SIERRA VIEW MEDICAL CENTER
MEDICAL STAFF BYLAWS

TABLE OF CONTENTS

SIERRA VIEW MEDICAL CENTER
MEDICAL STAFF BYLAWS

TABLE OF CONTENTS

SIERRA VIEW MEDICAL CENTER
MEDICAL STAFF BYLAWS

TABLE OF CONTENTS

SIERRA VIEW MEDICAL CENTER
MEDICAL STAFF BYLAWS

TABLE OF CONTENTS

TABLE OF CONTENTS

SIERRA VIEW MEDICAL CENTER
MEDICAL STAFF BYLAWS

TABLE OF CONTENTS

SIERRA VIEW MEDICAL CENTER
MEDICAL STAFF BYLAWS

TABLE OF CONTENTS

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ARTICLE I PURPOSES AND TERMS

1.1 PURPOSES OF THE BYLAWS

These bylaws are adopted in order to provide for the organization of the medical staff of SIERRA VIEW 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 directors, and relations with applicants to and members of the medical staff. The organized medical staff both enforces and complies with these medical staff bylaws

1.2 DEFINITIONS

1.2-1 ALLIED HEALTH PROFESSIONAL or “AHP” means an individual who is neither a physician, dentist, podiatrist, clinical psychologist nor an employee of the hospital, who assists in providing direct patient care services in the hospital under a defined degree of supervision by a 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 Directors to be credentialed through the Medical Staff Organization and provide patient care pursuant to approved standardized procedures and/or job descriptions, as defined in these Bylaws and related policies and procedures. The Board of Directors periodically determines the categories of individuals eligible for clinical privileges as an AHP. Allied Health Professionals are not eligible for Medical Staff Membership.

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 DIRECTORS 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, Allied Health Professionals, and others, to provide patient care. This includes access to those hospital resources (including equipment, facilities and hospital personnel), which are necessary to effectively exercise those privileges. All of these individuals are bound to comply with the medical staff bylaws, rules and regulations

1.2-6 COMPLETE APPLICATION shall mean an application for either initial appointment or reappointment to the Medical Staff, or an application for clinical privileges, that has been determined so by the applicable Department Chair, the Credentials Committee, the Medical Executive Committee and the Board of Directors, and include all required supporting documentation and verifications of information, and any additional information needed to perform the required review of qualifications and competence of the applicant.

1.2-7 DATE OF RECEIPT means the date any Notice or other communication was delivered personally; or if such Notice or communication was sent by mail, it shall mean 72 hours after the Notice or communication was deposited, postage prepaid, in the United States Mail.

1.2-8 DENTIST means a dentist or oral surgeon holding a DMD or DDS degree from an accredited College of Dental Surgery

1.2-9 DEPARTMENT means those members of the Medical Staff who, by virtue of their specialty training, are grouped into a Clinical Specialty.

1.2-10 EX OFFICIO means service by virtue of office or position held. An Ex Officio appointment is without vote, unless specified otherwise.

1.2-11 FEDERAL HEALTH CARE PROGRAM means a plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government, including but not limited to Medicare and Medi-Cal.

1.2-12 HEALTHCARE INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)– means a Federally mandated national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addresses the security and privacy of health data.

1.2-13 HOSPITAL means SIERRA VIEWMEDICAL CENTER.

1.2-14 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.

1.2-15 INVESTIGATION means a process formally 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 the usual activities of the medical staff well being committee.

1.2-16 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.

1.2-17 MEDICAL STAFF or STAFF means those physicians (MD or DO or their equivalent as defined in Section 2.2-2(a)), dentists and podiatrists who have been granted recognition as members of the medical staff pursuant to the terms of these bylaws.

1.2-18 MEDICAL STAFF YEAR means the period from January to December.

1.2-19 MEMBER means, unless otherwise expressly limited, any physician (MD or DO or their equivalent as defined in Section 2.2-2(a)), dentist or podiatrist holding a current license to practice within the scope of that license who is a member of the medical staff.

1.2-20 NOTICE means written communication by regular U.S. Mail, facsimile, hospital mail, or hand delivery.

1.2-21 NOTICE OF PRIVACY PRACTICES **–** means a mandated HIPAA document given to all patients receiving any type service with Sierra View Medical Center, which outlines access to health data, and it's use now, or in the future.

1.2-22 ORGANIZED HEALTH CARE ARRANGEMENT (OHCA's) **–** Are organized health care arrangements where several separate entities joint together for HIPAA purposes, to expedite the sharing of data for improvement of patient care and operations.

1.2-23 PATIENT CONTACT includes any admission, consultation, procedure (inpatient or outpatient), or response to emergency call performed in the Hospital. It shall not include referrals for diagnostic or laboratory tests or x-rays. For purposes of this definition, patient contacts include all areas in which the Hospital provides space, equipment, staff and financial resources as a licensee.

1.2-24 PHYSICIAN means an individual with an MD, 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,

1.2-25 PODIATRIST means a podiatrist holding a DPM degree from an accredited College of Podiatric Medicine.

1.2-26 PRACTITIONER means, unless otherwise expressly limited, any currently licensed physician, dentist, podiatrist (MD, DO, DPM, DDS), or licensed clinical psychologists.

1.2-27 PRESIDENT/CHIEF EXECUTIVE OFFICER (CEO) means the person appointed by the board of directors to serve in an administrative capacity.

1.2-28 PRIVILEGES means the permission granted to a Medical Staff Member to render specific patient services.

1.2-29 SPECIAL NOTICE means hand delivery, certified mail (return receipt requested), or overnight delivery service providing receipt.

1.2-30 STATE HEALTH CARE PROGRAM means MEDI-CAL's plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government and California State.

1.2-31 TELEMEDICINE means the use of electronic communication or other communication technologies to provide or support clinical care at a distance. Diagnosis and treatment of a patient may be performed via telemedicine link.

1.2-32 UNASSIGNED PATIENT means any individual who comes to the Hospital for care and treatment who does not have an attending physician, or who does not want the prior attending physician to provide his/her care while a patient at the Hospital.

1.3 NAME

The name of this organization is the Medical Staff of Sierra View Medical Center.

ARTICLE II MEMBERSHIP

2.1 NATURE OF MEMBERSHIP

No physician, dentist, podiatrist or licensed clinical psychologists 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, dentist or podiatrist is a member of the medical staff or has been granted temporary privileges in accordance with the procedures set forth in these bylaws. Appointment to the medical staff shall confer only such clinical privileges and prerogatives as have been granted in accordance with these bylaws.

2.2 QUALIFICATIONS FOR MEMBERSHIP

2.2-1 GENERAL QUALIFICATIONS

Membership on the Medical Staff and privileges shall be extended only to practitioner who are professionally competent and continuously meet the qualifications, standards, and requirements set forth in the Medical Staff Bylaws.

2.2-2 BASIC QUALIFICATIONS

A practitioner must demonstrate compliance with all basic standards set forth in this Section in order to have an application for medical staff membership accepted for review. The practitioner must:

a) 1) After January 1, 2014, an initial applicant for physician membership on the Medical Staff, except for retired or Honorary Staff, must hold an MD or DO degree and must have completed a residency training program accredited by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association and hold a valid and unsuspended license to practice medicine issued by the Medical Board of California or the California Board of Osteopathic Examiners. The completion of a residency training program is waived for Emergency Medicine Residents working in the Emergency Room. The Medical Executive Committee may make an exception for completion of an accredited residency training program for current medical school faculty that are trained outside the United States with completion of a one-year US accredited fellowship in their specialty of practice.

2) Podiatrists, except for the Retired or Honorary Staff, must hold a DPM degree and a valid and unsuspended certificate to practice podiatry issued by the Medical Board of California;

3) Dentists, except for the Retired or Honorary Staff, must hold a DDS or equivalent degree and a valid and unsuspended license to practice dentistry issued by the California Board of Dental Examiners;

4) Clinical psychologists must hold a PhD in clinical psychology, 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 license to practice clinical psychology issued by the California Board of Psychology and Division of Allied Health Professions of the Medical Board of California.

b) If practicing medicine, dentistry or podiatry, have a valid and unsuspended federal Drug Enforcement Administration (DEA) certificate.

c) Have professional liability insurance with an insurance carrier approved by the State Insurance Commissioner to conduct business in the State of California, or demonstrate membership in a physician's cooperative as defined in Section 1280.7 of the California Insurance Code, in not less than the minimum amounts as from time to time may be jointly determined by the board of directors and medical executive committee. Such insurance shall include a provision allowing for thirty (30) day notice to the medical staff of any cancellation or reduction.

d) Pledge to provide continuous care to his or her patients.

e) Each member of the medical staff (*exception*: by *Consulting Staff & Teleradiologist*) shall have an Office Practice and Home situation no greater than 30 minutes response time of the hospital so as not to impede the timely deliverance of patient care.

g) Applicants to the medical staff who are currently excluded from any health care program funded, in whole or in part, by the federal government, or any state health care program, including, but not limited to Medicare and Medi-Cal, are not eligible for medical staff membership and their applications will not be processed

A practitioner who does not meet these basic standards is ineligible to apply for Medical Staff membership, and the application shall not be accepted for review, except that applicants for the honorary Medical Staff do not need to comply with any of the basic standards. If it is determined during the processing that an applicant does not meet all of the basic qualifications, the review of the application shall be discontinued. An applicant who does not meet the basic standards is not entitled to the procedural rights set forth in these Bylaws.

2.2-3 ADDITIONAL QUALIFICATIONS FOR MEMBERSHIP

In addition to meeting the basic standards, the practitioner must:

a) Document his or her:
   1) Adequate education, training and experience in the requested privileges;
   2) Current professional competence;
   3) Good judgment; and
   4) Adequate physical and mental health status to demonstrate to the satisfaction of the Medical Staff that he or she is professionally and ethically competent so that patients can reasonably expect to receive the generally recognized professional level of quality of care for this community.

b) Be determined to:
   1) Adhere to the lawful ethics of his or her profession;

2) Be able to work cooperatively with others in the hospital setting so as to not adversely affect patient care or hospital operations; and
3) Be willing to participate in and properly discharge Medical Staff responsibilities.

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, IPA, PPO, PHO, hospital-sponsored foundation, or other organization or in contracts with a third party which contracts with this hospital.

2.4 NONDISCRIMINATION

No aspect of medical staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, color, religion, ancestry, national origin, disability, physical or mental impairment, marital status, sexual orientation, or registered domestic partner status, if after reasonable accommodation, the applicant complies with the medical staff bylaws, rules and regulations, and policies and procedures and other policies and procedures jointly adopted by the medical staff and board of directors, e.g., to ensure orderly hospital operations.

2.5 ADMINISTRATIVE AND CONTRACT PRACTITIONERS

(a) A practitioner contracting with the Hospital in an administrative capacity with clinical duties or privileges must be a member of the Medical staff, achieving his/her status by usual and customary application and appointment procedures described in these bylaws.

(b) Unless a practitioner's written contract provides otherwise, those privileges and membership made exclusive pursuant to a closed-staff policy will automatically terminate, without the right of access to the fair hearing procedures of Article VII of these Bylaws, upon termination or expiration of such practitioner's contract with the hospital.

(c) Contracts between practitioners and the Hospital shall prevail over these Bylaws; except that the contracts may not reduce any hearing rights granted when an action will be taken that must be reported to the Medical Board of California or the National Practitioner Data Bank.

(d) Practitioners who subcontract with practitioners who contract with the Hospital will automatically forfeit (without the right of access to the fair hearing procedures of Article VII of these Bylaws) any privileges and membership that are subject to an exclusive arrangement if their relationship with the contracting practitioner is terminated. The Hospital may enforce such automatic termination even if the subcontractor's agreement fails to specifically acknowledge this effect.

2.6 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

Except for the honorary and retired staff, the ongoing responsibilities of each member of the medical staff include:

(a) providing patients with quality of care meeting the professional standards of the medical staff of this hospital;

(b) abiding by the medical staff bylaws, rules and regulations and policies and procedures and other policies and procedures jointly adopted by the medical staff and board of directors, e.g., to ensure orderly hospital operations, including but not limited to policies and procedures related to the security of electronic health records;

(c) 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;

(d) preparing and completing in timely fashion medical records for all the patients to whom the member provides care in the hospital;

(e) abiding by the lawful ethical principles of the American Medical Association or member's professional association;

(f) aiding in any medical staff approved educational programs for medical students, interns, resident physicians, resident dentists, staff physicians and dentists, nurses and other personnel;

(g) working cooperatively with other medical staff members, nurses, hospital administration and others so as not to adversely affect patient care;

(h) making appropriate arrangements for coverage of that member's in-patients as determined by the medical staff;

(i) refusing to engage in improper inducements for patient referral;

(j) participating in continuing education programs as determined by the medical staff;

(k) participating in such emergency service coverage or consultation panels as may be agreed upon by the medical staff and board of directors;

(l) discharging such other staff obligations as may be lawfully established from time to time by the medical executive committee; and

(m) providing information to appropriate department or medical staff officers when he/she obtains credible information bearing upon a fellow medical staff member who may have been accused of unprofessional or unethical conduct and cooperate as reasonably necessary toward the appropriate resolution of any such matter;
(n) continuously meeting the qualifications for membership as set forth in these bylaws. Members shall cooperate in any physical or mental evaluation and any other information deemed necessary by the medical executive committee to enable an adequate evaluation of their qualifications; and
(o) notify the Chief of Staff and the CEO in writing promptly, and no later than 7 calendar days, following any action taken regarding the member's license, DEA registration, privileges

at other facilities, changes in liability insurance coverage, any report filed with the National Practitioner Data Bank, any changes in the most recent application, whenever the member is excluded from any health care program funded in whole or in part by the federal government, or any state health care program, including, but not limited to, Medicare and Medi-Cal, and any other action that could affect his/her Medical Staff standing and/or clinical privileges at the hospital.

(p**)** As a requirement *for continued membership and privileges, a practitioner must maintain compliance of quality and performance improvement benchmarks as required by CMS, Joint Commission and California Department of Public Health*

2.7 DISRUPTIVE BEHAVIOR, HARASSMENT AND DISCRIMINATION PROHIBITED

2.7-1 STANDARDS OF BEHAVIOR

All members of the medical staff are expected to conduct themselves at all times while on hospital premises in a courteous, professional, respectful, collegial, and cooperative manner, as further described in the medical staff's Code of Conduct Policy. This applies to interactions and communications with or relating to medical staff colleagues, allied health professional staff, nursing and technical personnel, other care-givers, other hospital personnel, patients, patients' family members and friends, visitors, and others. Such conduct is necessary to promote high quality medical care, maintain a safe work environment, and avoid disruption of hospital operations. Disruptive, discriminatory, or harassing behavior, as defined below, will not be tolerated.

2.7-2 DEFINITIONS

a) "Disruptive Behavior" is aberrant behavior manifested through personal interaction with physicians, Hospital personnel, health care professionals, patients, family members, or others, which interferes with patient care or could reasonably be expected to interfere with the process of delivering quality care as defined by the medical staff Code of Conduct. Examples of disruptive behavior include, but are not limited to, refusing to cooperate with other caregivers; rude and inappropriate comments, particularly in the presence of patients, family, or peers; improper use of medical records to criticize other caregivers or the hospital; and insistence on idiosyncratic procedures or services.

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

c) "Harassment" is a course of conduct (including but not limited to violence or threat of violence) directed at a specific person that seriously alarms, upsets, or annoys the person, and that serves no legitimate purpose. A single incident may constitute harassment if sufficiently egregious.

d) "Sexual harassment" is unwelcome verbal or physical conduct of a sexual nature, which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and visual

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

2.7-3 INVESTIGATION AND DISCIPLINARY ACTION

In the event that a member of the medical staff is the subject of a complaint alleging any of the behavior described in Section 2.7-2, the member shall be subject to the investigation and disciplinary action procedures and protections found in the medical staff's Code of Conduct Policy. Notwithstanding any other provision of these bylaws or the rules and regulations, documentation relating to such investigations, their conclusions, and any resulting corrective action shall be maintained by the medical staff office as peer review documents.

2.8 VOLUNTARY PARTICIPATION ON EMERGENCY CALL PANELS

Participation on the emergency call panel shall be voluntary. Membership on the medical staff shall not in any way be contingent on an applicant's willingness to participate on the emergency call panel.

