Committees, their composition, and their responsibilities in order to implement the principles found within these Bylaws, subject to the approval of the Governing Body, which shall not be withheld unreasonably. The Committee Manual shall be reviewed at least every two (2) years and revised as needed. The Committee Manual shall be deemed an integral part of the Medical Staff Bylaws.

ARTICLE XII.
MEETINGS AND ATTENDANCE REQUIREMENTS

12.1. Medical Staff Meetings

A. Annual Meeting. There shall be an annual meeting of the Medical Staff on a date and time and in a place determined by the President of the Medical Staff. The President or his/her designee shall present or report on actions taken during the preceding year and on other matters of interest and importance to the staff. In the odd numbered years, the slate of candidates approved by the MEC shall be presented to the Members for action. Notice of this meeting shall be given to Members at least thirty (30) days prior to the meeting.

B. Special Medical Staff Meetings. The President may call a special meeting of the Medical Staff at any time. The President shall also call a special meeting upon receipt of a written request from 25% of the Members of Active Staff. A Member requesting the special meeting shall state the purpose of such meeting in writing. The MEC shall schedule the meeting within thirty (30) days

after receipt of such request. No later than ten (10) days prior to the meeting, notice shall be mailed or delivered to the Members of the Medical Staff, which includes the stated purpose of the meeting. No business shall be transacted at any special meeting except that stated on the notice calling the meeting.

C. Regular Department and Committee Meetings. Chairmen may establish the time for holding regular meetings, and shall meet regularly, at least quarterly, to review and discuss patient care activities and to fulfill other responsibilities. Chairmen shall make every reasonable effort to ensure that the meeting dates are disseminated to the Members with adequate notice.

D. Special Department Meetings. A special meeting of any Department or Committee may be called by, or at the request of, the Chairman thereof, the MEC, President of the Medical Staff, or by written request from 25% of the Department or Committees' current voting Members, but not fewer than three (3) Members. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

12.2. Quorum

A. Definition. The presence of 25% of the total membership of the Active Medical Staff at any regular or special meeting of the Medical Staff shall constitute a quorum. The presence of 25% of the eligible voting Members of a Committee or Department, or three (3) Members, whichever is greater, shall constitute a quorum.

B. Manner of Action. Except as otherwise stated, the action of a majority of the Members present and voting at a meeting, at which a quorum is present, shall be the action of the group. Action may be taken without a meeting if a majority of Members agree in writing. Valid action may be taken without a meeting if it is acknowledged in writing setting forth the action so taken, to be signed by more than 50% of the Members entitled to vote. The meeting Chairman shall refrain from voting except when necessary to break the tie.

Committee action may be conducted by telephone or email conference which shall be deemed to constitute a meeting for the matters discussed in that telephone or email conference. Valid action may be taken without a meeting, if it is acknowledged in writing setting forth the action so taken, to be signed by more than 50% of the Members entitled to vote.

C. Rights of Ex-Officio Members. Medical Staff Members serving as ex-officio Members of Committees are those who serve by virtue of their office or position. They shall have all rights and privileges of regular Members except as otherwise specified.

D. Voting. Unless otherwise specified in these Bylaws, Active Members of the Medical Staff may vote in Medical Staff meetings or elections, and in Committee meetings. Other members of Medical Staff Committees are entitled to vote on Committee matters, at the discretion of the Committee Chairman.

12.3. Minutes

Minutes of all meetings shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The Chairman or designee shall sign the minutes. A permanent file of the minutes of each meeting shall be maintained. At least quarterly summary reports shall be provided to the MEC or other designated entity.

12.4. Attendance Requirements

A. Annual Medical Staff Meeting. All Active or Provisional status Active Medical Staff Members are expected to attend the Annual Medical Staff meeting.

B. Committee and Department Meetings. An Active Medical Staff Member is expected to attend at least 50% of the Department, Section, and Committee meetings to which the Member is assigned. Failure to meet the attendance requirements may be grounds for removal from a Committee or for corrective action. Attendance via web conferencing, email or electronic means may be accepted, depending on the decision of the Committee or Department Chair.

