



**St. Jude Medical Center**  
**Medical Staff Bylaws**

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2012

## ST. JUDE MEDICAL CENTER

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## COMMONLY USED TERMS AND ABBREVIATIONS

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**ABMS** – American Board of Medical Specialties

**APAHP** – Advance Practice Allied Health Professional

**CEO** – Chief Executive Officer

**CMA** – California Medical Association

**MEC** – Medical Executive Committee

**OMSS** – Organized Medical Staff Section, either within the CMA or AMA

## PREAMBLE

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**WHEREAS**, St. Jude Medical Center is a non-profit corporation organized under the laws of the State of California; and its purpose is to operate a general hospital providing patient care, education and research; and

**WHEREAS**, these Bylaws are adopted in order to provide for the organization of the Medical Staff of St. Jude Medical Center, and to provide a framework for self-government in order to permit the Medical Staff to discharge its responsibilities in matters involving the quality of medical care, and to govern the orderly resolution of those purposes. These Bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Board of Trustees, and relations with applicants to, and members of, the Medical Staff.

**WHEREAS**, it is recognized that the Medical Staff is accountable for the quality of medical care in the hospital and must accept and discharge this responsibility, subject to the authority of the hospital Board of Trustees, and that the cooperative efforts of the Medical Staff, the Chief Executive Officer and Board of Trustees are necessary to fulfill the hospital's obligations to its patients; and

**WHEREAS**, only duly qualified physicians, dentists, podiatrists and clinical psychologists are eligible for Medical Staff membership, privileges and prerogatives; and

**THEREFORE**, the physicians, dentists, podiatrists, clinical psychologists practicing in this hospital hereby organize themselves into a Medical Staff in conformity with these Bylaws.

## PHYSICIAN VALUES

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The Medical Staff of St. Jude Medical Center supports the four core values of Dignity, Excellence, Service and Justice of St. Jude Medical Center and the St. Joseph Healthcare System by the adoption of this statement of values for each physician member of the Medical Staff.

### **Care for the Whole Person**

Physicians ensure the spiritual, emotional, familial, and social dimensions of sickness and healing are met through their own efforts and/or through the resources and skills of other members of the health care team.

Physicians ensure the continuity of care for their patients.

Sickness and healing are important events that affect all dimensions of a person's life and lives of those they touch.

The critical personal and interpersonal dimensions of care are as important as modern clinical and treatment modalities.

### **Life and death**

Life is sacred.

Physicians courageously defend life, especially for the old, disabled and the vulnerable.

During the dying process physicians provide personal support, and ensure human dignity and optimal quality of life for their patients.

### **Decision Making**

Patients depend on the skill, information, and advice of physicians to make appropriate decisions.

Decisions about patient care involve both clinical expertise and the personal values of the patient and family members.

Informed and competent patients are the primary decision-makers in their own cases.

## **PHYSICIAN VALUES - Continued**

### **Communication**

The quality of patient care will be achieved in direct proportion to the clear, respectful, effective communication between physician, patient, family, and health care professional.

Patients and families need to receive timely and comprehensible information to enable them to make informed decisions.

Physicians communicate with other team members as professional peers who are serving the same goals.

Patient preferences concerning life support should not be presumed but explicitly requested. When patients predictably lose competence, there is an urgency to discuss this issue in a timely way.

Physicians provide access to information about Advance Healthcare Directives when appropriate.

### **Physicians, Nurses, and the Health Care Team**

Physicians, nurses, and other health care team members have a unique and privileged relationship with patients and their families, and their presence and professional expertise is of great importance in the care of patients.

Physicians regarding the care of their patients actively solicit the input of nurses and other health care professionals.

Physicians extend the same respect to nurses and other health care professionals that they themselves expect to receive.

## ARTICLE I PURPOSES AND TERMS

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### 1.1 PURPOSES OF THE BYLAWS

These bylaws are adopted in order to provide for the organization of the medical staff of St Jude Medical Center and to provide a framework for self-government in order to permit the medical staff to discharge its responsibilities in matters involving the quality of medical care, and to govern the orderly resolution of those purposes. These bylaws provide the professional and legal structure for medical staff operations, organized medical staff relations with the Board of Trustees, and relations with applicants to and members of the medical staff. The organized medical staff both enforces and complies with these medical staff bylaws.

These bylaws recognize that the organized medical staff has the authority to establish and maintain patient care standards, including full participation in the development of hospital-wide policy involving the oversight of care, treatment, and services provided by members and others in the hospital. The medical staff is also responsible for and involved with all aspects of delivery of health care within the hospital including, but not limited to, the treatment and services delivered by practitioners credentialed and 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 hospital depends on the mutual accountability, interdependence, and responsibility of the medical staff and the Board of Trustees for the proper performance of their respective obligations.

### 1.2 DEFINITIONS

- 1.2-1 CHIEF EXECUTIVE OFFICER means the person appointed by the Board of Trustees to serve in an administrative capacity.
- 1.2-2 AUTHORIZED REPRESENTATIVE or HOSPITAL'S AUTHORIZED REPRESENTATIVE means the individual designated by the hospital and approved by the Medical Executive Committee to provide information to and request information from the National Practitioner Data Bank according to the terms of these Bylaws.
- 1.2-3 BOARD OF TRUSTEES means the governing body of the hospital.



- 1.2-4 CHIEF OF STAFF means the chief officer of the medical staff elected by members of the medical staff.
- 1.2-5 CLINICAL PRIVILEGES or PRIVILEGES means the permission granted to medical staff members to provide patient care and include unrestricted access to those hospital resources (including equipment, facilities and hospital personnel) which are necessary to effectively exercise those privileges.
- 1.2-6 HOSPITAL means St. Jude Medical Center Fullerton, California.
- 1.2-7 IN GOOD STANDING means a member is currently not under suspension or serving with any limitation of voting or other prerogatives imposed by operation of the bylaws, rules and regulations or policy of the medical staff.
- 1.2-8 INVESTIGATION means a process specifically instigated by the Medical Executive Committee to determine the validity, if any, to a concern or complaint raised against a member of the medical staff, and does not include activity of the committee on physician well being.
- 1.2-9 MEDICAL EXECUTIVE COMMITTEE means the executive committee of the medical staff which shall constitute the governing body of the medical staff as described in these bylaws.
- 1.2-10 MEDICAL STAFF or STAFF means those physicians (MD or DO or their equivalent as defined in Section 2.2-2(a)), dentists, podiatrists and clinical psychologists who have been granted recognition as members of the medical staff pursuant to the terms of these bylaws.
- 1.2-11 MEDICAL STAFF YEAR means the period from January 1 to December 31.
- 1.2-12 MEMBER means, unless otherwise expressly limited, any physician (MD or DO or their equivalent as defined in Section 2.2-2(a)), dentist, podiatrist and clinical psychologist holding a current license to practice within the scope of that license who is a member of the medical staff.

- 1.2-13 PHYSICIAN means an individual with an MD or DO degree or the equivalent degree (i.e., foreign) as recognized by the Medical Board of California (MBC) or the Board of Osteopathic Examiners (BOE), who is licensed by either the MBC or the BOE.
- 1.2-14 PRACTITIONER means an individual licensed to practice one of the professions eligible for membership in the medical staff.
- 1.2-15 NAME of this organization is the Medical Staff of St. Jude Medical Center.

## ARTICLE II MEMBERSHIP

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### 2.1 NATURE OF MEMBERSHIP

No physician, dentist, podiatrist, clinical psychologist including those in a medical administrative position by virtue of a contract with the hospital, shall admit or provide medical or health-related services to patients in the hospital unless the physician is a member of the medical staff or has been granted temporary privileges in accordance with the procedures set forth in these bylaws. Medical staff membership shall confer only such clinical privileges and prerogatives as have been granted in accordance with these bylaws.

### 2.2 QUALIFICATIONS FOR MEMBERSHIP

Membership and privileges shall be granted, revoked or otherwise restricted or modified based only on the professional training and experience criteria as set forth in these bylaws.

#### 2.2-1 GENERAL QUALIFICATIONS

Only physicians, dentists, podiatrists, clinical psychologists shall be deemed to possess basic qualifications for membership in the medical staff, except for the Emeritus and retired staff categories in which case these criteria shall only apply as deemed individually applicable by the medical staff, and who

- (a) document their (1) current licensure, (2) adequate experience, education, and training, (3) current professional competence, (4) good judgment, and (5) current adequate physical and mental health status, so as to demonstrate to the satisfaction of the medical staff that they are professionally and ethically competent and that patients treated by them can reasonably expect to receive quality medical care, and (6) are certified or are progressing towards certification as defined further below.
- (b) are determined (1) to adhere to the ethics of their respective professions, (2) to be able to work cooperatively with others so as not to adversely affect patient care or hospital operations, (3) to keep as confidential, as required by law, all information or records received in

the physician-patient relationship, (4) to be willing to participate in and properly discharge those responsibilities determined by the medical staff, and (5) to be willing to keep confidential and discuss only within established Medical Staff Committees the proceedings of such medical staff activities related to Quality Assurance and Peer Review activities;

- (c) maintain in force professional liability insurance in not less than the minimum amounts, if any, as from time to time may be jointly determined by the Board of Trustees and Medical Executive Committee.
- (d) Maintain board certification, as follows:
  1. "Specialty board," as used in this section, means a national specialty board of, or recognized by, the American Board of Medical Specialties, the American Osteopathic Association, the American Board of Podiatric Surgery, or the American Board of Dentistry.
  2. A practitioner applying for appointment or reappointment to the Medical Staff and/or applying for new clinical privileges must, at the time of application, be certified by the specialty board pertaining to the practitioner's clinical privileges. Notwithstanding this requirement, a practitioner who completed his or her training program less than five years prior to his or her application for appointment or reappointment may be granted membership and privileges; however, such practitioner must become board certified within five (5) years from the practitioner's completion of his or her training program. Failure to become board certified in the time allowed shall render the practitioner ineligible for reappointment. The requirement for Board Certification does not apply to licensed clinical psychologists or to practitioners applying for membership without clinical privileges.
  3. Except otherwise provided below, all Medical Staff members are required to maintain board certification throughout their membership on the Medical Staff. Therefore, Medical Staff members must obtain recertification from the specialty board pertaining to the practitioner's clinical privileges if recertification is required in order to maintain board certification. A practitioner whose Medical Staff membership and privileges are terminated for failing to maintain board certification is not entitled to the hearing and appeal rights in these Bylaws.

4. The Medical Executive Committee, subject only to the approval of the governing body, may extend the time periods specified in this board certification section in extraordinary circumstances and for demonstrated good cause that occur in the 18-month period prior to the board certification deadline. In no event shall the Medical Executive Committee extend the time periods by more than 12 months. The Medical Executive Committee's decision that the extraordinary circumstances exception does not apply is not subject to the hearing and appeal rights in these Bylaws
5. If a current medical staff member fails the re-certification examination, he may request an extension of his membership and privileges for a time period not to exceed two months after the next recertification examination is offered. Included in the medical staff member's request for an extension must be a copy of the letter from the board which notified him of the results of the examination and the date of the next re-certification examination. The medical staff member must take the next scheduled examination and forward the results of the examination to the Medical Executive Committee prior to consideration of his reappointment. If the medical staff member does not become re-certified at this second attempt, the members medical staff membership and privileges may be terminated without hearing. Medical staff members who do not take the re-certification examination prior to the expiration of their appointment may not request an extension of his membership and privileges according to this paragraph, but may request an extension for extraordinary circumstances, as detailed above.
6. Medical Staff members who have maintained continuous Medical Staff membership since 2000, and who are ineligible to apply for board certification by the specialty board pertaining to the practitioner's clinical privileges, may be considered for renewal of medical staff membership if they can document sufficient training, experience, and competence, and otherwise meet the requirements of medical staff membership. This exception does not apply to Medical Staff members who are eligible to take the board certification examination(s), but have not obtained board certification.

## 2.2-2 PARTICULAR QUALIFICATIONS

- (a) Physicians. An applicant for physician membership in the medical staff, except for the Emeritus staff, must hold an MD or DO degree or their equivalent and a valid and unsuspended certificate to practice medicine issued by the Medical Board of California or the Board of Osteopathic Examiners of the State of California. For the purpose of this section, “or their equivalent” shall mean any degree (i.e., foreign) recognized by the Medical Board of California or the Board of Osteopathic Examiners. Such applicant must hold a valid and unsuspended DEA Certificate as appropriate to their specialty of practice in the hospital.
  
- (b) Limited License Practitioners.
  - 1. Dentists. An applicant for dental membership in the medical staff, except for the Emeritus staff, must hold a DDS or equivalent degree and a valid and unsuspended certificate to practice dentistry issued by the Board of Dental Examiners of California.
  
  - 2. Podiatrists. An applicant for podiatric membership on the medical staff, except for the Emeritus staff, must hold a DPM degree and a valid and unsuspended certificate to practice podiatry issued by the California Board of Podiatric Medicine.
  
  - 3. Clinical Psychologists. An applicant for clinical psychologist membership on the medical staff, except for the Emeritus staff, must hold a Ph.D. or Psy.D. degree in Psychology from an education institution accredited by a regional accreditation board. The applicant must have not less than two years clinical 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, and hold a valid and unsuspended certificate to practice clinical psychology issued by the Board of Psychology.

## 2.3 EFFECT OF OTHER AFFILIATIONS

No person shall be entitled to membership in the medical staff merely because that person holds a certain degree, is licensed to practice in this or in any other state, is a member of any professional organization, is certified by any clinical board, or because

such person had, or presently has, staff membership or privileges at another health care facility. Medical staff membership or clinical privileges shall not be conditioned or determined on the basis of an individual's participation or non-participation in a particular medical group, surgery center or other outpatient service facility, IPA, PPO, PHO, hospital-sponsored foundation, or other organization or in contracts with a third party which contracts with this hospital. Medical staff membership or clinical privileges shall not be revoked, denied, or otherwise infringed based on the member's professional or business interests. Neither the existence of an actual or potential conflict of interest, nor the disclosure thereof, shall affect a member's medical staff membership or clinical privileges.

## **2.4 NONDISCRIMINATION**

No aspect of medical staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, national origin, physical or mental impairment, or sexual orientation that does not pose a threat to the quality of patient care.

## **2.5 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP**

Except for the Emeritus Staff, the ongoing responsibilities of each member of the medical staff include:

- (a) providing patients with the quality of care meeting the professional standards of the medical staff of this hospital;
- (b) abiding by the Professional Code of Conduct;
- (c) abiding by the medical staff bylaws, medical staff rules and regulations, and medical staff and hospital policies that are related to the quality of care provided to patients in the hospital. Any question raised as to whether any hospital policy meets this standard shall be resolved by the Medical Executive Committee;
- (d) discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the member by virtue of medical staff membership, including committee assignments;
- (e) preparing and completing in timely fashion medical records for all the patients to whom the member provides care in the hospital;

- (f) abiding by the lawful ethical principles of the member's professional association;
- (g) aiding in any medical staff approved educational programs for medical staff physicians and dentists, nurses and other personnel;
- (h) working cooperatively with members, nurses, hospital administration and others so as not to adversely affect patient care;
- (i) making appropriate arrangements for coverage of that member's patients as determined by the medical staff;
- (j) refusing to engage in improper inducements for patient referral;
- (k) participating in continuing education programs as determined by the medical staff;
- (l) serving as a proctor or other peer reviewer, and otherwise participating in medical staff peer review as reasonably requested;
- (m) participating in such emergency service coverage or consultation panels as may be determined by the medical staff;
- (n) discharging such other staff obligations as may be lawfully established from time to time by the medical staff or Medical Executive Committee; and
- (o) providing information to and/or testifying on behalf of the medical staff or an accused practitioner regarding any matter under an investigation pursuant to paragraph 7.1-3, and those which are the subject of a hearing pursuant to Article VIII.
- (p) reporting to the Chief of Staff or designee in writing any extended illness, disability, or absence which will prevent him or her from participating in Hospital practice and/or Medical Staff business within 14 days of learning about such extended illness, disability, or absence;
- (q) reporting to the Chief of Staff or designee in writing within 14 days in the event of any formal action taken by government authorities to exclude the Member from participating in Medicare, Medicaid, or any other federal health care program as a sanction for unlawful conduct;



- (r) Notifying the medical staff, within fourteen (14) days of any changes in status regarding medical staff membership at other facilities, regardless of the nature of the change;
- (s) Providing written notice within ten (10) days to the Chief of Staff in the event member receives notice of any of the following events: the expiration, restriction, suspension, or revocation of the Member's license or DEA certification or the imposition of conditions of probation; any expiration, restriction, suspension, or revocation in the Member's policy of professional liability insurance; the taking against the Member of any final action for which a report is required to be filed under the Federal Health Care Quality Improvement Act and/or California Business and Professions Code Section 805 as such laws may be amended and/or replaced from time to time; the filing against the Member of any indictment alleging any criminal conduct or any fraud and/or abuse under the Medicare or Medi-Cal programs; the suspension or revocation of the Member's certification to participate in the Medicare or Medi-Cal programs; the entry of any judgment against the Member or settlement in any professional liability action; and any impairment of the Member's physical or mental health that adversely affects the Member's ability to provide quality patient care. A Medical Staff member who has been convicted of a felony which has a relationship to the member's qualifications, duties, or ethical conduct, shall immediately notify and disclose same to the Chief of Staff. Whether a felony has a relationship to the member's qualifications shall be determined by the Medical Executive Committee which will also determine action; and
- (t) Assist the hospital in fulfilling its governmental imposed uncompensated or partially compensated patient care obligations within the areas of his/her professional competence and credentials.
- (u) Abide by the Ethical and Religious Directives for Catholic Health Care Services developed by United States Conference of Catholic Bishops.

## ARTICLE III PROFESSIONAL CODE OF CONDUCT

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### 3.1 MEDICAL STAFF RESPONSIBILITIES

The purpose of the Professional Code of Conduct is to create a work environment that fosters respectful and constructive relationships among and between healthcare professionals, patients and staff.

All Medical Staff members and Advance Practice Allied Health professionals (“practitioners”) practicing in the Hospital will treat others with respect, courtesy, and dignity and conduct themselves in a professional and cooperative manner in accordance with the following principles:

- (a) Physicians ensure the continuity of care for their patients.
- (b) Patients and families need to receive timely and comprehensible information to enable them to make informed decisions.
- (c) Physicians communicate with other health care team members as professional peers.
- (d) Physicians extend the same respect to nurses and other health care professionals that they themselves expect to receive.
- (e) Personal conduct, whether verbal or physical, that negatively affects or that potentially may negatively affect patient care constitutes disruptive behavior. (This includes but is not limited to conduct that interferes with one’s ability to work with other members of the health care team. However, criticism that is offered in good faith with the aim of improving patient care should not be construed as disruptive behavior.)
- (f) The practitioner provides his/her patients with care at the generally recognized professional level of quality and efficiency established by the Medical Staff and Board of Trustees.
- (g) Physicians retain responsibility within their area of professional competence for the continuous care and supervision of each patient in the hospital for whom he/she is providing services, or arrange for a

suitable cross coverage to assure such care and supervision.

- (h) Practitioners abide by and comply with all requirements set forth in the Medical Staff Bylaws and Rules and Regulations and Policies.
- (i) Physicians prepare and complete in a timely fashion the medical and other required records for all patient they admit or in any way provides care to in the hospital.
- (j) Physicians abide by the lawful ethical principles of their profession.
- (k) When requesting a consultation, the attending physician is ultimately responsible for the coordination of the consultation.

### **3.2 COLLEGIAL & EDUCATIONAL INTERVENTION**

This Article outlines collegial and educational efforts that can be used by Medical Staff leaders to address inappropriate conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve the concerns that have been raised, and thus avoid the necessity of proceeding through the disciplinary process outlined in the Medical Staff Bylaws.

### **3.3 HARASSMENT PROHIBITED**

Harassment by a medical staff member against any individual (e.g., against another medical staff member, advance practice allied health staff, house staff, hospital employee or patient) on the basis of age race, creed, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex or sexual orientation shall not be tolerated.

“Verbal harassment” is derogatory comments or slurs with regard to one’s sex or sexual orientation, as well as unwelcome sexual advances.

“Physical harassment” is unwanted touching of another person, impeding or blocking movement or any physical interference with normal work, or movement when directed at an individual and originated specifically because of a person’s sex or sexual orientation.

“Sexual harassment” is unwelcome verbal or physical conduct of a sexual or gender-based nature which may include verbal harassment (such as epithets,

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

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

### **3.4 ORDERLY OPERATIONS**

In dealing with all incidents of inappropriate conduct, the protection of patients, employees, physicians, and others in the Hospital and the orderly operation of the Medical Staff and Hospital are paramount concerns. Complying with the law and providing an environment free from sexual harassment are also critical.

### **3.5 ACCEPTABLE CONDUCT**

Acceptable medical staff member conduct is not restricted by these bylaws and includes, but is not limited to:

- (a) advocacy on medical matters;
- (b) making recommendations or criticism intended to improve care;
- (c) exercising rights granted under the medical staff bylaws, rules and regulations, and policies;
- (d) fulfilling duties of medical staff membership or leadership;
- (e) engaging in legitimate business activities that may or may not compete with the hospital.

### **3.6 EXAMPLES OF INAPPROPRIATE CONDUCT**

To aid in both the education of Medical Staff members and the enforcement of this Article, examples of "inappropriate conduct" include, but are not limited to:

- (a) threatening or abusive language directed at patients, nurses, Hospital personnel, AHP, or other physicians (e.g., belittling, berating, and/or threatening another individual);
- (b) degrading or demeaning comments regarding patients, families, nurses, physicians, Hospital personnel, or the Hospital;
- (c) inappropriate physical contact with another individual that is threatening or intimidating;
- (d) inappropriate comments about the quality of care being provided by the Hospital, another Medical Staff member, or any other individual that are made outside of appropriate Medical Staff and/or administrative channels;
- (e) inappropriate medical record entries concerning the quality of care being provided by the Hospital or any other individual or are otherwise critical of the Hospital, other Medical Staff members or personnel;
- (f) refusal to abide by Medical Staff requirements as delineated in the Medical Staff Bylaws and Rules and Regulations (including, but not limited to, professional conduct, emergency call issues, response times, medical record keeping, and other patient care responsibilities, failure to participate on assigned committees, and an unwillingness to work cooperatively and harmoniously with other members of the Medical and Hospital Staffs);
- (g) inappropriate language, including but not limited to:
  - 1. Use of profanity or obscenity or similarly offensive language and vulgar or obscene expressions or gestures while in the Hospital and/or while speaking with nurses or other Hospital personnel, physicians or patients;
  - 2. Disrespectful language that impugns an individual's race, creed color,

national origin, religious, or political beliefs;

3. Criticism of an individual in front of patients or other healthcare professionals;

(h) Intimidating behaviors such as slamming or throwing of objects, verbal abuse, (yelling, shouting, etc), physical aggressiveness, and sexual harassment;

(i) Lack of timely and appropriate response to requests and concerns;

(j) Retaliation against anyone who has reported or assisted in investigating allegations of disruptive or inappropriate behavior; or

(k) carrying a gun or other weapon in the hospital.

### **3.7 GENERAL GUIDELINES AND PRINCIPLES**

Issues of employee conduct will be dealt with in accordance with the Hospital's Human Resources Policies. Issues of conduct by members of the Medical Staff will be addressed as outlined in the General Rules & Regulations of the Medical Staff

## ARTICLE IV CATEGORIES OF MEMBERSHIP

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### 4.1 CATEGORIES

The categories of the medical staff shall include the following: active, senior active, courtesy, community supportive, provisional, extended, emeritus, temporary, and administrative. Each time membership is granted or renewed, the member's staff category shall be determined.