2.9 ADMISSION HISTORY AND PHYSICAL EXAMINATION REQUIREMENTS

Every patient admitted to the Hospital, or otherwise requiring a history and physical examination as described in the Medical Staff Rules and Regulations, shall have a history and physical examination completed within twenty-four (24) hours after admission and at the time of check-in to the outpatient setting. The H&P must be updated if completed prior to admission or time of check-in to the outpatient setting. H&P must be on the chart, with an update note if necessary, prior to any surgery or any procedure requiring anesthesia, including moderate IV sedation. The history and physical examinations must be completed by a Physician or Practitioner who has been determined by the Medical Staff to be qualified and competent to perform history and physical examinations and who holds appropriate privileges. If a history and physical examination is performed by a practitioner authorized to perform such examinations by the Medical Staff but is not a Licensed Independent Practitioner, the history and physical examination must be reviewed and authenticated within twenty-four (24) hours after registration or admission and prior to any surgery or procedure requiring anesthesia, including moderate IV sedation, by a Licensed Independent Practitioner who has been authorized by the Medical Staff to perform history and physical examinations. Emergency procedures (life or limb threatening) may be done without a history and physical but a history and physical must be done after the procedure.

ARTICLE III CATEGORIES OF MEMBERSHIP

3.1 CATEGORIES

The categories of the medical staff shall include the following: active, courtesy, consulting, provisional, ambulatory, honorary and retired, telemedicine, and temporary. At appointment and each time of reappointment, the member's staff category shall be determined.

3.2 ACTIVE STAFF

3.2-1 QUALIFICATIONS

The active staff shall consist of members who:

(a) meet the 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 within 30 minutes of travel time to the hospital to provide appropriate continuity of quality care;

(c) who either regularly care for, or admit in excess of ten patients a year in the hospital;

(d) except for good cause shown as determined by the medical staff, have satisfactorily completed their designated term in the provisional staff category; and

3.2-2 PREROGATIVES

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

(a) admit patients and exercise such clinical privileges as are granted pursuant to Article V. The emergency room physician will not have admitting privileges;

(b) attend and vote on matters presented at general and special meetings of the medical staff and of the department and committees to which the member is duly appointed; and

(c) hold staff, division, or department office and serve as a voting member of committees to which the member is duly appointed or elected by the medical staff or duly authorized representative thereof.

3.2-3 TRANSFER OF ACTIVE STAFF MEMBER

After two consecutive years in which a member of the active staff fails to regularly care for or to admit in excess of ten patients, that member shall be automatically transferred to the appropriate category, if any, for which the member is qualified.

3.3 THE COURTESY MEDICAL STAFF

3.3-1 QUALIFICATIONS

The courtesy medical staff shall consist of members who:

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

(b) who do not regularly care for, or admit more than ten patients a year in the hospital;

(c) have satisfactorily completed appointment in the provisional category.

(d) Be certified by or currently qualify to take the board certification examination of a board recognized by the American Board of Medical Specialties, the American Board of Podiatric Surgery, the American Board of Orthopedic Podiatric Medicine or (2) a board or an association with equivalent requirements approved by the Medical Board of California in the specialty that the practitioner will practice at the hospital or (3) have completed a residency approved by Accreditation Council for Graduate Medical Education-approved post graduate training program that provides complete training in that specialty or subspecialty that the practitioner will practice at the hospital. (This section shall not apply to dentists {or clinical psychologists}..

3.3-2 PREROGATIVES

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

(a) admit patients to the hospital with the limitations of Section 3.3-1(b) and exercise such clinical privileges as are granted pursuant to Article V. The emergency room physician will not have admitting privileges; 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.

Courtesy staff members shall not be eligible to hold office in the medical staff.

3.3-3 LIMITATION

Courtesy staff members who admit or regularly care for more than ten patients for patients at the hospital shall, upon review of the medical executive committee, be obligated to seek appointment to the appropriate staff category.

3.4 THE CONSULTING MEDICAL STAFF

3.4-1 QUALIFICATIONS

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

(a) are not otherwise members of the medical staff and meet the qualifications set forth in Section 2.2, except that this requirement shall not preclude an out-of-state practitioner from appointment as may be permitted by law if that practitioner is otherwise deemed qualified by the medical executive committee;

(b) possess adequate clinical and professional expertise;

(c) are willing and able to come to the hospital on schedule or promptly respond when called to render clinical services within their area of competence;

(d) have satisfactorily completed appointment in the provisional category.

3.4-2 PREROGATIVES

The consulting medical staff member shall be entitled to:

(a) exercise such clinical privileges as are granted pursuant to Article V; and

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

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

3.5 AMBULATORY

3.5-1 QUALIFICATIONS

The ambulatory staff shall consist of members who:

(a) are not otherwise members of the medical staff and meet the qualifications for membership set forth in Section 2.2;

(b) do not have a Hospital in-patient practice but regularly provide professional services for patients in the community served by Sierra View Medical Center;

(c) have satisfactorily completed appointment in the provisional category; and

(d) be certified by or obtain certification within five (5) years of completion of training by a board recognized by the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), the American Board of Podiatric Surgery or the American Board of Orthopedic Podiatric Medicine, and

(e) have completed a residency approved by Accreditation Council for Graduate Medical Education (ACGME). That approved post graduate training program having completed in the specialty or subspecialty that the practitioner is practicing. (This does not apply to dentists or clinical psychologists).

Review of the office practice of a member of the ambulatory staff may be performed to evaluate the member's current professional competence and judgment.

3.5-2 PREROGATIVES

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

(a) Ambulatory staff members are not eligible to admit in-patients to the Hospital. They may not vote or hold office in this medical staff organization, but may serve on committees with or without vote at the discretion of the medical executive committee. They may attend general staff meetings and educational programs.

3.6 PROVISIONAL STAFF

3.6-1 QUALIFICATIONS

The provisional staff shall consist of members who:

(a) meet the general medical staff membership qualifications set forth in Sections 3.2-1(a) and (b) and (e), 3.3-1(a) and (e), or 3.4-1(a)-(d); and

(b) immediately prior to their application and appointment were not members (or were no longer members) in good standing of this medical staff.

3.6-2 PREROGATIVES

The provisional staff member shall be entitled to:

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

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

(c) are willing and able to come to the hospital on schedule or promptly respond when called to render clinical services within their area of competence;

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

3.6-3 OBSERVATION OF PROVISIONAL STAFF MEMBER

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

3.6-4 TERM OF PROVISIONAL STAFF STATUS

A member shall remain in the provisional staff for a period of twelve (12) months, unless that status is extended by the Medical Executive Committee for an additional period of up to twelve (12) months upon a determination of good cause, which determination shall not be subject to review pursuant to Articles VI or VII."

3.6-5 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, courtesy or consulting staff as appropriate, upon recommendation of the medical executive committee; and

(b) If the provisional staff member fails to complete a sufficient number of observed cases to enable evaluation of his/her performance, he/she shall be deemed to have voluntarily resigned from the medical staff; unless the Medical executive committee, in its sole discretion (but taking into consideration the reasonable availability of monitors), elects to extend the observation period.

(c) 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 directors regarding a modification or termination of clinical privileges or termination of medical staff membership.

3.7 TELEMEDICINE STAFF

3.7.1 QUALIFICATIONS

(a) The telemedicine staff under this category shall exercise privileges in the hospital or via telemedicine link, without vote or hold office in this medical staff organization, are members of the medical staff, and meet the qualifications for membership set forth in Section 2.2. These licensed independent practitioners have either total or shared responsibility for patient care, treatment, and services (as evidenced by having the authority to write orders and direct care, treatment, and services), or provide official readings of images, tracings, or specimens (interpretive services) .

(b) Telemedicine staff shall make use of electronic communication or other communication technologies to provide diagnosis and treatment or support clinical care at a distance.

(c) Credentialing and privileging shall be in accordance with Article IV 4.5. Applicants shall have satisfactorily completed appointment in the provisional category. In the case of teleradiology applicants, the medical staff may query hospital references (*in instances where there are more than five (5) hospital references*) for the most recent five(5) listed upon initial application and query an alternate group listed upon reappointment. Information on verifications obtained by a Joint Commission accredited entity may be accepted from the applicant's home facility, but must go through the alternate campuses (SVDH's) review process for approval to the SVDH medical staff .

(d) Be certified by or currently qualify to take the board certification examination of a board recognized by the American Board of Medical Specialties, the American Board of Podiatric Medicine or
(2) a board or an association with equivalent requirements approved by the Medical Board of California in the specialty that the practitioner will practice at the hospital or
(3) have completed a residency approved by Accreditation Council for Graduate Medical Education-approved post graduate training program that provides complete training in that specialty or subspecialty that the practitioner will practice at the hospital. (This section shall not apply to dentists.

3.8 HONORARY AND RETIRED STAFF

3.8-1 QUALIFICATIONS

(a) The honorary staff shall consist of physicians, dentists and podiatrists who do not actively practice at the hospital but are deemed deserving of membership by virtue of their outstanding reputation, noteworthy contributions to the health and medical

sciences, or their previous long-standing service to the hospital, and who continue to exemplify high standards of professional and ethical conduct.

(b) The Retired Staff

The retired staff shall consist of members who have retired from active practice and, at the time of their retirement, were members in good standing of the active medical staff for a period of at least 15 continuous years, and who continue to adhere to appropriate professional and ethical standards.

3.8-2 PREROGATIVES

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

3.9 TEMPORARY STAFF

3.9-1 QUALIFICATIONS

The temporary staff shall consist of physicians, dentists and podiatrists 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. Temporary Staff shall provide information as outlined in Section 4.5-1 of the Medical Staff Bylaws

3.9-2 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 assessment and improvement functions. They shall have no privileges to perform clinical services in the hospital. 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. Finally, they may attend medical staff meetings outside of their committees, upon invitation.

3.10 RESIDENT MEDICAL STAFF

3.10.1 QUALIFICATIONS

(a) Resident medical staff membership shall be held by post-doctoral trainees currently enrolled in the third year of an ACGME or AOA accredited Emergency Medicine residency program, with approval of the residency director.
(b) All resident medical staff members must hold a valid license to practice medicine issued by the Medical Board of California or the California Board of Osteopathic Examiners.
(c) All medical care provided by resident medical staff is under supervision of an attending physician in the Emergency Room.

(d) Resident medical staff membership terminates with termination from training program.

3.11 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 category, by other sections of these bylaws and by the medical staff rules and regulations.

3.12 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 5.4.

3.13 MODIFICATION OF MEMBERSHIP

On its own, upon recommendation of the credentials committee, or pursuant to a request by a member under Section 4.6-1(b), or upon direction of the board of directors as set forth in Section 6.2-6, the medical executive committee may recommend a change in the medical staff category of a member consistent with the requirements of the bylaws.

3.14 Maintenance of Board Certification.

All Members and all Privilege holders who are required by these Bylaws to attain board certification and/or subspecialty certification by a member board of the American Board of Medical Specialties (ABMS), a member board of the American Osteopathic Association Bureau of Osteopathic Specialists (AOABS), the American Board of Oral and Maxillofacial Surgery, the American Board of Podiatric Surgery, or the American Board of Podiatric Orthopedics and Primary Podiatric Medicine must also continuously maintain at least one board certification and/or subspecialty certification. The "continuous" aspect of this maintenance requirement may be temporarily waived for periods up to six months by individual application to the MEC which may act in its sole discretion. (This board certification maintenance requirement does not apply to dentists.)

ARTICLE IV APPOINTMENT AND REAPPOINTMENT

4.1 GENERAL

Except as otherwise specified herein, no person (including persons engaged by the hospital in administratively responsible positions) shall exercise clinical privileges in the hospital unless and until that person applies for and receives appointment to the medical staff or is granted temporary privileges as set forth in these bylaws, or, with respect to allied health practitioners, has been granted a service authorization under applicable medical staff policies. By applying to the medical staff for appointment or reappointment (or, in the case of members of the honorary staff, by accepting an appointment to that category), the applicant acknowledges responsibility to 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 abide by the medical staff bylaws, rules and regulations and policies and procedures and other policies and procedures jointly adopted by the medical staff and board of directors, e.g., to ensure orderly hospital operations as they exist and as they may be modified from time to time. Appointment to the medical staff shall confer on the appointee only such clinical privileges as have been granted in accordance with these bylaws.

4.2 BURDEN OF PRODUCING INFORMATION

In connection with all applications for appointment, reappointment, advancement, or transfer, the applicant shall have the burden of producing information for an adequate evaluation of the applicant's qualifications and suitability for the clinical privileges and staff category requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information. The applicant's failure to sustain this burden shall be grounds for denial of the application. To the extent consistent with law, this burden may include submission to a medical or psychological examination, at the applicant's expense, if deemed appropriate by the medical executive committee, which may select the examining physician. The applicant may select the examining physician from an outside panel of three physicians chosen by the medical executive committee.

4.3 APPOINTMENT AUTHORITY

Appointments, denials and revocations of appointments to the medical staff shall be made as set forth in these bylaws, but only after there has been a recommendation from the medical staff, or as set forth in Section 6.2-6.

4.4 DURATION OF APPOINTMENT AND REAPPOINTMENT

Except as otherwise provided in these bylaws, initial appointments to the medical staff shall be for a period of up to two years. Reappointments shall be for a period of up to two medical staff years.

4.5 APPLICATION FOR INITIAL APPOINTMENT AND REAPPOINTMENT

4.5-1 APPLICATION FORM

An application form shall be approved by the medical executive committee. The form shall require detailed information which shall include, but not be limited to, information concerning:

(a) Identifying information, including either a current picture hospital ID card or a valid picture ID issued by State or Federal agency, such as Drivers License or Passport;

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

(c) peer references familiar with the applicant's current professional competence and ethical character; All initial applicants will submit (3) Peer References. For the reappointment application, department action of an Active member in good standing shall be equal to positive peer reference. Physician with limited patient activity, Courtesy and Consulting status, shall submit (2) peer references.

(d) requests for membership categories, departments, and clinical privileges;

(e) previously successful or currently pending challenges to any licensure or registration (state, district, Drug Enforcement Administration) or the voluntary relinquishment of such licensure or registration.

(f) voluntary or involuntary termination of medical staff membership or any current or past challenges, voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital.

(g) current physical and mental health;

(h) final judgments or settlements made against the applicant in professional liability cases, and any filed and served cases pending; and

(i) professional liability coverage with minimum $ 1 million per occurrence /$3 million aggregate

(j) Annual PPD Attestation

(k) Annual Influenza Vaccine Attestation

(l) MMR/Varicella/Hepatitis B/Tdap Screening Attestation

4.5-2 EFFECT OF APPLICATION

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

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

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

(c) consents to inspection of records and documents that may be material to an evaluation of the applicant's qualifications 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) releases from any liability, all persons for their acts performed in connection with investigating and evaluating the applicant;

(e) releases from any liability, all individuals and organizations who provide information regarding the applicant, including otherwise confidential information;

(f) consents to the disclosure to other hospitals, medical associations, licensing boards, and to other similar organizations as 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;

(g) if a requirement then exists for medical staff dues, acknowledges responsibility for timely payment;

(h) pledges to provide for continuous quality care for patients;

(i) 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 providing "ghost" surgical or medical services, and refraining from delegating patient care responsibility to non-qualified or inadequately supervised practitioners; and

(j) pledges to be bound and abide by the medical staff bylaws, rules and regulations, and policies and procedures and other policies and procedures jointly adopted by the medical staff and board of directors, e.g., to ensure orderly hospital operations.

4.5-3 VERIFICATION OF INFORMATION

The applicant shall deliver a completed application and supporting documents to the appropriate medical staff officer and an advance payment of medical staff fees. The completed application and all supporting materials when available shall be transmitted to the Chair of each department in which the applicant seeks privileges for approval and to the credentials committee for review. The Medical Staff Service Department shall expeditiously seek to collect or verify the references, licensure status, and other evidence submitted in support of the application from primary source(s), whenever feasible. In the case of telemedicine or exclusive contracted applicants, the medical staff may query hospital references (in instances where there are more than five (5) hospital references) for the most recent five (5) listed upon initial application and query an alternate group upon reappointment. Information on verifications obtained by a Joint Commission accredited entity may be accepted from the applicant's home facility, but must go through the alternate campuses (SVDH's) review process for approval to the SVDH medical staff .

The hospital's authorized representative Medical Staff Service Department shall query the National Practitioner Data Bank regarding the applicant or member and submit any resulting information to the Chair of the respective Department for inclusion in the applicant's or member's credentials file.

The applicant shall be notified by registered mail of any problems in obtaining the information required, and it shall be the applicant's burden to obtain and provide any reasonably requested information. If the applicant does not respond within thirty (30) days, he or she shall be deemed to have voluntarily withdrawn his or her application. This period may be extended by the medical staff in its sole discretion only after a written and signed request by the applicant setting forth the reasons for the delay.