C. At the discretion of the Chairman, when a Practitioner's practice or conduct is scheduled for discussion at a regular Department, Section, or Committee meeting, the Practitioner may be requested to attend. Notice shall be given at least seven (7) days before the meeting and shall include the time and place of the meeting and a general description of the issue involved. Failure of a Practitioner to appear at any meeting for which notice was given, unless excused by the MEC upon a showing of good cause, may be a basis for corrective action.

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

E. Absence from Meetings. Any Practitioner who is absent from any Medical Staff, Department, or Committee meeting shall provide to the Chairman the reason for such absence. An excused absence may be granted by the Chairman and noted in the Medical Staff, Department, or Committee minutes.

When an absence from a Medical Staff Committee meeting has been excused by the Chairman, the Practitioner may arrange for a proxy to attend the Committee meeting on his/her behalf. The excused Practitioner shall have fulfilled his/her attendance obligation and the proxy shall be given credit for attending the Committee meeting.

F. Proxy. At the discretion of the Chairman, the person authorized to act for the Practitioner who is excused shall have the same voting rights as described in 12.2.4.

G. Executive Session. Executive Session is a meeting of a Medical Staff Department, Committee, or of the Medical Staff as a whole which only voting Medical Staff Members may attend, unless others are expressly requested by the Department or Committee Chairman to attend. Executive Session may be called by the Chairman at the request of any Medical Staff Department or Committee member, and shall be called pursuant to a duly adopted motion. Executive Session may be called to discuss peer review issues, personnel issues, or any other sensitive issues requiring enhanced confidentiality.

H. Retaliation Prohibited. Neither the Medical Staff, its members, Committees, or Department heads, the Governing Body, or its Chief Administrative Officer, or any other employee or agent of the Medical Center or Medical Staff, may engage in any punitive of retaliatory action against any Member of the Medical Staff or APP Staff should that Member claim a right or privilege afforded by, or seeks implementation of any provision of, these Medical Staff Bylaws.

The Medical Staff recognizes and embraces that it is the public policy of the State of California that a physician and surgeon, or other medical Practitioner on the Medical Staff, be encouraged to advocate for medically appropriate health care for his/her patients. The right to advocate

includes, but is not limited to, the ability of a Practitioner to protest a decision, policy, or practice that the Practitioner, consistent with that degree of learning and skill ordinarily possessed by reputable Practitioners-practicing according to the applicable legal standard of care, reasonably believes impairs the Practitioner's ability to provide medically appropriate health care to his/her patients. No person or entity, including but not limited to Medical Staff Members and Medical Center employees, agents, directors or owners, shall retaliate against or penalize any Member for such advocacy, or prohibit, restrict, or in any way discourage such advocacy, nor shall any person or entity prohibit, restrict, or in any way discourage a Member from communicating to a patient information in furtherance of medically appropriate health care.

This section does not preclude corrective and/or disciplinary action as authorized by these Medical Staff Bylaws, including for disruptive or otherwise inappropriate protest or purported advocacy, for violation of confidentiality, or for improper access to or publication of protected health information (PHI).

ARTICLE XIII.
IMMUNITY FROM LIABILITY

13.1. Immunity from Liability

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

B. For Providing Information. Each representative of the Medical Staff and Medical Center and all third parties shall be immune, to the fullest extent provided by law, from liability to an applicant or Member for damages or other relief by reason of providing information to a representative of the Medical Staff or Medical Center concerning such person who is, or has been, an applicant to or Member of the staff or who did, or does, exercise privileges or provide services at the Medical Center.

13.2. Activities and Information Covered

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

A. Application for membership, reappointment or 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.

F. Queries and reports concerning the National Practitioner Data Bank, peer review organization, the Medical Board of California, and similar queries and reports, including but not limited to queries of other State Medical Boards and other licensing agencies.

13.3. Releases

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

13.4. Indemnification

Medical Staff Officers, Department Chairmen, Section Directors, Committee Chairmen, Committee members and its appointed representatives (e.g., expert witnesses lay committee members, hearing officers) who act in good faith for and on behalf of the Medical Staff and the Medical Center in discharging their professional review activities pursuant to these Bylaws, and consistent with state and federal law, shall be indemnified by the County of San Bernardino to the fullest extent permitted by law. All disputes relating to the application of this provision shall be referred to the Dispute Mediation Committee for resolution (see Section 11.6).