Medical Staff members may request elevation or change of status in writing to the Medical Executive Committee. The Medical Executive Committee may, at its discretion, place applicants within the categories of the Medical Staff, which the Medical Staff deems appropriate.

### 4.2 ACTIVE STAFF

#### 4.2-1 QUALIFICATIONS

The active staff shall consist of members who:

- (a) meet the general qualifications for membership set forth in Section 2.2;
- (b) have offices or residences which, in the opinion of the Medical Executive Committee, are located closely enough to the hospital to provide appropriate continuity of quality care;
- (c) meet the point system as defined in the General Rules & Regulations;
- (d) except for good cause shown as determined by the medical staff, have satisfactorily completed their designated term in the provisional staff category.

#### 4.2-2 PREROGATIVES

Except as otherwise provided, the prerogatives of an active medical staff member shall be to:

- (a) admit patients and exercise such clinical privileges as are granted pursuant to Article VI;

- (b) attend and vote on medical staff bylaws and amendments and all other matters presented at general and special meetings of the medical staff and of the department and committees to which the member is duly appointed; and
- (c) if otherwise eligible, hold staff, clinical service, or department office and serve as a voting member of committees to which the member is duly appointed or elected by the medical staff or duly authorized representative thereof, so long as the activities required by the position fall within the member's scope of practice as authorized by law.
- (d) The active Medical Staff is the only category whose members are eligible for appointment to the senior active Medical Staff. An active staff member may request appointment to the senior active staff if he meets the eligibility requirements of that category of staff status and is otherwise in good standing with the Medical Staff.
- (e) Actively participate in Committee activities as requested by the Chief of Staff, Medical Executive Committee, or Chief Executive Officer. Regularly assist the hospital in fulfilling its obligations related to patient care within the areas of his/her professional competence, including but not limited to emergency service and back-up function as defined by the member's Department and/or Clinical Service rules and regulations, patient care review, peer review, utilization review, quality evaluation and related monitoring activities required of the Medical Staff, in supervising and proctoring initial appointees and AHPs, and in discharging such other functions as may be required from time to time.
- (f) Pay dues and any other assessments in the amounts designated by the Medical Executive Committee.

#### 4.2-3 TRANSFER OF ACTIVE STAFF MEMBER

After two consecutive years in which a member of the active staff fails to regularly care for patients in this hospital or be regularly involved in medical staff functions as determined by the medical staff, that member shall be automatically transferred to the appropriate category, if any, for which the member is qualified.



### **4.3 SENIOR ACTIVE STAFF**

#### **4.3.1 QUALIFICATIONS**

(a) Only members of the active staff may request appointment to the senior active staff and they must meet one of the requirements as noted below :

1. have been members of the staff for twenty-five (25) or more years (fifty percent of the twenty-five (25) years must have been as an active staff member);
2. have been members of the staff for fifteen or more years (fifty percent of the fifteen (15) years must have been as an active staff member) and are sixty years or older; or
3. have held the position of Past Chief of Staff.

(b) The senior active staff shall consist of practitioners who:

1. meet the general qualifications for membership set forth in Section 2.2;
2. have offices or residences which, in the opinion of the Medical Executive Committee, are located closely enough to the hospital to provide appropriate continuity of quality care;
3. meet the point system as defined in the General Rules & Regulations;
4. except for good cause shown as determined by the medical staff, have satisfactorily completed their designated term in the provisional staff category.

#### **4.3-2 PREROGATIVES**

Except as otherwise provided, the prerogatives of an active medical staff member shall be to:

- (a) admit patients and exercise such clinical privileges as are granted pursuant to Article VI;
- (b) attend and vote on medical staff bylaws and amendments and all other matters presented at general and special meetings of the medical staff

and of the department and committees to which the member is duly appointed;

- (c) hold staff, clinical service, or department office and serve as a voting member of committees to which the member is duly appointed or elected by the medical staff or duly authorized representative thereof, so long as the activities required by the position fall within the member's scope of practice as authorized by law;
- (d) actively participate in Committee activities as requested by the Chief of Staff, Medical Executive Committee, or Chief Executive Officer. Regularly assist the hospital in fulfilling its obligations related to patient care within the areas of his/her professional competence, including but not limited to, patient care review, peer review, utilization review, quality evaluation and related monitoring activities required of the Medical Staff, in supervising and proctoring initial appointees and AHPs, and in discharging such other functions as may be required from time to time; and
- (e) pay dues and CME assessments in amounts established by the Medical Executive Committee with the exception of past chiefs of staff who enjoy lifetime exemption from payment of dues and assessments.

#### **4.4 THE COURTESY MEDICAL STAFF**

##### **4.4-1 QUALIFICATIONS**

The courtesy medical staff shall consist of members who:

- (a) meet the general qualifications set forth in Section 2.2;
- (b) meet the point system as defined in the General Rules & Regulations;
- (c) do not regularly care for patients or are not regularly involved in medical staff functions as determined by the medical staff;
- (d) are members in good standing of the active or associate medical staff of another California licensed hospital, although exceptions to this requirement may be made by the Medical Executive Committee for good cause; and

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

#### 4.4-2 PREROGATIVES

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

- (a) admit patients to the hospital with the limitations of Section 4.4-1(b) and exercise such clinical privileges as are granted pursuant to Article VI; and
- (b) attend in a non-voting capacity meetings of the medical staff and the department of which the individual is a member, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment.
- (c) Courtesy staff members shall not be eligible to hold office in the medical staff.

#### 4.4-3 LIMITATION

Courtesy staff members who admit patients or regularly care for patients at the hospital shall, upon review of the Medical Executive Committee, be obligated to seek membership in the appropriate staff category.

### **4.5 COMMUNITY SUPPORTIVE STAFF**

#### 4.5-1 QUALIFICATIONS

The community supportive staff shall consist of members who:

- (a) meet the general qualifications for membership set forth in Section 2.2;
- (b) have offices or residences which, in the opinion of the Medical Executive Committee, are located closely enough to the hospital to provide appropriate continuity of quality care; consider the hospital to be one of their preferred hospitals for admission of their patients. However due to the type of their practice choose to have other physicians admit and care for their patients;

- (c) will not be required to undergo the Provisional Staff term nor proctoring requirements.

#### 4.5.2 PREROGATIVES

The prerogatives of a Community Supportive Medical Staff member shall be to:

- (a) Order outpatient diagnostic testing;
- (b) Visit their referred patients and review their charts and observe procedures, including surgeries with the specific consent of the patient and practitioner performing such procedures;
- (c) May not exercise any clinical privileges at the hospital including performing histories and physicals, assisting in surgery, ordering or prescribing any care or medications, or recording any information in the patient record.

#### 4.5.3 TRANSFER OF COMMUNITY SUPPORTIVE STAFF MEMBER

If a member request to be transferred to Active or Courtesy Staff status from Community Supportive Staff status, the Community Supportive Staff member must apply for Provisional Staff Member status and satisfy all requirements imposed on Provisional Members for advancement to Active or Courtesy Staff member status.

### 4.6 PROVISIONAL STAFF

#### 4.6-1 QUALIFICATIONS

- (a) The provisional staff shall consist of members who:
  - 1. meet the general medical staff membership qualifications set forth in Sections 2.2;
  - 2. immediately prior to their application and granting of membership were not members (or were no longer members) in good standing of this medical staff.
- (b) The Medical Staff membership and clinical privileges of practitioners who do not qualify for advancement to active or courtesy staff within

twelve (12) months following their initial appointment as provisional staff members shall be terminated. Such members may be entitled to the limited hearing and appeal as set forth in Article 8.2, consistent with the grounds for hearings identified in Article VIII. Practitioners who do not advance solely because of failure to complete medical records (7.4.3), failure to maintain malpractice insurance (7.4.5), failure to pay dues (7.4.4), shall be entitled to the grounds for a limited hearing and appeal as set forth in Article 8.2.

- (c) A practitioner may request elevation to a regular category of staff following a minimum of one (1) year on the provisional staff if all provisional requirements have been met.

#### 4.6-2 PREROGATIVES

The provisional staff member shall be entitled to:

- (a) admit or refer patients for admission and exercise such clinical privileges as are granted pursuant to Article VI; and
- (b) attend meetings of the medical staff and the department of which that person is a member, including open committee meetings and educational programs, and shall not have the right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment.

Provisional staff members shall not be eligible to hold office in the medical staff organization, but may serve on committees. A provisional member may not vote for Medical Staff officers, on Bylaws amendments, or on any matters presented at general and special meetings of the Medical Staff and of the Department and Clinical Service of which he is a member.

#### 4.6-3 OBSERVATION/FOCUSED PROFESSIONAL PRACTICE EVALUATION OF PROVISIONAL STAFF MEMBER

Each provisional staff member shall undergo a period of observation/focused professional practice evaluation (FPPE) by designated monitors as described in Section 6.3. The purpose of observation/FPPE shall be to evaluate the member's (1) proficiency in the exercise of clinical privileges initially granted and (2) overall eligibility for continued staff membership and advancement within staff categories. Observation/FPPE of provisional staff members shall

follow whatever frequency and format each department deems appropriate in order to adequately evaluate the provisional staff member including, but not limited to, concurrent or retrospective chart review, mandatory consultation, and/or direct observation. Appropriate records shall be maintained. The results of the observation/FPPE shall be communicated by the department chair to the credentials committee.

#### 4.6-4 ACTION AT CONCLUSION OF PROVISIONAL STAFF STATUS

- (a) If the provisional staff member has satisfactorily demonstrated the ability to exercise the clinical privileges initially granted and otherwise appears qualified for continued medical staff membership, the member shall be eligible for placement in the active or courtesy staff category, as appropriate, upon recommendation of the Medical Executive Committee; and
- (b) In all other cases, the appropriate department shall advise the credentials committee which shall make its report to the Medical Executive Committee which, in turn, shall make its recommendation to the Board of Trustees regarding a modification or termination of clinical privileges or termination of medical staff membership.

### **4.7 EXTENDED STAFF**

The Extended Staff shall consist of practitioners who provide services in a limited capacity for St. Jude Medical Center's Sponsored Care Programs.

#### 4.7.1 QUALIFICATIONS

Extended Staff members shall meet the following qualifications:

- (a) Previously been on the Active, Courtesy, Affiliate/Consulting or Emeritus Staff;
- (b) Meet the general medical staff membership qualifications set forth in Sections 2.2;
- (c) Current competency in the professional practice contemplated for St. Jude Medical Center's Sponsored Care Programs.

#### 4.7.2 PREROGATIVES

The prerogatives of Extended Staff members shall include:

- (a) exercise of clinical privileges granted pursuant to Article VI of these Bylaws (with proctoring as required for such respective privileges);
- (b) attendance at Hospital and/or Medical Staff meetings upon request regarding Sponsored Care Programs.

#### 4.7.3 LIMITATIONS

Extended Staff members shall not be eligible, as Extended Staff, to do the following:

- (a) admit patients as inpatients to the Hospital;
- (b) write orders for hospital inpatients;
- (c) vote on Medical staff matters;
- (d) qualify for point system

#### 4.7.4 RESPONSIBILITIES

Extended Staff members shall be responsible for carrying out the duties set forth in Section 2.5 within these Bylaws.

### **4.8 EMERITUS STAFF**

#### 4.8-1 QUALIFICATIONS

The Emeritus staff shall consist of physicians, dentists, podiatrists, clinical psychologists who do not actively practice at the hospital but are deemed deserving of membership by virtue of their outstanding reputation, noteworthy contributions to the health and medical sciences, or their previous long-standing service to the hospital, and who continue to exemplify high standards of professional and ethical conduct. In order to apply for Emeritus Staff a request in writing must be submitted to the Officer's for consideration.

#### 4.8-2 PREROGATIVES

Emeritus members are not eligible to admit patients to the hospital or to exercise clinical privileges in the hospital, or to vote or hold office in this medical staff organization, but they may serve on committees with or without vote at the discretion of the Medical Executive Committee. They may attend staff and department meetings, including open committee meetings and educational programs.

### **4.9 TEMPORARY STAFF**

#### 4.9-1 QUALIFICATIONS

The temporary staff shall consist of physicians, dentists, podiatrists, clinical psychologists who do not actively practice at the hospital but are important resource individuals for medical staff quality assessment and improvement activities. Such persons shall be qualified to perform the functions for which they are made temporary members of the staff.

#### 4.9-2 PREROGATIVES

Temporary medical staff members shall be entitled to attend all meetings of committees to which they have been appointed for the limited purpose of carrying out quality management functions. The quality management activities they may perform would include but not be limited to, reviewing medical charts, rendering opinions regarding the medical and/or surgical care provided in a given case and serving as member of a Judicial Review Committee. They shall have no privileges. They may not admit patients to the hospital or hold office in the medical staff organization. They may, however, serve on designated committees with or without vote at the discretion of the Medical Executive Committee. They may attend medical staff meetings outside of their committees, upon invitation.

### **4.10 ADMINISTRATIVE STAFF**

#### 4.10-1 QUALIFICATIONS

Administrative staff category membership shall be held by any physician who is not otherwise eligible for another staff category and who is retained by the hospital or medical staff solely to perform ongoing medical administrative activities.



The administrative staff shall consist of members who:

- (a) are charged with assisting the medical staff in carrying out medical-administrative functions, including but not limited to quality assessment and improvement and utilization review;
- (b) document their (1) current licensure, (2) adequate experience, education and training, (3) current professional competence, (4) good judgment, and (5) current physical and mental health status, so as to demonstrate to the satisfaction of the medical staff that they are professionally and ethically competent to exercise their duties.
- (c) are determined (1) to adhere to the ethics of their respective professions, (2) to be able to work cooperatively with others so as not to adversely affect their judgment in carrying out the quality assessment and improvement functions, and (3) to be willing to participate in and properly discharge those responsibilities determined by the medical staff.

#### 4.10-2 PREROGATIVES

The administrative staff shall be entitled to attend meetings of the medical staff and various departments, including open committee meetings and educational programs, but shall have no right to vote.

Administrative staff members shall not be eligible to hold office in the medical staff organization, admit patients or exercise clinical privileges within the medical center. They may request and be granted privileges to provide consultation and treatment in outpatient facilities associated with the medical center.

#### 4.11 LIMITATION OF PREROGATIVES

The prerogatives set forth under each membership category are general in nature and may be subject to limitation by special conditions attached to a particular membership, by other sections of these bylaws and by the medical staff rules and regulations.

#### 4.12 GENERAL EXCEPTIONS TO PREROGATIVES

Regardless of the category of membership in the medical staff, limited license members:

- (a) shall only have the right to vote on matters within the scope of their licensure. In the event of a dispute over voting rights, that issue shall be

determined by the chair of the meeting, subject to final decision by the Medical Executive Committee; and

- (b) shall exercise clinical privileges only within the scope of their licensure and as set forth in Section 6.4.

#### **4.13 MODIFICATION OF MEMBERSHIP**

On its own, upon recommendation of the credentials committee, or pursuant to a request by a member under Section 5.6-1(b), or upon direction of the Board of Trustees as set forth in Section 6.3-1 the Medical Executive Committee may recommend a change in the medical staff category of a member consistent with the requirements of the bylaws.

**ARTICLE V**  
**MEMBERSHIP AND MEMBERSHIP RENEWAL**  
**(Including Telemedicine Services)**

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**5.1 GENERAL**

- (a) Unless otherwise stated, for purposes of this article, all references to “applicant” and/or to “member” shall include practitioners who submit applications for initial and/or reappointment of membership and privileges.
  
- (b) Except as otherwise specified herein, no person (including persons engaged by the hospital in administratively responsible positions) shall exercise clinical privileges in the hospital unless and until that person applies for and obtains membership on the medical staff and is granted privileges as set forth in these bylaws, or, with respect to advance practice allied health practitioners, has been granted practice privileges or privileges under applicable medical staff policies. By applying to the medical staff for initial membership or renewal of membership (or, in the case of members of the emeritus staff, by accepting membership in that category), the applicant acknowledges responsibility to first review these bylaws and medical staff rules, regulations and policies, and agrees that throughout any period of membership that person will comply with the responsibilities of medical staff membership and with the bylaws, rules and regulations and policies of the medical staff as they exist and as they may be modified from time to time. Membership on the medical staff shall confer on the member only such clinical privileges as have been granted in accordance with these bylaws.

**5.2 BURDEN OF PRODUCING INFORMATION AND SUBMITTING A COMPLETE APPLICATION**

In order for the Medical Executive Committee to make a recommendation to the Board of Trustees concerning an applicant for appointment or reappointment to the Medical Staff or additional clinical privileges, the Medical Staff must have in its possession adequate information for a conscientious evaluation of the applicant’s training, experience and background as measured against the unique professional standards of this hospital. Accordingly, the Medical Staff will not take action on an application that is not “complete.” In connection with all applications for initial membership, membership

renewal, advancement, request for new privileges, or transfer, the applicant shall have the burden of producing information for an adequate evaluation of the applicant's qualifications and suitability for the clinical privileges and staff category requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information. The applicant's failure to sustain this burden shall be grounds for withdrawal or denial of the application or credentialing request.

- (a) To the extent consistent with law, this burden may include submission to a medical (including, but not limited to, blood, urine, or other biological tests) or psychological examination, at the applicant's expense, if deemed appropriate by the Medical Executive Committee. Any such examination shall be performed by a physician selected or approved by the Medical Executive Committee.
- (b) An application that is determined to be incomplete shall not qualify for a credentialing recommendation by any Medical Staff official or committee or by the Board of Trustees, regardless of any assessment or determination that may have been made as to its completeness at an earlier stage in the process. Should the applicant fail to make the application complete within the deadlines proscribed by the Medical Staff, its representatives, or committees, the application will be deemed withdrawn and the credentialing process will be terminated. Termination of the credentialing process under this provision shall not entitle the applicant to the hearing or appeal processes in Article VIII of these Bylaws. An application for appointment, reappointment or new clinical privileges shall be deemed "incomplete" unless and until the applicant:
  - 1. submits a written application, using the prescribed form, in which all of the requisite information is provided. All entries and attachments must be legible, understandable and substantively responsive on every point of inquiry;
  - 2. attends all required orientations;
  - 3. responds to all further requests from the Medical Staff, through its authorized representatives, for clarifying information or the submission of supplementary materials. This may include, but not necessarily be limited to, submission to a medical or psychiatric evaluation, at the applicant's expense. Except in unusual circumstances, the Medical Staff shall afford the applicant at least 30 days to provide the requested material. If the requested items

or information or materials are in the exclusive possession of another person or entity, the applicant shall take such measures as are necessary to obtain them or to arrange for them to be submitted to the Medical Staff directly by the source; and

4. has assisted as necessary in the solicitation of written evaluations from those listed by the applicant as references and from other potential sources of relevant information. Such assistance may include the signing of a special release or similar document, as requested.
- (c) An application for new or additional privileges by a member of the Medical Staff in good standing, for which there might or might not be a prescribed form, shall not be complete unless and until:
1. The applicant submits a written request for the privileges, supported by a complete description of the applicant's training, experience and other relevant qualifications, with documentation as appropriate.
  2. The applicant responds to any requests for additional information and materials as described above.
- (d) Until notice is received from the Board of Trustees regarding final action on an application for appointment, reappointment or new clinical privileges, the applicant shall be responsible for keeping the application current and complete by informing the Medical Staff, in writing, of any change in the information provided or of any new information that might reasonably have an effect on the applicant's candidacy. Failure to meet this responsibility will be grounds for denial of the application, nullification of an approval if granted, and/or immediate termination of medical staff membership.
- (e) Misstatement(s) or omission(s) in the application may result in a recommendation to deny the applicant's application for appointment, reappointment, or privilege request, or if such omissions or misstatements are discovered after membership and clinical privileges or practice prerogatives have been granted, then such misstatement(s) or omission(s) may result in the modification or revocation of the member's medical staff membership and clinical privileges or practice prerogatives. In either case, the Medical Staff shall promptly send written notice to the

applicant/member of such recommendation. Such action shall entitle the member to the hearing and appellate review process set forth in Article VIII of these Bylaws, however, the issues at such proceedings shall be limited to the narrow question of whether or not the member made a misstatement and/or omission.

- (f) Revocation, suspension, restriction, or other disciplinary or corrective action by any state licensing authority, professional organization, certification board, peer review body, or health care entity (including an IPA, HMO, PPO, health plan, or private payor) regarding a practitioner's license, certificate, membership or clinical privileges, whether contested or voluntarily accepted, may constitute grounds for denial of the applicant's application for appointment or reappointment for membership and clinical privileges or practice prerogatives. The Medical Staff shall consider the nature and gravity of the charges or allegations and any resulting disciplinary or corrective action, but shall not be obligated to conduct an investigation or evidentiary proceedings regarding events that occurred outside of this hospital.

### **5.3 AUTHORITY TO GRANT, DENY AND REVOKE MEMBERSHIP**

Approvals, denials and revocations of medical staff membership and/or privileges shall be made as set forth in these bylaws.

### **5.4 DURATION OF MEMBERSHIP AND MEMBERSHIP RENEWAL**

Except as otherwise provided in these bylaws, initial membership on the medical staff shall be for a period of two years. Membership renewals shall be for a period of up to two medical staff years.

### **5.5 APPLICATION FOR INITIAL MEMBERSHIP AND RENEWAL OF MEMBERSHIP**

#### **5.5-1 PRE-APPLICATION FORM**

All physicians will be required to meet the qualifications as defined for pre-application prior to being given an application for membership form.

#### **5.5-2 APPLICATION FORM**

An application form shall be developed by the Medical Executive Committee. The medical staff application forms are peer review and evaluation

documents, an official record of the Medical Executive Committee, and are afforded all protections pursuant to California Evidence Code Section 1157. The form shall require detailed information which shall include, but not be limited to, information concerning:

- (a) the applicant's qualifications, including, but not limited to, professional training and experience, current licensure, current DEA registration, certification of CPR training if applicable, and continuing medical education information related to the clinical privileges to be exercised by the applicant;
- (b) peer references familiar with the applicant's professional competence and ethical character;
- (c) requests for membership categories, departments, and clinical privileges;
- (d) past or pending professional disciplinary action, voluntary or involuntary denial, revocation, suspension, reduction or relinquishment of medical staff membership or privileges or any licensure or registration, and related matters; current physical and mental health status;
- (e) final judgments or settlements made against the applicant in professional liability cases, and any filed and served cases pending;
- (f) professional liability coverage, if any is required; and
- (g) any past, pending or current exclusion from a federal health care program.

Each application for initial membership on the medical staff shall be in writing, submitted on the prescribed form with all provisions completed (or accompanied by an explanation of why answers are unavailable), and signed by the applicant. When an applicant requests an application form, that person shall be given a copy of, or electronic access to, these bylaws, the medical staff rules and regulations.