If the applicant then fails to provide or arrange for the provision within thirty (30) days or any other date mutually agreed to when the extension was granted (whichever is later) of the necessary information, the applicant shall be deemed to have voluntarily withdrawn his or her application.

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

When collection and verification of information has been accomplished, the application and all such information shall be transmitted to the credentials committee and the appropriate department(s). No final action on an application may be taken until the application is completed and receipt of the Data Bank report.

4.5-4 DEPARTMENT ACTION

After receipt of the application, the Chair of each department for which the application is submitted, shall review the application and supporting documentation, may request additional information, and may conduct a personal interview with the applicant. The Chair shall evaluate all matters deemed relevant to a recommendation, including information concerning the applicant's provision of services within the scope of privileges granted, along with participation in relevant continuing education shall be provided by written report to the credentials committee, including. a recommendation as to appointment and/or reappointment, membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached. The Department Chair may also defer action on the application.

4.5-5 CREDENTIALS COMMITTEE ACTION

The credentials committee shall review the application; evaluate the supporting documentation, the department chair's report and recommendations, and other relevant information. The credentials committee may elect to interview the applicant and seek additional information. As soon as practicable, the credentials committee shall transmit to the medical executive committee its recommendations as to appointment and, if appointment is recommended, as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. The committee may also defer action on the application.

4.5-6 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 forward to the CEO, for prompt transmittal to the board of directors, a written report and recommendation as to medical staff appointment and, if appointment is recommended, as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. The committee may also defer action on the application. The reasons for each recommendation shall be stated.

4.5-7 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 promptly forwarded, together with supporting documentation, to the board of directors.

(b) Adverse Recommendation: When a recommendation of the medical executive committee is adverse to the applicant, the board of directors and the applicant shall be promptly informed by written notice. The applicant shall then be entitled to procedural rights as provided in Article VII.

4.5-8 ACTION ON THE APPLICATION

The board of directors 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. If, after referring a matter back to the medical executive committee, the board of directors and medical executive committee continue to disagree regarding the action to be taken the matter shall be referred to the Ad Hoc Dispute Mediation Committee. 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 directors shall affirm the recommendation of the medical executive committee unless the board of directors concludes that the medical staff has failed to fulfill a substantive duty or responsibility in matters pertaining to the quality of care.

(1) If the board of directors concurs in that recommendation, the decision of the board shall be deemed final action.

(2) If the tentative action of the board of directors is adverse, the CEO shall give the applicant written notice of the tentative adverse recommendation in accordance with Section 7.3-1 below, and the applicant shall be entitled to the procedural rights set forth in Article VII. In addition to the items listed in section 7.3-1, the notice provided under this section shall include the reasons for an adverse recommendation with respect to the application. If procedural rights are waived by the applicant, the decision of the board of directors shall be deemed final action.

(b) In the event the recommendation of the medical executive committee, or any significant part of it, is adverse to the applicant the procedural rights set forth in Article VII shall apply.

(1) If procedural rights are waived by the applicant, the recommendations of the medical executive committee shall be forwarded to the board of directors for final action.

(2) If the applicant requests a hearing following the adverse medical executive committee recommendation pursuant to Section 4.5-8(b) or an adverse board of directors tentative action pursuant to 4.5-8(a) (2), the board of directors shall take final action only after the applicant has exhausted all procedural rights as established by Article VII. After exhaustion of the procedures set forth in Article VII, the board shall make a final decision. The board's decision shall be in writing and shall specify the reasons for the action taken.

4.5-9 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 CEO.

(b) A decision and notice to appoint or reappoint shall include, if applicable: (1) the staff category to which the applicant is appointed; (2) the department to which that person is assigned; (3) the clinical privileges granted; and (4) any special conditions attached to the appointment.

4.5-10 REAPPLICATION AFTER ADVERSE DECISION

(a) An applicant or member of the medical staff who has received a final adverse decision except as otherwise allowed (per Section 4.5-10(b)), cannot reapply for Medical staff membership or the Privileges affected by the adverse action for at least 24 months after the action became final. After the waiting period, the applicant or member may reapply. The application will be processed like an initial application or request, plus the applicant or member shall document that the basis for the adverse action no longer exists, that he or she has corrected any problems that prompted the adverse action, and/or he or she has complied with any specific training or other conditions that were imposed.

(b) For the purposes of this section 4.5-10, an action is considered adverse only if it is based on the type of occurrence that 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), or to pay dues (which can be cured by paying dues), or to maintain professional liability insurance (which can be cured by obtaining the insurance).

(b) For the purposes of this section 4.5-10, the action is considered final on the latest date on which the application or request was withdrawn, a member's resignation became effective, or upon completion of: (i) all hearings and appellate reviews and (ii) all judicial proceedings pertinent to the action service within two (2) years after the completion of the hospital proceedings.

4.5-11 TIMELY PROCESSING OF APPLICATIONS

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

(a) evaluation, review, and verification of application and all supporting documents by the medical staff office: 90 days from receipt of all necessary documentation;

(b) 30 days is allotted to the applicant following notification by registered mail of his/her burden to produce additional information. This period may be extended only with a written and signed request by the applicant as to the delay. Failure to provide this information will result in a withdrawal of his/her application for consideration.

(c) review and recommendation by department(s): 30 days after receipt of all necessary documentation from the medical staff office;

(d) review and recommendation by credentials committee: 30 days after receipt of all necessary documentation from the department(s);

(e) review and recommendation by executive committee: 30 days after receipt of all necessary documentation from the credentials committee; and

(e) final action: 120 days after receipt of a complete application by the medical staff office or 7 days after conclusion of hearings.

4.6 REAPPOINTMENT AND REQUESTS FOR MODIFICATIONS OF STAFF STATUS OR PRIVILEGES

4.6-1 APPLICATION

(a) At least 6 months prior to the expiration date of the current staff appointment (except for temporary appointments), a reapplication form approved by the medical executive committee shall be mailed or delivered to the member. If an application for reappointment is not received at least 90 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 45 days prior to the expiration date, each reappointment application shall be submitted to the Medical staff Service Department for processing. The reapplication form shall include all information necessary to update and evaluate the qualifications of the applicant including, but not limited to, the matters set forth in Section 4.5-1, as well as other relevant matters.

(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, except that such application may not be filed within 12 months of the time a similar request has been denied. Any Active medical staff member who requests to change his/her status must provide an advance thirty (30) day written notice to the Medical Staff Service Department for processing.

4.6-2 EFFECT OF APPLICATION

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

4.6-3 STANDARDS AND PROCEDURE FOR REVIEW

When a staff member submits application for reappointment, , or when the member submits an application for modification of staff status or clinical privileges, the member shall be subject to an in-depth review generally following the procedures set forth in Sections 4.5-3 through 4.5-11.

4.6-4 FAILURE TO FILE REAPPOINTMENT APPLICATION

Medical staff appointments/reappointment for membership is granted for a maximum of two years, with no grace period. Failure to timely file a completed application for reappointment, or

a failure to cooperate timely in providing additional information as requested by the reviewing committees, shall result in an automatic termination of membership and privileges and prerogatives at the expiration of the current staff appointment. [A reappointment application received past the due date or following such termination shall be processed in the manner specified for applications for initial appointment.] In the event membership terminates for the reasons set forth herein, the procedures set forth in Article VII shall not apply.

4.6-5 ON-GOING PROFESSIONAL PRACTICE EVALUATION

All members shall be subject to an ongoing professional practice evaluation every six (6) months in accordance with the Medical Staff's OPPE Policy.

4.7 LEAVE OF ABSENCE

4.7-1 LEAVE STATUS

A medical staff member may obtain a voluntary leave of absence from the staff upon submitting a written request, with a thirty (30) day written notice, to the medical executive committee stating the approximate period of leave desired, which may not exceed one (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.

4.7-2 TERMINATION OF LEAVE

At least 30 days prior to the termination of the leave of absence, or at any earlier time, the medical staff member may request reinstatement of privileges by submitting a written notice to that effect to the medical executive committee. The staff member shall submit a summary of activities during the leave. The medical executive committee shall make a recommendation concerning the reinstatement of the member's privileges and prerogatives, which may be granted subject to monitoring and/or proctoring as determined by the medical executive committee, and the procedure provided in Sections 4.1 through 4.5-11 shall be followed.

4.7-3 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 member whose membership automatically terminated shall have thirty (30) days to request that the Medical executive committee excuse his/her failure to request reinstatement. A request for Medical staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

4.7-4 MEDICAL LEAVE OF ABSENCE

The medical executive committee shall determine the circumstances under which a particular medical staff member shall be granted a leave of absence for the purpose of obtaining treatment for a medical condition or disability. In the discretion of the medical executive

committee, unless accompanied by a reportable restriction of privileges, the leave shall be deemed a “medical leave” which is not granted for a medical disciplinary cause or reason.

4.7-5 MILITARY LEAVE OF ABSENCE

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

ARTICLE V CLINICAL PRIVILEGES

5.1 EXERCISE OF PRIVILEGES

Except as otherwise provided in these bylaws, a member providing clinical services at this hospital shall be entitled to exercise only those clinical privileges specifically granted. 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 governing body of this hospital only upon recommendation of the medical staff, only for reasons directly related to quality of patient care and other provisions of the medical staff bylaws, and only following the procedures outlined in these bylaws.

5.2 DELINEATION OF PRIVILEGES IN GENERAL

5.2-1 REQUESTS

Each application for appointment and reappointment to the medical staff must contain a request for the specific clinical privileges desired by the applicant. A request by a member for a modification of clinical privileges may be made at any time, but such requests must be supported by documentation of training and/or experience supportive of the request.

5.2-2 BASES FOR PRIVILEGES DETERMINATION

Requests for clinical privileges shall be evaluated upon evidence based criteria, such as the member’s education, training, experience, current demonstrated professional competence and judgment, clinical performance, current health, 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.

5.2-3 CRITERIA FOR “CROSS-SPECIALTY” OR NEW PRIVILEGES WITHIN THE HOSPITAL

Any request for clinical privileges that are new to the hospital shall initially be reviewed by the appropriate departments, in order to establish the need for, and appropriateness of, the new

procedure or services. Any request for new clinical privileges that overlap more than one department shall initially be reviewed by the appropriate in order to address criteria for the procedure. The medical executive committee 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 medical executive committee may establish an ad hoc committee with representation from all appropriate departments.

5.3 PROCTORING

5.3-1 GENERAL PROVISIONS

Except as otherwise determined by the medical executive committee, all initial appointees to the medical staff and all members granted new clinical privileges shall be subject to a period of proctoring as further described in the Sierra View Medical CenterRules and Regulations Reference Number 1016. Each appointee or recipient of new clinical privileges shall be assigned to a department where performance on an appropriate number of cases as established by the medical executive committee, or the department as designee of the medical executive committee, shall be observed and/or evaluated by the chair of the department, or the chair's designee, during the period of proctoring specified in the department's rules and regulations, to determine suitability to continue to exercise the clinical privileges granted in that department. The exercise of clinical privileges in any other department shall also be subject to direct observation by that department's chair or the chair's designee. The member shall remain subject to such proctoring until the medical executive committee has been furnished with:

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

(i) which may include, but not limited to: concurrent or retrospective case review, mandatory consultation, and/or direct observation. The member has the burden of complying with and completing all proctoring requirements, must notify and schedule proctoring at the convenience of the proctor, and must timely respond to questions that may arise regarding patient care.

(ii) Appropriate records shall be maintained and completed. Proctoring valuation forms must be forwarded to Medical Staff Service Department for inclusion in the member's credentials file. Results of proctoring shall be communicated by the Department Chair to the Credentials Committee and the Medical Executive Committee.

(iii) The member shall remain subject to proctoring until notified in writing by the medical staff that he no longer is subject to proctoring.

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

(c) If the member fails to complete the required number of proctored cases within the time frame established by his/her department, he/she shall be deemed to have voluntarily withdrawn his/her request for membership or clinical privileges, and he/she shall not be afforded the procedural rights provided in Article VII. However, the department Chair may recommend and the Medical executive committee as the discretion to extend the time for completion of proctoring in appropriate cases.

5.3-2 MEDICAL STAFF ADVANCEMENT

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

5.4 CONDITIONS FOR PRIVILEGES OF LIMITED LICENSE PRACTITIONERS

5.4-1 ADMISSIONS

(a) Except as provided by subdivision (b), Limited License Practitioners do not admit. When dentists, oral surgeons and podiatrists conduct or directly supervise the a history and physical examination on the portion related to their scope of practice, 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 the admitting Primary Care physician shall assume care.

(b) 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 perform a history and physical examination pertaining to their area of expertise and determine the ability of their patient to undergo surgical procedures Completion of a history and physical by a qualified oral and maxillofacial surgeon under this subsection (b) shall satisfy the appraisal portion of the requirements of Section 5.4-3, below. For patients with existing medical conditions or abnormal findings beyond the surgical indications, a physician member of the medical staff must conduct or directly supervise the admitting history and physical examination, except the portion related to 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 oral and maxillofacial surgeon's lawful scope of practice.

5.4-2 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.

5.4-3 MEDICAL APPRAISAL

All patients attended 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 for 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).

5.5 TEMPORARY CLINICAL PRIVILEGES

5.5-1 IMPORTANT PATIENT CARE NEEDS

a) CARE OF A SPECIFIC PATIENT

Temporary clinical privileges may be granted for an important care or service need where good cause exists provided that the procedure described in Section 5.5-4 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, provided that the procedure described in Section 5.5-4 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 120 days in a twelve (12) month period, unless the medical executive committee recommends a longer period for good cause.

5.5-2 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 directors, provided that the application is complete, 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 temporary privileges shall not exceed [120 days].

5.5-3 TEMPORARY MEMBERSHIP AND TEMPORARY PRIVILEGES NOT CO-EXTENSIVE

Temporary members of the medical staff pursuant to Section 6.2-3 are not, by virtue of such membership, granted temporary clinical privileges.

5.5-4 APPLICATION AND REVIEW

(a) Upon receipt of a completed application and supporting documentation from a physician or AHP authorized to practice in the hospital, the CEO or designee upon recommendation by the Chief of Staff or Department Chair may grant temporary privileges to an applicant who appears to have qualifications, ability and judgment consistent with Section 2.2-3, but only after:

(1) receipt and evaluation of responses to queries of the National Practitioner Data Bank and the Medical Boards, and verification of Malpractice Insurance coverage, Education, Training and current competence

(2) contact of least one person who

(i) has recently worked with the applicant;

(ii) has directly observed the applicant's professional performance over a reasonable time

5.5-5 GENERAL CONDITIONS

(a) If granted temporary privileges, the applicant shall act under the supervision of the chair of the department 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 VI and/or VII of these bylaws or unless affirmatively renewed following the procedure as set forth in Section 5.5-4. A medical staff applicant's temporary privileges shall automatically terminate if the applicant's initial application is withdrawn. As necessary, the appropriate department chair or, in the chair's absence, the chair of the medical executive committee, shall assign a member of the medical staff to assume responsibility for the care of such member's patient(s). The wishes of the patient shall be considered in the choice of a replacement medical staff member;

(c) Requirements for proctoring and monitoring, including but not limited to those in Section 5.3, shall be imposed on such terms as may be appropriate under the circumstances.

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

5.6 EMERGENCY AND DISASTER PRIVILEGES

5.6-1 EMERGENCY PRIVILEGES

(a) In the case of an emergency, any member of the medical staff, 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 a patient or to save a patient from serious harm. 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, 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.

5.6-2 DISASTER PRIVILEGES

In the case of a disaster in which the emergency management plan has been activated and the hospital is unable to handle the immediate patient needs, the Chief Executive Officer, Chief of Staff, or designee may grant emergency disaster privileges upon presentation of a valid picture ID (issued by state, federal, or regulatory agency e.g. driver's license or passport, and at least one of the following:

a. A current license to practice or primary source verification of the license.
b. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT).
c. Identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state or municipal entity.
   Presentation by current hospital or medical staff member(s) with personal knowledge regarding practitioner's identity.

1. <u>Verification of Information</u>

   Verification of the required information shall be done as soon as feasible by the Medical Staff Service Department/designee or as soon as feasible.

   a. The National Practitioner Data Bank and OIG/GSA databases will be queried if possible.
   b. Emergency privileges will be immediately terminated in the event that any information received through the verification process indicates any adverse information or suggests the person is not capable of rendering services in an emergency.