ARTICLE XIV.
CONFIDENTIALITY OF INFORMATION

14.1. Authorization and Conditions

By applying for or exercising Medical Staff membership within the Medical Center, an applicant:

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

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 Medical Center who would be immune from liability under Article XIII of these Bylaws.

D. Acknowledges that the provisions of Article XIII and this Article are express conditions to an application for Medical Staff membership, the continuation of such membership, and to the exercise of privileges at the Medical Center.

14.2. Confidentiality of Information

A. General. Records and proceedings of all Medical Staff Committees having the responsibility of evaluation and improvement of quality of care rendered in the Medical Center, 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 XI, and meetings of special or ad hoc Committees created by the MEC or by Departments, and including information regarding any Practitioner or applicant to this Medical Staff shall, to the fullest extent permitted by law, be confidential.

B. Breach of Confidentiality. As effective peer review and consideration of the qualifications of Medical Staff Members and Applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of Medical Staff Departments, Sections, or Committees, except in conjunction with other Medical Center,

professional society, or licensing authority, is outside appropriate standards of conduct for this Medical Staff, violates the Medical Staff Bylaws, and shall be deemed disruptive to the operations of the Medical Center. If it is determined that such a breach has occurred, the MEC may undertake such corrective action as it deems appropriate.

14.3. Patient Privacy

A. Commitment to Privacy Rule Compliance. The use and disclosure of health information is governed, in part, by the Standards for Privacy of Individually Identifiable Health Information pursuant to the Health Insurance Portability and Accountability Act of 1996 (the "Privacy Rule") and the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), as they may be amended from time to time. Members and Advanced Practice Professionals shall protect the privacy of patients' health information as required by the Privacy Rule, the HITECH Act, and applicable state law. Further, the Medical Staff is committed to complying with the Privacy Rule in a manner that reasonably minimizes disruption to quality patient care.

B. Organized Health Care Agreement. The Privacy Rule permits multiple covered entities that provide care in a clinically integrated care setting, such as a Medical Center setting, to declare themselves an Organized Health Care Arrangement ("OHCA"). OHCA status generally permits its health care practitioner participants to use and disclose health information for purposes of treatment, payment, and health care operations of the arrangement. Covered activities include peer review, credentialing, quality assurance, and utilization review. Consequently, OHCA status protects patient privacy while minimizing disruption to quality patient care. Accordingly, by applying for and exercising Medical Staff or APP Staff membership at the Medical Center, each Practitioner agrees to participate in the Medical Center's OHCA and, as OHCA Members, all applicants and Practitioners shall abide by the Medical Center's Privacy Policies and Procedures.

C. Joint Notice of Privacy Practices. The Privacy Rule requires a health care practitioner that is a Covered Entity (as defined in the Privacy Rule) to deliver a notice of privacy practices to a patient no later than the Practitioner's first date of service to the patient. Healthcare practitioners that participate in an OHCA may comply with this requirement by joint notice. The implementation of a joint notice streamlines compliance with the Privacy Rule. Accordingly, with respect to Protected Health Information (as defined in the Privacy Rule) created or received by an applicant or Practitioner in connection with his/her provision of services in the Medical Center, by applying for and exercising Medical Staff or APP Staff membership at the Medical Center, each applicant and Practitioner agrees to abide by the terms of the joint Notice of Privacy Practices of the Medical Center and the Medical Staff then in effect.

D. Discipline. Whenever a Practitioner or applicant uses or discloses health information in a manner inconsistent with the Medical Center's Privacy Policies and Procedures or joint Notice of Privacy Practices, the Practitioner may be disciplined in accordance with these Bylaws.

ARTICLE XV.
MEDICAL STAFF RULES, MANUALS, AND POLICIES

15.1. Amendments to Medical Staff Rules and Regulations, Manuals, and Policies

A. In addition to the Medical Staff Bylaws, there are Medical Staff rules and regulations, manuals, and policies that govern the activities of Practitioners at the Medical Center. The Bylaws and these associated documents are referred to collectively as the Medical Staff Documents. These Medical Staff rules and regulations, manuals, and policies shall be considered an integral part of the

Medical Staff Bylaws and shall be amended in accordance with this section. The process to amend the Medical Staff Bylaws is described in Article XVI.