### 5.5-3 EFFECT OF APPLICATION

In addition to the matters set forth in Section 5.1, by applying for membership on the medical staff each applicant:

- (a) signifies willingness to appear for interviews in regard to the application;
- (b) authorizes consultation with others who have been associated with the applicant and who may have information bearing on the applicant's competence, qualifications and performance, and authorizes such individuals and organizations to candidly provide all such information;
- (c) consents to inspection of records and documents that may be material to an evaluation of the applicant's qualifications and ability to carry out clinical privileges requested, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying;
- (d) in accordance with Section 5.2.(a) consents to any requested medical or psychological examination and the inspection of the records of any such examination including blood, urine or other biological testing or other physiological testing, at any time during the appointment process or during his or her membership on the medical staff;
- (e) releases from any liability, to the fullest extent provided by law, all persons for their acts performed in connection with investigating and evaluating the applicant;
- (f) 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;
- (g) consents to the disclosure to other hospitals, medical associations, licensing boards, and to other similar organizations as required by law, any information regarding the applicant's professional or ethical standing that the hospital or medical staff may have, and releases the medical staff and hospital from liability for so doing to the fullest extent permitted by law;
- (h) agrees to provide for continuous quality care for patients;



- (i) agrees to fully cooperate with all medical staff peer review and/or Quality Assurance processes including providing all information as requested and appearing for interviews if requested;
- (j) 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, refraining from failing to disclose to patients when another surgeon will be performing the surgery, and refraining from delegating patient care responsibility to non-qualified or inadequately supervised practitioners or advance practice allied health practitioners; and
- (k) pledges to be bound by the medical staff bylaws, rules and regulations, and policies.
- (l) agrees that if membership and privileges are 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; including, but not limited to, any change in professional licensure or certification; any change in privileges, staff category or staff status at any health care facility or medical group; or any adverse action, recommendation, or accusation by any licensing body, health care facility, medical group, or third-party payor, whether or not the member is challenging the adverse action, recommendation, or accusation;
- (m) agrees to exhaust all remedies available under these Medical staff Bylaws and not to commence a legal action against the Medical Staff or any Department, Clinical Service, Committee or member of the Medical Staff, or against the Medical Center for any investigation or action taken in accordance with the provisions of these Medical Staff Bylaws, the Rules and Regulations of the Medical Staff or the Corporate Bylaws of the Medical Center.
- (n) agrees to immediately inform the Medical Staff of any changes or developments affecting or changing the information provided in or with his or her application.

- (o) attests to the correctness and completeness of the information provided and acknowledges that any misstatement, misrepresentation or omission will constitute grounds for denial of appointment and privileges or for the immediate revocation of same.
- (p) acknowledges responsibility for timely payment of Medical Staff dues and assessments.
- (q) agrees to abide by the Ethical and Religions Directives for Catholic Health Care Services developed by United States Conference of Catholic Bishops.
- (r) agrees to attend the required orientation for new appointments. Exceptions can be made for good cause by the Credentials Committee Chairman.

#### 5.5-4 VERIFICATION OF INFORMATION

The applicant shall deliver a completely filled-in, signed, and dated application and supporting documents to the appropriate medical staff office and an advance payment of medical staff dues and fees paid to the medical staff, as required. The Chief Executive Officer shall be notified of the application. The application and all supporting materials then available shall be transmitted to the chair of each department in which the applicant seeks privileges and to the credentials committee. The credentials committee, and the Chief Executive Officer when requested to assist by the credentials committee, shall expeditiously seek to collect or verify the references, licensure status, and other evidence submitted in support of the application. The hospital's authorized representative shall query the National Practitioner Data Bank and the Medical Board of California or other appropriate licensing body regarding the applicant or member and submit any resulting information to the credentials committee for inclusion in the applicant's or member'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. When collection and verification of information other than the National Practitioner Data Bank is accomplished, all such information shall be transmitted to the appropriate department chair and credentials committee. The applicant will be notified and required to attend the orientation for new applicants. All new applicants will be given three times to attend the required orientation. Failure to attend any of the three orientation times offered will result in the applicants file being deemed incomplete and therefore withdrawn. Exceptions can be made for good cause

as determined by the chair of credentials committee. No final action on an application may be taken until receipt of the Data Bank report and state licensing board report, if any. An applicant whose application is not completed within 90 days after the Medical Staff office received it shall be automatically removed from consideration for staff membership. Such an applicant's application may thereafter be reconsidered only if all information therein which may change over time, including but not limited to hospital reports and personal references, have been resubmitted.

#### 5.5-5 DEPARTMENT ACTION

After receipt of the application, the chair or appropriate committee of each department to which the application is submitted, shall review the application and supporting documentation, and may conduct a personal interview with the applicant at the chair's or committee's discretion. The chair or appropriate committee shall evaluate all matters deemed relevant to a recommendation, 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 hospital performance improvement activities, and the re-applicant's participation in relevant continuing education and shall transmit to the credentials committee a written report and recommendation as to membership and, if membership is recommended, as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached. The chair may also request that the Medical Executive Committee defer action on the application.

#### 5.5-6 CREDENTIALS COMMITTEE ACTION

The credentials committee shall review the application, evaluate and verify the supporting documentation, the department chair's report and recommendations, and other relevant information. The credentials committee may elect to interview the applicant, which shall be documented in writing, and seek additional information. As soon as practicable, the credentials committee shall transmit to the Medical Executive Committee a written report and its recommendations as to membership and, if membership is recommended, as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the membership. The committee may also recommend that the Medical Executive Committee defer action on the application.

#### 5.5-7 MEDICAL EXECUTIVE COMMITTEE ACTION

At its next regular meeting after receipt of the credentials committee report and recommendation, or as soon thereafter as is practicable, the Medical Executive Committee shall consider the report and any other relevant information. The Medical Executive Committee may request additional information, return the matter to the credentials committee for further investigation, and/or elect to interview the applicant. The Medical Executive Committee shall immediately forward to the Chief Executive Officer, for prompt transmittal to the Board of Trustees, or in cases eligible for expedited processing, the committee duly appointed by the board to handle expedited cases, a written report and recommendation as to medical staff membership and, if membership is recommended, as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the membership. The committee may also defer action on the application. The reasons for each recommendation shall be stated.

#### 5.5-8 EFFECT OF MEDICAL EXECUTIVE COMMITTEE ACTION

- (a) Favorable Recommendation: When the recommendation of the Medical Executive Committee is favorable to the applicant, it shall be immediately forwarded, together with supporting documentation, to the Board of Trustees or, in cases eligible for expedited processing, applicable committee duly appointed by the Board to handle expedited calls.
- (b) Adverse Recommendation: When a final recommendation of the Medical Executive Committee is adverse to the applicant, the Board of Trustees and the applicant shall be promptly informed by written notice. The applicant shall then be entitled to procedural rights as provided in Article VII.

#### 5.5-9 ACTION ON THE APPLICATION

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

- (a) If the Medical Executive Committee issues a favorable recommendation, the Board of Trustees or its duly appointed committee in cases eligible for expedited processing shall affirm the recommendation of the Medical Executive Committee if the Medical Executive Committee's decision is supported by substantial evidence.
  - 1. If the Board of Trustees concurs in that recommendation, the decision of the board shall be deemed final action.
  - 2. If the tentative final action of the Board of Trustees is unfavorable, the Chief Executive Officer shall give the applicant written notice of the tentative adverse recommendation and the applicant shall be entitled to the procedural rights set forth in Article VIII. If procedural rights are waived by the applicant, the decision of the Board of Trustees shall be deemed final action.
  - 3. In cases eligible for expedited processing, if the duly appointed committee and the Board concur in that recommendation, the positive decision shall be ratified by the Board of Trustees at its next regularly scheduled meeting. The ratification by the board shall be deemed final. If the committee's decision is adverse to the applicant, or the Board fails to ratify the committee's decision, the matter shall be referred back to the Medical Executive Committee for evaluation.
  
- (b) If the Medical Executive Committee recommends denial of appointment or denial of any requested privilege, the procedural rights set forth in Article VIII shall apply if such denial will result in a report to the Medical Board of California or the National Practitioner Data Bank.
  - 1. If procedural rights are waived by the applicant, the recommendations of the Medical Executive Committee shall be forwarded to the Board of Trustees for final action, which shall affirm the recommendation of the Medical Executive Committee if the Medical Executive Committee's decision is supported by substantial evidence.
  - 2. If the applicant requests a hearing following the adverse Medical Executive Committee recommendation pursuant to Section 5.5-9(b) or an adverse Board of Trustees tentative final action pursuant to 5.5-9(a) (2), the Board of Trustees shall take final action only after

the applicant has exhausted all procedural rights as established by Article VIII. After exhaustion of the procedures set forth in Article VIII, the board shall make a final decision and shall affirm the decision of the judicial review committee if the judicial review committee's decision is supported by substantial evidence, following a fair procedure. The board's decision shall be in writing and shall specify the reasons for the action taken.

- (c) Applicants are ineligible for expedited processing if, at the time membership may be granted, any of the following has occurred:
  - 1. The applicant submits an incomplete application.
  - 2. The Medical Executive Committee makes a final recommendation that is adverse or with limitation.
  - 3. There is a current challenge or previously successful challenge to licensure.
  - 4. The applicant has received an involuntary termination of medical staff membership at another organization.
  - 5. The applicant has received involuntary limitation, reduction, denial, or loss of medical privileges.
  - 6. There has been a final judgment adverse to the applicant in a professional liability action.
  - 7. The department, credentials committee, Medical Executive Committee, governing body, or Chief of Staff determines that expedited processing is inappropriate.

#### 5.5-10 NOTICE OF FINAL DECISION

- (a) Notice of the final decision shall be given to the Chief of Staff, the Medical Executive and the credentials committees, the chair of each department concerned, the applicant, and the Chief Executive Officer.
- (b) A decision and notice to grant or renew membership shall include, if applicable: (1) the staff category to which the applicant becomes a member; (2) the department to which that person is assigned; (3) the

clinical privileges granted; and (4) any special conditions attached to the membership.

#### 5.5-11 REAPPLICATION AFTER ADVERSE DECISION

- (a) A waiting period shall apply to the following practitioners:
  - 1. An applicant who:
    - (i) Has received a final adverse decision regarding appointment or the granting of privileges, or
    - (ii) Withdrew his or her application or request for membership or privileges following an adverse recommendation by the Medical Executive Committee or the governing body.
  - 2. A former member who has:
    - (i) Received a final adverse decision resulting in termination of medical staff membership and/or privileges; or
    - (ii) Resigned from the medical staff, relinquished privileges, or failed to file an application for reappointment while an investigation was pending or following the Medical Executive Committee or governing body issuing an adverse recommendation.
  - 3. A member who has received a final adverse decision resulting in:
    - (i) Termination or restriction of his or her privileges; or
    - (ii) Denial of his or her request for additional privileges.
- (b) Ordinarily the waiting period shall be 36 months. However, for practitioners whose adverse action included a specified period or conditions of retraining or additional experience, the Medical Executive Committee may exercise its discretion to allow earlier reapplication upon completion of the specified conditions. Similarly, the Medical Executive Committee may exercise its discretion, with approval of the Board of Trustees, to waive the 36-month period in other circumstances where it reasonably appears, by objective measures that changed circumstances warrant earlier consideration of an application.

- (c) An action is considered adverse only if it is based on the type of occurrences which might give rise to corrective action. An action is not considered adverse if it is based upon reasons that do not pertain to medical or ethical conduct, such as actions based on a failure to maintain a practice in the area (which can be cured by a move), to pay dues (which can be cured by paying dues), or to maintain professional liability insurance (which can be cured by obtaining the insurance).
- (d) The action is considered final on the latest date on which the application or request was withdrawn, a member's resignation became effective, when a member has waived his or her right to a hearing to challenge an adverse recommendation, or upon completion of (i) all medical staff and hospital hearings and appellate reviews, and (ii) all judicial proceedings pertinent to the action served within two years after the completion of the hospital proceedings.
- (e) Except as otherwise allowed in this section, practitioners subject to waiting periods cannot reapply for medical staff membership or the privileges affected by the adverse action for at least 36 months after the action became final. After the waiting period, the practitioner may reapply. The application will be processed like an initial application or request plus the practitioner shall document that the basis for the earlier adverse action no longer exists, that he or she has corrected any problems that prompted the adverse action, and/or he or she has complied with any specific training or other conditions that were imposed.

#### 5.5-12 TIMELY PROCESSING OF APPLICATIONS

Applications for staff membership and reappointment 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 complete applications:

- (a) evaluation, review, and verification of application and all supporting documents by the medical staff office: 35 days from receipt of all necessary documentation;



- (b) review and recommendation by department(s): 45 days after receipt of all necessary documentation from the medical staff office;
- (c) review and recommendation by credentials committee: 45 days after receipt of all necessary documentation from the department(s);
- (d) review and recommendation by Medical Executive Committee: 45 days after receipt of all necessary documentation from the credentials committee; and
- (e) The Board of Trustees shall then take final action on the application within forty-five (45) days.

The time periods specified herein are to assist those named in accomplishing their tasks and shall not be deemed to create any right for the applicant to have his/her application processed within those periods.

## **5.6 MEMBERSHIP RENEWALS AND REQUESTS FOR MODIFICATIONS OF STAFF STATUS OR PRIVILEGES**

### **5.6-1 APPLICATION**

- (a) At least 90 days prior to the expiration date of the current staff membership (except for temporary membership), a reapplication form developed by the Medical Executive Committee shall be mailed or delivered to the member. If an application for renewal of membership is not received at least 60 days prior to the expiration date, written notice shall be promptly sent to the applicant advising that the application has not been received. At least 60 days prior to the expiration date, each medical staff member shall submit to the credentials committee the completed application form for renewal of membership to the staff for the coming year, and for renewal or modification of clinical privileges. The reapplication form shall include all information necessary to update and evaluate the qualifications of the applicant including, but not limited to, the matters set forth in Section 5.5-2, as well as other relevant matters. Upon receipt of the application, the information shall be processed as set forth commencing at Section 5.5-4.
- (b) A medical staff member who seeks a change in medical staff status or modification of clinical privileges may submit such a request at any time

upon a form developed by the Medical Executive Committee, except that such application may not be filed within 6 months of the time a similar request has been denied. The Medical Executive Committee may make an exception to this period if it imposed additional training requirements on the applicant at the time the application was denied and the applicant has fulfilled those requirements.

#### 5.6-2 EFFECT OF APPLICATION

The effect of an application for renewal of membership or modification of staff status or privileges is the same as that set forth in Section 5.5-3.

#### 5.6-3 STANDARDS AND PROCEDURE FOR REVIEW

When a staff member submits the first application for renewal of membership, and every two years thereafter, or when the member submits an application for modification of staff status or clinical privileges, the member shall be subject to an in-depth review generally following the procedures set forth in Sections 5.5-4 through 5.5-12. The medical staff also shall consider information from the physician's performance evaluations.

#### 5.6-4 FAILURE TO FILE APPLICATION FOR RENEWAL OF MEMBERSHIP

If the member fails to submit a completed application for renewal of membership within the time period and completed as required by Section 5.6-1, the member shall be deemed to have resigned membership in the medical staff. In the event membership terminates for the reasons set forth herein, the procedures set forth in Article VIII shall not apply. A practitioner whose appointment expires as a result of a failure to submit a complete application may reapply for medical staff membership and privileges as an initial applicant, unless the practitioner is subject to a waiting requirement, as detailed in these bylaws.

### **5.7 LEAVE OF ABSENCE**

#### 5.7-1 LEAVE STATUS

At the discretion of the Medical Executive Committee, a medical staff member may obtain a voluntary leave of absence from the staff upon submitting a written request to the Medical Executive Committee stating the approximate period of leave desired, which may not exceed 1 year. During the period of

the leave, the member shall not exercise clinical privileges at the hospital, and membership rights and responsibilities shall be inactive, but the obligation to pay dues, if any, shall continue, unless waived by the medical staff.

#### 5.7-2 TERMINATION OF LEAVE

At least 30 days prior to the termination of the leave of absence, or at any earlier time, the medical staff member may request reinstatement of privileges by submitting a written notice to that effect to the Medical Executive Committee. The staff member shall submit a summary of relevant activities during the leave, if the executive committee so requests. The Medical Executive Committee shall make a recommendation concerning the reinstatement of the member's privileges and prerogatives, and the procedure provided in Sections 5.1 through 5.5-12 shall be followed.

#### 5.7-3 FAILURE TO REQUEST REINSTATEMENT

Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the medical staff and shall result in automatic termination of membership, privileges, and prerogatives. A practitioner whose membership is terminated shall be entitled to request a hearing subject to the Limited Hearing and Appeal as it applies in Section 8.2 for the sole purpose of determining whether the failure was with or without good cause. A request for Medical Staff membership subsequently received from a member so terminated shall be processed in the manner specified for applications for initial appointments.

#### 5.7-4 MEDICAL LEAVE OF ABSENCE

- (a) A Medical Staff member may obtain a medical leave of absence from the Medical Staff by submitting written notice to the Medical Executive Committee stating the approximate time period of the leave, which may not exceed one year. During that period of leave, the member's clinical privileges, prerogatives and responsibilities shall be suspended.
- (b) A Medical Staff member may be placed on a medical leave of absence by the chairman of the clinical Department to which he/she is assigned or by the Chief of Staff. This placement of medical leave of absence will be made after conferring with the involved physician that they are, in fact, on a medical leave of absence but have not previously requested a stated leave as such. The physician will be notified via a certified letter

from the Chief of Staff that they are being placed on a voluntary medical leave of absence. This notification will include the information listed in Section 5.7-5 regarding termination of medical leave.

- (c) During the duration of the medical leave of absence, the Medical Staff member may be reappointed to the Medical Staff pending final verification of health status as required in Section 5.2 of these Medical Staff Bylaws
- (d) The Medical Executive Committee shall determine the circumstances under which a particular medical staff member shall be granted a leave of absence for the purpose of obtaining treatment for a medical condition or disability. In the discretion of the Medical Executive Committee, unless accompanied by a reportable restriction of privileges, the leave shall be deemed a “medical leave” which is not granted for a medical disciplinary cause or reason.

#### 5.7-5 TERMINATION OF MEDICAL LEAVE

The Medical Staff member on medical leave of absence shall request reinstatement of his/her privileges and prerogatives in writing to the Medical Executive Committee with a letter from the physician’s attending physician confirming that the physician is able to resume Medical Staff obligations and if any limitations are applicable. The Medical Executive Committee may request the physician to submit to a third party objective physical assessment for current health status. The Chief of Staff, with ratification by the Medical Executive Committee, shall recommend whether to approve the member’s request for reinstatement of privileges, prerogatives and, thereafter, the procedures followed. Failure to submit to a requested physical examination by a third party physician shall automatically extend the leave of absence, but for no more than one year period as provided for in Section 5.7-4 (a).

#### 5.7-6 MILITARY LEAVE OF ABSENCE

Requests for leave of absence to fulfill military service obligations shall be granted upon notice and review by the Medical Executive Committee. Reactivation of membership and clinical privileges previously held shall be granted, notwithstanding the provisions of Sections 5.7-2 and 5.7-3, but may be granted subject to monitoring and/or proctoring as determined by the Medical Executive Committee.

## ARTICLE VI CLINICAL PRIVILEGES

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### 6.1 EXERCISE OF PRIVILEGES

Except as otherwise provided in these bylaws, a member providing clinical services at this hospital shall be entitled to exercise only those clinical privileges specifically granted. Said privileges and services must be hospital specific, within the scope of any license, certificate or other legal credential authorizing practice in this state and consistent with any restrictions thereon, and shall be subject to the rules and regulations of the clinical department and the authority of the department chair and the medical staff. Medical staff privileges may be granted, continued, modified or terminated by the Board of Trustees of this hospital only upon recommendation of the medical staff, only for reasons significantly and substantially related to quality of patient care and other provisions of the medical staff bylaws, and only following the procedures outlined in these bylaws.

### 6.2 DELINEATION OF PRIVILEGES IN GENERAL

#### 6.2-1 REQUESTS

- (a) Each application for initial membership or renewal of membership to the medical staff must contain a request for the specific clinical privileges desired by the applicant. All requests for clinical privileges will include a statement by applicant certifying that they are able to safely perform the privileges for which they have requested with or without reasonable accommodations. A request by a member for a modification of clinical privileges may be made at any time, but such requests must be supported by documentation of training and/or experience supportive of the request. Requests for modification that involve the granting of additional privileges must be reviewed pursuant to the process outlined in Article IV of these Bylaws.

#### 6.2-2 BASES FOR PRIVILEGES DETERMINATION

- (a) Requests for clinical privileges shall be evaluated on the basis of the member's education, training, experience, current demonstrated professional competence and judgment, clinical performance, current

health status, ethics and judgment, and the documented results of patient care and other quality review and monitoring which the medical staff deems appropriate. Privilege determinations may also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a member exercises clinical privileges. Such information may include:

1. history, if any, of voluntary and/or involuntary relinquishment of any licensure or registration,
  2. history, if any, of voluntary and/or involuntary termination of medical staff memberships,
  3. history, if any, of voluntary and/or involuntary limitation, reduction or loss of clinical privileges,
  4. current professional liability insurance related to privilege(s) request, and any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant, and
  5. query results from the National Practitioner Data Bank (NPDB) and licensing board, if relevant.
- (b) No specific privilege may be granted to a member if the task, procedure or activity constituting the privilege is not available within the hospital despite the member's qualifications or ability to perform the requested privilege.
- (c) The applicant requesting new privilege(s) or additional privileges shall have the burden of establishing their qualifications and clinical competency in the clinical privileges requested.

#### 6.2-3 CRITERIA FOR "CROSS-SPECIALTY" PRIVILEGES WITHIN THE HOSPITAL

Any request for clinical privileges that are either new to the Hospital or that overlap more than one department shall initially be reviewed by the appropriate departments, in order to establish the need for, and appropriateness of, the new procedure or services. The MEC shall facilitate the establishment of hospital-wide credentialing criteria for new or trans-

specialty procedures, with the input of all appropriate departments, with a mechanism designed to ensure that quality patient care is provided for by all individuals with such clinical privileges. In establishing the criteria for such clinical privileges, the MEC may establish an ad-hoc committee with representation from all appropriate Departments.

### **6.3 PROCTORING/FOCUSED PROFESSIONAL PRACTICE EVALUATION**

#### **6.3-1 GENERAL PROVISIONS**

Except as otherwise determined by the Medical Executive Committee, all initial members to the medical staff and all members granted new clinical privileges shall be subject to a period of proctoring/focused professional practice evaluation (FPPE). Each member or recipient of new clinical privileges shall be assigned to a department where performance on an appropriate number of cases as established by the Medical Executive Committee, or the department as designee of the Medical Executive Committee, shall be observed by the chair of the department, or the chair's designee, during the period of proctoring/FPPE specified in the department's rules and regulations, or privilege form to determine suitability to continue to exercise the clinical privileges granted in that department. The exercise of clinical privileges in any other department shall also be subject to direct observation by that department's chair or the chair's designee. The member shall remain subject to such proctoring/FPPE until the Medical Executive Committee has been furnished with:

- (a) a report signed by the chair of the department(s) to which the member is assigned describing the types and numbers of cases observed and the evaluation of the applicant's performance, a statement that the applicant appears to meet all of the qualifications for unsupervised practice in that department, has discharged all of the responsibilities of staff membership, and has not exceeded or abused the prerogatives of the category to which membership was granted; and
- (b) a report signed by the chair of the other department(s) in which the member may exercise clinical privileges, describing the types and number of cases observed and the evaluation of the applicant's performance and a statement that the member has

satisfactorily demonstrated the ability to exercise the clinical privileges initially granted in those departments.

#### 6.3-2 FAILURE TO COMPLETE PROCTORING/FPPE

If a new member fails within the time of provisional membership to furnish the proctoring/FPPE required, or if a member exercising new clinical privileges fails to furnish such proctoring/FPPE within the time allowed by the department, those specific clinical privileges shall automatically terminate, and the member shall be entitled to request a hearing subject to the Limited Hearing and Appeal as it applies in Section 8.2.

#### 6.3-3 MEDICAL STAFF ADVANCEMENT

The failure to obtain release from proctoring/FPPE for any specific clinical privileges shall not, of itself, preclude advancement in medical staff category of any member. If such advancement is granted absent completion of proctoring/FPPE, continued proctorship on the uncertified procedure shall continue for the specified time period.

### 6.4 CONDITIONS FOR PRIVILEGES OF LIMITED LICENSE PRACTITIONERS

#### 6.4-1 ADMISSIONS

When dentists and any oral surgeons, podiatrists, clinical psychologists who do not hold history and physical privileges who are members of the medical staff admit patients, a physician member of the medical staff with history and physical privileges must conduct or directly supervise the admitting history and physical examination except the portion related to dentistry, podiatry or clinical psychology, and assume responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside of the limited license practitioner's lawful scope of practice.