2. <u>Conditions of Emergency Privileges:</u>

   a. The emergency designee must practice under the direction and supervision of an existing member of the Sierra View Medical Center Medical Staff.

b. The emergency designee will sign a statement attesting that the information given to the hospital is accurate.
c. The emergency designee agrees to be bound by all hospital policies and rules, as well as Medical Staff Bylaws, Rules and Regulations, and any directives from the Department Chairperson, supervising physician or any other hospital or medical staff leader.
d. Emergency privileges will be valid only for the duration of the disaster, and will automatically terminate at the end of needed services.
e. Based on information obtained regarding the professional practice of the volunteer, the organization will make a decision within 72 hours related to the continuation of the disaster privileges initially granted.
f. Practitioner performance will be monitored to ensure the delivery of quality patient care by the designee. A record of all patients seen and/or treated by the designee will be maintained.

5.7 MODIFICATION OF CLINICAL PRIVILEGES OR DEPARTMENT ASSIGNMENT

On its own, upon recommendation of the credentials committee, or pursuant to a request under Section 4.6-1(b), the medical executive committee may recommend a change in the clinical privileges or department assignment(s) of a member. If it is a reduction in privileges due to medical disciplinary cause or reason, procedural rights may be triggered pursuant to Article VII. All new or additional privileges granted to a current medical staff member are subject to monitoring in accordance with procedures similar to those outlined in Section 5.3.

5.8 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 VII.

ARTICLE VI PEER REVIEW AND CORRECTIVE ACTION

6.1 PEER REVIEW

The medical staff *[committees and/or departments]* are responsible for carrying out delegated review and quality improvement functions in accordance with the medical staff's peer review policy. Such peer review activities include, but are not limited to, quality improvement, utilization review, on-going professional practice evaluation (the evaluation of quality data, privilege volume data, and individual case reviews), focused professional practice evaluation (including individual monitoring, proctoring, and focused reviews), and other review and evaluation activities. Peer review activities are designed to include evaluation of all practitioners in accordance with the general competencies of patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and system-based practice, as further described in the medical staff's peer review policy. They may counsel, educate, refer for education or evaluation, issue letters of warning or censure, or institute retrospective or concurrent monitoring (so long as the practitioner is only required to provide reasonable notice of admissions and procedures) in the course of carrying out their duties without initiating formal corrective action proceedings. Comments, suggestions and warnings may be issued orally or in writing. The practitioner shall be given an opportunity to respond in writing and may be given an opportunity to meet with the

committee or department. Any informal actions, monitoring or counseling shall be documented in the member's file. Medical executive committee approval is not required for such actions, although the actions shall be reported to the medical executive committee. This shall not be construed to confer any rights upon a practitioner to any routine monitoring and education prior to corrective action. These actions shall not constitute a restriction of privileges or grounds for any formal hearing or appeal rights under Article VII.

6.2 CORRECTIVE ACTION

6.2-1 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, rules and regulations, and policies and procedures and other policies and procedures jointly adopted by the medical staff and board of directors, *e.g.,* to ensure orderly hospital operations; or (4) 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.

6.2-2 INITIATION

A request for an investigation or corrective action must be in writing, submitted to the medical executive committee or Chief of Staff, and supported by reference to specific activities or conduct alleged. If the medical executive committee initiates the request, it shall make an appropriate recordation of the reasons.

6.2-3 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 5.5, should circumstances warrant. If the investigation is delegated to an officer or committee other than the medical executive committee, such officer or committee shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the medical executive committee as soon as practicable. The report may include recommendations for appropriate corrective action. The member shall be notified that an investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The individual or body investigating the matter may, but is not obligated to, conduct interviews with persons involved; however, such investigation shall not constitute a "hearing" as that term is used in Article VII, nor shall the procedural rules with respect to hearings or appeals apply. 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.

6.2-4 EXECUTIVE COMMITTEE ACTION

As soon as practicable after the conclusion of the investigation, the medical executive committee shall take action, and file documentation with respect thereto in the member's file. Actions the medical executive committee may take include, without limitation:

(a) determining no corrective action be taken and, if the executive committee determines there was no credible evidence for the complaint in the first instance, documenting that fact in the member's file;

(b) deferring action for a reasonable time where circumstances warrant;

(c) issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude 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;

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

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

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

(g) referring the member to the Physician Well-Being Committee for evaluation and follow-up as appropriate

(h) recommending suspension, revocation or probation of medical staff membership; and

(i) taking other actions deemed appropriate under the circumstances.

6.2-5 SUBSEQUENT ACTION

(a) If the medical executive committee determines that no corrective action is required or only a letter of warning, admonition, reprimand, or censure should be issued, the decision shall be transmitted to the board of directors.

(b) If the medical executive committee recommends an action that is a ground for a hearing under Section 7.2, the practitioner shall be given notice of the adverse recommendation and of the right to request a hearing in accordance with Section 7.3-1. The board of directors may be informed of the recommendation, but shall take no action until the member has either waived his or her right to a hearing or completed the hearing.

6.2-6 INITIATION BY BOARD OF DIRECTORS

If the medical executive committee fails to investigate or take disciplinary action in response to information about a member's competence, performance, or conduct that is provided in accordance with the provisions of this Article VI, and if the board of directors determines that the medical executive committee's failure to proceed is contrary to the weight of the evidence, the board of directors 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 staff 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 the board of director's direction, the board of directors may initiate the ad hoc dispute mediation process set forth in Article X of these bylaws (unless immediate action is required to protect the health or safety of any individual, in which event the procedures for summary suspension shall apply). If the dispute mediation process does not result in action by the medical executive committee, and the board of directors still believes action is necessary, then the board of directors may initiate an investigation or corrective action after written notice to the medical executive committee. However, the board of directors shall not initiate an investigation or corrective action under this section unless it has documented a reasonable and good faith belief that the medical staff has failed or declined to fulfill a substantive duty or responsibility pertaining to the quality of delivery of patient care. In addition, any investigation or corrective action by the board of directors shall only be taken after written notice to the medical executive committee, and shall fully comply with Articles VI and VII of these medical staff bylaws, and the board of directors shall not act precipitously, unreasonably, or in bad faith.

6.3 SUMMARY RESTRICTION OR SUSPENSION

6.3-1 CRITERIA FOR INITIATION

Whenever failure to take such action may result in an imminent danger to the health of any individual, the chief of staff, the medical executive committee, or the head of the department or designee in which the member holds privileges 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 directors, the medical executive committee and the CEO. The notice of action given to the medical executive committee shall constitute a request to initiate corrective action, and the procedures set forth in Section 6.2 shall be followed. 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 6.3-2 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.

6.3-2 WRITTEN NOTICE OF SUMMARY RESTRICTION OR SUSPENSION

Within three (3) working days of imposition of a summary restriction or suspension, the affected medical staff member shall be provided with written notice of such action. This initial written notice shall include a brief statement the basis for the action This initial notice shall not substitute for, but is in addition to, the notice required under Section 7.3-1 (which applies in all cases where the medical executive committee does not immediately terminate the summary action). The notice under Section 7.3-1 may supplement the initial notice provided under this

section, by including any additional relevant facts supporting the need for summary action or other corrective action.

6.3-3 MEDICAL EXECUTIVE COMMITTEE ACTION

Within one (1) week after such summary restriction or suspension has been imposed, a meeting of the medical executive committee 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 VII, 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 two (2) working days of the meeting.

6.3-4 PROCEDURAL RIGHTS

Unless the medical executive committee promptly terminates the summary restriction or suspension, it shall remain in effect during the pendency and completion of the hearing and appellate review process to which the member is entitled under Article VII. Any hearing under Article VII may be consolidated with the hearing on any additional corrective actions that are recommended so long as the hearing on the summary action and any additional corrective actions commences in accordance with Section 7.3-3.

6.3-5 INITIATION BY BOARD OF DIRECTORS

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 directors (or designee) may immediately suspend or restrict a member's privileges if a failure to suspend those privileges is likely to result in an imminent danger to the health of any person, provided that the board of directors (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 restriction or suspension.

Such a suspension or restriction is subject to ratification by the medical executive committee. If the medical executive committee does not ratify such a summary suspension or restriction within two (2) working days, excluding weekends and holidays, the summary restriction or suspension shall terminate automatically. If the medical executive committee does ratify the summary suspension or restriction, all other provisions under Section 6.3 of these bylaws will apply.

6.4 AUTOMATIC SUSPENSION OR LIMITATION

In the following instances, the member's privileges or membership may be suspended or limited as described, and such action shall not give rise to the procedural rights of Article VII. However, the member may *[appear before the medical executive committee][submit a written statement to the medical executive committee]* addressing the question of whether the grounds for automatic suspension as set forth below have occurred.

6.4-1 LICENSURE

(a) Revocation, Suspension and Expiration: Whenever a member's license or other legal credential authorizing practice in this state is revoked, suspended or expired, 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.

6.4-2 CONTROLLED SUBSTANCES

(a) Revocation, Restriction, Suspension and Expiration: Whenever a member's DEA certificate is revoked, restricted, suspended, or expired the member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.

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

6.4-3 MEDICAL RECORDS

(a) Members of the medical staff are required to complete medical records within such reasonable time as may be prescribed by the medical executive committee. Automatic suspensions shall occur as follows:

i. For failure to complete medical records within fourteen (14) days after the patient is discharged, a practitioner's privileges and his or her rights to admit patients and to provide any other professional services shall be automatically suspended if he or she has failed to complete the records within ten (10) days after he or she is given a final written notice and shall remain so suspended until all delinquent medical records are completed.

(c) With the exception of emergency care, for which only the practitioner is qualified and available to render, and the care of patients already hospitalized at the time of suspension, such automatic suspension shall include all admitting and privileges, as well as scheduling of elective operations and assisting at operations. With the exception of care of patients already hospitalized and under the care of the practitioner at the time of the suspension, it is the responsibility of any physician should he or she be suspended under this provision, to obtain substitute coverage for his or her patients, including coverage for service on the Emergency Room Back-up Call Schedule. Unverified emergency admissions shall not be used to bypass such restriction. The suspended member shall not attend any patient

admitted by another member unless he is the only practitioner available for a specific emergency consultation.

(d) The Medical executive committee may when it deems necessary, impose corrective action. If within [ninety days] after implementation of suspension the member has not completed the delinquent records, the member's membership and privileges shall be automatically terminated.

6.4-4 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 13.3, shall be ground for automatic suspension of a member's clinical privileges, and if within six (6) months after written warnings of the delinquency the member does not pay the required dues or assessments, the member shall be deemed to have voluntarily resigned.

6.4-5 PROFESSIONAL LIABILITY INSURANCE

Failure to maintain professional liability insurance shall be grounds for automatic suspension of a member's clinical privileges until insurance is reinstated, including coverage for acts/omissions during the lapsed period, and if within ninety (90) days after written warnings of the delinquency the member does not provide evidence of required professional liability insurance, the member shall be deemed to have voluntarily resigned.

6.4-6 EXCLUDED PROVIDERS

(a) Failure to provide the notice required under Section 2.6(o) regarding exclusion from federal and state programs in a timely manner shall result in automatic termination of the member's membership and privileges.

(b) A medical staff member who is excluded from any health care program funded in whole or in part by the federal government, or any state health care program, including, but not limited to, Medicare and Medi-Cal, shall be automatically terminated from the medical staff.

6.4-7 FELONY CONVICTION OR PLEA

A practitioner who has been convicted of, or who has plead guilty or no contest to, a felony related directly to his/her professional practice or patient relationships shall not be entitled to apply for initial appointment to the medical staff. If a member of the medical staff is convicted of, or pleads guilty or no contest to a felony directly related to his/her professional practice or patient relationships, the member's medical staff membership and privileges shall be automatically suspended pending review by the medical executive committee. If the medical executive committee confirms that the felony was directly related to the member's professional practice or patient relationships, the member's staff membership and privileges shall terminate without right to a hearing. If the medical executive committee determines the felony was not directly related to the member's professional practice or patient relationships, the members shall be permitted to request reinstatement.

6.4-8 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 or department 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 the requested information and/or satisfied the special attendance requirement which has been made by the medical executive committee.

6.4-9 MEDICAL EXECUTIVE COMMITTEE DELIBERATION

As soon as practicable after action is taken or warranted as described in Section 6.4-1(b) or (c), 6.4-2, 6.4-5 or 6.4-8, 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.

ARTICLE VII HEARINGS AND APPELLATE REVIEWS

7.1 GENERAL PROVISIONS

7.1-1 EXHAUSTION OF REMEDIES

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

7.1-2 APPLICATION OF ARTICLE

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

7.1-3 TIMELY COMPLETION OF PROCESS

The hearing and appeal process shall be completed within the established time frames.

7.1-4 FINAL ACTION

Except for summary actions, recommended adverse actions described in Section 7.2 shall become final only after the hearing and appellate rights set forth in these bylaws have either been exhausted or waived, and only upon being adopted as final actions by the board of directors.

7.1-5 DEADLINE FOR SEEKING JUDICIAL REVIEW

Request for judicial review of the final decision, pursuant to California Code of Civil Procedure section 1094.5, must be filed not later than ninety (90) days following the date on which the decision becomes final. Notice of such deadline shall be included in notice of the final decision.

7.2 GROUNDS FOR HEARING

Except as otherwise specified in these bylaws, any one or more of the following actions or recommended actions, if based on a medical disciplinary cause or reason, shall constitute grounds to request a hearing:

(a) denial of medical staff membership;

(b) denial of medical staff reappointment;

(c) suspension of staff membership or privileges for greater than 14 days;

(d) termination of medical staff membership;

(e) denial of requested clinical privileges;

(f) involuntary reduction or restriction of current clinical privileges (including involuntary imposition of significant consultation or proctoring requirements (excluding proctoring incidental to provisional status and Section 5.3) for a cumulative total of 30 days or more in any 12-month period; or

(g) termination of all clinical privileges.

7.3 REQUESTS FOR HEARING

7.3-1 NOTICE OF ACTION OR PROPOSED ACTION

In all cases in which action has been taken or a recommendation made as set forth in Section 7.2, the 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 brief description of the reasons for the proposed action; (3) the right to request a hearing pursuant to Section 7.3-3, and that such hearing must be requested within thirty (30) days and shall indicate whether the member will be represented by an attorney at the hearing; and (4) a summary of the rights granted in the hearing pursuant to the medical staff bylaws, including the right to representation by legal counsel.

7.3-2 HEARINGS PROMPTED BY BOARD OF DIRECTORS ACTION

If the hearing is based upon an adverse decision or recommendation of the board of directors, the board of directors or its designee shall fulfill the duties assigned to the medical executive committee or the chief of staff for when the medical executive committee is the body whose decision prompted the hearing. This shall include, but not be limited to, preparing the notice of adverse action or recommended action and right to a hearing, scheduling the hearing, providing the notice of hearing and statement of charges, and designating the judicial review committee, presenter and witnesses.

7.3-3 REQUEST FOR HEARING

(a) The member shall have thirty (30) days following receipt of notice of such action to request a hearing. The request shall be in writing addressed to the medical executive committee with a copy to the board of directors, and shall state, in writing, whether he or she will be represented by an attorney at the hearing. In the event the member does not request a hearing within the time and in the manner described, the member shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved.

7.3-4 TIME AND PLACE FOR HEARING

Upon receipt of a request for hearing, the medical executive committee or Chief of Staff shall schedule a hearing and, within thirty (30) days give notice to the member of the time, place and date of the hearing. The date of the commencement of the hearing shall be not less than thirty (30) days nor more than sixty (60) days from the date of receipt of the request by the medical executive committee for a hearing; provided, however, that when the request is received from a member who is under summary suspension the hearing shall be held as soon as the arrangements may reasonably be made, so long as the member has at least thirty (30) days from the date of notice to prepare for the hearing or waives this right.

7.3-5 NOTICE OF HEARING

Together with the notice stating the place, time and date of the hearing, 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 and a list of the charts in question, where applicable

7.3-6 JUDICIAL REVIEW COMMITTEE

(a) When a hearing is requested, the medical executive committee or Chief of Staff shall recommend a judicial review committee to the board of directors for appointment. The board of directors shall be deemed to approve the selection unless it provides written notice to the medical executive committee stating the reasons for its objection within 5 days. The judicial review committee shall be composed of not less than three (3) members of the Active Medical staff. The judicial review committee members shall gain no direct financial benefit from the outcome, and shall not have acted as accusers, investigators, fact finders, and 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. In the event that it is not feasible to appoint a judicial review committee from the Active Medical staff, the medical executive committee or Chief of Staff may appoint members from other staff categories or practitioners who are not members of the medical staff. Such appointment shall include designation of the chair. Membership on a judicial review committee, where possible, shall consist of one member who shall have the same healing arts licensure as the accused, and where feasible, include an individual practicing the same specialty as the member. All other members shall have MD or DO degrees or their equivalent as defined in Section 2.2-2(a)(1). The medical executive committee or Chief Of Staff may appoint alternates meeting the above standards, as deemed appropriate.