B. Amendments to a manual or the rules and regulations may be made by a majority vote of the MEC, provided notice of any proposed amendments to these documents has been provided to Active Staff Members at least twenty-one (21) days prior to a final vote by the MEC. Any Active Staff Member may submit written comments on the proposed amendments to the MEC during the twenty-one (21) day notice period. All comments received will be reviewed by the MEC prior to final vote on any amendments.

C. Policies of the Medical Staff may be adopted and amended by a majority vote of the MEC and become effective following Board approval. No prior notice is required.

D. Amendments to a manual, the rules and regulations, or Medical Staff Policy may also be proposed by a petition signed by at least one-third (1/3) of Active Staff Members. Written notice of any such proposed petition amendment to these documents must be provided to the MEC. If the MEC agrees with the proposed petition amendments, they will be acted on accordingly. If the MEC disagrees with the proposed petition amendment, the Medical Staff Officers will meet with three (3) Members of the petitioner group to try and resolve the disagreement. If agreement cannot be reached through informal meetings, the President of the Medical Staff will initiate the Conflict Management Process as described in Section 11.8.

E. The MEC and the Board will have the power to provisionally adopt urgent amendments to rules and regulations and manuals, that are needed in order to comply with a law or regulation, without providing prior notice of the proposed amendments to the Active Medical Staff. Notice of provisionally adopted amendments will be provided to Active Staff Members as soon as possible. Active Staff Members will have thirty (30) Days to review and provide comments on the provisional amendments to the MEC. If no conflict between the Active Staff Members and the MEC is identified, the provisional amendments will stand. If there is conflict regarding the provisional amendments, the process for resolving conflicts set forth in Section 11.8 will be implemented.

F. Adoption of and changes to Medical Staff manuals, the rules and regulations, and policies will become effective when approved by the MEC and the Board or by successful Active Staff petition/vote sent directly to the Board following the Medical Staff Conflict Management Process, as described in Section 11.8.

G. Notice of amendments to Medical Staff Documents are to be made available to Practitioners in a timely and effective manner following Board approval.

15.2. Management of Conflicts Between Medical Staff Documents

A. Any identified conflict between Medical Staff Documents must be resolved by the MEC as soon as reasonably possible.

B. While awaiting permanent resolution of any conflicts, the following order of precedence will be followed:

1) Bylaws

2) Rules and Regulations

3) Committee Manual

4) Medical Staff Policies

15.3. Department Rules and Regulations

A Department may propose rules and regulations applicable to that Department provided such rules and regulations are not in conflict with any existing Medical Staff Documents. Department rules and regulations shall become effective following approval at a Departmental meeting and upon approval by the MEC and Board.

15.4. Scope of Medical Staff Documents and Amendment Exclusivity

Neither the Medical Staff nor the Governing Body shall unilaterally amend any Medical Staff Document, as defined in Section 15.1(a). Applicants and Members of the Medical and APP Staff shall be governed by all applicable provisions of the Medical Staff Documents. The mechanisms described in these Bylaws shall be the sole methods for the initiation, adoption, amendment, or repeal of Medical Staff Documents.

15.5. Medical Staff Representation by Legal Counsel

Upon the authorization of the Medical Staff, or of the MEC acting on its behalf, the Medical Staff may retain and be represented by independent legal counsel who, to the extent practicable, shall not be employed by a law firm representing the Medical Center. The Medical Staff shall enter into a written engagement letter with the individual or law firm selected to be independent legal counsel affirming that the Medical Staff, not the Medical Center, is the counsel's client, that the Counsel represents solely the interests of the Medical Staff, and that the attorney-client privilege of confidentiality applicable to all communications between the counsel and the Medical Staff is held solely by the Medical Staff, regardless of whether the Medical Staff or a third party pays the counsel's fees. In the event the counsel is paid for by a third party, the counsel shall also provide a written assurance to the Medical Staff that there will be no interference by the third party with the counsel's independence of professional judgment or with the attorney-client relationship, as required by State Bar of California Rules of Professional Conduct, Rule 3-310.

ARTICLE XVI.
AMENDMENT OF THE MEDICAL STAFF BYLAWS

16.1. Procedure to Amend the Bylaws

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

1) The MEC, with the recommendation of the Bylaws Committee, or on its own motion, may recommend amendment of the Bylaws to the voting Members of the Active Staff.