#### 6.4-2 SURGERY

Surgical procedures performed by dentists and podiatrists shall be under the overall supervision of the chair of the department of surgery or the chair's designee.



#### 6.4-3 MEDICAL APPRAISAL

All patients admitted for care in a hospital by a dentist or oral and maxillofacial surgeon , podiatrist , clinical psychologist shall receive the same basic medical appraisal as patients admitted to other services, and the dentists or oral and maxillofacial surgeons, podiatrists ,clinical psychologists shall seek consultation with a physician member to determine the patient's medical status and need for medical evaluation whenever the patient's clinical status indicates the presence of a medical problem. Where a dispute exists regarding proposed treatment between a physician member and a limited license practitioner based upon medical or surgical factors outside of the scope of licensure of the limited license practitioner, the treatment will be suspended insofar as possible while the dispute is resolved by the appropriate department(s).

### 6.5 TEMPORARY CLINICAL PRIVILEGES

Temporary privileges are allowed under two circumstances only: to address a patient care need and to permit patient care to be provided while an application is pending.

#### 6.5-1 PATIENT CARE NEEDS

##### (a) Care of Specific Patient

Temporary clinical privileges may be granted where good cause exists to allow a physician, dentist, podiatrist, or clinical psychologist to provide care to a specific patient (but not more than 2 times during a calendar year) provided that the procedure described in Section 6.5-4 has been completed.

##### (b) Locum Tenens

Temporary clinical privileges may be granted to a person serving as a locum tenens for a current member of the medical staff to meet the care needs of that member's patients in his/her absence, provided that the procedure described in Section 6.5-4 has been completed. Such person may attend only patients of the member(s) for whom that person is providing coverage, for a period not to exceed 30 days, unless the Medical Executive Committee recommends a longer period for good cause.

##### (c) Other Important Patient Care Needs

Temporary clinical privileges may be granted to allow a physician, dentist, podiatrist, or clinical psychologist to fulfill an important patient care treatment or service need (but not more than 45 days during a calendar year) provided that the procedure described in Section 6.5-4 has been completed.

(d) Instructor/Proctor

Temporary clinical privileges may be granted on a case-by-case basis for individuals who are utilized to act as an instructor or proctor for a new privilege/procedure or at the request of a department. Temporary privileges may be granted for an initial period of thirty (30) days.

(e) Limitations

In no event shall temporary privileges be granted if there is a current or previously successful challenge to professional licensure or registration, involuntary termination of medical staff membership at any other organization, or involuntary limitation, reduction, denial or loss of clinical privileges.

6.5-2 PENDING APPLICATION FOR MEDICAL STAFF MEMBERSHIP

Temporary clinical privileges may be granted to an applicant while that person's application for medical staff membership and privileges is completed and awaiting review and approval of the Medical Executive, committee or the Board of Trustees, provided that the procedure described in Section 6.5-4(a) has been completed, and that the applicant has no current or previously successful challenge to professional licensure or registration, no involuntary termination of medical staff membership at any other organization, and no involuntary limitation, reduction, denial or loss of clinical privileges. Such persons may only attend patients for a period not to exceed 120 days.

6.5-3 TEMPORARY MEMBERSHIP AND TEMPORARY PRIVILEGES NOT CO-EXTENSIVE

Temporary members of the medical staff pursuant to Section 6.1-4 are not, by virtue of such membership, granted temporary clinical privileges.

#### 6.5-4 TEMPORARY PRIVILEGES - APPLICATION AND REVIEW

- (a) Upon receipt of a completed application and supporting documentation from a physician, dentist, podiatrist, clinical psychologist authorized to practice in California, the Chief Executive Officer on the recommendation of either the applicable clinical department chairperson or the Chief of Staff, may grant temporary privileges to a member who appears to have qualifications, ability and judgment consistent with Section 2.2-1, but only:
1. With respect to applications by a locum tenens, or to fulfill an important patient care need, after verification of current licensure and current competence; or
  2. With respect to an instructor/proctor for a new privilege/procedure.
  3. With respect to a new applicant awaiting review and approval of the medical staff executive committee and the governing body in compliance with the requirements in Section 6.5-3, after the following has been completed:
    - (i) Completed application form to include biographical data; training and current staff affiliations;
    - (ii) Privileges Requested List;
    - (iii) Documentation of professional liability insurance;
    - (iv) Copy of current controlled substances certificate (DEA);
    - (v) Copy of current license primary source verified by the hospital as clear and in good standing;
    - (vi) Copy of current CPR, Fluoroscopy certification, if applicable;
    - (vii) Verification of one peer reference;
    - (viii) The National Practitioner Data Bank report regarding the applicant for temporary privileges has been received and evaluated and current California licensure has been verified.

The Medical Staff Office through the chairman of the Department involved or his/her designee, must be given a minimum of seven (7) working days advance notice in order for the Medical Staff Services department to accomplish the minimum verification required and to submit the application and results of verification to the chairman of the Department, or his/her designee, for review and recommendation to the Chief of Staff and Chief Executive Officer.

- (b) If the applicant requests temporary privileges in more than one department, interviews shall be conducted and written concurrence shall first be obtained from the appropriate department chairs and forwarded to the credentials committee. In the event of a disagreement between the Chief Executive Officer or his or her designee and the Medical Executive Committee regarding the granting of temporary clinical privileges, the matter shall be resolved as set forth in Section 5.5-8.

#### 6.5-5 GENERAL CONDITIONS

- (a) If granted temporary privileges, the applicant shall act under the supervision of the department chair to which the applicant has been assigned, and shall ensure that the chair, or the chair's designee, is kept closely informed as to the applicant's activities within the hospital.
- (b) Temporary privileges shall automatically terminate at the end of the designated period, unless earlier terminated or suspended under Articles VII and/or VIII of these bylaws or unless affirmatively renewed following the procedure as set forth in Section 6.5-5. A medical staff applicant's temporary privileges shall automatically terminate if the applicant's initial membership application is withdrawn or if the Medical Executive Committee recommends denial of the application. As necessary, the appropriate department chair or, in the chair's absence, the chair of the Medical Executive Committee, shall assign a member of the medical staff to assume responsibility for the care of such member's patient(s). The wishes of the patient shall be considered in the choice of a replacement medical staff member.
- (c) Requirements for proctoring and monitoring, including but not limited to those in Section 6.3, shall be imposed on such terms as may be

appropriate under the circumstances upon any member granted temporary privileges by the Chief of Staff after consultation with the departmental chair or the chair's designee.

- (d) All persons requesting or receiving temporary privileges shall be bound by the bylaws and rules and regulations of the medical staff.

## **6.6 EMERGENCY PRIVILEGES**

- (a) In the case of an emergency involving a particular patient, any member of the medical staff with clinical privileges, to the degree permitted by the scope of the applicant's license and regardless of department, staff status, or clinical privileges, shall be permitted to do everything reasonably possible to save the life of the patient or to save the patient from serious harm provided that the care provided is within the scope of the individual's license. The member shall make every reasonable effort to communicate promptly with the department chair concerning the need for emergency care and assistance by members of the medical staff with appropriate clinical privileges, and once the emergency has passed or assistance has been made available, shall defer to the department chair with respect to further care of the patient at the hospital.
- (b) In the event of an emergency under subsection (a), any person shall be permitted to do whatever is reasonably possible to save the life of a patient or to save a patient from serious harm. Such persons shall promptly yield such care to qualified members of the medical staff when it becomes reasonably available.

## **6.7 DISASTER PRIVILEGES**

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

within 72 hours to determine whether the disaster privileges should be continued.

- (b) The verification process of the credentials and privileges of individuals who receive disaster privileges under this subsection shall be developed in advance of a disaster situation. This process shall begin as soon as the immediate disaster situation is under control, and shall meet the following requirements in order to fulfill important patient care needs:
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. This privileging process is identical to the process established under the medical staff bylaws for granting temporary privileges to fulfill an important patient care need.
  5. Those authorized under subsection (a) may grant disaster privileges upon presentation of a valid picture ID issued by a state, federal or regulatory agency and at least one of the following:
    - (i) A current picture hospital ID card clearly identifying professional designation.
    - (ii) A current license to practice.
    - (iii) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT) or MRC, ESAR-VHP, or other recognized state or federal organizations or groups.

- (iv) Identification indicating that the individual has been granted authority by a federal, state, or municipal entity to render patient care in disaster circumstances.
  - (v) Identification by current hospital or medical staff member(s) with personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during a disaster.
- (c) Current professional licensure of those providing care under disaster privileges is verified from the primary source as soon as the immediate situation is under control and completed within 72 hours, unless extraordinary circumstances prohibit verification, in which case the following is documented:
  - 1. The reasons verification could not be performed within 72 hours,
  - 2. Evidence of demonstrated ability to continue to provide adequate care, treatment and services.
  - 3. An attempt to rectify the situation as soon as possible.
- (d) Members of the medical staff shall oversee those granted disaster privileges.

## **6.8 HISTORY AND PHYSICAL PRIVILEGES**

### **(a) History and Physicals, Generally**

Histories and physicals can be conducted or updated and documented only pursuant to specific privileges granted upon request to qualified physicians and other practitioners who are members of the medical staff or seeking temporary privileges.

### **(b) Oral and Maxillofacial Surgeons and Podiatrists**

- 1. Oral and maxillofacial surgeons who have successfully completed a postgraduate program in oral and maxillofacial surgery accredited by a nationally recognized accrediting body approved by the U.S. Office of Education and have been determined by the medical staff to be competent to do so, may, be granted the privileges to perform

a history and physical examination related to oral and maxillofacial surgery.

2. Podiatrists who have been determined by the medical staff to be competent to do so, may, be granted the privileges to perform a history and physical examination.
3. For patients with existing medical conditions or abnormal findings beyond the surgical indications, a physician member of the medical staff with history and physical privileges must conduct or directly supervise the admitting history and physical examination, except the portion related to podiatric or oral and maxillofacial surgery, and assume responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside of the podiatrist's or oral and maxillofacial surgeon's lawful scope of practice.

(c) Timing Requirement

Every patient receives a history and physical within twenty-four hours after admission, unless a previous history and physical performed within thirty days of admission (or registration if an outpatient procedure) is on record, in which case that history and physical will be updated within twenty-four hours of admission. Every patient admitted for surgery must have a history and physical in the medical record prior to surgery, unless a previous history and physical performed within thirty days prior to the surgery is on record, in which case that history and physical must be updated and be in the medical record prior to surgery.

## **6.9 MODIFICATION OF CLINICAL PRIVILEGES OR DEPARTMENT ASSIGNMENT**

On its own, upon recommendation of the credentials committee, or pursuant to a request under Section 5.6-1(b), the Medical Executive Committee may recommend a change in the clinical privileges or department assignment(s) of a member. The Medical Executive Committee may also recommend that the granting of additional privileges to a current medical staff member be made subject to monitoring in accordance with procedures similar to those outlined in Section 6.3-1.



#### **6.10 LAPSE OF APPLICATION**

If a medical staff member requesting a modification of clinical 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.

#### **6.11 TRANSPORT AND ORGAN HARVEST TEAMS**

Properly licensed practitioners who individually, or as members of a group or entity, have contracted with the hospital to participate in transplant and/or organ harvesting activities may exercise clinical privileges within the scope of their agreement with the hospital.

## ARTICLE VII EVALUATION AND CORRECTIVE ACTION

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### 7.1 EVALUATION OF MEMBERS

Peer review, fairly conducted, is essential to preserving the highest standards of medical practice. All members are subject to evaluation based on medical staff peer review criteria, consistent with these bylaws. Evaluation results are used in privileging, system improvement, and when warranted, corrective action.

#### 7.1-1 PEER REVIEW CRITERIA

Departments shall develop and routinely update peer review criteria based on current practices and standards of care, which shall be the criteria used in evaluating the performance of members and privileges holders. Included in the departmental peer review criteria are the types of data to be collected for evaluation. Department criteria are subject to the approval of the Medical Executive Committee. Approved criteria as updated are made known and accessible to all members.

#### 7.1-2 REVIEW OF INITIAL MEMBERS

All initial grants of privileges shall be subject to proctoring and initial review under these bylaws (also known as focused professional practice evaluation (FPPE)) and shall otherwise be reviewed for compliance with the relevant departmental peer review criteria.

#### 7.1-3 REVIEW OF MEMBERS

All members and privilege holders not otherwise subject to initial review (FPPE) are reviewed for compliance with the relevant department peer review criteria on an on-going basis also known as ongoing professional practice evaluation (OPPE). In addition to information gathered under routine screening, complaints and concerns are analyzed in light of the department peer review criteria using mechanisms determined by the department. Members are kept apprised of reviews of their performance. Performance monitoring, corrective action or other measures are implemented or recommended.

#### 7.1-4 EXTERNAL PEER REVIEW

External peer review may be used to inform medical staff peer review as outlined in the medical staff policy on Professional Practice Evaluation.

## **7.2 CORRECTIVE ACTION**

#### 7.2-1 CRITERIA FOR INITIATION

Any person may provide information to the medical staff about the conduct, performance, or competence of its 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 hospital; (2) unethical (3) contrary to the medical staff bylaws and rules or regulations; or (4) a failure to comply with the Ethical and Religious Directives for Catholic Healthcare Services or (5) below applicable professional standards, a request for an investigation or action against such member may be initiated by the Chief of Staff, a department chair, or the Medical Executive Committee.

#### 7.2-2 INITIATION

A request for an investigation must be in writing, submitted to the Medical Executive Committee, and supported by reference to specific activities or conduct alleged. If the Medical Executive Committee itself initiates the investigation, no such written request is necessary but the Medical Executive Committee shall make an appropriate recording of the reasons.

#### 7.2-3 INVESTIGATION

If the Medical Executive Committee concludes an investigation is warranted, it shall direct an investigation to be undertaken. The Medical Executive Committee may conduct the investigation itself, or may assign the task to an appropriate medical staff officer, medical staff department, or standing or ad hoc committee of the medical staff. The Medical Executive Committee in its discretion may appoint practitioners who are not members of the medical staff as temporary members of the medical staff for the sole purpose of serving on a standing or ad hoc committee, and not for the purpose of granting these practitioners temporary clinical privileges under Section 6.5, should circumstances warrant. If the investigation is delegated to an officer of committee other than the Medical Executive Committee, such officer or

committee shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the Medical Executive Committee as soon as practicable. The report may include recommendations for appropriate corrective action. The member shall be notified that an investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The individual or body investigating the matter may, but is not obligated to, conduct interviews with persons involved; however, such interviews shall not constitute a "hearing" as that term is used in Article VIII, nor shall the procedural rules with respect to hearings or appeals apply. Despite the status of any investigation, at all times the Medical Executive Committee shall retain authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension, termination of the investigative process, or other action.

#### 7.2-4 MEDICAL EXECUTIVE COMMITTEE ACTION

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

- (a) determining no corrective action be taken and, if the Medical Executive Committee determines there was no reasonably credible evidence for the complaint in the first instance, removing any adverse information from the member's file;
- (b) referring the member to the Physician Well-being Committee for evaluation and follow-up as appropriate;
- (c) deferring action for a reasonable time where circumstances warrant;
- (d) issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude department heads 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;

- (e) recommending the imposition of terms of probation or special limitation upon continued medical staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admission, mandatory consultation, or monitoring;
- (f) recommending reduction, modification, suspension or revocation of clinical privileges;
- (g) recommending reductions of membership status or limitation of any prerogatives directly related to the member's delivery of patient care;
- (h) recommending suspension, revocation or probation of medical staff membership; and
- (i) taking other actions deemed appropriate under the circumstances.

#### 7.2-5 SUBSEQUENT ACTION

If corrective action as set forth in Section 7.2-4(a)-(i) is recommended by the Medical Executive Committee, that recommendation shall be transmitted to the board of trustees.

The board shall give the Medical Executive Committee's recommendation great weight. So long as the recommendation is supported by credible information the recommendation of the Medical Executive Committee shall be adopted by the board as final action unless the member requests a hearing, in which case the final decision shall be determined as set forth in Article VIII.

#### 7.2-6 INITIATION BY BOARD OF TRUSTEES

If the Medical Executive Committee fails to investigate or take disciplinary action contrary to the weight of the evidence, the Board of Trustees may direct the Medical Executive Committee to initiate investigation or disciplinary action, but only after consultation with the Medical Executive Committee. The board's request for Medical Executive Committee action shall be in writing and shall set forth the basis for the request. If the Medical Executive Committee fails to take action in response to that Board of Trustees direction, the Board of Trustees may initiate corrective action after written notice to the Medical

Executive Committee, but this corrective action must comply with Articles VII and VIII of these medical staff bylaws.

### **7.3 SUMMARY RESTRICTION OR SUSPENSION**

#### **7.3-1 CRITERIA FOR INITIATION**

Whenever a member's conduct appears to require that immediate action be taken to protect the life or well-being of patient(s) or to reduce a substantial and imminent likelihood of significant impairment of or danger to the life, health, safety of any patient, prospective patient, or other person, the Chief of Staff, the Medical Executive Committee, the head of the department or designee, in which the member holds privileges, or the chief medical officer or designee may summarily restrict or suspend the medical staff membership or clinical privileges of such member. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition, and the person or body responsible shall promptly give written notice to the Board of Trustees, the Medical Executive Committee and the CEO. In addition, the affected medical staff member shall be provided with a written notice of the action which notice fully complies with the requirements of Section 7.3-2 below. The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary restriction or suspension, the member's patients shall be promptly assigned to another member by the department chair or by the Chief of Staff, considering, where feasible, the wishes of the patient in the choice of a substitute member.

#### **7.3-2 WRITTEN NOTICE OF SUMMARY SUSPENSION**

Within two working days of imposition of a summary suspension, the affected medical staff member shall be provided with written notice of such suspension. This initial written notice shall include a brief statement of facts demonstrating that the suspension was necessary because failure to suspend or restrict the practitioner's privileges summarily could reasonably result in the substantial and imminent likelihood of significant impairment or danger described in Section 7.3-1. The statement of facts provided in this initial notice shall also include a summary of one or more particular incidents giving rise to the assessment of imminent danger. This initial notice shall not substitute for, but is in addition to, the notice required under Section 8.4-1 (which applies in all cases where the Medical Executive Committee does not immediately terminate the summary suspension). The notice under Section

8.4-1 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.

#### 7.3-3 MEDICAL EXECUTIVE COMMITTEE ACTION

Within one week after such summary restriction or suspension has been imposed, a meeting of the Medical Executive Committee or a subcommittee appointed by the Chief of 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 Medical Executive Committee may impose, although in no event shall any meeting of the Medical Executive Committee, with or without the member, constitute a "hearing" within the meaning of Article VIII, nor shall any procedural rules apply. The Medical Executive Committee may modify, continue, or terminate the summary restriction or suspension, but in any event it shall furnish the member with notice of its decision within three working days of the meeting.

#### 7.3-4 PROCEDURAL RIGHTS

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

#### 7.3-5 INITIATION BY BOARD OF TRUSTEES

If the Chief of Staff, members of the Medical Executive committee and the head of the department (or designee) in which the member holds privileges are not available to summarily restrict or suspend the member's membership or clinical privileges, the Board of Trustees (or designee) may immediately suspend a member's privileges if a failure to suspend those privileges is likely to result in the substantial and imminent likelihood of significant impairment or danger described in Section 7.3-1, provided that the Board of Trustees (or designee) made reasonable attempts to contact the Chief of Staff, members of the Medical Executive Committee and the head of the department (or designee) before the suspension.

Such a suspension is subject to ratification by the Medical Executive Committee. If the Medical Executive Committee does not ratify such a summary suspension within two working days, excluding weekends and

holidays, the summary suspension shall terminate automatically. If the Medical Executive Committee does ratify the summary suspension, all other provisions under Section 7.3 of these bylaws will apply. In this event, the date of imposition of the summary suspension shall be considered to be the date of ratification by the Medical Executive Committee for purposes of compliance with notice and hearing requirements.

#### **7.4 AUTOMATIC SUSPENSION OR LIMITATION**

In the following instances, the member's privileges or membership may be suspended or limited as described, and the member shall be entitled to a limited hearing under Section 8.2. If the member requests such a hearing the only issue to be determined in the proceeding shall be whether the grounds for automatic suspension as set forth below exist.

##### **7.4-1 LICENSURE**

- (a) **Revocation and Suspension:** Whenever a member's license or other legal credential authorizing practice in this state is revoked or suspended, medical staff membership and clinical privileges shall be automatically revoked as of the date such action becomes effective.
- (b) **Restriction:** Whenever a member's license or other legal credential authorizing practice in this state is limited or restricted by the applicable licensing or certifying authority, any clinical privileges which the member has been granted at the hospital which are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.
- (c) **Probation:** Whenever a member is placed on probation by the applicable licensing or certifying authority, membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

##### **7.4-2 CONTROLLED SUBSTANCES**

Whenever a member's DEA certificate is revoked, expired, limited, or suspended, 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.

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

#### 7.4-3 MEDICAL RECORDS

Members of the medical staff are required to complete medical records within such reasonable time as may be prescribed by the Medical Executive Committee. A limited suspension in the form of withdrawal of admitting and other related privileges until medical records are completed, shall be imposed by the Chief of Staff, or the Chief of Staff's designee, after notice of delinquency for failure to complete medical records within such period. For the purpose of this Section, "related privileges" means on-call service for the emergency room, scheduling surgery, assisting in surgery, consulting on hospital cases, and providing professional services within the hospital for future patients. Bona fide vacation or illness may constitute an excuse subject to approval by the Medical Executive Committee. Members whose privileges have been suspended for delinquent records may admit patients only in life-threatening situations. The suspension shall continue until lifted by the Chief of Staff or his or her designee. Medical records delinquency that is repeated, flagrant, or egregious shall constitute independent grounds for corrective action under Section 7.2-1.

#### 7.4-4 FAILURE TO PAY DUES/ASSESSMENTS

Failure without good cause as determined by the Medical Executive Committee, to pay dues or assessments, as required under Section 15.2, shall be ground for automatic suspension of a member's clinical privileges, and if within six months after written warnings of the delinquency the member does not pay the required dues or assessments, the member's membership shall be automatically terminated.

#### 7.4-5 PROFESSIONAL LIABILITY INSURANCE

Failure to maintain professional liability insurance shall be ground for automatic suspension of a member's clinical privileges, and if within 90 days after written warnings of the delinquency the member does not provide

evidence of required professional liability insurance, the member's membership shall be automatically terminated.

#### **7.4-6 FAILURE TO SATISFY SPECIAL ATTENDANCE REQUIREMENT**

Failure of a member without good cause to provide information or appear when requested by a medical staff committee as described in these bylaws shall result in the referral to the Medical Executive Committee 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.

#### **7.4-7 MEDICAL EXECUTIVE COMMITTEE DELIBERATION**

As soon as practicable after action is taken or warranted as described in Section 7.4-1(b) or (c), 7.4-2, or 7.4-4, or 7.4-5, the Medical Executive Committee shall convene to review and consider the facts, and may recommend any further corrective action as it may deem appropriate in accordance with these bylaws.

### **7.5 FELONY CONVICTION**

The Chief of Staff and Chief Executive Officer may suspend a practitioner who has been convicted of a felony from practicing in the hospital. Such suspension shall become effective immediately upon such conviction regardless of whether or not an appeal from the judgment is taken or pending. Such suspension shall remain in effect until the matter is resolved by subsequent action of the Medical Executive Committee and the Board of Trustees, or through corrective action by the Medical Executive Committee, if the Medical Executive Committee decides that the felony conviction has substantial relationship to the qualifications, functions or duties of the Medical Staff member. Such practitioners shall be entitled to the procedural rights affordable by Section 8.2, limited hearing and appeal.