[(b) Alternatively, the body whose decision prompted the hearing and the member may mutually agree to use an arbitrator in accordance with the provisions of California Business and Professions Code Section 809 et seq. If an arbitrator is used he/she shall be selected using a process mutually accepted by the body whose decision prompted the hearing and the member. The arbitrator need not be either a health professional or an attorney. The arbitrator shall carry out all of the duties assigned to the hearing officer and to the judicial review committee.]

(c) The judicial review committee*[, or the arbitrator, if one is used,]* shall have such powers as are necessary to discharge its or his or her responsibility hereunder.

7.3-7 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.

7.3-8 POSTPONEMENTS AND EXTENSIONS

Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted in these bylaws may be permitted by the hearing officer on a showing of good cause, or upon agreement of the parties. If a hearing officer has not yet been appointed, this authority is conferred on the Chair of the judicial review committee, or if none has yet been appointed, on the chief of staff.

7.4 HEARING PROCEDURE

7.4-1 PREHEARING PROCEDURE

(a) The member may inspect and copy (at his or her expense) any documentary information relevant to the charges that the Medical staff has in its possession or under its control. The medical executive committee may inspect and copy at its expense any documentary information relevant to the charges that the member has in his or her possession or under his or her control. The requests for discovery shall be fulfilled as soon as practicable. Failures to comply with reasonable discovery requests at least thirty (30) days prior to the hearing shall be good cause for a continuance of the hearing.

(b) At the request of either party, the parties must exchange all documents that will be introduced at the hearing. The documents must be exchanged at least ten (10) days prior to the hearing. A failure to comply with this rule shall be good cause for a continuance of the hearing.

(c) Not less than fifteen (15) days prior to the hearing, each party shall furnish to the other a written list of the names and addresses of the individuals, so far as is then reasonably known or anticipated, who are expected to testify or give evidence in support of that party at the hearing. The failure to provide the name of any witness at least ten (10) days prior to the hearing shall be good cause for a continuance of the hearing.

(d) The right to inspect and copy by either party does not extend to confidential information referring to individually identifiable practitioners other than the member under review.

(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:

(i) whether the information sought may be introduced to support or defend the charges;

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

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

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

(f) The member shall be entitled to a reasonable opportunity to question and challenge the impartiality of judicial review committee members and the hearing officer. Challenges to the impartiality of any judicial review committee member or the hearing officer shall be ruled on by the hearing officer.

(g) It shall be the duty of the member and the medical executive committee or its designee to exercise reasonable diligence in notifying the chair of the judicial review committee 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 prehearing decisions may be succinctly made at the hearing.

7.4-2 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.

The member shall be entitled to representation by legal counsel at his or her own expense in any phase of the hearing, if the member so chooses, and shall receive notice of the right to obtain representation by an attorney at law. In the absence of legal counsel, the member shall be entitled to be accompanied by and represented at the hearing only by a practitioner licensed to practice in the state of California who is not also an attorney at law, and the medical executive committee shall appoint a representative who is not an attorney. The medical executive committee shall not be represented by an attorney at law if the member is not so represented. Notwithstanding the foregoing and regardless of whether the member elects to have attorney representation at the hearing, the parties shall have the right to consult with legal counsel to prepare for a hearing.

7.4-3 THE HEARING OFFICER

The medical executive committee or Chief of Staff shall recommend a hearing officer to the board of directors to preside at the hearing. The board of directors shall be deemed to

approve the selection unless it provides written notice to the medical executive committee stating the reasons for its objections within 5 days. The hearing officer shall be an attorney at law qualified to preside over a quasi-judicial hearing, but attorneys from a firm regularly utilized by the hospital, the medical staff or the involved medical staff member or applicant for membership, for legal advice regarding their affairs and activities shall not be eligible to serve as hearing officer. The hearing officer shall gain no direct financial benefit from the outcome and must not act as a prosecuting officer or as an advocate. The hearing officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The hearing officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions, which pertain to matters of law, procedure or the admissibility of evidence. If the hearing officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the hearing officer may take such discretionary action as seems warranted by the circumstances, in accordance with California law. 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.

7.4-4 RECORD OF THE HEARING

A shorthand reporter shall be present to make a record of the hearing proceedings, and the pre-hearing proceedings if deemed appropriate by the hearing officer. The cost of attendance of the shorthand reporter shall be borne by the 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.

7.4-5 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.

7.4-6 MISCELLANEOUS RULES

Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under this Article. Any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The judicial review committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate. At its discretion, the judicial review committee may request or permit both sides to file written arguments. The hearing process shall be completed within a reasonable time after the notice of the action is received, unless the hearing officer issues a written decision that the member or the medical executive committee failed to provide information in a reasonable time or consented to the delay.

7.4-7 BURDENS OF PRESENTING EVIDENCE AND PROOF

(a) At the 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 or member shall not be permitted to introduce information requested by the medical staff but not produced during the application or corrective action process unless the applicant or member 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 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.

7.4-8 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 hearing. Both the medical executive committee and the member may submit a written statement at the close of the hearing. Upon conclusion of the presentation of oral and written evidence, or the receipt of closing written arguments, if submitted, the hearing shall be closed.

7.4-9 BASIS FOR DECISION

The decision of the judicial review committee shall be based on the evidence introduced at the hearing, including all logical and reasonable inferences from the evidence and the testimony. The decision of the judicial review committee shall be subject to such rights of appeal as described in these bylaws.

7.4-10 DECISION OF THE JUDICIAL REVIEW COMMITTEE

Within thirty (30) days after final adjournment of the 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 fifteen (15) days. A copy of said decision also shall be forwarded to the CEO, the board of directors, 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 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.

7.5 APPEAL

7.5-1 TIME FOR APPEAL

Within ten (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 thereupon become the final action of the medical staff. The board of directors shall consider the action or recommendation and shall give it great weight.

7.5-2 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 7.5-5; or (c) the decision was not supported by the findings.

7.5-3 TIME, PLACE AND NOTICE

If an appellate review is to be conducted, the appeal board shall, within thirty (30) days after receipt of request for appellate review, 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 thirty (30) nor more than sixty (60) 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 fifteen (15) days from the date of the notice. The time for appellate review may be extended by the appeal board for good cause.

7.5-4 APPEAL BOARD

The board of directors may sit as the appeal board, or it may appoint an appeal board, which shall be composed of not less than three (3) members of the board of directors. 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 directors 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. The appeal board shall have the power to issue subpoenas to the extent conferred by applicable law.

7.5-5 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. Appeal board proceedings shall be held in executive session, however, the subject of the appeal may request that the oral statements be held in public session. The appeal board may thereupon conduct, at a time convenient to itself, deliberations outside the presence of the appellant and respondent and their representatives and in executive session. The appeal board shall present to the board of directors its written recommendations as to whether the board of directors should affirm, modify, or reverse the judicial review committee decision consistent with the standard set forth in Section 7.5-6, or remand the matter to the judicial review committee for further review and decision.

7.5-6 DECISION

(a) Except as provided in Section 7.5-6(b), within thirty (30) days after the conclusion of the appellate review proceedings, the board of directors shall render a final decision. The board of directors may affirm, modify, reverse the decision or remand the matter for further review by the judicial review committee for reconsideration stating the purpose for the referral. The board of directors shall give great weight to the judicial review committee recommendation, and shall not act arbitrarily or capriciously. The board of directors may, however, exercise its independent judgment in determining whether a practitioner was afforded a fair hearing, whether the decision was reasonable and warranted, and whether any bylaw, rule or policy relied upon by the judicial review committee is unreasonable and unwarranted. If the board of directors determines that the practitioner was not afforded a fair hearing in compliance with the bylaws, the board of directors shall remand the matter.

(b) 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 directors. This further review and the time required to report back shall not exceed thirty (30) days in duration except as the parties may otherwise agree or for good cause as jointly determined by the chair of the board of directors and the judicial review committee.

(c) The decision shall be in writing, shall specify the reasons for the action taken, and provide findings of fact and conclusions articulating the connection between the evidence produced at the hearing, and the decision reached, and shall be forwarded to the chief of staff, the medical executive and credential committees, the subject of the hearing, and the CEO. Notice of the decision shall include notice of the deadline for filing a request for judicial review, as described in Section 7.1-5.

7.5-7 RIGHT TO ONE HEARING

Except in circumstances where a new hearing is ordered by the board of directors 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.

7.6 EXCEPTIONS TO HEARING RIGHTS

7.6-1 APPROPRIATENESS OF EXCLUSIVE CONTRACTS

The hearing rights of this Article VII do not apply to a practitioner whose application for medical staff membership and privileges was denied, reduced or terminated as a result of a decision to close or continued closure of a medical staff department pursuant to Section 13.9 of these bylaws.

7.6-2 AUTOMATIC SUSPENSION OR LIMITATION OF PRACTICE PRIVILEGES

No hearing is required when an action has been taken pursuant to Section 6.4.

7.6-3 CLINICAL DEPARTMENT/DIVISION CREATION OR ELIMINATION

A medical staff clinical department or division may be created, eliminated, modified, or combined upon recommendation of the medical executive committee and approval of the board of directors in accordance with Section 9.1 of these bylaws. Except as otherwise provided for in these bylaws, the termination of privileges pursuant to the creation, elimination, modification or combination of a clinical department or division shall not be subject to the procedural rights otherwise set forth in Article VII.

7.7 REPORTING

The CEO and chief of staff shall cause the authorized representative to report adverse actions to the Medical Board of California and the National Practitioner Data Bank in the manner, and within the time required by, federal and state statutes and regulations, as may be amended from time to time. In the event of any inconsistency between the medical staff bylaws and federal and state statutes and regulations, the latter shall govern.

ARTICLE VIII OFFICERS

8.1 OFFICERS OF THE MEDICAL STAFF

8.1-1 IDENTIFICATION

The officers of the medical staff shall be the chief of staff, vice chief of staff, immediate past chief of staff, and secretary-treasurer.

8.1-2 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.

8.1-3 NOMINATIONS

(a) The medical staff election year shall be each odd numbered medical staff year. A nominating committee of at least three (3) active medical staff members shall be elected by the general medical staff. The process for electing and approving the nominating committee shall be completed not later than ninety (90) days prior to the annual staff meeting to be held during an election year or at least forty-five (45) days prior to any special election. The nominating committee shall nominate one or more nominees for each office. The 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 thirty (30) days prior to the 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 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 twenty (20) 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 ten (10) days prior to the meeting. Nominations from the floor will be recognized if the nominee is present and consents.

8.1-4 ELECTIONS

The vice chief of staff and secretary-treasurer shall be elected at the annual meeting of the medical staff, which falls during the election year. Voting shall be by secret written ballot, and authenticated sealed mail ballots may be counted. Written ballots shall include handwritten signatures on the envelope for comparison with signatures on file, when necessary. A nominee shall be elected upon receiving a majority of the valid votes cast. 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 written ballot at its next meeting or a special meeting called for that purpose.

8.1-5 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. After having completed his/her (2) year term as vice chief, to provide continuity, the vice chief will automatically assume the position of chief of staff. No one person can be elected for more than two (2) consecutive terms in the same office.

8.1-6 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 (1/3) of the members of the medical staff eligible to vote for officers. Recall shall be considered at a special meeting called for that purpose.

Recall shall require a two-thirds (2/3) vote of the medical staff members eligible to vote for medical staff officers who actually cast votes at the special meeting in person or by mail ballot.

8.1-7 VACANCIES IN ELECTED OFFICE

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

8.2 DUTIES OF OFFICERS

8.2-1 CHIEF OF STAFF

The chief of staff shall serve as the chief officer of the medical staff. The duties 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) serving as medical staff representative at any hospital deliberation affecting the discharge of medical staff responsibilities, and interacting with the administrator and board of directors 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 directors and to the administrator;

(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 directors and administration, as well as outside licensing or accreditation agencies.

8.2-2 VICE CHIEF OF STAFF

The vice chief of staff shall assume all duties and authority of the chief of staff in the absence of the chief of staff. The vice chief of staff shall be a member of the medical executive committee and of the joint conference committee, and shall perform such other duties as the chief of staff may assign or as may be delegated by these bylaws, or by the medical executive committee.

This includes when asked, to serve as medical staff representative for any hospital deliberation affecting the discharge of medical staff responsibilities, and interacting with the administrator and board of directors.

8.2-3 IMMEDIATE PAST CHIEF OF STAFF

The immediate past chief of staff shall be a member of the medical executive committee, and shall perform such other duties as may be assigned by the chief of staff or by the medical executive committee.

8.2-4 SECRETARY-TREASURER

The secretary-treasurer shall be a member of the 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 and general medical staff meetings;

(c) calling meetings on the order of the chief of staff or medical executive committee;

(d) attending to all appropriate correspondence and notices on behalf of the medical staff;

(e) receiving and safeguarding all funds of the medical staff;

(f) excusing absences from meetings on behalf of the medical executive committee; and

(g) performing such other duties as ordinarily pertains to the office or as may be assigned from time to time by the chief of staff or medical executive committee.

(h) this includes when asked, to serve as medical staff representative for any hospital deliberation affecting the discharge of medical staff responsibilities, and interacting with the administrator and board of directors.

(i) be the election officer and supervise the medical staff officers election and these bylaws amendment votes and certify the results to the medical staff.

ARTICLE IX CLINICAL DEPARTMENTS AND DIVISIONS

9.1 ORGANIZATION OF CLINICAL DEPARTMENTS AND DIVISIONS

The medical staff shall be divided into clinical departments. Each department shall be organized as a separate component of the medical staff, and shall have a chair selected and entrusted with the authority, duties, and responsibilities specified in Section 9.6. With the exception of hospital-based departments, i.e., anesthesiology, emergency medicine, pathology, and radiology, at least five (5) active medical staff members of a specialty are required to form a department. A department may be further divided, as appropriate, into divisions which shall be directly responsible to the department within which it functions, and which shall have a division chief selected and entrusted with the authority, duties and responsibilities specified in Section 9.7. When appropriate, the medical executive committee may recommend to the medical staff and board of directors the creation, elimination, modification, or combination of departments or divisions.

9.2 CURRENT DEPARTMENTS AND DIVISIONS

The current departments and divisions are:

(a) Department of Anesthesiology;
(b) Department of Emergency Medicine;
(c) Department of Family Medicine;
(d) Department of Internal Medicine;
(e) Department of Pediatrics;
(f) Department of Obstetrics/Gynecology;
(g) Department of Radiology/Pathology; and
(h) Department of Surgery.

9.3 ASSIGNMENT TO DEPARTMENTS AND DIVISIONS

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

9.4 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 guidelines 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 appointment or reappointment 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 bylaws, rules and regulations, and policies and procedures and other policies and procedures jointly adopted by the medical staff and board of directors, *e.g.*, to ensure orderly hospital operations; 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 at least quarterly 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 .

(n) Determine whether the department member's medical records meet regulatory mandates and adhere to the Medical Staff Bylaws and Rules and Regulations. Track and counsel department members identified for documentation performance improvement; and

(o) Review and evaluation of medical records, or a representative sample, to determine whether they: (1) properly describe the condition and diagnosis, the progress of the patient during hospitalization and at the time of discharge, the treatment and tests provided, the results thereof, and adequate identification of individuals responsible for orders given and

treatment rendered; and (2) are sufficiently complete at all times to facilitate continuity of care and communications between individuals providing patient care services in the hospital.

9.5 FUNCTIONS OF DIVISIONS

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

9.6 DEPARTMENT CHAIRS

9.6-1 QUALIFICATIONS

Each department shall have a chair and vice-chair that shall be members of the active staff and shall be qualified by training, experience and demonstrated ability in at least one of the clinical areas covered by the department. If required by California hospital licensure regulations, Department chairs must be board certified or eligible in their appropriate specialty or have comparable training and experience. Comparable training and experience is defined, for the purposes of these bylaws, as successful completion of a residency approved by the ACGME or AOA, at least five (5) years practice in the specialty, and acknowledgement by the Medical executive committee that the practitioner possesses the expertise to act as a consultant in his or her respective medical specialty.