2) By a written petition signed by at least one-third (1/3) of the Active Staff Members requesting the MEC initiate a proposal to amend the Bylaws. Such petition shall identify exact language to be added, changed, or deleted. If the MEC agrees with the proposed change, it may recommend the change as provided in subsection 16.1.A.1, above. If the MEC does not agree with the proposed change, the MEC shall meet with proponents of the proposed change to discuss and attempt to resolve the disagreement. If the disagreement has not been resolved within sixty (60) days from the date the proposal was delivered to the MEC, the President of the Medical Staff shall initiate the Medical Staff Conflict Management Process as described in Section 11.8.

B. Action by the Active Staff

1) The MEC will email proposed Bylaw amendments to the voting Active Staff Members along with an electronic ballot. In addition to the proposed amendments, each voting Member will be emailed a copy of any existing Bylaw language that will be modified or deleted. The ballot and associated materials will be sent to the Member's personal email address as listed with the Medical Staff office. To be counted, electronic ballots must be completed and returned to the Medical Staff office within twenty (20) days of the date the email was sent.

2) At least 25% of eligible Active Staff Members must submit a ballot to achieve a quorum in a Bylaws amendment vote. Provided a 25% quorum is reached, to be adopted, a proposed amendment of the Bylaws must be approved by more than 50% of the Active Staff Members submitting an electronic ballot vote as part of that quorum.

C. Approval by the Governing Body. Upon approval by the Active Staff as provided above, the proposed Bylaws change shall be submitted to the Governing Body for approval. The Governing Body shall give great weight to the Active Staff's proposed change. Within sixty (60) days receipt of the proposed Bylaws by the Governing Body, the Governing Body shall take action. The Governing Body may not unreasonably withhold its approval from the Active Staff's recommended change. If the Governing Body takes no action or votes to disapprove any part of the recommended change, the matter may be referred to the Dispute Mediation Committee for mediation, as provided in Section 11.6. The Bylaws become effective only upon Governing Body approval.

D. Exclusivity and Review. The Medical Staff Bylaws and the Governing Body Bylaws shall be consistent. Similarly, the Medical Staff manuals, rules and regulations, and policies shall be consistent with the Medical Staff Bylaws. Neither the Medical Staff nor the Governing Body may unilaterally amend the Bylaws or other Medical Staff Documents. The mechanisms described herein shall be the sole methods for the initiation, adoption, amendment, or repeal of the Medical Staff Bylaws.

The Medical Staff Bylaws shall be reviewed as necessary, but at least every two (2) years, by the Bylaws Committee, which shall report to the MEC.

16.2. Technical and Editorial Amendments

The MEC shall have the power to adopt such amendments to the Bylaws and other Medical Staff Documents as are, in its judgment, technical modifications, clarifications, reorganization or renumbering of the Bylaws, or amendments made necessary because of punctuation, spelling, or other errors of grammar or expression or inaccurate cross-references. Such amendments shall be effective immediately and shall be permanent if not disapproved by the Governing Body. The action to amend may be taken by motion and acted upon in the same manner as any other motion before the MEC. After MEC approval, such amendments shall be submitted to the Governing Body for its approval.

16.3. Effect of the Bylaws

Upon adoption and approval as provided in Section 16.1, and in consideration of the mutual promises and agreements contained in these Bylaws, the Governing Body and the Medical Staff, intending to be legally bound, agree that these Bylaws shall constitute part of the contractual relationship existing between the Medical Center and the Medical Staff Members, both individually and collectively.

No Medical Staff governing document, or no Governing Body Bylaws or other Medical Center governing document, shall include any provision purporting to allow unilateral amendment of the Medical Staff Bylaws or other Medical Staff governing document.

Medical Center Bylaws, policies, rules, or other Medical Center requirements that conflict with Medical Staff Bylaws provisions, rules, regulations, manuals, and/or policies and procedures, shall not be given effect and shall not be applied to the Medical Staff or its individual Members. Any disputes shall be resolved through the Dispute Mediation Committee as described in Section 11.6., or Conflict Management Process as described in Section 11.8.

16.4. Affiliations

Affiliations between the Medical Center and other Medical Centers, health care systems or other entities shall not, in and of themselves, affect these Bylaws.

16.5. 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 genders wherever either term is used.