## ARTICLE VIII HEARINGS AND APPELLATE REVIEWS

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### 8.1 GENERAL PROVISIONS

#### 8.1-1 EXHAUSTION OF REMEDIES

If adverse action described in Section 8.3 is taken or recommended, the applicant or member must exhaust the remedies afforded by these bylaws before resorting to legal action.

#### 8.1-2 APPLICATION OF ARTICLE

For purposes of this Article, the term “member” may include “applicant” and those with temporary privileges, as it may be applicable under the circumstances, unless otherwise stated.

#### 8.1-3 TIMELY COMPLETION OF PROCESS

The hearing and appeal process shall be completed within a reasonable time.

#### 8.1-4 FINAL ACTION

Recommended adverse actions described in Section 8.3 shall become final only after the hearing and appellate rights set forth in these bylaws have either been exhausted or waived, and only upon being adopted as final actions by the Board of Trustees.

#### 8.1-5 INDIVIDUAL EVALUATIONS VS. REQUESTS TO REVIEW RULES AND REQUIREMENTS

The sole purpose of the hearings and appeals provided in this Article is to evaluate individual medical staff members on the basis of bylaws, rules, regulations, policies and standards of the medical staff and hospital. The judicial review committees provided for under this Article have no authority to modify, limit or overrule any established bylaw, rule, regulation, policy or requirement (collectively “rules or requirements”), and shall not entertain challenges to such rules and requirements. Any medical staff member wishing to challenge an established rule or requirement must first notify the Medical

Executive Committee of the rule or requirement he /she wishes to challenge and of the basis for the challenge. No medical staff member shall initiate any judicial challenge to a rule or requirement until the Board of Trustees, following action by the Medical Executive Committee, has reviewed the rule or requirement in question and has either decided not to reconsider, or has upheld, the particular rule or requirement.

## **8.2 GROUNDS FOR A LIMITED HEARING AND APPEAL**

Any one of the following Medical Staff administrative actions or recommended actions shall constitute grounds for a limited hearing and appeal and shall not be subject to the other procedural rights set forth in this Article.

- (a) Failure to reinstate a member to the Medical Staff after a leave of absence because of non-compliance with the reinstatement requirements as defined in Section 5.7-3.
- (b) Failure to reappoint a member to the Medical Staff because of failure to submit a reappointment application or reappointment fee after notice as defined in Section 5.6-4.
- (c) Termination of Medical Staff membership or clinical privileges because of failure to comply with the proctoring requirements for initial applicants or for Medical Staff members who have requested new privileges as defined in Section 6.3-2.
- (d) Suspension or termination of clinical privileges because of revocation, restriction, suspension or expiration of a license to practice as defined in Section 7.4-1.
- (e) Suspension or termination of Medical Staff membership or clinical privileges because of revocation, restriction, suspension or expiration of a DEA certificate as defined in Section 7.4-2.
- (f) Suspension or termination of Medical Staff membership or clinical privileges because of failure to complete medical records on a timely basis as defined in Section 7.4-3.
- (g) Suspension or termination of Medical Staff membership or clinical privileges because of failure to maintain the required amount of professional liability insurance as defined in Section 7.4-5.

- (h) Suspension or termination of Medical Staff membership or clinical privileges because of failure to pay required dues or assessments as defined in Section 7.4-4.
- (i) Suspension or termination of Medical Staff membership or clinical privileges because of felony conviction which is substantially related to the qualifications, functions or duties of Medical Staff membership as defined in Section 7.5.
- (j) Any denial of Medical Staff membership or clinical privileges or reappointment to the Medical Staff because of Medical Staff administrative reasons, not involving a medical disciplinary cause or reason, that need not be reported to the Medical Board of California.
- (k) Suspension or termination of Medical Staff membership or clinical privileges because of failure to appear under Special Appearance as defined in Section 7.4-6.

A petitioner shall have thirty (30) days following the date of receipt of such action or recommended actions to request a limited hearing. Said request shall be effectuated by a written request to the Chief of Staff with a copy to the Chief Executive Officer. In the event the petitioner does not request a limited hearing within the time and manner set forth herein the petitioner shall be deemed to have accepted the recommendation, decision or action involved and it shall thereupon become the final action of the Medical Staff.

The Credentials Committee shall meet with the petitioner to adjudicate the matter and shall render a written decision within thirty (30) days of the completion of that process. This limited hearing shall be conducted in a manner and upon such terms as the Credentials Committee reasonably deems appropriate, and shall be limited to whether, without good cause, the petitioner has failed to comply with the requirements set forth in the Medical Staff Bylaws and/or Medical Staff Rules & Regulations. If the petitioner is dissatisfied with the decision, he or she may appeal the decision to the Medical Executive Committee. The Medical Executive Committee shall then render the final decision of the Medical Staff.

The Board of Trustees shall consider the final decision of the Medical Staff within forty-five (45) days but that decision shall not be binding on the Board of Trustees.

### **8.3 GROUNDS FOR FAIR HEARING**

Except as otherwise specified in these bylaws, any one or more of the following actions or recommended actions shall be deemed actual or potential adverse action and constitute grounds for a hearing if the final imposition of such action would require a report to be filed under Section 805 of the California Business and Professions Code:

- (a) denial of medical staff membership;
- (b) denial of requested advancement in staff membership status, or category;
- (c) denial of renewal of medical staff membership;
- (d) demotion to lower medical staff category or membership status;
- (e) suspension of staff membership;
- (f) revocation of medical staff membership;
- (g) denial of requested clinical privileges;
- (h) involuntary reduction of current clinical privileges;
- (i) suspension of clinical privileges; or
- (j) termination of all clinical privileges.

### **8.4 REQUESTS FOR FAIR HEARING**

#### **8.4-1 NOTICE OF ACTION OR PROPOSED ACTION**

In all cases in which action has been taken or a recommendation made as set forth in Section 8.3, the Chief of Staff or designee on behalf of the Medical Executive Committee 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 Medical Board of California and/or to the National Practitioner Data Bank if required; (2) a summary of the reasons for the proposed action including the acts or omissions with which the member is charged; (3) the right to request a fair hearing pursuant to Section 8.4-2, and that such hearing must be requested within thirty (30) days; and (4) a summary of the rights granted in the fair hearing pursuant to the medical staff bylaws. If the recommendation or final proposed action is reportable to the Medical Board of California and/or to the National Practitioner Data Bank, the written notice shall state the proposed text of the report(s); in their sole discretion, however,

the Medical Executive Committee and/or the hospital may modify the text of the reports prior to submission to the Medical Board or the National Practitioner Data Bank.

#### 8.4-2 REQUEST FOR FAIR HEARING

The member shall have 30 days following receipt of notice of such action to request a fair hearing. The request shall be in writing addressed to the Medical Executive Committee with a copy to the Board of Trustees. In the event the member does not request a fair 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.

#### 8.4-3 TIME AND PLACE FOR FAIR HEARING

Upon receipt of a request for fair hearing, the Medical Executive Committee shall schedule a fair hearing and, within 30 days give notice to the member of the time, place and date of the fair hearing. Unless extended by the hearing officer or by agreement of the parties, the date of the commencement of the hearing shall be not less than 30 days from the date of notice, nor more than 60 days from the date of receipt of the request by the Medical Executive Committee for a fair hearing; provided, however, that when the request is received from a member who is under summary suspension the fair hearing shall be held as soon as the arrangements may reasonably be made, so long as the member has at least 30 days from the date of notice to prepare for the fair hearing or waives this right.

#### 8.4-4 NOTICE OF FAIR HEARING AND NOTICE OF CHARGES

Together with the notice stating the place, time and date for commencement of the fair hearing, which date shall not be less than 30 days after the date of the notice unless waived by a member under summary suspension, the Chief of Staff or designee on behalf of the Medical Executive Committee shall provide the reasons for the recommended action, including the acts or omissions with which the member is charged, a list of the charts in question, where applicable, and a list of the witnesses (if any) expected to testify at the hearing on behalf of the Medical Executive Committee. The content of this list is subject to update pursuant to Section 8.5-1.

#### 8.4-5 JUDICIAL REVIEW COMMITTEE

- (a) When an applicant or member requests a hearing, the Chief of Staff shall appoint a Judicial Review Committee. The Judicial Review Committee shall be composed of not less than three (3) members of the medical staff along with the appointment of a member to serve as an alternate. Such appointment shall include designation of the Chair.
- (b) 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. Knowledge of the matter involved shall not preclude a member of the medical staff from serving as a member of the Judicial Review Committee.
- (c) In the event that it is not feasible to appoint a Judicial Review Committee from the active orthopedic staff or active medical/surgical staff, the Chief of Staff may appoint members from any other staff category or practitioners who are not members of the medical staff.
- (d) The Judicial Review Committee shall include at least one member who shall have the same healing arts licensure as the accused and, where feasible, shall include an individual practicing the same specialty as the member. The failure to include an individual practicing the same specialty as the member shall not be grounds to invalidate the outcome of the hearing.
- (e) Each member of the Judicial Review Committee must attend each hearing session or Committee meeting, unless both parties agree that any one member need not attend a particular hearing session or Committee meeting.
- (f) At the sole discretion of the Medical Executive Committee, an arbitrator may be appointed in lieu of a Judicial Review Committee. The arbitrator is selected using the process detailed in Section 8.5-4, which, by accepting membership and privilege on this medical staff, the member agrees is acceptable. The arbitrator shall meet the same qualifications as the Hearing Officer. The arbitrator shall carry out all the duties assigned to the Hearing Officer and to the Judicial Review Committee. If an arbitrator is appointed, no separate Judicial Review Committee or Hearing Officer



shall be appointed, and all references in these Bylaws to the Judicial Review Committee or Hearing Officer duties and responsibilities shall be read as the arbitrator's duties and responsibilities.

- (g) The Judicial Review Committee, or the arbitrator, if one is used, shall have such powers as are necessary to discharge its or his/her responsibilities.

#### 8.4-6 FAILURE TO APPEAR OR PROCEED

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

#### 8.4-7 POSTPONEMENTS AND EXTENSIONS

Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted in these bylaws may be permitted by the hearing officer on a showing of good cause, or upon agreement of the parties. extensions of time necessary to appoint the judicial review committee, hearing officer, and/or arbitrator shall be deemed good cause so long as both parties are proceeding in good faith.

### 8.5 FAIR HEARING PROCEDURE

#### 8.5-1 PREHEARING PROCEDURE

- (a) If either side to the hearing requests in writing a list of witnesses, then at least ten (10) days before commencement of the hearing each party shall furnish to the other a written list of the names of the individuals who are anticipated to testify in support of that party at the hearing. Failure to disclose the identity of a witness at least ten (10) days before commencement of the hearing shall constitute grounds for a continuance. Nothing in the foregoing shall preclude the testimony of additional witnesses whose possible participation was not reasonably anticipated. The parties shall notify each other as soon as they become aware of the possible participation of such additional witnesses. The failure to have provided the name of any witness at least ten days prior to the hearing date at which the witness is to appear shall constitute good cause for a continuance.
- (b) Each party shall have the right to inspect and copy, at its expense, any documents or other evidence relevant to the charges which the other

party has in its possession or control as soon as practicable after receipt of such a request. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable members, other than the member under review.

- (c) The failure by either party to provide access to the information discussed in Section 8.5-1(b) at least thirty (30) days before the hearing shall constitute good cause for a continuance.
- (d) The member and the Medical Executive Committee shall have the right to receive copies of all evidence expected to be introduced at the hearing. Failure to produce such documents ten (10) days before commencement of the hearing shall constitute good cause for a continuance.
- (e) The hearing officer shall consider and rule upon any request for access to information and may impose any safeguards the protection of the peer review process and justice requires. In so doing, the hearing officer shall consider:
  - 1. whether the information sought may be introduced to support or defend the charges;
  - 2. the exculpatory or inculpatory nature of the information sought, if any;
  - 3. the burden imposed on the party in possession of the information sought, if access is granted; and
  - 4. any previous requests for access to information submitted or resisted by the parties to the same proceeding.
- (f) The member and the Medical Executive Committee shall be entitled to a reasonable opportunity to question and challenge the impartiality of judicial review committee members and the hearing officer or arbitrator. Challenges to the impartiality of any judicial review committee member or the hearing officer or arbitrator shall be ruled on by the hearing officer.
- (g) It shall be the duty of the member and the Medical Executive Committee or its designee to exercise reasonable diligence in notifying the hearing officer or arbitrator of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions

concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be succinctly made at the hearing.

#### 8.5-2 REPRESENTATION

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

- (a) If the practitioner wishes to be accompanied at the hearing by an attorney, he/she shall state the notice of such intent in the written Request for Hearing, as provided in Section 8.4-2 above.
- (b) The Medical Executive Committee representative shall not be accompanied by an attorney if the practitioner is not accompanied by an attorney. The foregoing shall not be deemed to deprive any party of its right to the assistance of legal counsel for the purpose of preparing for the hearing.
- (c) Attorneys for either party may accompany their clients in the hearing sessions in order to advise their clients, although any such attorney shall not examine witnesses, shall not address the judicial review committee, and shall not make any oral statement whatsoever in the hearing.
- (d) Whether or not attorneys are present in the hearing pursuant to this article, the practitioner and the Medical Executive Committee may be represented at the hearing by a practitioner licensed to practice medicine in the State of California who is not also an attorney at law.
- (e) The hearing officer or arbitrator shall not allow the presence of attorneys at the hearing to be disruptive or cause a delay in the hearing process.
- (f) The member and the Medical Executive Committee may stipulate to allow greater participation by attorneys in the hearing than this Article provides. Otherwise, the above provisions of this Section will control.

### 8.5-3 THE HEARING OFFICER

- (a) If the Medical Executive Committee elects to use a judicial review committee, then the Medical Executive Committee shall appoint\_a hearing officer to preside at the hearing. The hearing officer shall be an attorney at law qualified to preside over a quasi-judicial hearing, but an attorney regularly utilized by the hospital for legal advice regarding its 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.
- (b) The Medical Executive Committee will attempt to appoint a hearing officer that is acceptable to the member. In the event that the Medical Executive Committee and the member cannot agree on the hearing officer, the Medical Executive Committee will appoint a hearing officer only if (1) the hearing officer has not been served as a hearing officer for the hospital in the preceding three years, and (2) if the hearing officer agrees not to accept appointment as a hearing officer for the hospital for at least five years following the conclusion of the hearing and appeal process.
- (c) 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.
- (d) The hearing officer shall be entitled to determine the order of and procedure for the presentation of 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.
- (e) The hearing officer has the authority to impose limits on the amount of time each party has to present evidence. The hearing officer shall not impose limits arbitrarily, but shall allow each party to submit written statements regarding the amount of time necessary to present its case.
- (f) 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 action as may be warranted by the circumstances, including limiting the scope of examination and cross-examination and

setting fair and reasonable time limits on either side's presentation of its case. The hearing officer shall be entitled to exercise discretion in limiting the number of witnesses and the overall amount of evidence introduced at the hearing.

- (g) The hearing officer is authorized to exercise discretion in limiting the ability of either party to communicate with witnesses outside the realm of the hearing.
- (h) When no attorney accompanies any party to the proceedings, the Hearing Officer shall have the authority to interpose and rule on appropriate objections throughout the course of the hearing. The hearing officer shall not, however, have the authority to override or revise the Representation section of these Bylaws.
- (i) If requested by the Judicial Review Committee, the hearing officer may participate in the deliberations of such committee and be a legal advisor to it, but the hearing officer shall not be entitled to vote.

#### 8.5-4 APPOINTMENT OF ARBITRATOR

When the Medical Executive Committee has elected to use an Arbitrator to review the matter, an Arbitrator who meets the Hearing Officer qualifications detailed in this Article shall be appointed and preside over the hearing as follows:

- (a) Within 10 days of requesting a hearing, the member must send to the Medical Executive Committee a list of at least three attorneys whom he or she would accept as Arbitrator. If the member fails to provide a list, then the Medical Executive Committee shall initiate the Arbitrator selection process as if it had rejected the member's list of nominees as provided below.
- (b) The Medical Executive Committee may select the Arbitrator from the member's list. If the Medical Executive Committee does not accept any of the Arbitrator nominees identified by the member, the Medical Executive Committee must provide the member a written list of at least three potential Arbitrators within ten days after rejection of the member's list.

- (c) The member shall have five days from his/her receipt of the Medical Executive Committee's list to select an Arbitrator from the list. If the member fails to select an Arbitrator or to reject all the names on the list within that time, then the Medical Executive Committee may select any person on its list as the Arbitrator.
- (d) If the member timely rejects the Medical Executive Committee's list, then the member and the Medical Executive Committee shall each designate one name from their respective lists. The persons designated shall, within five days, select an Arbitrator who shall be appointed subject to *voir dire*. If the persons designated fail to select an Arbitrator timely, the process shall be repeated with other names selected from the parties' respective lists until an Arbitrator is selected.
- (e) If, for any reason, the person so identified is not available, cannot otherwise serve, or, after *voir dire*, is unacceptable to both the Medical Executive Committee and the member, the same process set forth in this will be followed until an Arbitrator is selected and agrees to serve.
- (f) If the failure or refusal of the member to agree to an Arbitrator makes it impracticable to commence the hearing within the time frames set forth above, the time for commencement of the hearing shall be extended to thirty (30) days after an Arbitrator is selected.
- (g) Nothing in the above sections shall be construed as limiting the ability of the member and Medical Executive Committee to select an arbitrator through a different, mutually acceptable process.

#### 8.5-5 RECORD OF THE FAIR HEARING

A shorthand reporter shall be present to make a record of the fair hearing proceedings, and the pre-hearing proceedings if deemed appropriate by the hearing officer. The cost of attendance of the shorthand reporter shall be borne by the hospital, 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 oral evidence shall be taken only on oath administered by any person lawfully authorized to administer such oath.

#### 8.5-6 RIGHTS OF THE PARTIES

Within reasonable limitations, both sides at the hearing may call and examine witnesses for relevant testimony, introduce relevant exhibits or other documents, cross-examine or impeach witnesses who shall have testified orally on any matter relevant to the issues, and otherwise rebut evidence, as long as these rights are exercised in an efficient and expeditious manner. The member may be called by the Medical Executive Committee and examined as if under cross-examination.

#### 8.5-7 MISCELLANEOUS RULES

- (a) Judicial rules of evidence and procedure relating to the conduct of the fair hearing, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under this Article. Any relevant evidence, including hearsay, shall be unobjectionable and shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.
- (b) Evidence of mediation, compromise or offers of settlement, as well as any conduct or statements made in negotiation thereof, is inadmissible to prove either parties' opinion regarding the strength or weakness of the actions that provide the grounds for the hearing.
- (c) Upon motion by the Medical Executive Committee, the hearing officer shall exclude evidence that was not provided during an appointment, reappointment or privilege application review or during corrective action despite the requests of the peer review body for such information, unless the practitioner can prove he or she previously acted diligently and could not have submitted the information.
- (d) The Judicial Review Committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate.
- (e) Both parties may file and submit to the hearing officer written arguments and motions on any issue which may arise during the course of the hearing. The hearing officer shall ensure that the parties have opportunities to respond to any motion or argument the other party makes. The hearing officer may set page limits and deadlines for the written arguments and oppositions or replies to such arguments. The

hearing officer's ruling on any written argument or motion must be in writing and must be entered into the hearing record. Neither party may make motions or offer written arguments directly to the Judicial Review Committee unless specifically permitted by the hearing officer.

- (f) Both the parties and the hearing officer shall endeavor to complete the hearing within a reasonable time.
- (g) Upon motion of either party or the Hearing Officer, the Judicial Review Committee may terminate the hearing if it finds that either party has (1) exhibited flagrant or repeated noncompliance with this Article in a manner that prejudices the other party or results in repeated delays to the hearing process, or (2) has egregiously interfered with the orderly conduct of the hearing. A finding that the termination results from the member's noncompliance or egregious conduct shall result in a finding that the member has waived his or her right to a hearing. The hearing officer shall be permitted to advise the Judicial Review Committee regarding his or her recommendation with regard to the disposition of the motion. Evidence of, or a finding that, a party intended to prejudice the other party, delay the hearing process, or interfere with the orderly conduct of the hearing is not necessary to support or grant the motion to terminate the hearing.

#### 8.5-8 BURDENS OF PRESENTING EVIDENCE AND PROOF

- (a) At the fair hearing the Medical Executive Committee shall have the initial duty to present evidence for each case or issue in support of its action or recommendation. The member shall be obligated to present evidence in response.
- (b) An applicant shall bear the burden of persuading the judicial review committee, by a preponderance of the evidence, of the applicant's qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning the applicant's current qualifications for membership and privileges. An applicant shall not be permitted to introduce information requested by the medical staff but not produced during the application process unless the applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.



- (c) Except as provided above for applicants, throughout the fair hearing, the Medical Executive Committee 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. In meeting this burden, the Medical Executive Committee shall not be limited to presenting only that information available to it at the time it imposed or recommended the action, but rather may present all relevant information (within the limits discussed elsewhere in this article) available to it at the time of the hearing.
- (d) The Medical Executive Committee is not required to prove each and every charge or issue in front of the Judicial Review Committee in order for its actions and/or recommendation(s) to be found reasonable and warranted.
- (e) “Reasonable and warranted” means within the range of alternatives reasonably open to the Medical Executive Committee under the circumstances, and not necessarily that the action or recommendation is the only measure or the best measure that can be taken or formulated in the judicial review committee’s opinion.

#### 8.5-9 ADJOURNMENT AND CONCLUSION

After consultation with the chair of the judicial review committee, the hearing officer may adjourn the hearing and reconvene the same without special notice at such times and intervals as may be reasonable and warranted, with due consideration for reaching an expeditious conclusion to the fair hearing. Both the Medical Executive Committee and the member may submit a written statement at the close of the hearing, within guidelines as to length, format and submission dates approved by the hearing officer in consultation with the judicial review committee or its chairperson. Upon conclusion of the presentation of oral and written evidence, or the receipt of closing written arguments, if submitted, the fair hearing shall be closed.

#### 8.5-10 BASIS FOR DECISION

The decision of the judicial review committee shall be based on the evidence introduced at the fair hearing, including all logical and reasonable inferences from the evidence and the testimony.

## 8.5-11 DECISION OF THE JUDICIAL REVIEW COMMITTEE

Within 30 days after final adjournment of the fair hearing, the judicial review committee shall render a decision which shall be accompanied by a report in writing and shall be delivered to the Medical Executive Committee. If the member is currently under suspension, however, the time for the decision and report shall be 15 days. A copy of said decision also shall be forwarded to the CEO, the Board of Trustees, and to the member. The report shall contain a concise statement of the reasons in support of the decision including findings of fact and a conclusion articulating the connection between the evidence produced at the fair hearing and the conclusion reached. Both the member and the Medical Executive Committee shall be provided a written explanation of the procedure for appealing the decision. The decision of the judicial review committee shall be subject to such rights of appeal or review as described in these bylaws, but shall otherwise be affirmed by the Board of Trustees as the final action if the judicial review committee's findings are supported by substantial evidence, following a fair procedure, and the final action or recommendation approved by the judicial review committee is reasonable and warranted.

## 8.6 APPEAL

### 8.6-1 TIME FOR APPEAL

Within 10 days after receipt of the decision of the judicial review committee, either the member or the Medical Executive Committee may request an appellate review. A written request for such review shall be delivered to the Chief of Staff, the CEO, and the other party in the hearing. If a request for appellate review is not requested within such period, that action or recommendation shall be affirmed by the Board of Trustees as the final action if it is supported by substantial evidence, following a fair procedure.

### 8.6-2 GROUNDS FOR APPEAL

A written request for an appeal shall include an identification of the grounds for appeal and a clear and concise statement of the facts in support of the appeal. The grounds for appeal from the hearing shall be: (a) substantial non-compliance with the procedures required by these bylaws or applicable law which has created demonstrable prejudice; (b) the decision was not supported by substantial evidence based upon the hearing record or such additional information as may be permitted pursuant to Section 8.6-5.