9.6-2 SELECTION

Department chairs and vice-chairs shall be elected every two (2) years by those members of the department who are eligible to vote for general officers of the medical staff. Vacancies due to any reason shall be filled for the unexpired term through special election by the respective department with such mechanisms as that department may adopt. If there is a vacancy for the chairman and the unexpired term is less than one year, the vice chairman shall assume the chairman role, without need for a special election. Department Chairperson shall not concurrently serve as officer of the medical staff.

9.6-3 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 officers shall be eligible to succeed themselves.

9.6-4 REMOVAL

After election removal of department chairs and vice-chairs from office may occur for cause by a two-thirds (2/3) vote of the medical executive committee and a two-thirds (2/3) vote of the department members eligible to vote on departmental matters who cast votes.

9.6-5 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) recommend criteria for clinical privileges that are relevant to the care provided by the department. Recommend delineated clinical privileges for each member of the department. Oversee the process of monitoring the quality of patient care and professional performance rendered by members with clinical privileges in the department through a planned and systematic process;

(d) oversee 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. Oversee the orientation and continuing education needs of all persons within the department.

(e) assessing/recommending offsite sources for needed patient care services. Make recommendations on the need for space and other resources needed by the department.

(f) Coordinating patient care provided by the department's members with nursing and ancillary patient care services.

(g) 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;

(h) 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

(i) transmit to the medical executive committee the department's recommendations concerning practitioner appointment and classification, reappointment, criteria for clinical privileges, monitoring of specified services, and corrective action with respect to persons with clinical privileges in the department;

(j) endeavor to enforce the medical staff bylaws, rules, policies and regulations within the department;

(k) implement within the department appropriate actions taken by the medical executive committee;

(l) integration of the department/service into primary functions of the organization. Coordination and integration of interdepartmental and intra-departmental services. Development of and implementation of policies and procedures that guide and support the provisions of services. Participate in every phase of administration of the department, including 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;

(m) assist in the preparation of such annual reports, including budgetary planning, pertaining to the department as may be required by the medical executive committee;

(n) 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.

(o) The Department Chair when appropriate may order a specialty consultation for a patient admitted under any admitting physician member of department, if the chair decides that the patient will benefit from such consultation even when the admitting physician has not requested one.

9.7 DIVISION CHIEFS

9.7-1 QUALIFICATIONS

Each division shall have a chief who shall be a member of the active medical staff and a member of the division, and shall be qualified by training, experience, and demonstrated current ability in the clinical area covered by the division.

9.7-2 SELECTION

Each division 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.

9.7-3 TERM OF OFFICE

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

9.7-4 REMOVAL

After appointment and ratification, a division chief may be removed by the department chair and the medical executive committee.

9.7-5 DUTIES

Each division chief shall:

(a) act as presiding officer at division meetings;

(b) assist in the development and implementation, in cooperation with the department chair, of programs to carry out the quality review, and evaluation and monitoring functions assigned to the division;

(c) evaluate the clinical work performed in the division;

(d) conduct investigations and submit reports and recommendations to the department chair regarding the clinical privileges to be exercised within the division by members of or applicants to the medical staff; 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 X COMMITTEES

10.1 DESIGNATION

Medical staff committees shall include but not be limited to, the medical staff meeting as a committee of the whole, meetings of departments and divisions, meetings of committees established under this Article, and meetings of special or ad hoc committees created by the Chief of Staff, the medical executive committee (pursuant to this Article) or by departments (pursuant to Sections 9.4(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. All Committee composition shall include the Chief Executive Officer, or designee, as a non-voting member.

10.2 GENERAL PROVISIONS

10.2-1 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.

10.2-2 REMOVAL

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

10.2-3 VACANCIES

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

10.3 MEDICAL EXECUTIVE COMMITTEE

10.3-1 COMPOSITION

All active members of medical staff in good standing are eligible to become member of Medical Executive Committee. The Medical Executive Committee shall consist of the following persons:

(a) the officers of the medical staff;

(b) the department chairs

(c) one at large member of active medical staff of any discipline elected by the General Medical Staff as non-voting member.

10.3-2 DUTIES

The duties of the medical executive committee shall include, but not be limited to:

(a) representing and acting on behalf of the medical staff in the intervals between medical staff meetings, subject to such limitations as may be imposed by these bylaws;

(b) coordinating and implementing the professional and organizational activities and policies of the medical staff;

(c) receiving and acting upon reports and recommendations from medical staff departments, divisions, committees, and assigned activity groups;

(d) recommending actions to the board of directors on matters of a medical-administrative nature;

(e) recommending to the board of directors policies regarding the structure of the medical staff, the mechanisms to review credentials and delineate individual clinical privileges, the granting of individual staff memberships and privileges, participation in the organizational performance improvement activities and mechanisms of the medical staff, termination of medical staff membership and fair hearing procedures, needed changes to medical staff bylaws, and other matters relevant to the operation of an organized medical staff;

(f) evaluating the medical care rendered to patients in the hospital;

(g) participating in the development of all medical staff and hospital policy, practice, and planning;

(h) reviewing the qualifications, credentials, performance and professional competence, and character of applicants and staff members, and making recommendations to the board of directors at least quarterly regarding staff appointments and reappointment assignments to departments, clinical privileges, and corrective action;

(i) 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;

(j) taking reasonable steps to develop continuing education activities and programs for the medical staff;

(k) 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;

(l) reporting to the medical staff at each regular staff meeting;

(m) assisting in the obtaining and maintenance of accreditation;

(n) developing and maintenance of methods for the protection and care of patients and others in the event of internal or external disaster;

(o) 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;

(p) reviewing the quality and appropriateness of services provided by contract physicians and contracted services for patient care, if any. In case of contracted services for patient care, a designated physician representative shall report data regarding patient satisfaction, volume, quality and appropriateness of equipment and services to the medical executive committee for review.

(q) reviewing and approving the designation of the hospital's authorized representative for National Practitioner Data Bank purposes; and

(r) establishing a mechanism for dispute resolution between medical staff members (including limited license practitioners) involving the care of a patient.

(s) review and make recommendations for medical staff and hospital policies, rules and regulations relating to medical records, including completion, forms and formats, filing, indexing, storage, destruction, availability and methods of enforcement; and

(t) provide liaison with hospital administration and medical records personnel in the employ of the hospital on matters relating to medical records practices.

(u) provide review on contracted services for patient care with a physician representative reporting quality data to medical executive committee

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

i. review and approve the hospital's patient safety plan, and review and revise the plan at least once a year, or more often as necessary to incorporate advancements in patient safety practices;
ii. receive and review reports of patient safety events, including but not limited to all adverse events or potential adverse events that are determined to be preventable (as defined by state law);
iii. monitor implementation of corrective action for patient safety; and
iv. make recommendations to eliminate future patient safety events.

10.3-3 MEETINGS

The medical executive committee shall meet as often as necessary, but at least ten (10) times per year, and shall maintain a record of its proceedings and actions. The CEO or designee shall be invited to attend all meetings in a non-voting capacity. The "Open" session at any MEC meeting shall be open to all disciplines who are members of the medical staff.

10.4 CREDENTIALS COMMITTEE

10.4-1 COMPOSITION

The credentials committee shall consist of not less than three (3) members of the active staff selected on a basis that will ensure, insofar as feasible, representation of major clinical specialties and each of the staff departments. At a minimum, the Department Chairs of the Internal Medicine, Family Practice and Surgery Departments shall be members of the Credentials Committee.

10.4-2 DUTIES

The credentials committee shall:

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

(b) submit required reports and information on the qualifications of each practitioner applying for membership or particular clinical privileges including recommendations with respect to appointment, membership category, department affiliation, clinical privileges, and special conditions;

(c) investigate, review and report on matters referred by the chief of staff or the medical executive committee regarding the qualifications, conduct, professional character or competence of any applicant or medical staff member; and

(d) submit periodic reports to the medical executive committee on its activities and the status of pending applications.

10.4-3 MEETINGS

The credentials committee shall meet as often as necessary at the call of its chair, but at least quarterly. The committee shall maintain a record of its proceedings and actions and shall report to the medical executive committee.

10.5 JOINT CONFERENCE COMMITTEE

10.5-1 COMPOSITION

The joint conference committee shall be composed of an equal number of members of the board of directors i.e. BOD Chair and Vice-Chair and of the medical executive committee i.e Chief of Staff and Vice-Chief of Staff, .The CEO, Vice President Patient Care Services and Director of Medical Staff Services shall be a non-voting ex-officio members. The Chairship of the committee shall alternate yearly between the Board of Directors and the medical staff.

10.5-2 DUTIES

(a).The joint conference committee shall constitute a forum for the discussion of matters of hospital and medical staff policy, practice, and planning, including accreditation by The Joint Commission and disaster planning, and a forum for interaction between the board of directors and the medical staff on such matters as may be referred by the medical executive committee, the medical staff, or the board of directors. The joint conference committee shall exercise any other responsibilities set forth in these bylaws.

(b) **AD HOC DISPUTE MEDIATION COMMITTEE**
All disputes between hospital administration or the board of directors and the medical staff ("Party" or "Parties" as applicable) relating to the medical staff's rights of self-governance as set forth in California Business and Professions Code Section 2282.5 ("Dispute") that have not been resolved by prior informal meetings and discussions shall be addressed and mediated in accordance with the process described in this Section. In the event either Party determines that a Dispute exists, such Party shall give written notice to the other Party, stating the nature of the Dispute. Within three (3) business days following receipt of such notice, both Parties shall appoint representatives to the committee as provided below. Neither Party shall initiate any legal action related to the Dispute until the committee has completed its efforts to mediate the Dispute.

DUTIES

The members shall appoint an outside professional mediator as the fifth member, and the mediator shall serve as chair of the committee, but shall have no vote. The Parties

shall cooperate to select the mediator from a list of candidates provided by a service such as JAMS (Judicial Arbitration and Mediation Service) or the American Arbitration Association. The cost of the mediator shall be divided equally between the Parties.

The committee shall receive and promptly review the written request(s) for initiation of the Dispute mediation process. The committee may request such assistance as it deems necessary to gather relevant information and consider the opposing viewpoints. The committee then shall meet and confer in good faith to formulate a recommendation for mediation of the Dispute. The committee's efforts shall continue for up to sixty (60) days. After that period, the mediator shall prepare a written report of the committee's findings and recommendations and transmit it to the Parties if the committee has reached consensus, or the committee may ask the Parties for additional time to consider the Dispute. Both Parties must agree to any such extension of time. If the committee has not reached consensus, but chooses not to request additional time, the mediator shall submit a written report outlining any areas of agreement and the remaining issues, but shall not make any recommendations. Following receipt of the mediator's report, the Parties may adopt the committee's recommendations, agree to some alternative resolution of the Dispute, or refer the Dispute back to the committee with instructions for further mediation efforts. Unless requested by the Parties to continue its deliberations, the committee shall dissolve thirty (30) days after the mediator has made his or her report to the Parties.

10.5-3 MEETINGS

The Joint Conference Committee may meet, annually or as needed, and shall transmit written reports of its activities to the Medical Executive Committee and to the Board of Directors.

10.6 OPERATING ROOM COMMITTEE

10.6-1 COMPOSITION

The operating room committee shall consist of one representative from the following medical staff departments: anesthesiology, obstetrics/ gynecology, surgery; nursing service and hospital administration. Any member of the Medical Staff may attend with the permission of the Chairman.

10.6-2 DUTIES

The duties of the operating room committee shall include:

(a) establishing standards for patient care in the operating room;

(b) assisting in the development of policies and procedures regarding the operating room operations, i.e., block time;

(c) provide evaluation, appraisal, selection, and procurement of equipment for the operating room;

(d) make recommendations concerning surgical supplies stocked in operating room;

(f) participation in the annual operating room capital budget decisions;

(g) maintaining a record of all activities relating to operating room functions and submitting periodic reports and recommendations to the medical executive committee concerning those activities;

(h) may establish committees or other mechanisms as necessary and desirable to perform properly the function of the operating room committee; and

(i) take appropriate action when important problems in patient care or opportunities to improve care are identified.

10.6-3 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 medical executive committee as needed but at least quarterly.

10.7 UTILIZATION REVIEW COMMITTEE

10.7-1 COMPOSITION

The utilization review committee shall consist of sufficient members to afford fair representation and be in compliance with the Utilization Review Plan. Subcommittees may be appointed by the committee for departments or divisions as the committee may deem appropriate. The Utilization Review Committee or designee will also act as the oversight committee for the duties and responsibilities of Medical Records review functions.

10.7-2 DUTIES

The duties of the utilization review committee or designee shall include:

(a) conducting utilization review studies designed to evaluate the appropriateness of admissions to the hospital, lengths of stay, discharge practices, use of medical and hospital services and related factors which may contribute to the effective utilization of services. The committee shall communicate the results of its studies and other pertinent data to the medical executive committee and shall make recommendations for the utilization of resources and facilities commensurate with quality patient care and safety;

(b) establishing a utilization review plan which shall be approved by the medical executive committee; and

(c) obtaining, reviewing, and evaluating information and raw statistical data obtained or generated by the hospital's case management system.

(d) evaluating the medical necessity of admissions, continued hospital services and professional services furnished, for particular patients where appropriate, and ensuring that (i) the attending physician is consulted and afforded an opportunity to present his/her views, and the availability of hospital facilities and services is considered prior to any decision that an admission or further inpatient stay is not medically necessary; (ii) a determination that admission or continued stay is not medically necessary is made by at least two physician members if the responsible practitioner does not concur with the determination or fails to present his/her view; and (iii) written notice of any decision that further inpatient care is not medically necessary is given within two (2) days following that determination. Reviews may not be conducted by a practitioner who has a direct financial interest in the hospital, and no practitioner shall have review responsibility for any case in which he or she was professionally involved

(e) Medical Records duties to include:

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

(2) review and make recommendations for medical staff and hospital policies, rules and regulations related to medical records, including completion, forms and formats, filing, indexing, storage, destruction, availability and methods of enforcement; and

(3) provide liaison with hospital administration and medical records personnel in the employ of the hospital on matters relating to medical records practices.

10.7-3 MEETINGS

The utilization review committee shall meet as often as necessary at the call of its chair, but at least on a quarterly basis. It shall maintain a record of its findings, proceedings and actions, and shall report its activities and recommendations to the Medical Executive Committee.

10.8 PHARMACY AND THERAPEUTICS COMMITTEE

10.8-1 COMPOSITION

The pharmacy and therapeutics committee shall consist of at least two (2) representatives from the medical staff, a voting representative from the pharmaceutical service, and voting representatives from the nursing service and hospital administration.

10.8-2 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.

10.8-3 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 shall report its activities and recommendations to the medical executive committee as needed but at least quarterly.

10.9 INFECTION CONTROL COMMITTEE

10.9-1 COMPOSITION

The infection control committee shall consist of at least 3 members of the Active Medical staff and representation from the nursing service, administration, and an individual employed in a surveillance or epidemiological capacity. It may include non-voting consultants in microbiology and non-voting representatives from relevant hospital services.

10.9-2 DUTIES

The duties of the infection control committee shall include:

(a) developing a hospital-wide infection control program and maintaining surveillance over the program;

(b) developing a system for reporting, identifying and analyzing the incidence and cause of health-care-associated infections, including assignment of responsibility for the ongoing collection and analytic review of such data, and follow-up activities, receiving and reviewing reports of such infections, monitoring implementation of corrective action for such infections, and making recommendations to eliminate future such infections;

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

(d) developing written policies defining special indications for isolation requirements;

(e) coordinating action on findings from the medical staff's review of the clinical use of antibiotics;

(f) acting upon recommendations related to infection control received from the chief of staff, the medical executive committee, departments and other committees; and

(g) reviewing sensitivities of organisms specific to the facility.

10.9-3 MEETINGS

The infection control committee shall meet as often as necessary at the call of its chair but at least once every quarter. It shall maintain a record of its proceedings and shall submit reports of its activities and recommendations to the medical executive committee.

10.10 BYLAWS COMMITTEE

10.10-1 COMPOSITION

The bylaws committee shall consist of at least 3 members of the Active Medical staff.

10.10-2 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 promulgated by the medical staff, its departments and divisions;

(b) submitting recommendations to the medical executive committee for changes in these documents as necessary to reflect current medical staff practices, laws, regulations and accreditation standards; and

(c) receiving and evaluating for recommendation to the medical executive committee suggestions for modification of the items specified in subdivision (a).

10.10-3 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.

10.11 PERFORMANCE IMPROVEMENT COMMITTEE

10.11-1 COMPOSITION

The Performance Improvement Committee shall consist of such members as may be designated by the Chief of Staff or the medical executive committee including, insofar as possible, at least one representative from each clinical department, from the nursing service and from administration senior management, Chief of Staff and CEO or designee.

10.11-2 DUTIES

The performance improvement committee shall perform the following duties as outlined in the Performance Improvement Plan including, but not limited to:

(a) recommend for approval of the medical executive committee plans for maintaining quality patient care within the hospital. These may include mechanisms to:

(1) establish systems to identify potential problems in patient care;

(2) set priorities for action on problem correction;

(3) refer priority problems for assessment and corrective action to appropriate departments or committees;

(4) monitor the results of performance improvement activities throughout the hospital; and

(5) coordinate performance improvement activities.

(b) submit regular confidential reports to the medical executive committee on the quality of medical care provided and on performance improvement activities conducted.

10.11-3 MEETINGS

The committee shall meet as often as necessary at the call of its chair, but at least quarterly. It shall maintain a record of its proceedings and report its activities and recommendations to Medical executive committee.

10.12 PHYSICIAN WELL BEING COMMITTEE

10.12-1 COMPOSITION

The physician well being committee shall be comprised of no less than three (3) active 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 two (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 quality improvement committees while serving on this committee.

10.12-2 DUTIES

The committee may receive referrals and self-referrals, as well as reports related to the health, well-being, or impairment of medical staff members. The committee shall evaluate the credibility of a complaint, allegation or concern. 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. The committee shall monitor the activities and safety of patients under the care of physicians in rehabilitation and periodically thereafter, and shall initiate action if a monitored practitioner fails to complete any required rehabilitation. Such activities shall be confidential, including the identity of informants; 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.

10.12-3 MEETINGS

The committee shall meet as often as necessary, or at referral from the medical executive committee. It shall maintain only such record of its proceedings as it deems advisable, but shall report on its activities to the medical executive committee at least quarterly.

10.13 INTERDISCIPLINARY PRACTICE COMMITTEE

10.13-1 COMPOSITION

The interdisciplinary practice committee (IPC) shall consist of, at a minimum, the VP of Patient Care Services**,** the CEO or designee, and an equal number of physicians appointed by the medical executive committee and registered nurses appointed by the director of nursing. Licensed or certified health professionals other than registered nurses who perform functions requiring standardized procedures shall be included in the committee. The chair of the

committee shall be a physician member of the active medical staff appointed by the medical executive committee.

10.13-2 DUTIES

The IPC shall perform functions consistent with the requirements of law and regulation. The IPC shall routinely report to the board of directors through the medical executive committee and, in addition, shall submit an annual report directly to the board of directors and the medical executive committee. The duties shall include:

(a) evaluating and making recommendations regarding the need for and appropriateness of the performance of in-hospital services by allied health practitioners (AHPs).

(b) evaluating and making recommendations regarding:

(1) the mechanism for evaluating the qualifications and credentials of AHPs who are eligible to apply for and provide in-hospital services;

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

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

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

(c) making recommendations regarding appropriate monitoring, supervision, and evaluation of AHPs who may be eligible to perform in-hospital services.

(d) evaluating and reporting whether in-hospital services proposed to be performed or actually performed by AHPs are inconsistent with the rendering of quality medical care and with the responsibilities of members of the medical staff.

(e) evaluating and reporting on the effectiveness of supervision requirements imposed upon AHPs who are rendering in-hospital services.

(f) periodically evaluating and reporting on the efficiency and effectiveness of in-hospital services performed by AHPs.

10.13-3 MEETINGS

The IPC 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 it shall submit reports of its activities and recommendations to the Medical executive committee.

(b) assist in developing processes to assure optimal patient care and contribute to the continuing education of each practitioner.

(c) establish liaison with the quality assessment and 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/educational needs of the medical staff.

(f) advise administration of the financial needs of the continuing medical education program.

10.14 BIOETHICS COMMITTEE

10.14-1 COMPOSITION

The bioethics committee shall consist of physician members and such other staff members as the medical executive committee may deem appropriate. It may include nurses, lay representatives, social workers, clergy, ethicists, attorneys, administrators and representatives from the Board of Directors, although a majority shall be physician members of the medical staff. The Committee shall be chaired by a member of the Medical Staff. Only members of the Medical Staff may exercise voting rights.

10.14-2 DUTIES

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

10.14-3 MEETINGS

The bioethics committee shall meet at least quarterly, or 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.

10-15 PATIENT SAFETY COMMITTEE

10-15-1COMPOSITION

The patient safety committee shall consist of the Chief of Staff and at least one Active Staff member, CEO, VP of Patient Care Services, Executive Director of Risk Management, Director of Risk Management, Director of Infection Prevention, Director of Pharmacy, Director of PI, and Safety Officer.

10.15-2 DUTIES

The Patient Safety Committee shall:

(a) Receive and review reports of patient safety events, monitor implementation of corrective actions, make recommendations to eliminate future patient safety events, review and revise the Patient Safety Plan
annually and more often if necessary to evaluate, update and incorporate advancements in patient safety practices.

(b) Provide the Board of Directors annually with a report to include all system or process failures, the number and type of sentinel events, whether patients and families were informed of sentinel event and all actions to improve safety, both proactively and in response to actual occurrences.

10.15-3 MEETINGS

The Patient Safety Committee shall meet as often as necessary at the call of its chair, but at least quarterly. The committee shall maintain a record of its proceedings and actions and shall report findings, conclusions and recommendations to the Medical Executive Committee and Board of Directors.

ARTICLE XI GENERAL MEDICAL STAFF MEETINGS

11.1 MEETINGS

11.1-1 ANNUAL MEETING

There shall be an annual meeting of the medical staff. The chief of staff, or such other officers, department or division heads, or committee chairs the chief of staff or medical executive committee may designate, shall present reports on actions taken during the preceding year and on other matters of interest and importance to the members. Notice of this meeting shall be given to the members at least seven (7) days prior to the meeting.

11.1-2 REGULAR MEETINGS

Regular meetings of the members shall be held at least each quarter, except that the annual meeting shall constitute the regular meeting during the quarter 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.

11.1-3 AGENDA

The order of business at a meeting of the medical staff shall be determined by the chief of staff and medical executive committee. The agenda shall include, insofar as feasible:

(a) reading and acceptance of the minutes of the last regular and all special meetings held since the last regular meeting;

(b) administrative reports from the chief of staff, departments, and committees, and the CEO;

(c) election of officers when required by these bylaws;

(d) reports by responsible officers, committees and departments on the overall results of patient care audits and other quality review, evaluation, and monitoring activities of the staff and on the fulfillment of other required staff functions as needed;

(e) old business; and

(f) new business.

11.1-4 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 twenty five percent (25%) 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 thirty (30) days after receipt of such request. No later than ten (10) days prior to the meeting, notice shall be mailed or delivered to the members of the 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.

11.2 COMMITTEE AND DEPARTMENT MEETINGS

11.2-1 REGULAR MEETINGS

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

11.2-2 SPECIAL MEETINGS

A special meeting of any medical staff committee, department or division may be called by the chair thereof, the medical executive committee, or the chief of staff, and shall be called by written request of twenty five percent (25%) of the current members, eligible to vote, but not less than two (2) members.

11.3 QUORUM

11.3-1 STAFF MEETINGS

The approval of fifty one percent (51%) percent of the Active medical staff present and participating at any regular Department/Committee meeting, or special meeting in person, or through written ballot, shall constitute a quorum for the purpose of amending these bylaws or the rules and regulations of the medical staff or for the election or removal of medical staff officers. Those members present shall constitute a quorum for all other actions.

11.3-2 DEPARTMENT AND COMMITTEE MEETINGS

A quorum of fifty one percent (51%) percent of the voting members shall be required for Medical Executive, and Credentials Committees. A quorum of twenty-five percent (25%) of the voting members shall be required for departmental meetings, but in no event less than three (3) voting members. For all other committees, a quorum shall consist of those members present, but in no event less than two (2) voting members.

11.4 VOTING AND MANNER OF ACTION

11.4-1 VOTING

Unless otherwise specified in these bylaws, only Active members of the medical staff may vote in Medical Staff Departmental/Committees 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.

11.4-2 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the members present and voting at a meeting shall be the action of the group. A Department/Committee meeting at which a quorum as prescribed by each Department /Committee is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at

least a majority of the required quorum for such meeting, or such greater number as may be specifically required by these bylaws. Committee action may be conducted by telephone conference, which shall be deemed to constitute a meeting for the matters discussed in that telephone conference. Valid action may be taken without a meeting by a committee if it is acknowledged by a writing setting forth the action so taken which is signed by at least two-thirds (2/3) of the members entitled to vote at such Department/Committee.

11.5 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.

11.6 ATTENDANCE REQUIREMENTS

11.6-1 REGULAR ATTENDANCE

Except as stated below, attendance at meetings is encouraged, but is not required.

11.6-2 SPECIAL ATTENDANCE

At the discretion of the chair or presiding officer, when a member's practice or conduct is scheduled for discussion at a department, division, 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 fourteen (14) days prior to the meeting and shall include the time and place of the meeting and a general indication of the issues 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.

11.7 CONDUCT OF MEETINGS

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

11.8 EXECUTIVE SESSION

Executive session is a meeting of a medical staff committee which only voting medical staff committee members may attend, unless others are expressly requested by the committee to attend. Executive session may be called by the presiding officer at the request of any medical staff committee member, and shall be called by the presiding officer/chair 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. The Chief Executive Officer or his designee may be invited as a non-voting member.

ARTICLE XII CONFIDENTIALITY, IMMUNITY AND RELEASES

12.1 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;

© agrees to be bound by the provisions of this Article and to waive all legal claims against any representative of the medical staff or the hospital who would be immune from liability under Section 12.3 of this Article; and

(d) acknowledges that the provisions of this Article are express conditions to an application for medical staff membership, the continuation of such membership, and to the exercise of clinical privileges at this hospital.

12.2 CONFIDENTIALITY OF INFORMATION

12.2-1 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 divisions, meetings of committees established under Article X, and meetings of special or ad hoc committees created by the chief of staff, 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.

12.2-2 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, divisions, or committees, except in conjunction with other hospital, professional society, or licensing authority peer review activities, 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.

12.3 ACCESS TO AND RELEASE OF CONFIDENTIAL INFORMATION

Medical staff records, including committee and department records and credentials files may be accessed and released only in accordance with the Medical Staff's policy and procedure on access to medical staff records.

12.4 IMMUNITY FROM LIABILITY

12.4-1 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.

12.4-2 FOR PROVIDING INFORMATION

Each representative of the medical staff and hospital and all third parties shall be immune 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.

12.5 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 appointment, reappointment, or clinical privileges;

(b) corrective action;

© hearings and appellate reviews;

(d) utilization reviews;

(e) other department, or division, committee, or medical staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and

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

12.6 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.

12.7 INDEMNIFICATION

The hospital shall indemnify, defend and hold harmless the medical staff, its individual members and its appointed representatives (e.g. expert witnesses, lay committee members, hearing officers) from and against losses and expenses (including attorney's 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, quality assessment, or activities related to establishing standards, policies and/or procedures pursuant to the self-governing medical staff provisions, 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. , provided the member was acting without malice and in good faith and is otherwise eligible for indemnification under, and follows the procedures set forth in, the hospital's "Indemnification Policy and Procedure." All disputes relating to the application of this provision shall be referred to the Ad Hoc Dispute Mediation Committee for resolution.

12.8 PATIENT PRIVACY

12.8-1 COMMITMENT TO PRIVACY RULE COMPLIANCE.

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

12.8-2 ORGANIZED HEALTH CARE ARRANGEMENT.

The Privacy Rule permits multiple covered entities who provide care in a clinically integrated care setting, such as the hospital setting, to declare themselves an Organized Health Care Arrangement ("OHCA"). OHCA status generally permits its health care provider participants to use and disclose health information for purposes of treatment, payment and health care operations of the arrangement. Such activities include peer review, credentialing, quality assurance and utilization review. As such, OHCA status protects patient privacy while minimizing disruption to quality patient care. Accordingly, by applying for and exercising clinical privileges at the hospital, each member and Allied Health Professional agrees to participate in the hospital's OHCA. As such, all members or Allied Health Professionals shall abide by the hospital's Privacy Policies and Procedures.

12.8-3 JOINT NOTICE OF PRIVACY PRACTICES.

The Privacy Rule requires a health care provider that is a Covered Entity (as defined in the Privacy Rule) to deliver a notice of privacy practices to a patient no later than the provider's first date of service to the patient. Health care providers that participate in an OHCA may comply with this requirement by joint notice. The implementation of a joint notice streamlines compliance with the Privacy Rule. Accordingly, with respect to Protected Health Information (as defined in the Privacy Rule) created or received by a member or Allied Health Professional in connection with his or her provision of services in the Hospital, by applying for and exercising clinical privileges at the hospital, each member and Allied Health Professional agrees to abide by the terms of the joint Notice of Privacy Practices of the hospital and the medical staff then in effect.

12.8-4 DISCIPLINE

Whenever a member or Allied Health Professional uses or discloses health information in a manner inconsistent with the hospital's Privacy Policies and Procedures or joint Notice of Privacy Practices, the member/Professional may be disciplined in accordance with these Bylaws.

ARTICLE XIII GENERAL PROVISIONS

13.1 RULES AND REGULATIONS

The Medical Executive Committee is hereby authorized to establish medical staff rules, and policies as provided in this Article. Rules and policies shall be reviewed every [2] years.

13.1-1 GENERAL RULES

The Medical Executive Committee may propose the adoption, amendment or repeal of general medical staff rules for approval by the Board of Directors, following notice to the voting members of the Active Staff. General medical staff rules shall become effective when approved by the Board of Directors which approval shall not be unreasonably withheld. If the Board of Directors withholds its approval for a general rule recommended by the Medical Executive Committee, the Medical Executive Committee may submit the matter to an Ad Hoc Dispute Mediation Committee for mediation as provided in Article X, Section 10.5-2 (b).

13.1-2 MEDICAL STAFF POLICIES

Policies shall be developed as necessary to implement more specifically the general principles found within these Medical Staff Bylaws and the Medical Staff Rules. The policies may be adopted, amended, or repealed by majority vote of the Medical Executive Committee and shall be presented to the Governing Board for final approval. Such policies shall not be inconsistent with the medical Staff Bylaws, Rules and Regulations or other policies.

13.1-3 INITIATION OF GENERAL RULES OR POLICIES BY ACTIVE STAFF MEMBERS

Voting members of the active staff may propose adoption, amendment or repeal of general rules or of medical staff policies by following the process provided in Article XIV, Section 14-1 (b), below.

13.1-4 URGENT AMENDMENT OF RULES

The Medical Executive Committee, with the approval of the Board of Directors, may adopt amendments to general medical staff rules or provisiona
lly without notice to the general medical staff upon a documented need for an urgent amendment to comply with applicable law or regulation. Following notice of such action, voting members of the active staff, by petition signed by at least one-third of such members, may ask the Medical Executive Committee to reconsider such changes.

13.1-5 EXCLUSIVITY

Neither the medical staff nor the Board of Directors shall unilaterally amend the rules or policies. Applicants and members of the medical staff shall be governed by such rules and policies as are properly initiated and adopted. If there is a conflict between the bylaws and the rules or policies, the bylaws shall prevail. The mechanisms described herein shall be the sole methods for the initiation, adoption, amendment, or repeal of the medical staff rules and policies.

13.2 ACTIVE STAFF PETITION TO MEDICAL EXECUTIVE COMMITTEE

If voting members of the active staff, by written petition signed by at least one-third of such members, ask the Medical Executive Committee to reconsider any action or policy of the Medical Executive Committee, the Medical Executive Committee shall promptly schedule a meeting with up to three individuals representing those who have signed the petition to discuss the request.

13.3 DUES OR ASSESSMENTS

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

ARTICLE XIII GENERAL PROVISIONS

13.4 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.

13.5 DIVISION OF FEES

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

13.6 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 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, division or committee
c/o medical staff coordinator, chief of staff
Sierra View Medical Center
465 West Putnam Avenue
Porterville, California 93257

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.

13.7 DISCLOSURE OF INTEREST

All nominees for election or appointment to medical staff offices, department chairships, or the medical executive committee shall, at least twenty (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 which could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the medical staff.