#### 8.6-3 TIME, PLACE AND NOTICE

If an appellate review is to be conducted, the appeal board shall, within 35 days after receipt of notice of appeal, schedule a review date and cause each side to be given notice of the time, place and date of the appellate review. The date of appellate review shall not be less than 15 nor more than 90 days from the date of such notice, provided however, that when a request for appellate review concerns a member who is under suspension which is then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made, not to exceed 30 days from the date of the notice. The time for appellate review may be extended by the appeal board for good cause.

#### 8.6-4 APPEAL BOARD

The Board of Trustees may sit as the appeal board, or it may appoint an appeal board which shall be composed of not less than 5 members of the Board of Trustees. Knowledge of the matter involved shall not preclude any person from serving as a member of the appeal board, so long as that person did not take part in a prior hearing on the same matter. The appeal board may select an attorney to assist it in the proceeding, but that attorney shall not be entitled to vote with respect to the appeal. The attorney firm selected by the Board of Trustees shall be neither the attorney firm that represented either party at the hearing before the judicial review committee nor the attorney who assisted the hearing panel or served as hearing officer.

#### 8.6-5 APPEAL PROCEDURE

The proceeding by the appeal board shall be in the nature of an appellate hearing based upon the record of the hearing before the judicial review committee, provided that the appeal board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the judicial review committee in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the judicial review hearing; or the appeal board may remand the matter to the judicial review committee for the taking of further evidence and for decision. Each party shall have the right to be represented by legal counsel, or any other representative designated by that party in connection with the appeal, to present a written statement in support of that party's position on appeal, and to personally appear and make oral argument. The appeal board may thereupon conduct, at a time convenient to itself,

deliberations outside the presence of the appellant and respondent and their representatives. The appeal board shall present to the Board of Trustees its written recommendations as to whether the Board of Trustees should affirm, modify, or reverse the judicial review committee decision consistent with the standard set forth in Section 8.6-6, or remand the matter to the judicial review committee for further review and decision.

#### 8.6-6 DECISION

- (a) Except as provided in Section 8.8-6(b), within 30 days after the conclusion of the appellate review proceedings, the Board of Trustees shall render a final decision and shall affirm the decision of the judicial review committee if the judicial review committee's decision is supported by substantial evidence, following a fair procedure.
- (b) Should the Board of Trustees determine that the judicial review committee's findings are not supported by substantial evidence or that the final action or recommendation approved by the judicial review committee is not reasonable and warranted, the board may modify or reverse the decision of the judicial review committee and may instead, or shall, where a fair procedure has not been afforded, remand the matter to the judicial review committee for reconsideration, stating the purpose for the referral. 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 recommendations to the Board of Trustees. This further review and the time required to report back shall not exceed 30 days in duration except as the parties may otherwise agree or for good cause as jointly determined by the chair of the Board of Trustees and the judicial review committee.
- (c) The decision shall be in writing, shall specify the reasons for the action taken and shall be forwarded to the Chief of Staff, the Medical Executive Committee, the subject of the hearing, and the CEO.

#### 8.6-7 RIGHT TO ONE FAIR HEARING

Except in circumstances where a new hearing is ordered by the Board of Trustees 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 evidentiary hearing and one appellate review on any matter which shall have been the subject of adverse action or recommendation.

## **8.7 EXCEPTIONS TO FAIR HEARING RIGHTS**

### **8.7-1 PRIVILEGES AFFECTED BY EXCLUSIVE CONTRACTS**

- (a) A medical staff member providing professional services under a contract with the hospital shall not have medical staff privileges terminated for reasons pertaining to the quality of care provided by the medical staff member without the same rights of fair hearing and appeal as are available to all members of the medical staff.
- (b) Except as specified in this Section, the termination of privileges following the decision determined to be appropriate by the medical staff to close a department/service pursuant to an exclusive contract or to transfer an exclusive contract shall not be subject to the procedural rights set forth in Section 8.3. To the degree termination of certain specific privileges, but not all privileges, of a medical staff member are warranted by an exclusive contract, whether in the same or different specialty within the hospital as covered by the exclusive contract, other privileges of that member that are not affected by the institution of the exclusive contract shall remain granted and unchanged. Those specific privileges of a member that are terminated because of institution of an exclusive contract must be stricken from the list of approved privileges maintained by the medical staff for that member.

### **8.7-2 AUTOMATIC SUSPENSION OR LIMITATION OF PRACTICE PRIVILEGES**

No hearing is required when a member's license or legal credential to practice has been revoked or suspended as set forth in Section 7.4-1(a). In other cases described in Sections 7.3-1 and 7.3-2, the issues which may be considered at a hearing, if requested, shall not include evidence designed to show that the determination by the licensing or credentialing authority or certifying authority was unwarranted, but only whether the member may continue practice in the hospital with those limitations imposed.

### **8.7-3 FAILURE TO MEET MINIMUM QUALIFICATIONS**

An applicant for appointment, reappointment, or new privileges shall not be entitled to any hearing or appellate review rights if his/her membership or

privileges, application, or request is denied because of his/her failure to meet the minimum qualifications for membership as specified in these Bylaws.

#### 8.7-4 ADVANCED PRACTICE ALLIED HEALTH PROFESSIONALS

With the exception of clinical psychologists, Advanced Practice Allied Health Professionals (AHP's) are not entitled to the hearing rights set forth in this Article, but may be entitled to the rights in the Allied Health Professional Rules and Regulations.

### **8.8 MEDICO-ADMINISTRATIVE OFFICER**

The fair hearing rights of Article VII and VIII generally do not apply to the decision to remove a medico-administrative officer from his or her position. Removal from office of such persons shall instead be governed by the terms of their individual contracts and/or agreements with the hospital. However, the Article VII and VIII procedural rights shall apply if an adverse action is taken with respect to the practitioner's Medical Staff membership or privileges - provided the action is taken for a medical disciplinary cause or reason and, therefore, reportable to the Medical Board of California in accordance with Section 805 of the Business and Professions Code.

### **8.9 MEDIATION OF PEER REVIEW DISPUTES**

#### 8.9-1 PURPOSE

Mediation is a confidential process in which a neutral person facilitates communication between the Medical Executive Committee and a practitioner to assist them in reaching a mutually acceptable resolution of a peer review controversy in a manner that is consistent with the best interests of patient care.

The parties are encouraged to consider mediation whenever it could be productive in resolving the dispute.

#### 8.9-2 REQUEST

In order to obtain consideration of mediation, the practitioner must request mediation in writing, as defined herein, within 10 days of his/her receipt of a notice of action or proposed action that would give rise to a hearing pursuant to these Bylaws.

### 8.9-3 DEADLINES

If the practitioner and the Medical Executive Committee agree to mediation, all deadlines and time frames relating to the fair hearing process shall be tolled while the mediation is in process, and the practitioner agrees that no damages may accrue as the result of any delays attributable to the mediation.

Mediation cannot be used by either the medical staff or the practitioner as a way of unduly delaying the corrective action/fair hearing process. Accordingly, unless both the medical staff and the practitioner agree otherwise, mediation must commence within 30 days of the practitioner's request and must conclude within 30 days of its commencement. If the mediation does not resolve the dispute, the fair hearing process will promptly resume upon completion of the mediation.

### 8.9-4 SELECTION AND PROCESS

The parties shall cooperate in the selection of a mediator (or mediators). Mediators should be both familiar with the mediation process and knowledgeable regarding the issues in dispute. The mediator may also serve as the Hearing Officer at any subsequent hearing, subject to the agreement of the parties which may be given prior to the mediation or after, with the parties to decide when they will agree on this issue. The costs of mediation shall be shared two-thirds by the medical staff and one third by the practitioner. The inability of the medical staff and the practitioner to agree upon a mediator within the required time limits shall result in the termination of the mediation process and the resumption of the fair hearing process.

Once selected, the mediator and the parties, working together, shall determine the procedures to be followed during the mediation. Either party has the right to be represented by legal counsel in the mediation process.

### 8.9-5 CONFIDENTIALITY

All mediation proceedings shall be confidential and the provisions of California Evidence Code Section 1119 shall apply except that communications that confirm that mediation was mutually accepted and pursued may be disclosed as proof that otherwise applicable time frames were tolled or waived. Any such disclosure shall be limited to that which is necessary to confirm mediation was pursued, and shall not include any points that are substantive in nature or address the issues presented. Except as otherwise permitted in

this Section, no other evidence of anything said at, or any writing prepared for or as the result of, the mediation shall be used in any subsequent fair hearing process that takes place if the mediation is not successful.



## ARTICLE IX ADVANCE PRACTICE ALLIED HEALTH STAFF

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### 9.1 DEFINITIONS

Advanced Practice AHP: The definition of “Advanced Practice AHPs” as defined in the Advance Practice AHP Rules and Regulations is the same as stated in the Medical Staff Bylaws: Advanced Practice AHP (hereinafter referred to as “AHP”) means an individual, other than a licensed physician, dentist, clinical psychologist, or podiatrist, who provides direct patient care services in the Medical Center under a defined degree of supervision by a physician medical staff member who has been granted clinical privileges. AHPs exercise judgment within the areas of documented professional competence and consistent with the applicable State Practice Act. AHPs are designated by the Board of Trustees to be credentialed and privileged through the medical staff organization and are granted practice privileges via mechanisms defined in these AHP Rules & Regulations and the Medical Staff Bylaws and credentialing policies and procedures. The Board of Trustees periodically determines the categories of health care professionals eligible to apply for practice privileges as an AHP.

### 9.2 RESPONSIBILITIES

Each AHP shall:

- (a) Meet those responsibilities required by the medical staff and AHP rules and regulations and if not so specified, meet those responsibilities specified in Section 2.5 of Article II as are generally applicable to the more limited practice of the AHP.
- (b) Retain appropriate responsibility within his or her area of professional competence for the care of each patient in the hospital for whom he or she is providing services.
- (c) Participate, when requested, in patient care audit and other quality review, evaluation, and monitoring activities required of AHPs, in evaluating AHP applicants, in supervising initial AHP appointees of his or her 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.

## ARTICLE X OFFICERS

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### 10.1 OFFICERS OF THE MEDICAL STAFF

#### 10.1.-1 IDENTIFICATION

The officers of the medical staff shall be the Chief of Staff, Chief of Staff-elect, immediate past Chief of Staff, secretary-treasurer, and two (2) elected members-at-large, and one (1) elected Organization Medical Staff Section (OMSS) representative.

#### 10.1-2 QUALIFICATIONS

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

#### 10.1-3 NOMINATIONS

- (a) The Medical Staff election year shall be each even numbered Medical Staff year. A nominating committee shall be appointed by the Medical Executive Committee no later than one hundred twenty (120) days prior to the annual staff meeting to be held during the election year or at least forty-five (45) days prior to any special election. The nominating committee shall consist of the immediate past Chief of Staff who shall serve as the Chair, the elected members-at-large on the Medical Executive Committee, and one member from each of the clinical Departments of Cardiothoracic, Primary Care, Surgery, and Women and Children's chosen by vote of the Departments, or by Department chairman appointment, from among the active or senior active Medical Staff who are not then members of the Medical Executive Committee. The Nominating Committee shall meet and nominate one or more nominees for each office and for the elected member-at-large position on the Medical Executive Committee. Nominations of the Committee shall be reported to the Medical Executive Committee at least sixty (60) days prior to the annual meeting and shall be delivered or mailed to the

voting members of the Medical Staff at least forty (40) days prior to election.

- (b) Further nominations may be made for any office by any voting member of the medical staff, provided that the name of the candidate is submitted in writing to the chair of the nominating committee, is endorsed by the signature of at least 20 other members who are eligible to vote, and bears the candidate's written consent. These nominations shall be delivered to the chair of the nominating committee as soon as reasonably practicable, but at least 25 days prior to the date of election. If any nominations are made in this manner, the voting members of the medical staff shall be advised by notice delivered or mailed at least 10 days prior to the election.

#### 10.1-4 ELECTIONS

The Chief of Staff elect, the two (2) members-at-large, the one (1) OMSS member-at-large and secretary-treasurer shall be announced at the annual meeting of the medical staff which falls during the election year. Voting shall be by secret ballot as defined in the General Rules & Regulations. No proxy votes will be allowed. A nominee shall be elected upon receiving a majority (50% +1) of the valid votes cast. If no candidate for the office receives a majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes. In the case of a tie on the second ballot, the majority vote of the Medical Executive Committee shall decide the election by secret ballot at its next meeting or a special meeting called for that purpose.

#### 10.1-5 TERM OF ELECTED OFFICE

Each officer shall serve a two (2) year term, commencing on the first day of the medical staff year following the election. Each officer shall serve in each office until the end of that officer's term, or until a successor is elected, unless that officer shall sooner resign or be removed from office. At the end of that officer's term, the Chief of Staff shall automatically assume the office of immediate past Chief of Staff and the Chief of Staff elect shall automatically assume the office of Chief of Staff.

#### 10.1-6 RECALL OF OFFICERS

Any medical staff 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. Recall of a medical staff officer may be initiated by the Medical Executive Committee or shall be initiated by a petition signed by at least one-third of the members of the medical staff eligible to vote for officers. Recall shall be considered at a special meeting called for that purpose. The Officer who is to be recalled will have an opportunity to submit their written rebuttal to be sent along with the ballot. Recall vote shall be held within 2 weeks following the special meeting called for that purpose. Recall shall require a two-thirds vote of the medical staff members eligible to vote for medical staff officers who actually cast votes by secret ballot as defined in the general rules and regulations.

#### 10.1-7 VACANCIES IN ELECTED OFFICE

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

### **10.2 DUTIES OF OFFICERS**

#### 10.2-1 CHIEF OF STAFF

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

- (a) enforcing the medical staff bylaws and rules and regulations, implementing sanctions where indicated, and promoting compliance

with procedural safeguards where corrective action has been requested or initiated;

- (b) calling, presiding at, and being responsible for the agenda of all meetings of the medical staff;
- (c) serving as chair of the Medical Executive Committee and calling, presiding at, and being responsible for the agenda of all meetings thereof;
- (d) serving as an ex officio member of all other staff committees without vote, unless Chief of Staff membership in a particular committee is required by these bylaws;
- (e) interacting with the Chief Executive Officer in all matters of mutual concern within the hospital;
- (f) appointing, in consultation with the Medical Executive Committee, committee members for all standing committees other than the Medical Executive Committee and all special medical staff, liaison, or multi-disciplinary committees, except where otherwise provided by these bylaws and, except where otherwise indicated, designating the chairs of these committees;
- (g) representing the views and policies of the medical staff to the Board of Trustees at every Board of Trustees meeting;
- (h) being a spokesperson for the medical staff in external professional and public relations;
- (i) performing such other functions as may be assigned to the Chief of Staff by these bylaws, the medical staff, or by the Medical Executive committee;
- (j) serving on liaison committees with the Board of Trustees and administration, as well as outside licensing or accreditation agencies.
- (k) serving on liaison Committee with the Board of Trustees and administration, e.g., Joint Conference Committee, as well as outside licensing or accreditation agencies

#### 10.2-2 CHIEF OF STAFF-ELECT

The Chief of Staff-elect shall assume all duties and authority of the Chief of Staff in the absence of the Chief of Staff. The Chief of Staff elect shall be a member of the Medical Executive Committee and of the joint conference committee, shall attend and represent, at the direction of and in the absence of the Chief of Staff, the views and policies of the medical staff to the Board of Trustees at every Board of Trustees meeting and shall perform such other duties as the Chief of Staff may assign or as may be delegated by these bylaws, or by the Medical Executive Committee.

#### 10.2-3 IMMEDIATE PAST CHIEF OF STAFF

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

#### 10.2-4 SECRETARY-TREASURER

The secretary-treasurer shall be a member of the Medical Executive Committee. The duties shall include, but not be limited to:

- (a) maintaining a roster of members;
- (b) keeping accurate and complete minutes of all Medical Executive committee;
- (c) attending to all appropriate correspondence and notices on behalf of the medical staff;
- (d) receiving and safeguarding all funds of the medical staff;
- (e) submitting an annual budget of the funds of the medical staff;
- (f) submitting quarterly financial reports of the funds of the medical staff;
- (g) performing such other duties as ordinarily pertain to the office or as may be assigned from time to time by the Chief of Staff or Medical Executive committee.

### **10.3 OMSS REPRESENTATIVE – MEMBER-AT-LARGE**

The OMSS representative shall be a member of the Medical Executive Committee and shall perform, or assure the performance of, duties which shall include, but not be limited to:

- (a) Attendance of the American Medical Association (AMA), Organization Medical Staff Section, annual meeting and provide a report to the Medical Executive Committee on the current issues relating to the Medical Staff on a national level.
- (b) Attendance of the California Medical Association (CMA), Organization Medical Staff Section, annual meeting and provide a report to the Medical Executive Committee on the current issues relating to the Medical Staff on a state level.
- (c) Serve as a resource to the Bylaws committee on defining Medical Staff Organizational structure.
- (d) Assist the Medical Staff with advocacy issues relating to the Medical Staff organization.

### **10.4 MEMBERS-AT-LARGE**

The members-at-large shall be member of the Medical Executive Committee and shall perform, or assure the performance of, duties which shall include, but not be limited to:

- (a) Attending Officer meetings.
- (b) Acting as a resource for questions regarding information published in the Medical Staff newsletter.
- (c) Performing such other duties as ordinarily pertain to the office or as may be assigned from time to time by the Chief of Staff or Medical Executive Committee.

## **10.5 COMPENSATION OF MEDICAL STAFF OFFICERS**

Medical staff officers should be compensated for their work spent representing and leading the medical staff. Such compensation shall come from the medical staff bank account, for which the medical staff has sole responsibility. The payment to individual physicians should be in the amount determined by the Officers of the Medical Staff and shall not exceed fair market value. If the hospital provides any funds specifically earmarked for such compensation, those funds should be requested and accounted for in the medical staff budget for hospital approval. Payment to each physician under this provision shall be contingent upon each physician's proper performance of those duties, and the evaluation and determination of the quality of that performance is in the sole determination of the MEC.



## ARTICLE XI CLINICAL DEPARTMENTS AND CLINICAL SERVICES

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### 11.1 ORGANIZATION OF CLINICAL DEPARTMENTS AND CLINICAL SERVICES

The medical staff shall be organized into clinical departments. Each department shall be organized as a separate component of the medical staff and shall have a chair selected and entrusted with the authority, duties, and responsibilities specified in Section 11.7. A department may be further divided, as appropriate, into Clinical Services as defined in the department rules and regulations which shall be directly responsible to the department within which it functions, and which shall have a clinical service chief selected and entrusted with the authority, duties and responsibilities specified in Section 11.8. When appropriate, the Medical Executive Committee may recommend to the medical staff the creation, elimination, modification, or combination of departments or clinical services.

### 11.2 CURRENT DEPARTMENTS AND CLINICAL SERVICES

The current departments are: Cardiothoracic, Medicine, Surgery, Woman and Children's. All departments are required to maintain at least more than one specialty group.

#### 11.2.1 ESTABLISHING AND MAINTAINING A CLINICAL SERVICE

In order for a specialty group to become a Clinical Service the following criteria must be met and maintained:

- (a) Must have a minimum number of five (5) physicians in the group;
- (b) Must performs peer review;
- (c) Must meet regularly, but at a minimum four (4) times annually;
- (d) Attendees are required to attend 50% of their quarterly meetings.

Request for the establishment of a Clinical Service will be submitted to the Medical Executive Committee for approval.

### **11.3 ASSIGNMENT TO DEPARTMENTS AND CLINICAL SERVICES**

Each member shall be assigned membership in only one department, and to a clinical service, if any, within such department, but may also be granted clinical privileges in other departments or clinical service consistent with practice privileges granted.

### **11.4 FUNCTIONS OF DEPARTMENTS**

The general functions of each department shall include:

- (a) Conducting patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the department. The number of such reviews to be conducted during the year shall be as determined by the Medical Executive Committee in consultation with other appropriate committees. The department shall routinely collect information about important aspects of patient care provided in the department, periodically assess this information, and develop objective criteria for use in evaluating patient care. Patient care reviews shall include all clinical work performed under the jurisdiction of the department, regardless of whether the member whose work is subject to such review is a member of that department.
- (b) Recommending to the Medical Executive Committee criteria for the granting of clinical privileges and the performance of specified services within the department.
- (c) Evaluating and making appropriate recommendations regarding the qualifications of applicants seeking membership or renewal of membership and clinical privileges within that department.
- (d) Conducting, participating and making recommendations regarding continuing education programs pertinent to departmental clinical practice.
- (e) Reviewing and evaluating departmental adherence to: (1) medical staff policies and procedures and (2) sound principles of clinical practice.
- (f) Coordinating patient care provided by the department's members with nursing and ancillary patient care services.

- (g) Submitting written reports to the Medical Executive Committee concerning: (1) the department's review and evaluation activities, actions taken thereon, and the results of such action; and (2) recommendations for maintaining and improving the quality of care provided in the department and the hospital.
- (h) Meeting as often as necessary for the purpose of considering patient care review findings and the results of the department's other review and evaluation activities, as well as reports on other department and staff functions.
- (i) Establishing such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring protocols.
- (j) Taking appropriate action when important problems in patient care and clinical performance or opportunities to improve care are identified.
- (k) Accounting to the Medical Executive Committee for all professional and medical staff administrative activities within the department.
- (l) Appointing such committees as may be necessary or appropriate to conduct department functions.
- (m) Formulating recommendations for departmental rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to the approval by the Medical Executive Committee and the Board of Trustees.

#### **11.5 FUNCTIONS OF CLINICAL SERVICES**

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

## **11.6 DEPARTMENT QUALITY REVIEW COMMITTEES**

### **11.6.1 COMPOSITION**

Each Department may have a Department Quality Review Committee (QRC) consisting of not less than two (2) active staff members who shall be elected by mail ballot (department chair, vice-chair). In addition to the two elected members, the Quality Review Committees may appoint additional members as determined by the respective department chair and ratified by Medical Executive Committee.

### **11.6.2 FUNCTIONS OF THE DEPARTMENT QUALITY REVIEW COMMITTEE**

Each Department QRC functions may include, without limitation, retrospective patient care reviews, evaluation of patient care practices, credentials review and privileges delineation, and continuing education programs. The Department QRC shall transmit regular reports to the department chair on the conduct of its assigned functions.

## **11.7 DEPARTMENT CHAIRS**

### **11.7-1 QUALIFICATIONS**

Each department shall have a chair and vice-chair who shall be members of the active or senior active staff and shall be qualified by licensure, training, experience and demonstrated ability in at least one of the clinical areas covered by the department. Department chairs must be certified by an appropriate specialty board or must demonstrate comparable competence through the credentialing process.

### **11.7-2 SELECTION**

The Department election year shall be each even numbered Medical Staff year. At least sixty (60) days prior to the annual staff meeting, the members of the department will be notified that nominations for the department vice-chair member will be made at the next regularly scheduled Department meeting. Nominations may be submitted in writing prior to and/or in person at the meeting. The names of the nominees will be submitted to the voting members of the department and voted on by ballot as defined in the General Rules & Regulations. The election of the Department Chair and Vice-Chairman shall be subject to ratification by the Medical Executive Committee. Vacancies due to

any reason will be filled for the unexpired term through appointment by the Medical Executive Committee. Alternate methods for selection of chairmen and vice-chairmen may be used by the individual Departments subject to ratification by the Medical Executive Committee.

#### 11.7-3 TERM OF OFFICE

Each department chair and vice-chair shall serve a two [2] year term which coincides with the medical staff year or until their successors are chosen, unless they shall sooner resign, be removed from office, or lose their medical staff membership or clinical privileges in that department. Department chairs shall be eligible to succeed themselves.

#### 11.7-4 REMOVAL

After election and ratification, removal of department chairs and vice-chairs from office may occur for cause by a two-thirds vote of the Medical Executive Committee and a two-thirds vote of the department members eligible to vote on departmental matters who cast votes.

#### 11.7-5 DUTIES

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

- (a) act as presiding officer at departmental meetings;
- (b) report to the Medical Executive Committee and to the Chief of Staff regarding all professional and administrative activities within the department;
- (c) generally and continuously monitor the quality of patient care and professional performance rendered by members with clinical privileges in the department through a planned and systematic process; oversee and maintain the effective conduct of the patient care, evaluation, and monitoring functions delegated to the department by the Medical Executive Committee in coordination and integration with organization-wide quality assessment and improvement activities;

- (d) develop and implement departmental programs for retrospective patient care review, ongoing monitoring of practice, credentials review and privilege delineation, medical education, utilization review, and quality assessment and improvement and all other clinically related activities of the department;
- (e) be a member of the Medical Executive Committee, and give guidance on the overall medical policies of the medical staff and hospital and make specific recommendations and suggestions regarding the department;
- (f) transmit to the Medical Executive Committee the department's recommendations concerning practitioner membership and classification, renewal of membership, criteria for clinical privileges, monitoring of specified services, and corrective action with respect to persons with clinical privileges in the department;
- (g) endeavor to enforce the medical staff bylaws, rules, policies and regulations within the department;
- (h) implement within the department appropriate actions taken by the Medical Executive Committee;
- (i) participate in every phase of administration of the department, including recommending a sufficient number of qualified and competent persons to provide care, treatment, and services, and space and other resources needed by the department; cooperation with the nursing service and the hospital administration in matters such as personnel (including assisting in determining the qualifications and competence of department/service personnel who are not licensed independent practitioners and who provide patient care services), supplies, special regulations, standing orders and techniques;
- (j) assist in the preparation of such annual reports, including budgetary planning, pertaining to the department as may be required by the Medical Executive Committee;
- (k) assess and recommend to the Board of Trustees off-site sources for needed patient care, treatment, and services not provided by the department or the hospital;

- (l) integrate the department or service into the primary functions of the hospital, and coordinate and integrate interdepartmental and intradepartmental services ;
- (m) develop and implement departmental policies and procedures that guide and support the provision of care, treatment, and services in the department;
- (n) provide orientation and continuing education of all persons in the department or service;
- (o) recommend delineated clinical privileges for each member of the department; and
- (p) perform such other duties commensurate with the office as may from time to time be reasonably requested by the Chief of Staff or the Medical Executive Committee.

#### 11.7-6 COMPENSATION OF DEPARTMENT CHAIRS

Department Chairs should be compensated for their work spent representing and leading the medical staff. Such compensation shall come from the medical staff bank account, for which the medical staff has sole responsibility. The payment to individual physicians should be in the amount determined by the Officers of the Medical Staff and shall not exceed fair market value. If the hospital provides any funds specifically earmarked for such compensation, those funds should be requested and accounted for in the medical staff budget for hospital approval. Payment to each physician shall be contingent upon each physician's proper performance of those duties, and the evaluation and determination of the quality of that performance is in the sole determination of the MEC.

### **11.8 CLINICAL SERVICE CHIEFS**

#### 11.8-1 QUALIFICATIONS

The Clinical Service Chair election year shall be each even numbered Medical Staff year. Each clinical service shall have a chair who shall be a member of the active or senior active medical staff and a member of the clinical service, and shall be qualified by training, experience, and demonstrated current ability in the clinical area covered by the clinical service.

#### 11.8-2 SELECTION

Each clinical service chief shall be selected or elected with such mechanism as the medical staff may adopt. Vacancies due to any reason shall be filled for the unexpired term by the department chair.

#### 11.8-3 TERM OF OFFICE

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

#### 11.8-4 REMOVAL

After appointment and ratification, a clinical service chief may be removed by the department chair and the Medical Executive Committee.

#### 11.8-5 DUTIES

Each clinical service chief shall:

- (a) act as presiding officer at clinical service meetings;
- (b) assist in the development and implementation, in cooperation with the department chair, of programs to carry out the quality review, and evaluation and monitoring functions assigned to the clinical service;
- (c) evaluate the clinical work performed in the clinical service;
- (d) conduct investigations and submit reports and recommendations to the department chair regarding the clinical privileges to be exercised within the clinical service by members of or applicants to the medical staff; and
- (e) perform such other duties commensurate with the office as may from time to time be reasonably requested by the department chair, the Chief of Staff, or the Medical Executive Committee.



## ARTICLE XI COMMITTEES

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### 12.1 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 clinical services, meetings of committees established under this Article, and meetings of special or ad hoc committees created by the Medical Executive Committee (pursuant to this Article) or by departments (pursuant to Sections 11.4(i) and (l)). The committees described in this Article shall be the standing committees of the medical staff. Special or ad hoc committees may be created by the Medical Executive Committee to perform specified tasks. Unless otherwise specified, the chair and members of all committees shall be appointed by and may be removed by the Chief of Staff, subject to consultation with and approval by the Medical Executive Committee. Medical staff committees shall be responsible to the Medical Executive Committee.

### 12.2 GENERAL PROVISIONS

#### 12.2-1 TERMS OF COMMITTEE MEMBERS

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

#### 12.2-2 REMOVAL

If a member of a committee ceases to be a member in good standing of the medical staff, or loses employment or a contract relationship with the hospital, suffers a loss or significant limitation of practice privileges, or if any other good cause exists, that member may be removed by the Medical Executive Committee.

#### 12.2-3 VACANCIES

Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made; provided however, that if an individual who obtains membership by

virtue of these bylaws is removed for cause, a successor may be selected by the Medical Executive Committee.

## **12.3 MEDICAL EXECUTIVE COMMITTEE**

### **12.3-1 COMPOSITION**

The Medical Executive Committee shall consist of the following positions:

- (a) the following officers of the Medical Staff;  
  
Chief of Staff, Chief of Staff-elect, Immediate Past Chief of Staff, Secretary–Treasurer, Elected members-at large and the Elected OMSS Representative;
- (b) the Department Chairmen who shall have a vote. In the absence of the Department Chairman the Vice-Chairman who shall have a vote. No other alternate is acceptable;
- (c) the Clinical Service Chairmen who shall have a vote;
- (d) the Chief Executive Officer, Chief Operating Officer, Chief Medical Officer, Chief Nursing Officer, Vice-President of Operations, Medical Staff Advisor, Vice-President of Mission Integration and the Board of Trustees Chair/Representative as *ex officio* and without vote;
- (e) the Department Vice-Chairs may attend the Medical Executive Committee as *ex officio* without a vote, unless they are acting as the Department Chair in Section 12.3-1(b);

A Medical Executive Committee member can be removed from the committee only if the medical staff acts to remove that member from the position held as an officer, OMSS representative or at-large members, in the same manner as provided in Section 10.1-6 for the recall of officers, or, in the case of department chair, if the department acts to remove the member from the department chair as provided in Section 11.7-4.

Other individuals may be invited from time to time, to participate on specific issues, and with the approval of the chairman of the Medical Executive Committee.

### 12.3-2 DUTIES

The duties of the Medical Executive Committee, as delegated by the medical staff, are:

- (a) representing and acting on behalf of the medical staff in the intervals between medical staff meetings within the scope of its responsibilities and subject to such limitations as may be imposed by these bylaws;
- (b) coordinating and implementing the professional and organizational activities and policies of the medical staff;
- (c) receiving and acting upon reports and recommendations from medical staff departments, clinical services, committees, and assigned activity groups
- (d) recommending actions to the Board of Trustees on matters of a medical-administrative nature;
- (e) developing and adopting appropriate policies , to enable privileges holders to maintain the level of practice required under, and to more specifically implement, these Bylaws;
- (f) establishing appropriate criteria for cross-specialty privileges in accordance with Section 6.2-3,
- (g) making recommendations directly to the Board of Trustees based on medical staff organization concerns about the medical staff organization's structure, the process used to review credentials and delineate privileges and the delineation of privileges for each practitioner privileges through the medical staff process;
- (h) evaluating the medical care rendered to patients in the hospital;
- (i) participating in the development of hospital policy, practice, and planning;
- (j) reviewing the qualifications, credentials, performance and professional competence, and character of applicants and staff members, and making recommendations to the Board of Trustees at least quarterly regarding

staff membership and renewals of membership, assignments to departments, clinical privileges, and corrective action;

- (k) taking reasonable steps to promote ethical conduct and competent clinical performance on the part of all members including the initiation of and participation in medical staff corrective or review measures when warranted;
- (l) taking reasonable steps to develop continuing education activities and programs for the medical staff;
- (m) designating such committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the medical staff and approving or rejecting appointments to those committees by the Chief of Staff;
- (n) reporting to the medical staff at each regular staff meeting;
- (o) assisting in the obtaining and maintenance of accreditation;
- (p) developing and maintenance of methods for the protection and care of patients and others in the event of internal or external disaster;
- (q) appointing such special or ad hoc committees as may seem necessary or appropriate to assist the Medical Executive Committee in carrying out its functions and those of the medical staff;
- (r) reviewing the quality and appropriateness of patient care services provided by professional services;
- (s) reviewing and approving the designation of the hospital's authorized representative for National Practitioner Data Bank purposes;
- (t) establishing a mechanism for dispute resolution between medical staff members (including limited license practitioners) involving the care of a patient;
- (u) affirmatively implementing, enforcing and safeguarding 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:

1. initiating, developing and adopting medical staff bylaws, rules and regulations, and amendments thereto, subject to the approval of the hospital Board of Trustees, which approval shall not be unreasonably withheld;
  2. selecting and removing medical staff officers;
  3. assessing medical staff dues and utilizing the medical staff dues as appropriate for the purposes of the medical staff;
  4. the ability to retain and be represented by independent legal counsel at the expense of the medical staff;
  5. establishing, in medical staff bylaws, rules or regulations, criteria and standards for medical staff membership and privileges, and for enforcing those criteria and standards;
  6. establishing in medical staff bylaws, rules or regulations, clinical criteria and standards to oversee and manage quality assurance, utilization review and other medical staff activities including, but not limited to, periodic meetings of the medical staff and its committees and departments and review and analysis of patient medical records;
  7. taking such action as appropriate to enforce Section 15.7 of these bylaws regarding the prohibition against retaliation directed towards a member;
- (v) taking such other steps as appropriate to meet and confer in good faith, including using the Joint Conference Committee process, to resolve disputes with the governing body, or any other person or entity, regarding any self-governance rights of the medical staff.
- (w) 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, up to and including resort to resolution of the matter in the courts as permitted by law;

- (x) participating in the interview, review and selection of candidates for position of chief medical officer in the hospital.

#### 12.3-3 MEETINGS

The Medical Executive Committee shall meet as often as necessary, but at least 6 times a year and shall maintain a record of its proceedings and actions.

### **12.4 CREDENTIALS COMMITTEE**

#### 12.4-1 COMPOSITION

The Credentials Committee shall consist of the chairmen and vice-chairmen of the Departments and the Clinical Service chairman. The Credentials Committee chairman shall be the Immediate Past Chief of Staff.

#### 12.4-2 DUTIES

The credentials committee shall:

- (a) review and evaluate the qualifications of each practitioner applying for initial membership, renewal of membership, or modification of clinical privileges, and, in connection therewith, obtain and consider the recommendations of the appropriate departments;
- (b) submit required reports and information on the qualifications of each practitioner applying for membership or particular clinical privileges including recommendations with respect to membership, membership category, department affiliation, clinical privileges, and special conditions;
- (c) investigate, review and report on matters referred by the Chief of Staff or the Medical Executive Committee regarding the qualifications, conduct, professional character or competence of any applicant or medical staff member; and
- (d) submit periodic reports to the Medical Executive Committee on its activities and the status of pending applications.

### 12.4-3 MEETINGS

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

## **12.5 JOINT CONFERENCE COMMITTEE**

### 12.5-1 COMPOSITION

The joint conference committee shall be composed of an equal number of members of the Board of Trustees and of the Medical Executive Committee. The chairmen shall be the Chief of Staff or their designee and the Chairman of the Board of Trustees or their designee. The chairship of the committee shall alternate every other meeting between the Board of Trustees and the medical staff.

The Joint Conference Committee shall include three members of the Medical Staff and three members of the Board of Trustees. All members have equal voice and vote.

The Medical Staff membership shall be as follows:

- (a) Chief of Staff, Chief of Staff-Elect and Immediate Past Chief of Staff.

The Board of Trustees membership shall be as follows:

- (a) Chairman of the Board of Trustees, Chief Executive Officer of the hospital, one (1) other member of the Board of Trustees appointed by the Board of Trustees.

### 12.5-2 DUTIES

The joint conference committee shall constitute a forum for the discussion of matters of hospital and medical staff policy, practice, and planning, and the exclusive forum for interaction between the Board of Trustees and the medical staff on such matters as may be referred by the Medical Executive Committee or the Board of Trustees. The Joint Conference Committee shall serve as the body to handle medical staff and Board of Trustees disputes, and shall meet and confer in good faith to resolve such disputes. Dispute Resolution process shall be followed as defined in the General Rules & Regulations. Any

amendments to the Dispute Resolution process as defined in the General Rules & Regulations, shall be agreed upon at the Joint Conference Committee. The joint conference committee shall exercise any other responsibilities set forth in these bylaws.

#### 12.5-3 MEETINGS

The joint conference committee shall meet at least semi-annually, and shall transmit written reports of its activities to the Medical Executive Committee and to the Board of Trustees.

### **12.6 PHARMACY AND THERAPEUTICS COMMITTEE**

#### 12.6-1 COMPOSITION

The pharmacy and therapeutics committee shall consist of at least 5 representatives from the medical staff, a representative from the pharmaceutical service, clinical excellence, infection prevention & control, nutritional services, as well as from the nursing service and hospital administration. The Director of Pharmacy and the Clinical Coordinator will be afforded voting rights on this committee. The Committee may invite to its meeting persons within or outside the hospital who can contribute specialized or unique knowledge, skills, and judgment.

#### 12.6-2 DUTIES

The duties of the pharmacy and therapeutics committee shall include:

- (a) assisting in the formulation of professional practices and policies regarding the continuing evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs in the hospital, including antibiotic usage;
- (b) advising the medical staff and the pharmaceutical service on matters pertaining to the choice of available drugs;
- (c) making recommendations concerning drugs to be stocked on the nursing unit floors and by other services;
- (d) periodically developing and reviewing a formulary or drug list for use in the hospital;



- (e) evaluating clinical data concerning new drugs or preparations requested for use in the hospital;
- (f) establishing standards concerning the use and control of investigational drugs and of research in the use of recognized drugs;
- (g) maintaining a record of all activities relating to pharmacy and therapeutics functions and submitting periodic reports and recommendations to the Medical Executive Committee concerning those activities;
- (h) developing proposed policies and procedures for, and continuously evaluating the appropriateness of blood and blood products usage, including the screening, distribution, handling and administration, and monitoring of blood and blood components' effects on patients; and
- (i) reviewing untoward drug reactions.

#### 12.6-3 MEETINGS

The committee shall meet as often as necessary at the call of its chair but at least quarterly. It shall maintain a record of its proceedings and shall report its activities and recommendations to the Patient Safety/Performance Improvement Committee.

### **12.7 BYLAWS COMMITTEE**

#### 12.7-1 COMPOSITION

The bylaws committee shall consist of the Officers. The Chairman shall be the Immediate Past Chief of Staff.

#### 12.7-2 DUTIES

The duties of the bylaws committee shall include:

- (a) conducting an annual review of the medical staff bylaws, as well as the rules and regulations and policies promulgated by the medical staff;
- (b) developing and submitting recommendations to the Medical Executive Committee for changes in these documents as necessary to reflect or improve current medical staff practices; and

- (c) reviewing the hospital bylaws and policies for inconsistencies and conflicts with medical staff documents and reporting issues and recommendations to the Medical Executive Committee for its review.

#### 12.7-3 MEETINGS

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

### **12.8 PATIENT SAFETY AND PERFORMANCE IMPROVEMENT COMMITTEE**

#### 12.8-1 COMPOSITION

The patient safety and performance improvement committee shall consist of such members as may be designated by the Medical Executive Committee including, insofar as possible, at least the vice-chairs of each clinical department, chairs of the clinical services, the chair of CME Committee, Pharmacy & Therapeutics Committee, Interdisciplinary Practice Committee Infection Prevention & Control Committee and the Director of Pharmacy. The Chair may invite other members as needed.

#### 12.8-2 DUTIES

The patient safety and performance improvement committee shall perform the following duties:

Recommend for approval of the Medical Executive Committee plans for maintaining patient safety and quality patient care within the hospital which may include the following mechanisms:

- (a) establish systems to identify potential problems in patient care;
- (b) set priorities for action on problem correction;
- (c) refer priority problems for assessment and corrective action to appropriate departments or committees;
- (d) monitor the results of patient safety and quality assessment and improvement activities throughout the hospital; and

- (e) coordinate patient safety and quality assessment and improvement activities.
- (f) submit regular confidential reports to the Medical Executive Committee on the patient safety and quality of medical care provided and on quality assessment and improvement activities conducted.

#### 12.8-3 MEETINGS

The committee shall meet as often as necessary at the call of its chair, but at least quarterly. It shall maintain a record of its proceedings and report its activities and recommendations to the Medical Executive Committee and Board of Trustees on a regular basis, except that routine reports to the board shall not include peer evaluations related to individual members.

### **12.9 PHYSICIAN WELL-BEING COMMITTEE**

#### 12.9-1 COMPOSITION

The physician well-being committee shall be comprised of no less than 5 members of the medical staff, a majority of which, including the chair, shall be physicians. Except for initial appointments, each member shall serve a term of 2 years, and the terms shall be staggered as deemed appropriate by the Medical Executive Committee to achieve continuity. Insofar as possible, members of this committee shall not serve as active participants on other peer review or patient safety and performance improvement committee while serving on this committee.

#### 12.9-2 DUTIES

The physician well-being committee may receive reports related to the health, well-being, or impairment of medical staff members and, as it deems appropriate, may investigate such reports. With respect to matters involving individual medical staff members, the committee may, on a voluntary basis, provide such advice, counseling, or referrals as may seem appropriate. Such activities shall be confidential; however, in the event information received by the committee clearly demonstrates that the health or known impairment of a medical staff member poses an unreasonable risk of harm to hospitalized patients, that information may be referred for corrective action. The committee shall also consider general matters related to the health and well-

being of the medical staff and, with the approval of the executive committee, develop educational programs or related activities.

#### 12.9-3 MEETINGS

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

### **12.10 CLINICAL ETHICS COMMITTEE**

#### 12.10-1 COMPOSITION

The clinical ethics committee shall consist of physicians and such other staff members as the Medical Executive Committee may deem appropriate. It may include nurses, lay representatives, social workers, clergy, ethicists, attorneys, Chief Executive Officers and representatives from the Board of Trustees, although a majority shall be physician members of the medical staff.

#### 12.10-2 DUTIES

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

#### 12.10-3 MEETINGS

The committee shall meet as often as necessary at the call of its chair. It shall maintain a record of its activities and report to the Medical Executive Committee as needed.

## **12.11 INTERDISCIPLINARY PRACTICE COMMITTEE**

### 12.11-1 COMPOSITION

The interdisciplinary practice committee (IDPC) shall consist of, at a minimum, the chief nursing officer, the chief medical officer an equal number of physicians appointed by the Chief of Staff in consultation with the chair. The registered nurses shall be appointed by the chief nursing officer. Licensed or certified health professionals other than registered nurses who perform functions requiring standardized procedures shall be included in the committee, if feasible. The chair of the committee shall be a physician member of the active medical staff appointed by the Chief of Staff.

### 12.11-2 DUTIES

The IDPC shall perform functions consistent with the requirements of law and regulation. The IDPC shall routinely report through the patient safety and performance improvement committee.

### 12.11-3 MEETINGS

The IDPC shall meet at the call of the chair at such intervals as the chair may deem appropriate.

## **12.12 CONTINUING MEDICAL EDUCATION COMMITTEE**

### 12.12-1 COMPOSITION

The continuing medical education committee shall be composed of physician members and other health professionals of the hospital as determined by the chairperson.

### 12.12-2 DUTIES

The continuing medical education committee shall perform the following duties:

- (a) plan, implement, coordinate and promote ongoing special clinical and scientific programs for the medical staff. This includes:
  - 1. identifying the educational needs of the medical staff;
  - 2. formulating clear statements of objectives for each program;

3. assessing the effectiveness of each program;
  4. choosing appropriate teaching methods and knowledgeable faculty for each program; and
  5. documenting staff attendance at each program.
- (b) assist in developing processes to assure optimal patient care and contribute to the continuing education of each practitioner.
  - (c) establish liaison with the patient safety and performance improvement program of the hospital in order to be apprised of problem areas in patient care, which may be addressed by a specific continuing medical education activity.
  - (d) maintain close liaison with other hospital medical staff and department committees concerned with patient care.
  - (e) make recommendations to the Medical Executive Committee regarding library needs of the medical staff.
  - (f) advise administration of the financial needs of the continuing medical education program.

#### 12.12-3 MEETINGS

The continuing medical education committee shall meet as often as necessary, but at least quarterly. It shall maintain minutes of the program planning discussions and report to the Medical Executive Committee.

## ARTICLE XIII MEETINGS

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### 13.1 MEETINGS

#### 13.1-1 ANNUAL MEETING

There shall be an annual meeting of the medical staff. The Chief of Staff, or such other officers, department chairs, clinical service heads, committee chairs or Medical Executive Committee may designate, and present reports on actions taken during the preceding year and on other matters of interest and importance to the members. Notice of this meeting shall be given to the members at least 20 days prior to the meeting.

#### 13.1-2 REGULAR MEETINGS

Regular meetings of the members shall be held biannually, except that the annual meeting shall constitute the regular meeting during the half year in which it occurs. The date, place and time of the regular meetings shall be determined by the Medical Executive Committee, and adequate notice shall be given to the members.

#### 13.1-3 AGENDA

- (a) The order of business at a meeting of the medical staff shall be determined by the Chief of Staff. The agenda shall include, insofar as feasible:
- (b) administrative reports from the Chief of Staff and the Chief Executive Officer.

#### 13.1-4 SPECIAL MEETINGS

Special meetings of the medical staff may be called at any time by the Chief of Staff or the Medical Executive Committee, or shall be called upon the written request of 10% of the members of the active medical staff. The person calling or requesting the special meeting shall state the purpose of such meeting in writing. The meeting shall be scheduled by the Medical Executive Committee within 30 days after receipt of such request. No later than 10 days prior to the meeting, notice shall be mailed or delivered to the members of the staff which

includes the stated purpose of the meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

## **13.2 COMMITTEE AND DEPARTMENT MEETINGS**

### **13.2-1 REGULAR MEETINGS**

Except as otherwise specified in these bylaws, the chairs of committees, departments and clinical services may establish the times for the holding of regular meetings. The chairs shall make every reasonable effort to ensure the meeting dates are disseminated to the members with adequate notice.

### **13.2-2 SPECIAL MEETINGS**

A special meeting of any medical staff committee, department or clinical service may be called by the chair thereof, the Medical Executive Committee, or the Chief of Staff, and shall be called by written request of one-third of the current members, eligible to vote, but not less than 2 members.

## **13.3 QUORUM**

### **13.3-1 STAFF MEETINGS**

The presence of 50% of the total members of the active medical staff at any regular or special meeting in person shall constitute a quorum for purposes of a vote on removal of medical staff officers. The presence of 33 1/3% percent of such members shall constitute a quorum for all other actions unless otherwise noted.