13.8 NOMINATION OF MEDICAL STAFF REPRESENTATIVES

Candidates for positions as medical staff representatives to local, state and national hospital medical staff sections should be filled by such selection process as the medical staff may determine. Nominations for such positions shall be made by a nominating committee appointed by the medical executive committee.

13.9 MEDICAL STAFF ROLE IN EXCLUSIVE CONTRACTING

The board of directors may determine, as a matter of policy and in accordance with state and federal law, that certain hospital clinical facilities may be used only on an exclusive basis in accordance with written contracts between the hospital and qualified professionals, or in a limited fashion pursuant to a closed/limited staff policy. The medical staff may review and make recommendations to the board of directors regarding quality of care issues related to such exclusive arrangements 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.

ARTICLE XIV ADOPTION AND AMENDMENT OF BYLAWS

14.1 PROCEDURE

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

(a) The Medical Executive Committee, with the recommendation of the Bylaws Committee, or on its own motion, may recommend adoption, amendment or repeal of the bylaws to the voting members of the Active Staff as provided in this Article.

(b) Members of the Active Medical Staff, by a written petition signed by at least one-third of the voting members of the Active Staff, may initiate a proposal to adopt, amend or repeal the bylaws, rules and regulations, policies, and amendments thereto. Such petition shall identify exact language to be added, changed or deleted to the bylaws, rules and regulations or policies. All voting members of the Active Staff will be notified as provided in Section 14.2 below, to consider the proposed change.

14.2 ACTION BY THE ACTIVE STAFF

If a proposal is initiated as provided above, the Chief of Staff shall inform the voting members of the active staff that the text of the proposed change can be obtained from the Medical Staff Service Department. Not less than 30 days, and not more than 90 days, from the date of such notice, the president shall call a special meeting of the medical staff to consider the proposed change.

To be adopted, a proposed change to the bylaws requires quorum of 75% of voting members with approval from two-thirds of the ballots cast. Ballots may be cast in person, by written ballot or by telephone. Telephone ballots must be with a voting member and employee of the Medical Staff Office.

14.3 APPROVAL

Upon approval by the active staff as provided above, the proposed bylaws change shall be submitted to the Board of Directors for approval. The Board of Directors shall give great weight to the active staff's proposed change. If no action on the proposed change is taken by the Board of Directors within 60 days, the proposed change shall be deemed to have been approved by the Board of Directors. The Board of Directors may not unreasonably withhold its approval from the active staff's recommended change. If the Board of Directors votes to disapprove any part of the recommended change, the Board of Director's Chair shall give the Chief of Staff written notice of the reasons for non-approval within ten business days from the Board of Director's action. At the request of the Medical Executive Committee, the Board of Director's disapproval shall be submitted to the Ad Hoc Dispute Mediation Committee for mediation as provided in Article X, Section 10.5-2(b).

14.4 TECHNICAL AND EDITORIAL AMENDMENTS

The Chair of the Bylaws Committee shall review and approve technical modifications or clarifications, reorganization or renumbering of the bylaws, or amendments made necessary because of punctuation, spelling, or other errors of grammar or expression, or inaccurate cross-references. Such amendments shall be effective immediately and shall be permanent if not disapproved by the medical staff or the board of directors within ninety (90) days after adoption by the medical executive committee.

14.4 EXCLUSIVITY

The Medical Staff and the Hospital bylaws shall be consistent. Neither the Medical Staff nor the Board of Directors may unilaterally amend the bylaws. The mechanisms described herein shall be the sole methods for the initiation, adoption, amendment, or repeal of the medical staff bylaws.

14.5 CONSTRUCTION OF TERMS AND HEADINGS

The captions or headings in these bylaws are for convenience only and are not intended to limit or define the scope of or affect any of the substantive provisions of these bylaws. These bylaws apply with equal force to both genders wherever either term is used.

ARTICLE XV ALLIED HEALTH PROFESSIONALS

15.1 DEFINITIONS

"ALLIED HEALTH PROFESSIONAL (AHP)" means a health care professional, other than a physician, dentist, podiatrist or clinical psychologist, who holds a license or other legal credential, as required by California law, to provide certain professional services.

Allied Health Professionals are neither employees of the hospital nor, pursuant to the terms of these bylaws, eligible for medical staff membership, but have been granted a service authorization to provide certain clinical services.

"SERVICE AUTHORIZATION" means the permission granted to an Allied Health Professional to provide specified patient care services within his or her qualifications and scope of practice.

15.2 QUALIFICATIONS

An Allied Health Professional who is neither an employee of the hospital nor eligible for medical staff membership is eligible for a service authorization in this hospital if he or she:

(a.) Holds a license, certificate or other legal credential in a category of AHPs which the board of directors has identified as eligible to apply for service authorizations (*see Section 15.4-1*); and

(b.) Documents his or her experience, background, training, current competence, judgment, and ability with sufficient adequacy to demonstrate that any patient treated by the practitioner will receive care of the generally recognized professional level of quality established by the medical staff; and

(c.) Is determined, on the basis of documented references: to adhere strictly to the lawful ethics of his or her profession, to work cooperatively with others in the hospital setting so as not to affect adversely patient care, and to be willing to commit to and regularly assist the medical staff in fulfilling its obligations related to patient care, within the areas of the practitioner's professional competence and credentials; and

(d.) Agrees to comply with all Medical staff Bylaws, Medical staff and protocols to the extent applicable to the AHP; and

(e.) Maintains professional liability insurance with a suitable insurer, with minimum limits as determined jointly by the medical executive committee and board of directors.

15.3 CATEGORIES OF ALLIED HEALTH PROFESSIONALS ELIGIBLE TO APPLY FOR SERVICE AUTHORIZATION

The categories of AHPs, based on occupation or profession, which shall be eligible to apply for service authorization in the hospital and the corresponding service authorization prerogatives, terms, and conditions for each such AHP category shall be designated by the Board of Directors, upon the recommendation of the Medical Executive Committee, and when approved by the Board of Directors, shall be set forth in the Medical Staff rules and regulations. Such actions by the Medical Executive Committee and the Board of Directors shall be based upon the recommendations of the relevant departments for the designation of categories of AHPs eligible to apply for service authorization and the delineation of corresponding service authorization prerogatives, terms and conditions for each AHP category. The Board of Directors shall review the designation of categories of AHPs eligible to apply for service authorizations at least annually and at other times, within its discretion or upon the recommendation of the Medical executive committee.

Current Categories of AHP are: Certified Nurse Midwife; Physician Assistant; Certified Nurse Anesthetist; Nurse Practitioners; Ph.D (psychologist non-licensed clinical) ; OD (optometrist)

15.4 PROCEDURE FOR GRANTING SERVICE AUTHORIZATION

15.4-1 (a.) An AHP whose scope of practice allows independent practice must apply and qualify for a service authorization and must designate a physician member of the active medical staff who, concurrently with the AHPs application, applies for and is granted privileges to be responsible, to the extent necessary, for the general medical condition of patients for whom the AHP proposes to render services in the hospital.

(b.) An AHP whose scope of practice allows independent practice must apply and qualify for a service authorization and must designate a physician member of the active medical staff who has applied for, and been granted specific privileges in accordance with the medical staff bylaws, rules and regulations, to supervise and direct the exercise of service authorizations by the same category of AHP as that of the applicant. An AHP under this section may apply to work under the supervision of one active medical staff member or, within the medical executive committee's discretion, a group of medical staff members so long as each of the medical staff members has separately applied for and been granted privileges to supervise the AHP or the category of AHPs to which the applicant belongs. Whenever an AHP will be supervised by more than one Active Staff member, such supervision must be in strict accordance with rules and regulations developed by the appropriate department and approved by the medical executive committee.

(c.) All AHP applications for initial granting and renewal of service authorizations shall be submitted to the Interdisciplinary Practice Committee. All such applications shall be processed in a parallel manner to that provided in Articles IV and V for Medical staff members, except that the Interdisciplinary Practice Committee shall perform the function which would otherwise be performed by the Credentials Committee, unless otherwise specified in the medical staff rules and regulations.

15.4-2 Except as is provided under Article VII, 7.2, an AHP who (1) has received a final adverse decision regarding his or her application for a service authorization, or (2) withdrew his or her application for a service authorization following an adverse recommendation by the

Medical executive committee, or (3) after having been granted a service authorization has received a final adverse decision resulting in termination of the authorization, or (4) has relinquished his or her service authorization following the issuance of a Medical staff or Board of directors recommendation adverse to his or her service authorization, shall not be eligible to re-apply for the service authorization affected by such decision or recommendation for a period of at least 24 months from the date that the adverse decision became final, the application was withdrawn, or the AHP relinquished his or her service authorization.

15.4-3 An AHP who does not have licensure or certification in an AHP category identified as eligible for service authorizations pursuant to Section 15.4-1, may not apply for a service authorization but may submit a written request to the President/CEO, asking the Board of directors to consider designating the appropriate category of AHPs as eligible to apply for service authorizations. Upon receipt of such a request, the Board of directors shall forward a copy of the request to the Medical executive committee for its recommendation, and shall also request the recommendation of any affected department or division. The Board of Directors shall consider such request and the Medical executive committee's recommendation, as well as the recommendation of any affected department or division, either before or at the time of its annual review of the categories of AHP, in accordance with Section 15-3.

15.4-4 Each AHP who is granted a service authorization shall be assigned to the medical staff department appropriate to his or her occupational or professional training and, unless otherwise specified in the medical staff rules and regulations, shall be subject to terms and conditions that parallel those specified in Article II - Membership, as they may logically apply to AHPs and may be appropriately tailored to the particular category of AHPs. Each AHP who practices independently must maintain communication with the relevant physician under Section IV. 4.1in order to enable the physician to assume responsibility, to the extent it is indicated, for the general medical condition of the patient. Each AHP who does not practice independently shall be subject to the supervision of one or more members of the active Medical staff who have been granted privileges to provide such supervision or direction by the Board of directors upon recommendation of the Medical executive committee.

15.5 PREROGATIVES

The prerogatives which may be extended to a member of a particular category of AHP shall be defined in the medical staff rules and regulations. Such prerogatives may include:

(a.) Provision of specified patient care services subject to a medical staff member responsibility, to the extent indicated, for the patient's general medical condition and under the general oversight of the medical staff, and, where the AHP does not practice independently, also under the supervision and direction of a member of the active medical staff who has been granted specific privileges to supervise that category of AHP. AHP services must be consistent with the service authorization granted to the AHP and within the scope of the AHPs licensure or certification.

(b.) Service on medical staff and hospital committees except as otherwise expressly provided in the medical staff bylaws, rules and regulations. An AHP may not serve as chair of medical staff committees.

(c.) Attendance at meetings of the department to which he or she is assigned. An AHP may not vote at department meetings.

15.6 RESPONSIBILITIES

Each Allied Health Professional shall:

(a) Meet those responsibilities required by the medical staff rules and regulations and if not so specified, meet those responsibilities specified in Section 2.6 as are generally applicable to the more limited practice of the AHP. AHP require physician supervision; The scope of a given AHP is limited by his/her supervising physician. Whatever medical specialty a physician practices limits the AHP's scope of practice.

(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.

(d.) Countersignature requirements –

i AHP – Countersignatures, dated and timed for all medical records of all patients cared for by the AHP within 14 days.

ii The medical record for which an eligible AHP issued a Schedule II drug order must be reviewed, countersigned, and dated by the supervising physician within seven (7) days.

(e.) Certified Registered Nurse Anesthetists (CRNA) do not require physician supervision or signature of documents.

15.7 TERMINATION, SUSPENSION OR RESTRICTION OF SERVICE AUTHORIZATIONS

15.7-1 GENERAL PROCEDURES

(a) At any time, the Chief of Staff or Chairman of the Department or Division to which the AHP has been assigned may recommend to the medical executive committee that an AHP's service authorization be terminated, suspended or restricted. After investigation (including, if appropriate, consultation with the Inter-disciplinary Practice Committee), if the Medical executive committee (MEC) agrees that corrective action is appropriate, the MEC shall recommend specific corrective action to the hospital's Board of directors. A notification letter regarding the recommendation shall be sent by certified mail to the subject AHP. The notification letter shall inform the AHP of the recommendation and the circumstances giving rise to the recommendation. Nothing in this Section shall prevent the chief of staff, chair of the department or designee to which the AHP has been assigned, or medical executive committee from imposing a summary suspension or restriction. In such case, except for actions involving clinical psychologists, the procedure in this Section shall be followed. In cases involving clinical psychologists (licensed), the procedure in Section 6.3 shall be followed.

(b) Nothing contained in the Medical staff Bylaws shall be interpreted to entitle an Allied Health Professional, except a clinical psychologist, to the procedural rights set forth in Articles VI and VII. However, an AHP shall have the right to challenge any recommendation which would constitute grounds for a hearing under Article 7.2 of the Bylaws (to the extent that such grounds are analogous to the Allied Health Professional) by filing a written grievance (i.e. a letter objecting to the recommended action and requesting an interview) with the Medical executive committee within fifteen (15) days of receipt of the Notification Letter. Upon receipt of a grievance, the Medical executive committee or its designee shall appoint an ad hoc committee composed of practitioners not previously involved in the recommendation or otherwise biased to afford the AHP an opportunity for an interview concerning the grievance. Although such interview shall not constitute a "hearing" as established by Article VII of the Bylaws, and need not be conducted according to the procedural rules applicable to such hearings, the purpose of the interview is to allow both the AHP and the party recommending the action the opportunity to discuss the situation and produce evidence in support of their respective positions. Minutes of the interview shall be retained.

(c) Within 30 days following the interview, the ad hoc committee, based on the interview and all other aspects of the investigation, shall make a final recommendation to the board of directors, which shall be communicated in writing, sent by certified mail, to the subject AHP, with a copy to the medical executive committee. The final recommendation shall discuss the circumstances giving rise to the recommendation and any pertinent information from the interview. Prior to acting on the matter, the board of directors shall offer the affected practitioner and the medical executive committee the right to appeal to the Board or a subcommittee thereof, under such terms as the board of directors may determine. The final decision by the board of directors shall become effective upon the date of its adoption. The AHP shall be provided promptly with notice of the final action, sent by certified mail, with a copy to the medical executive committee.

15.7-2 AUTOMATIC SUSPENSION, TERMINATION OR RESTRICTION

A. Notwithstanding Section 15.7-1 above, an AHPs service authorization shall automatically terminate in the event that:

1. The AHPs certification, license or other legal credential expires or is revoked.

2. With respect to an AHP who must practice under physician supervision:

(a) The Medical staff membership or privileges to supervise the AHP of the supervising physician is terminated, whether such termination is voluntary or involuntary; or

(b) The supervising physician no longer agrees to act in such capacity for any reason or the relationship between the AHP and the supervising physician is otherwise terminated, regardless of the reason therefore;

Where the AHPs service authorization is automatically terminated for reasons specified in (b) above, the AHP may apply for reinstatement as soon as the AHP has found another physician active Medical staff member who agrees to supervise the AHP and receives privileges to do so. In this case, the medical executive committee may, in its discretion, expedite the reapplication process.

B. Notwithstanding Section 15.7-1, above, in the event that the AHP's certification or license is restricted, suspended, or made the subject of an order of probation, the AHPs service authorization shall automatically be subject to the same restrictions, suspensions, or conditions of probation.

C. Where the AHPs privileges are automatically terminated, suspended, or restricted pursuant to this subsection, the notice and interview procedures under subsection 15.7-1. shall not apply, and the Allied Health Professional shall have no right to an interview except, within the discretion of the medical executive committee, regarding any factual dispute over whether or not the circumstances giving rise to the automatic termination, suspension, or restriction actually exist.

15.7-3 APPLICABILITY OF SECTION

The rights afforded by this section shall not apply to any decision regarding whether a category of AHP shall be eligible for a service authorization and the terms or conditions of such decision pursuant to Section 15.3 of this article.

15.8 REAPPLICATION

Initial and renewal service authorization approvals shall be for a period of up to two years. Each Allied Health Professional must reapply for a renewed service authorization in accordance with Section 15.4.

ADOPTED by the medical staff:

Approved by the Medical Executive Committee June 4, 2007; 05/04/09, 07/12/10; 12/2/13; 07/06/16; 09/12/16 and 04/06/22
Approved by the General Medical Staff October 23, 2007; 06/02/09, 09/13/10; 12/3/13; 08/23/16; 10/24/16 and 05/09/22
Approved by the Board of Directors November 27, 2007; 06/23/09, 07/27/10; 4/2/13; 1/28/14; 10/25/16 and 05/24/22