### **13.3-2 DEPARTMENT AND COMMITTEE MEETINGS**

A quorum of 50% percent of the voting members shall be required for Medical Executive Committee meetings. For other committees, a quorum shall consist of 33 1/3% of the voting members of a committee but in no event less than 2 voting members. For department and clinical service meetings, a quorum shall consist of 33 1/3 % of the voting members of a committee but in no event less than 2 voting members unless otherwise defined in their department rules and regulations. The IRB quorum shall be defined by the IRB policies and procedures.



## **13.4 VOTING AND MANNER OF ACTION**

### **13.4-1 VOTING**

Unless otherwise specified in these bylaws, only members of the medical staff may vote in medical staff departmental or staff elections, and at department and medical staff meetings and all duly appointed members of medical staff committees are entitled to vote on committee matters, except as may otherwise be specified in these bylaws.

### **13.4-2 MANNER OF ACTION**

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

## **13.5 MINUTES**

Except as otherwise specified herein, minutes of meetings shall be prepared and retained. They shall include, at a minimum, a record of the attendance of members and the vote taken on significant matters. A copy of the minutes shall be signed by the presiding officer of the meeting.

## **13.6 SPECIAL ATTENDANCE**

At the discretion of the chair or presiding officer, when a member's practice or conduct is scheduled for discussion at a regular department, clinical service, or committee meeting, the member may be requested to attend. If a suspected deviation from standard clinical practice is involved, the notice shall be given at least 7 days prior to the meeting and shall include the time and place of the meeting and a general indication of the issue involved. Failure of a member to appear at any meeting to which notice was

given, unless excused by the Medical Executive Committee upon a showing of good cause, shall be a basis for corrective action.

### **13.7 CONDUCT OF MEETINGS**

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

### **13.8 EXECUTIVE SESSION**

Executive session is a meeting of a medical staff committee, department, or clinical service, or of the medical staff as a whole which only voting medical staff members who are not also employed by the hospital may attend, unless others are expressly requested by the member presiding at the meeting to attend.

Executive session may be called as follows:

- (a) by the presiding member ; or
- (b) at the request of any medical staff committee member, and shall be called by the presiding member pursuant to a duly adopted motion.

Executive session may be called to discuss peer review issues, ~~personnel issues~~, or any other sensitive issues requiring confidentiality. Action may not be taken in executive session.

## ARTICLE XIV CONFIDENTIALITY, IMMUNITY AND RELEASES

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### 14.1 AUTHORIZATION AND CONDITIONS

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

- (a) authorizes representatives of the hospital and the medical staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the applicant's professional ability and qualifications;
- (b) authorizes persons and organizations to provide information concerning such practitioner to the medical staff;
- (c) agrees to be bound by the provisions of this Article and to waive all legal claims against any representative of the medical staff or the hospital who would be immune from liability under Section 14.3 of this Article; and
- (d) acknowledges that the provisions of this Article are express conditions to an application for medical staff membership, the continuation of such membership, and to the exercise of clinical privileges at this hospital.

### 14.2 CONFIDENTIALITY OF INFORMATION

#### 14.2-1 GENERAL

Records and proceedings of all medical staff committees having the responsibility of evaluation and improvement of quality of care rendered in this hospital, including, but not limited to, meetings of the medical staff meeting as a committee of the whole; meetings of departments and clinical services; meetings of committees established under Article XII; hearings conducted pursuant to Article VIII; and meetings of special or ad hoc committees created by the Medical Executive Committee or by departments and including information regarding any member or applicant to this medical staff shall, to the fullest extent permitted by law, be confidential.

## 14.2-2 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, clinical services, or committees, except in conjunction with another hospital, a professional society, or a licensing authority, is outside appropriate standards of conduct for this medical staff, violates the medical staff bylaws, and will be deemed disruptive to the operations of the hospital. If it is determined that such a breach has occurred, the Medical Executive Committee may undertake such corrective action as it deems appropriate.

### 14.2.3 CONFIDENTIALITY OF CREDENTIALS FILES

All credentials files of applicants for Medical Staff membership and of Medical Staff members shall be retained in strict confidence in the Medical Staff Services department. It is expressly understood that the contents of the credentials files constitute records and proceedings of Medical Staff Committees that are responsible for evaluating and improving the quality of care provided in the hospital.

#### (a) Disclosure to Applicant or Medical Staff Members

1. An applicant for Medical Staff membership or a Medical Staff member who wishes to review any portion of his/her credentials file shall submit a written request that specifies the item(s) he wishes to see. Requests to review any portion of the credentials file that conform to the restrictions set forth below may generally be granted, but may be denied in unusual circumstances by the Chief of Staff, the hospital's Chief Executive Officer, or either's designee.
2. An applicant or member may inspect only his/her own credentials file (unless authorized to review another applicant's or member's file in accordance with the provisions set forth in Section (b) below) and may review only the following credentials file items:
  - (i) documents or correspondence the applicant or member personally prepared and submitted, e.g., his/her application or letters.

- (ii) documents or correspondence addressed and sent directly to the applicant or member.
    - (iii) public documents, such as copies of the applicant's or member's license to practice medicine.
  - 3. Copies of any items contained in the credentials file shall not be made for an applicant or a member unless:
    - (i) pursuant to paragraph (2) above, the applicant or member may inspect the item, and
    - (ii) approval for such copy to be made has been secured from the Chief of Staff, the hospital's Chief Executive Officer, or their designee.
  - 4. Except as provided in Paragraphs (2) and (3) above, applicants and members may not have access to any item or document contained in the credentials file except when disclosure is required by law, including the situations discussed in the Paragraph which follows, and approved by the Chief Executive Officer or the Chief of Staff or their designee.
  - 5. It is recognized that in order to provide an applicant or a member with an opportunity to prepare his/her defense for a judicial review Committee hearing, the Chief Executive Officer or the Chief of Staff may approve the disclosure of documents contained within the credentials file that are relevant to the charges against the applicant or member.
- (b) Disclosure to Medical Staff Officers and Medical Staff Committees or their Designees
- 1. The contents of the credentials files (of applicants for Medical Staff membership and Medical Staff members) may be disclosed, as appropriate to Medical Staff officers, including but not limited to the Chief of Staff and the chairman of the Department in which the practitioner seeks or has clinical privileges; to Medical Staff Committees; or to their designees.

2. Disclosure to such persons or entities shall occur whenever necessary to enable them to carry out their responsibilities of evaluating and improving the quality of care rendered in the hospital. For example, the contents of the credentials files may be disclosed to persons or Committees that are responsible for recommending appointment or reappointment to the Medical Staff and what, if any, clinical privileges shall be granted; for investigating any request for corrective action, or recommending what, if any, corrective action should be taken, and for quality management and peer review Committee activities.
3. Disclosure to Medical Staff officers and Medical Staff Committees, or their designees, shall occur within the Committee meeting or the Medical Staff Services department, except in rare instances which shall be determined by the Chief Executive Officer or Chief of Staff.

### **14.3 IMMUNITY FROM LIABILITY**

#### **14.3-1 FOR ACTION TAKEN**

Each representative of the medical staff and hospital shall be immune, to the fullest extent provided by law, from liability to an applicant 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 hospital.

#### **14.3-2 FOR PROVIDING INFORMATION**

Each representative of the medical staff and hospital and all third parties shall be immune, to the fullest extent provided by law, from liability to an applicant or member for damages or other relief by reason of providing information to a representative of the medical staff or hospital concerning such person who is, or has been, an applicant to or member of the staff or who did, or does, exercise clinical privileges or provide services at this hospital.

### **14.4 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 facility's or organization's activities concerning, but not limited to:

- (a) application for membership, renewal of membership, or clinical privileges;
- (b) corrective action;
- (c) hearings and appellate reviews;
- (d) utilization reviews;
- (e) other department, or clinical service, committee, or medical staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and
- (f) queries and reports concerning the National Practitioner Data Bank, peer review organization, the Medical Board of California, and similar queries and reports.

#### **14.5 RELEASES**

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

#### **14.6 INDEMNIFICATION**

The hospital shall indemnify, defend and hold harmless the medical staff and its individual members from and against losses and expenses (including attorneys' fees, judgments, settlements, and all other costs, direct or indirect) incurred or suffered by reason of or based upon any threatened, pending or completed action, suit, proceeding, investigation, or other dispute relating or pertaining to any alleged act or failure to act within the scope of peer review or quality assessment activities including, but not limited to, (1) as a member of or witness for a medical staff department, service, committee or hearing panel, (2) as a member of or witness for the hospital board or any hospital task force, group, or committee, and (3) as a person providing information to any medical staff or hospital group, officer, board member or employee for the purpose of aiding in the evaluation of the qualifications, fitness or character of a medical staff member or applicant. The medical staff or member may seek indemnification for such losses and expenses under this bylaws provision, statutory and case law, any available liability insurance or otherwise as the medical staff or member sees fit, and concurrently or in such sequence as the medical staff or member may choose. Payment of any losses

or expenses by the medical staff or member is not a condition precedent to the hospital's indemnification obligations hereunder. Any individual member of the medical staff who violates breach of confidentiality as defined under 14.2-2 shall not be covered under the hospital's indemnification obligations hereunder.



## ARTICLE XV GENERAL PROVISIONS

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### 15.1 MEDICAL STAFF (GENERAL) RULES AND REGULATIONS AND POLICIES

The Medical Staff shall initiate and adopt such Rules as it may deem necessary and shall periodically review and revise its Rules to comply with current Medical Staff practice. New Rules or changes to the Rules (proposed Rules) may emanate from any responsible committee, department, medical staff officer, or by petition signed by at least 10% of the voting members of the Medical Staff. Additionally, hospital administration may develop and recommend proposed Rules, and in any case should be consulted as to the impact of any proposed Rules on hospital operations and feasibility. Proposed Rules shall be submitted to the Medical Executive Committee for review and action, as follows:

- (a) Except as provided at Section 15.1-2(d), below, with respect to circumstances requiring urgent action, the Medical Executive Committee shall not act on the proposed Rule until the Medical Staff has had a reasonable opportunity to review and comment on the proposed Rule. *[This review and comment opportunity may be accomplished by posting proposed Rules on the Medical Staff website at least 30 days prior to the scheduled Medical Executive Committee meeting, together with instructions how interested members may communicate comments. A comment period of the last 14 days during the 30 day posting shall be afforded, and all comments shall be summarized and provided to the Medical Executive Committee prior to Medical Executive Committee action on the proposed Rule.]*
- (b) Medical Executive Committee approval is required, unless the proposed Rule is one generated by petition of at least 10% of the voting members of the Medical Staff. In this latter circumstance, if the Medical Executive Committee fails to approve the proposed Rule, it shall notify the Medical Staff. The Medical Executive Committee and the Medical Staff each has the option of invoking or waiving the conflict management provisions of Section 15.11:
  1. If conflict management is not invoked within 30 days it shall be deemed waived. In this circumstance, the Medical Staff's proposed Rule shall be submitted for vote, and if approved by the Medical Staff pursuant to Section 15.1-2(b)(3), the proposed Rule shall be forwarded to the Board of Trustees

for action. The Medical Executive Committee may forward comments to the Board of Trustees regarding the reasons it declined to approve the proposed Rule.

2. If conflict management is invoked, the proposed Rule shall not be voted upon or forwarded to the Board of Trustees until the conflict management process has been completed, and the results of the conflict management process shall be communicated to the Board of Trustees.
  3. With respect to proposed Rules generated by petition of the Medical Staff, approval of the Medical Staff requires the affirmative vote of a majority of the Medical Staff members voting on the matter by secret ballot as defined in the General Rules & Regulations provided at least 14 days advance written notice, accompanied by the proposed Rule, has been given, and at least a simple majority of valid votes have been cast.
- (c) Following approval by the Medical Executive Committee or favorable vote of the Medical Staff as described above, a proposed Rule shall be forwarded to the Board of Trustees for approval, which approval shall not be withheld unreasonably. The Rule shall become effective immediately following approval of the Board of Trustees or automatically within 60 days, following presentation to the Board of Trustees, if no action is taken by the Board of Trustees.
- (d) Where urgent action is required to comply with law or regulation, the Medical Executive Committee is authorized to provisionally adopt a Rule and forward it to the Board of Trustees for approval and immediate implementation, subject to the following. If the Medical Staff did not receive prior notice of the proposed Rule (as described at Section 15.1-2(a)) the Medical Staff shall be notified of the provisionally-adopted and approved Rule, and may, by petition signed by at least 10% of the voting members of the Medical Staff require the Rule to be submitted for possible recall; provided, however, the approved Rule shall remain effective until such time as a superseding Rule meeting the requirements of the law or regulation that precipitated the initial urgency has been approved pursuant to any applicable provision of this Section 15.1-2.

### 15.1.2 DEPARTMENTAL RULES, REGULATIONS

Subject to the approval of the Medical Executive Committee and the Board of Trustees, each Department shall form its own rules and regulations for the conduct of its affairs and the discharge of its responsibilities. Such rules and regulations shall not be inconsistent with these Bylaws, the Medical Staff (general) rules and regulations, or other policies of the hospital.

### 15.1.3 CLINICAL SERVICE RULES AND REGULATIONS

Subject to the approval of the Department to which the Clinical Service reports, the Medical Executive Committee and the Board of Trustees, each Clinical Service may form its own rules and regulations for the conduct of its affairs and the discharge of its responsibilities. Such rules and regulations shall not be inconsistent with these Bylaws, the Medical Staff (general) rules and regulations, or other policies of the hospital.

## 15.2 DUES OR ASSESSMENTS

The Medical Executive Committee shall have the power to recommend the amount of annual dues or assessments. The Officers are delegated the authority to determine the manner of expenditure of such funds received.

### 15.2-1 MEDICAL STAFF FUNDS

Medical Staff funds, regardless from what source (i.e., medical staff dues, hospital funds) shall be under the sole control of the Medical Staff and such funds may be administered by the hospital at the discretion of the Medical Staff.

### 15.2-2 HOSPITAL-PROVIDED FUNDS DEPOSITED TO THE MEDICAL STAFF FUND

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

## 15.3 AUTHORITY TO ACT

Any member or members who act in the name of this medical staff without proper authority shall be subject to such disciplinary action as the Medical Executive Committee may deem appropriate.

#### **15.4 DIVISION OF FEES**

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

#### **15.5 NOTICES**

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

Name and proper title of addressee, if known or applicable  
Name of department, clinical service or committee  
[c/o medical staff coordinator, Chief of Staff]  
St. Jude Medical Center  
101 East Valencia Mesa Drive  
Fullerton, CA 92635

Mailed notices to a member, applicant or other party, shall be to the addressee at the address as it last appears in the official records of the medical staff or the hospital.

#### **15.6 DISCLOSURE OF INTEREST**

All nominees for election or appointment to medical staff offices, department chairships, clinical chairships, committee chairship and their members, the Medical Executive Committee shall, at least 20 days prior to the date of election or appointment, disclose in writing to the Medical Executive Committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware, including contractual, employment or other relationships with the hospital, which could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the medical staff. Access to this information is defined in the medical staff (general) rules and regulations.

#### **15.7 MEDICAL STAFF ROLE IN EXCLUSIVE CONTRACTING**

The medical staff through the Medical Executive Committee shall review and make recommendations to the Board of Trustees regarding quality of care issues related to

exclusive arrangements for physician and/or professional services, prior to any decision being made, in the following situations:

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

#### **15.8 RETALIATION PROHIBITED**

- (a) Neither the medical staff, its members, committees or department heads, the governing body, its chief administrative officer, or any other employee or agent of the hospital or medical staff, may engage in any punitive or retaliatory action against any member of the medical staff because that member claims a right or privilege afforded by, or seeks implementation of any provision of, these medical staff bylaws.
- (b) The medical staff recognizes and embraces that it is the public policy of the State of California that a physician and surgeon be encouraged to advocate for medically appropriate health care for his or her patients. To advocate for medically appropriate health care includes, but is not limited to, the ability of a physician to protest a decision, policy, or practice that the physician, consistent with that degree of learning and skill ordinarily possessed by reputable physicians practicing according to the applicable legal standard of care, reasonably believes impairs the physician's ability to provide medically appropriate health care to his or her patients. No person, including but not limited to the medical staff, the hospital, its employees, agents, directors or owners, shall retaliate against or penalize any member for such advocacy or prohibit, restrict or in any way discourage such advocacy, nor shall any person prohibit, restrict, or in any way discourage a member from communicating to a patient information in furtherance of medically appropriate health care.
- (c) This section does not preclude corrective and/or disciplinary action as authorized by these medical staff bylaws.

## **15.9 MEDICAL STAFF REPRESENTATION BY LEGAL COUNSEL**

Upon the authorization of the medical staff, or of the Medical Executive Committee acting on its behalf, the medical staff may retain and be represented by independent legal counsel at its own expense.

## **15.10 PROFESSIONAL LIABILITY INSURANCE**

Each Medical Staff member granted clinical privileges and each advance practice allied health professional staff member granted practice privileges in the hospital shall maintain in force professional liability insurance in not less than the minimum amounts, if any, as from time to time may be jointly determined by the Board of Trustees and Medical Executive Committee, or shall provide other proof of financial responsibility in such manner as the Board of Trustees and Medical Executive Committee may from time to time establish, and with an insurance carrier admitted to market insurance in the State of California, or shall be and remain a member of the Physician Cooperative Trust as defined in the California Insurance Code with the same amounts of coverage, and operated in compliance with California law. The insurance shall be maintained continuously, including coverage for prior acts (tail & nose coverage). The insurance shall apply to all patients the practitioner treats and to all procedures the practitioner has privileges to perform in the hospital.

## **15.11 CONFLICT MANAGEMENT**

In the event of conflict between the Medical Executive Committee and the Medical Staff (as represented by written petition signed by at least 10% of the voting members of the Medical Staff) regarding a proposed or adopted Medical Staff Bylaws, Rule or policy, or other issue of significance to the Medical Staff, the Chief of Staff shall convene a meeting with the petitioners' representative(s). The foregoing petition shall include a designation of up to five (5) members of the voting Medical Staff who shall serve as the petitioners' representative(s). The Medical Executive Committee shall be represented by an equal number of Medical Executive Committee members. The Medical Executive Committee's and the petitioners' representative(s) shall exchange information relevant to the conflict and shall work in good faith to resolve differences in a manner that respects the positions of the Medical Staff, the leadership responsibilities of the Medical Executive Committee, and the safety and quality of patient care at the hospital. Resolution at this level requires a majority vote of the Medical Executive Committee's representatives at the meeting and a majority vote of the petitioner's representatives. Unresolved differences shall be submitted to the Board of Trustees for its consideration in making its final decision with respect to the proposed Rule, policy, or issue.

## ARTICLE XVI ADOPTION AND AMENDMENT OF BYLAWS

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### 16.1 PROCEDURE

Upon the request of (1) the Medical Executive Committee, or the Chief of Staff or the bylaws committee after approval by the Medical Executive Committee, or (2) upon timely written petition signed by at least 10% of the members of the medical staff in good standing who are entitled to vote, consideration shall be given to the adoption, amendment, or repeal of these bylaws. Within thirty (30) days of the approval of the proposed change to the bylaws by the Medical Executive Committee, a written notice of the proposed changes shall be sent to all active medical staff members for their assessment. Within 30 days a regular or special meeting of the medical staff shall be called and the proposed changes presented and discussed. Within twenty one days (21) after the proposed bylaws are presented at the regular or special meeting, secret ballots as defined in the general rules & regulations shall be sent to each active Medical Staff member. Neither the Medical Staff nor the Board of Trustees may unilaterally amend the Medical Staff Bylaws.

#### 16.1-1 AUTHORITY GRANTED TO THE MEDICAL EXECUTIVE COMMITTEE

Within thirty (30) days of the approval of the proposed change to the bylaws by the Medical Executive Committee, a written notice of the proposed changes shall be sent to all active medical staff members for their assessment. Within 30 days a regular or special meeting of the medical staff shall be called and the proposed changes presented and discussed. Within twenty one days (21) after the proposed bylaws are presented at the regular or special meeting, secret ballots as defined in the general rules & regulations shall be sent to each active Medical Staff member. Neither the Medical Staff nor the Board of Trustees may unilaterally amend the Medical Staff Bylaws.

#### 16.1-2 AUTHORITY GRANTED TO THE ORGANIZED MEDICAL STAFF

The authority to adopt or amend the medical staff bylaws resides with the organized medical staff and the governing body, and cannot be delegated.

The organized medical staff shall have the ability to adopt medical staff bylaws, and propose them directly to the governing body. The following criteria must be

met in order for an adoption or amendment to be considered a valid action by the organized medical staff.

- (a) The adoption or amendment must be in writing and signed by at least 10% of the voting members of the active category of the organized medical staff.
- (b) The adoption or amendment cannot contravene or be inconsistent with federal, state, or local law, regulation, or accreditation standards set forth by The Joint Commission.

If an adoption or amendment to the medical staff bylaws is undertaken, the organized medical staff must first communicate the adoption or amendment to the Medical Executive Committee (MEC), who will have 90 days from date of receipt to review the adoption or amendment, and – if in agreement – propose said adoption or amendment to the governing body.

If within 90 days of receipt the MEC is not in agreement with said adoption or amendment to rules and regulations and/or policy, the matter shall be subjected to the conflict resolution process defined under Article 15.11.

## **16.2 ACTION ON BYLAW CHANGE**

In order to enact a change, the affirmative vote of a majority (50%) of the voting members casting valid ballots shall be required.

## **16.3 APPROVAL**

Bylaw changes adopted by the medical staff shall become effective following approval by the Board of Trustees, which approval shall not be withheld unreasonably, or automatically within 90 days if no action is taken by the Board of Trustees. If approval is withheld, the reasons for doing so shall be specified by the Board of Trustees in writing, and shall be forwarded to the Chief of Staff, the Medical Executive Committee and the Bylaws Committee.

Medical staff members are provided with copies of the revisions in the bylaws, rules and regulations and medical staff policies. If approval is withheld, the reasons for doing so shall be specified by the Board of Trustees in writing, and shall be forwarded to the Chief of Staff, the Medical Executive and Bylaws Committee.



#### **16.4 EXCLUSIVITY**

The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the medical staff bylaws.

#### **16.5 EFFECT OF THE BYLAWS**

- (a) These bylaws may not be unilaterally amended or repealed by the medical staff or Board of Trustees.
- (b) No medical staff governing document and no hospital corporate bylaws or other hospital governing document shall include any provision purporting to allow unilateral amendment of the medical staff bylaws or other medical staff governing document.
- (c) Hospital corporate bylaws, policy, rules, or other hospital requirements that conflict with medical staff bylaw provisions, rules, regulations and/or policies and procedures, shall not be given effect and shall not be applied to the medical staff or its individual members.

#### **16.6 SUCCESSOR IN INTEREST/AFFILIATIONS**

##### **16.6-1 SUCCESSOR IN INTEREST**

These bylaws, and privileges of individual members of the medical staff accorded under these bylaws, will be binding upon the medical staff, and the Board of Trustees of any successor in interest in this hospital, except where hospital medical staffs are being combined. In the event that the staffs are being combined, the medical staffs shall work together to develop new bylaws which will govern the combined medical staffs, subject to the approval of the hospital's Board of Trustees or its successor in interest. Until such time as the new bylaws are approved, the existing bylaws of each institution will remain in effect.

##### **16.6-2 AFFILIATIONS**

Affiliations between the hospital and other hospitals, health care systems or other entities shall not, in and of themselves, affect these bylaws.

**16.7 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.

ADOPTED by the Medical Staff on

November, 22, 2011  
Date

\_\_\_\_\_  
Chief of Staff

\_\_\_\_\_  
Secretary-Treasurer

APPROVED by the Board of Trustees on

\_\_\_\_\_  
Date

\_\_\_\_\_  
Board of Trustees Chair